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# Legal capacity, developmental capacity, and impaired mental capacity in children under 16: Neurodevelopment and the law in Northern Ireland

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ABSTRACT

When people of any age, despite all possible support being provided, are unable to make a necessary decision, then it is important to have a legal framework which promotes and protects their rights. There is ongoing debate about how this can be achieved, in a non-discriminatory way, for adults but it is also an important consideration for children and young people.

In Northern Ireland, the Mental Capacity Act (Northern Ireland) 2016, when fully implemented will provide a non-discriminatory framework for those aged 16 and over. Arguably this addresses discrimination based on disability but continues to discriminate based on age. This article explores some of the possible ways the rights of those aged under 16 could be further promoted and protected.

These approaches may include: retaining the current combination of statute law but developing new guidance to inform practice for those aged under 16; codifying Gillick to clarify under what circumstances those aged under 16 can accept, and possibly also refuse, interventions; amend the Children (Northern Ireland) Order 1995 to provide a more comprehensive framework for health and welfare decision making; amend and extend the Mental Capacity Act (Northern Ireland) 2016 to apply to those aged under 16; or develop a new law specifically focused on the emerging capacity of those aged under 16.

There are complex issues involved including how to consider emerging or developmental decision-making ability, and the role of those with parental responsibility, but the complexities involved should not prevent these issues being addressed.

'I think the under-16s are a problem everywhere. We've had quite a lot of litigation here, but not only for under-16 s, 16- and 17-year-olds as well … There are really tricky questions about whether you have a separate regime for them and what the regime should be and to what extent should it recognise children's autonomy. And I don't have any simple answers to that at all.'

Rt Hon Lady Brenda Hale DBE (quoted in McKenna, 2022, p. 253).

## 1. Introduction

The life of people under 16 is often rich, complex and can develop rapidly, including through their emerging capacity to make decisions for themselves. However, the societal response to children under 16, and the associated legal framework, seems to struggle to keep pace with this and our still evolving understanding of how the developmental capacity of children emerges over time.

Northern Ireland has recently made a significant reform to its law relating to mental health and mental capacity through the enactment of the Mental Capacity Act (Northern Ireland) 2016 (MCA(NI)) (Harper, Davidson, & McClelland, 2016; Lynch, Taggart, & Campbell, 2017). The MCA(NI) 'fuses' mental health and mental capacity law in a single Act which bases compulsory interventions on a lack of mental capacity, not

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on the presence of mental disorder. It creates a single legislative framework for decision-making in both mental and physical health and social care. However, this statute does not apply to children under 16.[1] During the development of the Act, considerable thought was given to how it might include all people equally within its empowering and protecting provisions, but this was not in the end achieved. The personal and legal situations of children under 16 were not included in the legal simplification of a 'fusion' of mental health and mental capacity law, leaving residual, potential discrimination as a result of an incomplete law reform process. The complexity of the current legal framework for those aged under 16 presents ongoing challenges for all involved.

The relationships between science, medicine and the law are complex, even more so when it is a question of potentially contentious law reform involving international human rights commitments, multiple domestic statutes, and extensive domestic case law. The complexity that flows from varying disciplinary perspectives is also mixed with the confounding factor of a lack of clarity of the multiple elements which are engaged by any reasonable law reform process.

'Capacity' is sometimes used to refer to distinct things and this hinders both the analysis of the legal situation and the development of proposals for law reform. It is important that different yet related aspects of the topic are treated as distinct, although no suggestion is intended that they are always separable in law or in life.

**'Legal personhood'** is the capacity to have rights and duties within a legal system. Its possession does not in itself mean that a legal person has the same rights and duties as another legal person.

'**Legal capacity**' is used here to refer to a person's authority under law to make a particular decision, engage in a particular undertaking, or have a particular status. Common examples of legal capacity are the rights to get married, to vote, or to enter a contract of employment. Having legal capacity does not necessarily depend upon having the ability to make decisions relevant to it. 'Legal capacity' as used here is a socio-legal status which people may have a right to but may not be able to exercise in full or in part. It is thus a different use of the term to that of the UN Committee on the Rights of Persons with Disabilities (2014, para 8) definition of legal capacity as 'a universal attribute inherent in all persons by virtue of their humanity'.

A lack of '**Mental capacity**' is used here in the MCA(NI) sense to refer to the lack of the ability to make a decision *because of* 'an impairment of, or a disturbance in the functioning of, the mind or brain'.[2] There are thus two parts to a lack of mental capacity: an impairment or disturbance and a lack of at least one of four 'abilities'. The four aspects of the functional test are set out in Section 4 of the MCA (NI). To be 'unable to make a decision' about the relevant matter, the person must be: not able to understand the information relevant to the decision; not able to retain it for the time required to make the decision; not able to appreciate, use and weigh the information; or not able to communicate their decision. A person 16 or over has mental capacity, if they are *not unable* to make a decision as defined in the MCA(NI). The MCA(NI) contains a presumption of mental capacity for people within its scope, that is people 16 and over. A lack of 'mental capacity' can lead to the restriction or loss of a person's legal capacity, but such a lack is not necessarily causative in every situation as the legal capacity might be already directly restricted without questions about mental capacity arising.

