



LAW REFORM
COMMISSION/COIMISIÚN UM
ATHCHÓIRIÚ AN DLÍ

REPORT

CHILDREN AND THE LAW: MEDICAL TREATMENT

(LRC 103-2011)



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Law Reform Commission

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Full responsibility for this publication lies, however, with the Commission.

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INTRODUCTION

A Background to this Report

1. This Report forms part of the Commission's *Third Programme of Law Reform 2008-2014*¹ and follows the publication in 2009 of a *Consultation Paper on Children and the Law: Medical Treatment*.² The Consultation Paper made provisional recommendations for reform of the law concerning consent to, and refusal of, medical treatment involving persons under the age of 18. In the Consultation Paper and in this Report, the Commission uses the term "young person" to refer to 16 and 17 year olds; and the term "minor" to refer to persons under the age of 16.

2. Following the publication of the Consultation Paper, the Commission received a large number of submissions, which made clear the importance of this project and the sensitive nature of the issues it raised. While the submissions received expressed diverse views on the Commission's provisional recommendations, virtually all of them emphasised the need to clarify to the greatest extent possible the law, whether from the point of view of those under the age of 18, their parents and guardians,³ or health care professionals who provide for their medical treatment.

3. The Commission very much appreciates the great interest shown in this project, in particular through the large number of submissions received since the Consultation Paper was published, as well as through additional consultative meetings held with interested parties. These have greatly assisted the Commission in its deliberations leading to the preparation of this Report. Having taken into account the submissions received and the other elements of consultation mentioned, this Report therefore contains the Commission's final recommendations on this area, together with a draft *Health (Children and Consent to Health Care Treatment) Bill* to implement them.

¹ *Report on the Third Programme of Law Reform 2008-2014* (LRC 86-2007) Project 26.

² *Consultation Paper on Children and the Law: Medical Treatment* (LRC CP 59-2009). This is referred to as the Consultation Paper in the remainder of this Report.

³ The Commission, in its *Report on Legal Aspects of Family Relationships* (LRC 101-2010), recommended that the term "parental responsibility" should replace the term "guardianship" in connection with this aspect of family law. Pending the implementation of this recommendation, the Commission uses the term "guardianship" in the remainder of this Report.

4. The Commission notes that in 2009 it received the invaluable assistance of the Office of the Ombudsman for Children in arranging a Consultation Day with 15 to 18 year olds prior to the publication of the Consultation Paper. During this Consultation Day, the Commission heard the perspectives and voices of many young people. These views, which were summarised in the Consultation Paper, indicate that among the key issues to be considered in this context are: openness, the need for clear information on medical treatment (including information relevant to sexual relationships), and taking into account of the actual maturity of an individual, as well as his or her age. The Commission acknowledges the assistance provided by the Ombudsman for Children and her staff for organising the Consultation Day.

5. This project involves a continuation of the Commission's long-standing work on reform of the law concerning young persons and children. This has included the Commission's 1983 *Report on the Age of Majority*⁴ in which the Commission recommended that the general age of majority – the age at which a person is regarded as an adult for many purposes – should be reduced from 21 to 18. This was implemented in the *Age of Majority Act 1985*, and this change brought Ireland into line with other states in Europe, in North America and in Australia and New Zealand. The Commission emphasises that this current project does not involve a general review of whether the age of majority should be reduced but, as the detailed discussion in this Report indicates, the issue of medical treatment involving those under 18 has often featured in such general reviews and subsequent legislative changes.

6. Because this Report involves an examination of capacity to consent to, and to refuse, medical treatment, it also complements the Commission's more recent work on the law concerning mental capacity as it applies to those over 18 years of age. This work culminated in the Commission's 2006 *Report on Vulnerable Adults and the Law*,⁵ which contained a draft *Scheme of a Mental Capacity Bill*. The Report was based on a presumption of capacity for those over 18 years of age and a functional test of capacity, that is, a case-by-case test of capacity based on whether the person understands the nature and effect of the specific decision being made. The Commission's approach in the 2006 Report reflects recent international trends in this area, including the rights-based analysis found in the 2006 UN Convention on the Rights of Persons with Disabilities. The Commission is conscious that the Government is committed to publishing by the end of 2011 a *Mental Capacity Bill* that is consistent with the

⁴ (LRC 5-1983).

⁵ (LRC 83-2006).

2006 UN Convention.⁶ The Commission's work in this area also includes the 2009 *Report on Bioethics: Advance Care Directives*,⁷ in which the Commission reiterated the discussion in the 2006 Report that highlighted the movement towards the view that patients have the right to make informed decisions about their treatment.⁸ As stated in the 2006 and 2009 Reports, this involves a significant shift from a paternalistic approach – that decisions about healthcare options and treatment are primarily for health care professionals – towards the view that the patient must be actively engaged in a process that leads to informed decision making about his or her care and treatment options, including in the specific context of making an advance care directive.⁹ The Commission reiterates the importance of these developments in the current Report.

7. This Report also reflects some of the analysis on the rights of children, and their parents and guardians, discussed in detail in the Commission's 2010 *Report on Legal Aspects of Family Relationships*.¹⁰ In that Report, the Commission emphasised the importance of the voice of the child, as well as reflecting the weight to be given to the decision-making responsibility of those having parental responsibility for a child. These themes are also reflected in this Report.

8. The Commission is conscious that this Report is being published at a time when the rights of children, which currently includes all those under 18 years of age, are subject to wide-ranging debate in Ireland. This has involved at least two very different, but intersecting, matters. First, how the law should respond to the reports published since 2005 into the widespread abuse of children in the State, including abuse in institutional settings and clerical child sexual abuse, which had occurred during the second half of the 20th Century and into the first decade of the 21st Century.¹¹ Second, whether the rights of

⁶ The *Programme for Government 2011-2016* (March 2011), at 38, available at www.taoiseach.ie, contains a commitment to "introduce a Mental Capacity Bill that is in line with the UN Convention on the Rights of Persons with Disabilities." The *Government Legislation Programme, Summer Session 2011* (April 2011), available at www.taoiseach.ie, states that the *Mental Capacity Bill* is scheduled for publication in late 2011.

⁷ (LRC 94-2009).

⁸ (LRC 94-2009) at paragraph 1.08.

⁹ *Ibid.*

¹⁰ (LRC 101-2010).

¹¹ See, for example, the *Ferns Inquiry Report* (Government Publications, 2005), *Report of the Commission to Inquire into Child Abuse* (2009) (available at www.childabusecommission.com), *Dublin Archdiocese Commission of*

children should be given explicit recognition in the Constitution, arising from inquiries into vulnerable children and into the operation of the law concerning sexual offences involving, in particular, adolescents and young adults.¹² In the wake of these matters, for example, revised *2011 Children First: National Guidelines for the Protection and Welfare of Children* were published by the Minister for Children and Youth Affairs in July 2011.¹³ The Commission is aware that these matters – including the nature of any constitutional amendment to underpin more clearly the rights of children, whether the current age of consent in the criminal law of sexual offences should be reduced from 17 to 16 and also whether the voting age should be reduced from 18 to 16 – remain under active consideration as this Report is published. The Commission therefore emphasises that this Report does not deal with these wider matters, other than where they provide relevant analysis of the respective rights of children and their parents and guardians, and of the interests of the State, in the context of the scope of this Report.

B Scope of Report and Relevant Roles and Interests

9. The Commission considers that it is important to describe the scope of the Report, including what it does and does not address. The Report involves an examination and discussion of the law concerning medical treatment and health care as it applies to children and young people who are under 18 years of age. The Commission emphasises that this involves a wide range of health-related issues concerning persons under 18 years of age, including: dental care and treatment; over-the-counter medicines of specific relevance to adolescents, such as products related to skin conditions; prescriptions for antibiotics or contraceptives; counselling and treatment concerning mental health; an X ray;

Investigation Report (2009) (available at www.dacoi.ie) and *Report by Commission of Investigation into Catholic Diocese of Cloyne* (December 2010, published July 2011) (available at www.justice.ie).

¹² See, for example, *Report of the Kilkenny Incest Investigation* (Government Publications, 1993) and *Third Report of Joint Committee on the Constitutional Amendment on Children* (2010) (available at www.oireachtas.ie).

¹³ The Minister for Children and Youth Affairs also indicated that these would be placed on a statutory footing: see *The Irish Times* 16 July 2011. The Minister for Justice and Equality also published in July 2011 the *Scheme of a Criminal Justice (Withholding Information on Crimes against Children and Vulnerable Adults) Bill 2011* (available at www.justice.ie) which would, if enacted, require reporting of allegations of child sexual abuse.

treatment related to a soft tissue sports injury or broken arm; and surgery and treatment connected to cancer or a chronic condition such as cystic fibrosis.¹⁴

10. The Commission underlines, therefore, that this Report is not restricted to a narrow issue such as contraception, although the Commission acknowledges that this is a matter on which a good deal of media and public attention is likely to be focused. The Commission also notes that the Report does *not* deal with many of the wider policy issues with which this area is connected, such as the policies in place to deal with teenage pregnancy, reform of the law concerning the *availability* of contraception or whether health-related matters such as access to sunbeds by those under 18 should be regulated. Similarly, although the Commission recommends in this Report that persons under the age of 18 may be regarded as being capable of consenting to, or refusing, medical treatment, the proposals made do not involve a general reduction in the age of majority.

11. In approaching the preparation of this Report, the Commission was conscious that it must reflect the rights, roles and interests of children, parents and guardians, healthcare professionals and the State. In this respect, the Commission is conscious of the rights of children under the Constitution and under international human rights standards. Equally, the Constitution and international human rights standards recognise that parents have an integral role to play concerning their children, including in the context of medical treatment and health care received by them. Moreover, parents are generally well placed to safeguard the health and wellbeing of their children. As the relevant literature, health care practice and international human rights standards of recent years indicate, of course, parents must carry out their responsibilities in a manner that respects the evolving capacities of their child as they approach and reach adulthood. Parents and health and social care professionals have a responsibility to act in the best interests of those under 18 and to care for them in a manner that respects their dignity and wellbeing. Both parents and healthcare practitioners have a responsibility to adjust the levels of direction and support offered to a child, gradually enabling children to participate more in the realisation of their rights.

12. The Commission is also conscious that the State is required by the Constitution and under international human rights standards to ensure the protection and welfare of the child in general. Under the Constitution, and under specific legislation such as the *Child Care Act 1991*, carefully-judged intervention to protect children may be required where a child's parents have failed in their duty to the child. The State, through the courts, has also been required to intervene where children are in immediately life-threatening

¹⁴ See the examples given in paragraph 1.37, below.

situations. Under the Constitution, the courts have an inherent jurisdiction to act to vindicate the rights of, and to protect, vulnerable persons. Prior to the coming into force of the Constitution in 1937, this was referred to as the *parens patriae* jurisdiction of the courts, which clearly indicated a paternalistic approach; but under the Constitution, any such intervention would occur to vindicate and protect the rights of children.¹⁵ Thus, the Commission notes that, in one form or another, such necessary intervention remains a feature of the relevant law in Ireland – and also in the law of other States discussed in this Report.

13. Mason & McCall Smith refer to the triangular relationship of medicine, society and the law:

“The general rules of doctoring are being developed within a moral framework which is constantly being restructured by contemporary society while, at the same time, doctors frequently find themselves operating in an atmosphere of legal uncertainty.”¹⁶

14. The New South Wales Law Reform Commission also captured the complexity of such questions:

“This is an area where there are no easy answers about who should have a say and who should not... The law is a blunt instrument to have to deal with these sorts of considerations, and the formulation of an appropriate legislative framework to fall back on in these situations is particularly challenging. Any attempt at devising such a framework should acknowledge from the start the moral and emotional dimensions of this area of law, and its controversial nature which is susceptible to provoking at times, heated debate.”¹⁷

15. Ideally, through informed discussion and participation by all those involved – children, parents, guardians and health care professionals – practical

¹⁵ In *North Western Health Board v HW and CW* [2001] IESC 90, [2001] 3 IR 622 (discussed in paragraph 1.16, below), the Supreme Court reaffirmed that the pre-constitutional *parens patriae* jurisdiction concerning children had, in effect, been subsumed under the courts’ inherent jurisdiction under the Constitution to vindicate and protect rights where necessary. In that case, the Supreme Court declined to intervene to override the refusal of parents to give their consent to allow doctors to carry out the “heel prick” PKU blood test on their baby boy, because it was not clearly evident that the refusal threatened his life or immediate health.

¹⁶ Mason & McCall Smith *Law and Medical Ethics* (2006) at 23.

¹⁷ New South Wales Law Reform Commission, *Young People and Consent to Health Care* Report 119 (2008), at 31.

solutions and consensus can be reached that respect the rights and interests of all parties. When this is not possible, however, it is important to have in place a clear statutory framework that contains general principles. Nonetheless, given the complexities of the issues raised, it would not be possible to draft legislation that could provide definitive solutions to all the moral, ethical and public policy questions involved. For this reason, and reflecting the approach taken in most other countries, the Commission has taken the view in this Report that, on a number of specific matters, a statutory Code of Practice, based on the principles in the draft *Health (Children and Consent to Medical Treatment) Bill* attached to the Report, should provide detailed guidance as to how specific scenarios would be worked out in practice.

16. The Commission now turns to provide a brief overview of the Report.

C Outline and Overview of this Report

17. In Chapter 1, the Commission discusses the general literature on child and early adulthood development, which reflects the reality that individuals mature in a gradual manner from infancy to adulthood and that this is also affected by their particular environment. This literature has influenced the development of the law concerning children and young adults, both nationally and internationally, with the result that some laws refer to a specific age as the basis for determining the legal competence or liability of a person under 18, while others focus on the maturity of the person. These laws often include the need to have regard to the continuing role of parents or guardians, and the need to ensure that the welfare of children is a paramount factor. The Commission then sets out the principles that flow from the literature, and from the relevant constitutional and international human rights instruments in this area. These principles (which require respect for the rights of children and of their parents/guardians, having regard to the need to ensure that the best interests of the child are a primary consideration) form the basis for the Commission's detailed analysis in this Report. The Commission then discusses in Chapter 1 the broad scope of health care and medical treatment covered in the Report, the voice of the child in the health care setting and the nature and extent of confidentiality.

18. In Chapter 2, the Commission discusses the detailed aspects of consent to, and refusal of, healthcare treatment by individuals under the age of 18, having regard to the general principles set out in Chapter 1. The Commission discusses decision-making by young persons, that is, 16 and 17 year olds, and, separately, minors, that is, those under the age of 16. In Chapter 2, the Commission begins by discussing the current legal position in Ireland, including the effect of section 23 of the *Non-Fatal Offences Against the Person Act 1997* which provides, in the context of criminal law, that consent to medical

treatment by a 16 and 17 year old has the same status as if he or she was an 18 year old. The Commission also discusses the position in Irish case law of those under 16, which reflects the general literature as well as legal developments in other countries concerning mature minors. The Commission then discusses in detail statutory provisions and case law concerning health care involving those under 18 in a number of countries, in particular, England and Wales, Northern Ireland, Scotland, Canada, Australia and New Zealand. The Commission concludes Chapter 2 by setting out its recommendations concerning consent to and refusal of treatment for those under 18. The Commission's approach is that this should be as consistent as possible with the proposed reform of the law on mental capacity for those over 18, and the Commission therefore favours a functional test of capacity. The Commission sets out its recommendations concerning 16 and 17 year olds, and then sets out separately its recommendations for those under 16.

19. In Chapter 3, the Commission discusses issues of capacity and healthcare decision-making involving children and young people who engage with mental health services. The Commission notes that the general principles and detailed recommendations set out in Chapters 1 and 2 also apply in the context of mental health provision. In Chapter 3, the Commission's discussion does not deal with mental health law in general, but focuses primarily on the admissions process under the *Mental Health Act 2001*. The Chapter contains a brief overview of the extent of mental health issues involving children and young people in Ireland and the appropriateness of available services. The Commission then examines the rights of children and young people in the context of mental health legislation and service provision, followed by a discussion of the provisions of the *Mental Health Act 2001* as they relate to children and young people, including its shortcomings in this respect. The Commission then sets out recommendations for reform of the *Mental Health Act 2001* as it applies to children and young people, which includes recommending the introduction of a new category of "intermediate" admission and treatment.

20. Chapter 4 is a summary of the Commission's recommendations in the Report.

21. Appendix A contains a draft *Health (Children and Consent to Health Care Treatment) Bill* to implement the general recommendations for reform made in the Report.

22. Appendix B contains an *Outline Scheme of a Mental Health (Amendment) Bill* to implement the recommendations in Chapter 3 for reform of the *Mental Health Act 2001* as it applies to persons under 18.

CHAPTER 1 CHILD AND EARLY ADULTHOOD DEVELOPMENT AND GENERAL LEGAL PRINCIPLES

A Introduction

1.01 In this Chapter, the Commission begins in Part B with a brief discussion of the general literature on child and early adulthood development, which reflects the reality that individuals mature in a gradual manner from infancy to adulthood and that this is also affected by their particular environment. This literature has influenced the development of the law concerning children and young adults, both nationally and internationally, with the result that some laws refer to a specific age as the basis for determining the legal competence or liability of a person under 18, while others focus on the maturity of the person. These laws often include the need to have regard to the continuing role of parents or guardians, and the need to ensure that the welfare of children is a primary consideration. In Part C, the Commission then sets out the principles that flow from the literature, and from the relevant constitutional and international human rights instruments in this area. These principles (which require respect for the rights of children and of their parents/guardians, having regard to the need to ensure that the best interests of the child are a primary consideration) form the basis for the Commission's detailed analysis in this Report. In Part D, the Commission discusses the broad scope of medical treatment covered in the Report. In Part E the Commission discusses the voice of the child in the health care setting and in Part F the Commission discusses the nature and extent of confidentiality.

B Gradual Maturing From Childhood to Adulthood and Influence on the Law

1.02 In this Part, the Commission briefly surveys the general international literature on childhood and early adulthood development,¹ which is

¹ Much of the recent international literature is summarised in Lansdown, *The Evolving Capacities of the Child* (UNICEF Innocenti Research Centre, 2005). See also Fortin, *Children's Rights and the Developing Law* 3rd ed (Cambridge University Press, 2009).

also mirrored in comparable material in Ireland.² The literature emphasises that there is no universal definition of childhood, and that the concept varies according to the societal setting in which it is discussed. An accurate description of the concept of “childhood” must, therefore, include not merely a biological aspect but also a social element. Thus, the reality that individuals mature in a gradual manner from infancy to adulthood must take account of the particular society in which they grow up. The biological development of children to puberty is, largely, dependent on the general standard of nutrition in a society. In developed countries such as Ireland, children now reach puberty earlier by comparison with previous Irish generations and also by comparison with children in some contemporary developing countries. The general literature also notes that some societies differentiate between the approach taken to male and female children, but in Ireland (at least in recent decades) male and female children are treated equally.

1.03 Conversely, while children in Ireland are developing biologically to puberty at an earlier age, their exposure to some aspects of the adult world, notably the paid work environment, has increasingly been postponed to a later age. Developed countries and economies require a workforce that is highly educated, communicative and independent, which means that more children and young people will remain in education for extended periods. By contrast, in developing countries many very young children continue to join the labour market at an early age. For young people in developed countries such as Ireland, postponing participation in the paid workforce may lead, at some levels and relatively speaking, to reduced responsibility and a greater degree of dependency (or even risk-taking, as in the case of “boy racers”), whereas their contemporaries in developing countries, who are actively engaged in paid (and domestic) work, may have taken on, again at certain levels, relatively high levels of responsibility.

1.04 It is also important to note, of course, that exposure of very young children to the labour market does not indicate that, in those countries, the child was asked for their views and willingly participated after a mature, informed,

² See Greene, “Children as Social Actors”, paper delivered at Irish Human Rights Commission and Law Society of Ireland Conference on *Achieving Rights-Based Child Law* (14 October 2006), available at www.ihrc.ie, and Shannon, *Fourth Report of the Special Rapporteur on Child Protection: A Report Submitted to the Oireachtas* (December 2010), available at www.dohc.ie. In the specific context of this Report, see Logan, “The Rights of Children in Healthcare: the Views of the Ombudsman for Children” (2008) 14, 2 MLJI 66 and McMahon *et al*, “The Prescribing of Contraception and Emergency Contraception to Girls Aged Less than 16 – What are the Views and Beliefs of GPs and of Parents?” (2010) 16, 2 MLJI 91.

reflective analysis; still less that there was any informed assessment by their parents or guardians that this was in their best interests. Equally, the earlier onset of puberty in developed countries such as Ireland may lead to earlier engagement with another aspect of the adult world, the development of personal and intimate relationships – and related issues of sexualisation. As with early participation in the labour market, the fact of earlier engagement in personal and intimate relationships – and sexualisation – does not, as such, indicate that the young people involved have willingly participated after a mature, informed, reflective analysis, or that they have developed a level of maturity that matches their activities.

1.05 The Commission also discusses in this Part how the literature on childhood and early adulthood development has influenced the law in Ireland. In this respect, the Commission notes that society (including the relevant legal framework) has a responsibility to support children's rights as they develop, must involve them in decision-making and at the same time provide appropriate protection bearing in mind their level of maturity (including immaturity).

(1) *Stages of development from infancy to adulthood*

1.06 The most significant international human rights instrument in this area, the 1989 UN Convention on the Rights of the Child (UNCRC), defines a child as a person under the age of 18. This reflects the position in Ireland, where the view that adulthood begins generally at 18 is reflected in the Constitution which sets the voting age at 18 (since 1972, when by referendum the voting age was reduced from 21), in the *Age of Majority Act 1985* which specifies 18 as the age at which a person reaches adulthood for the purposes of commercial contracts and others aspects of civil liability (again reducing it from 21), and in the *Family Law Act 1995* which provides that a person must be 18 to marry (in this instance, raising it from the previous age of 16). This also reflects the general position in many developed countries where 18 is currently marked as the boundary between childhood, or minority, and adulthood, majority.

1.07 As to the development of those under 18, and bearing in mind the difficulty in drawing clear lines in this area, the literature on childhood and early adulthood development refers to various stages including infancy, early childhood, puberty, adolescence and adulthood. Since individuals reach these stages at different times, and since childhood is nowadays accurately described as involving not only a biological aspect but also a social aspect, the literature also contains various "age bands" rather than specific ages which broadly correspond to these stages of development. In general terms, therefore, these can be described in this way:

Infancy: this usually refers to the first year of a child's life, though sometimes it is also taken to include up to 3 years of age ("toddler").³

Early childhood: generally refers to age 3 to 10 or 11, often coinciding in developed countries with primary level schooling.

Pre-adolescence: approximately age 10 to 12.

Puberty: the age at which the human body becomes capable of reproduction. For girls, this usually begins at about 10 or 11, while for boys it begins at 12 or 13. Girls usually complete puberty by 15 to 17, while boys do so at 16 to 18.

Adolescence: generally taken to coincide with the teenage years from 13 to 19. It also often coincided with puberty, but pre-adolescent puberty is, in many countries, now more common because of improved living conditions and better nutrition. "Early adolescence" is generally taken to run from about 13 to 15. The end of adolescence, at 18 or 19, marks the beginning of adulthood in biological terms.

(2) Development of decision-making capacity from infancy to adulthood

1.08 In parallel with the physical and reproductive development of children and young persons, the literature also focuses on the development of decision-making capacity of human beings through these ages. Again, in broad terms, these can be described in this way:⁴

Infants to pre-adolescents: up to age 12. Children up to 3 years are not able to understand the perspective of others, and lack any significant decision-making capacity. From age 3 to 11, children are increasingly able to recognise that people have different perspectives, and gradually acquire the ability to see another's point of view. By age 11, children begin to be able to understand a third-person perspective and appreciate that people may have mixed feelings about something. Children up to about 12 are, broadly, focused on the immediate, and do

³ In law, the word "infant" has often meant a person up to 18 years of age, as was the case in the *Guardianship of Infants Act 1964* as originally enacted. Section 12 of the *Children Act 1997* provides that any reference in the 1964 Act to "infant" should be read as "child". In its 2010 *Report on Legal Aspects of Family Relationships* (LRC 101-2010), the Commission has recommended that the 1964 Act be replaced by a *Child and Parental Responsibility Act*, a draft Bill for which was appended to the Report.

⁴ See the literature summarised in Lansdown, *The Evolving Capacities of the Child* (UNICEF Innocenti Research Centre, 2005) at 23ff.

not have, in general terms, the ability to distinguish between the actual and the possible. They do not, therefore, tend to be able to test hypotheses and plan for the future or to be able to be introspective and make judgements. The majority of those under 12 do not, therefore, generally have the cognitive ability or judgement skills to make major decisions that could affect their lives.

Pre-adolescents and early adolescents: age 12 to 15. In general, typical 12 and 13 year olds may believe that a problem has only one solution, and that acts or solutions are either right or wrong. By 14 and 15, there is a considerable growth in the ability to make critical and pragmatic decisions and choices and the development of moral reasoning. Many in this age group can, therefore, test hypotheses, plan for the future and have the cognitive ability or judgement skills to make major decisions that could affect their lives. Others may, however, find it difficult to imagine risks and consequences of decisions and to recognise the vested interests of others, and this may be associated with the loss of brain tissue in those areas of the brain controlling impulses, risk-taking and self-control. .

*Adolescents: 16 and 17 year olds.*⁵ By this age, most adolescents are capable of quite sophisticated decision-making. This does not mean that their judgement is well-informed or mature, and risk-taking is still a characteristic of decision-making at this age. This in turn may lead to behaviour which is dangerous for the young person or society. Equally, many 16 and 17 year olds make more mature decisions by comparison with those over 18.

1.09 The Commission notes that the literature on childhood and early adulthood development does not suggest that policy, or laws, concerning children should be divided into these three broad age bands, in which children under 12 are “presumed to lack capacity”, those between 12 and 15 “presumed to have some capacity” and those aged 16 and 17 “presumed mostly to have capacity.” The literature emphasises, indeed, that children, just like adults, demonstrate differing levels of competence in different contexts. The Commission now turns to a brief overview of this aspect of the literature.

⁵ While adolescence stretches past 17, the Commission is particularly concerned with the capacity of 16 and 17 year olds because the age of majority in Ireland is (since the enactment of the *Age of Majority Act 1985*) already 18, so that 18 and 19 year olds are already deemed legally competent for most important decisions, including healthcare decisions.

(3) *The influence of context in the development of decision-making capacity in those under 18*

1.10 Studies have indicated, for example, that a child's place within a family, such as whether they have older or younger siblings, is likely to impact on capacity and levels of assumed responsibility. The level of support and encouragement that a child is given also has a significant impact on competence. Equally, the exposure of children to specific, and unusual, situations can greatly influence their competence in decision-making.

1.11 In the specific context of this Report, an English 1993 study⁶ on children's capacity to consent to surgery indicates that children as young as 8 years old who have experienced extensive levels of medical treatment can acquire the ability not only to understand their condition and propose treatments, but also to make wise decisions, often involving life or death implications. Children's levels of understanding were developed according to their individual experience, coupled with the levels of expectation and support available to them. Extremely young children who had experienced high levels of medical intervention often had the capacity to make painful and difficult decisions. It is clear, therefore, that a person under 18 with, for example, cystic fibrosis is likely to have developed a greater level of maturity and decision-making capacity in connection with their healthcare treatment than a similarly-aged person who has not had a similar level of interaction with healthcare professionals. This approach emphasises, therefore, the need to avoid an exclusive focus on age.⁷

1.12 The literature also indicates that particular difficulties arise in the context of adolescence, a period of significant life change, characterised by rapid physical development, sexual maturation and growing social expectations. While adolescents in developed countries are better-educated, better informed and healthier than ever before, this has the disadvantage that in a rapidly-changing and globalised world, they are exposed to many influences from the adult world at a vulnerable time in their development. While society must ensure a rights-based approach to children as they make decisions and develop towards adulthood, it is also recognised that adolescents will need some level of protection and help in personal decision-making, decisions that directly affect children's own lives but which they may lack the experience or knowledge to

⁶ Alderson, *Children's Consent to Surgery*, (Open University Press, 1993), cited in Lansdown, *The Evolving Capacities of the Child* (UNICEF Innocenti Research Centre, 2005), at 25.

⁷ Greene, "Children as Social Actors", paper delivered at Irish Human Rights Commission and Law Society of Ireland Conference on *Achieving Rights-Based Child Law* (14 October 2006), available at www.ihrc.ie.

make in their own best interests.⁸ Ultimately, the literature indicates that respect for children’s evolving capacity to take responsibility for decision-making must be balanced against their relative lack of experience, the risks encountered, and the potential for exploitation and abuse.

(4) Influence on the law

1.13 This general overview of the literature on the stages of development from infancy to early adulthood indicates that, at various points, in particular through the teenage years, children and young people develop increasingly sophisticated cognitive capacity and related decision-making judgement. The Commission notes that, not surprisingly, this reality has had a major influence on the development of the law in this area.

1.14 For the purposes of this Report, the two major issues are: firstly, when does a “child” or “young person” become an “adult” and, second, to what extent can a “child” or “young person” be deemed capable, or competent, to make decisions either together with, or independently from, their parents or guardians.

1.15 As to when a “child” or “young person” becomes an “adult,” there has been general agreement that a defined age should mark that break. In medieval times, when the ability to hold a sword was important that age was set at 21, and for many “Western” countries such as Ireland this persisted as the “age of majority” until well into the 20th Century. In the second half of the 20th Century, most countries reviewed the age of majority downwards, largely because people matured earlier due to improved living conditions and better nutrition with the resulting consequence that there was more active participation in society by 18 to 21 year olds. In the second half of the 20th Century, many people between 18 and 20 were unable to obtain loans without a guarantee from their parents or guardians, and so commercial organisations were among those who argued for a reduction in the age of majority from 21 to 18.⁹ As a result, many states reduced the age of majority from 21 to 18, as happened in

⁸ In addition to this category of personal decision-making, three other categories requiring a protective approach have been noted: protection from physical and emotional harm, protection from harmful social or economic factors and protection from exploitation and abuse: see Lansdown, *The Evolving Capacities of the Child* (UNICEF Innocenti Research Centre, 2005), at 33.

⁹ See, for example, the discussion in the Commission’s *Report on the Age of Majority, the Age for Marriage and Some Connected Subjects* (LRC 5-1983).

Ireland under the *Age of Majority Act 1985*.¹⁰ As already mentioned, this also reflects the recognition at international level, in the 1989 UN Convention on the Rights of the Child (UNCRC), that adulthood begins at 18 and that childhood runs to 18.

1.16 As to whether a “child” or “young person” can be regarded as competent to make decisions either together with, or independently from, their parents or guardians, the law could, broadly, be described as mirroring the general literature and the understanding of how individuals mature over time. Thus, in respect of very young children, the law has long held the general view that parents and guardians must always be primarily accountable and responsible for their safety and welfare. Consequently, parents and guardians take the major decisions on behalf of their very young children, and this remains a key aspect of the law in this area in most countries, including Ireland. This means that, in general, a decision by parents or guardians concerning their very young children will be upheld even if this is in conflict with the views of professional persons. For example, in *North Western Health Board v HW and CW*¹¹ the Supreme Court upheld the refusal of parents to allow doctors to carry out the “heel prick” PKU blood test on their baby son, even though the Court acknowledged that most parents are happy to consent to this test. In accordance with Articles 41 and 42 of the Constitution (which as discussed below reflect international human rights instruments on the primacy of parental decision-making in this context), their decision as parents would only be overturned if the decision would threaten the life or urgent health needs of the very young child.

1.17 As a child matures through pre-adolescence and adolescence, the role of the parent and guardian might lessen to one degree or another, so that the child’s decision-making should be given some degree of recognition. Reflecting the general literature that different children mature differently, there has also been a general reluctance to specify a definite age under the age of adulthood (whether this has been set at 18 or 16) at which a child should be regarded as being competent or accountable for their decision-making. Instead, in some instances some quite young ages have been specified as thresholds for specific purposes, whereas a more general “maturity” or “understanding” test, without reference to a specific age, has been used for other purposes.

¹⁰ The 1985 Act implemented the main recommendations in the Commission’s 1983 *Report on the Age of Majority, the Age for Marriage and Some Connected Subjects* (LRC 5-1983).

¹¹ [2001] IESC 90, [2001] 3 IR 622.

1.18 Thus, the age of criminal responsibility in Ireland is based on a generally applicable age threshold of 12,¹² which broadly corresponds with the beginning of adolescence and the type of understanding and insight that goes with that, as discussed above. Setting a specific age of responsibility, rather than legislating for a general “maturity” test, reflects the perceived importance of certainty in the context of the application of the criminal law. Equally, and reflecting the specific needs of those aged 12 to 17, the Irish criminal process also provides for different arrangements for dealing with breaches of the criminal law, including more concerted efforts to avoid the full rigours of the criminal process.¹³

1.19 By contrast with this age-specific limit of 12 years, section 24(b) of the *Child Care Act 1991* provides that, in child care proceedings, a court must “in so far as is practicable, give due consideration, having regard to his age and understanding, to the wishes of the child.” Similarly, section 24(2) of the *Adoption Act 2010* provides that, where a child over 7 years of age is considered for adoption, the Adoption Authority must give due consideration to the wishes of the child “having regard to his or her age and understanding.” Authoritative case law in Ireland has taken the same approach. In *McK v Information Commissioner*,¹⁴ the Supreme Court recognised, in the context of a health care setting, that the views of a 17 year old young person “are very relevant”¹⁵ and may also override the general presumed entitlement of a parent to health information about their children.

1.20 The approach taken in the *Child Care Act 1991 and the Adoption Act 2010*, and by the Supreme Court in *McK v Information Commissioner*, reflects the literature discussed above, as well as relevant international legal standards concerning children, notably set out in the 1989 UN Convention on the Rights of the Child (UNCRC). Article 5 of the UNCRC provides that the

¹² See section 52 of the *Children Act 2001*, as amended by section 129 of the *Criminal Justice Act 2006*. The general age of criminal responsibility is set at 12, though it is 10 for murder, rape and aggravated sexual assault. This lower age, which attracted criticism during the Oireachtas debate on the 2006 Act, appears to have been influenced by the highly-publicised murder in 1993 of a 2-year-old English boy Jamie Bulger by two children, Robert Thompson and Jon Venables, who were both 10 at the time.

¹³ Thus, the *Children Act 2001*, as amended, provides for various interventions to divert young offenders from the usual court-based consequences of breaches of the criminal code.

¹⁴ [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260.

¹⁵ [2006] 1 IR 260, at 268. The case is discussed at paragraph 1.65, below.

State must respect the rights and responsibilities of parents, or other caregivers, to provide “appropriate direction and guidance in the exercise by the child of their rights in a manner consistent with the evolving capacities of the child.” Article 5 thus reflects the view that parental rights and responsibilities must also take account of the “evolving capacities of the child.” This is also linked with Article 18 of the UNCRC, which states that “the best interests of children will be [the] basic concern” of all those involved in ensuring the effective implementation of the rights of children.

C Guiding Principles for this Report

1.21 The Commission now turns to set out the guiding principles it has used in preparing this Report. The Commission considers that it would be useful to include these general principles in the draft *Health (Children and Consent to Medical Treatment) Bill* attached to the Report. This is consistent with the Commission’s approach in the 2006 *Report on Vulnerable Adults and the Law*,¹⁶ which inserted a list of guiding principles in the draft Scheme of a *Mental Capacity Bill* attached to that Report. This approach has also been used in existing legislation in this area, such as the *Guardianship of Infants Act 1964*, the *Child Care Act 1991* and the *Adoption Act 2010*, each of which set out general principles concerning the paramount importance of the welfare of the child and also the need to take account of the views of the child.¹⁷

(1) The Constitution and international standards concerning parental responsibility and the rights of children

1.22 Reflecting the literature already discussed, Irish law has long recognised in a number of areas a gradual transition from complete dependency in childhood to independence at adulthood at 18 (or, before the *Age of Majority Act 1985*, at 21).¹⁸ Since the coming into force of the Constitution of Ireland in 1937 and the advent of a rights-based analysis to this area, a similar approach has been taken. Article 41.1.1^o of the Constitution provides that:

“The State recognises the Family as the natural primary and fundamental unit group of society.”

¹⁶ (LRC 83-2006).

¹⁷ See section 3 of the *Guardianship of Infants Act 1964*, section 24 of the *Child Care Act 1991* and section 24(2) of the *Adoption Act 2010*, discussed below.

¹⁸ See the discussion in Chapter 2 of the various ages below 18 at which persons are deemed competent for specific purposes.

1.23 Article 41.1.1^o is sometimes regarded as an unusually strong recognition of the importance of the family unit, but it is virtually identical to Article 16.3 of the 1948 UN Universal Declaration of Human Rights, which states:

“The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.”

1.24 Given that the 1948 UN Declaration was approved 11 years after the 1937 Constitution, it is clear that Article 41.1.1^o cannot be described simply as reflecting a 1930s view of the family, still less the view of a particular religious perspective.¹⁹ Indeed, since the second half of the 20th Century the relevant international instruments have continued to support this approach to the family. Thus, Article 23.1 of the 1966 UN International Covenant on Civil and Political Rights (ICCPR) involves a remarkable reflection of the text of Article 41.1.1^o and provides:

“The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.”

1.25 Similarly, the Preamble to the 1989 UN Convention on the Rights of the Child (UNCRC) reiterates that the family is “the fundamental group of society.” The 1966 and 1989 UN Conventions thus underline that Article 41.1.1^o reflects a contemporary view at international level of the fundamental importance of the family unit. It is not surprising, therefore, that this approach is reflected not only in Article 41 of the Constitution of Ireland but also in the law of other states, such as Germany and Australia.²⁰ For example, section 43(1)(b) of the Australian (federal) *Family Law Act 1975* states that, in family law proceedings, Australian courts must have regard to “the need to give the widest possible protection and assistance to the family as the natural and fundamental group unit of society.” The Australian 1975 Act was clearly intended to codify Article 23.1 of the 1966 ICCPR.²¹

¹⁹ See the discussion in the following: Hogan and Whyte (eds) *Kelly: The Irish Constitution* 4th ed (LexisNexis, 2003), paragraph 7.6.01, fn 1; Hogan, “DeValera, the Constitution and the historians” (2005) 40 *Irish Jurist* 293; and Gallagher, “The Irish Constitution – Its Unique Nature and the Relevance of International Jurisprudence” (2010) 45 *Irish Jurist* 22.

²⁰ Hogan and Whyte (eds) *Kelly: The Irish Constitution* 4th ed (LexisNexis, 2003), paragraph 7.6.01, fn 2, citing Article 6 of the 1949 German *Grundgesetz* (the German Basic Law, in effect its Constitution) and section 43(1)(b) of the Australian (federal) *Family Law Act 1975*.

