Mental health and capacity laws in Northern Ireland

Examining the position of children and young people

MENTAL HEALTH AND CAPACITY LAWS IN NORTHERN IRELAND: EXAMINING THE POSITION OF CHILDREN AND YOUNG PEOPLE

Anne-Maree Farrell,[*] Elizabeth Agnew,[+] Patrick Hann[#]

Accepted for Publication: 3 October 2024

ABSTRACT

Mental health and capacity laws applicable to children and young people in Northern Ireland lack clarity and coherence, with significant gaps in service provision and safeguarding. Drawing on an examination of such laws, we argue that law reform is needed. In the short term, we suggest there is merit in publishing statutory guidance, such as a Code of Practice, to address both the issue of evolving capacity in children, and to facilitate best practice in policy and practice. This modest reform in the short term should be accompanied by a firm political commitment to ensuring that Northern Ireland's innovative fusion mental capacity legislation is fully brought into force in the medium term. Law reform should form part of a holistic approach on the part of Northern Ireland's policy-makers towards improving mental healthcare provision for children and young people in line with a human rights-based approach. This would include the following: increased allocation of funding and resources to facilitate more timely access to suitable treatment and related services; enhancing participation in policy, judicial and clinical decision-making that impacts their lives; and employing a range of executive accountability mechanisms to drive improvements in such provision over time.

KEYWORDS children – human rights – mental capacity – mental health law – Northern Ireland – young people

*Edinburgh Law School, University of Edinburgh, UK; +School of Law, Queen's University Belfast, UK; #Royal Victoria Hospital, Belfast Health and Social Care Trust, Belfast, UK. Note that an earlier version of this article was presented by the second author at the Northern/Ireland Health Law and Ethics Network on 24 June 2021. The authors would like to acknowledge the helpful feedback received at the workshop, as well as that provided by the anonymous journal reviewers. The research for this paper was undertaken as part of a Wellcome funded project, 'A Research Network in Healthcare Law, Policy and Ethics on the island of Ireland' (218831/A/19/Z). The support of Wellcome is gratefully acknowledged.

I.INTRODUCTION

Rates of mental ill-health among children and young people in Northern Ireland (NI) are high, with 11% being at risk of emotional and behaviour problems; 1 in 8 experiencing emotional difficulties; and 1 in 10 conduct problems.[1] While the prevalence of mental illness in this population is broadly similar to other parts of the UK,[2] it is complicated by significant socio-economic deprivation,[3] as well as the legacy of decades of violent sectarian conflict which have contributed to inter-generational trauma, adversely affecting family relationships.[4] Indeed, it has been estimated that over 40% of young people in NI live with parents who have 'high or moderate experience of the conflict', placing them at significant risk of poor mental health.[5] For many years, it has been difficult to ascertain the extent of mental ill-health amongst this population, in the absence of the systematic collection and evaluation of available data. It is a state of affairs that has been the subject of ongoing criticism on the part of the NI Commissioner for Children and Young People (NICCY).[6] However, recently published survey data has identified over 45% of those aged 16 years as having 'a probable mental illness'.[7] This is in addition to 25% of referrals to NI child and adolescent mental health service (CAMHS) being

[1] L Bunting et al, Rationale and Methods of the "Northern Ireland Youth Wellbeing Survey" and Initial Findings from the Strengths and Difficulties Questionnaire' (2022) 27(3) Clinical Child Psychology and Psychiatry 670, 680-2.
[2] N Bond and S O'Neill, Factors Affecting Mental Health and Wellbeing in Children and Young People in Northern Ireland (Office of the Mental Health Champion for Northern Ireland, 2023) 2.
[3] Report of the Children's Commissioners of the United Kingdom of Great Britain and Northern Ireland to the United Nations Committee on the Rights of the Child, December 2020, 30 <https://www.childcomwales.org.uk/wp-content/uploads/2020/12/UN-report-2020-examination-.pdf>, accessed 12 August 2024.
[4] S McAlister, P Scraton and D Haydon, 'Childhood in Transition: Growing up in 'Post-Conflict' Northern Ireland' (2014) 12(3) Children's Geographies 297-331; F Ferry, E Ennis, B Bunting et al, 'Exposure to Trauma and Mental Health Service Engagement Among Adults who were Children of the Northern Ireland Troubles of 1968 to 1998' (2017) 30 Journal of Traumatic Stress 593.
[5] E Fitzgerald et al, *The Transgenerational Impact of 'The Troubles' in Northern Ireland*, School of Psychology, Queens University Belfast, 1-2 <https://www.qub.ac.uk/schools/psy/files/Filetoupload,784073,en.pdf > accessed 12 February 2024; S Thompson, 'Trauma from Troubles Evident in Higher Rates of Mental Health Problems among Young People in Northern Ireland' *The Irish Times*, 7 March 2023.
[6] NI Commissioner for Children and Young People (NICCY), 'Still Waiting- Implementation NICCY Progress Update Monitoring Report', 4 February 2023 <https://www.niccy.org/mental-health-review-still-waiting/> accessed 12 August 2024; see also G Davidson et al, 'Comparing Mental Health and Mental Capacity Law Data Across Borders: Challenges and Opportunities' (2024) 92 Intl J Law Psych 101949.
[7] Bond and O'Neill (n 2) 10.

categorised as 'emergency or urgent', compared with 10% for the rest of the UK.[8] Waiting lists for CAMHS have also significantly increased in the wake of the Covid-19 pandemic, with many waiting for significant periods of time for access to treatment or otherwise being rejected for referral to CAMHS.[9] While the current NI Mental Health Strategy expresses a commitment to increasing access to, as well as funding for, mental healthcare provision for children and young people,[10] the most recent report of the NICCY has highlighted that there is still a long way to go towards realising this commitment in practice. This is against a background of longstanding institutional fragmentation, chronic under-funding and poorly resourced service provision of mental health services more generally.[11] It is no exaggeration to say that mental healthcare provision for children and young people has been, and continues to be, in a state of crisis in NI,[12] against a background where the overall cost of mental ill-health in NI is estimated to be at least £3.4 billion.[13]

Compounding these problems is the current dysfunctional state of NI's mental health and capacity laws applicable to children and young people. While there is a voluminous literature examining mental health and capacity law in other jurisdictions in the UK, such as England

[8] NI Department of Health, Regional Mental Health Crisis Service Implementation Plan, 2021-2031 <https://www.health-ni.gov.uk/publications/mental-health-strategy-2021-2031> accessed 12 August 2024.
[9] At the time of writing, the overall number of children waiting for CAMHS is currently the highest it has been since NICCY started monitoring waiting times in 2017, see NICCY (n 6) 5.
[10] NI Department of Health, Mental Health Strategy 2021-2031, <https://www.health-ni.gov.uk/publications/mental-health-strategy-2021-2031> accessed 12 August 2024. Note there is a commitment to increasing funding for NI CAMHS to 10% of adult mental health funding, see NI Department of Health, Mental Health Strategy 2021-2031, Delivery Plan 2023/24, Action Point 10 <https://www.health-ni.gov.uk/publications/mental-health-strategy-2021-2031> accessed 12 August 2024.
[11] Report of the Children's Commissioners (n 3) 25-27.
[12] B Campbell, 'Calls for Ring-Fenced Funding as Young People Struggle to Access Mental Health Services' Belfast Telegraph, 9 February 2023.
[13] NI Audit Office, *Mental Health Services in Northern Ireland* (NI Audit Office, 2023) 20, drawing on a 2019 cost estimate reported in D McDaid et al, The Economic Case for Investing in the Prevention of Mental Health Conditions in the UK (LSE, 2022).

and Wales,[14] as well as healthcare decision-making involving children and young people,[15] how such analyses intersect with the NI legal framework have been significantly under-researched in the health law literature to date and this article seeks to make an original contribution in this regard. Drawing primarily on an examination of two key pieces of legislation – the Mental Health (Northern Ireland) Order 1986 (MHO),[16] and the Mental Capacity Act (Northern Ireland) 2016 (MCANI)[17] – we argue that such laws lack clarity and coherence, with significant gaps in service provision and safeguarding. In making such an argument, we recognise that a range of proposals have been made to date with respect to reforming the existing legal framework.[18] However, we are concerned that they are too ambitious to be realised in the short to medium term. This is due to persistent political dysfunction in NI, which is unique in the UK setting, and is attributable to the legacy of a violent sectarian conflict, colloquially known as 'The Troubles', which lasted 25 years in the closing decades of the twentieth century.[19] Notwithstanding a peace agreement bringing the conflict to an end over twenty-five years ago,[20] there have been successive collapses of NI power-sharing institutions since such time due to ongoing sectarian political divisions. During periods when such institutions were not operating, direct rule by the UK government was re-imposed. The cumulative effect over time of such political instability has led to dysfunction in

