



Northern Ireland
Assembly

Research and Information Service Research Paper

21 September 2012

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The Mental Capacity Bill and Children under 16

NIAR 366-12

The paper is in response to a research request from the Committee for Health, Social Services and Public Safety in relation to the key issues and stakeholder perspectives on the proposed Mental Capacity (Health, Welfare and Finance) Bill and children under 16 years of age.

Note: This paper constitutes research material only and should not be taken as legal advice or a substitute for it.

Key Points

- The Department of Health, Social Services and Public Safety (DHSSPS) is developing new capacity based legislation known as the Mental Capacity Bill. This will fuse mental capacity law and mental health law in a single Bill framework. In the rest of the UK, mental capacity legislation applies to people over 16, and separate mental health legislation applies to children and adults who require formal treatment for a mental disorder.
- The new Bill is designed to protect people who are unable to make a specific decision about their health, welfare or finances. In keeping with the rest of the UK, the DHSSPS proposes that the Bill will generally apply to those aged 16 and over who 'lack capacity'. Special provision to the Bill will be included for children under 16 who require compulsory assessment or treatment of a mental disorder. These children will have access to the same safeguards in the Bill as those over 16 who are subject to the same intervention.
- The proposals regarding the age 16 threshold has been subject to much debate. Part of the difficulty is that children reach maturity and decision making capacity at different stages and are not assumed to have capacity in the same way adults are. Different pieces of law also govern when children can consent to or, make certain decisions for themselves.
- At present, important decisions about a child's welfare are generally taken by those with parental responsibility, and this is laid out in statute in the Children (Northern Ireland) Order, 1995. This states that any decisions should be taken in their best interests and when reaching decisions, consideration must be given to the voice of the child commensurate with the child's maturity. However, an example of an exception to this is that children under 16 are able give their consent to medical treatment if they are assessed as being 'Gillick competent'. This adds further complexity to the issue.
- Two children's rights organisations have concerns about the DHSSPS proposals for under 16s. They argue that the wider exclusion of under 16s from the Bill will impact on vulnerable children, particularly 'mature minors' who lack capacity, such as those with a mental illness. These organisations also have concerns that the majority of children under 16 that are 'voluntary' inpatients will be unable to access the Bill's safeguards - unless formally detained. They also suggest that the proposals go against Bamford's view that "consideration might be given to a rebuttable presumption of capacity in 12-16s", and are not fully compliant with the UN Convention on the Rights of the Child (UNCRC), namely Article 12.
- The DHSSPS state that the application of the Bill reflects assumptions made in current statute law about capacity and consent. It does not believe that the Bill is the vehicle to assess emerging capacity in children, and is reluctant to include provisions that could undermine parental authority or have unforeseen implications on other legislation. The DHSSPS have sought legal advice to ensure that their proposals are compliant with the UNCRC. Their view is that nothing in the UNCRC prohibits the inclusion of a lower age limit. The DHSSPS have proposed a separate, cross-departmental project to examine the issue further. When complete, the outcome may mean that the new Bill is amended.

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1. Introduction

The Department of Health, Social Services and Public Safety (DHSSPS) is developing a Mental Capacity Bill which will fuse mental capacity and mental health law into a single Bill framework. Such a pioneering approach is however, not without contention or challenge. This paper explores one such issue – the applicability of the Bill to those under 16 years of age. Following an overview of the purpose of the Bill, the debate about capacity and children under 16 is provided from the perspective of the DHSSPS and from two children’s rights organisations; the Children’s Law Centre (CLC) and the Northern Ireland Commissioner for Children and Young People (NICCY).

2. The Bamford Review

In 2002, the DHSSPS commissioned an independent review of the law and policy affecting people with mental ill-health or a learning disability. This became known as the Bamford Review. In its final report - ‘*A Comprehensive Legislative Framework*’ (2007), the Review recommended that new and modernised mental capacity legislation should be created in the form of a single Bill for Northern Ireland.¹ It also recommended that any new legislation should include 1) enhanced protections for people unable to make decisions for themselves and 2) a set of principles - explicitly written into the legislation, to protect the human rights of those with mental illness or a learning disability.²

In 2009, in response to the Bamford Review, the DHSSPS consulted on its legislative proposals.³ Following this, the then Health Minister announced his intention to prepare a single Bill encompassing mental capacity and mental health provisions.⁴

3. Mental Capacity Background

3.1 What the current law says about capacity

Mental capacity refers to the ability to make a particular decision at the time when it needs to be made.⁵ Capacity is said to be key to a person’s autonomy.⁶ In order for consent to be valid, the person must be competent to make the decision. In general terms, a person has capacity if they are able to comprehend, retain, use and weigh the information in the decision-making process, and to communicate their decision.⁷

Contrary to other parts of the UK, Northern Ireland does not have legislation to enable an intervention to be made in the life of a person lacking capacity to make their own

¹ The Bamford Review of Mental Health and Learning Disability. A Comprehensive Legislative Framework (2007) <http://www.dhsspsni.gov.uk/legal-issue-comprehensive-framework.pdf>

² These principles include autonomy, justice, benefit and least harm.

³ DHSSPS *A Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland*.

⁴ DHSSPS: Consultation on an Equality Impact Assessment for New Mental Capacity Legislation. Available online at: <http://www.dhsspsni.gov.uk/showconsultations?txtid=43469> Website accessed 23.8.12.

⁵ Mental Health Foundation Website. What is mental capacity? Available online at: http://www.amcat.org.uk/what_is_mental_capacity/

⁶ Assessing decision-making capacity: children under 16. *Nurse Prescribing*. Vol 6, No 6. p266

⁷ DHSSPS (2003) Reference Guide to consent for examination, treatment or care, p3.

decisions. Instead, mental capacity is governed by common law (case law) which presumes that every person has the capacity to make their own decisions, including decisions that are deemed unwise. However, when a person lacks capacity to consent to a decision, others may need to make important decisions or interventions on their behalf. Under common law, such decisions should be taken provided there is a reasonable belief that the person lacks capacity and the intervention is made in the person's best interests.⁸

Individuals who have impaired decision-making ability are among the most vulnerable members of our society. People may never have had, or can lose their capacity to make decisions through illness, injury or disability.⁹ This could be the result of a stroke, a brain injury, a mental health problem, dementia, or a learning disability. The ability to make decisions may depend on the nature and severity of the condition, or the difficulty of the decision.¹⁰ In addition, capacity can fluctuate, for example, if a person is in pain and taking medication. A loss of capacity can also be temporary, for example due to drugs or alcohol misuse.