²¹ See, for example, Australian Law Reform Commission, *Family Violence – A National Legal Response* (ALRC Report 114, 2010) paragraph 4.42, referring to

1.26 Article 42.1 of the Constitution reinforces the statement in Article 41 that the family is the fundamental unit group of society by acknowledging that the family is “the primary and natural educator of the child.” Article 42.5 provides that only in “exceptional circumstances” where parents “fail in their duty towards their children” the State may “supply the place of parents.” Article 42.5 also states that any such role of the State must have due regard for the rights of the child. As with Article 41.1.1^o, Article 42 is reflected in relevant international human rights documents. Thus, Article 18 of the 1989 UN Convention on the Rights of the Child (UNCRC) states that “[p]arents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child” and that the State must provide appropriate assistance to parents and guardians. Article 9 provides that the State may only intervene to separate a child from parents against their will where “such separation is necessary for the best interests of the child.”

1.27 The provisions of Articles 41 and 42 of the Constitution, and the relevant international instruments such as the 1948 UN Universal Declaration of Human Rights, the 1966 ICCPR and the 1989 UNCRC, contain the following important elements: (a) parents and guardians have primary responsibility for the upbringing and development of their children, (b) the State may intervene to supply the place of parents only in exceptional circumstances where this is necessary, and (c) the rights of the child, and their best interests, must always be taken into account in this context.

1.28 In terms of the general status of the rights of the child under the Constitution, Walsh J stated in the Supreme Court decision *G v An Bord Uchtála*:

“The child’s natural rights spring primarily from the natural right of every individual to life, to be reared and educated, to liberty, to work, to rest and recreation, to the practice of religion, and to follow his or her conscience... The child’s natural right to life and all that flows from that right are independent of any right of the parent as such.”²²

1.29 It is clear that the younger a child is, the greater the responsibility that is imposed on parents or guardians to ensure that the rights of children are implemented and protected; and that the State may only intervene to override any parental decision in exceptional instances. For example, in *North Western*

the Second Stage speech on the *Family Law Bill* (which became the 1975 Act) of the then Australian Attorney General, Lionel Murphy (who had cited the ICCPR in this context).

²² *G v An Bord Uchtála* [1980] IR 32 at 69.

*Health Board v HW and CW*²³ the Supreme Court did not override the refusal of parents to consent to doctors carrying out the “heel prick” PKU blood test on their baby boy. Even though the Supreme Court noted that most parents would be happy to have the test carried out and the medical view was that the test be done, it decided that any overriding of parental decision-making would only be suitable if the refusal threatened the child’s life or immediate health. Equally, as the child grows and develops to maturity through adolescence and into their teenage years, their emerging capacity to exercise their rights jointly with, and then independently of, their parents must also be recognised. In *McK v Information Commissioner*,²⁴ the Supreme Court recognised, in the context of a health care setting, that the views of a 17 year old young person are very relevant and may also override the general presumed entitlement of a parent to health information about their children.

1.30 The approach of the Supreme Court in the *G* case, the *North Western Health Board* case and the *McK* case is consistent with the literature on child development discussed above and the relevant international instruments in this area. It is also consistent with the extensive case law and legislation in other states which the Commission discusses in Chapter 2, below. This approach recognises a number of important points: that a child has rights that are independent of any right of the parent as such; that these rights are, during the child’s early years, exercised on behalf of the child, usually by the child’s parents or guardians; that the rights remain the rights of the child as they develop towards maturity and adulthood; and that there are various points, sometimes based on an age threshold and sometimes based on an assessment of maturity and capacity, at which the law recognises that the child can exercise these rights independently of their parents or guardians even before they reach full adulthood at the age of 18. As a result, the law acknowledges that a person under 18 years of age is, in a number of contexts, an independent rights-holder that is commensurate with the progressive development and maturity of that person.

1.31 The Commission has therefore concluded that this analysis of the rights of children in the context of the family should be reflected in the approach it takes to the specific issues addressed in this Report, and in the draft Bill appended to it. The Commission accordingly recommends that legislation should be enacted dealing with consent to, and refusal of, medical treatment concerning persons under the age of 18, and which would include the following general principles: having regard to the recognition in the Constitution and

²³ [2001] IESC 90, [2001] 3 IR 622, discussed in paragraph 2.28, below.

²⁴ [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260, discussed at paragraph 1.65, below.

international instruments of the family as the fundamental group in society, parents and guardians have primary responsibility for the upbringing and development of their children; the State may intervene to supply the place of parents in exceptional circumstances where this is necessary; the rights of the child, and their best interests, must always be taken into account in this context; a child has rights that are independent of any right of the parent as such; that these rights are, during the child's early years, exercised on behalf of the child, usually by the child's parents or guardians; that these rights remain the rights of the child as they develop towards maturity and adulthood; and that there are various points, sometimes based on an age threshold and sometimes based on an assessment of maturity and capacity, at which the law recognises that the child can exercise these rights independently of their parents or guardians even before they reach full adulthood at the age of 18.

1.32 *The Commission recommends that legislation should be enacted dealing with consent to, and refusal of, medical treatment concerning persons under the age of 18, and that it should include the following general principles: having regard to the recognition in the Constitution and international instruments of the family as the fundamental group in society, parents and guardians have primary responsibility for the upbringing and development of their children; the State may intervene to supply the place of parents in exceptional circumstances where this is necessary; the rights of the child, and their best interests, must always be taken into account in this context; a child has rights that are independent of any right of the parent as such; these rights are, during the child's early years, exercised on behalf of the child, usually by the child's parents or guardians; these rights remain the rights of the child as they develop towards maturity and adulthood; and there are various points, sometimes based on an age threshold and sometimes based on an assessment of maturity and capacity, at which the law recognises that the child can exercise these rights independently of their parents or guardians even before they reach full adulthood at the age of 18.*

(2) Best interests of the child

1.33 The Commission also considers that it is important to recognise, bearing in mind the literature on the development of children, that while a child can develop a sense of maturity and capacity for decision-making before the age of 18, this capacity and decision-making cannot be equated with the decision-making of a person with longer experience. In that respect, another important feature in the literature on children's rights is the need to ensure that

any outcome is in the best interests of the child.²⁵ In this context, it is important to ensure that respect for the rights of the child also takes account of an objective assessment of what is in the child's interests. In Irish law, the best interests test already forms part of the legal framework applicable to decisions about children. Thus, section 3 of the *Guardianship of Infants Act 1964*, section 24 of the *Child Care Act 1991* and section 24 of the *Adoption Act 2010* require that decisions concerning children be based on their best interests.

1.34 The best interests test has sometimes been criticised as amounting to no more than a simple paternalistic test of “parents know best” or, in the context of this Report, “doctor knows best”. When the best interests test is seen, however, in the light of a rights-based approach, it is clear that it is not paternalistic in nature but has an objective aspect that ensures an appropriate level of protection against outcomes that would be inconsistent with the rights of children. This objective aspect of the best interests test has been emphasised, for example, in the 2009 decision of the Supreme Court of Canada in *AC v Manitoba (Director of Child and Family Services)*.²⁶ It is notable that the best interests test has also been incorporated into international rights-based instruments on children, including the 1989 UN Convention on the Rights of the Child. This objective best interests test ensures, therefore, that the health care outcome in an individual case is not to be equated with the particular preferences of the person under 18, his or her parents or guardians (subject to the presumption that their views should be given priority under Article 41), still less of any person acting in the place of parents or guardians (such as the Health Service Executive exercising powers under the *Child Care Act 1991*). The Commission emphasises that this is as important in the context of physical health care as it is in the context of mental health care. Indeed, the Commission notes that, in the very specific context of the detention of a young person under the *Mental Health Act 2001*, an objective best interests test ensures that all those involved in decision-making under the 2001 Act do not equate any person's preferences for specific forms of treatment with the best interests of the child or young person. Viewed in this light, the Commission has therefore concluded, and recommends, that the “best interests” test, assessed objectively by reference to the rights of the child, should be included as a primary

²⁵ See Thomas & O’Kane “When Children’s Wishes and Feelings Clash with their Best Interests” (1998) 6 *International Journal of Children’s Rights* 137 at 138, Alston “The Best Interests Principle: Towards a Reconciliation of Culture and Human Rights” (1994) 8 *International Journal of Law & Family* 1 at 9. Eekelaar “The Interests of the Child and the Child’s Wishes: The Role of Dynamic Self-Determinism” (1994) 8(1) *International Journal of Law Policy & Family* 42.

²⁶ [2009] SCC 30, [2009] 2 SCR 181, discussed at paragraph 2.118, below.

consideration in the approach it takes to the specific issues addressed in this Report, and in the draft Bill appended to it.

1.35 *The Commission recommends that its proposed legislation on consent to, and refusal of, health care and medical treatment concerning persons under the age of 18 should include as a primary consideration the best interests of the child, assessed objectively by reference to the rights of the child.*

D Definition of Health Care and Treatment

1.36 The Commission now turns to discuss how to define the scope of the health care and medical treatment with which this Report is involved. This is important in the context of describing the scope of the recommendations in this Report, and of the draft Bill appended to the Report.

1.37 In order to approach this aspect of the Commission's recommendations, it is important to note the range and scope of the types of health care and related medical treatments involving children and young people. These include:

- dental care and treatment
- eye care and treatment
- over-the-counter medicine of specific relevance to adolescents, such as products related to skin conditions
- prescription for antibiotics
- prescription for contraception
- advice and counselling on general health and development
- counselling and treatment concerning mental health
- prescription for anti-depressants
- admission to mental health facility
- X ray
- treatment related to a soft tissue sports injury or broken arm
- surgery for removal of the appendix
- surgery and treatment connected to cancer
- surgery and treatment connected with a chronic condition such as cystic fibrosis
- paediatric research and clinical trials.

1.38 The Commission noted in the Consultation Paper that existing legislation does not contain a single, generally applicable, term to define “medical treatment” or “health care.” Given the wide range of care and treatment involved and the changing nature of health care and treatments, this is not surprising.

1.39 The Commission notes that a number of definitions of health care and health services that have been enacted in the context of specific legislation concerning health care may provide some useful reference points. For example, section 2 of the *Health Insurance Act 1994* defines health services as:

“medical, surgical, diagnostic, nursing, dental, chiropody, chiropractic, eye therapy, occupational therapy, physiotherapy, or speech therapy services or treatment or services or treatment provided in connection therewith, or similar services or treatment.”

1.40 In the specific context of consent to treatment, section 23 of the *Non-Fatal Offences Against the Person Act 1997*, discussed in detail in Chapter 2 below, refers to consent concerning “surgical, medical or dental treatment” which section 23(2) of the 1997 Act states:

“includes any procedure undertaken for the purposes of diagnosis and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.”

1.41 In the Consultation Paper, the Commission provisionally recommended a broad definition of health care and treatment, rather than a prescriptive one which would run the risk of excluding specific forms of care and treatment, including those that might develop in the future. The Commission affirms this approach in this Report, in particular because of the need to ensure that the definition is future-proofed, and to ensure that children and young people have access to the types of health care and treatment they need. The Commission considers that this should include, at the least, the scope of “surgical, medical or dental treatment” as defined in section 23 of the *Non Fatal Offences Against the Person Act 1997*, but that it should also extend beyond this to encompass the examples of care and treatment already mentioned.

1.42 The Commission reiterates that, bearing in mind the wide range of these examples of care and treatment, a broad definition of health care and medical treatment should be used, encompassing diagnosis and treatment. The word “treatment” in this context would include invasive exploratory acts carried out for the purposes of diagnosis. The definition would include medical, surgical, nursing, pharmaceutical, dental and mental health services.

1.43 Health care and treatment may be provided by a range of health care professionals. This can include dentists, doctors and nurses, as well as the

wider health and social care services such as dieticians, occupational therapists, physiotherapists, podiatrists, radiographers, social workers and social care workers. These professions are regulated under the *Health and Social Care Professionals Act 2005*.

1.44 The definition of health care should also include aspects which are preventative, such as health promotion and the provision of advice, information and counselling. It is also without prejudice to specific areas of health care already regulated by, for example, the *Control of Clinical Trials Act 1987*.

1.45 As stated in the Consultation Paper, the Commission does not seek to differentiate between physical and mental health on the issues of capacity and consent.²⁷ The definition of health care would therefore include psychiatric treatment and related mental health treatments.

1.46 Bearing in mind the breadth of scope of the Report, the use of an inclusive, but non-exhaustive, list may be helpful to set out clearly what is included in the broad definition of health care and treatment. The Commission has therefore concluded, and thus recommends, that, for the purposes of its proposed legislation on health care and treatment concerning persons under the age of 18, health care and medical treatment should be defined as including:

- (a) the provision of surgical, medical, nursing, pharmaceutical, dental and mental health care or treatment, including the prescription or supply of drugs;
- (b) any assessment or examination for the purposes of diagnosis, including invasive exploratory acts;
- (c) any procedure undertaken for the purposes of preventing a disease or illness;
- (d) any procedure which is ancillary to any treatment as it applies to that treatment (including but not limited to anaesthesia);
- (e) a course of treatment or a group of associated treatments;
- (f) any treatment carried out by a health and social care professional, within the meaning of the *Health and Social Care Professionals Act 2005*;
- (g) health promotion, and
- (h) the provision of advice, information and counselling in connection with any of the above.

²⁷ (LRC CP 59-2009 at 6.123).

1.47 *The Commission recommends, that, for the purposes of its proposed legislation on health care and treatment concerning persons under the age of 18, health care and medical treatment should be defined as including:*

- (a) the provision of surgical, medical, nursing, pharmaceutical, dental and mental health care or treatment, including the prescription or supply of drugs;*
- (b) any assessment or examination for the purposes of diagnosis, including invasive exploratory acts;*
- (c) any procedure undertaken for the purposes of preventing a disease or illness;*
- (d) any procedure which is ancillary to any treatment as it applies to that treatment (including but not limited to anaesthesia);*
- (e) a course of treatment or a group of associated treatments;*
- (f) any treatment carried out by a health and social care professional, within the meaning of the Health and Social Care Professionals Act 2005;*
- (g) health promotion, and*
- (h) the provision of advice, information and counselling in connection with any of the above.*

E Voice of the Child in the Healthcare Setting

1.48 In all areas of health care and medical treatment, it is important that the voice of the child is heard and respected. The Commission's examination of the treatment of the child in the healthcare setting in Ireland reveals a considerable emphasis on protecting the child and acting in his or her best interests. In this Report, the Commission examines this important matter in the context of the need to recognise what can be described as the participation rights of the child.

1.49 There is currently no statutory guidance on the treatment of children and young people in a health care setting, although helpful non-statutory guidance has been published on the need for health care professionals to listen to the views of the young patient, regardless of the patient's age or maturity. Despite the existence of a range of different documents focusing on specific issues such as alcohol use and mental health, there is no single document setting out suitable standards of care for children, guidelines for treating

children in hospital, and appropriate levels of participation by children.²⁸ Furthermore, the separate issues of information provision, assent to treatment and consent to treatment are often dealt with together. As discussed below, the Oireachtas already recognises the capacity of 16 and 17 year olds to consent to health care treatment in section 23 of the *Non Fatal Offences Against the Person Act 1997*, although this is limited to the criminal law setting. As the Commission recommends in this Report, this should be extended to the civil law setting. While the Commission takes a different view concerning those under 16 years of age – and many of those children may not have the capacity to consent to health or medical treatment – they nonetheless have a right to be informed as to health care matters that affects them and to express their views, and perhaps their *assent* even if not necessarily their *consent*. Thus, at least one Irish children’s hospital advises staff as follows:

“Decision-making involving the health care of children and adolescents should include, to the greatest extent feasible, the assent of the patient as well as the participation of the parents and the healthcare professional. Serious consideration must be given to each patient’s developing capacity for participating in decision-making.”²⁹

1.50 Section 23(1) of the *Non-Fatal Offences Against the Person Act 1997*, while it deals with consent to medical treatment by persons of 16 and 17 years of age, does not explicitly acknowledge the right of a child or young person to participate in decisions regarding his or her medical treatment.

1.51 As already discussed above, a very young child’s rights will naturally be exercised by his or her parents or guardians, but as the child grows and matures the active participation by the child in the exercise of his or her rights becomes more and more important. Participation by children is highly beneficial, as it enhances their communication and development skills and improves the relationship between children and adults. Giving children a voice in matters that affect them does not require that they be given the sole responsibility for all decisions. A research study carried out in 2006 for the Office of the Minister for Children noted:

“decision-making for children is a complex process that evolves over time and may be shared or contested with parents and health professionals depending on the type of decision. [The study] suggests a

²⁸ Kilkelly, *Children’s Rights in Ireland* (Tottel Publishing 2008) at 405. For further discussion, see Consultation Paper at 4.94.

²⁹ *Staff Guidelines in Relation to Obtaining Consent for Children and Young People* (Crumlin Children’s Hospital, December 2007) at 2.2.

pragmatic approach, which recognises that children need protection while at the same time allowing flexibility for the child's emerging knowledge and self-determination."³⁰

1.52 This approach, with which the Commission concurs, is echoed in some existing legislation concerning children. Thus, where a child over 7 years of age is considered for adoption, the Adoption Authority must give due consideration to the wishes of the child "having regard to his or her age and understanding;"³¹ and, in care proceedings, a court must "in so far as is practicable, give due consideration, having regard to his age and understanding, to the wishes of the child."³²

1.53 This is also reflected in relevant international Conventions on children. For example, Article 13 of the Hague Convention on the Civil Aspects of International Child Abduction (which was implemented by the *Child Abduction and Enforcement of Custody Orders Act 1991*) states that the designated national authority (in Ireland, the High Court) may refuse to order the return of an abducted child if the child objects and has attained "an age and degree of maturity at which it is appropriate to take account of his views."

1.54 Similarly, Article 12(1) of the UN 1989 Convention on the Rights of the Child (UNCRC) states:

"States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."³³

³⁰ Coyne et al *Giving Children a Voice: Investigation of children's experiences of participation in consultation and decision-making in Irish hospitals* (Office of the minister for Children 2006) at 57.

³¹ See section 24(2) of the *Adoption Act 2010*.

³² See section 24(b) of the *Child Care Act 1991*.

³³ Section 6 of *The Children (Scotland) Act 1995* reflects this aspect of the UNCRC: "A person shall, in reaching any major decision which involves (a) his fulfilling a parental responsibility or the responsibility mentioned in section 5(1) of this Act or (b) his exercising a parental right or giving consent by virtue of that section, have regard so far as practicable to the views (if he wishes to express them) of the child concerned, taking account of the child's age and maturity, and to those of any other person who has parental responsibilities or parental rights in relation to the child (and wishes to express those views); and without prejudice to the generality of this subsection a child twelve years of age or more shall be presumed to be of sufficient age and maturity to form a view."

1.55 The UN Committee on the Rights of the Child, in commenting on the right of the child to be heard stated:

“The realisation of the provisions of the [UNCRC] requires respect for the child’s right to express his or her views and to participate in promoting the healthy development and well-being of children. This applies to individual health-care decisions, as well as to children’s involvement in the development of health policy and services.”³⁴

1.56 This is also consistent with the Commission’s general recommendation in its 2010 *Report on Legal Aspects of Family Relationships*³⁵ that the voice of the child be taken into account in circumstances which concern him or her.

1.57 In this context, the Commission agrees with the sentiment expressed in the Government’s 2000 National Children’s Strategy:

“It is important that giving children a voice is not interpreted as a passing responsibility for decisions and their consequences to children. The intention is to ensure that in achieving a decision which is in the best interests of the child, the child should have an active part and know that his or her views are respected.”³⁶

1.58 It is evident that, in this respect, it is necessary to ensure that the voice of the young patient is heard in the healthcare setting, to enable children and young people to grow and mature, reaching a point where the individual who has capacity can participate in and make decisions about his or her own healthcare and treatment. The Commission therefore recommends that when treating children, health care professionals must give children an opportunity to express their views and to give these views due weight, in accordance with the child’s age and maturity.

1.59 *The Commission recommends that, when treating children, health care professionals must give children an opportunity to express their views and to give these views due weight, in accordance with the child’s age and maturity.*

³⁴ Committee on the Rights of the Child “The Right of the Child to be Heard” (General Comment No.12 of 2009 CRC/C/GC/12) at 98.

³⁵ (LRC 101 – 2010), in particular, at paragraphs 4.18 and 4.22.

³⁶ *The National Children’s Strategy: Our Children Their Lives* (Stationary Office Dublin 2000) at 3.1.

F Confidentiality

1.60 Related to the right of the child to have his or her voice heard in the health care context is the right of the child to be heard in a confidential setting. The importance of confidentiality as an aspect of the healthcare provider-patient relationship is clear and should not be limited by age. The importance placed on confidentiality by young people is consistently recognised in research and was echoed during the Commission's consultation with young people in 2009 in advance of the Consultation Paper. The Commission accepts that, regardless of the age at which young people should be legally capable of consenting independently to medical treatment, there is a need to respect confidentiality.

1.61 Arising from the Commission's consultation, it appears that confidentiality is a particularly important issue for young people in the context of general health concerns and anxieties which they may discuss with a general practitioner. It is important to note that young people often visit their local GP or healthcare professional simply for advice or reassurance, particularly in relation to personal concerns about puberty and development. In such cases there is often no need for prescribed medical treatment, and the patient is satisfied by the provision of general information and guidance.

1.62 In this context, the Medical Council's 2009 *Guide to Ethical Conduct and Behaviour* states that confidentiality is a fundamental principle of medical ethics, central to the trust between patients and doctors and that patients are entitled to expect that information held about them will be held in confidence, save in certain limited circumstances.³⁷

1.63 In relation to children and young people, the 2009 *Guide* states:

"When treating children and young people, you should remember your duties of confidentiality... subject to parental rights of access to medical records which may arise by law. You should tell these young patients that you cannot give an absolute guarantee of confidentiality."

1.64 As the Medical Council's 2009 *Guide* correctly notes,³⁸ confidentiality can never be absolutely guaranteed to any patient (of whatever age), but health care professionals are aware that a general duty of confidentiality is owed to all patients, including those under 18 years of age. As also mentioned in the Medical Council's 2009 *Guide*, legislation such as the *Freedom of Information*

³⁷ *Guide to Ethical Conduct and Behaviour* 6th ed (Medical Council, 2009), paragraphs 24 and 25.

³⁸ Disclosure may be required by law, or may be necessary to protect the patient or others from harm. Disclosure may also be necessary to protect the public interest.

Act 1997 (Section 28(6)) Regulations 1999,³⁹ made under the *Freedom of Information Act 1997*, prescribe the classes of individuals whose records may be made available to parents and guardians. Regulation 3(1) of the 1999 Regulations states that access to personal information “shall” be granted where the requester is a parent or a guardian of the individual to whom the record relates and where the individual is under 18 years of age. Regulation 3(1) also states that access to the personal information of a minor shall be granted where it would, having regard to all of the circumstances, and to any guidelines drawn up and published by the Minister, be “in the patient’s best interests.”

1.65 The application of the 1999 Regulations arose in *McK v Information Commissioner*.⁴⁰ In this case, a father (who had separated from his wife some years before) had visited his 12 year old daughter in hospital, and was told that she had been admitted for an unspecified viral condition. He then applied under the 1999 Regulations for more detailed information concerning his daughter’s admission, but this was refused by the hospital and, on appeal, the Information Commissioner upheld the refusal. The High Court and, on further appeal, the Supreme Court decided that the Information Commissioner should have approached the request for information by acknowledging that a parent was, in general, entitled under the 1999 Regulations to the information. The Supreme Court unanimously held that this arose by virtue of the central position of the parent under Articles 41 and 42 of the Constitution and the consequent presumption that access by a parent to health information concerning their child would be in the child’s best interests. This presumption should have been applied by the Information Commissioner before considering any evidence which could rebut that entitlement.

1.66 The Supreme Court added an important caveat to this because, by the time the Court heard the case, which was 6 years after the hospital admission at issue, the daughter was 17½ years of age. In this respect, Denham J (who delivered the Court’s judgment) stated that the Information Commissioner would have to reconsider the application in light of the specific circumstances of the case “especially the age of the minor, nearly 18 years of age, whose views now are very relevant.”⁴¹ In light of this analysis by the Supreme Court, the Information Commissioner reconsidered the matter.⁴² She

³⁹ *Freedom of Information Act 1997 (Section 28(6)) Regulations 1999* (SI No.47 of 1999).

⁴⁰ [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260.

⁴¹ [2006] 1 IR 260, at 268.

⁴² *Annual Report of the Information Commissioner 2006* at 21-23, available at www.oic.gov.ie.

accepted that the father had a presumptive entitlement to the information, and she then heard evidence from his daughter. The Commissioner had regard to her age and to her maturity, as well as the cogent reasons she advanced for not disclosing the information sought by her father.⁴³ In this context, the Information Commissioner also referred to section 23 of the *Non-Fatal Offences Against the Person Act 1997* as indicating a recognition by the Oireachtas that minors aged 16 have the capacity to determine what is in their best interests in the context of medical treatment. The Information Commissioner held that there was sufficient evidence that disclosure of the minor's medical records to her father would not serve her best interests, and that this rebutted the presumption of parental entitlement to a child's personal information. The Information Commissioner also stated that, taking into account that the daughter's welfare was paramount, to grant her father access to her personal medical records would, as a matter of probability, cause her damage, both educationally and emotionally.

1.67 In light of this discussion, the Commission accepts that a combination of the relevant provisions of the Medical Council's 2009 *Guide to Ethical Conduct and Behaviour* Guide and of the approach taken in the *McK* case provide useful reference points in the application of the principle of confidentiality to a person under 18. In that respect, the Commission has concluded, and recommends, that when treating persons under 18, health care professionals must ensure respect for confidentiality, subject to any specific statutory obligations to disclose medical records. The Commission also recommends that this confidentiality must also have regard to the rights of parents and guardians to access to relevant health information, and that this information should be given where it would, having regard to all of the circumstances, be in the best interests of the person under 18 and to the general principles already set out in this Report, above.

1.68 *The Commission recommends that when treating persons under 18, health care professionals must ensure respect for confidentiality, subject to any specific statutory obligations to disclose medical records. The Commission further recommends that this confidentiality must also have regard to the rights of parents and guardians to access to relevant health information, and that this information should be given where it would, having regard to all of the circumstances and to the general principles already set out in this Report, be in the best interests of the person under 18.*

⁴³ Ms McK had not spoken to her father for a number of years before the request for information and contact with her father caused her stress and anxiety. She viewed the request as an attack on her privacy and did not believe disclosure of the information would be in her best interests.

CHAPTER 2 CAPACITY OF MINORS AND YOUNG PERSONS TO CONSENT TO AND REFUSE TREATMENT

A Introduction

2.01 In this Chapter the Commission discusses the detailed aspects of consent to, and refusal of, healthcare treatment by individuals under the age of 18, having regard to the general principles set out in Chapter 1. The Commission discusses decision-making by young persons, that is, 16 and 17 year olds, and, separately, minors, that is, those under the age of 16. In Part B, the Commission discusses the current legal position in Ireland, including the effect of section 23 of the *Non-Fatal Offences Against the Person Act 1997* which provides, in the context of criminal law, that consent to medical treatment by a 16 and 17 year old has the same status as if he or she was an 18 year old. The Commission also discusses the position in Irish case law of those under 16, which reflects the general literature as well as legal developments in other countries concerning mature minors. In Part C, the Commission then discusses in detail statutory provisions and case law concerning health care involving those under 18 in a number of countries, in particular, England and Wales, Northern Ireland, Scotland, Canada, Australia and New Zealand. In Part D, the Commission sets out its recommendations concerning consent to and refusal of medical treatment for those under 18. The Commission's approach is that this should be as consistent as possible with the proposed reform of the law on mental capacity for those over 18, and the Commission therefore favours a functional test of capacity. The Commission sets out its recommendations concerning 16 and 17 year olds, and then sets out separately its recommendations for those under 16.

B Capacity of Persons under 18 to Consent to and Refuse Treatment in Ireland

2.02 In this Part, the Commission discusses the current legal position in Ireland concerning people under 18 years of age, beginning with an outline of the general position. The Commission then discusses section 23 of the *Non-Fatal Offences Against the Person Act 1997* which provides, in the context of criminal law only, that consent to medical treatment by a 16 and 17 year old has the same status as if he or she was an 18 year old. The Commission also discusses the need to examine any proposals for reform in the wider context of

proposals to introduce a modern statutory framework on mental capacity and decision-making by those over 18. The Commission's 2006 *Report on Vulnerable Adults and the Law*¹ contained a draft Scheme of a *Mental Capacity Bill*. The Report was based on a presumption of capacity for those over 18 years of age and a functional test of capacity, that is, a case-by-case test of capacity based on whether the person understands the nature of the specific decision being made. The Commission's approach in the 2006 Report reflects recent international trends in this area, including the rights-based analysis found in the 2006 UN Convention on the Rights of Persons with Disabilities. The Commission is conscious that the Government is committed to publishing by the end of 2011 a *Mental Capacity Bill* that is consistent with the 2006 UN Convention.²

(1) Irish law on age categories generally

2.03 Reflecting the literature on child development discussed in Chapter 1, Irish law does not set out a single age at which a person suddenly takes on all the rights – and responsibilities – of a member of society. Instead, the law sometimes sets certain ages as thresholds, where rights and responsibilities are granted to young people as they move from childhood to adulthood, and sometimes refers to the need to have regard to a combination of age and maturity.

2.04 Of course, the key threshold in law between childhood and adulthood is, in general, a person's 18th birthday which, since the enactment of the *Age of Majority Act 1985*,³ is the date on which a person becomes an adult for many purposes of the civil law. Reaching 18, the age of majority, thus signals the end of many protections granted to children and young people by virtue of their young age, their position as children or minors, and marks an important legal watershed.

2.05 Below the age of 18, a person's 16th birthday is also another significant juncture in the progression, in law, from childhood to adulthood, from

¹ (LRC 83-2006).

² The *Programme for Government 2011-2016* (March 2011), p.38, available at www.taoiseach.ie, contains a commitment to "introduce a Mental Capacity Bill that is in line with the UN Convention on the Rights of Persons with Disabilities." The *Government Legislation Programme, Summer Session 2011* (April 2011), available at www.taoiseach.ie, states that the *Mental Capacity Bill* is scheduled for publication in late 2011.

³ The 1985 Act implemented the main recommendations in the Commission's *Report on the Age of Majority, the Age for Marriage and Some Connected Subjects* (LRC 5-1983).

minority to majority status. Traditionally, as outlined in the Consultation Paper,⁴ a 16 year old was granted a significant measure of independence on his or her 16th birthday. This remains reflected in current legislation, for example the *Protection of Young Persons (Employment) Act 1996* (many, though not all, restrictions on employment are lifted at age 16) and the *Education (Welfare) Act 2000* (16 is the school-leaving age). These Acts both use the age of 16 to distinguish between “children” and “young persons”, and they grant 16 year olds an increased measure of independence.

2.06 In terms of health care and medical law, the age of 16 has also been largely accepted as the age of consent to medical treatment in a number of countries worldwide, including Ireland. As discussed below, section 23(1) of the *Non-Fatal Offences Against the Person Act 1997*, which applies in the context of criminal law only, states that the consent of a 16 and 17 year old to medical treatment has the same legal status as if they were an 18 year old adult.

2.07 Under the *Health Acts 1947 to 1970*, a person aged 16 years may choose his or her own doctor, obtain a medical card, consent to an operation and apply for a disabled person’s maintenance allowance.⁵ Similarly, Regulation 4(1) of the *European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004*⁶ states that, for the purposes of the 2004 Regulations, “adult’ means a person who has attained the age of 16 years.” The 2004 Regulations, which supplement requirements in the *Control of Clinical Trials Act 1987*, implemented Directive 2001/20/EC on good clinical practice in the conduct of clinical trials on medicinal products for human use. The 2001 Directive makes certain exclusions from its terms for “minors” but without defining the age under which a person is a minor for the purposes of the Directive. This is understandable given the diversity of opinion among EU Member States regarding the age of majority and, thus, when a person is a minor. The Irish 2004 Regulations that implemented the 2001 Directive would appear to have drawn on the existing *Health Acts* by defining an adult as a person aged 16 and over, and may also have been influenced in this respect by the comparable UK Regulations that implemented the 2001 Directive.⁷ Similarly,

⁴ (LRC CP 59-2009) at 2.23.

⁵ See also the Commission’s Working Paper *The Law Relating to the Age of Majority, the Age for Marriage and Some Connected Subjects* (Working Paper No 2, 1977), Appendix B “Relationships Between Age and the Law”.

⁶ SI No.190 of 2004.

⁷ Regulation 2(1) of the UK *Medicines for Human Use (Clinical Trials) Regulations 2004* (SI 1031/2004) (the 2004 Regulations implemented the 2001 Directive) provides: “adult’ means a person who has attained the age of 16 years.”

the Department of Health's *Draft Human Tissue Bill 2009*,⁸ published in 2009, proposes to define a child as a person under 16 years of age,⁹ and it appears that the proposed *Health Information Bill* will also take the same approach.¹⁰

2.08 As noted in the Consultation Paper, children and young people are often treated in adult hospital wards before reaching 18 years of age, and 16 seems to be considered a cut off point for admission to paediatric hospitals and wards.¹¹ For example a 2007 report¹² revealed that the maximum age of treatment in both the Emergency Department and in-patient admission in one children's hospital¹³ was 15 years of age. Another children's hospital¹⁴ operated on the basis of admitting children up to 16 years of age in both the Emergency Department and in-patient admission. A third¹⁵ also used the cut off point of 16 years in respect of the Emergency Department, and the age of 14 years for in-patient admission, with flexibility up to 16 years of age. While practice varies to some degree, therefore, depending on the hospital and the particular circumstances, the Commission notes that in general, young people are not treated in a paediatric setting once they reach 16 years of age.

⁸ *Draft Proposals for General Scheme of the Human Tissue Bill 2009 (Department of Health and Children, 2009)*, available at www.dohc.ie. The Draft 2009 Bill proposes to implement the recommendations of the 2006 *Report into Post-Mortem Practice and Procedures* (prepared by Dr Deirdre Madden), also available at www.dohc.ie.

⁹ Sections 2.17 and 3.11 of the *Draft Proposals for General Scheme of the Human Tissue Bill 2009*, 65-66 and 97, respectively.

¹⁰ Referred to in *Draft Proposals for General Scheme of the Human Tissue Bill 2009*, 66. The *Government Legislation Programme, Summer Session 2011* (April 2011), available at www.taoiseach.ie, states that the *Health Information Bill* is scheduled for publication in 2011.

¹¹ LRC CP 59-2009 at 4.11.

¹² *High Level Framework Brief for the National Paediatric Hospital: Final Report* (Health Service Executive and Department of Health and Children, October 2007) at 47.

¹³ Temple St Children's Hospital, Dublin.

¹⁴ Adelaide and Meath Hospital, incorporating the National Children's Hospital, Tallaght.

¹⁵ Our Lady's Children's Hospital Crumlin.

(2) Consent to treatment by those under 18 and the Non-Fatal Offences Against the Person Act 1997

2.09 Section 23(1) of the *Non-Fatal Offences Against the Person Act 1997* provides that, in the context of criminal law only, consent to medical treatment by a person aged 16 or 17 years of age has the same status as if he or she was an 18 year old, of full age. It is important to note that the 1997 Act implemented the main recommendations made by the Commission in its 1994 *Report on Non-Fatal Offences Against the Person*.¹⁶ In that 1994 Report, the Commission discussed the position in other countries where the criminal law concerning offences against the person, including assault, had been reformed.¹⁷ In particular, in the context of the defence of consent to a charge of assault, the Commission recognised that many other countries had provided that the position concerning consent to medical treatment by 16 and 17 year olds should be clarified. The Commission emphasised in the 1994 Report the distinction between criminal liability on the one hand and civil liability on the other hand. The Commission noted that the capacity of 16 and 17 year olds to consent to treatment *in the context of civil liability* had been addressed in section 8 of the English *Family Law Reform Act 1969*, and that the position in the UK of those under 16 had been dealt with in 1985 in the landmark test case decision of the UK House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority*.¹⁸ These developments on *civil liability* in the UK – and in other countries since the 1980s – are discussed in detail in Part C, below. In the 1994 Report, the Commission clearly limited its recommendations to the criminal law area:

“The *Gillick* decision might or might not be followed by our Supreme Court in a civil case but in criminal cases certainty should be imported, where possible, and we recommend that legislation be introduced similar to section 8 of the English *Family Law Reform Act 1969*.”¹⁹

2.10 It is clear, therefore, that the Commission’s intention was to confine its recommendation to the criminal law sphere. As the Commission noted, it was unclear in 1994 whether the approach in *Gillick* might or might not be followed

¹⁶ Law Reform Commission *Report on Non-Fatal Offences Against the Person* (LRC 45-1994).

¹⁷ Law Reform Commission *Report on Non-Fatal Offences Against the Person* (LRC 45-1994), paragraphs 9.166-9.169.

¹⁸ [1985] UKHL 7, [1985] 3 All ER 402. The *Gillick* case is discussed below, paragraph 2.62ff.

¹⁹ Law Reform Commission *Report on Non-Fatal Offences Against the Person* (LRC 45-1994) at paragraph 9.169.

in Ireland. Since then, as already noted in this Report, the Supreme Court has decided in *McK v Information Commissioner*²⁰ that, in a health care setting, the views of a young person who is 17 “are very relevant” and may sometimes override a parent’s presumed entitlement to be able to access health care information concerning their children.²¹ Similarly, in *D v Brennan and Ors*,²² which is discussed below, the High Court has acknowledged that a 16 or 17 year old can, in certain circumstances, give a valid consent in the health care setting without the need for parental involvement. These decisions indicate that the general approach in the *Gillick* case, which in turn reflects the literature on child development and international instruments discussed in Chapter 1, above, as well as similar approaches in the law of the countries - discussed below, has, since 1994, been applied in Ireland.

2.11 Because the 1994 Report recommended that legislation similar to section 8 of the English *Family Law Reform Act 1969* be introduced to deal with consent in the criminal law setting, the Commission now turns to a comparison between section 8 of the 1969 Act and section 23 of the *Non-Fatal Against the Person Act 1997*, which implemented that recommendation. Section 8 of the English 1969 Act (which as the Commission discusses in Part C, below, was replicated in Northern Ireland in section 4 of the *Age of Majority Act (Northern Ireland) 1969*) states:

“(1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

(2) In this section “surgical, medical or dental treatment” includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.

(3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.”

²⁰ [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260.

²¹ [2006] 1 IR 260. 268. See the discussion at paragraph 1.48ff, above.

²² *D v Brennan and Ors* High Court, 9 May 2007.

2.12 The text of section 23 of the 1997 Act was clearly modelled directly on section 8 of the English 1969 Act (and section 4 of the Northern Ireland 1969 Act). Section 23 of the 1997 Act states:

“(1) The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as it would be if he or she were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent or guardian.

(2) In this section “surgical, medical or dental treatment” includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.

(3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.”

2.13 The *Non-Fatal Offences Against the Person Act 1997* deals with criminal liability only and, as recommended by the Commission in its 1994 Report, section 23 of the 1997 Act provides a defence to a charge of assault where a health care professional provides treatment to a 16 and 17 year old. Given that the origins of section 23 of the 1997 Act can be traced to the Commission’s 1994 Report, it is unlikely that section 23 could be interpreted as applying in the civil law context.