[14] See e.g., A Alghrani, P Case and J Fanning (eds), 'Special Issue: The Mental Capacity Act 2005 – Ten Years On' (2016) 24(3) Med L Rev 311 ff. More recently, J Laing, 'Reforming the Mental Health Act: Will More Rights Lead to Fewer Wrongs?' (2022) 30(1) Med L Rev 158.
[15] For a recent overview of law in the area, see e.g., E Cave and H Cave, 'Skeleton Keys to Hospital Doors: Adolescent Adults Who Refuse Life-Sustaining Medical Treatment' (2023) 86(4) MLR 984; C Auckland, 'Authenticity and Identity in Adolescent Decision-Making' (2024) 87(2) MLR 245.
[16] Mental Health (Northern Ireland) Order 1986, Northern Ireland Orders in Council, 1986 No. 595 (N.I. 4) (hereinafter referred to as the 'MHO').
[17] Mental Capacity Act (Northern Ireland) 2016, Acts of the Northern Ireland Assembly, c. 18 (hereinafter referred to as 'MCANI').
[18] For a recent overview of such proposals, see P Anderson et al, 'Legal Capacity, 'Developmental Capacity, and Impaired Mental Capacity in Children under 16: Neurodevelopment and the Law in Northern Ireland' (2024) 87 Intl J Law Psych 101872.
[19] C McGrattan, *Northern Ireland, 1968-2008: The Politics of Entrenchment* (Palgrave Macmillan 2010); D McKittrick and D McVea, *Making Sense of the Troubles: A History of the Northern Ireland Conflict* (Penguin Books 2012).
[20] See UK Government, The Belfast Agreement 1998, <https://www.gov.uk/government/publications/the-belfast-agreement> accessed 12 August 2024.

the management of health and social care, including a lack of consistent momentum with regards to policy and law reform in areas, such as mental healthcare.[21]

Given this political context, we adopt a cautious approach in proposing law reform in order to drive improvements to NI mental health and capacity laws applicable to children and young people. In the first instance, we suggest that statutory guidance in the form of a Code of Practice be developed to address both the issue of evolving capacity in children and to facilitate best practice in policy and practice. This modest reform in the short term should be accompanied by a firm political commitment to ensuring that NI's mental capacity legislation (i.e., MCANI) is fully brought into force. We further argue that such reform should form part of a holistic approach on the part of NI policy-makers towards improving mental healthcare provision for children and young people. We suggest that the best way to achieve improved provision is through embedding a human rights-based approach in mental healthcare policy and practice, in particular respecting the principles of autonomy and participation. In doing so, a children's rights perspective is promoted, which is grounded in the United Nations Convention on the Rights of the Child (CRC)[22] and prioritises non-discriminatory participation and the empowerment of children and young people.

Drawing on select CRC rights, identified in the final section of the article, we propose that an enhanced human rights-based approach to mental healthcare provision for children and young people in the NI context would ideally involve the following: increasing the allocation of funding and resources to facilitate more timely access to suitable treatment and related services; enhancing children's autonomous participation in policy, judicial and clinical decision-making

[21] For an overview, see AM Farrell et al, 'Mental Health Policies and Laws on the Island of Ireland', Edinburgh Law School Working Paper 2022, SSRN, No. 2022/07, 27 April 2022.
[22] United Nations Convention on the Rights of the Child, General Assembly Resolution 44/25 of 20 November 1989 with entry into force 2 September 1990 (hereinafter referred to as 'CRC').

that impacts their lives; and employing a range of executive accountability mechanisms to drive improvements in such provision over time. In making these arguments, we recognise that a range of human rights instruments could be said to impact the legal framework impacting the provision of NI mental healthcare for children and young people, and we do make reference to such instruments in the body of the article. In advancing our specific argument regarding the need to better embed a human rights-based approach in NI mental healthcare provision for children and young people, however, we draw inspiration primarily from a CRC perspective. This is because the CRC is tailored specifically towards children as rights-holders, as well as recognising that they may be in need of specific protections due to their minority status, in circumstances where questions involving parental responsibility must also be taken into account.[23]

In order to examine these arguments, we first provide a brief overview of NI's political and constitutional status, as well as its overarching legal framework for managing the welfare, wellbeing and human rights of children and young people. We then examine NI's mental health and capacity laws, Codes of Practice and guidelines. For the purposes of this article, we focus only on the applicability of such laws in the civil, rather than the criminal justice, context. We use the term 'children' to refer to those aged under 16 years, and 'young people' to refer to those aged 16 and 17 years of age. The term 'adult' is used to refer to those aged 18 years and over, in line with NI law on attaining the age of majority.[24] We then examine the position of children, especially those between 12 and 16 years of age, exploring the mix of common law, statute and human rights instruments applicable in NI, that inform the approach taken to their evolving capacity. In doing so, we use the term 'English' for reasons of brevity in referencing

[23] This draws in part on C Parker, 'Children's Mental Health Care: Decision-Making and Human Rights' in B Kelly and M Donnelly (eds), *Routledge Handbook on Mental Health Law* (Routledge 2024) 149.
[24] Age of Majority Act (Northern Ireland) 1969, s 1(1).

case law and statute from the England and Wales jurisdiction. In the final part of the article, we consider how existing mental health and capacity laws could be reformed as part of a holistic approach to improving NI mental healthcare provision for children and young people.

II. MENTAL HEALTH AND CAPACITY LAWS APPLICABLE TO CHILDREN AND YOUNG PEOPLE IN NORTHERN IRELAND

A. Introduction and Overview

It is important to first provide a brief overview of NI's political and constitutional dynamics, in order to contextualise the fragmented and uneven development of the existing mental health and capacity legal framework applicable to children and young people. By way of background, NI is a devolved nation of the UK comprising six counties in the North-East of the island of Ireland. While the jurisdiction was formally created in 1921, its constitutional status, including whether it should remain part of the UK or form part of a united Ireland, was one of the factors in a violent conflict, commonly known as The Troubles, of which previous mention has been made.[25] The Belfast Agreement re-established devolved power-sharing institutions which now include the NI Executive, which represents the devolved administration, and the NI Assembly, which is the devolved legislature. Since the signing of the peace agreement in 1998, there have been successive periods where direct rule has been re-imposed by the UK government, due to local sectarian political divisions bringing about the collapse of power-sharing institutions. Most recently, agreement was reached between local parties to restore such institutions after they had lapsed for a period of two years.[26] Nevertheless, NI power-sharing arrangements are

[25] McGrattan (n 19); McKittrick and D McVea (n 19).
[26] J Rutter and M Fright, 'Government Deal with the DUP to Restore Power Sharing in Northern Ireland' Institute for Government, 1 February 2024.

likely to remain fragile, due to ongoing sectarian tensions, as well as continuing political friction over the border between NI and Ireland, which has been exacerbated by Brexit.[27]

The mental health and capacity legal framework applicable to children and young people includes NI-specific laws, such as the Children (Northern Ireland) Order 1995 (NICO), which in general terms provides the legal framework for the care, upbringing and protection of children in NI.[28] Under the NICO, the child's welfare is 'the paramount consideration',[29] which is determined by reference to specified criteria including the child's ascertainable wishes and feelings in light of their age and understanding; their physical, emotional and educational needs; the likely effect of any change in their circumstances; their age, sex, background and any characteristics which the court considers relevant; any harm suffered or which is at risk of being suffered; and how capable their parents are of meeting their needs.[30] The paramountcy principle is at the heart of the NICO, which also finds recognition across a range of UK legislation and jurisprudence, as well as international legal instruments. It has been suggested that the NICO is a suitable vehicle for enhancing a more rights-based approach towards children and young people.[31] However, it does not specifically address matters pertaining to involuntary treatment for children's mental disorders or their deprivation of liberty, which we consider are more suitably dealt with separately under NI's mental health and capacity laws, and discuss in further detail below.[32]

[27] Guardian staff and agency, 'What Does Return to Power Sharing Mean for Northern Ireland?' *The Guardian*, 3 February 2024.
[28] The five principles of the Children (Northern Ireland) Order 1995 (hereinafter referred to as 'NICO') are paramountcy, partnership, parental responsibility, protection and prevention.
[29] NICO, s 3(1).
[30] Ibid, s 3(3)(a)-(f).
[31] See Anderson et al (n 18).
[32] For support for this view, see Baroness Hale of Richmond, 'Re D and Legal Issues to Be Considered in Children's Decision-Making', Queen's University Belfast, 23 October 2023, 10-11.