'**Developmental capacity**' is used here to refer to the emerging or evolving capacity of the child to make decisions and it is a consequence of the developmental stage of the child. The age at which developmental capacity is no longer material is set by laws which establish full legal capacity at a particular age for all, or for particular, decisions. Below such a set age for the attainment of legal capacity, legal mechanisms may exist which recognise legal capacity case-by-case based on the developmental capacity of the child: recognition that a child aged under 16 may have 'Gillick competence' to consent to treatment being a key example of such an approach.[3]

Questions of legal capacity for decision-making in under 16 s tend to focus primarily on developmental capacity, but questions of mental capacity may also arise. Distinguishing the roles of impairment in the functioning of the mind and of insufficient mental development may present challenges in practice. There can be no purely legal solution to these challenges but one possibility could be to add developmental capacity or immaturity to the impairment aspect of the mental capacity test. Having the best legal framework achievable can support good decision-making in the face of these challenges and can support the attempt to act and to make decisions in the best interests of the child under 16.

In what follows we discuss how laws relating to legal capacity and mental capacity in Northern Ireland relate to the development of the decision-making capacity of children under 16. We review the evidence, psychological and physiological, around the developing capacity of children and young people. We also propose some options for the possible development of the law in this area.

## 2. Approaches of the current legal context to decision-making of and for under 16 s

### 2.1. UN convention on the rights of the child

Article 1 of the UN Convention on the Rights of the Child (UNCRC) (1989) states:

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

This definition of scope allows for the possibility that the law may treat children as having legal capacity in advance of them attaining 'adult' status as defined within the UNCRC.

That children have an evolving capacity to make decisions is recognised in international human rights law in Article 12, Paragraph 1 of the UNCRC:

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.

This was further reinforced by the United Nations Committee on the Rights of the Child, 2009in its General Comment on the right of the child to be heard, "Paragraph 1 assures, to every child 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 age and maturity." (p. 5). This right of the child to participate in a decision-making process with respect to them, does not require that the child be the decision-maker. The Committee on the Rights of the Child has confirmed that "children's evolving capacities have a bearing on their independent decision-making in their health issues" (United Nations Committee on the Rights of the Child, 2013, para. 21; Varadan, 2019).

The UNCRC does not specify particular legal frameworks which would be compliant with this article. However, there is a clear

[1] The selection of under 16 as the relevant age for the discussion here is largely based on the scope of the MCA(NI). In other jurisdictions, a different age may well be the appropriate basis for analysis – for example, where mental capacity legislation only applies to people aged 18 and older.

[2] MCA Section 3. (1) For the purposes of this Act, a person who is 16 or over lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for himself or herself about the matter (within the meaning given by section 4) because of an impairment of, or a disturbance in the functioning of, the mind or brain.

[3] Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL)

requirement that States must recognise evolving capacity. Arguably as applied to particular cases, the 'due weight' to be given may mean that the decision-making capacity of the child is such that they should be granted the legal capacity to make the specific decision they face.

Article 3(1) of the UNCRC requires that:

In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

This emphasis on the consideration of the best interests of the child runs throughout the UNCRC and is a general obligation which does not apply only where the child is considered to lack decisional capacity or mental capacity. Article 12 applies within such situations, which means that the views of the child, in accordance with their age and maturity', should be given due weight in the consideration of their best interests.

### 2.2. UN convention on the rights of persons with disabilities

Article 12(1) of the UN Convention on the Rights of Persons with Disabilities (2008) reaffirms that persons with disabilities have the right to recognition everywhere as persons before the law. This reaffirmation of legal personhood includes children under 16 with disabilities.

Article 12(2) of the UNCRPD requires that States Parties recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. This means that there should be no actual or potential restrictions of legal capacity which apply to people solely because of their disability. However, it does not mean that the legal capacity of a disabled child cannot be restricted on other grounds such as age. Article 7 of the UNCRPD stresses the full legal personhood of children with disabilities on an equal basis with other children and mirrors the requirements of the UNCRC with respect to best interests and the views of the child:

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.

Article 5(1) of the UNCRPD on 'Equality and non-discrimination' affirms that:

States Parties recognise that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

It is difficult to reconcile this requirement of international human rights law with any approach which permits detention and treatment of people with mental disabilities on the basis of the presence of a mental disability. The mental capacity-based approach taken in the Mental Capacity Act (Northern Ireland) 2016 (see section 3 below) addresses discrimination against people with mental disabilities by providing a single legislative framework covering both physical and mental health and social care interventions. However, the retention of the Mental Health (Northern Ireland) Order 1986 for under 16 s means that this issue of disability discrimination is not addressed (see section 3.1 below). A solution which meets the requirements of articles 12, 7 and 5 of the UNCRPD is required.

The relation between the obligations of the UNCRC and those of the UNCRPD remain a matter of debate. Further, the implications of article 12 of the UNCRPD for children with disabilities remain unclear – this is perhaps particularly so if that article is interpreted as by the Committee on the Rights of Persons with Disabilities in its General Comment No.1. (Sandland, 2017).

### 2.3. Northern Ireland statutory provisions

The Mental Capacity Act (NI) 2016 does not in general apply to children under 16 years old.[4] The decision to limit the scope of the MCA (NI) to those aged 16 and over was because it was the age identified as an important threshold at which young people can for the first time make many of the important decisions in life such as deciding to leave home, to leave school, or to marry (the latter with parental assent) (Black, 2012).[5] There is thus no statute in Northern Ireland relating to the mental capacity of children under 16, with this important area being left to the common law. The legal capacity of those under 16 is determined by other statutes and by case law: in particular, by the Children (Northern Ireland) Order 1995, the Criminal Justice Act (Northern Ireland) 1966, and the Age of Majority Act (Northern Ireland) 1969.