2.14 As the Commission noted in the Consultation Paper,²³ there is a fundamental difference between, on the one hand, the limited nature of a defence to the criminal offence of assault provided for in section 23 of the 1997 Act and, on the other, the wider acknowledgement of a minor’s entitlement to exercise a right concerning their autonomy in terms of healthcare.

2.15 Section 23(1) of the 1997 Act does not contain any reference to persons under 16 years of age, which might be thought to create doubts as to whether the section is: (a) facilitative, in that it provides for consent by a person aged 16 or 17, without necessarily preventing persons under 16 from giving consent; or (b) preventative, in that persons under 16 are prevented from giving consent.²⁴ This was also addressed in the Commission’s 1994 Report. As

²³ (LRC CP 59-2009) at 4.03.

²⁴ *Ibid* at 4.05.

already noted, section 23(3) of the 1997 Act, which is identical in wording to section 8(3) of the English 1969 Act (and section 4(3) of the Northern Irish 1969 Act), states:

“Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.”²⁵

2.16 The Commission, commenting on section 8(3) of the English 1969 Act in its 1994 *Report on Non-Fatal Offences Against the Person*, suggested that this saver recognised existing common law legitimate consents by persons under 16 years of age.²⁶ In this respect, the 1969 decision of the English Court of Appeal in *Hewer v Bryant*,²⁷ discussed below, clearly supports this view that the common law recognised the independent decision-making capacity of persons under 16. To that extent, the decision in *Gillick* in 1985 built on this general legal position.

2.17 Given that section 23(3) of the 1997 Act follows precisely the wording of the English 1969 Act (and Northern Ireland 1969 Act), the Commission considers that the Irish courts would interpret section 23(3) as a saver intended to incorporate and preserve the common law on the capacity of persons under 16.²⁸ Nonetheless, and bearing in mind that section 23 of the 1997 Act is a criminal law statute only, the Commission considers that the law should not remain in a state of doubt on such an important matter but should be clarified in terms of civil law liability. This would be of benefit not only to persons under 18 but also their parents and guardians and health care practitioners.

(3) Refusal of treatment as a corollary to consent

2.18 The right to refuse treatment is generally viewed as the natural corollary of the right to consent to treatment and therefore it is arguable that, under the 1997 Act, since a 16 or 17 year old can consent to medical treatment, he or she can therefore refuse medical treatment. The wording “as effective as it would be if he or she had attained full age” in section 23(3) of the 1997 Act is significant, because the refusal of a person of full age is treated as a corollary of consent; therefore the refusal of a 16 or 17 year old could also be viewed as a corollary of consent.

²⁵ Section 25 of the New Zealand Guardianship Act 1968 contains an identical saver.

²⁶ Law Reform Commission *Report on Non-Fatal Offences Against the Person* (LRC 45-1994) at 9.168.

²⁷ [1969] 3 All ER 578, discussed at paragraph 2.54, below.

²⁸ (LRC CP 59-2009) at 4.07.

2.19 Much of the case law in Ireland in relation to refusal of treatment has centred on decisions concerning adult patients and the issue of life-sustaining treatment. As already noted, however, the Supreme Court in *McK v Information Commissioner*²⁹ dealt with the position of a 16/17 year old in a health care setting, and, in *D v Brennan and Ors*,³⁰ discussed below, the High Court also dealt with this issue. The Commission first discusses the Irish case law on refusal concerning adults and then discusses the cases concerning those under 18.

2.20 The decision of the Supreme Court in *Re a Ward of Court (No.2)*³¹ and of the High Court case *Fitzpatrick v FK (No.2)*³² dealt with the refusal of medical treatment involving adults. Both cases emphasise the importance of respect for autonomy, dignity and bodily integrity in the context of refusal of medical treatment. In *Re a Ward of Court (No.2)*³³ the Supreme Court clearly recognised a constitutional right to personal autonomy, stating that a competent person of full age and capacity has the right to refuse medical treatment, even though the consequence of the refusal may lead to death. One of the Supreme Court judges, O’Flaherty J stated:

“consent to medical treatment is required in the case of a competent person... and, as a corollary, there is an absolute right in a competent person to refuse medical treatment even if it leads to death.”³⁴

2.21 In *Fitzpatrick v FK*,³⁵ the High Court ordered that a 23 year old Congolese woman (Ms K), who had refused a blood transfusion on the basis that this was contrary to her religious views as a Jehovah’s Witness, should be

²⁹ [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260. See the discussion at paragraph 1.65ff, above.

³⁰ *D v Brennan and Ors* High Court, 9 May 2007.

³¹ [1996] 2 IR 79. This case, which concerned the removal of artificial feeding and hydration from a 42 year old woman in a near persistent vegetative state, attracted a great deal of media coverage at the time. It was, however, heard *in camera* and the parties were not identified at the time of the court proceedings: see *Re a Ward of Court (No 1)* [1996] 2 IR 73. Ten years later, in 2006, her mother Margaret Chamberlain wrote to *The Irish Times* (11 April 2006) identifying herself and naming her daughter Lucy Chamberlain as the “Ward of Court” in the title of the 1996 case.

³² [2008] IEHC 104, [2009] 2 IR 7.

³³ *Re Ward of Court (No 2)* [1996] 2 IR 79.

³⁴ *Ibid* at 129.

³⁵ [2006] IEHC 392, [2007] 2 IR 406.

given the transfusion in order to save her life. In *Fitzpatrick v FK (No 2)*³⁶ Laffoy J concluded, after a full hearing, that the transfusion had been lawfully given.

2.22 The case of *Fitzpatrick v FK (No.2)*,³⁷ which is discussed in detail in the Consultation Paper,³⁸ provides a comprehensive analysis of the test to be applied to assess a person's capacity in the context of refusal of medical treatment. In brief, Laffoy J held that the test of capacity employed to assess such a decision is a functional one which is time and issue specific. In this respect, Laffoy J approved the following test set out in an English case:

“whether the patient's cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made.”³⁹

2.23 The decision in *Fitzpatrick v FK (No.2)* turned on whether Ms K's capacity was impaired to the extent that she could no longer give an informed consent or refusal. Laffoy J concluded that Ms K's capacity was impaired to the extent that she did not have the ability to accept a blood transfusion. Therefore, the administration of the transfusion was not an unlawful act and did not constitute a breach of her rights under the Constitution.

2.24 This functional, decision-specific, test of mental capacity is consistent with the Commission's key recommendation in its 2006 *Report on Vulnerable Adults and the Law*⁴⁰ that a functional test of mental capacity should be enacted into law, which would reflect the rights-based analysis found in the 2006 UN Convention on the Rights of Persons with Disabilities. The functional test was included in the draft *Scheme of a Mental Capacity Bill* appended to the Commission's 2006 Report and was also included in the Government's *Scheme of a Mental Capacity Bill 2008*, which is likely to form the basis for a *Mental Capacity Bill*, expected to be published in 2011.⁴¹

³⁶ [2008] IEHC 104, [2009] 2 IR 7.

³⁷ *Ibid.*

³⁸ (LRC CP 59-2009) at 5.09.

³⁹ Citing Lord Donaldson in *Re T (refusal of medical treatment)* [1992] 4 All ER 649.

⁴⁰ (LRC 83-2006).

⁴¹ The *Programme for Government 2011-2016*, at 38, contains a commitment to “introduce a Mental Capacity Bill that is in line with the UN Convention on the Rights of Persons with Disabilities.” The *Government Legislation Programme*,

2.25 Laffoy J also explained that the assessment of capacity must have regard to:

“the gravity of the decision, in terms of the consequences which are likely to ensue from the acceptance or rejection of the proffered treatment.”

2.26 The reference by Laffoy J to the “gravity of the decision” has also featured in the case law on the capacity of persons under the age of 18. For example, in *North Western Health Board v HW and CW*⁴² the Supreme Court held that the primacy of parental decision-making for their children will only be overturned if the decision would threaten the life or urgent health needs of the very young child. A similar approach was taken by the Supreme Court of Canada in *AC v Manitoba (Director of Child and Family Services)*.⁴³

(4) *The Constitution, parental responsibility and the rights of persons under 18*

2.27 As already discussed in this Report in the context of the relevant general principles,⁴⁴ the position concerning the rights of children under the Constitution of Ireland was summarised in this way by Walsh J in the Supreme Court decision *G v An Bord Uchtála*:⁴⁵

“The child’s natural rights spring primarily from the natural right of every individual to life, to be reared and educated, to liberty, to work, to rest and recreation, to the practice of religion, and to follow his or her conscience... The child’s natural right to life and all that flows from that right are independent of any right of the parent as such.”

2.28 As the Commission has also already noted, in the context of very young children a decision by parents or guardians concerning their children will be upheld even if this is in conflict with the views of professional persons. For example, in *North Western Health Board v HW and CW*⁴⁶ the Supreme Court upheld the refusal of parents to allow doctors to carry out the “heel prick” PKU blood test on their baby son, even though the Court acknowledged that most parents are happy to consent to this test. The Court held that the primacy of

Summer Session 2011 (April 2011), available at www.taoiseach.ie, states that the *Mental Capacity Bill* is scheduled for publication in late 2011.

⁴² [2001] IESC 90, [2001] 3 IR 622, discussed at paragraph 2.28, below.

⁴³ 2009 SCC 30, [2009] 2 SCR 181, discussed at paragraph 2.119, below.

⁴⁴ See paragraph 1.21, above.

⁴⁵ *G v An Bord Uchtála* [1980] IR 32 at 69.

⁴⁶ [2001] IESC 90, [2001] 3 IR 622.

parental decision-making under Articles 41 and 42 of the Constitution (which the Commission has already noted reflect international human rights standards) will only be overturned (using the courts inherent jurisdiction to protect vulnerable persons, a post-constitutional version of the *parens patriae* jurisdiction) if the decision would threaten the life or urgent health needs of the very young child. In support of this analysis, Keane CJ's judgment in the *North Western Health Board* case referred to many court decisions from other states concerning the respective roles, responsibilities and rights of parents and young children. Keane CJ also referred to an English case, *Re E (A Minor)*,⁴⁷ which had involved a 15 year old boy, who was also a Jehovah's Witness and who had refused a blood transfusion. Keane CJ pointed out that the judge in the case, Ward J, had ordered the blood transfusion to proceed on the ground that, among other matters, the 15 year old in question "was not of sufficient understanding and maturity to give a full and informed consent."⁴⁸

2.29 The *North Western Health Board* case involved a baby boy and the reference to the English case of a 15 year old was clearly not central to the Supreme Court's analysis, but it indicates an awareness that the case of a 15 year old requires different analysis by comparison with that of a baby boy. Indeed, when the issue of the capacity of a young person at the age spectrum approaching adulthood arose directly in *McK v Information Commissioner*,⁴⁹ the Supreme Court held that the views of a young person who is 17 "are very relevant"⁵⁰ and may sometimes override a parent's presumed entitlement to be able to access health care information concerning their children.

2.30 The authority and responsibility of parents concerning their children can, therefore, be analysed using a sliding scale. Their authority and responsibility is at the high end of this sliding scale when the children are very young; and, as the child reaches their teenage years and approaches 18, it gradually moves to the lower end of the scale. In the 1969 English case *Hewer v Bryant*,⁵¹ Lord Denning MR summarised this sliding scale by stating that the

⁴⁷ *Re E (a minor) (wardship: medical treatment)* [1993] 1 FLR 386, discussed at paragraph 2.80, below.

⁴⁸ *North Western Health Board v HW and CW* [2001] IESC 90, [2001] 3 IR 622, at 701 (judgment of Keane CJ, summarising *Re E (a minor) (wardship: medical treatment)* [1993] 1 FLR 386).

⁴⁹ [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260. See the discussion at paragraph 1.65ff, above.

⁵⁰ [2006] 1 IR 260, 268.

⁵¹ *Hewer v Bryant* [1969] 3 All ER 578, 582, discussed at paragraph 2.54, below.

authority of parents in respect of their children “starts with a right of control and ends with little more than advice.”

2.31 In *D v Brennan and Ors*,⁵² the High Court used the same sliding scale approach evident in the Supreme Court decisions in *North Western Health Board v HW and CW*⁵³ and *McK v Information Commissioner*.⁵⁴ Against the backdrop of a difficult and complex factual background, the Court discussed the decision-making capacity of children, in particular those who are almost 18, in a health care setting. In the *D* case, the applicant was 16 years of age when she became pregnant. A scan revealed that her unborn baby had the fatal brain condition anencephaly (in effect, the absence of any brain cavity development), indicating that the baby could not survive. Having considered this information, the applicant decided that she should travel to England to terminate the pregnancy.

2.32 Independently of her pregnancy (arising from a domestic incident between the applicant and her mother, the details of which were not revealed), the Health Service Executive (HSE) obtained an interim care order in the District Court under the *Child Care Act 1991*, so that the applicant was then under the care of the HSE. In discussions between the applicant and her designated HSE social worker, the applicant reiterated her wish to travel to England for a termination. It appears that the HSE indicated that she should be prohibited from travelling to England for this purpose, but it also appeared that no decision had been made by the HSE as to whether this was consistent with the applicant’s “welfare” or whether the views of the applicant had been taken into account, as required by section 3 of the 1991 Act.

2.33 The applicant then applied to the High Court for a declaration that she had a right to travel to England for a termination and that any order prohibiting her from travelling would be invalid. The HSE initially opposed the

⁵² High Court, 9 May 2007. The judgment in this case had not been circulated publicly at the time of writing (July 2011). The Commission’s discussion of the case in this Report is based on a number of sources: the detailed discussion in Shannon, *Child Law* (Round Hall, 2010), paragraphs 7.06-7.11; the applicant’s submissions in the case, available at <http://www.ihr.org/publications/list/ad-minor-submissions>; and newspaper reports of the hearing (*The Irish Times*, 4-5 May 2007 and 10 May 2007). A transcript of the judgment in the case was made available to the European Court of Human Rights in connection with its decision in *A, B and C v Ireland* [2010] ECHR 2032: see paragraph 99 of the Court’s judgment.

⁵³ [2001] IESC 90, [2001] 3 IR 622.

⁵⁴ [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260.

application, but during the hearing in the High Court (in which the judge dealing with the case, McKechnie J, criticised the HSE for having failed to make a “welfare” determination under the 1991 Act) it was granted an adjournment in order to apply to the District Court to allow that court to determine whether an order should be made under the 1991 Act permitting the applicant to travel to England. Although all parties indicated to the District Court that the court was not prohibited from making such an order, it refused to make such an order. The HSE then applied to the High Court to have that refusal quashed, which the High Court heard together with the applicant’s case.

2.34 McKechnie J emphasised that the case did not involve any substantive issue concerning abortion, and was limited to the question of whether the applicant could lawfully be prohibited from travelling abroad. The applicant had turned 17 by the time of the court hearing, but as she remained a minor the Court had to determine her capacity to make this decision and whether her decision-making could operate independently of either the HSE or her mother. The applicant submitted that the HSE was, at most, acting in *loco parentis* under the 1991 Act and had no greater rights than her mother. She also submitted that her mother’s constitutional right as a parent would have to yield to the applicant’s constitutional right to travel, and that the HSE was not in any greater position than her mother would have been.⁵⁵ The case therefore involved submissions on the constitutional rights of children and their connection with, and independence from, the rights of parents.

2.35 As already discussed, some laws such as section 23 of the *Non-Fatal Offences Against the Person Act 1997* set a specific age at which a person is deemed to have capacity, whereas others, including the *Child Care Act 1991* refer to tests based on maturity. Bearing in mind that, in the *D* case, the issue was primarily whether the applicant had the maturity to decide whether to travel to England, the applicant submitted that the case fell within the parameters of the Supreme Court’s analysis in *McK v Information Commissioner*⁵⁶ that the views of a young person who is nearly 18 “are very relevant,”⁵⁷ and that the “applicant is 17 years and is at a time when her constitutional rights are waxing to full maturity and those of a parent waning accordingly.”⁵⁸ This clearly reflected the “sliding scale” approach discussed above.

⁵⁵ See paragraph 42 of the applicant’s submissions in the case, available at <http://www.ihrc.ie/publications/list/ad-minor-submissions>.

⁵⁶ [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260.

⁵⁷ [2006] 1 IR 260, at 268. See the discussion at paragraph 1.65ff, above.

⁵⁸ See paragraph 8 of the applicant’s submissions in the case, available at <http://www.ihrc.ie/publications/list/ad-minor-submissions>

2.36 In the *D* case, both the applicant and her mother were actually in agreement that she should travel to England for a termination, but McKechnie J had to consider whether, given that the HSE was in *loco parentis* under the *Child Care Act 1991*, the HSE (or the District Court exercising its powers under the 1991 Act) could override the expressed wishes of the applicant. In this respect, McKechnie J stated:

“It is imperative to recognise that children are born with rights and those rights continue right throughout childhood into teenage years, and become unaffected in their entirety by the parental relationship on reaching majority. These rights, which originally must be exercised on behalf of infants, usually by their parents, remain the rights of the children; and, commensurate with the progressive development and maturity of such a child, become capable of partial and, thereafter, full expression as adulthood arrives.”

2.37 McKechnie J commented that the applicant had displayed good moral judgement because she could have travelled to England without saying anything to the HSE, or could have pretended that she was feeling suicidal, which would have brought her within the parameters of a lawful termination in accordance with the Supreme Court decision in *Attorney General v X*.⁵⁹ Instead, she had chosen to resolve the issues involved by engaging in the judicial review proceedings. McKechnie J concluded that the applicant had shown “courage, integrity and maturity” throughout her ordeal in the wake of discovering the condition of her unborn baby. On this basis, McKechnie J held that there was no impediment to the applicant exercising her right to travel to England and he accordingly made the declarations sought by her.

2.38 By way of briefly summarising the case law in this area, the Commission notes that in *G v An Bord Uchtála*⁶⁰ the Supreme Court affirmed that the rights of children are “independent of any right of the parent as such.” Where a child is very young, the Supreme Court concluded in *North Western Health Board v HW and CW*⁶¹ that these rights are, in general, exercised on behalf of the child by his or her parents, subject to the exceptional circumstances referred to in Article 42 of the Constitution, and this in turn reflects the relevant international human rights instruments in this area. Where the child is at the other end of the age spectrum and is approaching adulthood in their teenage years, the Supreme Court has held, in *McK v Information*

⁵⁹ [1992] 1 IR 1.

⁶⁰ [1980] IR 32 at 69.

⁶¹ [2001] IESC 90, [2001] 3 IR 622.

*Commissioner*⁶² (and the High Court also took this approach in the *D* case), that the child's maturing capacity must be taken into account, which is of course consistent with the analysis in the *G* case that the child's rights are independent of the parent's rights. As already indicated, this sliding scale approach is also consistent with the long-standing approach of the common law, exemplified in the 1969 English decision *Hewer v Bryant*.⁶³ This sliding scale approach also has the advantage that it is in keeping with the literature on child development already discussed in this Report as well as the development of case law and legislation in other countries, which is discussed in Part C, below.

(5) *Problems arising in practice for those under 18, for parents/guardians and healthcare practitioners, and the 2009 Medical Council Guidelines*

2.39 The decisions in the Irish cases discussed support the general view that, as a child moves towards 18 years of age, their decision-making capacity waxes (increases) as, correspondingly, the decision-making position of their parents gradually wanes (decreases). In the specific context of this Report, the enactment by the Oireachtas of section 23 of the *Non-Fatal Offences Against the Person Act 1997* reflects a similar approach. In addition, a test based on maturity broadly mirrors the capacity test for those over 18 which, as already discussed in this Report, the Commission fully supports.

2.40 Nonetheless, the position is not as clear as in other countries where well-developed case law – as well as legislation that applies to both the civil and criminal law settings – has provided a clear framework under which health care practitioners can work with those under 18. As discussed in Part C, in England and Wales, the enactment of the *Family Law Reform Act 1969* (and, in Northern Ireland, the equivalent *Age of Majority Act (Northern Ireland) 1969*) provided clarity in the civil law setting in respect of 16 and 17 year olds. The decision of the UK House of Lords in 1985 in *Gillick v West Norfolk and Wisbech Area Health Authority*⁶⁴ provided a degree of comparable clarity concerning those under 16, at least in the context of contraception. The *Gillick* decision reflected the then-developing concept of the “mature minor” and the Commission discusses in Part C developments in other countries, both before and after the *Gillick* decision. This has included many legislative provisions that clarify the position, as well as other landmark court decisions, including the 2009 decision

⁶² [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260. See the discussion at paragraph 1.65ff, above.

⁶³ [1969] 3 All ER 578, at 582, discussed in paragraph 2.54, below.

⁶⁴ [1985] UKHL 7, [1985] 3 All ER 402.

of the Supreme Court of Canada in *AC v Manitoba (Director of Child and Family Services)*.⁶⁵

2.41 Thus, while the decisions in the *McK* case and the *D* case are at least consistent with the view that 16 and 17 year olds often have the capacity to make significant health care decisions, and that the concept of a “mature minor” is also consistent with this approach, there is no definitive legal framework that clarifies the respective rights and responsibilities of those under 18, their parents and guardians, still less the health care professional who come in contact with them.

2.42 The Commission is especially conscious in this respect that clarity is needed in the healthcare setting in respect of the legal capacity of 16 and 17 year olds (in particular, as far as civil liability is concerned) and of those under 16. The ambiguity surrounding this area has created practical problems for health care practitioners. A 2005 training manual of the Irish College of General Practitioners highlights the present difficulties:

“The legal situation regarding consent and minors remains confused and there is no indication that legislation addressing the issue is imminent. However doctors, and GPs in particular, encounter this issue in clinical practice on a regular if not daily basis.”

2.43 It is not surprising, therefore, that many of the submissions received by the Commission on the Consultation Paper stated that reform of the law on children and medical treatment would be welcome and is overdue.

2.44 In the absence of a clear legislative framework, health care practitioners have referred to section 23 of the *Non-Fatal Offences Against the Person Act 1997* to support their approach to consent from 16 and 17 year olds. The confusing nature of the present legal situation is brought sharply into focus when one considers the legal position of a person under 16 years of age who is a parent. It is largely accepted that a young mother can consent to medical treatment on behalf of her child yet her legal capacity to make decisions in relation to her own medical treatment is unclear.⁶⁶ The Commission received a number of submissions debating this issue, and highlighting the difficulties faced by healthcare providers, when treating a child whose mother is 14 or 15 years of age. These situations are often complex, involving a sick child, a young

⁶⁵ 2009 SCC 30, [2009] 2 SCR 181.

⁶⁶ Staff Guidelines for Obtaining Consent for Non Emergency Treatment/Services from Parents of Children and Young People under 18 Years of Age. See: <http://www.hse.ie/eng/services/Publications/services/Children/medicalconsent.pdf>

mother,⁶⁷ a grandparent and a healthcare practitioner who must adhere to the requirements of an uncertain law while also acting in the best interests of the child. One of the points raised by healthcare providers is that the mother of the child and the grandparent of the child may not have a very good relationship, or perhaps the grandparent may not be willing or available to commit to acting as a quasi-guardian for his or her grandchild.

2.45 In this context, and in the absence of a general statutory framework, the Medical Council's 2009 *Guide to Professional Conduct and Ethics*⁶⁸ provides useful guidance as to the approach of doctors when dealing with persons under 18. The relevant provisions in the 2009 *Guide* are:

“43 Children and minors

43.1 Children and young people should be involved as much as possible in discussions about their healthcare. When you are talking to a child or young person, it is important to give them information in an age-appropriate manner, listen to their views and treat them with respect.

43.2 Patients aged 16 years and over are entitled by law to give their own consent to surgical, medical or dental treatment [the 2009 *Guide* refers in a footnote to section 23 of the *Non-Fatal Offences Against the Person Act 1997*]. This entitlement does not apply to other areas such as organ or tissue donation or participation in medical research.

43.3 A refusal of treatment by a patient between 16 and 18 years, which is against medical advice and parental wishes, is of uncertain legal validity. In this event, you should consider seeking legal advice before acting on such a decision.

43.4 Where the patient is under the age of 16 years, it is usual that the parents will be asked to give their consent to medical treatment on the patient's behalf.

⁶⁷ A father's right to consent to medical treatment on behalf of his child is largely dependent on whether or not the father is a guardian of the child. Currently, non-marital fathers do not have automatic joint guardianship responsibility. In the Commission's *Report on Legal Aspects of Family Relationships* (LRC 101-2010), the Commission recommended that non-marital fathers should have automatic joint guardianship responsibility (which the Commission also recommended should be renamed joint parental responsibility).

⁶⁸ Medical Council's 2009 *Guide to Professional Conduct and Ethics* (7th ed, 2009), available at www.medicalcouncil.ie.

43.5 In exceptional circumstances, a patient under 16 might seek to make a healthcare decision on their own without the knowledge or consent of their parents. In such cases you should encourage the patient to involve their parents in the decision, bearing in mind your paramount responsibility to act in the patient's best interests.

43.6 When treating children and young people, you should remember your duties of confidentiality as provided in paragraph 24 [of the 2009 *Guide*], subject to parental rights of access to medical records which may arise by law [the 2009 *Guide* refers in a footnote to the *Freedom of Information Act 1997 (Section 28(6)) Regulations 1999*]. You should tell these young patients that you cannot give an absolute guarantee of confidentiality.”

2.46 The Commission notes the following aspects of the Medical Council's 2009 *Guide*:

- As to 16 and 17 year olds, paragraph 43.2 of the 2009 *Guide* is consistent with the existing legislative provisions in this area, notably section 23 of the *Non-Fatal Offences Against the Person Act 1997*. While the Commission has already pointed out that the 1997 Act is limited to the criminal law only, the 2009 *Guide* correctly refers to the 1997 Act for the purpose of providing guidance to doctors.
- Paragraph 43.2 of the 2009 *Guide* also correctly notes, as has the Commission in this Report, that the definition of medical treatment in the 1997 Act is limited in scope. The Commission has recommended in this Report that the scope of health care and treatment should be expanded, without prejudice to other specific provisions such as the legislation dealing with clinical trials.
- It is clear that the Medical Council felt constrained by the fact that section 23 of the 1997 Act refers to consent to treatment only, so that paragraph 43.3 of the 2009 *Guide* takes a more cautious approach to refusal of treatment. As discussed above, the Commission has concluded that it is appropriate to view capacity to refuse treatment as a corollary to capacity to consent to treatment, and paragraph 43.3 of the 2009 *Guide* underlines the need for a clearer legislative framework in this area.
- As to those under 16, paragraphs 43.4 and 43.5 of the 2009 *Guide* also reflect in general terms the current law as set out in the Irish decisions already referred to, such as the *G*, *McK* and *D* cases, which in turn reflect the provisions on the family in Article 41 of the Constitution and in the relevant international standards already discussed in this Report. Thus, the 2009 *Guide* correctly identifies that

the “usual” position is that parents should be asked for their consent, but that in “exceptional circumstances” the doctor would “encourage” the under 16 year old to involve their parents, bearing in mind the doctor’s “paramount responsibility to act in the patient’s best interests.” While this general guidance is useful, the Commission notes that it does not provide specific guidance on the nature of the “best interests” test. Nor does it refer to a maturity test, which as the Commission has already noted is already part of Irish law (through both the case law and legislation already noted in this Report).

- Paragraph 43.6 of the 2009 *Guide* refers to the competing interests of patient confidentiality and of access by parents to health information concerning their children; and the 2009 *Guide* refers in this respect in a footnote to the *Freedom of Information Act 1997 (Section 28(6)) Regulations 1999*. The Commission has already noted in this Report that the 1999 Regulations were discussed by the Supreme Court in the *McK* case, in which the Court concluded that a maturity test could displace the usual presumption in favour of parental access. The Commission considers that a general legislative framework would also bring greater clarity and specificity to this aspect of health care treatment for those under 18.

2.47 The Commission acknowledges that the Medical Council’s 2009 *Guide* has provided as much general guidance to doctors as is feasible in the absence of any general legislative framework in Ireland. Because the 2009 *Guide* is necessarily limited to doctors, and in the absence of any general legal framework or comprehensive guidance, a number of hospitals in Ireland have developed practice guidelines for all health professionals. Guidelines developed by one of the leading children’s hospital in Dublin state that, in the light of current legal uncertainty, it is prudent practice to attempt to obtain the consent of an appropriate next of kin who is competent to consent (where the consent is in the best interests of the child), including all parties in the consent process. These guidelines state that it is also important to ensure that, if the next of kin gives or give consent, their signature is recorded and that such situations are recorded in detail in the patient’s medical records. In cases of doubt or uncertainty these guidelines recommend, in line with the Medical Council’s 2009 *Guide*, that healthcare providers seek further legal advice. From the Commission’s point of view, it seems highly impractical and burdensome for healthcare providers to obtain the consent of a child’s grandparent, and possibly seek legal advice, before they can feel legally secure in treating the child.

2.48 A number of submissions received by the Commission drew attention to other areas of difficulty and confusion in respect of capacity and consent for the medical care of a person under 16 years of age. For example, issues often

arise over who may consent to medical treatment for a foster child,⁶⁹ or a child who is in care. In relation to attempts to obtain consent from parents or guardians when a child or young person is in foster care or in the care of the Health Service Executive under the *Child Care Act 1991*, the situation creates practical problems and delay in obtaining consent for necessary treatment. This is particularly the case where the child or young person in question does not have a good relationship with his or her parents or guardians, or in situations where the parent or guardian is hostile and uncooperative.

2.49 In connection specifically with children under 16 years of age, health care practitioners have, in the absence of any clear legislative framework and in an attempt to implement the general approach in the Medical Council's 2009 *Guide*, adopted the "mature minor" concept developed in other countries, which the Commission discusses below. In a 2009 study of Irish GPs,⁷⁰ some doctors viewed as persuasive the "Fraser Guidelines", the criteria set out by Lord Fraser in the 1985 UK House of Lords decision in *Gillick v West Norfolk and Wisbech Area Health Authority*,⁷¹ discussed below. Indeed, the approach in the Irish cases discussed, such as the *McK* case and the *D* case, are consistent with the "mature minor" concept in *Gillick* and in the comparable case law and legislation in other countries discussed below. Nonetheless, it is not perhaps surprising that the 2009 study found that 53.8% of the surveyed GPs felt "legally exposed" when consulted by girls under 16 seeking contraception. The survey also found that 33.9% of parents felt that a GP who prescribed to a girl under 16 could be pursued legally by her parents, though in this respect the Commission notes that Irish case law – and the proviso in section 23(3) of the *Non-Fatal Offences Against the Person Act 1997* – suggests that the consent of some persons under 16 is valid and that some element of parental responsibility may be "waning" even at that age.

⁶⁹ Regulation 16(2)(d) of the *Child Care (Placement of Children in Foster Care) Regulations 1995* (SI No.260 of 1995), made under the *Child Care Act 1991*, states that foster parents must seek appropriate medical aid for the child if the child suffers from illness or injury. Guidance issued by the Department of Health and Children suggests that foster carers have the capacity to consent to urgent medical treatment if, in the clinical judgement of the medical practitioner, it is necessary in the interest of the child's welfare: see Appendix 2 of the *National Standards for Foster Care* (Department of Health and Children, 2003).

⁷⁰ McMahan et al, "The Prescribing of Contraception and Emergency Contraception to Girls Aged Less than 16 – What are the Views and Beliefs of GPs and of Parents?" (2010) 16, 2 MLJI 91.

⁷¹ [1985] UKHL 7, [1985] 3 All ER 402.

2.50 The 2009 study of actual prescribing by GPs indicates that 82% had prescribed to a girl under 16.⁷² Of these, 38% said it was always with parental consent, 59% said they sometimes had parental consent and 3% never obtained parental consent. Those involved in the study were also asked whether they considered such prescribing was lawful. In response, 60.2% of parents and 38.5% of GPs considered that it was not legal, while 14% of parents and 31.6% of GPs thought it was legal. The Commission notes that this view appears to confuse the age of consent in the context of the criminal law, which is 17, with the lawfulness of providing contraceptive treatment; these are two distinct legal matters.

2.51 The 2009 study also indicated that existing practice may focus largely on age rather than a maturity test. This is so even though, as already noted, some legislation in Ireland as well as decisions such as the *McK* case and the *D* case have already applied such a maturity test, and that this approach also reflects relevant international standards concerning children. The 2009 study also indicated that all those involved in the process would welcome clear guidance on the matter, and this reinforces the Commission's approach in this project. Indeed, the necessarily general nature of the discussion in the Medical Council's 2009 *Guide* also supports the need for a clearer legislative framework.

C Capacity of Persons under 18 to Consent to and Refuse Treatment in Other Countries

2.52 The Commission now turns to examine the development of the approach in other countries concerning consent to, and refusal of, health care treatment by persons under 18. The Commission examines the relevant developments in England and Wales, Northern Ireland, Scotland, Canada, Australia and New Zealand. Some of these countries have enacted clear legislative rules on 16 and 17 years olds which clarify that they have capacity to consent to and refuse medical treatment. Indeed, in Scotland the general age of majority has been reduced from 18 to 16, and this includes of course the right to consent to, and refuse, treatment. As to those under 16, variations on a "mature minor" rule have been developed, and the issue has often been incorporated into suitable legislative frameworks supported by detailed guidance. In parallel with legislation, "mature minor" tests have been developed through landmark test cases, such as the 1985 decision of the UK House of Lords in *Gillick v*

⁷² McMahon et al, "The Prescribing of Contraception and Emergency Contraception to Girls Aged Less than 16 – What are the Views and Beliefs of GPs and of Parents?" (2010) 16, 2 MLJI 91.

*West Norfolk and Wisbech Health Authority*⁷³ and the 2009 decision of the Supreme Court of Canada in *AC v Manitoba (Director of Child and Family Services)*.⁷⁴

(1) England and Wales

2.53 As already mentioned, since the enactment of section 8 of the English *Family Law Reform Act 1969*, English law has clearly provided that 16 and 17 year olds have capacity to consent to medical treatment. The 1969 Act implemented the key recommendations in the 1967 *Report of the Committee on the Age of Majority*, the Latey Report,⁷⁵ which had recommended that the general age of majority be reduced from 21 to 18, and that 16 and 17 year olds should be deemed to have capacity to consent to, and to refuse, medical treatment. As also already noted, while section 8 of the English 1969 Act formed the basis for the almost identical text in section 23 of the *Non-Fatal Offences Against the Person Act 1997*, the 1969 Act dealt with the issue of civil and criminal liability whereas the Irish 1997 Act deals with criminal liability only.

2.54 The position of those just under 18 years of age had also been discussed in 1969 by the English Court of Appeal in *Hewer v Bryant*,⁷⁶ a case decided just one month before the 1969 Act was enacted⁷⁷ and in which one of the judges, Lord Denning MR, referred with approval to the general approach taken in the 1967 Latey Report, on which the 1969 Act was based. The *Hewer* case concerned the statutory time limit for bringing a personal injuries action. When the plaintiff was 15 years old, he was injured in a car driven by the defendant while on a farm training vocational course. Because he was a minor at the time, any claim would have to have been taken on his behalf by an adult such as his father; but his father decided not to do so.⁷⁸ Under the relevant

⁷³ [1985] UKHL 7, [1985] 3 All ER 402.

⁷⁴ 2009 SCC 30, [2009] 2 SCR 181.

⁷⁵ *Report of the Committee on the Age of Majority* (chaired by Latey J), Cmnd.3342, July 1967.

⁷⁶ [1969] 3 All ER 578.

⁷⁷ The *Hewer* case was decided in June 1969, and the English *Family Law Reform Act 1969* was enacted in July 1969.

⁷⁸ This was because the father thought that (a) the plaintiff, his son, would make a full recovery and (b) there was no insurance in place to deal with the type of car crash that had occurred. When his father later realised that his son was, in fact, quite badly affected by the accident and that the claims would be covered by insurance, it was too late for the father to bring proceedings, and this was why the son brought the claim.

provisions of the UK *Limitation Act 1939*, there was a general three year time limit for bringing the claim, but this only applied to adults. For those under the age of majority, which was 21 at the time, the English *Limitation Act 1939* regarded such persons as being under an “age disability” and so the general three year time limit only began to run when the plaintiff reached 21. Three weeks after his 21st birthday, the plaintiff began a claim against the defendant, which was over 5 years after the car crash. The defendant argued that the claim was statute-barred under the 1939 Act because of another provision in the 1939 Act which stated that the normal three year limitation period applied if the person under 21 was, at the time of the accident, “in the custody of a parent.” If this provision applied, the plaintiff’s claim would have been statute barred.

2.55 The English Court of Appeal had to decide whether “custody” as used in the UK *Limitation Act 1939* was: (a) a legal concept meaning that all minors, at that time those under 21, remained completely under the custody and control of their parents until they reached the then age of majority at 21; or (b) a factual concept, so that a person such as the plaintiff was only in the custody of their parents if the parents were actually exercising “care and control” over him. The Court decided that the 1939 Act was intended to mean the factual concept, that is, actual care and control. In this respect, the evidence indicated that the plaintiff was not in his father’s “custody” within the meaning of the 1939 Act, because when he had been attending the farm training vocational course he paid his own way while on the course, including paying his own bus and train fares home on his occasional free weekends. On that basis, the Court concluded that the plaintiff’s claim was not statute-barred, and the case against the defendant was allowed to proceed.

2.56 One of the judges in the case, Karminski LJ, also noted that if, for example, the father had applied to court for a custody order over his son it would probably not have been given. He stated:

“in the circumstances of this case the court would be at least very slow to make an order in respect of a mature boy approaching the age of 16, especially as such an order would be very difficult to enforce if the boy refused to obey it.”⁷⁹

2.57 Another judge in the *Hewer* case, Lord Denning MR, took a similar view, namely that the concept of “custody” by a parent was a factual concept rather than a legal concept. He therefore rejected the “legal concept” view, set out in 1883 in *Re Agar-Ellis*,⁸⁰ that a person remained under the complete

⁷⁹ [1969] 3 All ER 578, at 588.

⁸⁰ (1883) 24 Ch D 317, at 326, in which Brett MR had stated: “... the law in England... is, that the father has control over the person, education and conduct of his children until they are twenty-one years of age. That is the law.”

custody and control of their parents until they were 21. Lord Denning MR pointed out that *Re Agar-Ellis*:

“reflects the attitude of a Victorian parent towards his children. He expected unquestioning obedience to his commands. If a son disobeyed, his father would cut him off with 1 shilling. If a daughter had an illegitimate child, he would turn her out of the house. His power only ceased when the child became 21.”⁸¹

2.58 He added: “I decline to accept a view so much out of date.” Lord Denning MR then went on to state that the law should be updated to reflect the reality of the position of parents and their teenage children in the second half of the 20th century. His analysis, which is set out below, included a reference to the 1967 Latey Report whose recommendations would, just one month later, be enacted in the *Family Law Reform Act 1969*. Lord Denning MR stated:

“The common law can, and should, keep pace with the times. It should declare, in conformity with the recent *Report on the Age of Majority* [the 1967 Latey Report], that the legal right of a parent to the custody of a child ends at the eighteenth birthday; and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, the older he is. *It starts with a right of control and ends with little more than advice.*”⁸²

2.59 The general view of the English Court of Appeal in the *Hewer* case involves an important approach to analysing the relationship between parents and their older teenage children. The Court rejected the “legal ownership” concept of “custody” taken in the 1883 decision in *Re Agar-Ellis*. Instead, a more realistic analysis was taken, in which the court accepted that it would, for example, be futile to insist on enforcing custody orders on someone who was almost 16 years old. Indeed, Karminski LJ referred to a 15-nearly-16 year old as a “mature boy”, which anticipates the concept of the “mature minor” that was developed in later cases, such as the *Gillick* case discussed below (and comparable cases in other countries, also discussed below).