Another more recent piece of legislation is the Children's Services Co-operation Act (Northern Ireland) 2015.[33] This Act imposes a statutory duty on children's authorities, as well as between such authorities and the NI Executive, to facilitate co-operation with respect to functions which may contribute to the well-being of children and young persons.[34] This also includes their mental health.[35] As part of its statutory obligations, the NI Executive is required to publish a Children and Young Person's Strategy setting out how it proposes to improve the well-being of children and young persons.[36] The current Strategy was published in January 2021, which references the CRC, and aims for improvements in a range of children's services covering information-sharing, monitoring and evaluation processes.[37] As the NICCY has pointed out, however, the publication of the Strategy was well overdue and was in any case hampered by an 'absence of robust data' regarding CRC rights and gaps in children's services, in particular mental healthcare services.[38] More troubling for present purposes is the fact that the inter-relationship between the two Strategies, namely the NI Mental Health Strategy and the Children and Young Person's Strategy, is not made clear in terms of how they will work together to provide suitable mental healthcare for children and young people, and in line with the CRC.

Human rights instruments such as the Human Rights Act 1998 (HRA), as well as jurisprudence, also form part of NI's existing mental health and capacity legal framework applicable to children and young people. Indeed, concerns about human rights protections increasingly form

[33] Children's Services Co-operation Act (Northern Ireland) 2015, Acts of the Northern Ireland Assembly, 2015, c. 10.
[34] Ibid.
[35] Ibid, ss 1(2)(a) and 2.
[36] Ibid, s 3.
[37] NI Department of Education, Children and Young Persons' Strategy 2020-2030 <https://www.education-ni.gov.uk/publications/children-and-young-peoples-strategy-2020-2030> accessed 12 August 2024.
[38] NICCY, 'Still Waiting'- A Rights Based Review of Mental Health Services and Support for Children and Young People, 2018. For a recent update on progress with respect to the recommendations outlined in the 'Still Waiting+' report, see NICCY (n 6).

part of legal challenges in NI over decision-making and orders involving questions of children's capacity, involuntary treatment for mental disorders, and detention for other reasons.[39] ECHR rights which are of particular relevance to mental healthcare provision include Article 3 (prohibition of torture, inhuman or degrading treatment or punishment); Article 5 (right to liberty and security); Article 8 (right to respect for family and private life); and Article 14 (right not to have ECHR rights secured in a discriminatory way). Other relevant international human rights instruments include the CRC, the Convention on the Rights of Persons with Disabilities (CRPD),[40] and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[41]

Of particular interest in terms of what we discuss later in the article include the following CRC rights: Article 3 (child's best interests to be primary consideration), Article 5 (parental guidance and children's evolving capacities), Article 12 (respect for children's lives in all matters impacting their lives, including opportunity to be heard in legal and administrative proceedings) and Article 24 (child's right to the highest standard of health). This is in addition to relevant Articles set out in the CRPD, which include Article 7 (children with disabilities),[42] and Article 12(3) (supported decision-making in the exercise of legal capacity).[43] Although there is no specific reference made to people with disabilities (including children with disabilities), subsequent published commentary on aspects of CEDAW have made it clear that

[39] For an overview, see Northern Ireland Human Rights Commission 'Response to Public Consultation on the Draft Mental Health Strategy 2021-2031 for Northern Ireland', April 2021.
[40] United Nations Convention on the Rights of Persons with Disabilities, UN General Assembly, 24 January 2007, A/RES/61/106 (hereinafter referred to as the 'CRPD').
[41] United Nations Convention on the Elimination of All Forms of Discrimination against Women (hereinafter referred to as CEDAW).
[42] See e.g., Article 7(1) CPRD which states that '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.'
[43] In relation to the supported decision-making model, see e.g., CRPD, Art 12(3); see also United Nations Committee on the Rights of Persons with Disabilities, General Comment No. 1, Article 12 – Equal Recognition Before the Law, adopted 11 April 2014, CRPD/C/GC/1, para 16, p. 4.

reference to people with disabilities should include taking account of the specific needs of girls and women, particularly in relation to Article 12 (access to health care).[44] Notwithstanding their different focus, it has been argued that all three international Conventions 'need to be understood collectively in order to gain a comprehensive understanding of the human rights of all children with disabilities, and the associated obligations on States to respect, fulfil and protect those rights'.[45] While the UK has ratified all three Conventions,[46] it has not incorporated them into domestic law. The exception to this is the recent incorporation of the CRC into Scots law.[47] However, the Conventions have been referred to, and taken account of, by UK public bodies, as well as in jurisprudence relating to questions of mental capacity involving children and young people, and this will be examined in more detail later in the article. In the next section, we provide an overview of key aspects of NI mental health and capacity laws applicable to children and young people. Given the fact that it has proved to be a problematic issue in terms of proposed law reform in the area, there is a particular focus on questions of evolving capacity for children aged between 12 and 16 years of age.

B. NI Mental Health and Capacity Laws

There are two key pieces of legislation which are relevant to children and young people: namely, the MHO and the MCANI. In relation to the former, the MHO has been described as a piece of 'traditional mental health legislation', having been in force for over thirty-five years.[48] Given the passage of time, it has been argued that it no longer represents best practice, showing a lack of due respect for the principles of autonomy, justice and benefit, as well as

[44] UN Women, CEDAW, General Recommendations Made by the Committee on the Elimination of Discrimination against Women General, Recommendation No. 24 (20th session, 1999).
[45] UNICEF, Using the Human Rights Framework to Promote the Rights of Children with Disabilities: Discussion Paper: An Analysis of the Synergies between CRC, CRPD and CEDAW, 14.
[46] The UK ratified the CEDAW on 7 April 1986, the CRC on 16 December 1991 and the CRPD on 8 June 2009.
[47] United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024, 2024 asp 1.
[48] C Harper, G Davidson and R McClelland, 'No Longer "Anomalous, Confusing and Unjust": The Mental Capacity Act (Northern Ireland) Act 2016' (2016) 22 Int J Mental Health and Capacity Law 57.

failing to incorporate appropriate human rights protections.[49] As things stand, the MHO provides the legal basis for the involuntary treatment of 'mental disorder', which is defined as 'mental illness, mental handicap and any other disorder or disability of mind'.[50] Although a fourteen day assessment period is required prior to involuntary treatment,[51] the wide-ranging definition justifying involuntary treatment has nevertheless been criticised as giving rise to the potential for persons to be detained due to 'moral, social, political, or cultural judgements', rather than for reasons of safety or necessity.[52]

Clinical decision-making regarding involuntary admission for assessment is based on diagnosis and risk; the presence of mental illness or severe mental impairment, and where a failure to detain may lead to substantial risk of serious physical harm to self or others.[53] The MHO is accompanied by a short Code of Practice, which provides further information about the provision of mental healthcare in line with the MHO.[54] Notwithstanding this approach to involuntary treatment under the MHO, it is relatively rare in practice for a formal diagnosis to be given to children under 16 years of age, which it has been suggested reflects a 'tentative approach' on the part of NI medical practitioners about the potential adverse impact a formal

[49] The Bamford Review of Mental Health and Learning Disability (Northern Ireland), A Comprehensive Legislative Framework, 2007, 2 (hereinafter referred to as the 'Bamford Review'). <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/legal-issues-executive-summary.pdf> accessed 12 August 2024.

[50] MHO, Art 3(1).

[51] See NI Department of Health, 'Mental Capacity Act Background' <https://www.health-ni.gov.uk/mental-capacity-act-background> accessed 12 August 2024.

[52] G Davidson, M McCallion and M Potter, *Connecting Mental Health and Human Rights* (Northern Ireland Human Rights Commission 2003), 20. Note the UK Supreme Court judgment, *In the Matter of An Application for Judicial Review by RM* (A Person Under a Disability) [2024] UKSC 7 where it overturned an earlier NI Court of Appeal judgment ([2022] NICA 35) holding that the difference in wording in the criteria for 'detention for treatment' did not suggest a higher threshold as between the MHO and mental health legislation in England and Wales.

[53] MHO, Arts 3-4. The criteria for involuntary admission for assessment are: the patient is suffering from a mental illness or severe mental impairment of a nature or degree which warrants their detention in hospital for assessment and failure to detain the patient would create a substantial likelihood of serious physical harm to themselves or others.