The Children (Northern Ireland) Order 1995 is the principal statute governing the care, upbringing and protection of children in Northern Ireland. In determining any question with respect to the upbringing of a child, or its property or income, a court must have the child's 'welfare' as its paramount consideration.[6] In making, varying, or discharging residence, contact or other Orders with respect to children, the court must have particular regard to 'the ascertainable wishes and feelings of the child concerned (in the light of his age and understanding)".[7] The Children Order thus recognises the evolving developmental capacity of the child, but does not legislate with respect to the legal capacity of a child, nor does it address issues arising from a lack of mental capacity. In other words, while the wishes and feelings of the child are important, and the child's welfare is paramount, the Children Order does not fully ensure that the legal capacity of a child, including the right to make decisions if they have the relevant mental capacity, is protected.

The Criminal Justice (Children) (Northern Ireland) Order 1998 sets the minimum age of criminal responsibility at 10 years old.[8] The UN Committee on the Rights of the Child UNCRC [2019][9] stated that maturity is still evolving in children aged 12 to 13 and they are therefore "unlikely to understand the impact of their actions or to comprehend criminal proceedings". There have been calls for this to be reviewed in the rest of the UK jurisdictions, including in Northern Ireland (Anderson, 2022).

The Age of Majority Act (Northern Ireland) 1969 sets the age of majority in Northern Ireland at 18 and establishes that consent by persons over 16 to surgical, medical and dental treatment is effective:

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. (Section 4(1)).

In the current period of phased implementation of the MCA(NI), that

[4] "1.—(1) The principles in subsections (2) to (5) must be complied with where for any purpose of this Act a determination falls to be made of whether a person who is 16 or over lacks capacity in relation to a matter." However, in exercising its powers under Part 10 of the Act relating to criminal justice, the court is not necessarily restricted by a requirement for a lack of capacity.

[5] For an overview of the issues and various positions taken in the development of the legislation, see Black, L.-A. (2012). *The Mental Capacity Bill and Children under 16*. Northern Ireland Assembly Research and Information Service, NIAR 366–12, (2012).

[6] Children (Northern Ireland) Order 1995, 3(1).

[7] Children (Northern Ireland) Order 1995, 4 and 3(a).

[8] Article 3: "It shall be conclusively presumed that no child under the age of 10 can be guilty of an offence."

[9] UN Committee on the Rights of the Child (2019), General Comment, no. 24, para 22.

from 2019 until the time of writing in late 2022, the Mental Health (NI) Order 1986 continues to apply in many circumstances, including in full and as amended to children under the age of 16.

There is currently no statutory coverage of issues of mental capacity of under 16 s in Northern Ireland, nor where their legal capacity is determined as being related to their mental capacity or developmental capacity. Case law relating to 'Gillick competence' does consider issues relating to the evolving developmental capacity of a child under 16 and allows specific legal capacity on this basis. Clarity and consistency about the mental capacity of under 16 s would be helpful to promote understanding, accessibility and best practice but also has the attraction of addressing the potential discrimination of continuing to rely on the Mental Health (NI) Order 1986.

### 2.4. Case-law considerations

Case-law has established that a child under 16 can be recognised as having the legal capacity to make decisions for themselves if they are assessed as being 'Gillick Competent'. The term was coined from *Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL)*, where the court determined that a child under 16-years-old could consent to medical treatment if the child has sufficient understanding and intelligence to make the relevant decision. So, if a young person under 16-years-old is found to be Gillick Competent, then they can consent to a specific medical treatment. However, it does not allow them to refuse a specific treatment – notwithstanding the fact that to decide for one thing is usually to decide against another. For all children, including those aged 16 and 17, in some circumstances, their treatment decisions can still be overridden by the courts.[10]

There have been a number of significant recent developments in UK case law with respect to Gillick competence and emerging capacity. Mr. Justice Cobb considered in *Re S (A Child) (Child Parent: Adoption Consent) [2019] 2 Fam 177* the competence of a mother under the age of 16 to consent to her baby being placed for adoption. Mr. Cobb held that it was appropriate and helpful in determining Gillick competence to read across and borrow from the relevant concepts and language in the England & Wales Mental Capacity Act 2005, but cognisant of some fundamental differences, in particular that the assumption of capacity in section 1(2) of the Act did not apply, and there was no requirement for any impairment or disturbance in the functioning of the mind or brain as there is in section 2(1) of the Mental Capacity Act 2005.

*Bell and another* vs *The Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274* determined whether informed consent in the legal sense can be given by children and young people in regard to puberty blockers. Professor Scott (Director of University College London's Institute of Cognitive Neuroscience) reported that, "All the evidence we have suggests that the complex, emotionally charged decisions required to engage with this treatment are not yet acquired as a skill at this age (adolescence), both in terms of brain maturation and in terms of behaviour."