2.60 Lord Denning MR took the same general approach, noting that the virtually complete “control” of parents concerning their very young children gave way, realistically, to “little more than advice” as the children reached the age of majority of 18. As he noted this was exactly as the 1967 Latey Report had recommended and which Lord Denning (who was not only a judge of the Court of Appeal but also a member of the UK House of Lords in its legislative role) may have been aware was about to be implemented a month later in the

⁸¹ [1969] 3 All ER 578, at 582.

⁸² [1969] 3 All ER 578, at 582 (emphasis added).

English *Family Law Reform Act 1969*. This approach to the waning of the parental role, and the corresponding waxing of the role of children, also anticipated the approach taken in later international standards, such as the 1989 UN Convention on the Rights of the Child, and is now also reflected in Irish legislation (such as the *Child Care Act 1991* and the *Adoption Act 2010*) and Irish case law (such as the *McK* case and the *D* case), discussed above.

2.61 The position of those under 16 years of age was not dealt with explicitly in the English *Family Law Reform Act 1969*. As already noted, however, section 8(3) of the 1969 Act amounted to a “saver” clause, in that it preserved whatever capacity was already conferred on those under 16 by the existing common law rules on capacity, which the decision in the *Hewer* case had reinforced in a modern setting.

2.62 This was the background to the landmark 1985 decision of the UK House of Lords⁸³ in *Gillick v West Norfolk and Wisbech Health Authority*.⁸⁴ The *Gillick* decision has been described as the most significant English case of the 20th century on the legal relationship between parents and children,⁸⁵ though the decision in *Hewer* had already clearly indicated that “mature” persons under 16 had important decision-making capacity that could operate independently of their parents. No doubt, the discussion in 1969 of the decision-making capacity of a 15 year old male in the context of the application of limitation periods to personal injuries litigation did not attract the publicity that the discussion in 1985 of the decision-making capacity of a 15 year old to access the contraceptive pill.

2.63 The *Gillick* case concerned a challenge by Mrs Gillick, a mother of five daughters under the age of 16, to the legality of guidance issued in 1980 by the English Department of Health and Social Security to health authorities, including West Norfolk and Wisbech Area Health Authority. The key part of the guidance stated:

“There is widespread concern about counselling and treatment for children under 16. Special care is needed not to undermine parental responsibility and family stability. The Department would therefore hope that in any case where a doctor or other professional worker [such as a nurse] is approached by a person under the age of 16 for advice in these matters, the doctor, or other professional, will always seek to persuade the child to involve the parent or guardian (or other person in loco parentis) at the earliest stage of consultation, and will proceed from

⁸³ Since 2009, replaced in terms of its judicial function by the UK Supreme Court.

⁸⁴ [1984] 1 All ER 365 (English High Court); [1985] 1 All ER 533 (English Court of Appeal); [1985] UKHL 7, [1985] 3 All ER 402 (UK House of Lords).

⁸⁵ Bainham *Children and the Modern Law* (3rd ed Family Law 2005) at 346.

the assumption that it would be most unusual to provide advice about contraception without parental consent.

It is, however, widely accepted that consultations between doctors and patients are confidential; and the Department recognises the importance which doctors and patients attach to this principle. It is a principle which applies also to the other professions concerned. To abandon this principle for children under 16 might cause some not to seek professional advice at all. They could then be exposed to the immediate risks of pregnancy and of sexually-transmitted diseases, as well as other long-term physical, psychological and emotional consequences which are equally a threat to stable family life. This would apply particularly to young people whose parents are, for example, unconcerned, entirely unresponsive, or grossly disturbed. Some of these young people are away from their parents and in the care of local authorities or voluntary organisations standing in loco parentis.

The Department realises that in such exceptional cases the nature of any counselling must be a matter for the doctor or other professional worker concerned and that the decision whether or not to prescribe contraception must be for the clinical judgement of a doctor.”

2.64 The 1980 guidance can be broken down into 6 elements: (i) that special care was needed “not to undermine parental responsibility and family stability” and that, therefore, a doctor “will always seek to persuade the child to involve the parent or guardian doctor at the earliest stage of consultation”; (ii) that the doctor “will proceed from the assumption that it would be most unusual to provide advice about contraception without parental consent”; (iii) that consultations between doctors and patients are confidential, and that this applies to those under 16; (iv) that the confidentiality of consultations needs to be upheld because its absence could cause some under 16s not to seek professional advice at all, which could then expose them to “the immediate risks of pregnancy and of sexually-transmitted diseases, as well as other long-term physical, psychological and emotional consequences which are equally a threat to stable family life;” (v) that these risks would apply particularly to young people whose parents are, for example, unconcerned, entirely unresponsive, or grossly disturbed, and that this would especially apply where the young people are in the care of the State or voluntary organisations standing in loco parentis; and (vi) that in the “exceptional cases” described in the guidance, the counselling to be given is a matter for the doctor or other professional worker, such as a nurse, and “that the decision whether or not to prescribe contraception must be for the clinical judgement of a doctor.”

2.65 The 1980 guidance therefore proceeded on the basis that it would be "most unusual" to provide advice about contraception without parental consent. Because it also referred to certain cases where difficulties might arise if the doctor refused to promise that his advice would remain confidential, it concluded that the DHSS realised that "in such exceptional cases" the decision whether or not to prescribe contraception must be for the clinical judgment of a doctor. In effect, therefore, the guidance stated that in those circumstances a doctor would not be acting unlawfully by prescribing contraceptives, primarily the contraceptive pill, to a young person under 16 years of age to protect her from the risks of pregnancy or sexually-transmitted disease. Crucially, the guidance stated that this could be done without parental knowledge let alone consent, though only in the "exceptional" and "unusual" cases specified. This guidance was based on the authorities' view of the then-existing common law position concerning the capacity of those under 16 to consent to certain medical treatment.

2.66 Mrs Gillick applied for a declaration that the advice in the guidance was unlawful because it breached her parental rights. The *Gillick* case thus required the English courts to consider two related matters: the rights and entitlement of parents concerning their children, in particular their adolescent children; and the mental capacity of those children. It also required the courts to decide whether a version of the "mature minor" rule, which had in some respect already been acknowledged in section 8(3) of the *Family Law Reform Act 1969* and in the *Hewer* case (and which was beginning to evolve at that time in other countries), could or should be developed in English law.

2.67 In *Gillick* the UK House of Lords decided, by a 3-2 majority, that the guidance issued by the English Department of Health and Social Security was lawful.⁸⁶ The three judges in the majority agreed with the 1969 decision of the Court of Appeal in *Hewer v Bryant*,⁸⁷ discussed above, that parental rights in relation to their children recede as their child matures, and they also concluded that a strict age rule in relation to consent to medical treatment for those under 16 (as opposed to the clear rule for 16 and 17 year olds in section 8 of the English *Family Law Reform Act 1969*) would not take account of the growing maturity and capacity of the child. The majority judgments in *Gillick* stressed that the significant factor in assessing the capacity of a person under 16 was

⁸⁶ In the English High Court, in *Gillick v West Norfolk and Wisbech Area Health Authority* [1984] 1 All ER 365 Woolf J had upheld the legality of the 1980 DHSS guidance. The English Court of Appeal overturned that decision ([1985] 1 All ER 533), and the UK House of Lords ultimately took the same view as Woolf J and upheld the legality of the DHSS guidance

⁸⁷ [1969] 3 All ER 578.

not the age of the individual but his or her ability to understand fully what was proposed.

2.68 The House of Lords in *Gillick* thus decided that a child under the age of 16 does not lack capacity by virtue of age alone, and that his or her capacity should not be determined by reference to a judicially fixed age limit. One of the judges in the majority, Lord Scarman stated:⁸⁸

“I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed... The law relating to parent and child is concerned with the problems of the growth and maturity of the human personality. If the law should impose on the process of ‘growing up’ fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change.”⁸⁹

2.69 It is clear, therefore, that Lord Scarman was reluctant to set down a definitive rule concerning those under 16 and preferred a maturity test instead. This approach is consistent with the literature on child development and early adulthood already discussed by the Commission in Chapter 1, above.

2.70 One of the other judges in the majority in the *Gillick* case, Lord Fraser, went somewhat further by setting out five matters which, if followed by a prescribing doctor, would mean that the doctor would be acting lawfully in prescribing contraceptives to an under 16 year old. These five matters, or guidelines, have become known as the “Fraser Guidelines” and, crucially mean that a doctor can proceed, as Lord Fraser stated, “without the parents’ consent or even knowledge.” In the relevant part of his judgment, Lord Fraser stated:

“The doctor will, in my opinion, be justified in proceeding without the parents’ consent or even knowledge provided he is satisfied on the following matters:

1. that the girl (although under 16 years of age) will understand his advice
2. that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice
3. that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment

⁸⁸ [1985] 3 All ER 402, at 422-3.

⁸⁹ [1985] 3 All ER 402, at 422-3.

4. that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer
5. that her best interests require him to give her contraceptive advice, treatment or both without parental consent.”⁹⁰

2.71 Although these five matters were set out by Lord Fraser alone, rather than a majority of the judges in the *Gillick* case, the “Fraser Guidelines” as they have become known, have virtually achieved the status of definitive rules. The “Fraser Guidelines” are certainly followed as best practice in England in the context of providing contraception to young people under 16 years of age. Indeed, they were repeated in full in guidelines issued by the English Department of Health in 1986 and updated in 2004, replacing the 1980 guidance which had led to the *Gillick* case itself. The 2004 guidance reiterated the principle of confidentiality that had been set out in the 1980 guidance, and then stated:

“It is considered good practice for doctors and other health professionals to consider the following issues when providing advice or treatment to young people under 16 on contraception, sexual and reproductive health.

If a request for contraception is made, doctors and other health professionals should establish rapport and give a young person support and time to make an informed choice by discussing:

- The emotional and physical implications of sexual activity, including the risks of pregnancy and sexually transmitted infections.
- Whether the relationship is mutually agreed and whether there may be coercion or abuse.
- The benefits of informing their GP and the case for discussion with a parent or carer. Any refusal should be respected. In the case of abortion, where the young woman is competent to consent but cannot be persuaded to involve a parent, every effort should be made to help them find another adult to provide support, for example another family member or specialist youth worker.
- Any additional counselling or support needs.

Additionally, it is considered good practice for doctors and other health professionals to follow the criteria outlined by Lord Fraser in 1985, in the House of Lords’ ruling in the case of *Victoria Gillick v West Norfolk and Wisbech Health Authority and Department of Health and Social Security*. These are commonly known as the *Fraser Guidelines*:

⁹⁰ [1985] 3 All ER 402, at 413.

- the young person understands the health professional's advice;
- the health professional cannot persuade the young person to inform his or her parents or allow the doctor to inform the parents that he or she is seeking contraceptive advice;
- the young person is very likely to begin or continue having intercourse with or without contraceptive treatment;
- unless he or she receives contraceptive advice or treatment, the young person's physical or mental health or both are likely to suffer;
- the young person's best interests require the health professional to give contraceptive advice, treatment or both without parental consent."⁹¹

2.72 It is clear, therefore, in the wake of this revised guidance from the DHSS, that English health care practitioners are required to adopt as best practice the "Fraser Guidelines" from the *Gillick* case. The decision in *Gillick* has also had a wider influence in the development of various legislative provisions in England dealing with children. While the *Gillick* case was confined to contraception, the "Fraser Guidelines" have become a general template for a more wide-ranging "mature minor" rule in English law. Focusing in particular on the test of mental capacity referred to by Lord Scarman, and the first matter mentioned by Lord Fraser in the "Fraser Guidelines" – that the person under 16 understands the health care advice being given – the English version of the "mature minor" rule is also sometimes summarised as being that the person under 16 "is *Gillick* competent" or "has *Gillick* competence."

2.73 The essence of the English "mature minor" rule, or "*Gillick* competence," is therefore that the person under 16 understands the health care advice being given. This general rule has, since 1985, been included in legislative provisions which set out a test of the legal capacity of a person under 18, including the "mature minor" under 16, to consent to and refuse medical treatment generally. In this respect, the English *Children Act 1989* contains five provisions which give a person under the age of 18 – who has sufficient understanding to make an informed decision (referred to by Lord Scarman in *Gillick* and the first matter referred to in the "Fraser Guidelines" in *Gillick*) – the power to refuse to submit to medical and psychiatric examinations and other

⁹¹ *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health* (English Department of Health, 2004), available at www.dh.gov.uk.

assessments.⁹² For example, section 38(6) of the English *Children Act 1989*, which deals with interim care orders concerning a “child”, that is, a person under 18 years of age, states:

“Where the court makes an interim care order, or interim supervision order, it may give such directions (if any) as it considers appropriate with regard to the medical or psychiatric examination or other assessment of the child; *but if the child is of sufficient understanding to make an informed decision he may refuse to submit to the examination or other assessment.*” (emphasis added)

2.74 As already mentioned, this version of a maturity test is consistent with international standards in this area, including for example the 1989 UN Convention on the Rights of the Child (UNCRC), and in comparable provisions in Ireland in for example, the *Child Care Act 1991*. In this context, it is important to note that some elements of the “Fraser Guidelines” in the *Gillick* case, and the comparable approach in the English *Children Act 1989*, take a rights-based view of those under 16. It is equally important to note that another important element of both the common law and statutory approaches to those under 16 is that the “best interests” of the person under 16 remains a matter to take into account. Thus, while the *Gillick* case remains a landmark decision in this area, subsequent cases have pointed out that the views of a person under the age of 16 cannot be equated with those of an 18 year old, who has actually reached the age of majority. In some cases, the question that arises is, as in *Gillick*, what role parents have, while in others the question of some other overriding consideration, such as the preservation of life, is involved.

2.75 As to the role of parents, two decisions of the English Court of Appeal, *Re R*⁹³ and *Re W*,⁹⁴ led to the development of the concept of “concurrent consent.” The first of these cases, *Re R*, involved a 15 year old girl who had a mental health illness which involved periods of violent and suicidal behaviour followed by lucid thought. The 15 year old refused to take medication. Wardship proceedings, under which she would be subject to court supervision, were then initiated. The English Court of Appeal concluded that, even if she were “*Gillick* competent” (and because of the extremity of her behaviour the Court held she could not be), consent could be given by somebody else with parental responsibility, or by the court using its inherent powers to act as the

⁹² See sections 38(6), 43(8), 44(7) and paragraphs 4(4)(a) and 5(a) of Schedule 3 of the *Children Act 1989*. See Brazier and Bridge “Coercion or caring: analysing adolescent autonomy” (1996) 16 *Legal Studies* 84 at 96.

⁹³ *Re R (a minor) (wardship: consent to medical treatment)* [1991] 4 All ER 177.

⁹⁴ *Re W (a minor) (medical treatment: court's jurisdiction)* [1992] 4 All ER 627.

equivalent of a parent (referred to in England as the *parens patriae* jurisdiction of the courts). One of the judges, Lord Donaldson, likened consent to a key and concluded that refusal to have treatment by a “*Gillick* competent” child did not prevent the necessary consent being obtained by another source, that is, another “key holder”, whether her parents or a court.

2.76 In the second case, *Re W*,⁹⁵ a 16 year old who had *anorexia nervosa* refused any medical treatment for her condition. As in *Re R*, above, wardship proceedings were then initiated. In this case, the Court decided that section 8 of the English *Family Law Reform Act 1969*, discussed above, did not give the 16 year old child an absolute right to refuse treatment; rather, it protected the doctors from criminal prosecution by allowing her to consent as if she were an adult. In this respect, a new analogy was introduced by Lord Donaldson, on the basis that keys could lock as well as unlock and a minor cannot lock the door to treatment. This was based on viewing consent as a flak jacket, to protect doctors from prosecution:

“Anyone who gives him a flak jacket may take it back, but the doctor only needs one and as long as he continues to have one he has the legal right to proceed.”⁹⁶

2.77 Applying the general approach in the *Gillick* case, the Court in *Re W* accepted that as a child matured so did his or her ability to express his or her wishes and feelings. In this case, however, the Court concluded that the fifth matter set out in the “Fraser Guidelines” from *Gillick* – what was in her best interests – meant that her wishes should not be carried out, especially because one symptom of anorexia was, at least, in part, a desire not to get better.

2.78 The analogies used by Lord Donaldson in these two English cases have been criticised as reducing consent to a mere formality, designed to protect doctors from litigation.⁹⁷ It has also been suggested that the “concurrent consent” approach involves a retreat from *Gillick* and the approach in the English *Children Act 1989*, creating a precedent that mature minors cannot refuse treatment in certain instances. It has also been suggested that this is inconsistent with the fundamental principle of consent by setting a higher tariff for refusing a medical examination or procedure than for consenting to one.⁹⁸

⁹⁵ *Re W (a minor) (medical treatment: court's jurisdiction)* [1992] 4 All ER 627.

⁹⁶ *Re W (a minor) (medical treatment: court's jurisdiction)* [1992] 4 All ER 627 at 635.

⁹⁷ Eekelaar “White Coats or Flak Jackets? Doctors, Children and the Courts-Again” (1993) 109 *Law Quarterly Review* 182 at 185.

⁹⁸ Devereux et al “Can Children withhold consent to treatment?” (1993) *BMJ* 1459 at 1460.

While this criticism of the judgments in *Re R* and *Re W* may have some merit, in particular by suggesting that “parallel consents” may be valid, the Commission notes that the 15 and 16 year olds involved in those cases were living with illnesses which greatly affected their judgement and mental capacity to make a choice.

2.79 In addition, the Commission notes that, in some circumstances, it is clear that, in exercising its inherent jurisdiction and in applying a “best interests” test, a court may come to a result that is at variance with the wishes of the young person. This is especially so where the case is one of “life or death,” and where the courts may, in cases of doubt, apply a presumption in favour of life. Indeed, the Commission also took this view in the case of persons over 18 years of age in its 2009 *Report on Bioethics: Advance Care Directives*.⁹⁹ This was also the outcome in five other English cases, *Re E*,¹⁰⁰ *Re S*,¹⁰¹ *Re L*,¹⁰² *Re M*¹⁰³ and *Re P*,¹⁰⁴ which involved the refusal of treatment by a person under 16 being overridden by the courts for reasons connected to the issue of life preservation rather than parental consent. All but *Re M* involved the refusal of blood products on religious grounds.

2.80 The first of these cases, *Re E*,¹⁰⁵ which was referred to by Keane CJ in his judgment in *North Western Health Board v HW and CW*,¹⁰⁶ involved a 15 year old boy, who was a Jehovah’s Witness and who had refused a blood transfusion that was to be administered to treat his recently-diagnosed leukaemia. As Keane CJ pointed out in the *North Western Health Board* case, Ward J in *Re E* had ordered the blood transfusion to proceed on the ground that, among other matters, the 15 year old in question “was not of sufficient understanding and maturity to give a full and informed consent.”¹⁰⁷ Ward J acknowledged that the boy, who would be 16 about 6 weeks after the case was

⁹⁹ *Report on Bioethics: Advance Care Directives* (LRC 94-2009), paragraph 1.106.

¹⁰⁰ *Re E (a minor) (wardship: medical treatment)* [1993] 1 FLR 386.

¹⁰¹ *Re S (a minor) (medical treatment)* [1994] 2 FLR 1065.

¹⁰² *Re L (medical treatment: Gillick competency)* [1998] 2 FLR 810.

¹⁰³ *Re M (medical treatment: consent)* [1999] 2 FLR 1097.

¹⁰⁴ *Re P* [2004] 2 FLR 1117.

¹⁰⁵ *Re E (a minor) (wardship: medical treatment)* [1993] 1 FLR 386.

¹⁰⁶ [2001] IESC 90, [2001] 3 IR 622. See the discussion in paragraph 2.28, above

¹⁰⁷ *North Western Health Board v HW and CW* [2001] IESC 90, [2001] 3 IR 622, at 701, judgment of Keane CJ, summarising *In re E (a minor) (wardship: medical treatment)* [1993] 1 FLR 386.

heard, was “of sufficient intelligence to be able to take decisions about his own well-being, but I also find that that there is a range of decisions of which some are outside his ability fully to grasp their implications.”¹⁰⁸

2.81 Bearing in mind that the boy was nearly 16, Ward J accepted that his wish not to have a transfusion as part of his treatment was “a very important matter which weighs very heavily in the scales I have to hold in balance.”¹⁰⁹ As the case was a matter of life and death (Ward J delivered his judgment at 10pm on a Friday night having heard the case that day and having visited the boy in hospital), Ward J concluded that his refusal of treatment was not the product of a full and free informed will. In this respect, the approach of Ward J in *Re E* is comparable to the approach of the High Court in *Fitzpatrick v FK (No.2)*,¹¹⁰ in which Laffoy J took into account the gravity of the consequences of refusal of a blood transfusion in concluding that the decision of a 23 year old woman did not pass the functional test of capacity.

2.82 It may be that the approach of Ward J in *Re E* – and of Laffoy J in *Fitzpatrick v FK (No.2)* – is open to the criticism that it implies that the strongly-held religious beliefs of adolescents – or of a 23 year-old woman – are given less standing than would be appropriate.¹¹¹ In the Commission’s view, however, the decisions in the blood transfusion cases are consistent with other decisions in this area. The Commission notes that, in all these cases, the courts have emphasised that, in exercising their inherent jurisdiction in any “life or death” situation, the life and welfare of the young person (and, in *Fitzpatrick v FK (No.2)*, the life and welfare of a 23 year old woman) weighs heavily with the courts. Indeed, this was the approach in the English case that did not involve a blood transfusion, *Re M*.¹¹² This case involved a 15 year old girl who refused to consent to a heart transplant. Johnson J did not simply state that M was incompetent and therefore incapable of refusing the treatment in question. Rather, he stated that the authorisation of the treatment was in her best interests.

¹⁰⁸ *Re E (a minor) (wardship: medical treatment)* [1993] 1 FLR 386, 391.

¹⁰⁹ *Ibid*, at 393.

¹¹⁰ [2008] IEHC 104, [2009] 2 IR 7, discussed at paragraphs 2.23-2.25, above.

¹¹¹ Devereux et al “Can Children withhold consent to treatment?” (1993) BMJ 1459 at 1459.

¹¹² *Re M (medical treatment: consent)* [1999] 2 FLR 1097.

2.83 The decision in *R (Axon) v Secretary of State for Health*¹¹³ has signalled a renewed focus on the autonomy of children, and it has been suggested that this raises doubts as to any apparent retreat from *Gillick*.¹¹⁴ The circumstances could be described as “*Gillick Part 2*,” because the claimant argued that the English Department of Health’s 2004 guidelines on the provision of contraception to young people under 16 years of age, which had incorporated the “Fraser Guidelines,” were unlawful. In the *Axon* case, the specific complaint was that the 2004 guidelines stated that young people under 16 years of age are owed the same duty of confidentiality as any other person. Mrs Axon claimed that this interfered with her rights and responsibilities as a parent and contravened Article 8(1) of the European Convention on Human Rights (ECHR), which guarantees respect for family and private life. It was also argued that the 2004 guidelines went further than the “Fraser Guidelines” in *Gillick*.

2.84 In the English High Court, Silber J held against the claimant. He concluded that the decision in *Gillick* had clearly ruled that a doctor could lawfully give advice to a competent minor without parental knowledge. Furthermore, the claimant’s argument was contrary to the high duty of confidentiality applicable in the context of medical information, the legal rights of young people, and international principles of human rights which require respect for the autonomy of young people. Competent children, Silber J held, are entitled to the same duty of confidentiality as adults and there is a strong public interest in the maintenance of confidences, particularly in the context of young people seeking advice on matters of sexual health.

2.85 In relation to the claim concerning Article 8(1) of the ECHR, Silber J stated that the ECHR shows that the duty of confidence owed by a medical professional to a competent young person is a high one and can only be overridden for a very powerful reason. The *Axon* case served to uphold the view that competent young people with capacity, that is, who are *Gillick* competent or who pass a “mature minor” test, are owed the same duty of confidentiality as adults. The position in relation to the nature of the duty of confidentiality owed to young people who are not *Gillick* competent, however, remains unclear.

2.86 Silber J, referring to the *Gillick* case, stated that the parental right to determine whether a young person will have medical treatment terminates if and when the young person achieves a sufficient understanding and intelligence to understand fully what is proposed.

¹¹³ [2006] 1 FCR 175. See O’Connor, “The Rights of Children to Medical Confidentiality: *Gillick* Revisited” (2006) 24 ILT 188 (Part I), 199 (Part II).

¹¹⁴ Herring *Family Law* (3rd ed Pearson Longman 2007) at 427.

2.87 Commenting on the *Axon* case, Herring sees this statement as an implication that, if a child is competent, a parent has no right to determine what treatment a child will receive, thereby rejecting the notion of concurrent consents.¹¹⁵ The Commission accepts that Herring's analysis cannot, however, be taken as a definitive view of English law. Nonetheless, it appears to be consistent with developments in other countries, notably in Canada, which are discussed below.¹¹⁶ At the very least, however, the *Axon* case can be seen as a strong affirmation of the principles laid down in *Gillick* and an explicit recognition of the decision-making rights of young people.¹¹⁷

(2) Northern Ireland

2.88 The law – and related guidance – in Northern Ireland has, broadly, followed developments in England and Wales – and those in this State. Thus, the *Age of Majority Act (Northern Ireland) 1969* was enacted by the Parliament of Northern Ireland (whose legislative functions are now carried out, since post-1998 devolution, by the Northern Ireland Assembly) in order to implement the key element of the 1967 Latey Report. The Northern Ireland 1969 Act thus reduced the age of majority from 21 to 18 and also mirrored other comparable provisions in the English *Family Law Reform Act 1969*. Thus, section 4 of the *Age of Majority Act (Northern Ireland) 1969* is worded in identical terms to section 8 of the English 1969 Act (which, as already noted, was the model for section 23 of the *Non-Fatal offences Against the Person Act 1997*) and states:

“(1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

(2) In this section “surgical, medical or dental treatment” includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.

¹¹⁵ Herring *Family Law* (3rd ed, Pearson Longman 2007) at 428.

¹¹⁶ See paragraphs 2.116ff, below.

¹¹⁷ Taylor “Reversing the Retreat from *Gillick*? R (*Axon*) v Secretary of State for Health” (2007) 19(1) *Child & Family Law Quarterly* 81 at 93.

(3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.”

2.89 Northern Ireland legislation has also implemented a “mature minor” test of “sufficient understanding” along the lines of the comparable provisions in English legislation (and the equivalent legislation in this State). Thus, Article 57(6) of the *Children (Northern Ireland) Order 1995*, which deals with interim care orders concerning a “child”, that is, a person under 18 years of age, is worded virtually identically to section 38(6) of the English *Children Act 1989* (and in this State in the *Child Care Act 1991*) and states:

“Where the court makes an interim care or interim supervision order, it may give such directions (if any) as it considers appropriate with regard to the medical or psychiatric examination or other assessment of the child; *but if the child is of sufficient understanding to make an informed decision he may refuse to submit to the examination or other assessment.*” (emphasis added)

2.90 Similarly, in the context of adoption, Article 9 of the *Adoption (Northern Ireland) Order 1987* provides that a court or adoption agency must ensure that the welfare of the child involved is the most important consideration. Article 9(b) adds that (as is the case under the *Adoption Act 2010* in this State), the court or adoption agency is required to:

“ascertain the wishes and feelings of the child regarding the decision and give due consideration to them, having regard to his age and understanding.”

2.91 Delivering a public lecture in 2003,¹¹⁸ the Northern Ireland High Court judge Gillen J noted that the obligation in Article 57(6) of the *Children (Northern Ireland) Order 1995* to give due weight to the views of the child implemented in Northern Ireland the provisions of Article 12 of the 1989 UN Convention on the Rights of the Child (UNCRC).¹¹⁹ He added:

“If we are to make progress we must increasingly consider the concept of rights which visualises that children will either take their own decisions or at least have a strong say in matters affecting them. We

¹¹⁸ Gillen, “*O Tempore, O Mores*” (2004) 55 NILQ 55 (the Daniel O’Connell Lecture, delivered at St Malachy’s College, Belfast, 23 November 2003). The title of the lecture (“Oh the Times, Oh the Customs”) refers to one of Cicero’s famous oratorical phrases in a speech to the Roman Senate in 63BC condemning the attempted overthrow of the Roman Republic by Catilina.

¹¹⁹ *Ibid*, at 64-65.

must be wary lest compassion for children shades into unthinking condescension...¹²⁰ In our court system children need a voice, someone who is able to listen to anything they wish to say and tell them what they need to know”¹²¹

2.92 In 2005, Gillen J applied the approach he had set out in his 2003 public lecture in *Re Z and T (Freeing Order Application)*,¹²² in which he had to consider whether a 6 year old girl should be placed for adoption. He noted that Article 9 of the *Adoption (Northern Ireland) Order 1987* (referred to above) emphasises the child’s welfare as a significant consideration, and it also provides that the court should ascertain the wishes and feelings of the child having regard to the child’s age and understanding. In this respect, Gillen J stated:¹²³

“I recognise that this child is not *Gillick* competent and would... accommodate herself to an adoption, nonetheless I regard her stated wishes that she does not want to be adopted as having some significance.”

2.93 Thus, while Gillen J noted that the 6 year old was not *Gillick* competent, her views were relevant to the decision of the court under the *Adoption (Northern Ireland) Order 1987*. Gillen J ultimately concluded that an adoption order would not be compatible with the child’s welfare and best interests. The decision in this case indicates that the courts in Northern Ireland have applied the principles in *Gillick v West Norfolk and Wisbech Area Heath Authority*.

2.94 Indeed, the judicial application of *Gillick* in Northern Ireland had been anticipated in an article by Gillian Kerr written in 1984.¹²⁴ She had pointed out that the 1983 decision of the English High Court in *Gillick*, which had upheld the

¹²⁰ *Ibid*, at 65, citing Bainham, “Can we Protect Children and Protect their Rights?” (2002) 32 *Family Law* 279

¹²¹ *Ibid*, at 65, citing *Re A* [2001] 1 FLR 715.

¹²² [2005] NIFam 6.

¹²³ *Re Z and T (Freeing Order Application)* [2005] NIFam 6, at para 21 of the judgment. Similarly, in *Re Jakub and Dawid* [2009] NIFam 23, at paragraph 45 of the judgment, Stephens J stated that he had “taken into consideration the views of the children in accordance with their age and maturity” in a case involving the recognition and enforcement of a Polish court’s residence order under Regulation (EC) No.2201/2003 (“Brussels II *bis*”) on the recognition and enforcement of judgments in family proceedings.

¹²⁴ Kerr, “Medical Treatment of Children” (1984) 35 NILQ 185.

validity of the 1980 DHSS guidance at issue (and which the UK House of Lords subsequently upheld in 1985¹²⁵), largely reflected existing common law on the capacity of minors to consent to treatment. She commented: “[i]n relation to the consent of minors to medical treatment for themselves, the better view seems to be that their consent is effective where they understand the full implications of the procedure.”¹²⁶ In the difficult cases involving, for example, treatment related to “pregnancy, sexually transmitted disease and drug abuse,” she commented that “faced with a choice between giving necessary treatment in confidence or the rejection of treatment and advice, most doctors and judges would agree that confidentiality was appropriate.”¹²⁷ These comments largely reflect the ultimate reception of *Gillick* in Northern Ireland, as indicated by decisions such as *Re Z and T (Freeing Order Application)*.¹²⁸

2.95 In addition, as already noted, in this respect the legislative provisions and case law in Northern Ireland also mirror the literature on child development and relevant international standards in this area, including the 1989 UN Convention on the Rights of the Child (UNCRC), which the Commission has discussed in Chapter 1. In broad terms, therefore, the legal position in Northern Ireland concerning those under 18 is virtually identical to the position in England and Wales. They also reflect the comparable statutory provisions in this State, discussed above.

2.96 As to relevant guidance in this area, in the wake of the decision of the UK House of Lords in 1985 in the *Gillick* decision, in 1987 the Northern Ireland Department of Health and Social Services reviewed its guidance on providing contraceptive services to young people. The 1987 guidance reflected the revised English DHSS guidance published in 1986 after the *Gillick* case (and further revised in 2004). The Northern Ireland Department of Health and Social Services concluded that, since the UK House of Lords was the highest court in the UK (since 2009, replaced by the UK Supreme Court) and since the decision was based on an analysis of the comparable common law, “there is no reason

¹²⁵ Gillian Kerr’s 1984 article was written shortly after the decision of the English High Court in 1983 in *Gillick v West Norfolk and Wisbech Area Heath Authority* [1984] 1 All ER 365, in which Woolf J had upheld the legality of the 1980 DHSS guidance. The article was written before the Court of Appeal had overturned that decision ([1985] 1 All ER 533) and before the House of Lords ([1985] UKHL 7, [1985] 3 All ER 402) had ultimately taken the same view as Woolf J and had upheld the legality of the DHSS guidance.

¹²⁶ Kerr, “Medical Treatment of Children” (1984) 35 NILQ 185, at 193.

¹²⁷ *Ibid*, at 193.

¹²⁸ [2005] NIFam 6.

to suppose therefore that the decision in the *Gillick* case would not be followed by the Northern Ireland courts.”¹²⁹ This approach is supported by the use of “*Gillick* competence” in the courts in Northern Ireland as a basis for determining the maturity of persons under 16, as evidenced in *Re Z and T (Freeing Order Application)*.¹³⁰

2.97 In this light, in 2003 the Northern Ireland Department of Health, Social Services and Public Safety issued a *Reference Guide to Consent for Examination, Treatment or Care*.¹³¹ This 2003 *Reference Guide* builds on the Department’s 1987 guidance document referred to above, and provides comprehensive guidance to health and social care professionals concerning consent to, and refusal of, treatment, both for adults over 18 and young persons and children under 18. The 2003 *Reference Guide* draws on relevant English case law on this issue, including the *Gillick* case and the subsequent English case law on consent to and refusal of treatment, which has been discussed above.¹³²

2.98 As to persons under 18, the 2003 *Reference Guide* points out that, under section 4 of the *Age of Majority Act (Northern Ireland) 1969*, “people aged 16 or 17 are entitled to consent to their own medical treatment, and any ancillary procedures involved in that treatment, such as an anaesthetic.”¹³³ It also points out that the same test of capacity as applies to adults, the functional test, is applicable to 16 and 17 year olds. As to parental involvement with 16 and 17 year olds, it states:¹³⁴

¹²⁹ *Family planning service*. HSS(CH)1/87 (Northern Ireland Department of Health and Social Services, 8 May 1987). See also *Re Shearer and Corrie’s Judicial Application* [1993] 2 NIJB 12, High Court of Northern Ireland (Queen’s Bench Division) 22 January 1993 (Carswell J), in which the Court appeared to accept the applicability in Northern Ireland of the English DHSS 1986 guidance issued after *Gillick*.

¹³⁰ [2005] NIFam 6.

¹³¹ Available at <http://www.dhsspsni.gov.uk>.

¹³² The 2003 *Reference Guide* does not refer to any decisions of the Northern Ireland courts. It was published before the decision in *Re Z and T (Freeing Order Application)* [2005] NIFam 6.

¹³³ *Reference Guide to Consent for Examination, Treatment or Care* (Northern Ireland Department of Health, Social Services and Public Safety, 2003) (available at <http://www.dhsspsni.gov.uk>), Chapter 3, paragraph 2.1, p.20.

¹³⁴ *Ibid.*, Chapter 3, paragraph 2.4, at 21.

“If the requirements for valid consent are met, it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to that of the young person. It is, however, good practice to encourage the young person to involve their family in the decision-making process, unless the young person specifically wishes to exclude them.”

2.99 As to those under 16, the 2003 *Reference Guide* states:¹³⁵

“Following the case of *Gillick*, the courts have held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention. This is sometimes described as being ‘*Gillick* competent’... As the understanding required for different interventions will vary considerably, a child under 16 may therefore have the capacity to consent to some interventions but not to others.”

2.100 The 2003 *Reference Guide* adds:¹³⁶

“The concept of *Gillick* competence is said to reflect the child’s increasing development to maturity. In some cases, for example because of a mental disorder, a child’s mental state may fluctuate significantly so that on some occasions the child appears *Gillick* competent in respect of a particular decision and on other occasions does not. In cases such as these, careful consideration should be given to whether the child is truly *Gillick* competent at any time to take this decision.”

2.101 As to parental involvement with those under 16, the 2003 *Reference Guide* states:¹³⁷

“If the child is *Gillick* competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. However where the decision will have on-going implications, such as long-term use of contraception, it is good practice to encourage the child to inform his or her parents unless it would clearly not be in the child’s best interests to do so.”

2.102 The Commission notes that the 2003 *Reference Guide* provides extremely useful guidance for all health and social care professionals in

¹³⁵ *Ibid.*

¹³⁶ *Ibid.*

¹³⁷ *Ibid.*

Northern Ireland concerning the position of those under 18. The Commission also notes that the guidance applies across the range of professionals who are likely to be involved in the wide scope of health care, as already defined in this Report in Chapter 1, which those under 18 are likely to seek. In this State, while the Medical Council's 2009 *Guide to Ethical Conduct and Behaviour*, discussed already, provides some useful guidance in this respect, it is not as detailed as the comparable elements in the 2003 *Reference Guide*, nor does it (nor could it) provide guidance to professionals other than doctors.

2.103 Having noted that the 2003 *Reference Guide* provides extremely useful guidance for all health and social care professionals, the Commission also notes that its discussion of the concept of *Gillick* competence, that is, the "mature minor" concept, does not set out clearly all of the factors, such as the 5 factors set out in the "Fraser Guidelines," which are to be found more clearly articulated in the English DHSS guidance discussed above. The Commission concludes, nonetheless, that the approach taken in the 2003 *Reference Guide* provides an extremely helpful basis on which to develop guidance that would supplement an appropriate legal framework.

(3) Scotland

2.104 Scottish law differs from the law in England, Wales and Northern Ireland in an important respect, in that the *Age of Legal Capacity (Scotland) Act 1991* sets the age of majority at 16. The 1991 Act implemented the recommendations made in the Scottish Law Commission's 1987 *Report on the Legal Capacity and Responsibility of Minors and Pupils*.¹³⁸ The Commission's 1987 Report recommended that 16 should be the age at which a person has full legal capacity, including capacity to consent to medical treatment. The Scottish Commission recommended a flexible exception for persons under 16 years of age, in effect mirroring the test in what became the English *Children Act 1989*,¹³⁹ discussed above, and which derived from the "mature minor" rule in the *Gillick* case.