The concept of capacity in terms of the child is particularly complex. Children develop their ability to make decisions at different stages and are not assumed to have capacity in the same way that adults do. Different pieces of law also govern circumstances when children can make certain decisions for themselves, and this is discussed further in sections 7 and 8 of the paper.

4. Current Mental Health Legislation

In order to better understand the provisions in the new Bill, it is perhaps useful to outline how mental disorder treatment is currently provided in Northern Ireland.

At present, the Mental Health (Northern Ireland) Order (1986) (MHO) provides the legal framework regarding **the compulsory admission and treatment of patients** suffering from a *mental disorder*. It covers three main areas namely:

- **Compulsory** admission, detention, care and treatment of patients suffering from a *mental disorder*, who pose a serious risk to themselves or others.
- Guardianship and management of the patients' property and affairs.
- Individuals with a mental disorder within the criminal justice system.

This is a very powerful piece of legislation because it has the power to take away an individual's rights; for example to treat them against their will and to deprive them of their liberty.

⁸ However, this concept can be fraught with difficulty in that there is a risk that substitute decisions makers act "paternalistically".

⁹ Department of Health (England) website. Mental Capacity. Available online at: <http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/SocialCare/Deliveringsocialcare/MentalCapacity/index.htm>

¹⁰ General Medical Council (2008) Consent: patients and doctors making decisions together. (Guidance) p28.

Very few patients with a mental disorder¹¹ are treated as formal patients under the MHO; the majority are treated as voluntary patients. The following diagram shows the two pathways currently used to treat patients in hospital with a mental disorder (as involuntary and voluntary patients).

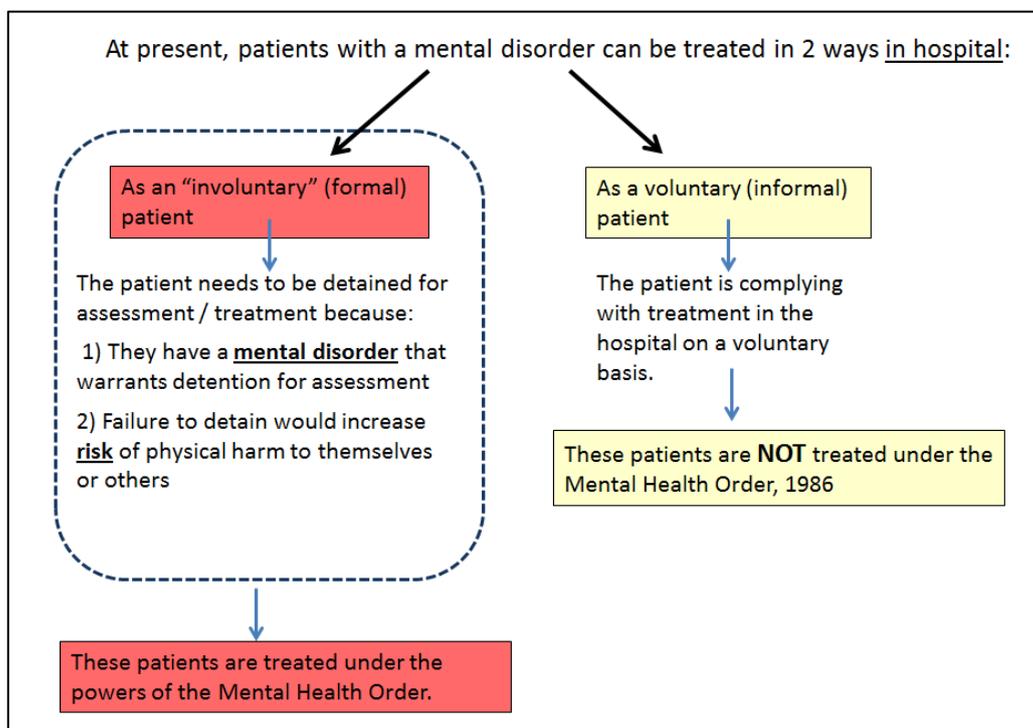


Figure 1. Voluntary and involuntary patients with a mental health disorder

The pathway on the right in Figure 1 concerns voluntary patients. As previously mentioned, the **majority of children and adults who are treated for a mental illness or mental disorder do so on a voluntary basis**, in other words, they are compliant and not resisting treatment. These patients do not fall under the powers of the MHO and they have the same rights as people being treated for physical illnesses. Although the term 'voluntary' implies that the person has given their consent to the treatment, this is not always the case. For example, a patient can be compliant in that they are not resisting, but they may (or may not) have the capacity to give informed consent. This issue is further complicated in relation to children under 16 where the voluntary nature of the patient may be established because someone is exercising parental responsibility and has given their consent on the child's behalf.

The pathway on the left of Figure 1 concerns involuntary patients. These 'formal' patients can be compulsorily detained for assessment and/or treated without their consent under the MHO if they are deemed to have a mental disorder and they present

¹¹ Examples include major depression, schizophrenia, dementia, bipolar disorders, and learning disability. The MHO defines 'mental disorder' as "*mental illness, mental handicap, and any other disorder or disability of mind*".

a risk to themselves or others.¹² This approach to compulsorily intervene and deprive someone of their liberty is controversial; on the one hand restricting a person's autonomy, yet on the other, seeking to protect the individual (and others) from harm.