[54] Guidelines on the Use of the Mental Health (Northern Ireland) Order 1986, October 2011 (GAIN Guidelines) <https://www.rqia.org.uk/RQIA/files/d8/d8e257e6-cf4f-4d39-bc46-ad37be0ece99.pdf> accessed 12 August 2024.

mental health diagnosis might have on a child's 'emerging identity.'[55] The MHO also provides certain safeguards for a person who is being deprived of their liberty, with time limits set out for each stage of compulsory admission for assessment and treatment, as well as how and when applications can be made to the Review Tribunal.[56] Prescribed forms are completed by the treating medical practitioner, the Responsible Medical Officer (RMO), providing holding powers for assessment and, if required, treatment.[57] The completed forms are then sent to the NI Regulation and Quality Improvement Authority (RQIA), which is empowered to scrutinise and monitor all MHO forms.[58] Once submitted, a child's representative may challenge their detention under the MHO which can be done within the assessment period (i.e., the first fourteen days), or during the treatment period after that. A patient's detention for treatment is then monitored at set intervals until the treating medical practitioner deems it safe for them to be discharged. If a request for detention is left unchallenged, the case will automatically come before the Review Tribunal after one year, in the case of a child.[59]

The operation of time limits under the MHO have long been viewed as problematic, with concerns expressed about unlawful patient detention and young people being unnecessarily

[55] L Bunting, C McCartan, G Davidson et al, The Mental Health of Children and Parents in Northern Ireland: Results of the Youth Wellbeing Prevalence Survey, October 2020, 17.
[56] MHO, Arts 9 and 12 (compulsory admission and treatment); Art 71 (application to Review Tribunal).
[57] MHO, Part II, Forms 7-11. When completed by a Consultant Psychiatrist, a Form 7 provides holding powers to assess a patient for up to seven days. If a Form 7 is completed by a Junior Doctor, it provides holding powers for 48 hours which can be extended for up to seven days when a Form 8 is completed by a Consultant Psychiatrist. After examination, Forms 9-12 renew holding powers for a further assessment and then for treatment. Time limits range from between seven days to one year. In total, a patient can be detained for up to two years (one year in the case of a child or young person) before their case would be presented to the Review Tribunal if the patient has not challenged the detention prior to then.
[58] MHO, Art 86. See Guidance for the Completion of Prescribed Forms (Forms 1-12) under the Mental Health (NI) Order 1986 <https://www.rqia.org.uk/RQIA/files/36/360f384f-197f-4e46-9ff4-58eae75800ff.pdf> accessed 12 August 2024.
[59] See GAIN Guidelines, Mental Health (NI) Order 1986 – Interactive Flowcharts <https://gain-ni.org/flowcharts/> accessed 12 August 2024. During the treatment period, the patient can challenge the detention once during the first six months, once during the second six months and once during each year after that.

detained within in-patient facilities for years.[60] This was exacerbated by the Covid-19 pandemic with the implementation of an emergency MHO Code of Practice in 2020-21 which further extended time limits for detention and holding powers.[61] Although this proved to be a temporary state of affairs, it nevertheless added to existing concerns that (extended) time limits under the MHO have the potential to interfere with a patient's human rights, in areas such as access to review of their treatment and in relation to delays in appealing clinical decision-making about such treatment. [62] This could be seen as particularly problematic in relation to children and young people subject to the MHO with the potential for decisions about involuntary treatment to remain unchallenged for up to two years, significantly limiting their participatory rights and representing a clear violation of the CRC, for example.[63]

In the early 2000s, the Bamford Review began what would be a lengthy examination of law, policy and provisions affecting people assessed with mental health needs and learning disabilities in NI. The Review produced several reports, including one which recommended comprehensive reform of NI's mental health and capacity laws.[64] One of the guiding principles underpinning the Review was to incorporate a human rights approach to mental health services and law reform,[65] given that they failed to respect the dignity of the person and did not promote individual autonomy.[66] The work undertaken as part of the Bamford Review in the early 2000s meant that full account was not taken at the time of the CRPD, which was adopted in 2007.

[60] Davidson McCallion and Potter (n 52); D Haydon (ed), Northern Ireland NGO Stakeholder Report to Inform the UN Committee on the Rights of the Child's 'List of Issues Prior to Reporting', prepared by the NI Children's Law Centre on behalf of the NI NGO Sector, December 2020.
[61] Coronavirus Act 2020, s 10, Sch 10; Mental Health (Northern Ireland) Order 1986 Code of Practice Coronavirus Act 2020.
[62] AM Farrell and P Hann, 'Mental Health and Capacity Laws in Northern Ireland and the Covid-19 Pandemic: Examining Powers, Procedures and Protections under Emergency Legislation' (2020) 71 Intl J Law Psych 10162.
[63] Specifically, CRC Art 37(b) which states that a child should only be deprived of their liberty 'for the shortest appropriate period of time'.
[64] Bamford Review (n 49).
[65] Ibid, 3.
[66] Davidson McCallion and Potter (n 52).

Following the publication of the Bamford Review reports, there ensued a lengthy consultation period regarding mental health law reform, which was complicated by political instability and the collapse of power-sharing institutions in NI.[67] After an extended period of time and the eventual restoration of such institutions, the MCANI was eventually passed by the NI Assembly, receiving Royal Assent in 2016. It is considered to be an innovative and ground-breaking piece of legislation, adopting a 'fusion approach' which brings together capacity and mental health law across medical specialities.[68] What this means in practice is that impairment of decision-making capacity and best interests are now the only criteria to be used when making decisions across health and social care.[69]

For present purposes, it is also important to emphasise that the approach taken in the MCANI only applies to those aged 16 years and over. While the default legal position in NI is that a child is ordinarily defined as someone under the age of 18 years,[70] the age limit applied in the MCANI reflects in large part the approach taken in other pieces of NI and other UK legislation, which recognises that young people 16 years and over can give consent to surgical, medical and dental treatment. This recognition of the evolving maturity of young people in specified respects was also recognised during the consultation process leading up to the adoption of the MCANI, where it was accepted that those aged 16 years and over should come within its remit and that additional safeguards should be put in place, given the existing definition of a 'child' under domestic and international laws.[71] Therefore, the MCANI applies to all those aged 16 years and over with respect to determinations of capacity, and they enjoy the additional

[67] A Mohdin, 'Timeline of Northern Ireland's Power-Sharing Crisis', The Guardian, 26 April 2019; J Sargeant, 'Direct Rule in Northern Ireland' Institute for Government, 31 July 2019.
[68] J Dawson and G Szmukler, 'Fusion of Mental Health and Incapacity Legislation' (2006) 188(6) Brit J Psych 504.
[69] G Lynch, C Taggart and P Campbell, 'Mental Capacity Act (Northern Ireland) 2016' (2017) 41(6*)* BJPsych Bull 353-357.
[70] See Age of Majority Act (n 24).
[71] NI Department of Health, Draft Mental Capacity Bill, Consultation Document, May 2014, 38.

safeguards and protections that are in place under the legislation. Once the MCANI is fully implemented, it is anticipated that the MHO will no longer apply to young people aged 16 and 17 years (in addition to those who have reached the age of majority), although it will continue to apply to those under 16 years of age.

To date, there has only been partial enactment of the MCANI, which has involved bringing the Deprivation of Liberty Safeguards (DoLS) scheme into force.[72] The scheme is accompanied by a Code of Practice that affirms that mental capacity is to be presumed and the burden of proof (balance of probabilities) is on those seeking to assert incapacity to show otherwise and on the basis of reasonable belief, taking account of the factors noted below. The test for capacity is whether or not a person aged 16 years or over is unable to make a decision for themselves because of 'an impairment of, or disturbance in the function of the mind or brain', whether temporary or permanent and whatever its origin.[73] A determination of incapacity is time and decision specific,[74] and any intervention must be taken on a best interest's basis.[75] Factors to be taken into account in determining whether a person has the capacity are based on a functional assessment which includes their ability to understand, use, weigh and appreciate, communicate and retain the information relevant, or required, to (the process of) making the decision in question.[76]

While the MCANI has been welcomed as being grounded in a human rights approach, it has nevertheless attracted criticism for not being fully compliant with international human rights instruments, in particular the CRPD. This is because the MCANI includes a best interests test

[72] NI Department of Health, Deprivation of Liberty Safeguards Code of Practice. November 2019.
[73] MCANI, s 3(1) & (2)(a).
[74] Ibid, s 3(1).
[75] MCANI, Deprivation of Liberty Safeguards Code of Practice, ch 7, ss 2, 7.
[76] Ibid, ch 5, s 4.

as part of assessing capacity for those aged 16 years and over,[77] instead of drawing a distinction between the notion of legal capacity and mental capacity, as highlighted under Article 12 CRPD.[78] Making such a distinction would have made clear that questions of mental capacity only refer to the person's decision-making skills, rather than being used to deny the legal capacity of a person with (mental) disabilities.[79] During the consultation process regarding the MCANI Bill, there was also stakeholder criticism over the failure to take account of the evolving capacity of those under 16 years of age in the Bill. First, there were concerns about the potential impact on vulnerable children who would not be able to access safeguards and protections under the MCANI (once passed), particularly those in this age range who were assessed as lacking capacity and were being treated as voluntary inpatients. Second, the Bill was not compliant with Article 12 CRC in terms of ensuring increased children's participation in clinical, institutional and judicial decision-making that impacted provision of mental health treatment.[80] Third, there had been a failure to include within the Bill a statutory rebuttable presumption of capacity for those aged between 12 and 16 years, as had been proposed by the Bamford Review.[81]

[77] For an overview of the issues that arose in taking account of the CRPD, in particular the issue of the decision to still include 'best interests in the reform of NI's mental capacity laws, see M Potter, The Mental Capacity Bill and Human Rights, Research Paper, NI Assembly Research and Information Service, NIAR 278-15, 6 October 2015.