2.105 Section 1(1)(b) of the *Age of Legal Capacity (Scotland) Act 1991* states that, in general:

"a person of or over the age of sixteen years shall have legal capacity to enter into any transaction."

¹³⁸ Scottish Law Commission *Report on the Legal Capacity and Responsibility of Minors and Pupils* (Report 110 1987).

¹³⁹ *Ibid*, at 3.67.

2.106 Section 9 of the 1991 Act defines “transaction” as a transaction which has legal effect and includes the giving by a person of any consent having legal effect.

2.107 The *Age of Legal Capacity (Scotland) Act 1991* therefore gives young people full legal capacity to enter into most transactions at the age of 16. Under the 1991 Act, there appear to be no grounds to enable a parent, guardian or the courts to override the refusal of treatment by a 16 year old, unless the 16 year old in question otherwise lacks capacity, based on a functional test.

2.108 As to persons under 16, section 2(4) of the *Age of Legal Capacity (Scotland) Act 1991* states:

“A person under the age of sixteen shall have legal capacity to consent on his own behalf to any surgical, medical or dental treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.”

2.109 The language of section 2(4) is enabling in that it refers only to capacity to consent with no mention of refusal of medical treatment as the corollary of consent. A number of commentators have treated this provision as encompassing the legal capacity to refuse medical treatment as well as the capacity to consent to medical treatment.¹⁴⁰ The wording of section 2(4) also suggests that no concurrent power of consent is retained by the parent of a “section 2(4) competent” child (that is, a “mature minor”). Furthermore, section 90 of the *Children (Scotland) Act 1995* states that a child who is capable under section 2(4) may only be examined or treated under the 1995 Act if he or she consents to the examination or treatment. As discussed above, the comparable statutory provisions in the English *Children Act 1989* have been interpreted as being subject to the inherent protective role of the courts concerning children (reflecting its long-standing wardship or *parens patriae* jurisdiction) to override a refusal where the courts consider that the person under 16 lacks capacity. In order to ensure that any such approach would avoid a paternalistic view that does not take account of the relevant rights of a person under 16, it may be that the approach taken in the English *Axon* case, discussed above, would be followed in Scotland.

2.110 In 2006, the Scottish Executive’s Department of Health issued *A Good Practice Guide on Consent for Health Professionals in the NHS Scotland*. The 2006 *Good Practice Guide* is, broadly, comparable to the English (2004)

¹⁴⁰ Norrie, *The Law Relating to Parent and Child in Scotland* (2nd ed W. Green 1999) at 480, Elliston, *The Best Interests of the child in Healthcare* (Routledge Cavendish 2007) at 112.

and Northern Ireland (2003) Guides discussed above, but reflects the different position in Scottish law as to the age of majority. Thus, the 2006 *Good Practice Guide* points out that, under the *Age of Legal Capacity (Scotland) Act 1991*, when persons reach their 16th birthday, they gain the legal capacity to make decisions which have legal effect, unless the person lacks the appropriate mental capacity.¹⁴¹ The 2006 *Good Practice Guide* also states that where a child, that is a person under 16, has capacity to make a health care decision, the 1991 Act requires that the child's decision should be respected, even where it differs from the opinion of the healthcare professional and the child's parents.

2.111 *In re Houston, Applicant*¹⁴² involved a 15 year old boy who was deemed competent under section 2(4) of the 1991 Act and who resisted an application under section 18 of the *Mental Health (Scotland) Act 1984* to have him admitted to a mental health hospital. The central question to be decided was whether parental consent could override the refusal of a competent minor. The judge in the Sheriff's Court who dealt with the case held that section 2(4) of the 1991 Act applied to both consent and refusal, so that the consent of the 15 year old's mother could not override his refusal. He stated:¹⁴³

“It seems to be illogical that, on the one hand, a person under the age of 16 should be granted the power to decide upon medical treatment for himself while, on the other hand, his parents have the right to override his decision. I am inclined to the view that the minor's decision is paramount and cannot be overridden.”

2.112 There are, however, limitations to the *Houston* case.¹⁴⁴ Thus, section 11(2) of the *Children (Scotland) Act 1995* provides for the making of applications in relation to parental rights and responsibilities. An application for a specific issue order can be made by a person with an interest, such as a doctor. This is limited to persons under 16 years of age because sections 1(2) and 2(7) of the *Children (Scotland) Act 1995* provide for the cessation of parental responsibilities and rights when a child reaches the age of 16, except for the responsibility to provide guidance which ends on a child's 18th birthday.

¹⁴¹ *A Good Practice Guide on Consent for Health Professionals in the NHS Scotland* (Scottish Executive Health Department 2006).

¹⁴² [1996] SCLR 943. Discussed in the Consultation Paper: LRC CP 59-2009 at 5.115.

¹⁴³ [1996] SCLR 943, at 945 (Sheriff McGowan).

¹⁴⁴ See LRC CP 59-2009 at 5.117. See Grubb “Refusal of Treatment: Competent Child and Parents” 5 *Med. L. Rev.* (1997) at 237-259, Elliston *The Best Interests of the Child in Healthcare* (Routledge Cavendish 2007) at 114.

Section 6 of the *Adults with Incapacity (Scotland) Act 2000* states that, for the purposes of the Act, an adult is a person who has attained the age of 16 years.

2.113 It is clear that in Scotland the age of 16 is well established in law as the age at which a young person may assume responsibility for his or her healthcare. In respect of essential medical treatment, it is worth noting the discussion of the Scottish Law Commission in the 1987 Report which preceded the enactment of the 1991 Act as to a proposed requirement that the treatment be in the young person's best interests:

“If it is accepted that a child may consent if he or she is of sufficient maturity to understand the treatment proposed then the test should apply whether the treatment concerned is for his benefit or not. In that respect, the young person should be treated no differently from anyone else capable of consenting.”¹⁴⁵

2.114 The absence of a best interests requirement raises some questions in relation to the refusal of essential medical treatment. For example, may a competent young person under the age of 16 refuse medical treatment which is in his or her best interests? The legal situation is not clear in this respect. The deliberate absence of a best interests requirement suggests that a young person with capacity may make healthcare decisions regardless of what is deemed to be in his or her best interests. However if the *Age of Legal Capacity (Scotland) Act 1991* is read in conjunction with the *Children (Scotland) Act 1995* a different conclusion may be reached. Section 16 of the 1995 Act states that the welfare of a child shall be the court's paramount consideration.

2.115 The 2006 *Good Practice Guide* issued by the Scottish Executive's Health Department also states that refusal of consent by or on behalf of a child may be overridden by the courts under Section 11(2) of the 1995 Act, which provides for applications in relation to parental rights and responsibilities. An application for a specific issue order can be made by a person with an interest, such as a doctor.

(4) Canada

2.116 In Canada, many Provinces retain 18 as the general age of majority, but in respect of medical treatment there has been a general move towards conferring full capacity on persons from 16 years of age. In addition, for those under 16 years of age, a “mature minor” rule is well established.¹⁴⁶ While the “mature minor” rule has predominantly been developed at common law, a

¹⁴⁵ Scottish Law Commission *Report on the Legal Capacity and Responsibility of Minors and Pupils* (Report 110 1987) at 3.77.

¹⁴⁶ (LRC CP 59-2009) at 4.19 to 4.51.

number of relevant statutory provisions have also been enacted.¹⁴⁷ Provisions enacted in British Columbia and New Brunswick in 1973 and 1975 are similar to those enacted in other countries at the time, such as England and Australia.¹⁴⁸ These provisions can be contrasted with more recent legislative developments in Ontario and Prince Edward Island,¹⁴⁹ which are based on a functional approach to capacity and the general presumption that a person is capable of making a healthcare decision. A number of statutory provisions in force in other provinces, in relation to substitute decision making and health care directives, confer a presumption of legal capacity on individuals aged 16 years of age in terms of health care decision making.

2.117 A number of the Canadian provinces and territories, including Alberta and Manitoba, have not enacted specific healthcare consent legislation in this respect, and continue to rely on the mature minor rule, supplemented by child welfare legislation.

2.118 The relationship between the mature minor rule and child welfare legislation has been debated in the courts, primarily in respect of refusal of essential medical treatment. If a mature minor makes a decision to which child welfare authorities object, the authorities may seek to override the mature minor's status of legal capacity and have the decision to refuse medical treatment quashed, on the basis that the child is in need of protection.¹⁵⁰ The incorporation of the best interests principle in various statutory provisions means that mature minors will only have their decision to refuse medical

¹⁴⁷ Newfoundland and Labrador: section 12 of the *Child, Youth and Family Services Act 1998*, section 3 of the *Neglected Adults Welfare Act 1990*, section 7 of the *Advance Care Directives Act 1995*.

¹⁴⁸ In 1976, New Brunswick adopted the *Medical Consent of Minors Act*. British Columbia: *Infants Act 1973 (amended in 1992 to become part of the Infants Act 1996)*.

¹⁴⁹ Ontario: *Consent to Treatment Act 1992*, replaced by the *Health Care Consent Act 1996*, codified the common law on consent to medical treatment. Young people of or above 16 years of age also benefit from section 2(2) of the *Substitute Decisions Act 1992* which states: "A person who is sixteen years of age or more is presumed to be capable of giving or refusing consent in connection with his or her own personal care." Prince Edward Island: *Consent to Treatment and Health Care Directives Act 1999*.

¹⁵⁰ See Ferguson *The end of An Age: Beyond Age Restrictions for Minors Medical Treatment Decisions* (Paper prepared for the Law Reform Commission of Canada, 2004) at 8-21 for a detailed discussion of the relationship between health care consent legislation, the mature minor rule, child welfare legislation and the *parens patriae* jurisdiction of the courts.

treatment upheld if the decision is deemed to be in their best interests. Several cases involving the refusal of medical treatment, primarily in the context of refusal of blood transfusions by Jehovah's Witnesses, have come before the courts. These have led to important decisions on the legal capacity of a person under 16 to refuse medical treatment and how child welfare legislation and the courts' inherent jurisdiction to protect children (based on the long-standing wardship or *parens patriae* jurisdiction) can affect this.

2.119 In this respect, the Commission considers that a 2009 decision of the Supreme Court of Canada provides a valuable analysis of the law on healthcare decision-making in the context of refusal of essential treatment. In *AC v Manitoba (Director of Child and Family Services)*¹⁵¹ the Supreme Court of Canada analysed Canadian law on the mature minor rule and the legal capacity of competent minors to make health care decisions. The case involved a 14 year old girl who was admitted to hospital with internal bleeding caused by Crohn's disease. She was a devout Jehovah's Witness, and some months before hospitalisation she had signed an advance care directive refusing blood products on account of her religious beliefs. After receiving advice on her situation, she stated that she understood the reason why a blood transfusion was recommended and the consequences of refusal. When her condition deteriorated, her doctors stated that the bleeding was now causing an imminent serious risk to her health and perhaps her life.

2.120 The Manitoba Director of Child and Family Services considered that she was a child in need of protection and applied for a treatment order authorising a blood transfusion under section 25(8) of the Manitoba *Child and Family Services Act* which provides, subject to section 28(9), for the authorisation of treatment for a person under 16 where the court considers this is "in the best interests of the child." Section 25(9) of the Act states that where a person is 16 or over, no medical treatment can be ordered by the court without the child's consent unless the court is satisfied that the child is unable to understand either the relevant information or the reasonably foreseeable consequences of the treatment decision.

2.121 After a relatively brief hearing, the Manitoba High Court made the order requested; three units of blood were given to the girl and she made a full recovery within days. The girl and her parents appealed the order to the Manitoba Court of Appeal, and also argued that section 25(8) of the Manitoba *Child and Family Services Act* was in breach of her constitutional rights under the 1982 *Canadian Charter of Rights and Freedoms*, notably her right to freedom of conscience and religion, her right to life and her right to equal treatment under the law. In particular, it was noted that section 25(9) of the

¹⁵¹ 2009 SCC 30, [2009] 2 SCR 181.

Manitoba Act contained a presumption of capacity for a person over 16 years of age (the age of capacity or majority) whereas no such presumption of capacity applied to a person under 16. The Manitoba Court of Appeal dismissed the constitutional claims and also approved the blood transfusion treatment orders made. On further appeal, the Supreme Court of Canada dismissed the case by a 6-1 majority.

2.122 The leading joint judgment of four of the judges of the Supreme Court of Canada in the *AC* case, *LeBel, Deschamps, Abella and Charron JJ*, was delivered by Abella J. Abella J described the mature minor rule as a recognition by the common law that children are entitled to a degree of decision-making autonomy that reflects their evolving intelligence and understanding.¹⁵² The evolutionary and contextual character of maturity makes it difficult to define and evaluate, yet the right of mature adolescents to have their medical decision making ability valued means that an assessment of maturity must be undertaken with respect and rigour.¹⁵³ Abella J stated:

“It is a sliding scale of scrutiny, with the adolescent’s views becoming increasingly determinative depending on his or her ability to exercise mature, independent judgement. The more serious the nature of the decision, and the more severe its potential impact on the life or health of the child, the greater the degree of scrutiny that will be required.”¹⁵⁴

2.123 In her judgment in the *AC* case, Abella J reviewed the development of the “mature minor” rule in the wake of the UK House of Lords decision in *Gillick v West Norfolk and Wisbech Area Health Authority*,¹⁵⁵ discussed above, noting that it had been applied on many occasions in the Canadian courts. She also referred to the extensive literature on child development and adolescence, which the Commission has already referred to briefly in this Report. In this respect, Abella J notably considered that the mature minor rule must be carried out in tandem with a best interests test. She also noted that respect for the autonomy of the person under 16 must not be equated with accepting the views of that person in all instances. Abella J commented:

“There is considerable support for the notion that while many adolescents may have the technical ability to make complex decisions, this does not always mean they will have the necessary maturity and independence of judgment to make truly autonomous choices. As Jane

¹⁵² *Ibid* at paragraph 46.

¹⁵³ *Ibid* at paragraph 96.

¹⁵⁴ *Ibid* at paragraph 22.

¹⁵⁵ [1985] UKHL 7, [1985] 3 All ER 402.

Fortin significantly observes: ‘... cognitive capacity to reach decisions does not necessarily correlate with “mature” judgment’ (*Children’s Rights and the Developing Law* (2nd ed. 2003), at p. 73)...

Clearly the factors that may affect an adolescent’s ability to exercise independent, mature judgment in making maximally autonomous choices are numerous, complex, and difficult to enumerate with any precision. They include ‘the individual physical, intellectual and psychological maturity of the minor, the minor’s lifestyle [and] the nature of the parent-child relationship’ (Manitoba Law Reform Commission, *Minors’ Consent to Health Care*, p. 32). While it may be relatively easy to test cognitive competence alone, as the social scientific literature shows, it will inevitably be a far more challenging exercise to evaluate the impact of these other types of factors. The difficulty and uncertainty involved in assessing maturity has prompted some experts to suggest that children should be entitled to exercise their autonomy only insofar as it does not threaten their life or health.”¹⁵⁶

2.124 The approach of Abella J in the *AC* case reflects, therefore, the literature on child development and adolescence, namely, that (a) the technical or cognitive capacity of adolescents to make decisions does not necessarily mean their decisions will always be mature; (b) many complex and varying factors must be considered in determining whether a particular person under 16 is capable of making mature judgements; and (c) while the growing maturity of the person must be taken into account as they reach young adulthood, where their immediate health or life is at issue the court must assess on an objective basis what is in their “best interests.”

2.125 Abella J then applied this approach in concluding that the “best interests” test in section 25(8) of the Manitoba *Child and Family Services Act* was not in conflict with AC’s rights under the 1982 *Canadian Charter of Rights and Freedoms*. She accepted that any legislation would be “inherently arbitrary” if it deprived an adolescent under the age of 16 the opportunity to demonstrate sufficient maturity, but that this was not the situation in this instance. Abella J stated:¹⁵⁷

“... the “best interests” test referred to in s. 25(8) of the [Manitoba *Child and Family Services Act*], properly interpreted, provides that a young person is entitled to a degree of decisional autonomy commensurate with his or her maturity. The result of this interpretation of s. 25(8) is that adolescents under 16 will have the right to demonstrate mature

¹⁵⁶ 2009 SCC 30, [2009] 2 SCR 181, at paragraphs 72, 78 and 79.

¹⁵⁷ *Ibid* at paragraphs 114-115.

medical decisional capacity. This protects both the integrity of the statute and of the adolescent. It is also an interpretation that precludes a dissonance between the statutory provisions and the [1982 *Canadian Charter of Rights and Freedoms*], since it enables adolescents to participate meaningfully in medical treatment decisions in accordance with their maturity, creating a sliding scale of decision-making autonomy. This, in my view, reflects a proportionate response to the goal of protecting vulnerable young people from harm, while respecting the individuality and autonomy of those who are sufficiently mature to make a particular treatment decision.”

2.126 Abella J noted in this respect that the “best interests” test had also been included in the 1989 UN Convention on the Rights of the Child, discussed above, to which Canada (like Ireland) is a State party. In the Commission’s view, Abella J’s analysis is entirely consistent with the comparable approach taken by the Irish Supreme Court in the *McK* case and the Irish High Court in the *D* case, discussed above. It is also consistent with the analysis in the English cases such as *Hewer* and *Gillick*, also discussed above.

2.127 Bearing in mind that Abella J surveyed the general literature on child development and adolescence that had emerged since the mid 1980s (when the *Gillick* case was decided), the Commission notes that she also set out a list of 7 factors which could be taken into account in this respect. Abella J stated:¹⁵⁸

“[T]he evolutionary and contextual character of maturity makes it difficult to define, let alone definitively identify. Yet the right of mature adolescents not to be unfairly deprived of their medical decision-making autonomy means that the assessment must be undertaken with respect and rigour. The following factors may be of assistance:

[1] What is the nature, purpose and utility of the recommended medical treatment? What are the risks and benefits?

[2] Does the adolescent demonstrate the intellectual capacity and sophistication to understand the information relevant to making the decision and to appreciate the potential consequences?

[3] Is there reason to believe that the adolescent’s views are stable and a true reflection of his or her core values and beliefs?

[4] What is the potential impact of the adolescent’s lifestyle, family relationships and broader social affiliations on his or her ability to exercise independent judgment?

¹⁵⁸ *Ibid* at paragraph 96.

[5] Are there any existing emotional or psychiatric vulnerabilities?

[6] Does the adolescent's illness or condition have an impact on his or her decision-making ability?

[7] Is there any relevant information from adults who know the adolescent, like teachers or doctors?"

2.128 Abella J emphasised that this list of 7 factors was not intended as a mandatory formula, but instead was intended "to assist courts in assessing the extent to which a child's wishes reflect true, stable and independent choices." The Commission agrees that this is the correct approach to take in what is a complex area. The Commission also notes that these 7 factors have at least three important benefits: (a) they clearly take a rights-based approach to assessing the competence of decision-making of mature minors, those under 16; (b) they acknowledge the many factors that should be taken into account in respect of medical treatment, including an objective assessment of the "best interests" of those under 16; and (c) they are more than an updated version of the "Fraser Guidelines" from the *Gillick* case, because they are not confined to the narrow issue discussed in *Gillick* of access to the contraceptive pill. In the Commission's view, therefore, the analysis by Abella J in the *AC* case constitutes a very useful basis on which to formulate specific recommendations concerning those "mature minors" under 16, to which the Commission turns in Part D, below.

(5) Australia

2.129 In Australia, there has also been a gradual move towards conferring full capacity on persons from 16 years of age, in particular in respect of medical treatment. In addition, for those under 16 years of age, the common law in Australia mirrors the mature minor approach developed in England, Scotland, Canada and New Zealand.

2.130 Legislation on the subject of young people's capacity to consent to medical treatment has also been enacted in New South Wales and South Australia.¹⁵⁹

2.131 In 1992, in *Secretary, Dept of Health and Community Services v JWB*,¹⁶⁰ the High Court of Australia developed a mature minor rule. The joint judgment for the Court (of Mason CJ, Dawson, Toohey and Gaudron JJ) approved the general approach taken by the majority of the UK House of Lords

¹⁵⁹ South Australia: *Consent to Medical Treatment and Palliative Care Act 1995*. New South Wales: Section 49 of the *Minors (Property and Contracts) Act 1970*.

¹⁶⁰ *Secretary, Dept of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

in *Gillick v West Norfolk and Wisbech Area Health Authority*,¹⁶¹ which has been discussed in detail above. The High Court of Australia stated:

“The proposition endorsed by the majority in that case [*Gillick*] was that parental power to consent to medical treatment on behalf of a child diminishes gradually as the child’s capacities and maturity grow and that the rate of development depends on the individual child... This approach although lacking the certainty of a fixed age rule, accords with experience and psychology... It should be followed in this country as part of common law.”

2.132 The Court also referred briefly to refusal of treatment, but did not endorse the principles laid down by the English Court of Appeal in *Re R* and *Re W*, discussed above. The joint judgment for the Court contained this footnote referring to *Re R* but also citing criticism of the Court of Appeal’s decision:

“As to the priority of parental rights and the capacity of a child to refuse medical treatment for mental illness, see *In Re R*... But also see the comment on Lord Donaldson’s judgment by Bainham in ‘The Judge and the Competent Minor’...”

2.133 The status of a minor to refuse medical treatment therefore remains unclear in Australian law, but as in the UK and Ireland a court may, using its inherent jurisdiction (the equivalent of the old *parens patriae* jurisdiction), override a young person’s refusal of treatment.

2.134 In relation to life-sustaining treatment, the Supreme Court of Western Australia decided in 2004, in *Minister for Health v AS*,¹⁶² that the court will almost always override a child’s decision to refuse life-sustaining or life-prolonging treatment, in accordance with the child’s best interests. Pullin J stated that the court’s power using its inherent jurisdiction to countermand the wishes of a child patient is to be exercised sparingly and with great caution, but that there are cases where it is necessary to do so. He added that the views of the child are of course relevant to the best interests analysis and the court would exercise great caution in overturning them, but that these wishes alone shall not be determinative.

2.135 The Commission notes that this approach is broadly in line with the view taken in the states already reviewed, including Ireland, and with the specific guidance set out by Abella J in the Canadian case *AC v Manitoba (Director of Child and Family Services)*.¹⁶³

¹⁶¹ [1985] UKHL 7, [1985] 3 All ER 402.

¹⁶² [2004] WASC 286, 33 Fam. L.R. 223.

¹⁶³ 2009 SCC 30, [2009] 2 SCR 181.

(6) New Zealand

2.136 The move towards a 16 year old reference point for determining capacity to consent, in particular in the context of health care treatment, is also evident in New Zealand. Section 36 of the New Zealand *Care of Children Act 2004* states:

“A consent, or refusal to consent, to any of the following, if given by a child of or over the age of 16 years, has effect as if the child were of full age:

- (a) any donation of blood by the child
- (b) any medical, surgical or dental treatment or procedure (including a blood transfusion...) to be carried out on the child for the child’s benefit by a person professionally qualified to carry it out.”

2.137 Section 36 of the 2004 Act uses the word “benefit”, which is not limited by any qualification, so that this may not be restricted to a health benefit.¹⁶⁴ The 2004 Act clearly states that young people aged 16 and 17 years of age can consent to or refuse medical treatment. Furthermore, their decision cannot be overridden by a parent or guardian. The medical practitioner is not required to assess the capacity of the 16 or 17 year old in question, rather capacity is presumed.

2.138 It is not clear whether parents retain a co-existing right to consent to or refuse medical treatment for their 16 year old child. In light of the Australian and Canadian jurisprudence, it is unlikely that New Zealand courts would recognise concurrent rights of consent retained by parents of a competent child. Section 30 of the 2004 Act states that the High Court and Family Courts have concurrent jurisdiction in respect of children and may make an order placing a child under the guardianship of the court, either generally or for any particular purpose, such as obtaining consent for medical treatment.¹⁶⁵

2.139 Section 36 of the 2004 Act does not refer to the capacity of young people under the age of 16 to consent to medical treatment. As is the case in the other countries discussed above, it has been suggested that the common law rights of a “mature minor” under 16 in relation to medical treatment have not been limited by statutory provisions such as the 2004 Act and that:

“the better view is that minors’ common law capacity to consent to medical treatment has not been extinguished by the New Zealand

¹⁶⁴ Skegg & Paterson *Medical Law in New Zealand* (Thompson Brokers 2006) at 190.

¹⁶⁵ *Ibid* at 203.

legislation, and that the consent of those under the age of 16 will sometimes be effective in law.”¹⁶⁶

2.140 It appears that, in practice, there is acceptance by the medical profession of a capacity-based approach to consent.¹⁶⁷ In addition, as with the other countries discussed above, it seems likely that, in a situation where the life of a minor was threatened by the refusal of medical treatment, the courts would intervene and authorise the treatment. Section 11 of the *New Zealand Bill of Rights Act 1990*, which applies equally to children, states that everyone has the right to refuse to undergo any medical treatment. This is subject, however, to section 5 which states that rights and freedoms may be subject to reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.¹⁶⁸

D Discussion and Recommendations on Healthcare Decision Making by under 18s

2.141 In this Part, the Commission sets out its recommendations concerning consent to and refusal of medical treatment for those under 18. The Commission’s approach is that this should be as consistent as possible with the proposed reform of the law on mental capacity for those over 18, and the Commission therefore favours a functional test of capacity. The Commission sets out its recommendations concerning 16 and 17 year olds first, and then sets out separately its recommendations for those under 16.

(1) The functional test of capacity

2.142 As already noted in this Report, in its 2006 *Report on Vulnerable Adults and the Law*,¹⁶⁹ which contained a draft Scheme of a *Mental Capacity Bill*, the Commission recommended that mental capacity legislation should be enacted which would include a presumption of capacity for any person aged 18

¹⁶⁶ *Ibid* at 189.

¹⁶⁷ McLean “Children and Competence to Consent: Gillick Guiding Medical Treatment in New Zealand” (2000) 31 *Victoria U Wellington L Rev* 551 at 555, Thompson “Whose Right to Choose? A Competent Child’s Right to Consent to and Refuse Medical Treatment in New Zealand” (2001-2002) 8 *Canterbury Law Review* 145 at 177.

¹⁶⁸ See Thompson “Whose Right to Choose? A Competent Child’s Right to Consent to and Refuse Medical Treatment in New Zealand” (2001-2002) 8 *Canterbury Law Review* 145 at 173.

¹⁶⁹ (LRC 83-2006).

years or more and that this legislation should also include a functional test of capacity. As explained in the 2006 Report, the Commission favours the functional approach to capacity because this is consistent with an approach based on the individual's personal rights and also determines whether the person understands the specific decision being considered at the time it is being made, whether this involves buying a house or undergoing medical treatment. It is also consistent with the right-based approach in the 2006 UN Convention on the Rights of Persons with Disabilities. The Commission notes that the Government's *Scheme of a Mental Capacity Bill 2008*,¹⁷⁰ which is intended to implement the Commission's 2006 Report, also adopts the functional approach to capacity. The Commission is also conscious that the Government is committed to publishing by the end of 2011 a *Mental Capacity Bill* that is consistent with the 2006 UN Convention.¹⁷¹

2.143 In the 2006 Report, the Commission rejected the use of a "status approach" to determining capacity. The status approach involves making a decision on a person's legal capacity based on the presence or absence of certain characteristics, such as age or mental illness. This approach (which is reflected in some current legislation such as the *Lunacy Regulation (Ireland) Act 1871*) has been replaced in many states, notably because the "status approach" involves making a long term judgement on a person's capacity, based on a once-off examination of their status that often applies indefinitely into the future.

2.144 The Commission considers that the proposals in this Report must be as consistent as possible with this wider context of proposals to introduce a modern statutory framework on mental capacity and decision-making for those over 18. The Commission notes that the functional test of capacity is also consistent with the recognition of the rights of children in the Constitution of Ireland, discussed above. It is also consistent with the relevant international human rights standards in this area, notably those in the 1989 UN Convention on the Rights of the Child (UNCRC).

(2) 16 and 17 year olds and presumed capacity to consent to, and refuse, medical treatment

¹⁷⁰ Available at www.justice.ie.

¹⁷¹ The *Programme for Government 2011-2016* (March 2011), p.38, available at www.taoiseach.ie, contains a commitment to "introduce a Mental Capacity Bill that is in line with the UN Convention on the Rights of Persons with Disabilities." The *Government Legislation Programme, Summer Session 2011* (April 2011), available at www.taoiseach.ie, states that the *Mental Capacity Bill* is scheduled for publication in late 2011.

2.145 The Commission has already noted that the Oireachtas has accepted in section 23 of the *Non Fatal Offences Against the Person Act 1997* that, in connection with medical and healthcare decisions, 16 and 17 year olds should be presumed to have capacity to consent to medical treatment (albeit the 1997 Act is limited to the criminal law sphere). The Commission has also noted that the decision of the Supreme Court in *McK v Information Commissioner*,¹⁷² which arose in a health care setting, held that the views of a young person who is over 17 “are very relevant”¹⁷³ and that they may sometimes override a parent’s presumed entitlement to be able to access health care information concerning their children.

2.146 Having regard to the comparative analysis in Part C, it is clear that the approach in the 1997 Act has been replicated in virtually every State surveyed in the context of potential civil liability, sometimes by way of court decisions but increasingly in terms of legislation that deals specifically with consent to, and refusal of, health care treatment. The Commission therefore reiterates here the suitability of a functional approach to capacity for 16 and 17 year olds in the context of potential civil liability concerning health care treatment.

2.147 Following the publication of the Consultation Paper,¹⁷⁴ the submissions received by the Commission broadly supported the provisional recommendations in respect of 16 and 17 year olds. The Commission notes that these submissions, and existing practice as evidenced by the Medical Council’s 2009 *Guide to Ethical Conduct and Behaviour*, have taken the view that section 23 of the *Non Fatal Offences Against the Person Act 1997*, although confined to the criminal law sphere, should be seen as setting the correct general approach, namely, that 16 and 17 year olds have capacity to consent to medical treatment. Indeed, the submissions suggested that, since section 23 of the 1997 Act greatly resembled comparable statutory provisions in other countries that apply both in the criminal law and civil law context, it would assist all those involved – 16 and 17 year olds, parents, guardians and health care professionals – to have the position in Irish law clarified in this manner.

2.148 The Commission notes that this analysis reflects the picture in many other countries, including those already discussed, where legislation has provided for many years that 16 and 17 year olds should be deemed fully competent both to consent to, and to refuse, medical treatment. Indeed, many countries, including Scotland, have moved beyond the area of medical

¹⁷² [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260.

¹⁷³ [2006] 1 IR 260, at 268. See the discussion at paragraph 1.65ff, above.

¹⁷⁴ (LRC CP 59-2009).

treatment to reduce the age of majority from 18 to 16, so that 16 and 17 year olds have the status of adults in those countries and have general competence in respect of virtually all decision-making that affect them.

2.149 The Commission notes that the submissions received also supported the view expressed in the Consultation Paper, that this approach should apply to consent to, and refusal of, treatment. The Commission agrees that issues of consent and refusal should not be treated differently, as the literature, clinical practice and case law in this area generally treats refusal as the corollary of consent. Indeed, as many of the leading court decisions discussed above indicate, to treat them differently would create an unworkable distinction because the standard needed to satisfy the capacity test would rise, or fall, in accordance with whether a person was consenting to or refusing treatment. For this reason, the Commission has concluded, and recommends, that the general recommendation concerning 16 and 17 year olds should apply to consent to, and refusal of, treatment.

2.150 The Commission reiterates here that this project and Report is confined to health care decision-making rather than this wider scope of decision-making. It is sufficient to note for the purposes of this project and Report that, as far as health care treatment is concerned, virtually all countries have taken the view, both in terms of health care practice and the relevant legislative framework, that a 16 year old and 17 year old should, in general, be regarded as competent to consent to, and refuse, medical treatment. This approach reflects the well-documented literature that this age group has reached a state of sufficient understating and maturity that there should be a presumption that they have the capacity to make these decisions independently, and therefore on the same basis (at least for this purpose, whatever about the wider debate as to reducing the general age of majority to 16) as an 18 year old who, under the current law, has reached the age of majority (that is, adulthood).

2.151 The Commission has therefore concluded, and recommends, that legislation should clearly provide that, in general, a person who is 16 or 17 years of age is presumed to have capacity to consent to, and refuse, health care treatment. The effect of this is to clarify that, for the purposes of civil liability – section 23 of the *Non Fatal Offences Against the Person Act 1997* already deals with criminal liability – a 16 and 17 year old is presumed to have the same capacity, as far as health care is concerned, as an 18 year old has under the current law. The Commission considers that the current wording of section 23 of the *Non Fatal Offences Against the Person Act 1997* provides a useful statutory precedent in this respect, subject to the need to provide that: (a) the proposed statutory framework would apply to the civil liability setting and (b) that it would, in general, deal with refusal of treatment and not merely consent to treatment. On this basis, the Commission therefore recommends that the

proposed statutory framework should provide that a minor aged 16 years of age is presumed to have the capacity to consent to, and to refuse, any health care treatment, as already defined in this Report; that this capacity is, in the context of any potential civil liability, as effective as it would be if he or she were of full age, that is 18 years of age; and that where a minor has given such an effective consent to, or refused, any such treatment it shall not be necessary to obtain any consent for it, or refusal of consent for it, from his or her parent or guardian.

2.152 As a result, in general terms, a 16 and 17 year old would not be subject to any countervailing test, such as whether the specific treatment is in their “best interests.” The Commission notes that, since the 16 and 17 year old – like an 18 year old under the present law – will be *presumed* to have capacity, this would be subject to contrary evidence that the person lacks capacity. As already noted, many of the legislative provisions enacted in other countries in this area provide for this situation. Thus, if it is proved on the balance of probabilities (the standard of proof in civil cases) that a 16 or 17 year old does *not* have capacity to make a particular healthcare decision, his or her parents or guardians will, in general terms, retain the entitlement to make the healthcare decision on his or her behalf in accordance with the provisions of the Constitution and relevant international instruments concerning the role of parents and guardians and the general principles already set out in Chapter 1 of this Report. In addition, as discussed below, the “best interests” test may be applicable where life sustaining treatment is involved or where a person under 16 is involved.

2.153 This general approach is, of course, subject to certain other existing legislative limits and requirements. This includes existing requirements in, for example, the *Control of Clinical Trials Act 1987*, the *European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004*,¹⁷⁵ the *Child Care Act 1991* or the *Mental Health Act 2001*. The Commission is also conscious that planned legislation may also affect this general approach, such as the proposed *Human Tissue Bill*, the proposed *Health Information Bill*¹⁷⁶ or any proposal, for example, to regulate access to sunbeds for those under 18.

2.154 The Commission accordingly recommends that, having regard to the general principles already set out in this Report, the proposed legislative framework on health care treatment should provide that, in general, a person who is 16 or 17 years of age is presumed, in the context of any potential civil

¹⁷⁵ SI No.190 of 2004.

¹⁷⁶ See paragraph 2.07, discussing the *Draft Proposals for General Scheme of the Human Tissue Bill 2009* (Department of Health and Children, 2009), available at www.dohc.ie, and the *Health Information Bill*, which is scheduled for publication in 2011.

liability, to have capacity to consent to, and refuse, health care treatment, as already defined in this Report; that this capacity is as effective as it would be if he or she were of full age, that is 18 years of age; that the presumption of capacity is subject to contrary evidence that the person lacks capacity; and that where a 16 or 17 year old has given such an effective consent to, or refused, any such treatment it shall not be necessary to obtain any consent for it, or refusal of consent for it, from his or her parent or guardian. The Commission also recommends that this is subject to certain other existing legislative limits and requirements, including existing requirements in, for example, the *Control of Clinical Trials Act 1987*, the *European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004*,¹⁷⁷ the *Child Care Act 1991* and the *Mental Health Act 2001*. The Commission also recommends that this should also have regard to planned legislation, such as the proposed *Human Tissue Bill*, the proposed *Health Information Bill* or any proposal, for example, to regulate access to sunbeds for those under 18.

2.155 *The Commission recommends that, having regard to the general principles already set out in this Report, the proposed legislative framework on health care treatment should provide that, in general, a person who is 16 or 17 years of age is presumed, in the context of any potential civil liability, to have capacity to consent to, and refuse, health care treatment, as already defined in this Report; that this capacity is as effective as it would be if he or she were of full age, that is 18 years of age; that the presumption of capacity is subject to contrary evidence that the person lacks capacity; and that where a 16 or 17 year old has given such an effective consent to, or refused, any such treatment it shall not be necessary to obtain any consent for it, or refusal of consent for it, from his or her parent or guardian. The Commission also recommends that this is subject to certain other existing legislative limits and requirements, including existing requirements in, for example, the Control of Clinical Trials Act 1987, the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004, the Child Care Act 1991 and the Mental Health Act 2001. The Commission also recommends that this should also have regard to planned legislation, such as the proposed Human Tissue Bill, the proposed Health Information Bill or any proposal, for example, to regulate access to sunbeds for those under 18.*

(3) Refusal of life-sustaining treatment by a 16 and 17 year old

2.156 It is important to state that, in the majority of situations where a 16 and 17 year old either consents to or refuses treatment, the consequences of such a decision are not life threatening. The Commission accepts that while, in general, consent and refusal should be treated similarly, additional

¹⁷⁷ SI No.190 of 2004.

considerations need to be taken into account where life-sustaining treatment is refused.

2.157 In this respect, the Commission notes that, in its 2006 *Report on Vulnerable Adults and the Law*,¹⁷⁸ the Commission recommended that the issue of life sustaining treatment concerning persons over 18 years of age should be subject to specific statutory rules. Equally, in its 2009 *Report on Bioethics: Advance Care Directives*,¹⁷⁹ the Commission concluded that advance care directives involving refusal of life-sustaining treatment should involve specific treatment. This reflects the Commission's general approach that the law in this area should operate on the basis of a presumption in favour of life, and this in turn is derived from the important and high status given to the right to life in the Constitution of Ireland and, indeed, in international human rights documents such as Article 2 of the Council of Europe's 1950 Convention on Human Rights and Fundamental Freedoms.

2.158 This approach is also consistent with the approach taken in the Canadian cases discussed above and in the legislative provisions in other countries where this matter has been specifically addressed, as also discussed above. These cases and legislative provisions involve an assessment of the capacity of a person under 18, and they then apply an objective best interests standard in a way which ensures that the judgement of a child's best interests is informed in a real and meaningful way by the voice of the child.

2.159 In the current project and Report, the Commission reiterates this approach, and therefore recommends that in cases where an individual under the age of 18 refuses life sustaining treatment, an application should be made to the High Court to adjudicate on the refusal. In such a case, the High Court could intervene to order treatment that is necessary to save life and where this is in the best interests of the young person. In the event of such an application, the Commission also recommends that the person under 18 shall be separately represented.

2.160 *The Commission recommends that, in the context of refusal of life sustaining treatment by a person under the age of 18, an application may be made to the High Court to determine the validity of the refusal. The High Court may order treatment that is necessary to save life and where this is in the best interests of the person under 18 years of age. The Commission also recommends that in any such application the person under 18 shall be separately represented.*

¹⁷⁸ (LRC 83-2006).