In terms of numbers, Departmental data shows that around 1,000 patients were detained at admission under MHO in 2011/12.¹³ The number of children under 18 years of age who are subject to the MHO are few and this number is decreasing - around 70 children under 18 years of age were detained for treatment in 2011/12.¹⁴

5. Purpose of the Mental Capacity Bill

The main purpose of the new Mental Capacity Bill is to provide a coherent legislative framework for acting for and making decisions on behalf of people who lack capacity and in doing so, provide additional safeguards. These safeguards are designed to protect these individuals in accordance with the seriousness of the intervention being proposed. It is also envisaged that the Bill will reduce the stigma associated with having separate mental health legislation so that people with mental illness are treated on an equal basis to those with physical illnesses. In other words, people over 16 with a mental illness can no longer be compulsorily detained and treated against their will unless they are found to lack capacity.

The Bill will cover everyday decisions such as what to eat, to major decisions that may deprive a person of their liberty. It will apply to the civil population and those within the criminal justice system, and it will have a significant impact on those who work, or care, for people who lack capacity.

5.1 Principles

The Bill is based on a set of principles; the main one being 'autonomy'. This principle aims to empower individuals to exercise their own mental capacity. In keeping with this, the Department proposes to introduce a *statutory presumption of mental capacity*— that is, that people have the right to make their own decisions, and be responsible for them, until there is evidence that the person lacks capacity.¹⁵ The principle of best interests will also underpin the Bill. This includes for example, taking the wishes of person who lacks capacity into account and enabling them to participate as far as possible in the decision making process.

¹² The Order contains provisions in relation to some individuals who may, because of the nature and degree of their mental disorder, place themselves and or/others at risk. When this occurs, and when the individual is deemed to be unable or unwilling to accept care and treatment, the law places a responsibility on certain health and social care professionals and others to intervene.

¹³ DHSSPS NI Hospital Statistics: Mental Health and Learning Disability, p17.

¹⁴ Data obtained from C. Harper via correspondence with RQIA FoI request. In 2009/10 115 children under 18 were receiving treatment under the MHO, in 2010/11 there were 101 children, and in 2011/12 70 children were being treated under the MHO.

¹⁵ DHSSPS (2010) Mental Capacity (Health, Welfare and Finance) Bill Equality Impact Assessment, p?

5.2 Assessment of capacity and safeguards

Before any intervention is made, there will be a requirement to establish if the person can make the decision for themselves.¹⁶ This is because at the core of the capacity issue is the ability (or inability) of a person to consent to something.

It is proposed by the DHSSPS that the statutory test of capacity can only be applied to those **over 16** in the new Bill. This test will apply to interventions that have significant consequences or are intrusive. However a formal assessment of capacity will only need to be completed where a serious intervention is proposed, not for more routine interventions.¹⁷

Deciding whether an individual lacks capacity (for example by a social worker, lawyer, doctor) will be decision-specific, in other words, applied on a decision-by-decision basis. The statutory test will be a two stage process.

STATUTORY TEST FOR OVER 16s

The first stage will be a **diagnostic** test; does the person have “an *impairment of, or disturbance to, the functioning of the mind or brain?*”¹⁸

The second stage will be a **functional** test to ascertain if, as a result of the impairment or disturbance, the individual has the ability to use, retain, weigh the information in order to make and communicate their decision.¹⁹

Figure 2. Statutory test of capacity in individuals over 16

In addition, a range of safeguards (that go beyond the current common law provisions) will be provided. This includes for example, the right to an independent advocate or consultation with a nominated person. Departmental Officials have also advised that approach taken in the Bill will be one of reciprocation; the more serious or intrusive the intervention on the person lacking capacity - or where there is objection or resistance to the intervention, the greater the safeguards will be.²⁰

5.3 Common law defence of necessity

The Bill will also offer protection to the person making the intervention, provided they are not acting in a negligent manner. The common law ‘defence of necessity’ will be codified in the new Bill and form a central part of it. When a person does not have the capacity to consent to an intervention/decision concerning their care, treatment or welfare,²¹ the defence of necessity gives protection from civil or criminal liability to the person

¹⁶ DHSSPS EQIA Common questions arising, p3.

¹⁷ Where interventions are routine or urgent, these can proceed on the reasonable belief that capacity does exist. Where the intervention is non-routine and is serious – a formal assessment of capacity should be completed.

¹⁸ NI Assembly Official Report Hansard 9.5.12. Mental Capacity Bill. Departmental Briefing, p6.

¹⁹ EQIA (2009) <http://www.dhsspsni.gov.uk/equality-impact-assessment-for-new-mental-capacity-legislation.pdf>, p5.

²⁰ NI Assembly Hansard. 28.6.12 Justice Committee. Mental Capacity Bill.

²¹ The defence of necessity does not apply to financial matters.

intervening (e.g. carer, health professional). This protects that person from being prosecuted or sued provided that:²²

- the person being assisted is believed to lack capacity to consent;
- that all practicable steps have been taken to help the person;
- that any intervention is in the **person's best interests** (for example taking their views and wishes into account and consulting with relevant others); and,
- the additional safeguards of the new Bill have been met (if appropriate).²³

Details on the assessment of capacity, and how the other safeguards of the Bill will operate will be provided in a Code of Practice accompanying the new Bill.

6. Mental capacity and mental health legislation in the UK

Undoubtedly the single approach to the new Bill is innovative; the rest of the UK and the Republic of Ireland have developed 'mental health' and 'mental capacity' legislation under two separate Acts.²⁴ The uniqueness of the single Bill in NI also means there are no exact models from other jurisdictions in which to draw upon or compare.²⁵ In neighbouring jurisdictions, **mental capacity legislation** applies to those over 16 years of age in Scotland, England and Wales.²⁶ In the Republic of Ireland, mental capacity legislation - when enacted, will apply to those over 18 (Table 1 overleaf).

²² The protection offered is only to the extent that the person intervening would have been protected if the person had capacity to consent and had consented. The protection offered does not cover any negligence.

²³ DHSSPS Guidance: protection from liability for certain acts: Codification of Common Law Doctrine of Necessity.

²⁴ DHSSPS Consultation on an Equality Impact Assessment for New Mental Capacity Legislation. pp 2-3.