[78] Note that the Committee on the Rights of Persons with Disabilities (CRPD Committee) in interpreting Article 12 CRPD (equal recognition before the law) affirmed that 'all persons with disabilities have full legal capacity' and noted that 'legal capacity is the ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency)'. The Committee suggested that it was this latter aspect which was often conflated with questions of mental capacity, leading to the establishment of substitute decision-making regimes, often based on best interests, see CRPD Committee, General Comment (No. 1) Equal recognition before the law, Eleventh Session, 31 March–11 April 2014, paras 11-15. For a contrary view on this issue, see A Ruck Keene et al, 'Mental Capacity – Why Look for a Paradigm Shift?' (2023) 31 Med L Rev 340, 350.

[79] Anderson et al (n 18); Harper et al. (n 48); CRPD Committee (n 78).

[80] L-A Black, 'The Mental Capacity Bill and Children Under 16' NIAR 366-12, Research and Information Service Research Paper, Northern Ireland Assembly, 21 September 2012, 3.

[81] Bamford Review (n 49) 64. The Wessely Review, which examined options for reform of the Mental Health Act 1983 (England and Wales), recommended that 'there should be a single approach' set out in statute which establishes the circumstances in which 'children are able to make their own decisions' in this context, see Modernising the Mental Health Act Increasing Choice, Reducing Compulsion, Final Report of the Independent Review of the Mental Health Act 1983, December 2018, 174. Note that this recommendation was not taken forward in the UK government's proposals for reform of the Act, see UK Parliament, House of Commons Library, Reforming the Mental Health Act, Research Briefing, published 18 July 2024.

In response, the NI Department of Health (or the Department of Health, Social Services and Public Safety (DHSSPS) as it was then known at the time) stated that it did not consider the MCANI Bill to be the 'vehicle to assess emerging capacity in children', and it was 'reluctant to include provisions that could undermine parental authority or have other unforeseen implications on other legislation.'[82] In light of these identified concerns, the DHSSPS further stated it would establish a separate, cross-departmental project to consider how best to proceed.[83] In the end, an amendment to Part 2 of the MHO was introduced via the MCANI in relation to involuntary treatment of children under 16 years of age, which came into effect on 2 December 2019.[84] There is now an explicit requirement to take account of a child's best interests as the primary consideration regarding decision-making involving involuntary treatment, where a child under the age of 16 years is 'being assessed or treated for a mental disorder'.[85] This includes how to determine best interests in relation to the child;[86] the provision of independent advocates;[87] and the imposition of duties upon hospital managers to ensure the patient's environment in the hospital is suitable having regard to his or her age'(subject to the patient's needs).[88]

What follows from the drawing of this aged-based legislative distinction between those over and those under 16 years of age is that the latter group is excluded from accessing a range of safeguards and human rights protections under the MCANI.[89] In the end, this exclusion appears to have been rooted in concerns about the implications of creating a statutory recognition of presumption of (evolving) capacity for those between 12 and 16 years of age both in and

[82] Black (n 80) 3.
[83] Ibid, para 9.1.
[84] See MCANI, s 266; Schedule 8; see also MCANI, Explanatory Notes.
[85] MHO Art 3A.
[86] Ibid, Art 3B.
[87] Art 3C.
[88] Art 3D(2).
[89] See Haydon et al (n 60); NICCY (n 38) 27; Anderson et al (n 18) 6.

beyond the healthcare context. This is in addition to what it would mean for the idea of parental responsibility as understood under both the NICO and the common law.[90] In the next section of the article, we turn to examine case law in the England and Wales jurisdiction which has examined the evolving capacity of children in relation to the provision of healthcare treatment, and consider its relevance for the NI context.

C. Children, Young People and Evolving Capacity: The Jurisprudential Position

In this section of the article, we draw on select examples from jurisprudence in the England and Wales jurisdiction, which have examined questions of capacity, best interests and parental responsibility for those between 12 and 16 years of age. This is on the basis that such jurisprudence continues to be relevant in the context of NI's mental health and capacity legal framework applicable to children and young people A key starting point is the early seminal House of Lords judgment in *Gillick* which recognised children as 'right-holders',[91] holding that where children are found to be of 'sufficient intelligence and understanding', the 'parental right yields to the child's right to make his [/her] own decisions.'[92] Following this case, *Gillick* competence became the established test for determining whether those under 16 years of age had the capacity to consent to medical treatment. In the more recent judgment of the Court of Appeal in *Bell v Tavistock*, it confirmed that, in line with *Gillick*, it remained a matter for clinicians rather than the courts to assess in consultation with their young patients whether they were competent to consent to the medical treatment in question.[93]

[90] NI Department of Health (n 71) 38.
[91] E Cave, 'Goodbye Gillick? Identifying and Resolving Problems with the Concept of Child Competence' (2014) 34(1) LS 103.
[92] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 [186] (Lord Scarman).
[93] *Bell & Anor v Tavistock & Portman NHS Foundation Trust & Ors* [2021] EWCA Civ 1363 [81] (Lord Burnett of Maldon CJ).

Where particular difficulties have arisen for the courts is where a child wishes to exercise full autonomy and refuse life-preserving medical treatment. In this regard, it has been recognised that *Gillick* competence is not absolute. This was noted by Lord Donaldson in *Re R (A Minor) (Wardship: Consent to Treatment)* where it was held that it was still within the court's jurisdiction to override decisions by '*Gillick* competent' children.[94] In particular, how to interpret when a child was able to refuse such treatment has proved to be a difficult proposition for English courts.[95] In such cases, the courts have for the most part taken the view that a child who is under 16 years of age is not able to refuse medical treatment, particularly life-saving treatment. Limiting a child's autonomy within this context is justified for two main reasons: first, the more serious the condition the greater understanding and capacity required;[96] and second, refusal of life-saving treatment can 'threaten' a child's welfare and the court has a duty to intervene in such cases.[97] As Cave has observed, it is in such cases that the *Gillick* test has 'shown signs of strain.'[98]

Indeed, English courts' conservatism in this regard has even extended to overriding refusals involving medical treatment where the young person is over the age of 16 years. This was exemplified in the *An NHS Foundation Hospital v P*,[99] where a 17-year-old young woman refused life-saving treatment after an overdose. Despite an on-call consultant psychiatrist assessing her as having the capacity to make her own decisions, the court found it had a 'positive and operational duty' under Article 2 ECHR to act, even where a *Gillick* competent

[94] [1992] Fam. 11 [26] (Lord Donaldson).
[95] See E Cave, 'Confirmation of the High Court's Power to Override a Child's Treatment Decision: A NHS Trust v X (In the matter of X (A Child) (No 2)) [2021] EWHC 65 (Fam)' (2021) Med L Rev 1; C O'Neill, *Religion, Medicine, and the Law* (Routledge, 2018).
[96] See e.g., *L (Medical Treatment: Gillick Competence), Re* [1998] 2 F.L.R. 810.
[97] In *Re W* [1993] Fam. 64, it was held that even if a child is close to majority, the court can still exercise its inherent protective jurisdiction to ensure the welfare of the child is of paramount consideration.
[98] Cave (n 91) 105.
[99] *An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam). Also known as *P (A Child), Re*.