¹⁷⁹ (LRC 94-2009).

(4) Advance care directives by 16 and 17 year olds

2.161 In the 2009 *Report on Bioethics: Advance Care Directives* the Commission defined the term “advance care directive” as the advance expression of wishes by a person, at a time when they have the capacity to express their wishes, about certain treatment that might arise at a future time when they no longer have the capacity to express their wishes.¹⁸⁰ The Commission recommended in the 2009 Report that, consistently with the Council of Europe 2009 *Recommendation on Principles Concerning Continuing Powers of Attorney and Advance Directives for Incapacity*,¹⁸¹ a legislative framework for advance care directives for those aged 18 and over should be enacted in the context of proposed mental capacity legislation. The Commission also noted that advance care directives are not restricted to end-of-life settings but can also arise in a continuing-life setting.¹⁸² In addition, it is important to point out that advance care directives be seen in the wider setting of overall health care planning (which is not confined to consent to or refusal of medical treatment), particularly in the context of children and young people dealing with long term illness.

2.162 The Commission reiterates here the view expressed in the Consultation Paper that those under 18 with capacity should not be denied the opportunity to engage fully in healthcare planning by way of making an advance care directive. In light of the general approach taken above concerning 16 and 17 year olds, the Commission has concluded, and recommends, that a 16 and 17 year old should be presumed to have capacity to make an advance care directive. The Commission also reaffirms the view it expressed in the Consultation Paper that an assessment of a minor and young person by a trained and experienced health care professional is crucial in determining capacity, rather than assuming capacity – or lack of capacity – purely on the basis of age. As the literature on child development discussed in Chapter 1 illustrates, one cannot disregard the experience of an individual in respect of the particular healthcare decision. In that respect the literature supports the view that personal experience and understanding are relevant and often determinative of a particular child or young person’s ability to understand and make informed decisions regarding his or her health care. This point was

¹⁸⁰ Law Reform Commission *Report on Bioethics: Advance Care Directives* (LRC 94 -2009) at 2.

¹⁸¹ Recommendation CM/Rec(2009)11 of the Committee of Ministers to member states on principles concerning continuing powers of attorney and advance directives for incapacity (9 December 2009).

¹⁸² Law Reform Commission *Report on Bioethics: Advance Care Directives* (LRC 94 -2009) at 1.13.

echoed in a number of submissions received by the Commission, which stressed the importance of the individual's particular experience and capacity to make an advance care directive.

2.163 The Commission therefore recommends that the legislation proposed in this Report should provide that a 16 or 17 year old is presumed to have capacity to make an advance care directive. The Commission also recommends that where an advance care directive is being considered by or for a 16 and 17 year old a specific assessment be made by a trained and experienced health care professional of that person's capacity to understand the nature and consequences of the advance care directive.

2.164 *The Commission recommends that the legislation proposed in this Report should provide that a 16 or 17 year old is presumed to have capacity to make an advance care directive. The Commission also recommends that where an advance care directive is being considered by or for a 16 and 17 year old a specific assessment be made by a trained and experienced health care professional of that person's capacity to understand the nature and consequences of the advance care directive.*

(5) Persons under 16 and health care treatment

2.165 The Commission has already noted that the decisions of the Supreme Court in *McK v Information Commissioner*¹⁸³ and of the High Court in *D v Brennan and Ors*¹⁸⁴ recognise that a mature minor under the age of 16 is capable, under Irish law, of making significant health care decisions as an independent rights holder. This reflects the general principle stated by Walsh J in *G v An Bord Uchtála*¹⁸⁵ that the rights of children are "independent of any right of the parent as such." This approach is also seen in specific statutory provisions that have regard to the "maturity and understanding" of a child, such as the provisions discussed in the *Child Care Act 1991* and the *Adoption Act 2010*.

2.166 This approach in Irish law is consistent with the reality of the growing maturity of children as they reach adolescence and early adulthood, which is reflected in the general literature in this area discussed by the Commission in Chapter 1. It is also clear that, in this respect, Irish law reflects developments in other countries, including the views expressed in 1969 in the English case

¹⁸³ [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260, discussed at paragraph 1.65ff, above.

¹⁸⁴ *D v Brennan and Ors* High Court, 9 May 2007, discussed in paragraph 2.31ff, above.

¹⁸⁵ *G v An Bord Uchtála* [1980] IR 32 at 69.

*Hewer v Bryant*¹⁸⁶ that the authority of parents in respect of their children “starts with a right of control and ends with little more than advice.” The generality of that statement has given rise to the development of the “mature minor” test in decisions such as those of the UK House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority*¹⁸⁷ and of the Supreme Court of Canada in *AC v Manitoba (Director of Child and Family Services)*.¹⁸⁸ The more recent decisions, such as the Canadian decision *AC* case, have also specifically taken into account the relevant international human rights standards in this area, notably the 1989 UN Convention on the Rights of the Child (UNCRC).

2.167 The Commission reiterates here its view that, in general, the law should apply a functional test of capacity to those under 18. The Commission considers, however, that a presumption of capacity should not apply to those under 16, so that it is necessary to clarify how to assess the maturity and understanding of those individuals. In this respect, the Commission acknowledges that the Medical Council’s 2009 *Guide to Professional Conduct and Ethics*¹⁸⁹ provides a useful starting point. As already noted, the 2009 *Guide*, though necessarily confined to providing guidance to doctors, reflects in general terms the current law as set out in the Irish decisions already referred to, such as the *G*, *McK* and *D* cases, which in turn reflect the provisions on the family in Articles 41 and 42 of the Constitution and in the relevant international standards already discussed in this Report. Thus, the 2009 *Guide* correctly identifies that the “usual” position is that parents should be asked for their consent, but that in “exceptional circumstances” the doctor would “encourage” the under 16 year old to involve their parents, bearing in mind the doctor’s “paramount responsibility to act in the patient’s best interests.” While this general guidance is useful, the Commission notes that it does not provide specific guidance on the nature of the “best interests” test. Nor does it refer to a maturity test, which as the Commission has already noted is currently part of Irish law (through both the case law and legislation already noted in this Report).

2.168 As the Commission has already noted, in a 2009 study of GPs in Ireland,¹⁹⁰ it is clear that, in the absence of detailed professional guidance, the

¹⁸⁶ [1969] 3 All ER 578, at 582.

¹⁸⁷ [1985] UKHL 7, [1985] 3 All ER 402.

¹⁸⁸ 2009 SCC 30, [2009] 2 SCR 181.

¹⁸⁹ Medical Council’s 2009 *Guide to Professional Conduct and Ethics* (7th ed, 2009), available at www.medicalcouncil.ie.

¹⁹⁰ McMahan et al, “The Prescribing of Contraception and Emergency Contraception to Girls Aged Less than 16 – What are the Views and Beliefs of GPs and of Parents?” (2010) 16, 2 MLJI 91, discussed at paragraph 2.50, above.

“Fraser Guidelines” from the *Gillick* case are viewed as persuasive guidance by a significant number of GPs and healthcare practitioners. Since the “Fraser Guidelines” have formed the basis for the authoritative guidance documents published in England and Wales (1986 and 2004), Northern Ireland (2003) and Scotland (2006), discussed above, it is not surprising that health care professionals in Ireland would be influenced by these developments. The Commission notes that while the “Fraser Guidelines” provide helpful and detailed criteria for assessing maturity and related matters, they are restricted to the specific issue that arose in the *Gillick* case, namely, the provision of contraception. By contrast, the authoritative guidance documents from other countries discussed above involve an analysis of issues of capacity, maturity and best interests in the broader context of health care decision-making generally, and also against the background of the relevant international human rights standards that have developed since the mid 1980s. In this respect, the Commission notes that more recent analysis, such as that by the Supreme Court of Canada in *AC v Manitoba (Director of Child and Family Services)*,¹⁹¹ provides a more complete reference point for the development of guiding principles in this area.

2.169 The Commission has already set out in Chapter 1 the relevant general guiding principles that apply to this area, in particular the inter-relationship between the rights of children, the rights of parents and guardians and the application of a rights-based “best interests” test. In addition, the Commission considers that the “sliding scale” referred to by the Canadian decision in *AC v Manitoba (Director of Child and Family Services)*¹⁹² is especially relevant in the context of persons under the age of 16 because the interpretation of what is in the best interests of a person under 16 is aided by the sliding scale approach. This means that there is a scale of scrutiny or analysis against which a child’s best interests is measured. The maturity of the child and the decision to be made are both factors which are fed into the sliding scale. In Ireland, as the Commission has already noted, the Supreme Court in *McK v Information Commissioner*¹⁹³ has recognised that the views of the person under 16 become increasingly determinative as he or she matures so that the greater the child’s level of maturity the greater the weight granted to the child’s views. This is balanced against the specific decision to be made, because the more serious the nature of the decision and the more severe its potential impact

¹⁹¹ 2009 SCC 30, [2009] 2 SCR 181.

¹⁹² 2009 SCC 30, [2009] 2 SCR 181.

¹⁹³ [2004] IEHC 4, [2004] 1 IR 12; [2006] IESC 2, [2006] 1 IR 260, discussed at paragraph 1.65ff, above.

on the health and well being of the child, the greater the degree of scrutiny required.

2.170 Consistently with this approach, and in light of the submissions received since the publication of the Consultation Paper, the Commission has also concluded that, for those under the age of 16, the law should not set out a detailed, prescriptive, legislative framework that would differentiate between, for example, those aged 14 and 15 and those under the age of 14. In this respect, the Commission agrees with the submissions received that the suggestion in the Consultation Paper that a distinction might be drawn between those aged 14 and 15, on the one hand, and those under 14, on the other hand,¹⁹⁴ would not be practicable and would, rather, run the risk of leading to increased complexity for all those involved in this area, whether those under 16, their parents or guardians as well as professional health care providers. In preparing this Report, the Commission also accepts that such a prescriptive approach, in which age rather than maturity was the determining factor, does not reflect the literature on child development (which the Commission discussed in Chapter 1) and the reality of gradual maturing and understanding during adolescence.

2.171 The Commission has therefore concluded, and recommends, that for those under 16, a non-prescriptive approach be taken in which the proposed legislative framework should not include a presumption of capacity for those under 16, but should provide that he or she may consent to, and refuse, health care treatment where it is established that the person under 16 has the maturity and understanding to appreciate the nature and consequences of the specific health care treatment decision. The Commission also recommends that, in the case of health care treatment involving those under 16, the usual situation should be that parents or guardians, who have the primary responsibility for the upbringing and development of children (as provided for in Article 42.1 of the Constitution and Article 18 of the 1989 UN Convention on the Rights of the Child (UNCRC)), are involved in the decision-making process. The Commission also recommends that the person under 16 should be encouraged and advised to communicate with and involve his or her parents or guardians, as already provided for in the Medical Council's 2009 *Guide to Professional Conduct and Ethics*.¹⁹⁵ The Commission therefore also recommends that it is only in "exceptional" circumstances (the term used in Article 42.5 of the Constitution, and in authoritative published guidance such as the 2003 Northern Ireland

¹⁹⁴ See in particular the provisional recommendations in the Consultation Paper, at paragraphs 4.127 (14 and 15 year olds) and 4.128 (12 and 13 year olds).

¹⁹⁵ Medical Council's 2009 *Guide to Professional Conduct and Ethics* (7th ed, 2009), available at www.medicalcouncil.ie.

Reference Guide to Consent for Examination, Treatment or Care,¹⁹⁶ discussed above), and having regard to the need to take account of an objective assessment of both the rights and the best interests of the person under 16, that health care treatment would be provided for those under 16 without the knowledge or consent of parents or guardians.

2.172 The Commission also recommends that the “sliding scale” test and the 7 specific factors identified by the Supreme Court of Canada in 2009 in *AC v Manitoba (Director of Child and Family Services)*¹⁹⁷ should also be incorporated into the proposed statutory framework. As the discussion of the *AC* in this Report illustrates, the analysis by the Supreme Court of Canada in 2009 took account of relevant international human rights standards that have been put in place in recent years, notably the 1989 UN Convention on the Rights of the Child. This rights-based approach also reflects the Commission’s approach, which is itself consistent with the law in Ireland on the respective rights of children and parents already discussed in this Report. The approach in the *AC* case has adopted a more wide-ranging analysis when compared with the limited scope of the circumstances that the UK House of Lords were required to deal with in 1985 in *Gillick v West Norfolk and Wisbech Area Health Authority*.¹⁹⁸ In that respect, the analysis in the *AC* case reinforces the reality that the “mature minor” rule is more wide-ranging in scope than the prescribing of the contraceptive pill. Indeed, in 1969, an early version of the “mature minor” rule was applied by the English Court of Appeal in *Hewer v Bryant*¹⁹⁹ in the context of the application of limitation periods in a personal injuries claim.

2.173 The Commission accordingly recommends that the proposed legislative framework should provide that, in determining whether a minor under 16 has the maturity and capacity to consent to, and to refuse, health care treatment as already defined in this Report, the following factors should be taken into account:

- (a) whether he or she has sufficient maturity to understand the information relevant to making the decision and to appreciate its potential consequences;
- (b) whether his or her views are stable and a true reflection of his or her core values and beliefs, taking into account his or her physical and

¹⁹⁶ Available at <http://www.dhsspsni.gov.uk>.

¹⁹⁷ 2009 SCC 30, [2009] 2 SCR 181.

¹⁹⁸ [1985] UKHL 7, [1985] 3 All ER 402.

¹⁹⁹ [1969] 3 All ER 578.

mental health and any other factors that affect his or her ability to exercise independent judgement;

(c) the nature, purpose and utility of the treatment;

(d) the risks and benefits involved in the treatment, and

(e) any other specific welfare, protection or public health considerations, in respect of which relevant guidance and protocols such as the *2011 Children First: National Guidelines for the Protection and Welfare of Children* (or any equivalent replacement document)²⁰⁰ must be applied.

2.174 *The Commission recommends that the proposed legislative framework should not include a presumption of capacity for those under 16, but should provide that a person under 16 may consent to, and refuse, health care treatment where it is established that he or she has the maturity and understanding to appreciate the nature and consequences of the specific health care treatment decision. The Commission also recommends that, in the case of health care treatment involving those under 16, the usual situation should be that parents or guardians, who have the primary responsibility for the upbringing and development of children, are involved in the decision-making process; that the person under 16 should be encouraged and advised to communicate with and involve his or her parents or guardians; and that, therefore, it is only in exceptional circumstances, and having regard to the need to take account of an objective assessment of both the rights and the best interests of the person under 16, that health care treatment would be provided for those under 16 without the knowledge or consent of parents or guardians.*

2.175 *The Commission also recommends that the proposed legislative framework should provide that, in determining whether a person under 16 has the maturity and capacity to consent to, and to refuse, health care treatment as already defined in this Report, the following factors are to be taken into account:*

(a) whether he or she has sufficient maturity to understand the information relevant to making the specific decision and to appreciate its potential consequences;

²⁰⁰ In July 2011, the Minister for Children and Youth Affairs launched the revised *2011 Children First: National Guidelines for the Protection and Welfare of Children* and indicated that these would be placed on a statutory footing: *The Irish Times* 16 July 2011. The Minister for Justice and Equality also published in July 2011 the *Scheme of a Criminal Justice (Withholding Information on Crimes against Children and Vulnerable Adults) Bill 2011*, which would, if enacted, require reporting of allegations of child sexual abuse.

(b) whether his or her views are stable and a true reflection of his or her core values and beliefs, taking into account his or her physical and mental health and any other factors that affect his or her ability to exercise independent judgement;

(c) the nature, purpose and utility of the treatment;

(d) the risks and benefits involved in the treatment, and

(e) any other specific welfare, protection or public health considerations, in respect of which relevant guidance and protocols such as the 2011 *Children First: National Guidelines for the Protection and Welfare of Children* (or any equivalent replacement document) must be applied.

(6) Defence of good faith

2.176 The Commission emphasises that the proposed statutory framework, including the guiding principles set out in Chapter 1 and the specific matters set out in this Part, should be facilitative. This is consistent with the Commission's approach in its 2009 *Report on Bioethics: Advance Care Directives*.²⁰¹ It means that the proposed statutory framework is intended to clarify the position of all those involved in the process – those under 18, parents, guardians and professionals – and that health care professionals who act in good faith should not be at risk of any civil liability. Indeed, the risk of potential civil liability was referred to in the 2009 study of Irish GPs discussed above.²⁰² In this respect, and having regard to the submissions received since the publication of the Consultation Paper, the Commission has concluded, and therefore recommends, that the proposed statutory framework should include, in respect of potential civil liability, a defence of good faith for health care practitioners who treat children and young people under 18 years of age. Section 23 of the *Non-Fatal Offences Against the Person Act 1997* already provides a comparable defence in terms of criminal liability. The Commission recommends that the defence would apply to a health care practitioner who, acting in good faith and exercising due diligence, makes a decision to provide medical treatment, or a decision to withhold medical treatment, in respect of a child or a young person under 18 years of age. The Commission also recommends that acting in good faith and exercising due diligence would be defined as where the health care professional acts consistently with the general principles and specific matters, including as to assessment of capacity of those under 16, in the proposed statutory framework.

²⁰¹ See *Report on Bioethics: Advance Care Directives* (LRC 94-2009), Chapter 4.

²⁰² McMahon et al, "The Prescribing of Contraception and Emergency Contraception to Girls Aged Less than 16 – What are the Views and Beliefs of GPs and of Parents?" (2010) 16, 2 MLJI 91.

2.177 *The Commission recommends that the proposed statutory framework should include, in respect of potential civil liability, a defence of good faith for health care practitioners who treat children and young people under 18 years of age. The Commission recommends that the defence would apply to a health care practitioner who, acting in good faith and exercising due diligence, makes a decision to provide medical treatment, or a decision to withhold medical treatment, in respect of a child or a young person under 18 years of age. The Commission also recommends that acting in good faith and exercising due diligence would be defined as where the health care professional acts consistently with the general principles and specific matters, including as to assessment of capacity of those under 16, in the proposed statutory framework.*

(7) Statutory Code of Practice

2.178 The Commission has already noted in the Introduction to this Report²⁰³ that, ideally, through informed discussion and participation by all those involved – those under 18, parents, guardians and health care professionals – practical solutions and consensus can be reached that respect the rights and interests of all those involved. When this is not possible, however, it is important to have in place a clear statutory framework. Given the complexities of the issues raised, which is clear from the discussion in this Report, the proposed statutory framework cannot provide definitive solutions to all the moral, legal, ethical and public policy questions involved.

2.179 It is clear that, in the countries surveyed in Part C, there is a recognised need to supplement any general legislative framework with guidance material to provide detailed guidelines that concern situations that arise in clinical practice. The Commission notes that, in its 2006 *Report on Vulnerable Adults and the Law*,²⁰⁴ which contained a draft *Scheme of a Mental Capacity Bill*, the Commission proposed that a statutory Code of Practice should be prepared and published for the purpose of providing practical guidance on, for example, the application in practice of the presumption of capacity and related matters. Similarly, the Commission reiterated this approach in its 2009 *Report on Bioethics: Advance Care Directives*²⁰⁵ concerning guidance as to the applicability and validity of advance care directives. In the context of this Report, a statutory Code of Practice would provide detailed guidance on complex issues of consent, refusal and confidentiality, allowing health care professionals to treat children and young people in a manner which recognises their rights and those of their parents and guardians, while also

²⁰³ See paragraph 15 of the Introduction to the Report, above.

²⁰⁴ (LRC 83-2006).

²⁰⁵ See *Report on Bioethics: Advance Care Directives* (LRC 94-2009), Chapter 4.

enabling the practitioner to work in a manner which is consistent with relevant ethics frameworks.

2.180 It is important to note that complex medical situations involve circumstances which are specific and personal to the particular individual with the particular medical concern. As the many court decisions surveyed in this Report indicate, there are a range of complex medical and ethical issues which patients and healthcare professionals face on a daily basis, for example the refusal of blood products, the treatment of anorexia, the dilemmas faced by patients coping with a terminal illness – these examples reflect the diversity and difficulty inherent in health care decision making, which is more pronounced when the patient concerned is under 18 years of age. In this respect, the Commission notes that a number of models exist on which to base any Code of Practice, such as the Guides developed in Northern Ireland (2003), England and Wales (2004) and Scotland (2006) that have been referred to and discussed in Part C, above. The Commission notes that a guide such as the 2003 Northern Ireland *Reference Guide to Consent for Examination, Treatment or Care*²⁰⁶ has the advantage of providing wide-ranging guidance on health care treatment both for those over 18 and those under 18 within the general context of a reformed law on mental capacity.

2.181 In addition to providing needed practical guidance, another advantage associated with such Codes of Practice is that they may be regularly revised, and thus provide an up to date guide to health care practice and ethics, without the need to amend the legislative framework.

2.182 The Commission accordingly recommends that the Minister for Health and the Minister for Children and Youth Affairs should establish a broad-based Working Group which would assist the Ministers in preparing a Code of Practice in this area. The Commission does not intend to set out a prescriptive list of those who might be members of such a Working Group or who would be consulted in preparing the Code of Practice, but clearly it would need to involve a wide range of bodies. Those involved or consulted could include, for example, the Medical Council, the Irish College of General Practitioners, the Irish College of Psychiatry, the Mental Health Commission, An Bord Altranais, the Dental Council, the National Parents Council, the HSE Crisis Pregnancy Programme, the Ombudsman for Children, Headstrong (the National Centre for Youth Mental Health) and Barnardos.

2.183 As with the possible membership of the Working Group that would assist in preparing the Code of Practice, the Commission does not intend to set out a prescriptive list of the range of health care treatment settings on which guidance should be provided. It is sufficient to note that it would involve both

²⁰⁶ Available at <http://www.dhsspsni.gov.uk>.

physical and mental health care settings. It could, therefore, provide guidance on:

- dental care and treatment
- eye care and treatment
- over-the-counter medicine of specific relevance to adolescents, such as products related to skin conditions
- prescription for antibiotics
- prescription for contraception
- advice and counselling on general health and development
- counselling and treatment concerning mental health
- prescription for anti-depressants
- admission to approved mental health care centre
- X ray
- surgery and treatment related to a broken arm
- surgery for removal of the appendix
- surgery and treatment connected to cancer
- surgery and treatment connected with a chronic condition such as cystic fibrosis and
- paediatric research and clinical trials.

2.184 The Commission has concluded, and therefore recommends, that the Minister for Children and Youth Affairs, in consultation with the Minister for Health, should establish a broad-based Working Group which would assist the Minister in preparing and publishing a Code of Practice based on the principles in the proposed statutory framework. The Commission also recommends that the Code of Practice would provide detailed guidance as to the application of the proposed statutory framework in the context of all forms of health care and treatment settings as already defined in this Report.

2.185 *The Commission recommends that the Minister for Children and Youth Affairs, in consultation with the Minister for Health, should establish a broad-based Working Group which would assist the Minister in preparing and publishing a Code of Practice based on the principles in the proposed statutory framework. The Commission also recommends that the Code of Practice would provide detailed guidance as to the application of the proposed statutory framework in the context of all forms of health care and treatment settings as already defined in this Report.*

CHAPTER 3 MENTAL HEALTH

A Introduction

3.01 In this chapter the Commission discusses issues of capacity and healthcare decision-making involving children and young people who engage with mental health services. The Commission notes that the general principles and detailed recommendations set out in Chapters 1 and 2 also apply in the context of mental health provision. In this Chapter, the Commission's discussion does not deal with mental health law in general, but focuses primarily on the admissions process under the *Mental Health Act 2001*. The Commission notes that the *Programme for Government 2011 to 2016* proposes a general review of the *Mental Health Act 2001* and the Commission considers that the recommendations made in this Chapter could form part of that general review.¹ Part B contains a brief overview of the extent of mental health issues involving children and young people in Ireland and the appropriateness of available services. Part C examines the rights of children and young people in the context of mental health legislation and service provision. Part D discusses the provisions of the *Mental Health Act 2001* as they relate to children and young people, including its shortcomings in this respect. Part E contains the Commission's recommendations for reform of the *Mental Health Act 2001* as it applies to children and young people, which includes recommending the introduction of a new category of "intermediate" admission and treatment.

B Mental Health Issues and Appropriate Mental Health Services

3.02 The extent of mental health issues involving children and young people was discussed in detail in the Consultation Paper, drawing on information and statistics from a range of reports and research papers. Mental health issues were also raised by many children and young people with whom the Commission consulted.²

¹ For this reason, the Commission's recommendations in this Chapter have been incorporated into the *Outline Scheme of a Mental Health (Amendment) Bill* in Appendix B of this Report.

² (LRC CP 59-2009) at 1.59

(1) The range of mental health issues

3.03 Submissions received by the Commission from young people have highlighted mental health as a subject of particular concern, stating that not enough information and support is available in this area. Young people have emphasised that relevant legislation ought to look at the issue of mental health from a young person's perspective, and should aim to protect the young person, taking their best interests into consideration.

3.04 A submission received by the Commission suggested that a child or young person with experience of mental illness be represented on the Mental Health Commission. The Commission agrees that the experience and views of the child or young person would add greatly to the work of the Mental Health Commission. This is discussed in more detail below.

3.05 Children of any age can suffer from a mental illness or mental health difficulties, but adolescence is a typical time for the development of such problems. Headstrong, the National Centre for Youth Mental Health, has estimated that in Ireland, at any given time, one in five young people are experiencing serious emotional distress.

“Young people experiencing mental health difficulties often imagine that everyone else is somehow managing to cope and that they are in some way different or weird for feeling the way they do. The reality is that mental health problems are a lot more common in young people than most of us realise.”³

3.06 Adolescent mental distress and concerns can have long term implications. The 2008 Annual Report of the Child and Adolescent Mental Health Services (CAMHS) stated that the majority of illnesses borne in childhood, and particularly in adolescence, is caused by mental disorders. Furthermore, the majority of adult mental health disorders have their onset in adolescence.⁴ The Report also stated that the prevalence of mental health disorders in young people is increasing with time.⁵

3.07 The high rates of suicide in Ireland have been well documented, with suicide considered as the leading cause of death amongst young people.⁶ There is a strong link between suicide and self harm, as engaging in self harm is the strongest predictor of future suicidal behaviour. The 2008 Report of the

³ Bates et al *Someone to Turn To Someone to Talk To* (Headstrong 2009) at 16.

⁴ Child and Adolescent Mental Health Services: First Annual Report 2008 (Health Service Executive 2009) at 6.

⁵ *Ibid.*

⁶ Bates et al *Someone to Turn To Someone to Talk To* (Headstrong 2009) at 18.

National Registry of Deliberate Self Harm Ireland revealed a total of 11,700 presentations to hospitals in Ireland, an increase of 6% from 2007 figures.⁷ These figures do not include the numbers of people who engage in self harm without receiving medical attention.

3.08 Deliberate self harm is largely confined to younger age groups, particularly young women. The peak rate for self-harm in relation to age and gender is found amongst young women aged 15-19.⁸ The 2008 Report found that one in every 156 adolescent girls were treated in hospital as a result of deliberate self harm. The Report also found an increase in deliberate self harm amongst boys and girls aged 10-14 years.⁹

(2) Appropriate service provision

3.09 It is clear that children and young people need appropriate, high-quality, accessible mental health services to help them cope with such concerns. At a local level there is a need for a holistic, community-based approach to the prevention of mental health problems. A vital aspect of health care for adolescents is simply to have access to a reliable person to confide in and talk to about their difficulties and health concerns. This is particularly important in relation to mental health difficulties such as depression, insecurity and low self-esteem. The importance of GPs as an early point of contact, offering opportunities for timely intervention and treatment, was documented in the National Strategy for Action on Suicide Prevention.¹⁰ Moreover, the 2008 Annual Report of the Child and Adolescent Mental Health Services (CAMHS) revealed that the vast majority of referrals come from general practitioners.¹¹

⁷ *National Registry of Deliberate Self Harm Ireland: Annual Report 2008* (National Suicide Research Foundation) at i.

⁸ *National Office for Suicide Prevention Annual Report 2008* (Health Service Executive) at 28, *National Office for Suicide Prevention Annual Report 2006* (Health Service Executive) at 26.

⁹ *National Registry of Deliberate Self Harm Ireland: Annual Report 2008* (National Suicide Research Foundation) at i.

¹⁰ *Reach Out: National Strategy for Action on Suicide Prevention 2005-2014* (Health Service Executive 2005) at 31.

¹¹ In 2008, 76.6 % of referrals were from general practitioners and child health services, 9.4% of referrals were from educational services, 5.6% were from primary care services, 3.2% of referrals were from social services, 2.7% of referrals were self referrals and 2.4% of referrals were from other sources. *Child and Adolescent Mental Health Services: First Annual Report 2008* (Health Service Executive 2009) at 14.

3.10 As discussed in the Consultation Paper, children as young as 13 have availed of addiction services. Alcoholism is a huge problem in Irish society, and children who become addicted to alcohol from an early age often do not have adequate support from parents and family, particularly if there is a family history of alcohol abuse.

3.11 People from all social classes and backgrounds can develop a mental health disorder but certain young people may be particularly at risk due to a history of mental illness, family breakdown, abuse, learning disability, bereavement or substance abuse.¹² Children and young people sometimes face a clash of personalities and attitudes in their home and familial environment, leading to disruptive behaviour and the consequent development of mental health problems. Disruptive and aggressive behaviour, however, can be the product of intolerance and hostility rather than an inherent mental health issue. This is particularly relevant in light of concerns raised by the Mental Health Commission with regard to behaviourally disturbed children who come under the auspices of the *Mental Health Act 2001* as opposed to the *Children Act 2001*. These children may be disruptive, hostile and in need of expert care and supervision but this does not mean that they should be placed in the mental health system.¹³ It has been suggested that the provisions of the *Children Act 2001* on family welfare conferences could be utilised in such circumstances to guard against the unnecessary and unsuitable placement of children in the mental health system.¹⁴ The Mental Health Commission's *Annual Report 2009* drew attention to the practice, stating:

“We are concerned by the occupation of scarce CAMH [Child and Adolescent Mental Health] beds by individuals with no diagnosable mental disorder often with social problems ‘with nowhere to go’. This is inappropriate and potentially damaging to these individuals as well as depriving others of needed beds.”¹⁵

3.12 A number of commentators have discussed appropriate and beneficial responses to youth mental health and recommended the introduction or improvement of different mental health services. It is widely acknowledged that mental health services are not meeting current demand and there are

¹² *Get Connected: Developing an Adolescent Friendly Health Service* (National Conjoint Child Health Committee 2001) at 23.

¹³ Mental Health Commission *Response to the Law Reform Consultation Paper on Children and the Law: Medical Treatment* (2010) at 10.

¹⁴ Part 2 of the *Children Act 2001*.

¹⁵ *Annual Report 2009: Book One Part Two* (Mental Health Commission 2010) at 83.

considerable gaps in service provision.¹⁶ In 2009, the Mental Health Commission stated that Child and Adolescent Mental Health Services (CAMHS), which has responsibility for providing services to all children up to 18 years of age, were at that time not in a position to fulfil their obligations.¹⁷ Community facilities such as day hospitals and clinics were at that time inadequate, and waiting for an appointment could take over a year.¹⁸ The CAMHS Annual Report 2008 served to confirm this as it revealed that only 54 of the recommended 99 CAMH teams were then in place, and staff numbers in 49 community teams were below recommended levels. There was also a significant variation in the distribution and disciplinary composition of the workforce across teams and regions with 18 teams rating their premises as inadequate or totally unsuitable.¹⁹

3.13 One of the key failings in respect of necessary mental health services for children and adolescents is the shortage of approved centres for in-patient treatment which has led to the practice of treating young people, as young as 11 years of age, in adult psychiatric wards.²⁰ The Mental Health Commission referred to this practice as:

“inexcusable, counter-therapeutic and almost purely custodial in that clinical supervision is provided by teams unqualified in child and adolescent psychiatry.”²¹

3.14 In 2009, the Mental Health Commission published an addendum to the Code of Practice relating to the admission of children under the *Mental*

¹⁶ See Lynch et al “Challenging Times: Prevalence of psychiatric disorders and suicidal behaviours in Irish adolescents” (2006) 29 *Journal of Adolescence* 570; Kilkelly *Children’s Rights in Ireland* (Tottel Publishing 2008) at 433; “Mental Health Services still do not reflect new policies” *The Irish Times* 15 May 2009; and “Major gaps still exist in psychiatric teen services” *The Irish Times* 31 March 2009.

¹⁷ *Annual Report 2008: Book One Part Two* (Mental Health Commission 2009) at 63.

¹⁸ *Annual Report 2008: Book One Part Two* (Dublin: Mental Health Commission 2009) at 63.

¹⁹ *Child and Adolescent Mental Health Services: First Annual Report 2008* (Health Service Executive 2009) at 24.

²⁰ (LRC CP 59-2009) at 6.18. See *Report of the Inspector of Mental Hospitals for year ending 2003* (Dept of Health and Children 2004) at 25.

²¹ *Annual Report 2008: Book One Part One* (Mental Health Commission 2009) at 29.

Health Act 2001, aimed at phasing out the admission of children and adolescents to adult units and centres. By December 2011 no child under 18 years of age should be admitted to an adult unit in an approved centre, save in exceptional circumstances. Regarding children and adolescents who live a considerable distance away from the approved centres for children, it is probable that they will fall under the category of exceptional circumstances, and continue to be treated in local approved centres for adults (modified to address their particular needs) in order to remain close to family support.

3.15 Such an admission should only take place in exceptional circumstances, where there is no available alternative. It should also be noted that it may in fact be for the benefit of the child or young person that he or she be admitted to a centre which is not geographically close to home, in circumstances where that child's problems begin at home or are exacerbated by the family home environment. The practice of placing children and young people in adult psychiatric wards and approved centres for adults represents a violation of the rights of children under a number of international instruments. In respect of age appropriate accommodation, the Council of Europe's 2000 White Paper on the Protection of Human Rights and Dignity of People Suffering from a Mental Disorder refers specifically to the living conditions of minors, stating that they should be treated and reside in separate premises from those in which adults reside, unless this is against the interest of the minor in question.²² Similarly, the 1991 UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care also state that the environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age.²³ Article 29 of the 2003 UN General Comment on Adolescent Health and Development focuses specifically on young people with mental illness, stating that in the event of hospitalisation or institutionalisation, adolescents should be separated from adults, where appropriate.²⁴

3.16 The Commission also notes that the English *Mental Health Act 1983*, as amended by the *Mental Health Act 2007* (the amendments coming into effect

²² Council of Europe *White Paper on the protection of human rights and dignity of people suffering from a mental disorder, especially those placed as involuntary patients in a psychiatric establishment* (Council of Europe 2000) at 8.4

²³ *Ibid* at 13(2).

²⁴ Committee on the Rights of the Child "Adolescent health and development in the context of the Convention on the Rights of the Child" (General Comment No 4 of 2003 CRC/GC/2003/4 1 July 2003) at 29.

in 2010),²⁵ has addressed concerns in relation to the negative experiences of young people placed on adult psychiatric wards. Section 131 of the 1983 Act, as amended, provides that children and young people under the age of 18 should be accommodated in an age-appropriate environment, with access to physical and educational facilities in order to allow to their personal, social and educational development to continue.

3.17 The Commission notes that, since 2009, considerable improvements have taken place in this aspect of the CAMH services. In its Annual Report 2010,²⁶ the Mental Health Commission pointed out that in 2010, 36% of admissions (155 admissions) were to adult units, which was a 24% decrease by comparison with 2009 (193 admissions). Similarly, there was a 65% increase in admissions of children to child units in 2010 by comparison with 2009.²⁷ The Commission echoes the Mental Health Commission's welcome to and approval of these development, subject to this proviso: if a completely holistic approach to service provision is applied, it must also be asked whether hospital admission, even to an age-appropriate ward, is actually "appropriate" in its widest sense.

3.18 In this respect, it has been noted in a 2010 Report for the Mental Health Commission that, for example, young people with drug and alcohol problems have been admitted to hospital inappropriately, leading sometimes "to inappropriate short term admissions that... in many other areas would be considered 'social admissions,' more appropriately dealt with by social services."²⁸ The Commission also notes that any such "social admissions" are highly questionable in terms of the rights of children under the Constitution of Ireland and the 1989 UN Convention on the Rights of the Child. In particular, they must give rise to questions as to whether they can be seen as conforming with an objective assessment of the best interests of the child or young person, as discussed in Chapter 1 of this Report. In the Commission's view, it is

²⁵ The amendments made by the 2007 Act to the 1993 Act arose in part from a report published by the Children's Commissioner for England, which revealed widespread negative experiences of young people on adult psychiatric wards. See *Pushed into the shadows - young people's experiences of adult mental health facilities* (Children's Commissioner for England, 2007).

²⁶ *Annual Report 2010: Book One Part Two* (Mental Health Commission 2011) at 42.

²⁷ *Ibid.* at 43.

²⁸ See Bonnar, *Report for the Mental Health Commission on Admission of Young People to Adult Mental Health Wards in the Republic of Ireland* (Mental Health Commission, December 2010), at paragraph 2.4, available at www.mhcirl.ie.

imperative that a young person, going through an important stage of physical and mental development, receives appropriate treatment in its widest sense, encompassing family, school and community support – and, if suitable and appropriate, medical treatment (including treatment in hospital).

C Rights of the Child in the Context of Mental Health Legislation

3.19 In this Part, the Commission discusses some of the shortcomings of the *Mental Health Act 2001* in respect of the protection of the individual rights of children and young people admitted and treated under the 2001 Act.

3.20 One matter of concern is that there is no specific section of the *Mental Health Act 2001* which relates specifically to persons under 18 years of age. This has led to confusion over which provisions are applicable to children and adults and which are applicable to adults only.²⁹ To quote from the Mental Health Commission:

“The provisions of the 2001 Act with regard to children need to be completely redrafted to take account of specific principles applying under human rights law and in national law. Children are being made to fit within the parameters of a law that was drafted with adults in mind.”³⁰

3.21 The Commission notes that the rights of children under Irish law, and relevant international human rights standards, as already discussed in this Report, are particularly relevant to the present discussion of the admission and treatment of children and young people under mental health legislation. The *Mental Health Act 2001* contains no clear reference to the rights of children and young people who are patients under the 2001 Act. Section 4 of the 2001 Act does contain a statement of rights, but it is unclear whether this section has a broad application in respect of both children and adults:

“(1) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.

²⁹ Sections 22, 59 and 69 have been noted in particular as causing considerable confusion.

³⁰ Mental Health Commission *Response to the Law Reform Consultation Paper on Children and the Law: Medical Treatment* (2010) at 34.

(2) Where it is proposed to make a recommendation or an admission order in respect of a person, or to administer treatment to a person, under this Act, the person shall, so far as is reasonably practicable, be notified of the proposal and be entitled to make any representations in relation to it and before deciding this matter due consideration shall be given to any representations duly made under this section.

(3) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, autonomy and privacy.”