²⁵ NI Assembly Hansard 5.10.11 DHSSPS Evidence session - Mental Capacity Bill. Departmental Briefing.

²⁶ DHSSPS (2011) Mental Capacity Bill, Departmental briefing, p3.

TABLE 1.	Mental Health Legislation	Age limitations?	Mental Capacity Legislation	Age limitations?
Scotland	Mental Health (Care and Treatment) (Scotland) Act, 2003	Applies to children and adults	Adults with Incapacity (Scotland) Act, 2000	Over 16s
England and Wales	Mental Health Act, 2007 (amended 1983 Act)	Applies to children & adults (Guardianship applies to over 16s) ²⁷	Mental Capacity Act, 2005	Over 16s (some parts only apply to over 18s) ²⁸
Republic of Ireland²⁹	Mental Health Act, 2001	Applies to children and adults ³⁰	Mental Capacity Bill is pending by the end of 2012; may take 18 months to be enacted.	18 +
Northern Ireland (current status)	Mental Health (NI) Order, 1986	Children & adults (Guardianship applies to over 16s)	No legislation at present	N/A
Northern Ireland (proposed)	The Mental Capacity Bill (incorporating mental health and mental capacity law) is pending.			New Bill will apply to over 16s via capacity gateway, and to under 16s with a mental disorder when the MHO is revoked

Table 1. Mental health and mental capacity legislation in the UK and Republic of Ireland

Mental health legislation in the UK and Republic of Ireland applies to children and adults who require formal treatment for a mental disorder. When the new Bill is enacted, the powers within the MHO will be revoked. It can be seen from Table 1 that, if mental health and mental capacity legislation in NI are merged into a single Bill that generally applies to those over 16, this will create a gap for children under 16 who have a mental health disorder who fall under current MHO legislation. The following section examines how the new Bill will address this gap and how it is envisaged the Bill will apply to persons over 16 and to children under 16.

7. Application of the New Bill

7.1 Persons over 16

The DHSSPS has advised of its intention that the new Bill will **generally apply to those over 16 years of age who lack capacity to make a decision about their health, welfare or finances.**

As the legislation is capacity based, the starting point is a presumption of capacity - until there is evidence to the contrary.³¹ If a person over 16 is deemed to 'have

²⁷ Guardianship is used to ensure the welfare of a patient in a community setting, as an alternative to detention in hospital.

²⁸ Such as Lasting Powers of Attorney, advanced decisions to refuse medical treatment, and statutory wills.

²⁹ Author's correspondence with John Kenny, Department of Justice and Equality. Response dated 26.7.12.

³⁰ The Act is currently under review and a number of recommendations regarding children, including that children aged 16 or 17 should be presumed to have capacity to consent / refuse mental healthcare and treatment are under review.

capacity' to make a particular decision, this should be respected and the provisions of the Bill will not apply to them - even if this would mean that for instance, the decision is unwise.³² Voluntary mental health patients who agree to treatment will fall outside the scope of the Bill because they do not lack capacity.

7.2 Persons under 16

Although the Bill will generally apply to those over 16 who lack capacity, the DHSSPS has advised that provision will be made for a small number of children under 16 who require compulsory assessment or treatment of a mental disorder. This will seek to bridge the gap created when the Bill merges into a single framework. However, given that data shows that 70 children under the age of 18 were detained at admission for a mental disorder in 2011/12, this is a relatively small number of children (and there will be even less that are under 16) that the Bill will apply to. This is a key issue for children's rights organisations who are concerned that the majority of children with a mental health condition are treated as voluntary patients. Therefore these children will not have access to the same safeguards and protections as those provided under the Bill to children who are formally detained. It is worth repeating however that the Bill and its safeguards will not apply to voluntary patients aged 16 and over. This is based on the assertion that they do not lack capacity.

As part of the proposals, any decisions regarding the child must ensure that their welfare is paramount and their views are taken into account. For those under 16, the Bill will include additional safeguards such as age appropriate accommodation and equal access to education resources.³³

The DHSSPS advocate that it is not possible to assess capacity in children in the same way as adults because of their developmental stage. As a result, the capacity test criteria applied to those over 16 will not be used. Instead, children under 16 who require compulsory intervention in relation to a mental illness will be based on an assessment of 'risk' and 'necessity'. This assessment is based on the following criteria³⁴:

³¹ For patients over 16 with a mental disorder, their capacity will be assessed before a decision is taken on whether they can be compulsorily detained and/or treated.

³² An example would be where a decision not to have treatment results in the person's death (e.g. refusing cancer treatment).

³³ This can apply to children who have a learning disability or an acquired brain injury for example.

³⁴ DHSSPS (2010) Mental Capacity (Health, Welfare and Finance) Bill Equality Impact Assessment , p6.

STATUTORY ASSESSMENT FOR CHILDREN UNDER 16

The child has an impairment of, or disturbance in, the functioning of the mind or brain and:

- *they pose substantial risk of serious physical or psychological harm to themselves or others; and*
- *there is appropriate medical treatment available to them; and*
- *there is no other way to deal with the person other than by compulsory measures/detention.*

Figure 3. Statutory assessment for children under 16.

If we refer back to the statutory test for those aged 16 and over (page 9), the first part - the diagnostic test of capacity (*an impairment of, or disturbance in, the functioning of the mind or brain*) is the same for children under 16 as it is for persons over 16.

The DHSSPS has also advised that the child does not necessarily need to be formally detained in a hospital setting in order to have access to all the Bill's safeguards.³⁵ For example, a child could be compulsorily treated for a mental disorder in the community (which is aligned to Bamford's 'least restrictive' principle).³⁶

Children under 16 who do not satisfy the criteria above, will fall outside the scope of the proposed provisions in the Bill dealing with the assessment and treatment of mental disorder. Powers to deal with children who fall outside the legislation can be found in other child based legislation (such as the Children's Order or the Criminal Justice Order).³⁷

8. The Capacity and Children Under 16 Debate

The debate about capacity and children under 16s is an important and long standing issue that has generated concerns from children's rights organisations. Before exploring this issue further, it is useful to remind readers about several important aspects of policy, legislation, and human rights standards that have shaped this debate.