Dame Victoria Sharp, sitting with Lord Justice Lewis and Mrs. Justice Lieven, considered that the question as to whether a person under the age of 16-years is Gillick-competent to make the relevant decision will depend on the nature of the treatment proposed as well as that person's individual characteristics. The assessment is necessarily an individual one. Where the decision is significant and life changing then there is a greater onus to ensure that the child understands and is able to weigh the information. Efforts should be made to allow the child or young person to achieve Gillick competency where that is possible.

In order to achieve Gillick competence it is important not to set the bar too high. It is not appropriate to equate the matters that a clinician needs to explain to the matters that a child needs to understand to achieve Gillick competence. A person should be able to "understand an explanation of that information in broad terms and simple language". The child or young person needs to be able to demonstrate sufficient understanding of the salient facts. In deciding what facts are salient and what level of understanding is sufficient, it is necessary to have regard to matters which are those which objectively ought to be given weight in the future although the child might be unconcerned about them now.

Dame Sharp concluded: "Given the long-term consequences of the clinical interventions at issue in this case and given that the treatment is as yet innovative and experimental, we recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment."

It should be noted that this judgment was then appealed by the Tavistock and Portman NHS Foundation Trust and the Court of Appeal concluded that, as the Divisional Court had not concluded the Tavistock's policies and practices were unlawful, it was not in a position to provide guidance on determining consent.[11]

In addition to the case law relevant to the complexities of determining a child's competence, a further recent case has addressed the relevance of parental consent to whether an under 18 year old is deprived of their liberty. On 26 September 2019, the UK Supreme Court (Re D (A Child) {2019} UKSC 42), provided a decision in relation to deprivation of liberty and young people aged 16 and 17-years-old, changing how far parental responsibility can be interpreted in respect to deprivation of liberty. This means that for a young person 16 & 17-years-old, who lacks capacity, a parent/guardian cannot provide consent for Deprivation of Liberty. It was concluded that it was not within the scope of parental responsibility for D's parents to consent to a placement which deprived him of his liberty. For under 16 s the question on whether the child is confined and whether there is a valid consent for a confinement is less clear. In the recent case of Re D, Lady Hale stated that the situation for those under 16 was not considered by the Supreme Court but she acknowledged that the conclusion she reached in relation to those over 16-years-old could logically also apply to younger children whose liberty was restricted to an extent which was not normal for his or her age.

In conclusion, case law provides an ongoing and contested framework for considering emerging developmental capacity in under 16 s. There is still relatively little clarity on how to determine Gillick competence but some judges are adapting the functional test for lacking mental capacity to assess competence. Whilst parents as substitute decision-makers may seem prima facie appropriate for children up to the age of 10 or 11, between the ages of 12 and 15 seems more complex and uncertain and, although not directly considered in Re D, the scope of parental consent for those under 16 may need to be further explored.

## 3. Legal change without law reform for children under 16: the overshadowing of the Mental Health (Northern Ireland) Order 1986 by the Mental Capacity Act (Northern Ireland) 2016

The Mental Capacity Act (Northern Ireland) 2016 [MCA(NI)] is an example of 'fused' mental health and capacity legislation. It is a generic law defining a lack of mental capacity and it is applicable, inter alia, to all health and social care decisions where an intervention is proposed, consent is required, and the person lacks mental capacity. Before its introduction, there was no statute in Northern Ireland governing interventions for people who lacked the mental capacity to consent. Decisions were previously taken under common law based on the presumption of capacity and the doctrine of necessity (best interests) or resolved in the High Court. Criteria for the involuntary treatment of those with mental illness were laid out in the Mental Health (Northern

[10] Re M (A Child) (Refusal of Medical Treatment) [1999]; Re W (A minor) (Medical treatment court's jurisdiction) [1992] 3 WLR 758; Re X (A Child) (No 2): An NHS Trust v X [2021] EWHC 65 (Fam)

[11] Bell and another -v- The Tavistock and Portman NHS Foundation Trust and others [2021] EWCA Civ 1363 Appeal No. C1/2020/2142

Ireland) Order 1986 (MHO) and were based on mental disorder ('mental illness, mental handicap and any other disorder or disability of mind'[12]) and risk (failure to detain leading to a substantial risk of serious physical harm to self or others),[13] with no requirement for consent or the capacity to decide. The MHO applies to all ages, including children under 16. This means that many decisions about the care and treatment of children under 16 continue to be made without legal requirement for consideration and/or respect for their mental capacity although the Code of Practice for the MHO does provide some guidance.[14]

In chapter 4 of its report "A comprehensive legal framework for mental health and learning disability" , the Bamford Review of Mental Health and Learning Disability (2007) articulated a set of well-known principles (autonomy, justice, benefit, least harm) which should provide a sound ethical basis for new legislation. These principles 'recognise and support the dignity of the person' *without distinction or reservation with respect to age*, whilst also accepting the need to balance tensions between the principles. The Report noted the 'overlap' of capacity issues with 'the needs of children', in particular as those needs are protected in other legislation. The Bamford Review accepted that:

Legislation for mental disorders which is based on substitute decision-making has particular implications for the interface with Children's legislation since children reach decision-making capacity at different stages in their development, their parents have special rights and responsibilities with regard to them and there is already legislation which applies to welfare. … A small number of children and young people will also require the support of specific legislation and the proposed principles for legislation recognise their particular needs. (5.44).