3.22 The Mental Health Commission has stated that section 4 of the 2001 Act should be interpreted as applying to both children and adults. However, as discussed in Part D below, it is clear that the specific rights and best interests of children and young people are not currently provided for specifically in the 2001 Act. Indeed, children and young people are not granted the opportunity to make decisions or representations in respect of their admission and treatment. Furthermore, there is no requirement to inform the child or young person, much less take their views into account, which seems to be at variance with section 4(2) of the 2001 Act.

3.23 In the Commission’s view, more concrete provisions outlining the rights of children and young people are necessary to ensure that these rights are upheld and protected. The principle of best interests, for example, is a fundamental cornerstone of children’s rights and is an important element of the Commission’s recommendations in respect of healthcare and the medical treatment of children and young people. As discussed in Chapter 1, an assessment of the best interests of a child should be informed by the views of the child. Furthermore, an interpretation of best interests must be carried out from a holistic viewpoint, encompassing emotional as well as physical well-being, and to avoid the “social admissions” already mentioned.

3.24 Recognition of the evolving capacities of children and young people, as discussed in Chapter 1, is another principle which must be respected in the context of mental health legislation. Articles 5 and 12 of the 1989 UN Convention on the Rights of the Child (UNCRC) are particularly significant. Article 5 refers to the evolving capacities of children, and the responsibility of parents and others to continually adjust the levels of support and guidance offered to children, gradually enabling children to participate more in the realisation of their rights. Article 12 also carries an obligation to inform children, to ensure that they receive all the necessary advice and information to make a decision in their best interests. It is clear that the operation of the *Mental Health*

Act 2001 does not permit children and young people to realise their Article 12 rights. As outlined below, all rights in respect of information, participation and decision making are vested entirely in the parents or guardians of the child or young person, or the District Court.

3.25 Article 24 of the UNCRC refers to the rights of children in the context of healthcare provision, namely the right of the child to the highest attainable standard of health. Article 25 provides that State Parties:

“recognise the right of a child who has been placed by the competent authorities for the purpose of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement”.

3.26 Article 29 of the General Comment on Adolescent Health and Development builds on Article 24, focusing specifically on the treatment of adolescents with mental disorders, stating that the adolescent patient should be given the maximum possible opportunity to enjoy all his or her rights as recognised under the UNCRC.³¹ Also, State parties must ensure that adolescents have access to a personal representative other than a family member to represent their interests, where necessary and appropriate. This is discussed below, in light of the failure to represent and advocate for children and young people who are admitted and treated under the 2001 Act.

3.27 As discussed below, the *Mental Health Act 2001* is silent on the rights of children and young people to be informed and partake in discussions and decisions concerning their mental health. The development by the Mental Health Commission of the Headspace Toolkit is very important in this respect. The Toolkit is a guide aimed at providing age appropriate, accessible information to young people who are inpatients of mental health services. The Toolkit is written in a familiar, colloquial manner and covers essential topics such as the rights afforded to inpatients, what a patient may expect in terms of accommodation and treatment, and how a child or young person can speak out or make a complaint.

3.28 Section 25 of the *Mental Health Act 2001*, which provides for the involuntary admission of children, is discussed below. For present purposes it is sufficient to state that section 25 does not contain any significant safeguards

³¹ Committee on the Rights of the Child “*Adolescent health and development in the context of the Convention on the Rights of the Child*” (General Comment No 4 of 2003 CRC/GC/2003/4 1 July 2003).

which would ensure that children and young persons who are involuntarily admitted and treated have access to information and representation.

(1) Comparative mental health law

3.29 A brief examination of mental health legislation in force in other countries serves to highlight the lack of attention paid to the rights of children and young people by the *Mental Health Act 2001*. Mental health legislation in many other countries, discussed below, places a higher emphasis on the capacity of children and young people (particularly those aged 16 and 17 years of age) to participate, either partially or fully in healthcare decision making.

3.30 In England and Wales, the Code of Practice on the *Mental Health Act 1983*, updated in light of the *Mental Health Act 2007*, contains a detailed chapter on the admission and treatment of children and adolescents.³² The updated Code of Practice provides a clear and detailed overview of how mental health law in England has changed in order to respect and safeguard the rights of children and young people. Again, the Code refers to a number of principles, echoing those found in Australian legislation, discussed below. Fundamentally, the best interests of the child or young person must always be a significant consideration and their views, wishes and feelings should always be considered. Children and young people should also be kept as fully informed as possible, just as an adult would be, and should receive clear and detailed information concerning their care and treatment, explained in a way they can understand and in a format that is appropriate to their age.

3.31 Similarly, Part 2 of the *South Australia Mental Health Act 2009* contains a list of objects and guiding principles, which state that services should take into account the different developmental stages of children and young persons; and that children and young persons should be cared for and treated separately from other patients as necessary to enable the care and treatment to be tailored to their different developmental stages. Patients should be provided with comprehensive information about their illnesses, orders that apply to them, their legal rights, the treatments and other services that are to be provided or offered to them and what alternatives are available. Also, information should be provided in a way that ensures as far as practicable that it can be understood by those to whom it is provided.

3.32 The New South Wales *Mental Health Act 2007* also contains a list of principles for care and treatment, which include the principle that the age-related, gender-related, religious, cultural, language and other special needs of people with a mental illness or mental disorder should be recognised. Every effort that is reasonably practicable should be made to involve persons with a

³² *Code of Practice Mental Health Act 1983* (Department of Health TSO 2008).

mental illness or mental disorder in the development of treatment plans and plans for ongoing care, and people with a mental illness or mental disorder should be informed of their legal rights and other entitlements under the Act and all reasonable efforts should be made to ensure the information is given in the language, mode of communication or terms that they are most likely to understand.

(2) Discussion: 2001 Act and the rights of the child

3.33 Reverting to the 2001 Act, the Mental Health Commission's *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001* is an important document, and highlights some of the shortcomings of the Act in respect of the rights of children and young people. The Code draws particular attention to the failure of the Act to address issues of capacity and healthcare decision making. Also, the Code states that all children receiving treatment pursuant to the Act should be involved, consistent with their identified needs and wishes, in the planning, implementation and evaluation of their care and treatment. The Code of Practice, however, is not legally binding and does not provide a comprehensive statement of rights and principles for children and young people who are admitted and treated under the *Mental Health Act 2001*. In the Commission's view, it is doubtful whether the guiding principles contained in the *Code of Practice* and the few safeguards under section 25 of the 2001 Act, discussed below, are adequate to provide a robust defence of children's rights, particularly their right to participate in health care decisions.

3.34 Generally speaking, the focus of mental health legislation and service provision has changed considerably. The nature of service provision is much more inclusive and is focused on promoting capacity and accommodating persons with mental health problems within their community. This is reflected in a rights-based, capacity building approach to mental health legislation. The provisions of the *Mental Health Act 2001* as they pertain to children and young people do not reflect a rights-based approach to legislating for persons with mental illness or disorders.

D Specific Provisions on Children and Young People in the Mental Health Act 2001

3.35 The key structures and definitions upon which the *Mental Health Act 2001* are based apply to all persons treated under the 2001 Act. The definition of mental disorder in the 2001 Act applies to both children and adults, as do the categories of voluntary and involuntary admission.

(1) Voluntary admission

3.36 A voluntary patient is defined in the 2001 Act as "a person receiving care and treatment in an approved centre who is not the subject of an

admission order or a renewal order”. As discussed in the Consultation Paper, in light of the Supreme Court decision in *E.H. v St Vincent’s Hospital & Ors*,³³ the definition of a voluntary patient is a negative one, centred on what a voluntary patient is not, rather than what a voluntary patient is. The Commission reiterates its view that a voluntary admission must contain an element of voluntariness on behalf of the patient to consent to admission and treatment. A voluntary patient is not the subject of an admission or renewal order and therefore is not suffering from a mental disorder under section 2 of the 2001 Act. A voluntary patient is therefore regarded as a person who has the requisite capacity to consent to admission and treatment. A voluntary patient, who is under 18 years of age, however, is treated differently.

3.37 As mentioned above, the structures and definitions upon which the scheme of the 2001 Act is based, namely mental disorder, voluntary admission and involuntary admission, are applicable to both children and adults. There are, however, significant differences in the practical application of these important terms and definitions.

3.38 Importantly, the distinction between a voluntary and an involuntary patient is maintained in principle, but circumvented in practice in respect of persons under 18 years of age. The majority of children and young people requiring in-patient treatment are admitted at the request of, or through obtaining the consent of, a parent or guardian. This practice was questioned in the Consultation Paper and the Commission reiterates its view that the practice of admitting a child or a young person “voluntarily,” solely on the basis of parental consent, is flawed and out of line with the rights of children and the general principles set out in Chapter 1 of this Report.

3.39 The issue of obtaining parental consent for the voluntary admission and treatment of a child or young person appears to have developed as a response to the lack of reference to issues of capacity and consent in the 2001 Act in respect of persons under 18 years of age. This omission has caused considerable confusion over the capacity of a young person to make healthcare decisions in respect of his or her mental health.

3.40 The traditional acceptance of 16 years as the age at which young people have the legal capacity to make healthcare decisions is discussed above in Chapter 2. The *Mental Health Act 2001*, however, does not engage with section 23 of the *Non-Fatal Offences Against the Person Act 1997*, which provides that a minor aged 16 years of age may consent to medical treatment. The uneasy relationship between section 23 of the 1997 Act and the 2001 Act raises questions over the status of consent or refusal given by a young person

³³ [2009] IESC 46.

aged 16 years of age under the 2001 Act.³⁴ This uncertainty also extends to issues of capacity and consent in respect of young people under 16 years of age.

3.41 A quote from the Mental Health Commission's Code of Practice illustrates the failure of the *Mental Health Act 2001* to recognise the capacity of young people admitted as voluntary patients:

“where a child who is 16 years or older is being treated as a voluntary patient in an approved centre on the basis of consent given by his or her parents, it would appear that the child would not have a right to leave as such”

3.42 The term “voluntary” is not an accurate description of a patient who has not given consent to his or her admission, cannot consent to treatment and cannot leave the centre. Furthermore, persons who are admitted as voluntary patients do not have the same level of automatic protections and safeguards available to persons admitted as involuntary patients. The safeguards in place for children admitted as involuntary patients are in need of significant reform but at least the presence of such safeguards, regardless of their adequacy, serves to recognise that the rights of children and young people admitted in such circumstances must be protected.

3.43 The limited nature of the safeguards in place to protect the rights of children and young people admitted and detained under the 2001 Act is evident from the blurred distinction between voluntary and involuntary patients. Where this distinction is blurred, it is doubtful if appropriate safeguards can be applied as many of the available protections and safeguards are triggered only when a patient is admitted as an involuntary patient. The majority of children and young people are admitted as voluntary patients and therefore do not have an opportunity to engage with the safeguards available to patients admitted as involuntary patients. Furthermore, it is likely that the section 25 process of involuntary admission is being circumvented by simply obtaining parental consent to admit children and young people as voluntary patients. It is highly unsuitable to treat the terms of voluntary and involuntary as interchangeable by circumventing procedures of involuntary admission. This practice results in young people with a mental disorder being treated as voluntary patients, which may have an adverse effect on the type of treatment they receive and, as mentioned above, has an impact on the number and strength of safeguards available to them.

³⁴ See Keyes “Guarded Welcome for Mental Health Bill 1999” (2000) 6(1) *Medico Legal Journal of Ireland* at 29; and deVries “The New Mental Health Bill - Failing to be Progressive” (2000) 6(1) *Medico Legal Journal of Ireland* at 26.

3.44 The Mental Health Commission’s Headspace Toolkit, mentioned above,³⁵ attempts to clarify the confusion created by the use of the word “voluntary” in the context of the 2001 Act and the word in its ordinary context:

“Most of the young people you meet will be there as voluntary patients. The word voluntary may seem a little strange if you have not agreed to being admitted but according to the law your admission is voluntary if you are under 18 and your parents agreed to it.”³⁶

3.45 The Mental Health Commission has also referred to the detrimental effect which the practice of voluntary admission may have on the relationship between parents or guardians and their children, who are admitted under the Act as a direct result of parental consent.³⁷ For example, a young person aged 16 or 17 years of age who has capacity to make day to day decisions about his or her education, money, leisure, and general healthcare may become distrusting and hostile towards his or her parents who have consented to admission and treatment which may well be against the young person’s wishes. The quality of the parent-child relationship is a vital and an extremely influential part of every child and young person’s life, particularly when the young person is experiencing mental health difficulties. Family dynamics and relationships are obviously important to any child or young person, but are a particularly important source of support to the child or young person experiencing mental health difficulties. The majority of children and young people are treated with their families, and many interventions are targeted at both the patient and the family unit as a whole.

3.46 In the Commission’s view, it is also likely that the shortcomings of the 2001 Act in respect of the voluntary admission of children and young people infringe the European Convention on Human Rights (ECHR). In *Nielson v Denmark*,³⁸ the European Court of Human Rights held that parents have rights of parental authority which are protected under Article 8. These rights, however, are limited and it is incumbent on the State to provide safeguards against abuse. This view was reiterated in *Johanssen v Norway*,³⁹ where the court held

³⁵ Paragraph 3.27 above.

³⁶ *Headspace Toolkit: For Young People who are inpatients of Mental Health Services* (Mental Health Commission 2009) at 8.

³⁷ Mental Health Commission *Response to the Law Reform Consultation Paper on Children and the Law: Medical Treatment* (2010) at 9.

³⁸ (1988) 11 EHRR 175.

³⁹ (1996) 23 EHRR 33, at paragraphs 76-78.

that Article 8 of the ECHR should not be interpreted in a way which protects family life to the detriment of a child's health and development.

3.47 The decision in *Storck v Germany*⁴⁰ is particularly relevant to the present evaluation of the provisions of the *Mental Health Act 2001* as they pertain to children and young people detained as voluntary patients. The applicant was a woman who had spent 20 years in psychiatric institutions and hospitals, after her initial admission at 15 years of age, by way of parental consent. After a considerable period of time, it was revealed that the applicant had never suffered from schizophrenia, despite receiving treatment for the disorder, and her behaviour had been caused by conflict with her family. The court held that Member States have a positive obligation under Articles 5 and 8 of the ECHR to ensure effective supervision and review of decisions to detain or to treat without consent.⁴¹ Member States are also under an obligation to provide effective supervision and review of deprivations of liberty and interferences with the physical integrity of a young person.⁴²

3.48 Significant reforms have been carried out in England and Wales to strengthen the rights of children and young people who could otherwise be treated against their wishes, but with their parent's consent. Prior to the reforms brought about by the *Mental Health Act 2007*, practice in England was similar to the current situation in Ireland, where children and young people were admitted by their parents or guardians. Section 131 of the *Mental Health Act 1983* was amended by Section 43 of the *Mental Health Act 2007* to end the admission of 16 and 17 year olds on the basis of parental consent. As a result, 16 and 17 year olds who have capacity under the *Mental Capacity Act 2005* may consent to admission, even where one or more persons may have parental responsibility for them. This is consistent with section 8 of the English *Family Law Reform Act 1969*, which, as discussed in Chapter 2 above, is the statutory precedent for section 23 of the *Non Fatal Offences Against the Person Act 1997*.

3.49 In respect of children who are less than 16 years of age, those with capacity to consent to admission may do so, without the need for additional parental consent. In this regard, the child's capacity must be assessed carefully in relation to each decision that needs to be made, as the understanding for different interventions and treatments will vary considerably.

3.50 The law in other countries on the issues of capacity and consent in respect of mental health treatment indicate a much closer, and more appropriate, relationship between the law of capacity in respect of physical

⁴⁰ (2005) 43 EHRR 96. See also *HL v UK* [2004] ECHR 471.

⁴¹ (2005) 43 EHRR 96 at 113.

⁴² See Fenell *Mental Health: The New Law* (Jordans, 2007) at 305.

treatment and the law on capacity in respect of mental health treatment. For example, in New South Wales, a child or a young person may consent to admission as a voluntary patient, in tandem with rules of parental notification and rights of consent, which are linked to the age of the child in question.⁴³ The traditional threshold of 16 years of age is retained in the legislation, discussed in more detail in Chapter 2 above. In New South Wales, the age of 16 has been recognised as the age of consent to general medical treatment since 1970.⁴⁴

3.51 The South Australia *Mental Health Act 2009* applies to children in the same way as it applies to persons of full age. However, a distinction is drawn between young people aged 16 and 17 and those aged less than 16 years of age, in that a right conferred on a person under the Act may be exercised by a parent, if the person is under 16 years of age.⁴⁵ Similar to the legal position in New South Wales, the age of 16 is accepted as the age of consent to medical treatment. Section 6 of the *Consent to Treatment and Palliative Care Act 1995*, discussed in Chapter 2, states that a person of 16 years of age may make decisions about his or her medical treatment as validly and effectively as an adult.

3.52 In New Zealand, section 36 of the *Care of Children Act 2004* states that a young person aged 16 years of age may consent to or refuse medical treatment, and this is mirrored in the *Mental Health (Compulsory Assessment and Treatment) Act 1992* which states that the consent of a parent or guardian for the assessment or treatment of a person who has reached 16 years of age, shall not be sufficient consent for the purposes of the Act.⁴⁶

3.53 The Commission considers that the 2001 Act should be amended to end the practice of admitting children and young people as voluntary patients, solely on the basis of parental consent. Furthermore, the failure to recognise the capacity of children and young people, particularly those aged 16 and 17 years of age in respect of consent to mental health admission and treatment creates an arbitrary distinction between physical and mental health. Following the publication of its Consultation Paper, the Commission received a considerable number of submissions outlining the deficiencies of the practice of voluntary admission as it currently applies to children and young people, and supporting the Commission's recommendations to end the current practice of such admissions.

⁴³ Section 6 of the *New South Wales Mental Health Act 2007*.

⁴⁴ Section 49 of the *Minors (Property and Contracts) Act 1970*.

⁴⁵ Section 4 of the *South Australia Mental Health Act 2009*.

⁴⁶ Section 87 of the *Mental Health (Compulsory Assessment and Treatment) Act 1992*.

(2) Involuntary admission

3.54 Section 25 of the *Mental Health Act 2001* provides for the involuntary admission of children and young people. This system of involuntary admission is different to the system in place of the involuntary admission and treatment of adults. Children and young people clearly have different needs than adults but safeguards relating to the involuntary placement and treatment of children and young people should be at least as stringent as those in place for adults admitted and treated as involuntary patients.⁴⁷

3.55 In order to have a person involuntarily admitted, the Health Service Executive (HSE) may apply to the District Court for an order authorising the detention of a child in an approved centre, where it appears that the child is suffering from a mental disorder and the child requires treatment which he or she is unlikely to receive unless an order is made under section 25. The child or young person must be examined by a consultant psychiatrist who reports to the court as part of the application. Section 25(3) of the 2001 Act provides an exception to the general rule that the child or young person must be examined by a psychiatrist, where a parent is unwilling or unable to consent to the examination. Following an application under section 25(3) the court may give directions in respect of the appropriate care of the child, which may include detention. Section 25 of the 2001 Act does not contain a specific time frame within which a child must be examined by a psychiatrist, or what constitutes a permissible period of detention pending final determination, aided by the report of a psychiatrist. The Mental Health Commission has drawn attention to this issue, stating that the lack of objective medical expertise confirming the presence of a mental disorder may infringe Article 5(1) of the European Convention on Human Rights.⁴⁸

3.56 Furthermore, section 25 of the 2001 Act refers to the report of a consultant psychiatrist. As stated in the Consultation Paper, children and young people have specific mental health issues, which are not dealt with in general psychiatric adult practice.⁴⁹ The Mental Health Commission has recommended

⁴⁷ (LRC CP 59-2009) at 6.49.

⁴⁸ Mental Health Commission *Response to the Law Reform Consultation Paper on Children and the Law: Medical Treatment* (2010) at 10. See also *Litwa v Poland* (2001) 33 EHRR 53.

⁴⁹ (LRC CP 59-2009) at 6.10.

that, in so far as is practicable, the HSE should arrange for such a report to be made by a child and adolescent consultant psychiatrist.⁵⁰

3.57 As to the time frames under section 25 of the 2001 Act, the permissible periods of detention following a successful application consist of an initial detention period not exceeding 21 days, followed by periods not exceeding 3 and 6 months. As stated in the Consultation Paper, there is no mechanism for a person detained under section 25 of the 2001 Act to challenge a detention or seek a review of his or her detention or treatment. Therefore, a child or a young person detained under section 25 of the 2001 Act cannot challenge a period of detention between the initial admission order and a subsequent renewal order, or the period of time between each renewal order, which as noted above, may last for 6 months. The 6 month detention period between renewal orders under section 25 may be excessive in some cases and raise concerns in respect of proportionality.

3.58 The decision of the High Court in *SM v Mental Health Commission*⁵¹ is relevant in this respect, as it pertains to section 15 of the *Mental Health Act 2001*, which is concerned with the involuntary detention and treatment of adult patients. The central issue in the *SM* case was whether the power vested in a consultant psychiatrist under section 15 of the 2001 Act was satisfied when he or she makes a renewal order which states that the order does not exceed 12 months. The period of 12 months is the maximum period of time permitted under section 15(3). Mc Mahon J stated:

“Section 15, since it purports to restrict a constitutional right to liberty, albeit for the patient’s own good and the safety of others, should be interpreted in a proportionate way so that the detention is not for longer periods than are necessary to achieve the object of the legislation. The approach to an interpretation of the section should be that which is most favourable to the patient while yet achieving the object of the Act.”

3.59 The High Court held in the *SM* case that section 15, which refers to a renewal order for a period not exceeding 12 months, may not be interpreted as a renewal order for a fixed period of 12 months. Such an interpretation would prevent the psychiatrist from making shorter orders, in the best interests of the patient. The maximum period of 12 months detention orders may of course be used where appropriate, but otherwise the specific period of time must be

⁵⁰ Mental Health Commission *Code of Practice: Code of Practice Relating to Admission of Children under the Mental Health Act 2001* (Mental Health Commission 2006) at 18.

⁵¹ [2008] IEHC 441.

clearly indicated. The decision in the *SM* case resulted in the requirement to insert a specific date when renewal orders of the detention of adult patients are being made. The Mental Health Commission has stated that the same requirement should apply in respect of children and young people detained under section 25 of the 2001 Act.

3.60 The *Mental Health Act 2001* has relied heavily on the *Child Care Act 1991* in attempting to safeguard the rights of children and secure their best interests.⁵² The 1991 Act is primarily concerned with children in care and recognises the District Court as the primary forum for the adjudication of such care proceedings.⁵³ Section 25(14) of the 2001 Act incorporates a number of provisions from the 1991 Act, intended to safeguard the rights of children and young people who are involuntary patients.⁵⁴ As stated in the Consultation Paper, these provisions are not sufficient in the context of children and young people detained as involuntary patients.

3.61 For example, section 30 of the 1991 Act makes provision for the presence of a child during a court hearing. As discussed in the Consultation Paper, the provision is rather limited.⁵⁵ The provision seems to indicate that a child may only be present where his or her presence is necessary for the disposal of the case. Although a child or young person may request to be present, the utility of this is largely dependent on his or her knowledge that the provision exists. There is no reference to the maturity of the child, or his or her understanding of the particular proceedings.

3.62 Section 24 of the 1991 Act refers to the duty of the court to take the wishes of the child into consideration during court proceedings. The shortcomings of section 24 are discussed in the Consultation Paper⁵⁶ but for present purposes it is sufficient to state that section 24 does not ensure that the

⁵² The safeguards granted to children and young people admitted as involuntary patients under the 2001 Act are discussed at length in the Consultation Paper.

⁵³ Section 28 of the *Child Care Act 1991*.

⁵⁴ Section 25(14) of the *Mental Health Act 2001* states: "The provisions of sections 21, 22, 24 to 35, 37 and 47 of the *Child Care Act 1991* shall apply to proceedings under this section as they apply to proceedings under those sections with the modification that references to proceedings or an order under Part III, IV or VI of that [1991] Act shall be construed as references to proceedings or an order under this section and with any other necessary modifications."

⁵⁵ (LRC CP 59-2009) at 6.83.

⁵⁶ (LRC CP 59-2009) at 6.79.

voice of the child (discussed in Chapter 1 of this Report) is heard in line with Article 12 of the UN Convention on the Rights of the Child. Sections 21 and 22 of the 1991 Act deals with the appeal, variation and discharge of orders, which infers that a court may vary or discharge an order made under section 25. It is unlikely that a child or young person admitted under section 25 could utilise this provision, to have their admission reviewed, bearing in mind that the Act is rather silent on the participation rights of children and young people.

3.63 Section 26 of the 1991 Act provides for the appointment of a guardian *ad litem*. This is particularly important to children and young people detained under section 25, as they have no effective way of seeking review of their admission and treatment. The appointment of an advocate would support them and ensure that their views are taken into account. The guardian *ad litem* system, however, is under severe pressure at present. Therefore, much like sections 21 and 22 of the 1991 Act, discussed above, the practical utility of section 26 of the 1991 Act in relation to a child or young person who is detained as an involuntary patient is rather negligible.

3.64 The guiding principles in the Mental Health Commission's Code of Practice and the best interests requirement contained in section 4(2) of the 2001 Act may be considered as additional safeguards to supplement those contained in section 25. These supplementary safeguards are not, however, sufficient to form an adequate defence to protect the rights of children and young people admitted and treated under the 2001 Act.

3.65 Section 16 of the 2001 Act makes provision for information to be provided to persons who are admitted to approved centres. Although the application of this section is not restricted to adults detained as involuntary patients, it seems to have been interpreted to that effect. This provision of information is extremely important. Patients are alerted to their rights under the 2001 Act such as their right to legal representation and their right to communicate with the Inspector of Mental Health. The statement also informs the patient that they may be admitted as a voluntary patient if they wish, and that their admission as an involuntary patient shall be reviewed by the Mental Health Tribunal. This statement of information is a vital element of ensuring that patients are informed and aware of the nature of their admission. There is no reason why children and young people should not receive similar information, provided to them in a comprehensible, age-appropriate manner.

(3) Treatment

3.66 As discussed above, the 2001 Act does not engage with issues of capacity and healthcare decision making in respect of persons under 18 years of age. The uncertain relationship between the 2001 Act and section 23 of the *Non-Fatal Offences Against the Person Act 1997* has created considerable practical difficulties, as a young person aged 16 or 17 years of age may make a

range of healthcare decisions but cannot make any decisions which would fall within the remit of the 2001 Act.

3.67 A 16 year old may make healthcare decisions which are considered to be *outside* the remit of the 2001 Act, for example, when presenting to an Accident and Emergency Unit for mental distress or attending an outpatient or day care appointment. Similarly, a young person aged 16 years of age may consent to medical treatment which is unrelated to his or her mental illness or disorder. For example, a 16 or a 17 year old may leave the centre where he or she is receiving treatment under the 2001 Act, in order to consent to and receive medical treatment in another medical setting. When the young person returns to resume treatment in respect of his or her mental illness, however, he or she will have lost all rights in relation to healthcare decision making.

3.68 The Commission received a number of submissions which drew attention to the considerable confusion and inconsistencies caused by the lack of clarity on the relationship between capacity in respect of mental health and capacity in respect of physical health. It is difficult and somewhat arbitrary to attempt to draw a clear line between care and treatment of the physical self and care and treatment of the mind.

3.69 The illogicality of the present legal position as regards capacity under the 2001 Act is highlighted by the consideration of a typical situation involving a 16 or 17 year old experiencing mental health difficulties. The young person attends a GP and may consent to pharmaceutical treatment, with an anti-depressant for example. However, perhaps the young person feels that the treatment is not appropriate or perhaps the GP is unsure as to the most effective course of treatment. The GP may decide to refer the matter to a Child Psychiatrist. Upon receiving the referral however, it seems a line has been crossed, in terms of legal capacity to make healthcare decisions. The Child Psychiatrist, in light of the current confusion over the relationship between the *Non-Fatal Offences Against the Person Act 1997* and the *Mental Health Act 2001*, cannot treat the young person in question without parental involvement and consent.

3.70 In respect of voluntary patients, the Mental Health Commission's Code of Practice states that in order for treatment to be administered to a child who has been admitted voluntarily, that is admitted by parental consent, consent for the treatment must be obtained from one or both of the child's parents. Again, as discussed above, this serves to highlight the unsuitability of the term 'voluntary' to describe children and young people whose voluntary status under the Act derives solely from parental consent, and who cannot consent to or refuse treatment. The Commission is aware that in day to day practice, clinicians make these treatment decisions based on the best interests

of their patient, and such treatments are not available simply at the request of a parent. Nevertheless, clarity is important to ensure that patient's rights are protected, both in theory and in practice.

3.71 Section 61 of the 2001 Act regulates the provision of treatment of children and young people who are involuntary patients under section 25. The shortcomings of section 61 of the 2001 Act are discussed in the Consultation Paper. The 2007 *Review of the Operation of the Mental Health Act 2001*⁵⁷ referred to the drafting error in section 61, stating that the process of detention in respect of persons under 18, provided for in section 25, is quite different to the involuntary admission of an adult which is not reflected correctly in section 61. The Minister for Health has acknowledged the drafting error in section 61, which will be amended as soon as a suitable opportunity arises.

3.72 Section 61 states that where medication has been administered to a child or young person for a period of three months, the authorisation of the treating consultant psychiatrist and a second consultant psychiatrist is necessary in order to continue treatment for a further three month period. As stated in the Consultation Paper the three month period which passes before medication is approved under section 61 is excessive and should be addressed. Under the Act as it stands, it is permissible to prescribe medication to a child or a young person for a period of three months without even obtaining a second opinion.⁵⁸ Furthermore, the child or young person does not have the right to consent or even assent to the proposed treatment. Under section 60, the patient may be prescribed treatment without engaging in a discussion with his or her psychiatrist on the nature of the treatment, its merits and any side effects.

3.73 This represents a failure to respect the rights of children and young people who are patients under the *Mental Health Act 2001*. It is of the utmost importance to involve children in the management of their health care plans, to facilitate their participation and allow them to develop the skills to make decisions and assume responsibility for aspects of their health care. On a practical level, studies have shown that increased participation and patient choice can lead to improved treatment outcomes.⁵⁹ A presumption that the

⁵⁷ *Review of the Operation of the Mental Health Act 2001: Findings and Conclusions* (Department of Health and Children 2007) at 28.

⁵⁸ There is no requirement to discuss the proposed treatment with anyone, such as an advocate for the child, or the child's parents. It seems that a psychiatrist has relatively unrestricted decision-making power. See Donnelly "Treatment for a Mental Health Disorder: The Mental Health Act 2001, Consent and the Role of Rights" (2005) 40 *Irish Jurist* at 240.

⁵⁹ Madden *Medicine, Ethics and the Law* (Butterworths 2002) at 474.

child or young person cannot understand and express their views about their admission and treatment must not be made solely on the basis of the patient's minority status.

3.74 A requirement to discuss the proposed treatment with the child or adolescent would strengthen that child's rights. The child or young person should have an opportunity to participate in the drawing up of an individualised treatment plan. Under section 60 of the 2001 Act, which provides for the treatment of adults who are involuntary patients, patients are given the opportunity to consent to treatment in writing. An adult patient's proposed treatment plan is also contained in the statement of information presented to them upon their admission as an involuntary patient.

3.75 It is clear that, in respect of treatment administered under the *Mental Health Act 2001*, children and young people do not have their rights protected to the same degree as adults. As stated above in respect of admission and detention under the 2001 Act, safeguards in place to protect the rights and civil liberties of patients under mental health legislation should apply to all persons, including those under 18 years of age. Indeed, in some circumstances, the fact that children are often reliant on others to exercise their rights means that the safeguards in place for children and young people need to be more robust than those in place for adults.

3.76 Under section 25 of the 2001 Act, court approval must be obtained for more serious aspects of treatment, namely psychosurgery or electro-convulsive therapy. Again, there is no requirement to inform the child or young person or discuss treatment options. There is no representative to act on behalf of the child, nor is the child or young person required to be present in court when his or her treatment is being discussed and approved.

3.77 The court process in respect of obtaining consent for psychosurgery or electro-convulsive therapy is unclear. Section 25 does not provide any detail as to reports or evidence to be presented to the court to assist in such decision making, or whether for example a second opinion from an independent psychiatrist is necessary. The Mental Health Commission has stated that independent opinions in such situations are essential.⁶⁰

3.78 It is evident from the discussion in the preceding paragraphs that reform is needed in respect of the administration of treatment to children and young people who are admitted under the *Mental Health Act 2001*, whether as voluntary or involuntary patients.

⁶⁰ Mental Health Commission *Response to the Law Reform Consultation Paper on Children and the Law: Medical Treatment* (2010) at 17.

E Recommendations on Reform of the *Mental Health Act 2001*

3.79 In this Part, the Commission sets out its final recommendations for reform of the *Mental Health Act 2001* in so far as it applies to children and young people. In Part D, the Commission has discussed the absence in the 2001 Act of specific provisions concerning children and young persons. While the general principles discussed in Chapters 1 and 2 would, if enacted, apply to the 2001 Act, the Commission considers that it would be more appropriate to include in the 2001 Act a detailed set of suitably tailored provisions. These would allow those involved in the implementation of the 2001 Act a clear set of criteria by which the appropriateness of admissions could be gauged.

(1) Guiding principles and best interests

3.80 The Commission begins with a consideration of general principles. Based on the general recommendations in Chapter 2, these principles would clarify the specific approach to capacity of persons under 18 in connection with admissions under the 2001 Act. In keeping with this approach, the Commission also considers that the 2001 Act should include the type of objective best interests test discussed in Chapter 1. This would assist in ensuring that a full assessment is made of the most appropriate outcome for each child or young person. The best interests test would also assist in preventing the inappropriate “social admissions” referred to in Part D, above.⁶¹

3.81 The Commission has accordingly concluded, and therefore recommends, that the 2001 Act be amended to include specific provisions for persons under the age of 18, based on the general principles already recommended in this Report. The Commission also recommends that the 2001 Act should be amended to provide:

- (a) that children and young people admitted under the 2001 Act should be accommodated in an environment that is suitable for their age;
- (b) that children and young people may only be admitted under the 2001 Act if such an admission is in their best interests, objectively assessed by reference to their rights;
- (c) that the provisions outlined in the Mental Health Commission’s Code of Practice should be followed to ensure that children and young people can avail of age appropriate facilities and activities to allow their personal, social and educational development to continue;

⁶¹ See Bonnar, *Report for the Mental Health Commission on Admission of Young People to Adult Mental Health Wards in the Republic of Ireland* (Mental Health Commission, December 2010), discussed at paragraph 3.18, above.

(d) that children and young people should receive the least intrusive and restrictive treatment possible, in the least restrictive environment possible, for the shortest possible period in accordance with an individualised care plan;

(e) that children and young people should be provided with clear information regarding their proposed admission and treatment in a manner which is accessible and appropriate with regard to their age and understanding; and that this information should include details of their legal rights, and it should include information on the purpose, side effects, and any alternatives to the proposed treatment;

(f) that children and young people should have access to independent, specialised advocacy services and should have access to a personal representative, other than a family member, in circumstances where this is necessary and appropriate, and

(g) that the protections that apply to adults with respect to mental health treatment under the 2001 Act should apply equally to persons under 18.

3.82 *The Commission recommends that the Mental Health Act 2001 be amended to include specific provisions for persons under the age of 18, based on the general principles already recommended in this Report. The Commission also recommends that the 2001 Act should be amended to provide:*

(a) that children and young people admitted under the 2001 Act should be accommodated in an environment that is suitable for their age;

(b) that children and young people may only be admitted under the 2001 Act if such an admission is in their best interests, objectively assessed by reference to their rights;

(c) that the provisions outlined in the Mental Health Commission's Code of Practice should be followed to ensure that children and young people the patient can avail of age appropriate facilities and activities to allow their personal, social and educational development to continue.

(d) that children and young people should receive the least intrusive and restrictive treatment possible, in the least restrictive environment possible, for the shortest possible period in accordance with an individualised care plan;

(e) that children and young people should be provided with clear information regarding their proposed admission and treatment in a manner which is accessible and appropriate with regard to their age and understanding; and that this information should include details of their legal rights, and it should include information on the purpose, side effects, and any alternatives to the proposed treatment;

(f) that children and young people should have access to independent, specialised advocacy services and should have access to a personal representative, other than a family member, in circumstances where this is necessary and appropriate, and

(g) that the protections that apply to adults with respect to mental health treatment under the 2001 Act should apply equally to persons under 18.

(2) Voluntary admission and treatment

3.83 In order to address the shortcomings of the system of voluntary admission, it is necessary to recognise the capacity of children and young people to make healthcare decisions in respect of their own admission and treatment, and also to address the confusion created by the word “voluntary” in ordinary terms and the meaning attributed to it as a categorisation under the *Mental Health Act 2001*. The Commission has also concluded, and therefore recommends, that the 2001 Act should be amended to safeguard the rights of children and adolescents admitted by parental consent as voluntary patients so that they are afforded the same safeguards granted to adults.

3.84 In respect of decision-making concerning voluntary admission and treatment, it is imperative to distinguish between children and young people who have the capacity to make such a decision and those who do not. As already noted, the Commission’s recommendations on healthcare decision-making outlined in Chapter 2 are applicable in the context of mental health. Therefore, a young person aged 16 or 17 years of age is presumed to have capacity to consent to and refuse healthcare and treatment. Applying this in the context of the 2001 Act, young people aged 16 and 17 years of age may consent to or refuse voluntary admission and treatment.

3.85 Where a young person aged 16 or 17 does not have the capacity to make the admission or treatment decision in question, his or her parents or guardians may not provide an effective consent. In such a case, the only options for admission would be involuntary admission (where the child has a mental disorder) or intermediate admission (discussed below).

3.86 *The Commission recommends that that the Mental Health Act 2001 be amended to provide that a person who is 16 or 17 years of age is presumed to have capacity to consent to and refuse healthcare and medical treatment, including psychiatric treatment.*

3.87 The Commission considers that, to avoid any doubt on the matter, it recommends that the recommendations in Chapter 2 concerning persons under the age of 16 should also apply to the *Mental Health Act 2001*. The capacity of the child under 16 would have to be assessed in relation to each decision and

aspect of admission and treatment. The provision of clear information and guidance would be particularly important in such cases, as would the option of an independent advocate.

3.88 *The Commission recommends that, to avoid any doubt, the recommendations concerning healthcare decision-making by persons under 16 years of age should also be applied in the context of mental health, including decisions in respect of admission and treatment under the Mental Health Act 2001.*

3.89 Section 23 of the 2001 Act states that where a parent of a child who is being treated as a voluntary patient in an approved centre indicates that he or she wishes to remove the child, the child may be placed in the care of the Health Service Executive (HSE),⁶² if the relevant medical practitioner is of the opinion that the child is suffering from a mental disorder. Unless the HSE returns the child or young person to his or her parents, an application must be made to the District Court within a 3 day period in order to apply for involuntary admission. Under sections 23 and 24 of the 2001 Act, where an adult who is being treated as a voluntary patient requests to leave the approved centre, and the relevant medical practitioner is of the opinion that he or she is suffering from a mental disorder, he or she may be detained for a period not exceeding 24 hours.