child refused treatment.[100] While the court welcomed the child's participation during the proceedings and acknowledged that her wishes and feelings were 'an important component of the analysis of [her] welfare', particularly in relation to Article 8 ECHR, they were not 'decisive' and did not outweigh the courts' obligations under Article 2 ECHR to preserve life.[101] It was therefore held to be within the court's inherent jurisdiction to overrule the young woman's decision, with her best interests and welfare being the paramount consideration.[102] In the case in *E & F (Minors: Blood Transfusions)*, the two young people in question were Jehovah's Witnesses and were assessed as being *Gillick* competent. They wished to refuse life-saving treatment in the form of blood transfusions, if this became necessary during medical treatment. The Court of Appeal refused their appeals holding that while there was a need to balance 'two transcendent factors: the preservation of life and personal autonomy', it was the 'welfare principle' that remained the overriding consideration in the circumstances, particularly where there was a significant risk of harm or death. [103]

English courts have also been prepared on occasion to flex their judicial muscle to override parental consent in relation to the provision of medical treatment to children. Indeed, in exercising their inherent jurisdiction the courts have made it clear that their role is to 'take over the parents' duty to give or withhold consent in the best interests of the child.'[104] This was highlighted in the case of *An NHS Trust v MB*, where Justice Holman justified the decision to take this course of action on the grounds that parental views can become 'coloured' due to the emotive nature of such cases. While this might be 'understandable in human terms', the

[100] Ibid, para 15.
[101] paras 13, 15.
[102] para 12.
[103] *E & F (Minors: Blood Transfusion)* [2021] EWCA Civ 1888 [53] (McFarlane P).
[104] *Kings College Hospital NHS Foundation Trust v Takesha Thomas, Lanre Haastrup, Isaiah Haastrup* [2018] EWHC 127 (Fam) [69].

primary concern of the courts must remain the 'objective best interests of the child.'[105] Indeed, the position regarding the courts' inherent jurisdiction to overrule parental preferences continues to hold legal weight.[106] Such cases highlight the English courts' preparedness to override both child and parental/guardian decision-making regarding the issue of consent to, or conversely the refusal of, medical treatment, thus taking on the role of the 'judicial reasonable parent'.[107]

However, what is of particular interest for the NI context is how the courts have engaged in reasoning about the appropriate balance to be struck between parental/guardian roles and responsibilities, and the child's best interests in the context of evolving capacity. We highlight a few examples of varying judicial approaches to the issue. In the case of *Mabon v Mabon and others,* it was held that the children in question – aged 13, 15 and 17 years – had a right to separate legal representation. In granting this request, the court expressly referred to Article 12 CRC and noted that the judgment provided 'a timely opportunity to recognise the growing acknowledgment of the autonomy and consequential rights of children, both nationally and internationally.'[108] In a later case of *F (mother) and F (father),*[109] the parents of two children aged 11 and 15 years respectively, were in dispute over whether their children should receive the measles-mumps-rubella (MMR) vaccine. While the children's views were noted (giving a tokenistic nod to autonomy and participation principles) – both were against receiving the vaccines – the court ultimately took the position that their views were not 'balanced' and they should therefore receive the vaccine based on the welfare principle.[110] As Cave has observed,

[105] [2006] EWHC 507 (Fam), [16(x)].
[106] See e.g. *Great Ormond Street Hospital for Children NHS Foundation Trust v Yates and others* [2017] EWHC 972 (Fam) (also known as the 'Charlie Gard case').
[107] *X (A Child) (No. 2), Re* [2021] EWHC 65 (Fam), [21].
[108] *Mabon v Mabon and others* [2005] Fam. 366, [32].
[109] [2013] EWHC 2683 (Fam).
[110] Ibid.

what was problematic about the judgment was the way in which the court effectively sidelined the views of the children, focusing for the most part on the differing positions held by the parents.[111]

Although not strictly concerned with medical treatment, the case of *Re D (A Child)* is instructive with respect to how the court viewed competing rights: on the one hand, the rights of the young person in question under Article 5 ECHR (right to liberty and security); and on the other hand, those of the parents under Article 8 ECHR (right to private and family life), as well as the common law and statutory provisions, such as the Children Act 1989. The legal issue at stake in the case was whether parental consent with regards to the living arrangements for a 16-year-old boy contravened his Article 5 ECHR rights. While the court recognised that the boy's welfare should be 'the paramount consideration', it nevertheless went on to find that parental rights were not absolute and that the degree of supervision to which he had been subjected was 'not normal for a child of his age.' In the circumstances, a parent/guardian could not authorise what would be a breach of their child's Article 5 ECHR rights, regardless of whether a child has a mental disability or not (referring to Article 7 CRPD).[112]

In the wake of the *Re D* judgment, academic commentators such as Ruck Keene and Xu, have raised concerns about its legal and practical implications; the scope of 'parental responsibility' as defined under s 3 of The Children Act 1989,[113] and how DoLS schemes would likely work now in practice in the case of young people.[114] In contrast, Cave suggested that the judgment actually demonstrated the 'potential' of English courts to modernise the common law and

[111] E Cave, 'Adolescent Refusal of MMR Inoculation: F (mother) v F (father)' (2014) 77(4) MLR 630.
[112] [2019] UKSC 42, [45]. Note CRC, Art 7(1) requires all children with disabilities to be treated equally with other children.
[113] The Northern Irish equivalent being the NICO, s. 6.
[114] A Ruck Keene and X Xu, 'Case Comment: *Re D* (A Child) [2019] UKSC 42' (2020) 28(3) Med L Rev 595.

ensure that the human rights of children are safeguarded.[115] In the context of NI mental health and capacity laws, it is also clear that *Re D* applies. A parent, or anyone else with parental responsibility, cannot agree or consent to a deprivation of liberty for those aged 16 and 17 years of age. If a DoL is sought, and no other statutory power can be used, then the MCANI can be used to authorise this. Although if a DoL is required in a psychiatric hospital due for a mental disorder as specified under the MHO, for example, then that should be the legal framework used.[116]

The case of *Re X (A Child) (No.2*) is also illuminating, revealing the extent to which English courts are prepared to exercise their protective inherent jurisdiction over a young person described as 'mature and wise beyond her years.'[117] The case involved a 15-year-old (almost 16) who had refused a blood transfusion on religious grounds. The court made clear that even where a young person was considered to be *Gillick* competent or was otherwise presumed to have capacity under relevant legislation, they should not be considered as 'autonomous' in all circumstances.[118] In the context of a young person's refusal of life-preserving medical treatment, it was held that the court was entitled to overrule such a decision sitting in its inherent jurisdiction until they reached the age of 18 years, if it viewed the decision as not being in their best interests.[119] In seeking to give proper consideration to the young person's *Gillick* competence and existing ECHR rights, the court went on to order that a single blood transfusion be administered, but refused to approve a rolling programme of transfusions over a two-year

[115] Cave (n 91).
[116] See e.g. NI Department of Health, 'Mental Capacity Act FAQs', <https://www.health-ni.gov.uk/mental-capacity-act-faqs#:~:text=If%20a%2016%20or%2017,authorise%20a%20deprivation%20of%20liberty> accessed 12 August 2024.
[117] [2021] EWHC 65 (Fam), [4].
[118] *Re X (A Child) (No.2)* [2021] EWHC 65 (Fam) [120].
[119] Ibid.

period, on the grounds that as it ran the 'risk of privileging medical paternalism over judicial protection' and would diminish the young person's human dignity.[120]

With English jurisprudence continuing to play an important role in the NI mental health and capacity legal framework applicable to children and young people, what can we draw from the select case law examples highlighted above? While questions of children's evolving capacity are taken into account by English courts, such examples serve to highlight how this is likely to be determined on the facts in individual cases. In addition, how the courts have responded to human rights considerations in the context of children's medical treatment has been, and continues to be, 'haphazard',[121] reflecting what we would suggest is a degree of ongoing judicial discomfort with respect to fully engaging with a human rights-based approach in this context. While there appears to be a prima facie assumption that a child's evolving capacity will be taken into account in line with *Gillick*, and balanced against the competing parental/guardian preferences, the courts invariably revert to a best interests assessment in line with their inherent jurisdiction powers to override children's refusals of life-preserving medical treatment. While there was clearly more judicial comfort in *Re D* in terms of addressing the interference with the child's Article 5 ECHR rights where it involved deprivation of liberty, this was much less evident in the case of *Re X* where it involved recognising a young person's capacity to refuse life-preserving medical treatment. In this case, rights-based considerations were only factored into the way in which the medical treatment in question was to be administered.