The Review recommended specific legislation based on the same principles to supplement existing legislation relating to child welfare with 'special rights and protection' for children and young people who may fall under the proposed legislative approach (5.52). However, the Review did not articulate a clear vision of how the principles would apply in such new children's legislation. This absence of detail on legislative reform for children and young people is shared with the early academic literature around a 'fusion' approach (Dawson & Szmukler, 2006; Szmukler, Daw, & Dawson, 2010) and on mental health/capacity law reform in Northern Ireland (McCallion & O'hare, 2010; Niwa, 2007).

Following a public consultation in 2011, it was decided to fuse mental capacity and mental health law into a single bill. By putting impaired mental capacity at the heart of all non-consensual interventions and treating mental and physical conditions equally under the law, the stigma and discrimination associated with separate mental health legislation is reduced, with respect accorded to a person's autonomy and decision-making capacity regardless of whether he/she has a physical or mental illness. However, the complexity of the interactions of legal provisions for impaired mental capacity *for all* with those for children with insufficiently developed developmental capacity were acknowledged but perhaps viewed as too complex to address at that time.

The Act, which received Royal assent in 2016, puts into statute the common law definition of necessity and protects the person (D) doing the act from liability if D takes reasonable steps to establish whether the person (P) lacks capacity in relation to the matter in question and D reasonably believes that it is in P's best interests for the act to be done. It contains general safeguards to protect the person's right to take his/her own decision, with additional safeguards for more serious interventions such as compulsory treatment with serious consequences, deprivation of liberty, and community residence requirements. These safeguards include formal assessment of capacity, consultation with a nominated person, requirement for a second opinion, authorisation procedures, provision of independent advocacy support, and review by a tribunal.

The MCA(NI) is arguably more compatible with international human rights standards than the common law and Mental Health (NI) Order 1986 combination it aims to replace, particularly with respect to key European Convention on Human Rights (ECHR) obligations which it was in part specifically designed to meet.[15] However, as the MCA(NI) does not apply to those under the age of 16, the claim that the Act addresses the discriminatory nature of the Mental Health (NI) Order 1986 is somewhat undermined. The MHO (1986) continues to be in place for those under the age of 16 who require involuntary assessment and/or treatment in hospital for mental disorder. Thus, a piece of legislation which is seen to be discriminatory and stigmatising for adults is kept in place for children under the age of 16, a position which appears neither consistent nor sustainable.

### 3.1. Amendment of MHO by and in the light of MCA(NI)

The MHO remains in effect for children under 16 and there is no lack of mental capacity required for a child to be subject to this legislation. The core principle of the MCA(NI) of no compulsion other than on the basis of a lack of mental capacity, does not apply to children under 16. This retention of the MHO means that the issue of disability discrimination on the basis of mental disability remains for children under 16. A straightforward application of the MCA(NI) to people under 16 may not give sufficient regard to Article 3 of the UNCRC and Article 7 of the UNCRPD. Both reinforce that the best interests of the child should be the primary consideration. However, Article 3(2) of the UNCRC also requires States Parties "to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her'. Article 7(1) of the UNCRPD also requires States Parties to "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."

The MHO has been amended by Schedule 8 of the MCA(NI) to include a section relating to the 'Best interests of a patient under 16'. This adds the requirement that when someone is responsible for the treatment or care of a patient under 16, their 'primary consideration' must be the patient's best interests' (section 3A).[16] Section 3B articulates what must be done in the determination of a patient's best interests. These procedural and principled requirements closely mirror those of Section 7 of the MCA(NI) on establishing what is in a person's best interests when that Act is being applied,[17] but there are significant differences which aim to recognise to some extent the evolving developmental capacity of the child.

### 3.2. Participation in determination of their best interests

An expanded article 3B(5) of the MHO differs from the corresponding section 7(5) of the MCA(NI) on participation in best interest determinations which requires that the person should be encouraged and helped to participate as fully as possible in the determination of their

[12] Mental Health (Northern Ireland) Order 1986 Article 3(1)

[13] Mental Health (Northern Ireland) Order 1986 Article 4(2)

[14] Mental Health (Northern Ireland) Order 1986 Code of Practice paragraph 5.20 (a) Children under the age of 16 years who have 'sufficient understanding and intelligence' can take decisions about their own medical treatment in the same way as adults. Otherwise the permission of parents or guardians must be sought…If the parents or guardians do not consent to treatment, consideration should be given to both the use of child care legislation and the Order.

[15] See HL v United Kingdom (45,508/99), the 'Bournewood' case.

[16] Mental Capacity Act (Northern Ireland) 2016, Schedule 8 'Amendments of Mental Health Order', paragraph 4, 'General provisions about patients under 16', available at: https://www.legislation.gov.uk/nia/2016/18/schedule/8/enacted

[17] Mental Capacity Act (Northern Ireland) 2016, section 7. Available at: https://www.legislation.gov.uk/nia/2016/18/part/1/crossheading/establishing-what-is-in-a-persons-best-interests/enacted

best interests. Article 3B(5)(a) requires that the person making the best interest determination must, so far as reasonably practicable, encourage and help the child so as *to improve* their ability to participate in any decision about their care and treatment. This is the case even where the child does not have the legal capacity to make the decision in question themselves. The effect of this provision is arguably to not only require supportive interventions, but educative and formative interventions which aim at maximising developmental capacity. An interpretation bolstered by MHO 3B(5)(b) which requires that the child be provided 'in an appropriate way with information and advice about the treatment or care', even though within the MHO they cannot be recognised as having the legal capacity or mental capacity to make the decision themselves.