8.1 Bamford's view on children under 16

Regarding children and young people, Bamford acknowledged that the Children (NI) Order provided parental rights and responsibilities for children in terms of welfare and services; and that the welfare of the child must be paramount when decisions are being made, and that those decisions are in the best interests of the child. Bamford makes it clear that children and young people under 18 who are subject to substitute decision making, require special rights and protections. However Bamford only discusses capacity and consent issues relating to children in the context of 'health' decisions.

³⁵ Meeting with Departmental Officials, 2.8.12.

³⁶ This could mean for example, the young person living at home and getting medication every week from a doctor.

³⁷ Department of Justice. [Consultation on proposals to extend Mental Capacity Legislation to the Criminal Justice System in Northern Ireland and implications for Mental Health powers](#) p33.

Bamford states that consideration of a ‘rebuttable presumption of capacity’ in relation to health/treatment decisions *might* be given to mature minors:

*“While most people would agree that parents be substitute decision makers for children up to the age of 10 or 12, **consideration might be given to a rebuttable presumption of capacity between 12 and 16.** When a young person is deemed to lack capacity, parents would ordinarily have substitute powers until the age of 16. However if the child’s best interests are considered to be at significant risk, then treatment may have to be authorised.”³⁸*

Bamford also states that children’s needs must be recognised and protected through advocacy and representations, and that children should be involved in their care planning as much as possible.

8.2 International human rights standards

Two international human rights treaties are particularly important when considering the issue of children and capacity; the United Nations Convention on the Rights of the Child (UNCRC)³⁹ and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).⁴⁰

• UN Convention on the Rights of the Child (UNCRC) – Article 12

In 1991 the UK (including Northern Ireland) ratified the United Nations Convention on the Rights of the Child.⁴¹ The basic premise of the UNCRC is that children under the age of 18 are born with fundamental freedoms and the inherent rights of all human beings. There are four core principles of the Convention namely non-discrimination; devotion to the **best interests** of the child; the right to life, survival and development; and **respect for the views of the child**.

Emerging capacity in children and the opportunity to be heard is dealt with in **Article 12** of the UNCRC which states:

*12.1. 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.*

*12.2. For this purpose, the child shall in particular be **provided the opportunity to be heard in any judicial and administrative proceedings** affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.*

³⁸ The Bamford Review of Mental Health and Learning Disability. A Comprehensive Legislative Framework (2007) http://www.dhsspsni.gov.uk/legal-issue-comprehensive-framework.pdf_p64

³⁹ United Nations ‘Enable’ website: UNCRPD <http://www.un.org/disabilities/default.asp?id=150>

⁴⁰ United Nations UNICEF website: UNCRC <http://www.unicef.org/crc/> The Convention sets out a series of rights in 54 articles and two Optional Protocols.

⁴¹ DirectGov Children’s human rights. Available online at: http://www.direct.gov.uk/en/Parents/ParentsRights/DG_4003313

Article 12 is described as a unique provision in a human rights treaty in that it addresses the legal and social status of children, who on one hand lack the full autonomy of adults but, on the other, are holders of rights.⁴²

State compliance with the UNCRC is monitored by the Committee for the Rights of the Child. Periodic reports at a national level are published which highlight breaches and make recommendations for future compliance. The Committee for the Rights of the Child last examined the UK State Party in 2008 and is due again in 2014.

• **UN Convention on the Rights of Persons with Disabilities (UNCRPD) - Article 7**

The purpose of the UNCRPD is to promote and protect the rights of people with disabilities (that is, people with long term physical, mental, intellectual and sensory impairments).⁴³ Both the convention and the optional protocol became binding in the UK in 2009.⁴⁴ The UNCRPD states that disabled people have the same right to make and be supported to make their own decisions about important things as everyone else. Article 7 of the UNCRPD concerns children with disabilities. It states:

- 1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.*
- 2. In all actions concerning children with disabilities, the **best interests** of the child shall be a primary consideration.*
- 3. States Parties shall ensure that children with disabilities have the right to express **their views freely on all matters affecting them**, their views being given **due weight in accordance with their age and maturity**, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.*

Interestingly Article 7 of the UNCRPD does not appear to assume capacity in children nor does it delineate an “age criteria” for children.

In international law, the UK has ratified both the UNCRC and the UNCRPD and is therefore legally obliged to give effect to them in full and to protect the rights of these groups.⁴⁵ However, the UNCRC and the UNCRPD are not binding in domestic law, and therefore not judiciable in the UK.⁴⁶ In effect, there are no sanctions on

⁴² UN Committee on the Rights of the Child, General Comments. Available online at: <http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC-C-GC-12.doc> p5.

⁴³ UN enable website convention on the Rights of persons with disabilities <http://www.un.org/disabilities/default.asp?navid=24&pid=151#q1>

⁴⁴ The Optional Protocol establishes two procedures aimed at strengthening the implementation and monitoring of the Convention. The first is enables individuals to bring petitions to the Committee claiming breaches of their rights; the second is an inquiry procedure giving the Committee authority to undertake inquiries of grave or systematic violations of the Convention.

⁴⁵ Lundy, L. (2007) ‘Voice’ is not enough: conceptualising Article 12 of the UNCRC. British Educational Research Journal, 33:6 p928.

⁴⁶ Neither the Westminster Parliament or the NI Assembly has a formal duty to make sure that the legislation they pass is compatible with the UNCRC.

Governments for failing to deliver on these rights, except international embarrassment that elements of the minimum standards are not being adhered to.⁴⁷

8.3 Domestic legislation and case law

This section provides an overview of the key legislation and case law that governs children, and their capacity to consent or contribute to decision making.