Part of the problem experienced by English courts in assessing questions of evolving capacity for those under 16 years of age may also reflect the expert evidence they hear from medical

[120] Ibid, paras 168, 114.
[121] J Fortin, 'Accommodating Children's Rights in a Post Human Rights Act Era', (2006) 69(3) MLR 300.

practitioners who may also be struggling to assess capacity in their young patients. In the context of mental healthcare, accessing and according due weight to children's participatory rights and their ability to make decisions, can become extremely problematic. What constitutes capacity can be difficult to conceptualise and define. It may be the case that medical practitioners who work with children and young people need to apply their 'experience and instinct' when accessing children's agency within various contexts.[122] There can also be 'areas of confusion' surrounding when a child has capacity to refuse treatment,[123] or suffers from 'reduced capacity'.[124] In such circumstances, taking judicial account of evolving capacity in line with a human rights-based approach may not always be straightforward.

In sum, our review of select case law examples highlights the fact that English courts continue to struggle with delineating the boundaries of the relationship between a child's evolving capacity; the role of parents/health professionals in this regard; how to take account of best interests and to incorporate a human rights-based approach which focuses on principles of autonomy and participation, where appropriate.[125] This is particularly acute where a given set of facts involves decision-making arising from a child's refusal of life-preserving medical treatment. However, what it also makes clear is that the NI Department of Health's decision to exclude children under 16 years of age from the remit of the MCANI on the grounds that it could 'undermine' parental responsibility,[126] is not justifiable in light of current jurisprudence on the issue. This is because English courts have made it clear that the primary consideration is the child's best interests, and this is not overridden by parental responsibility (per *Mabon*).

[122] A Daly, 'Assessing Children's Capacity' (2020) 28 Int. J. Child. Rights 471.
[123] E Cave and Z Stavrinides, Medical Practitioners, Adolescents and Informed Consent Project Final Report (University of Leeds, 2013) 16.
[124] S Ogden, R Huxtable, R. and J Ives, 'Protocol for a Scoping Review to Understand What is Known about How GPs Make Decisions With, For and On Behalf of Patients who Lack Capacity' (2020) 10 BMJ Open 1.
[125] On the need to reframe the law to better take account of the relationship between best interests, professional duties and public responsibility in relation to the medical treatment of children, see J Bridgeman, *Medical Treatment of Children and the Law – Beyond Parental Responsibilities* (Routledge, 2021).
[126] NICCY (n 38) 14.

The courts have also indicated that account should be taken of human rights considerations in the specific circumstances of a given case. Indeed, a focus on the specific facts of a given case, rather than adopting a generalised approach, has been the approach taken by English courts time and time again in terms of dealing with children's evolving capacity in the context of medical treatment.[127] This should give us pause for thought in formulating reform proposals for improving NI's mental health and capacity legal framework, including whether legislative reform is the best way forward. This is not straightforward, given the neurological, professional and practical complexities faced when dealing with questions of children's evolving capacity in the context of healthcare decision-making, including their mental healthcare.[128] We now turn in the next section of the article to examine potential options for (law) reform as part of driving improvements to mental healthcare provision for children and young people in NI.

III. WHICH WAY FORWARD?

There have been several proposals put forward for reform of NI's mental health and capacity legal framework applicable to children and young people. As mentioned previously, in the early to mid-2000s, the Bamford Review examined a range of options in this area, recognising that the 'special needs' of children must be both recognised and protected.[129] This led the Review to recommend the introduction of a statutory rebuttable presumption of capacity in the case of children aged between 12 and 16 years. This would have been in addition to ensuring that children were afforded the same statutory protections as adults, where capacity assessments would result in 'significant restrictions' or 'deprivation of liberty', for example.[130] Although consistent with the approach taken under the common law (per *Gillick* competence),

[127] See e.g., *AB v CD* [2021] EWHC 741 (Fam) [121]-[122] (Lieven J).
[128] On the complexities that arise in terms of children's neurodevelopment in the context of assessing capacity, see Anderson et al (n 18) 6. Consideration may also need to be given to what might constitute 'adolescence' in the context of determining capacity, see Cave and Cave (n 15); Auckland (n 15).
[129] Bamford Review (n 49) 47.
[130] Ibid.

as well as a human rights-based approach,[131] NI policy-makers opted in the end not to transpose the Review's recommendation in this regard into the MCANI (when fully in force), for the reasons previously outlined. As a consequence, those under 16 years of age would continue to be excluded from the protections provided under the MCANI, if they were assessed as lacking capacity.[132]

While some provision has now been made to take account of best interest considerations in relation to involuntary treatment under the MHO, it nevertheless remains an outdated piece of mental health legislation, as previously noted. Indeed, what is particularly troubling is that the MHO continues to remain in operation in the absence of the MCANI being fully brought into force and so continues to apply to all children and young people under the age of 18 years. This is against a background where it was initially seen as a transition measure following the adoption of the MCANI in 2016. However, with successive collapses of NI power-sharing institutions since that time, there has been a lack of political impetus towards ensuring that the legislation was fully brought into force, alongside appropriate resourcing and funding being in place. At the time of writing, it is now 8 years since the MCANI was passed, with no indication offered by the NI Executive as to when all of its provisions will come into force. This looks likely to be the case for the foreseeable future. Therefore, MHO remains in place, notwithstanding statements to the contrary.[133] This lamentable state of affairs has adverse implications not only for young people (i.e., those aged 16 - 17 years who would come within the remit of the MCANI when fully in force), but we suggest it also serves to inhibit ongoing evaluation over time about how best to embed a human rights-based approach for children under 16 years of age within NI's overarching mental health and capacity legal framework. At

[131] see e.g. CRC, Arts 2, 3, 5 and 12.
[132] Anderson et al (n 18).
[133] NI Department of Health, Mental Capacity Act Background (n 51).

the very least, we would suggest that statutory guidance be published by way of MHO and MCANI Codes of Practice, which should be focused on the assessment and treatment of children and young people. Doing so would enable the following: first, to provide updated/current guidance on English case law developments in the area; second, to facilitate regular stakeholder consultations to evaluate what is and is not working in practice; and finally, to embed best practice in terms of enhancing a human rights approach in relation to managing mental health and capacity issues in children and young people.

Although it has been observed that the use of Codes of Practice in relation to 'mental health governance' is a 'peculiarly UK phenomenon',[134] it should be noted that their use in this area has raised concerns, with evidence available as to inconsistency in their interpretation and application by providers.[135] Notwithstanding such concerns, we consider their use to be beneficial in this context for a number of reasons in the NI context. First, they could include key principles and statements as to best practice, reflect evolving legal and policy dynamics in the field.[136] Second, they could encourage a shift in professional and institutional cultures over time to better inform a human rights-based approach to mental health and capacity laws applicable to children and young people. Finally, such Codes operate as flexible, soft law instruments which can much more easily accommodate changes in practice than would be the

[134] P Bartlett, 'Editorial: The Code of Practice and the Ambiguities of "Guidance"' (2009) 19 Criminal Behaviour and Mental Health 157.
[135] Laing (n 14), drawing on Care Quality Commission, Mental Health Act Code of Practice 2015: An Evaluation of How the Code is Being Used, last updated 25 June 2019 <https://www.cqc.org.uk/publications/major-report/mental-health-act-code-practice-2015-evaluation-how-code-being-used#:~:text=The%20Code%20is%20still%20not,guiding%20principles%20in%20the%20Code> accessed 12 August 2024.
[136] For example, the relevant NI regulator relies significantly on the Code of Practice for the MHO in its training modules for psychiatrists in the NI health system, see Regulation and Quality Improvement Authority (RQIA), Policy for Appointing Part II Medical Practitioners <https://www.rqia.org.uk/RQIA/media/RQIA/Resources/WhatWeDo/MentalHealth/Policy-for-Appointing-Part-II-Medical-Practitioners_April19.pdf> accessed 12 August 2024.

case with primary legislation.[137] Given NI's current political dynamics, having such flexibility means that Codes of Practice are a much more realistic and achievable law reform option in the short term. Indeed, and as mentioned previously, they are already in use in terms of providing guidance in areas such as DoLs, for example, with the NI Department of Health being permitted to revise them under both the MCANI and MHO in specified circumstances.[138] In the case of the MCANI, the requirement is explicit with the Department being 'required' to publish Codes of Practice 'for the guidance of persons assessing whether a person who is 16 or over has capacity in relation to any matter; and for the guidance of persons acting in connection with the care, treatment or personal welfare of another person who is 16 or over…',[139] and they can be taken into account where relevant by the courts.[140] It is therefore regrettable that such Codes have not been published to date.