Article (12)3 of the UNCRPD requires that States Parties 'take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'. Whilst such support may often be given in practice, there is no clear legal requirement for such support for under 16 s in the MHO matching the requirement of the MCA(NI) for over 16 s.

### 3.3. Determination of best interests

Section 7(2) of the MCA(NI) negatively rules out making a determination of best interests 'merely' on the basis of age. Section 3B(2) of the MHO differs in that the person making the determination must 'take into account C's age'. This appears to open space for weight to be given in practice to the developing decision-making capacity of the child, particularly in the light of the requirement that 'special regard' be given to the child's 'past and present wishes and feelings' and their 'beliefs and values' (MHO, article 3B(6)). Although not granting legal capacity to the child, these provisions are likely generative of a coherence of the content of a decision on the child's best interests with the decision the child wishes to or would make. MHO article 3B6(a) requires that special regard be given to 'any relevant written statement' made by the child, but unlike under the MCA(NI), there is no requirement on the child that she or he had mental capacity when making such a written statement. MHO article 3B6(b) simply refers to the child's 'beliefs and values' which is broader in applicability than the MCA(NI)'s 'the beliefs and values that would be likely to influence P's decision if P had capacity' (7(6)(b)). MCA(NI) imposes a requirement that special regard also be given to 'the other factors that P would be likely to consider if able to do so' (7(6)(c)), but this is not in the amended MHO. Considerations of mental capacity are effectively removed from the MHO version of these MCA(NI) clauses, but in a way that strives to recognise the developing nature of the child's decision capacity.

There is no doubt that the addition of these best interest requirements to the MHO adds safeguards for children under 16. However, the full range of key safeguards provided in the MCA(NI) for people over 16 are not provided. Only the requirement for the provision of an independent advocate is also in place in the amended MHO.

Other relevant legislation that governs the response to, and services provided for, children in need of support or at risk of harm includes the Children Order (Northern Ireland) 1995. In general, the Children Order applies to a person under 18. This legislation imposes a duty on Health and Social Care Trusts to provide a range of services for children defined as being 'in need'. Within the legislation, there are various legal options (e.g. Article 63, Emergency Protection order; Article 50, Care Order) which require an application to the Court and satisfying of 3 elements (threshold of significant harm, consideration of all other options and the best interests of the child). The concept of best interests is therefore already an important aspect of the current approach under the Children Order but a potentially more complex issue is the role of parental responsibility which is defined under Article 6(1) 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". In most cases, those with parental responsibility are entitled to make decisions about a child's welfare including about education, health care and other interventions, although this can depend on the nature of the proposed intervention, and the age and understanding of the child. The Re D judgment considered above, although focused on 16/17 year olds, does suggest the scope of parental decision making should also be more limited for those under 16.

Facilitating the meaningful participation of the child in conformity with Article 12 of the UNCRC is seen as a vital part of processes under the MHO. Whilst the issue of capacity is not mentioned, judgments have referred to the child's ability to give informed views varying according to the individual intelligence of the child and the circumstances of the case, with the child's views not being elevated above his welfare and best interests.

## 4. Neurodevelopment, the emerging developmental capacity of children under 16, and their implications for good law

Decision-making is an emerging capacity in young people, which develops according to their age and stage of development and encompasses both cognitive processes and emotional maturity. Adolescence is the period between childhood and adulthood during which it is assumed that a typically developing person acquires the ability to make autonomous decisions. Cognitive neuroscience and developmental psychology can inform our understanding of how a young person's developmental capacity emerges, in line with their cognitive and emotional development (Blakemore & Robbins, 2012). It is therefore important to incorporate this understanding of developmental capacity into legislation that governs a young person's legal capacity. In what follows, some key research findings are highlighted to illustrate this point, however a comprehensive review of the full range of research in the area of adolescent brain development is beyond the scope of this paper.

There have been significant advances in our understanding of adolescent brain development, over the last thirty years. This is partially attributable to the development of new brain imaging techniques, such as Magnetic Resonance Imaging [MRI]. Historically, the scientific consensus was that the first 8 years of childhood, were the most critical period of brain development, after which there was relatively limited further development. However, the current scientific consensus accepts there is a second period of substantial brain development in adolescence; this is a complex process that starts at the onset of puberty and continues into the mid-twenties. These changes in the adolescent brain are visible on MRI with significant changes in the grey and white matter components of the brain. MRI scans also demonstrate the activation of brain regions significantly differs between adolescents and adults, when they are completing the same tasks. Furthermore, the adolescent brain is now recognised to be highly plastic and having more capacity, relative to the adult brain, for positive change with well-targeted interventions. The implications of these adolescent brain changes include a substantial predisposition towards; taking risks versus safety, a preoccupation with peer influence and hypersensitivity to social exclusion.