- **The Children (Northern Ireland) Order 1995**

The Children (NI) Order is the most important statute governing the care, upbringing and protection of children in Northern Ireland. It is also principles based; the welfare of the child is paramount, decisions should be made in their best interests, and children should be included in any decision making. The general philosophy of the Order is that primary responsibility for raising children rests with those with parental responsibility.^{48,49} The Children (NI) Order defines parental responsibility as “*all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property*”.⁵⁰ This includes the entitlement to make all major decisions about a child’s welfare – their name, education, place of residence, medical treatment and so forth.⁵¹ Importantly, this is regardless of whether the child has capacity or not.

- **Gillick Competence (Case Law)**

An exception to the Children’s Order regarding parental responsibility is children who are considered ‘Gillick’ competent. The legal position concerning consent and refusal of **medical treatment** is different for children than it is for adults.⁵² Those under 16 who have sufficient understanding and intelligence to enable them to understand what is involved in a medical intervention or treatment – have a legal right to consent to that treatment.⁵³ In these cases, under common law, the child is described as being “Gillick competent” and s/he can consent to treatment/ intervention without their parent’s consent. The child’s consent cannot be overruled by a parent.⁵⁴ Nevertheless, the courts maintain that no child under 18 is wholly autonomous. Therefore, if a Gillick competent child refuses to accept treatment, consent may be sought from those with

⁴⁷ Potter, M. (2011) NI Assembly Research paper (313-11) Equality and Human Rights Legislation in Northern Ireland: A Review

⁴⁸ Parental responsibility could rest with parent/guardians, social services or the courts for example.

⁴⁹ In the Children (NI) Order “child” means a person under the age of 18 - except in Parts X, XI and XII which apply to fostering, child reminding and employment for which there are different age limitations.

⁵⁰ The Children (NI) Order 1995, Article 6.

⁵¹ Northern Ireland Child Care Law, “The Rough Guide”, Section 7 Principles of the Children Order.

⁵² DHSSPS (2003) Reference Guide to consent for examination, treatment or care, p20.

⁵³ In Scotland a child who is Gillick competent can give their consent or refuse treatment.

⁵⁴ Gillick competence ruling in the case *Gillick v West Norfolk and Wisbech Area Health Authority {1986} AC112*, which sought to decide in medical law whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. It lays down that the authority of parents to make decisions for their minor children is not absolute, but diminishes with the child’s evolving maturity; except in situations that are regulated otherwise by statute, the right to make a decision on any particular matter concerning the child shifts from the parent to the child when the child reaches sufficient maturity to be capable of making up his or her own mind on the matter requiring decision.

parental responsibility or the courts.⁵⁵ Again, any treatment decisions must be made in the child's best interests.⁵⁶

- **The Age of Majority Act (NI) 1969**

It is also worth noting the Age of Majority Act. This Act delineates the legal threshold that demarcates 'childhood' and 'adulthood' i.e. where a 'minor' ceases to be considered a child and has the legal capacity to be responsible for his/her own decisions. The Act reduced the age of majority from 21 to 18 years of age and it applies in England, Wales and Northern Ireland (the Age of Majority is 16 in Scotland). The Act entitles the young person to undertake certain actions such as making a will, voting, and being able to marry without parental consent, once they reach 18 years of age. It also provides that young people over 16 can give consent to surgical, medical or dental treatment if they are deemed to be capable of making informed decisions.⁵⁷

There are also a number of other statutes (beyond the scope of this paper) which govern when children in Northern Ireland can consent to, or make, certain decisions for themselves, such as when they can leave school or take alcohol and so forth.

8.4 Stakeholder Perspectives on the Under 16s Issue

The Committee for Health, Social Services and Public Safety took evidence from the Children's Law Centre, the Northern Ireland Commissioner for Children and Young People (NICCY) and the Department on this matter on 9 May 2012.⁵⁸ Table 2 overleaf illustrates the main issues (not an exhaustive list) from the perspectives of the DHSSPS and the two children's rights organisations. For ease of readership, the children's organisations evidence has been presented together, as these were based on similar themes; however both groups presented their own individual evidence.

⁵⁵ DHSSPS (2003) Reference Guide to consent for examination, treatment or care, p21.

⁵⁶ In Scotland Gillick has been codified in statute (Age of Legal Capacity Scotland Act, 1991). Children under 16 who have the capacity to consent to a health care intervention and case law may indicate that children are also able to refuse treatment.

⁵⁷ The Bamford Review of Mental Health and Learning Disability. A Comprehensive Legislative Framework (2007) <http://www.dhsspsni.gov.uk/legal-issue-comprehensive-framework.pdf> 64.

⁵⁸ NI Assembly Official Report Hansard 9.5.12. Mental Capacity (Health, Welfare and Finance) Bill. Northern Ireland.

Table 2. Summary of views regarding the children and capacity debate.