In terms of proposing law reform to better embed a human rights-based approach within NI's mental health and capacity legal framework, we suggest that particular account should be taken of key rights set out in the CRC.[141] In this regard, it would be important that the legal framework recognises that children have certain universal needs and protections by virtue of them being 'children', while also acknowledging that children as a 'group' are diverse. For example, the MHO applies in its entirety to children under the age of 16 years, which results in a failure to view children as a distinct group with particular needs. This is contrary to Article 2(2) CRC, which requires that States ensure that children are protected against 'all forms of discrimination.' In the absence of the MCANI being fully in force, it is an approach that could

[137] The third author currently practises as a psychiatrist in the NI health system. Although anecdotal, they report significant reliance on Codes of Practice on the part of NI health professionals in relation to the MHO (given its age) and the DoLS scheme (under the MCANI).
[138] See MHO, Art 111, which requires the laying of such Codes before the NI Assembly for approval within a specified time period.
[139] MCANI, s 288(1)(a) and (b).
[140] MCANI, s 289 (3).
[141] CRC, Art 4; UN Committee on the Rights of the Child (2016) General Comment No. 19 (2016) on Public Budgeting for the Realization of Children's Rights (Art. 4). CRC/C/GC/19.

lead not only to considerable stigmatisation of children whose treatment needs do not align with legislation that was primarily designed with adults in mind, but also because it could be argued that the design of the MHO is insufficiently flexible to offer a nuanced response to managing the evolving capacity of children and young people.[142]

As Byrne and Lundy have pointed out, it is vital that children understand their rights, in line with Article 42 CRC.[143] If the law is not clear, and in an accessible format suitable for a child's age and capacities, then children cannot fully engage with their participatory rights (Article 12), their rights to freedom of expression (Article 13) or their rights to access to information (Article 17), all of which have been described as 'crucial prerequisites for the effective exercise of the right to be heard.'[144] Clarity is especially important when dealing with issues which greatly impact children and young people's lives, such as deprivation of liberty orders and the provision of medical treatment. This is also relevant in the context of Article 12 rights involving a child with a disability (including a mental impairment). As confirmed by the UN Committee on the Rights of the Child, a child who has a disability is not deprived of their Article 12 rights, nor does it limit the weight that should be given to the views expressed.[145]

When assessing a child's best interests, what also becomes clear is that English courts, legislators and policy-makers place insufficient emphasis on a child's voice and agency in healthcare decision-making, including their mental healthcare. While recognising the importance of best interests and life preservation principles, there is a need for greater attention

[142] Davidson et al (n 52) 41.
[143] B Byrne and L Lundy, 'Children's Rights-Based Childhood Policy: A Six-P Framework', (2019) 23(3) Intl J Human Rights 362; see also Art 42 CRC which states that 'States Parties undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike.'
[144] UN Committee on the Rights of the Child, General Comment No. 12 (2009) The Right of the Child to Be Heard, CRC/C/GC/12, 20 July 2009, para 80.
[145] UN Committee on the Rights of the Child, General Comment No. 14 (2013) On the Right of the Child to Have His or Her Best Interests Taken As a Primary Consideration (Art.3, para. 1). CRC/C/GC/14, 11 (para 43-45); 13 (para 54).

to be paid to a child's autonomy and participatory rights in order to be CRC compliant, in particular with respect to the role of law in recognising children's Article 12 rights. While there is no hierarchy of CRC rights, how an adult (or court) views a child's best interests should not override the duty to respect such rights.[146] Therefore, tokenistic references to children's views are not enough,[147] in circumstances where greater visibility of CRC rights is required.[148] In particular, compliance with Article 12 CRC requires that legal frameworks are designed to ensure that support is provided for the participation of children and young people in decision-making processes that impact them. Up until relatively recently, the lack of recognition given to such participation within NI's mental health and capacity legal framework, as well as how this then impacts upon mental healthcare treatment and services for children and young people, has been stark.[149]

Ideally, taking account of CRC rights would involve fully incorporating the Convention into domestic law, which has not happened to date.[150] Absent that, the NICCY operates as an independent champion of children's rights, seeking to hold NI political leaders and policy-makers to account with respect to driving improvements to mental healthcare services, as well as the laws, applicable to children and young people. For the past four years, the Commissioner has produced a yearly report card on such services, as well as demanding increased transparency from the NI Executive with respect to data collection and analysis to drive improvements in the area.[151] More recently, there have been more examples in NI policy documentation where account has been taken of the CRC.[152] However, it is currently a

[146] Ibid.
[147] Cave and Stavrinides (n 123).
[148] G Lansdown, Promoting Children's Participation in Democratic Decision-Making (UNICEF, 2001) 1.
[149] Haydon (n 60) 11.
[150] The exception being the incorporation of the CRC into Scots law, see (n 47).
[151] NICCY, Mental Health Review – Still Waiting <https://www.niccy.org/mental-health-review-still-waiting> accessed 12 August 2024.
[152] NI Department of Education, Children and Young Persons Strategy (n 37).

piecemeal, rather than a whole-of-government, approach. This needs to change, particularly in light of the recent call on the part of the UN Committee on the Rights of the Child for 'mandatory child-rights impact assessment procedures for legislation and policies relevant to children' to be developed and implemented in NI.[153]

Any proposals for reform of NI's mental health and capacity laws must take account of how it fits within a holistic, rights-based approach to improving mental healthcare provision for children and young people in NI.[154] While the NI Executive has promised to increase funding in CAMHS to bring it into line with the rest of the UK (up to 10% of the overall NI mental healthcare budget), it is not exactly clear how and when this will take place. In the meantime, problems persist with respect to facilitating children's timely access to suitable mental healthcare and related services.[155] In promising such reforms, little, if any, reference is made to the importance of a (children's) rights-based approach in relation to driving improvements in mental healthcare provision, as well as the legal framework, in order to better address their needs. This is highlighted by the fact that, while CRC rights are clearly foregrounded in NI Children and Young People's Strategy, this is not the case in the NI Mental Health Strategy.[156]

In order to facilitate a more holistic, joined-up approach, there is a range of options available to NI policy-makers. Consideration should be given to creating a standing expert advisory group, to be supported by the NI Department of Health, which would draw together civil society actors, as well as clinical, legal and other experts, to advise on effective implementation strategies in mental healthcare provision and related laws. This could be in addition to

[153] Committee on the Rights of the Child Concluding Observations on the Combined Sixth and Seventh Periodic Reports of the United Kingdom of Great Britain and Northern Ireland, CRC/C/GBR/CO/6-7, Part III, A, 8(a), 22 June 2023.
[154] A point also made in relation to mental health law reform in England and Wales, see Laing (n 14) 173-4.
[155] NICCY (n 6); NI Department of Health, Mental Health Strategy (n 10) Actions 10-13, 44-50.
[156] NI Mental Health Strategy (n 10); NI Children and Young Person's Strategy (n 37).

establishing a standing consultative group, comprised of children and young people, who could participate in the process and offer their views on such matters. In terms of facilitating executive accountability, a suitably constituted standing Committee should be established in the NI Assembly, which could undertake regular reviews of policies relating to education, health and social care policy involving children and young people in NI. This could also include regular evaluations of how NI's mental healthcare services and related laws are working in practice for their benefit. With support from the NICCY in terms of independent monitoring, the Committee would then be in a position to offer suitable recommendations for driving improvements in the area over time.

IV. CONCLUSION

This article examined current NI mental health and capacity laws applicable to children and young people. As things stand, such laws lack clarity and coherence, resulting in dysfunction in mental healthcare provision and a failure to ensure appropriate human rights protections. This is particularly problematic in relation to addressing the issue of evolving capacity for children under 16 years of age. There needs to be a cultural and political shift in NI which is reflected in the over-arching mental health and capacity legal framework that fully recognises the autonomy of children and young people as rights-holders. In the short term, reform should involve the publication of Codes of Practice linked to the relevant legislation which would provide guidance on the management of mental health and capacity issues applicable to children and young people. Such Codes are flexible, non-legally binding instruments which could better embed rights-based norms, as well as offering guidance on how this can be implemented in practice. In the medium term, further reform should involve the full implementation of NI's mental capacity legislation (i.e., MCANI). In order for such reforms to be effective, they need to take place in the context of a holistic, whole-of-government approach

to ensure appropriately funded and resourced mental healthcare services for children and young people, in circumstances where there is equality of access in a timely manner. Such reforms need to be accompanied by a political commitment on the part of the NI Executive towards greater adherence to the CRC in mental healthcare law, policy and practice. Given persistent political dysfunction, such reforms are long overdue. NI's children and young people deserve better, for reasons of justice, fairness and equality.