Furthermore, Logical reasoning and information processing is not thought to develop much beyond mid-adolescence (Kuhn, 2009); thus it would be reasonable to expect that a typically developing young person, could well have acquired the capacity to understand, retain, use and weigh and communicate all the relevant information in respect of a specific decision by mid-adolescence. However these 'mental capacity' abilities are not the only skills required for decision-making. From a neurodevelopmental perspective, the ongoing development of executive functioning (the capacity to control and co-ordinate our thoughts and behaviour) and social cognition, throughout adolescence, would seem to have the biggest implications for a young person's capacity to make decisions (Blakemore & Choudhury, 2006). The *weigh* and *appreciate* elements of the capacity test are likely to be most affected by the ongoing development of the adolescent brain in these areas.

Adolescence is a time characterised by increased risk taking, a reduction in emotional regulation ability, and a tendency to attend preferentially to immediate rewards (especially social ones) in decision-

making as opposed to future consequences (Steinberg et al., 2018). Contrary to previous thinking, it is now understood that the brain is still developing during adolescence, and structural and functional changes (particularly in regions involved in social cognition and self-awareness) continue into the early twenties (Blakemore, 2012). The following findings in cognitive neuroscience research all have important implications for young people's ability to *weigh* and *appreciate* relevant information in respect of particular decisions: 'reward' areas of the brain are hypersensitive in adolescence, which increases risk taking, particularly in the presence of peers (Chein, Albert, O'Brien, Uckert, & Steinberg, 2011); young people's ability to inhibit their responses improves throughout adolescence Casey et al., 1997); there is evidence to suggest that adolescent decision making capacity is influenced by the emotional context of that decision - 'hot' context (situations of high emotional arousal) decision making capacity is poorer when compared to adults (Casey, Jones, & Hare, 2008).

On the basis of findings such as these, Sawyer, Azzopardi, Wickremarathne, and Patton (2018) argue in a recent Lancet editorial that "an expanded and more inclusive definition of adolescence is essential for developmentally appropriate framing of laws, social policies, and service systems". They suggest that an age range of 10–24 years of age would be a more appropriate definition of adolescence, which aligns with our contemporary understanding of biological, psychological and social transitions during adolescent growth.

Research into brain development throughout adolescence can make generalisations across groups of subjects at particular ages but there may be considerable variation between individuals. Young people involved with the criminal justice system or those with a mental health problem have a higher prevalence of neurodevelopmental disorders (Einfeld, Ellis, & Emerson, 2011; Hughes, Williams, Chitsabesan, Davies, & Mounce, 2012) and therefore are more likely to have impairments in their decision-making capacity than age matched peers. A clear legal capacity to be criminally responsible which is set at an age under 16 may well fail to deliver justice because it pays too little attention to the evidence of neuroscience.

## 5. Some possible approaches to the positive development of the law in Northern Ireland relating to decision-making of and for children under 16

There have been a number of key developments in children's rights, disability rights, and the relevant case law that reinforce the need for change to the current legal framework. It is less clear, however, exactly what that change should involve and so a number of possible alternative approaches are considered below. One approach considered during the development of the Mental Capacity Act (Northern Ireland) 2016 was to use it to consolidate all law relating to the decision-making capacity of children. However, the legal and neurodevelopmental issues considered above perhaps indicate that a more nuanced and multi-statute approach may better serve the best interests of children. The options presented here are thus indicative only of a range of approaches, several of which may be combined in various ways in constructive law reform for Northern Ireland.

These include: (1) retaining the current combination of statute law but developing new guidance to inform practice for those aged under 16; (2) codifying Gillick to clarify under what circumstances those aged under 16 can accept, and possibly also refuse, interventions; (3) amend the Children (Northern Ireland) Order 1995 to provide a more comprehensive framework for health and welfare decision making; (4) amend and extend the Mental Capacity Act (Northern Ireland) 2016 to apply to those aged under 16; and (5) develop a new law specifically focused on the emerging capacity of those aged under 16. For each one some of the potential strengths, complexities and limitations are identified. These may not be all of the possible approaches and it may be a combination of changes is needed but they hopefully provide alternatives to further inform the discussion of the changes that are needed.

### 5.1. Retaining the current law with new guidance to inform practice for children under 16

The possible strengths of retaining the current law and providing additional guidance is that it could be achievable relatively quickly and should not require substantial additional resources. It would also have the potential to clarify the requirements of the existing laws and promote good and more consistent practice across all the aspects of society where these processes are relevant. The combination of existing laws should already be familiar to those involved and so the process of introducing additional guidance should be relatively straightforward. The limitations of this approach are mainly that it would not address any of the main drivers for change. This approach would not address the discrimination identified by the Bamford Review, in having a separate mental health law which can enable compulsory intervention regardless of capacity. It also would not address the requirements of the UNCRPD to no longer have legal frameworks which are based on disability as a criterion for compulsory intervention instead of functional approaches which apply to all. More specifically it would not address the issues raised by the judgment in De D for 16 and 17 years olds, if that logic is extended to those aged under 16, so that it is not within the scope of parental responsibility to provide consent to interventions which involve deprivation of liberty.