Bamford:	
Children's rights organisations: Exclusion of under 16s from the legislation is in direct conflict with Bamford's recommendation for a <i>rebuttable presumption of capacity in children and young people under 16 years old</i> .	DHSSPS: Bamford recommended only that the DHSSPS give <i>consideration</i> to a "rebuttable presumption of capacity for 12-16 year olds". Bamford emphasised consideration be given to 'health' decisions. However the new Bill will also include welfare and finances. The DHSSPS is content it is reflecting Bamford's position. If a rebuttable presumption was given, it would create fundamental issues like which fields can capacity be exercised and how will parental responsibility be affected in the legislation.
Human Rights UNCRC:	
Children's rights organisations: The new Bill should take account of the UNCRC - notably Article 12: the Government shall assure the right to be heard to every child capable of forming his or her own views. New legislation should undergo 'child-rights proofing' against UNCRC. Also the General Comment accompanying Article 12 states that children's levels of understanding are not uniformly linked to their biological age and should be assessed on a case by case basis.	DHSSPS: Article 12 of UNCRC does not give children the 'right' to make decisions, but to have their voice heard. The UNCRC is not part of domestic law, but has been ratified and is influential in terms of government policy. DHSSPS have sought legal advice to ensure proposals in the Bill regarding those under 16 are compliant with the UNCRC. Nothing in the proposed legislation is inconsistent with Article 12 of the UNCRC.
Children Order:	
Children's rights organisations: The Children's Order is not recognised as an instrument which aims to maximise autonomous decision making by children and young people. The Children's Order does not provide any protection for mature minors under the age of 16 who lack capacity as a result of mental illness or learning disability.	DHSSPS: Mechanisms are already in place under the Children's Order to ensure voice of child is heard. The Children's Order is about the protection and care of children ensuring that their voice is heard when decisions are being made but ultimately recognising the rights of those exercising parental responsibility to make decisions on behalf of children. We would need to look at why the order is not working if there are gaps in provision for vulnerable children.
Bill's Safeguards:	
Children's rights organisations: Concerns that only children under 16 who are formally detained will be able to access the protections of the Bill; a small group of mature minors who lack capacity because of mental illness, learning disability, and those in the justice system who will not have access to the following safeguards: <ul style="list-style-type: none"> • Enhanced advocacy services; • New offence of ill treatment or neglect of those who lack capacity; • Statutory recognition of the views of carers; • Legal protection to those who provide care/ treatment; • Restraint - only permitted to prevent harm; <p>Such safeguards should be available to <u>both</u> formally detained and voluntary inpatients.</p>	DHSSPS: Where a child may need to be detained (which will be determined by a doctor), the Bill will provide different criteria to assess 'risk and necessity', than the 'capacity criteria' that will apply to over 16s. A child detained under the Bill will have access to all the safeguards provided in the Bill to someone who is over 16 (including additional safeguards in relation to age appropriate accommodation and education).
Detaining children:	
Children's rights organisations: It may make it easier to formally detain children under 16 because there is no requirement to establish a lack of capacity before applying test for formal detention in the under 16s; those over 16 will have added protection of not being subject to the test for detention if they are found to have capacity. The majority of patients with a mental disorder are	DHSSPS: It will not be easier to detain a child as the assessments based on "risk and necessity" will need to be completed and a doctor satisfied that they are met. Voluntary patients include children either assessed as Gillick competent who agree to treatment, or who are not Gillick competent - but their parents have agreed to their treatment.

voluntary therefore they will not have access to safeguards. This might mean it becomes advantageous for a child to be detained to access safeguards rather than being a voluntary patient.	The Bill will not create a situation where it would be preferable to detain a child under 16. The decision to detain and treat a child under 16 is taken by a doctor and would have to be made in the child's best interests.
Impact on child:	
Children's rights organisations: There is a possible adverse impact on the child who has been compulsorily detained for care/treatment in terms of the obligation to declare that he/she has been detained for treatment - e.g. to an employer, on drivers licence, insurance companies and so forth.	No direct response was given by the DHSSPS to this issue.
Gillick:	
Children's rights organisations: The continued application of the Gillick competence test regarding healthcare treatment decisions for children under 16 is inadequate as it allows children to accept medical treatment, without the need for parental permission or knowledge of the decision- but not to refuse it . Mature minors who are deemed to have capacity may be overruled if they do not decide on having treatment and therefore may be forced to accept treatment against their will. This does not sit well with Article 12 of the UNCRC in terms of the child's right to be heard.	DHSSPS: Gillick comes under common law in Northern Ireland. The codification of Gillick (this has been done in Scotland) is an option and has been proposed and could be achieved by amending the Age of Majority Act to 16. However CLC do not think the codification of Gillick goes far enough for under 16's; they want to see the decisions extended beyond health related matters. DHSSPS also suggest that the codification of Gillick would alter the nature of the Bill slightly– its purpose is to provide substitute decision making for people who lack capacity rather than extending capacity to enable children to make decisions.
Threshold of 16:	
<p>Children's rights organisations: '16' seems an arbitrary age. There are other 'significant' ages: for example '13' the age at which a young person can get a part time job, '18' the age they can vote. Numerous ages are prescribed in law when a young person can do things; the 16 age limit not suitably justified.</p> <p>The minimum age of criminal responsibility is '10', and mental capacity legislation will only apply to those over 16 – which could create further problems. This may also create issues for those in the Juvenile Justice system where protections may be available to some children but not others.</p> <p>It could also be argued that having the '16 years of age' threshold may lead to confusion for practitioners in terms of the different ways the Bill is accessed, for example for those aged 15 and those aged 17.</p>	<p>DHSSPS: The '16' threshold can be debated. The DHSSPS suggest that this is the age by which society assumes children have capacity to take good decisions about how their lives are run.</p> <p>Some NI legislation already makes provision for 16 and 17 year olds (eg when to leave school) and is appropriate that presumption of capacity applies to them. However for under 16's this situation is different. The Children's Order says the person who can give consent on behalf of those under 16 is someone exercising parental responsibility. An example of an exception to this is the Gillick competence which enables a child to agree to, but not refuse medical treatment. Any change in current law will have an impact on parental responsibility, for example we do not want legislation that enables a 14 year old to say "I do not want to live with my parents, I want to live with my grandparents", or "I don't want to go to this school, but that one".</p> <p>Capacity legislation also applies to those over 16 in other jurisdictions. Adults with Incapacity (Scotland) Act, equivalent to the NI Bill, only applies to over 16s. The Age of Legal Capacity (1991) legislation in Scotland was amended to 16 and codified Gillick in statute law and permits children under 16 to consent or refuse medical treatment.</p>
Deprivation of liberty:	
Children's rights organisations: Under the new Bill, if the State deprived an individual over 16 of their liberty, this must be justified and would be open to scrutiny. There will be no equivalent safeguards for those under 16. There could be considerable legal challenge to this.	DHSSPS: Deprivations of liberty usually arise in the context of caring for people with dementia. The European Court has said such situations must be authorised. The Bill will place a responsibility on facility managers to identify such cases and to gain authorisation, and this will apply to those aged 16 and over. For under 16s, the Children's Order provides the required safeguards and meets European Court standards by providing for constant, on-going judicial oversight of the management and care of children being held in circumstances that may equate to a deprivation of liberty.