3.90 In the Commission's view, the three day time frame in place under section 23 of the 2001 Act seems to be quite long, possibly to accommodate for an application to the District Court under section 25 of the 2001 Act. The Commission recommends that this should be included in the proposed Code of Practice (see Chapter 2, above) and considered in the light of current practice and whatever length of time is involved in the making of such an application. The Code of Practice could also include appropriate time frames to operate in such situations, where children and young people who have consented to admission and treatment as voluntary patients, request to leave the approved centre.

3.91 *The Commission recommends that the proposed Code of Practice already recommended in this Report should include guidance on appropriate time frames to operate in cases of voluntary and involuntary admissions.*

(3) Intermediate admission and treatment

3.92 As discussed in the Consultation Paper, categorisation of patients as voluntary or involuntary under the *Mental Health Act 2001* is only appropriate in relation to children and young people who consent to admission as voluntary patients, or are suffering from a mental disorder and are therefore categorised

⁶² Section 13(4) of the *Child Care Act 1991*.

as involuntary patients. The Commission reiterates here that a third category of “intermediate” admission would be more appropriate to describe children who do not have the capacity to consent to admission and are admitted by their parents. Children under the age of 16, without the capacity to consent to voluntary admission and treatment, would be admitted as intermediate patients with the consent of their parents or guardians.

3.93 Intermediate patients would have their admission reviewed in the same manner as the review of admission of an involuntary patient, with the exception that the psychiatrist on the Mental Health Tribunal would be an age-appropriate child or adolescent psychiatrist. In respect of the treatment of intermediate patients, the provision of information and guidance on the proposed treatment, its purpose, possible side effects and any alternatives would be discussed with the patient, where appropriate and his or her parents. Ideally, a treatment plan would be decided upon by the patient, his or her parents, and the psychiatrist, supported by the second opinion of a consultant psychiatrist.

3.94 *The Commission recommends the introduction of a third category of “intermediate” admission for children and young persons who are admitted under the Mental Health Act 2001 by way of the consent of persons having parental responsibility for them. The admission and treatment of intermediate patients would be subject to regular review, in the same manner as involuntary patients.*

(4) Involuntary admission

3.95 The Commission also accepts that the *Mental Health Act 2001* should be amended to safeguard the rights of children and young people with mental disorders who are admitted as involuntary patients under section 25 of the 2001 Act. The small number of safeguards imported into the 2001 Act from the *Child Care Act 1991* should be replaced with stronger and more definite protections, accessible and appropriate for children and young people.

3.96 Firstly, there are a number of procedural aspects under section 25 which may be improved. For example, section 25 refers to a report by a consultant psychiatrist. The Commission agrees with the Mental Health Commission that such a report should be made by a consultant child and adolescent psychiatrist.⁶³ An additional point made by the Mental Health Commission is that the system of involuntary admission operates on the assumption that, if the HSE is not involved, parents or guardians are only

⁶³ Mental Health Commission *Code of Practice: Code of Practice Relating to Admission of Children under the Mental Health Act 2001* (Mental Health Commission 2006) at 18.

permitted to make voluntary applications. Parents or guardians or interested persons such as a medical practitioner, a psychiatrist or a relative could make an application in some cases where the child or young person has a mental disorder and is in need of admission and treatment.

3.97 Copies of the admission order granted under section 25 should be given to parents and guardians to ensure they are kept informed. This also applies to the child or young person who is admitted, which is discussed further below.

3.98 The Commission reiterates its view, expressed in the Consultation Paper, that the system of involuntary admission of children and young people must be addressed. As stated in the Consultation Paper, there is no mechanism for a person detained under section 25 to challenge a detention or seek a review of his or her detention or treatment. A child or a young person detained under section 25 cannot challenge a period of detention between the initial admission order and a subsequent renewal order, or the period of time between each renewal order, which as noted above, may last for 6 months.

3.99 Also, in light of the decision in *SM v Mental Health Commission 2008*,⁶⁴ the consultant psychiatrist must be in a position to recommend an admission or renewal order for a period of time which is less than the maximum permissible period of time.

3.100 It has been suggested to the Commission that within a week of admission, a discussion shall take place between the treating psychiatrist and a second independent psychiatrist, possibly with input from other staff members. This meeting would discuss the general suitability of the admission and proposed treatments.

3.101 *The Commission recommends that a system of regular review of involuntary admissions be established, to be carried out by a consultant independent of the consultant involved in the initial admission. The opinion of the reviewing consultant should be supported by a second independent opinion.*

(5) Forum for review

3.102 The *Mental Health Act 2001*, drawing on the *Child Care Act 1991*, provides that the District Court is the appropriate forum to determine matters concerning a person under 18. This is reflected in section 25 of the 2001 Act, where the admission and review of children and young people who are involuntarily detained is carried out by the court. The admission of an adult who is detained as an involuntary patient is reviewed by the Mental Health Tribunal. The Tribunal comprises a legal member, a lay person and a consultant

⁶⁴ [2008] IEHC 441.

psychiatrist. The Mental Health Commission's *Reference Guide to the Mental Health Act* states that the primary function of the Tribunal is to ensure the protection of the rights of patients.⁶⁵ Patients have a right to attend the Tribunal if they wish and may be represented by a legal representative.

3.103 Submissions received by the Commission on the issue were in favour of a more informal arena of review, with an age appropriate focus and awareness of the importance of the voice of the child. The Commission reiterates its view, expressed as a provisional recommendation in the Consultation Paper, that a less formal arena, with an age appropriate focus is a more fitting option. Therefore, the Tribunal ought to be made up of a legal representative, a lay representative, and an age appropriate child psychiatrist. It is important that a forum which reviews the admission and treatment of children and young people must respect Article 12 of the 1989 UN Convention on the Rights of the Child and give the child or young person the opportunity to express his or her views and give them due weight in accordance with his or her age and maturity. The child or young person must be given the opportunity to participate, by attending the informal hearing, or possibly submitting his or her opinion in writing. The representative of the child or young person would also attend the hearing, to advocate for the patient.

3.104 *The Commission recommends that the District Court make the initial decision on admission of children and young people as involuntary patients for the purposes of the Mental Health Act 2001, but that a Mental Health Tribunal (with an age appropriate focus) rather than the District Court should review the admission.*

3.105 A significant shortcoming in the operation of section 25 of the 2001 Act is the failure to give children and young people, detained as involuntary patients, the choice to be admitted as voluntary patients. Adults who are detained as involuntary patients are provided with this choice, presented to them in the statement of information they receive within 24 hours of admission. Children and young people who have capacity should also be able to choose the least restrictive option of detention available to them.

3.106 *The Commission recommends that a consultant psychiatrist initially assess the child in order to decide which type of admission is appropriate under the circumstances and to assess whether the minor is providing consent or not, where the child has capacity to provide such consent. However, where the child has a mental disorder within the terms of section 25 of the 2001 Act, the choice of a child to become a voluntary patient could clearly be overridden.*

⁶⁵ *Reference Guide Mental Health Act 2001: Part One Adults* (Mental Health Commission) at 1.8.1

3.107 *The Commission also recommends that where a child is admitted as an involuntary patient, that individual should have the option to change their status to a voluntary patient where they satisfy the relevant criteria.*

(6) Information and advocacy

3.108 Children and young people detained under section 25 of the 2001 Act are particularly vulnerable and it is important that they are informed and represented. Therefore, the Commission recommends that children and young people, who are detained as involuntary patients, be presented with a statement of information, similar to the information given to adults detained as involuntary patients. Clearly, a statement of information aimed at children and young people must be age appropriate, and communicated to them in a manner and language with which they are comfortable.

3.109 *The Commission recommends that persons under 18 years of age who are admitted as involuntary patients under the Mental Health Act 2001 be given a statement of information, communicated to them in an age appropriate manner.*

3.110 As stated in the Consultation Paper, the Commission considers that independent and specialised advocacy services should be available to children and adolescents admitted and treated under the *Mental Health Act 2001*, as voluntary, involuntary or intermediate patients. The guiding principles outlined above also highlight the importance of specialised advocacy services for children and young people.

3.111 *The Commission recommends that all children and adolescents admitted and treated under the Mental Health Act 2001 should have access to an independent advocate.*

(7) Treatment

3.112 The Commission has also concluded that reform of the 2001 Act is required in respect of treatment of children and young people who are admitted and detained under the 2001 Act. It is of the utmost importance to involve children in the management of their health care plans, to facilitate their participation and allow them to develop the skills to make decisions and assume responsibility for aspects of their health care. Consistently with the Commission's recommendations outlined in Chapter 2, above, children and young people with the capacity to make a treatment decision could do so. If the treatment decision in question concerned the refusal of life sustaining treatment, the purported refusal would be addressed and adjudicated by the District Court. It is important to note that the proposed Code of Practice would include a number of guidelines to support clinicians in this context, helping them to make a decision on what treatments are considered to be life sustaining in different circumstances.

3.113 Where a child or young person does not have capacity to make a treatment decision, it is essential that safeguards are put into place to ensure that treatment is subject to regular and effective review. Review should be carried out by the treating consultant psychiatrist, supported by a second opinion, independent of the treating psychiatrist. Furthermore, both psychiatrists must discuss the treatment with the patient, and his or her views must be taken into account in determining whether or not the treatment is necessary and in the best interests of the patient.

3.114 The Commission accordingly recommends that the proposed Code of Practice recommended in this Report consider the time frame for review of treatment under the *Mental Health Act 2001*. The Commission has discussed the time frame with a number of medical specialists in this area and, while no general consensus has emerged, the Commission agrees with the views expressed to it that this might, initially, involve review after one month. The Commission recommends that this timeframe should be considered in the context of the development of the Code of Practice. The Commission also recommends that the Code of Practice consider stricter rules with respect to ECT and psycho-surgery with a view to prohibiting psycho-surgery for persons under 18 years of age.

3.115 *The Commission recommends that the proposed Code of Practice recommended in this Report consider the time frame for review of treatment of persons under the age of 18 under the Mental Health Act 2001, and that an initial review after one month should be considered in the context of the development of the Code of Practice. The Commission also recommends that the Code of Practice consider stricter rules with respect to ECT and psycho-surgery with a view to prohibiting psycho-surgery for persons under 18 years of age.*

CHAPTER 4 SUMMARY OF RECOMMENDATIONS

The recommendations made by the Commission in this Report are as follows.

4.01 The Commission recommends that legislation should be enacted dealing with consent to, and refusal of, medical treatment concerning persons under the age of 18, and that it should include the following general principles: having regard to the recognition in the Constitution and international instruments of the family as the fundamental group in society, parents and guardians have primary responsibility for the upbringing and development of their children; the State may intervene to supply the place of parents in exceptional circumstances where this is necessary; the rights of the child, and their best interests, must always be taken into account in this context; a child has rights that are independent of any right of the parent as such; these rights are, during the child's early years, exercised on behalf of the child, usually by the child's parents or guardians; these rights remain the rights of the child as they develop towards maturity and adulthood; and there are various points, sometimes based on an age threshold and sometimes based on an assessment of maturity and capacity, at which the law recognises that the child can exercise these rights independently of their parents or guardians even before they reach full adulthood at the age of 18. [paragraph 1.32]

4.02 The Commission recommends that its proposed legislation on consent to, and refusal of, health care and medical treatment concerning persons under the age of 18 should include as a primary consideration the best interests of the child, assessed objectively by reference to the rights of the child. [paragraph 1.35]

4.03 The Commission recommends, that, for the purposes of its proposed legislation on health care and treatment concerning persons under the age of 18, health care and medical treatment should be defined as including:

- (a) the provision of surgical, medical, nursing, pharmaceutical, dental and mental health care or treatment, including the prescription or supply of drugs;
- (b) any assessment or examination for the purposes of diagnosis, including invasive exploratory acts;

- (c) any procedure undertaken for the purposes of preventing a disease or illness;
- (d) any procedure which is ancillary to any treatment as it applies to that treatment (including but not limited to anaesthesia);
- (e) a course of treatment or a group of associated treatments;
- (f) any treatment carried out by a health and social care professional, within the meaning of the Health and Social Care Professionals Act 2005;
- (g) health promotion, and
- (h) the provision of advice, information and counselling in connection with any of the above. [paragraph 1.47]

4.04 The Commission recommends that, when treating children, health care professionals must give children an opportunity to express their views and to give these views due weight, in accordance with the child's age and maturity. [paragraph 1.59]

4.05 The Commission recommends that when treating persons under 18, health care professionals must ensure respect for confidentiality, subject to any specific statutory obligations to disclose medical records. The Commission further recommends that this confidentiality must also have regard to the rights of parents and guardians to access to relevant health information, and that this information should be given where it would, having regard to all of the circumstances and to the general principles already set out in this Report, be in the best interests of the person under 18. [paragraph 1.68]

4.06 The Commission recommends that, having regard to the general principles already set out in this Report, the proposed legislative framework on health care treatment should provide that, in general, a person who is 16 or 17 years of age is presumed, in the context of any potential civil liability, to have capacity to consent to, and refuse, health care treatment, as already defined in this Report; that this capacity is as effective as it would be if he or she were of full age, that is 18 years of age; that the presumption of capacity is subject to contrary evidence that the person lacks capacity; and that where a 16 or 17 year old has given such an effective consent to, or refused, any such treatment it shall not be necessary to obtain any consent for it, or refusal of consent for it, from his or her parent or guardian. The Commission also recommends that this is subject to certain other existing legislative limits and requirements, including existing requirements in, for example, the *Control of Clinical Trials Act 1987*, the *European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004*, the *Child Care Act 1991* and the *Mental Health Act 2001*. The Commission also recommends that this should also have regard to planned

legislation, such as the proposed Human Tissue Bill, the proposed Health Information Bill or any proposal, for example, to regulate access to sunbeds for those under 18. [paragraph 2.155]

4.07 The Commission recommends that, in the context of refusal of life sustaining treatment by a person under the age of 18, an application may be made to the High Court to determine the validity of the refusal. The High Court may order treatment that is necessary to save life and where this is in the best interests of the person under 18 years of age. The Commission also recommends that in any such application the person under 18 shall be separately represented. [paragraph 2.160]

4.08 The Commission recommends that the legislation proposed in this Report should provide that a 16 or 17 year old is presumed to have capacity to make an advance care directive. The Commission also recommends that where an advance care directive is being considered by or for a 16 and 17 year old a specific assessment be made by a trained and experienced health care professional of that person's capacity to understand the nature and consequences of the advance care directive. [paragraph 2.164]

4.09 The Commission recommends that the proposed legislative framework should not include a presumption of capacity for those under 16, but should provide that a person under 16 may consent to, and refuse, health care treatment where it is established that he or she has the maturity and understanding to appreciate the nature and consequences of the specific health care treatment decision. The Commission also recommends that, in the case of health care treatment involving those under 16, the usual situation should be that parents or guardians, who have the primary responsibility for the upbringing and development of children, are involved in the decision-making process; that the person under 16 should be encouraged and advised to communicate with and involve his or her parents or guardians; and that, therefore, it is only in exceptional circumstances, and having regard to the need to take account of an objective assessment of both the rights and the best interests of the person under 16, that health care treatment would be provided for those under 16 without the knowledge or consent of parents or guardians. [paragraph 2.174]

4.10 The Commission also recommends that the proposed legislative framework should provide that, in determining whether a person under 16 has the maturity and capacity to consent to, and to refuse, health care treatment as already defined in this Report, the following factors are to be taken into account:

- (a) whether he or she has sufficient maturity to understand the information relevant to making the specific decision and to appreciate its potential consequences;

(b) whether his or her views are stable and a true reflection of his or her core values and beliefs, taking into account his or her physical and mental health and any other factors that affect his or her ability to exercise independent judgement;

(c) the nature, purpose and utility of the treatment;

(d) the risks and benefits involved in the treatment, and

(e) any other specific welfare, protection or public health considerations, in respect of which relevant guidance and protocols such as the 2011 Children First: National Guidelines for the Protection and Welfare of Children (or any equivalent replacement document) must be applied. [paragraph 2.175]

4.11 The Commission recommends that the proposed statutory framework should include, in respect of potential civil liability, a defence of good faith for health care practitioners who treat children and young people under 18 years of age. The Commission recommends that the defence would apply to a health care practitioner who, acting in good faith and exercising due diligence, makes a decision to provide medical treatment, or a decision to withhold medical treatment, in respect of a child or a young person under 18 years of age. The Commission also recommends that acting in good faith and exercising due diligence would be defined as where the health care professional acts consistently with the general principles and specific matters, including as to assessment of capacity of those under 16, in the proposed statutory framework. [paragraph 2.177]

4.12 The Commission recommends that the Minister for Children and Youth Affairs, in consultation with the Minister for Health, should establish a broad-based Working Group which would assist the Minister in preparing and publishing a Code of Practice based on the principles in the proposed statutory framework. The Commission also recommends that the Code of Practice would provide detailed guidance as to the application of the proposed statutory framework in the context of all forms of health care and treatment settings as already defined in this Report. [paragraph 2.185]

4.13 The Commission recommends that the *Mental Health Act 2001* be amended to include specific provisions for persons under the age of 18, based on the general principles already recommended in this Report. The Commission also recommends that the 2001 Act should be amended to provide:

(a) that children and young people admitted under the 2001 Act should be accommodated in an environment that is suitable for their age;

(b) that children and young people may only be admitted under the 2001 Act if such an admission is in their best interests, objectively assessed by reference to their rights;

(c) that the provisions outlined in the Mental Health Commission's Code of Practice should be followed to ensure that children and young people the patient can avail of age appropriate facilities and activities to allow their personal, social and educational development to continue.

(d) that children and young people should receive the least intrusive and restrictive treatment possible, in the least restrictive environment possible, for the shortest possible period in accordance with an individualised care plan;

(e) that children and young people should be provided with clear information regarding their proposed admission and treatment in a manner which is accessible and appropriate with regard to their age and understanding; and that this information should include details of their legal rights, and it should include information on the purpose, side effects, and any alternatives to the proposed treatment.

(f) that children and young people should have access to independent, specialised advocacy services and should have access to a personal representative, other than a family member, in circumstances where this is necessary and appropriate, and

(g) that the protections that apply to adults with respect to mental health treatment under the 2001 Act should apply equally to persons under 18. [paragraph 3.82]

4.14 The Commission recommends that that the Mental Health Act 2001 be amended to provide that a person who is 16 or 17 years of age is presumed to have capacity to consent to and refuse healthcare and medical treatment, including psychiatric treatment. [paragraph 3.86]

4.15 The Commission recommends that, to avoid any doubt, the recommendations concerning healthcare decision-making by persons under 16 years of age should also be applied in the context of mental health, including decisions in respect of admission and treatment under the *Mental Health Act 2001*. [paragraph 3.88]

4.16 The Commission recommends that the proposed Code of Practice already recommended in this Report should include guidance on appropriate time frames to operate in cases of voluntary and involuntary admissions. [paragraph 3.91]

4.17 The Commission recommends the introduction of a third category of "intermediate" admission for children and young persons who are admitted

under the Mental Health Act 2001 by way of the consent of persons having parental responsibility for them. The admission and treatment of intermediate patients would be subject to regular review, in the same manner as involuntary patients. [paragraph 3.94]

4.18 The Commission recommends that a system of regular review of involuntary admissions be established, to be carried out by a consultant independent of the consultant involved in the initial admission. The opinion of the reviewing consultant should be supported by a second independent opinion. [paragraph 3.101]

4.19 The Commission recommends that the District Court make the initial decision on admission of children and young people as involuntary patients for the purposes of the *Mental Health Act 2001*, but that a Mental Health Tribunal (with an age appropriate focus) rather than the District Court should review the admission. [paragraph 3.104]

4.20 The Commission recommends that a consultant psychiatrist initially assess the child in order to decide which type of admission is appropriate under the circumstances and to assess whether the minor is providing consent or not, where the child has capacity to provide such consent. However, where the child has a mental disorder within the terms of section 25 of the 2001 Act, the choice of a child to become a voluntary patient could clearly be overridden. [paragraph 3.106]

4.21 The Commission also recommends that where a child is admitted as an involuntary patient, that individual should have the option to change their status to a voluntary patient where they satisfy the relevant criteria. [paragraph 3.107]

4.22 The Commission recommends that persons under 18 years of age who are admitted as involuntary patients under the *Mental Health Act 2001* be given a statement of information, communicated to them in an age appropriate manner. [paragraph 3.109]

4.23 The Commission recommends that all children and adolescents admitted and treated under the *Mental Health Act 2001* should have access to an independent advocate. [paragraph 3.111]

4.24 The Commission recommends that the proposed Code of Practice recommended in this Report consider the time frame for review of treatment of persons under the age of 18 under the *Mental Health Act 2001*, and that an initial review after one month should be considered in the context of the development of the Code of Practice. The Commission also recommends that the Code of Practice consider stricter rules with respect to ECT and psycho-surgery with a view to prohibiting psycho-surgery for persons under 18 years of age. [paragraph 3.115]

**APPENDIX A DRAFT HEALTH (CHILDREN AND CONSENT TO
HEALTH CARE TREATMENT) BILL 2011¹**

¹ This draft Bill implements the general reforms set out in the Report. The recommendations in Chapter 3, which concern the *Mental Health Act 2001*, are set out in the Outline Scheme of a Bill in Appendix B.

**DRAFT HEALTH (CHILDREN AND CONSENT TO HEALTH CARE
TREATMENT) BILL 2011**

ARRANGEMENT OF SECTIONS

Section

1. Short title and commencement
2. Interpretation
3. General principles
4. Best interests of child to be primary consideration
5. Due weight for views of child in accordance with child's age and maturity
6. Confidentiality
7. Health care and treatment involving 16 and 17 year old: general
8. Refusal of life-sustaining treatment by person under 18 years of age
9. Advance care directive by 16 and 17 year old
10. Health care and treatment involving person under 16 years of age: general
11. Civil liability: defence of good faith
12. Code of Practice

ACTS REFERRED TO

Child Care Act 1991	1991, No. 17
Control of Clinical Trials Act 1987	1987, No. 28
Health and Social Care Professionals Act 2005	2005, No. 27
Mental Health Act 2001	2001, No. 25

**DRAFT HEALTH (CHILDREN AND CONSENT TO HEALTH CARE
TREATMENT) BILL 2011**

BILL

entitled

AN ACT TO PROVIDE THAT CHILDREN, THAT IS THOSE UNDER 18 YEARS OF AGE, MAY CONSENT TO AND REFUSE HEALTH CARE TREATMENT IN ACCORDANCE WITH SPECIFIED PRINCIPLES AND CONDITIONS; AND TO PROVIDE FOR RELATED MATTERS

BE IT ENACTED BY THE OIREACHTAS AS FOLLOWS:

Short title and commencement

1.—(1) This Act may be cited as the Health (Children and Consent to Health Care Treatment) Act 2011.

(2) This Act comes into operation on such day or days as the Minister for Children and Youth Affairs, after consultation and with the consent of the Minister for Health, may appoint by order or orders either generally or with reference to any particular purpose or provision, and different days may be so appointed for different purposes or provisions.

Interpretation

2.—(1) In this Act, unless the context otherwise requires—

“child” means a person who has not reached the age of 18;

“health care and treatment” includes—

- (a) the provision of surgical, medical, nursing, pharmaceutical, dental and mental health care or treatment, including the prescription or supply of drugs;
- (b) any assessment or examination for the purposes of diagnosis, including invasive exploratory acts;
- (c) any procedure undertaken for the purposes of preventing a disease or illness;
- (d) any procedure which is ancillary to any treatment as it applies to that treatment (including but not limited to anaesthesia);
- (e) a course of treatment or a group of associated treatments;
- (f) any treatment carried out by a health or social care professional, within the meaning of the *Health and Social Care Professionals Act 2005*;
- (g) health promotion; and
- (h) the provision of advice, information and counselling in connection with any of the above;

“parent” has the same meaning as in the *Children and Parental Responsibility Act [20XX]*.²

Explanatory Note

The definition of “health care and treatment” in this section implements the recommendation in paragraph 1.47 of the Report.

General principles

3. — Every person concerned in the application of this Act shall have regard to the following general principles—

² This refers to the draft *Children and Parental Responsibility Bill* in the Commission’s *Report on Family Relationships* (LRC 101-2010). The draft Bill in the 2010 Report would replace, with amendments, the *Guardianship of Infants Act 1964*, as amended.

(a) in light of the role of the family as the fundamental group in society, and that parents and guardians have primary responsibility for the upbringing and development of their children, the State may intervene to supply the place of parents in exceptional circumstances where this is necessary;

(b) the rights of the child, and their best interests, must always be taken into account in this context;

(c) a child has rights that are independent of any right of the parent as such; that these rights are, during the child's early years, exercised on behalf of the child, usually by the child's parents or guardians; and

(d) these rights remain the rights of the child as they develop towards maturity and adulthood; and there are various points, sometimes based on an age threshold and sometimes based on an assessment of maturity and capacity, at which the law recognises that the child can exercise these rights independently of their parents or guardians even before they reach full adulthood at the age of 18.

Explanatory Note

This section implements the recommendation in paragraph 1.32 on the guiding principles to be applied in the legislative framework.

Best interests of child to be primary consideration

4.— Every person concerned in the application of this Act shall have regard to the best interests of the child, assessed objectively by reference to the rights of the child, as a primary consideration.

Explanatory Note

This section implements the recommendation in paragraph 1.35 that the best interests of the child, assessed objectively by reference to the rights of the child, is to be a primary consideration in the legislative framework.

Due weight for views of child in accordance with child's age and maturity

5.— When providing health care and treatment to a child, a health care professional shall give a child an opportunity to express his or her views and to give these views due weight, in accordance with the child's age and maturity.

Explanatory Note

This section implements the recommendation in paragraph 1.59 that a child be given the opportunity to express his or her views and that these be given due weight, in accordance with the child's age and maturity.

Confidentiality

6.— (1) When providing health care and treatment to a child, a health care professional shall ensure respect for confidentiality,

(2) The confidentiality in this section —

(a) is subject to any specific statutory obligations to disclose medical records, and

(b) shall have regard to the rights of parents and guardians to access to relevant health information, and this information shall be given where it would, having regard to all of the circumstances, be in the best interests of the child and to the general principles in *section 3*.

Explanatory Note

This section implements the recommendations in paragraph 1.68 concerning confidentiality.

Health care and treatment involving 16 and 17 year old: general

7.— (1) Subject to *section 8*, a person who is 16 or 17 years of age shall be presumed, in the context of any potential civil liability, to have capacity to consent to, and refuse, health care and treatment.

(2) The capacity of a person who is 16 or 17 years of age is as effective as it would be if he or she were of full age, that is, 18 years of age.

(3) The presumption of capacity of a person who is 16 or 17 years of age is subject to contrary evidence that the person lacks capacity.

(4) Where a 16 or 17 year old has given an effective consent to, or refused, any such treatment it shall not be necessary to obtain any consent for it, or refusal of consent for it, from his or her parent or guardian.

(5) This section is without prejudice to other relevant statutory provisions, including the Control of Clinical Trials Act 1987, the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004, the Child Care Act 1991 and the Mental Health Act 2001.

Explanatory Note

This section implements the recommendations in paragraph 2.155 concerning the general position as to health care and treatment involving 16 and 17 year olds. In general terms, it applies in the civil law setting the approach to consent involving 16 and 17 year olds already set out in section 23 of the *Non-Fatal Offences Against the Person Act 1997*.

Subsection (5) implement the specific recommendation in paragraph 2.155 that this general approach is without prejudice to other current relevant statutory provisions, including those in the *Control of Clinical Trials Act 1987*, the *European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004*, the *Child Care Act 1991* and the *Mental Health Act 2001*. Paragraph 2.155 also recommends that this should also have regard to planned legislation, such as the proposed *Human Tissue Bill*, the proposed *Health Information Bill* or any proposal, for example, to regulate access to sunbeds for those under 18. These proposed legislative provisions have not been included in *subsection (5)*.

Refusal of life-sustaining treatment by person under 18 years of age

8.— (1) Where a person under the age of 18 refuses life sustaining treatment, an application may be made to the High Court to determine the validity of the refusal.

(2) The High Court may order treatment that is necessary to save life and where this is in the best interests of the person under 18 years of age.

(3) In any such application to the High Court, the person under 18 shall be separately represented.

Explanatory Note

This section implements the recommendations in paragraph 2.160 concerning the refusal of life-sustaining treatment by a person under 18 years of age.

Advance care directive by 16 and 17 year old

9.— (1) A person who is 16 or 17 years of age shall be presumed to have capacity to make an advance care directive.

(2) Where a person who is 16 or 17 years of age is considering making an advance care directive, a specific assessment shall be made by a trained and experienced health care professional of that person's capacity to understand the nature and consequences of the advance care directive.

Explanatory Note

This section implements the recommendations in paragraph 2.164 concerning the making of an advance care directive by a 16 and 17 year old. The Commission's 2009 *Report on Bioethics: Advance Care Directives* (LRC 94-2009) deals with advance care directives by persons aged 18 years and over.

Health care and treatment involving person under 16 years of age: general

10.— (1) Subject to *section 8* and *subsection (2)*, a person who is under 16 years of age shall not be presumed, in the context of any potential civil liability, to have capacity to consent to, and refuse, health care and treatment.

(2) A person who is under 16 years of age may consent to, and refuse, health care treatment where it is established that he or she has the maturity and understanding to appreciate the nature and consequences of the specific health care and treatment decision.

(3) It shall be presumed, in the case of health care treatment involving a person under 16 years of age, that parents or guardians, who have the primary responsibility for the upbringing and development of children, are involved in the decision-making process.

(4) A person under 16 shall be encouraged and advised to communicate with and involve his or her parents or guardians and, therefore, it is only in exceptional circumstances, and having regard to the need to take account of an objective assessment of both the rights and the best interests of the person under 16, that health care and treatment is provided for those under 16 without the knowledge or consent of parents or guardians.

(5) In determining whether a person under 16 has the maturity and capacity to consent to, and to refuse, health care and treatment, the following factors shall be taken into account —

- (a) whether he or she has sufficient maturity to understand the information relevant to making the specific decision and to appreciate its potential consequences;
- (b) whether his or her views are stable and a true reflection of his or her core values and beliefs, taking into account his or her physical and mental health and any other factors that affect his or her ability to exercise independent judgement;
- (c) the nature, purpose and utility of the treatment;
- (d) the risks and benefits involved in the treatment; and
- (e) any other specific welfare, protection or public health considerations, in respect of which relevant guidance and protocols such as the 2011 Children First: National Guidelines for the Protection and Welfare of Children (or any equivalent replacement document) must be applied.

Explanatory Note

This section implements the recommendations in paragraph 2.174 and 2.175 concerning the general position as to health care and treatment involving those under 16 years of age.

Civil liability: defence of good faith

11.— (1) No civil liability shall be imposed on a health care practitioner who, acting in good faith and exercising due diligence, makes a decision to provide medical treatment, or a decision to withhold medical treatment, in respect of a person under 18 years of age.

(2) In this section, acting in good faith and exercising due diligence means where the health care professional acts consistently with the general principles and specific matters, including as to assessment of capacity of those under 16, in this Act.

Explanatory Note

This section implements the recommendations in paragraph 2.177 concerning the defence of good faith, in terms of potential civil liability, for a health care practitioner.

Code of Practice

12.— (1) The Minister for Children and Youth Affairs, in consultation with the Minister for Health, shall establish a Working Group to assist the Minister to prepare and publish a Code of Practice based on the principles in this Act.

(2) The Code of Practice shall provide detailed guidance as to the application of this Act in all forms of health care and treatment settings as defined in this Act.

Explanatory Note

This section implements the recommendations in paragraph 2.185 concerning the publication of a Code of Practice by the Minister for Children and Youth Affairs, in consultation with the Minister for Health. The Code of Practice, based on the assistance of a broad-based Working Group, would provide detailed guidance as to the application of the Commission's proposed legislative framework in all forms of health care and treatment settings as defined in the Report.

**APPENDIX B OUTLINE SCHEME OF MENTAL HEALTH
(AMENDMENT) BILL¹**

ARRANGEMENT OF HEADS

Head 1. General principles concerning detention of persons under 18 years of age

Head 2. Presumption of capacity of person who is 16 or 17 years of age

Head 3. General principles concerning persons under 16 years of age

Head 4. Intermediate admission

Head 5. Review of involuntary admissions

Head 6. Review role of District Court and of Mental Health Tribunal

Head 7. Initial assessment of person under 18 years of age

Head 8. Change from involuntary to voluntary patient

Head 9. Statement of information

Head 10. Access to independent advocate

Head 11. Code of Practice

¹ The Commission has not included these provisions in the draft *Health (Children and Consent to Health Care Treatment) Bill* in Appendix A as the *Programme for Government 2011 to 2016* proposes a general review of the *Mental Health Act 2001*. The Commission has concluded that it is preferable that the Outline Scheme of a Bill in this Appendix would form part of that general review.

OUTLINE SCHEME OF MENTAL HEALTH (AMENDMENT) BILL

Head 1. General principles concerning detention of persons under 18 years of age

(1) Provide that the Mental Health Act 2001 be amended to include specific provisions for persons under the age of 18, based on the general principles in the draft *Health (Children and Consent to Health Care Treatment) Bill* in this Report.

(2) Provide that the Mental Health Act 2001 be amended to provide:

(a) that children and young people admitted under the 2001 Act should be accommodated in an environment that is suitable for their age;

(b) that children and young people may only be admitted under the 2001 Act if such an admission is in their best interests, objectively assessed by reference to their rights;

(c) that the provisions outlined in the Mental Health Commission's Code of Practice should be followed to ensure that children and young people can avail of age appropriate facilities and activities to allow their personal, social and educational development to continue.

(d) that children and young people should receive the least intrusive and restrictive treatment possible, in the least restrictive environment possible, for the shortest possible period in accordance with an individualised care plan;

(e) that children and young people should be provided with clear information regarding their proposed admission and treatment in a manner which is accessible and appropriate with regard to their age and understanding; and that this information should include details of their legal rights, and it should include information on the purpose, side effects, and any alternatives to the proposed treatment.

(f) that children and young people should have access to independent, specialised advocacy services and should have access to a personal representative, other than a family member, in circumstances where this is necessary and appropriate; and

(g) that the protections that apply to adults with respect to mental health treatment under the 2001 Act should apply equally to persons under 18.

Note: this Head implements the recommendations in paragraph 3.82 of the Report.

Head 2. Presumption of capacity of person who is 16 or 17 years of age

Provide that the Mental Health Act 2001 be amended to include a provision that a person who is 16 or 17 years of age is presumed to have capacity to consent to and refuse healthcare and medical treatment, including psychiatric treatment.

Note: this Head implements the recommendation in paragraph 3.86 of the Report.

Head 3. General principles concerning persons under 16 years of age

Provide that the Mental Health Act 2001 be amended to provide that the provisions in the draft *Health (Children and Consent to Health Care Treatment) Bill* in this Report concerning healthcare decision-making by persons under 16 years of age should also be applied in the context of mental health, including decisions in respect of admission and treatment under the 2001 Act.

Note: this Head implements the recommendation in paragraph 3.88 of the Report.

Head 4. Intermediate admission

(1) Provide that the Mental Health Act 2001 be amended to provide for the introduction of a third category of “intermediate” admission for children and young persons who are admitted under the Mental Health Act 2001 by way of the consent of persons having parental responsibility for them.

(2) Provide that the admission and treatment of intermediate patients would be subject to regular review, in the same manner as involuntary patients.

Note: this Head implements the recommendations in paragraph 3.94 of the Report.

Head 5. Review of involuntary admission

(1) Provide that the Mental Health Act 2001 be amended to provide for a system of regular review of involuntary admissions, to be carried out by a consultant independent of the consultant involved in the initial admission.

(2) Provide that the opinion of the reviewing consultant should be supported by a second independent opinion.

Note: this Head implements the recommendations in paragraph 3.101 of the Report.

Head 6. Review role of District Court and of Mental Health Tribunal

(1) Provide that the Mental Health Act 2001 be amended to provide that the District Court make the initial decision on admission of children and young people as involuntary patients for the purposes of the Mental Health Act 2001.

(2) Provide that a Mental Health Tribunal (with an age appropriate focus) rather than the District Court should review the admission.

Note: this Head implements the recommendations in paragraph 3.104 of the Report.

Head 7. Initial assessment of person under 18 years of age

(1) Provide that the Mental Health Act 2001 be amended to provide that a consultant psychiatrist initially assess the child in order to decide which type of admission is appropriate under the circumstances and to assess whether the minor is providing consent or not, where the child has capacity to provide such consent.

(2) Provide that, however, where the child has a mental disorder within the terms of section 25 of the 2001 Act, the choice of a child to become a voluntary patient could be overridden.

Note: this Head implements the recommendations in paragraph 3.106 of the Report.

Head 8. Change from involuntary to voluntary patient

Provide that the Mental Health Act 2001 be amended to provide that where a child is admitted as an involuntary patient he or she should have the option to change their status to a voluntary patient where he or she satisfies the relevant criteria.

Note: this Head implements the recommendation in paragraph 3.107 of the Report.

Head 9. Statement of information

Provide that the Mental Health Act 2001 be amended to provide that persons under 18 years of age who are admitted as involuntary patients under the Mental Health Act 2001 be given a statement of information, communicated to them in an age appropriate manner.

Note: this Head implements the recommendation in paragraph 3.109 of the Report.

Head 10. Access to independent advocate

Provide that the Mental Health Act 2001 be amended to provide that all children admitted and treated under the Mental Health Act 2001 should have access to an independent advocate.

Note: this Head implements the recommendation in paragraph 3.111 of the Report.

Head 11. Code of Practice

(1) Provide that the proposed Code of Practice already recommended in this Report should include guidance on appropriate time frames to operate in cases of voluntary and involuntary admissions.

(2) Provide that the proposed Code of Practice already recommended in this Report consider the time frame for review of treatment of persons under the age of 18 under the Mental Health Act 2001, and that an initial review after one month should be considered in the context of the development of the Code of Practice.

(3) Provide that the proposed Code of Practice already recommended in this Report consider stricter rules with respect to ECT and psycho-surgery with a view to prohibiting psycho-surgery for persons under 18 years of age.

Note: this Head implements the recommendations in paragraphs 3.91 and 3.115 of the Report.



The Law Reform Commission is an independent statutory body established by the *Law Reform Commission Act 1975*. The Commission's principal role is to keep the law under review and to make proposals for reform, in particular by recommending the enactment of legislation to clarify, modernise and consolidate the law.

This role is carried out primarily under a Programme of Law Reform. The Commission's *Third Programme of Law Reform 2008-2014* was prepared and approved under the 1975 Act following broad consultation and discussion. The Commission also works on specific matters referred to it by the Attorney General under the 1975 Act. The Commission is also involved in making legislation more accessible through Statute Law Restatement, the Legislation Directory and the Classified List of Legislation in Ireland. Statute Law Restatement involves the administrative consolidation of all amendments to an Act into a single accessible text. The Legislation Directory is a searchable annotated guide to legislative changes. The Classified List of Legislation in Ireland comprises all Acts of the Oireachtas that are in force, organised under 36 major subject-matter headings.

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