### 5.2. Consolidating restrictions on legal capacity based on developmental capacity

It is not clear how section 4(1) of the Age of Majority Act (Northern Ireland) 1969 and the Gillick standard interrelate. Both seek to recognise the developing capacity of a child to make decisions relating to healthcare. To have legal capacity set by statute at 16 and over for consent to surgical, medical and dental treatment and yet also have a common law test which could in principle find someone under 16 as capable of consent is perhaps workable, but fails to provide the clarity of good law. It would arguably be better to have a single statute that both: (1) defines the age at which full legal capacity for such decisions is attained; and (2) covers how the developing capacity of children under that age should be managed. This could partly be achieved through a codification of Gillick and some of the case law relating to it. This could involve, for example, updating and extending the current Department of Health's 2003 guidance on consent[18] although this is focused on consent for examination, treatment or care and so the scope would be narrower than the potential guidance considered above in 5.1. A more robust approach could also involve consideration of placing Gillick competence within a statutory framework. A potentially very helpful approach has been recommended by the Joint Committee on the draft Mental Health Bill (for England and Wales). In its report[19] in January 2023 it recommended that "The Government should consult on the introduction of a statutory test for competency, or 'child capacity', for children under 16. This consultation should be wide ranging and consider the wider implications of this reform on other areas of law affecting children." (para. 222).

### 5.3. Amendment of the children (Northern Ireland) order 1995

The Children (Northern Ireland) Order 1995 could be amended to consolidate all legislation and case law relating to the legal, mental and decision-making capacity of children under 16. The main strength of

[18] Department of Health, Social Services and Public Safety (2003) Seeking consent: Workingwith children. Belfast: DHSSPS.

[19] House of Commons and House of Lords Joint Committee on the Draft Mental Health Bill (2023) Draft Mental Health Bill 2022. Report of Session 2022–23. Available online at https://committees.parliament.uk/committee/605/joint-committee-on-the-draft-mental-health-bill/

addressing issues within an amended law for children is that it would have the potential to replace a discriminatory mental health law, clarify the role and limitations of parental responsibility and potentially harmonise the wider legislative framework for children under 16, including Gillick, the Age of Majority Act (NI) 1969 and the Criminal Justice (Children) (Northern Ireland) Order 1998. It is also an existing and relatively familiar legal framework so the process of change may not be so complex. Such a reform could consolidate and reform the range of existing legal provisions relating to legal capacity based on developmental capacity. A reformed Children Order could create provisions for where a child lacks mental capacity, or such situations could be dealt with in an extended Mental Capacity Act (Northern Ireland) 2016.

### 5.4. Extension of the Mental Capacity Act (Northern Ireland) 2016

The immediate strength of extending the Mental Capacity Act (Northern Ireland) 2016 is that it responds to the need to address the potential discrimination of mental health law, the requirements of developing case law, and the obligations of the UNCRPD.

A possible approach is to use an extended MCA(NI) to cover situations where a child lacks developmental capacity, where they lack mental capacity (as defined by MCA(NI), or both. Alternatively, the Act could be retained in full for those over 16 and extended to all children under 16 who lack mental capacity because they are 'unable to make a decision for himself or herself about the matter … because of an impairment of, or a disturbance in the functioning of, the mind or brain' (Section 3(2)(a)). This would recognise the 'double vulnerability' of some children under 16.

The Mental Capacity Act (Northern Ireland) 2016 could be amended such that its scope is no longer limited to people 16 and over (section 1 (1)). The presumption of 'mental capacity' in MCA(NI) (section 1(2)) would not need amending if there was another legal basis setting legal capacity on the basis of age, or for determining the presence of developmental capacity warranting a recognition of legal capacity.

If the requirement for a causative impairment or disturbance were removed, then the Act would apply to all children who lack developmental, mental capacity, or both. This would make the safeguards in the Act available to all children, not just those with a mental impairment or disturbance. It is unlikely that the financial and human resources for this would be proportionate or available.

### 5.5. Development of a new comprehensive law relating to the developmental, mental, and legal capacity of those aged under 16

The most comprehensive approach could be to develop a new law specifically focused on the developmental capacity, mental capacity, and legal capacity of people under 16. Potentially this would also be the opportunity to create a unified and consistent legislative approach to emerging capacity across health, social and criminal matters. This would have the obvious advantage of providing a more comprehensive legal framework for those aged under 16 but it could still create tensions with the current or amended Children Order. Another issue could be that if it essentially created the equivalent of the Mental Capacity Act (Northern Ireland) 2016 then why not extend it, and if it created a different framework then the differences would need to be clearly justified.

## 6. Conclusion

While the prevailing assumption is that most young children have significant difficulties in making relevant decisions affecting their lives, the evidence from recent research in child development (reviewed above) reveals the nuanced nature of these issues and why this is so. The complexity of the debates about the associated legal framework is perhaps in part a reflection of the complex nature of developing decision-making capacity itself.

Reforming the law in Northern Ireland relating to the legal capacity of children is therefore also complex. Whilst there may be benefits in consolidating and simplifying the legal framework, care must be taken to ensure that this fully reflects the complexity of the issues and is in the best interests of children where both a still developing capacity to make decisions and a lack of mental capacity are in play with respect to a particular decision. How to address developmental capacity may present specific challenges.

In being the first legal jurisdiction to pass 'fusion' legislation, Northern Ireland is implementing an approach to mental health/mental capacity law that is attracting increasing interest around the world. The Mental Capacity Act (Northern Ireland) 2016 was the product of close working on the part of government, politicians, the community and voluntary sector, and professional organisations whose members are deeply engaged in its implementation in practice (in particular, psychiatrists and social workers). A similar effort to secure the extension of the principles and safeguards of the Act to children under 16 could also represent important progress in promoting and protecting the rights of all.

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