8.5 The DHSSPS perspective

In essence, the DHSSPS position is that the new Bill is reflecting the assumptions that are currently founded in statute around capacity and consent. The law in Northern Ireland states that in most circumstances, consent regarding children lies with those with parental responsibility under the Children's Order. The DHSSPS have reaffirmed that the Bill *only* applies to acts that require consent and thus the defence of necessity; it is not about enabling capacity in children under 16. The DHSSPS posit that a child's lack of decision making ability most commonly arises from their developmental stage, immaturity or lack of judgement, rather than an 'impairment or disturbance in the way the brain functions'. Furthermore, the DHSSPS does not want to include provisions in the new Bill that would undermine parental authority or have unforeseen implications on other legislation.⁵⁹ Moreover, if no age restriction for the capacity gateway is provided in the new Bill, this would give effect that all children under 16 are presumed to have capacity. The Department argue that this approach could create risks in terms of giving children responsibility for major decisions about themselves that are currently taken by those exercising parental responsibility. They also suggest wider ramifications from such changes, for example, in the court system.

8.6 Children's rights organisations perspectives

The two children's rights organisations (CLC and NICCY) are very supportive of the new Bill, but have concerns regarding the DHSSPS proposals for under 16s. In their view, it is imperative that Northern Ireland gets the most inclusive piece of legislation possible in relation to mental health and capacity, which also considers the particular needs of children and young people. They also suggest that a Bill which reforms mental health law and provides safeguards should not exclude those under the age of 16 - specifically the mature minor, from the workings of the Bill simply based on their age alone. Their perspective is that under the current proposals, only a very small percentage (around 0.5%) of under 16s who are inpatients in mental health hospitals would be formally detained and would have access to the safeguards; the majority of young people with mental health conditions are currently treated as voluntary patients and would therefore not have access to the safeguards and protections of the Bill. This, they contend, could have an adverse impact on very vulnerable children – such as those with mental health problems or learning disabilities, where it could be considered more advantageous to detain a child in order that they may access the safeguards of the Bill. Of particular concern is that these children will not have any right to access enhanced advocacy services. It is argued that this denies the child the right to be heard and for their views to be taken into account which goes against several human rights principles. It is also suggested that the under 16 issue should not be overlooked

⁵⁹ Parental responsibility refers to the rights and responsibilities that most parents have in respect of their children. A mother automatically has parental responsibility for her child from birth. However, the conditions for fathers gaining parental responsibility varies throughout the UK. In England, Wales and Northern Ireland, once a young person reaches 18, s/he is regarded in law as an adult and parental responsibility no longer applies.

because of implications or “unintended consequences” that may arise from changes in legislation.

9. Discussion

The researcher recently met with the DHSSPS and the two children’s organisations. All acknowledge the complexities arising from the under 16s issue and finding the balance will not be an easy feat. The situation is further complicated by the Bill’s unique approach, different pieces of law governing decision making and how these can interface harmoniously.

This is an important debate and not one that either the children’s lobby groups or the DHSSPS are shying away from. Finding a resolution may not be straightforward. However, some of the possible options going forward may include, but are not limited to:

- Keeping the current proposals as they stand.
- Codifying ‘Gillick’ in statute (to include the refusal of treatment).
- Introducing a mechanism to enable the assessment of capacity in mature minors on a case-by-case basis as proposed by CLC and NICCY.⁶⁰

The DHSSPS has also proposed that some of the issues concerning emerging capacity could be dealt with in a Special Project (as discussed below).

9.1 Special Project on emerging capacity of children

The DHSSPS have stated that children and substitute decision making is a much wider issue in terms of policy and society, and that further consideration and debate will be facilitated through a separate, cross-departmental project to examine “emerging capacity in children”.⁶¹ When the project reaches a conclusion, the DHSSPS have advised that the outcome could be reflected in the new Bill (or Act) if required. This might mean for example, that consideration is given to extending presumption of capacity, perhaps within a defined range of circumstances. However, despite welcoming the special project, the CLC and NICCY have several reservations. These include concerns that the special project is unlikely to address the concerns about access to the Bill safeguards for children under 16 who lack capacity and have a mental illness or learning disability, and that the project will not be completed in time for the introduction of the new Bill.

10. Other Jurisdictions

It has not been possible to conduct a complete review of legislation regarding children, capacity and consent in other jurisdictions because of the number of different laws that

⁶⁰ NI Assembly Official Report Hansard 9.5.12. Mental Capacity (Health, Welfare and Finance) Bill. Northern Ireland Commissioner for Children and Young People (NICCY) Briefing, p2.

⁶¹ Personal correspondence with DHSSPS in Castle Buildings, July 2012.

apply and the legal complexities involved in doing so. In addition, Northern Ireland is adopting an approach by amalgamating the two forms of mental capacity and mental health legislation that is not believed to have been completed anywhere else.

There are however, a number of jurisdictions, for example in Ontario, Canada that do assume capacity in people including children *within the context of health*.⁶² In Ontario the capacity test is applied equally to children and adults, regarding healthcare/ treatment decisions (welfare and finances are not included).⁶³ Here, in practice, the age of the child will often trigger an investigation into their capacity. However, rarely would a young child have the intellectual capacity to make complex medical conditions (the first branch of the capacity test requires a cognitive “ability to understand the information relevant to making a decision”). If the child is not capable of making the decision, a substitute decision maker is appointed.⁶⁴ Again, it is not possible to take this single piece of legislation in isolation; it would be necessary to consider this within context and implications of other legislation such as mental health, substitute decision making and child related laws in Ontario.

11. Conclusion

The issue of children and capacity is a complex, emotive issue that has generated both debate and some confusion. This paper has provided an outline of the new Capacity Bill and its application, paying particular attention to the debate regarding children under 16. The views of both children’s rights organisations and the Department have been presented. Whether or not these current proposals are implemented or changed remains to be seen. One thing that is shared amongst all stakeholders is a desire to get the best possible mental capacity legislation for Northern Ireland.

The Committee may wish to seek further views of independent experts / health professionals on the issue of consent, capacity and the child.

⁶² The Health Care Consent Act, 1996.

⁶³ Personal correspondence from Lora Patton (Canadian Consent and Capacity Board) to the author on 10.9.12.

⁶⁴ Ibid