

word 'securing' means that the State should also be responsible for funding the procurement of the views of the child. This would be in keeping with the comments of the Committee on the Rights of the Child as outlined above. However, the 2015 Act places the onus in this regard on the parties to the proceedings, at least in respect of the use of an expert to meet the obligation of hearing the voice of the child in the proceedings. The appointment of such an expert is a discretion inherent in the Court and it presumably does not usurp or unseat the other methods by which the voice of the child can be heard.

3.6 Conclusion and recommendations

The evolving nature of the law relating to guardianship, access and custody of children in this jurisdiction provides an opportunity to address the gaps in protection for the rights of the child. That opportunity has been, to a large extent, grasped by the enacted, but not yet in force, 2015 Act. In particular, it is clear that the changes to the law relating to guardianship are essential to ensuring that children are afforded the opportunity to have both parents actively involved in decision making processes affecting them.

In addition, the right of the child to be heard in the context of private family law proceedings needs to be addressed, particularly in terms of providing effective and accessible mechanisms to ensure that this is a meaningful and realisable right for children involved in private family law proceedings.

Thus, some recommendations are as follows:

- > The 2015 Act should be commenced without further delay.
- > A fully funded system in which the right of the child to have their voice heard in the private family law context, in line with their constitutional and international human rights should be put in place.
- > Arrangements relating to surrogacy should be legislated for and in a manner consistent with the rights of the child pursuant to international human rights law.
- > The State should ensure full compliance with international human rights law in this area by encouraging parents to exercise their rights in a manner consistent with the best interests of the child and the evolving capacity of the child.
- > Child inclusive mediation and other child centred methodologies should be explored, implemented, and fully funded in the private family law system.

CHAPTER 4:

Health and Healthcare

Professor Geoffrey Shannon

Article 24 of the UN Convention on the Rights of the Child (CRC) states that:

States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.¹

Article 24 then goes on to stipulate that states must take measures to diminish infant and child mortality, to ensure the provision of necessary health care to children, to combat disease and nutrition, to ensure pre-natal and post-natal care for mothers, to ensure appropriate access to information on health care, to develop preventive health care including family planning, to abolish harmful traditional practices and to encourage international co-operation in realising the right. The Committee on the Rights of the Child (hereafter the Committee) makes the point that 'the realization of the right to health is indispensable for the enjoyment of all the other rights in the Convention'.²

The Committee released in 2013 its General Comment No. 15 on *The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health*. General Comment No. 15 is based on the importance of interpreting the matter of children's health from a children's rights perspective. This involves the approach that all children have the right to survive, grow and develop, in a context of physical, emotional and social well-being, and every child should have the opportunity to reach his or her full potential.³ It is also based on the premise of the World Health Organisation that health 'is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.⁴

The comment is aimed at a wide range of duty bearers, including governmental and non-governmental organisations, those in the private sector and funding organisations. It is emphasised that states are obliged to ensure that all duty bearers are sufficiently aware of their obligations and responsibilities and are capable of meeting them, and that children themselves are also empowered to be involved in decisions affecting them.⁵

The Committee states that children's best interests should be at the centre of decisions affecting their health, for example in relation to providing, withholding or terminating treatment. This also includes the development and implementation of relevant policies and the allocation of resources. It is specified that the best interests of the child should:

1. Guide treatment options, superseding economic considerations where feasible;
2. Aid the resolution of conflicts of interest between parents and health workers; and
3. Influence the development of policies to regulate actions that impede the physical and social environments in which children live, grow and develop.⁶

The Committee stipulates that States should develop procedures to guide health workers apply the best interest of the child principle in the area of health.⁷

4.1 PARTICIPATION

A clear element of the best principle of the child is the right of children to be heard and to participate in decisions being made on their behalf. This applies in the medical arena as it does elsewhere. This is closely linked to the right of children to information, and the Committee has long emphasised that it is in the best interests of children to have access to 'appropriate information on health issues'.⁸ It is emphasised in the General Comment that the Article 12 right of children to be heard provides for children to express their views on all aspects of health provision and to have those views taken into account.

Children's views should, for example, be included in decision making at policy level regarding what services are needed, how they are best provided, what the barriers are as regards accessing services, measuring the quality of the services and how to assist children to take responsibility for their own health and development. For this purpose, the Committee stipulates that states should conduct regular participatory consultations with children in order for children's views and experiences to contribute to the design of health interventions and programmes.⁹ In this regard, the initiative taken by the Law Reform Commission in relation to its consultation on *Children and the Law: Medical Treatment* whereby children were widely consulted is to be welcomed.¹⁰

Of course participation by individual children in decision making regarding personal medical matters is also a vital part of vindicating the right of children to the highest possible standard of health. Research conducted on behalf of the Office of the Minister for Children identified a number of obstacles in Ireland to communicating with children on medical matters.¹¹ It was found that, whilst children's specialists appeared to engage

1 Convention on the Rights of the Child (adopted and opened for signature, ratification and accession on 20 November 1989) 1577 UNTS 3 (UNCRC) art 24.
 2 UN Committee on the Rights of the Child, 'General Comment No. 15: The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health' (13 April 2013) CRC/C/GC/15, 5.
 3 *ibid* 3.
 4 Preamble to the Constitution of the World Health Organization (WHO) as adopted by the International Health Conference, New York, 22 July 1946. See *ibid*.
 5 UN Committee on the Rights of the Child (n2) 4.

6 *ibid* 5.
 7 *ibid* 6.
 8 UN Committee on the Rights of the Child, 'General Comment No. 4 (2003) on adolescent health and development in the context of the Convention' (1 July 2013) CRC/GC/2003/4 para 10. Cited UN Committee on the Rights of the Child (n2) 6.
 9 UN Committee on the Rights of the Child (n2) 7.
 10 Children's Rights Alliance, 'Submission to the Law Reform Commission on: Children and the Law: Medical treatment' (Dublin, April 2010) <http://www.childrensrighs.ie/sites/default/files/submissions_reports/files/AllianceSubLRCChildrenMedicalTreatment16042010_0.pdf> accessed 14 July 2015.
 11 Office of the Minister for Children, *The Child's Right to be Heard in the Healthcare Setting: Perspectives of Children, Parents and Health Professionals* (OMC 2006) <http://www.dcy.gov.ie/documents/research/The_Childs_Right_to_be_heard_in_the_healthcare_Setting.pdf> accessed 14 July 2015.

in best practice regarding communicating with children, non-specialists did not appear to be as familiar with children's rights and the need to listen to children. It was found that the attitude of parents can determine whether children are heard in the healthcare setting. It was also found that professionals are often lacking in the time required to ensure that children are heard during the consultation and treatment process. Both the amount of appropriate physical space and the personal attitude of health professionals were also found to determine whether or not children were listened to.¹²

A number of recommendations were made in the report as regards addressing obstacles to hearing children in the healthcare setting. These recommendations are:

- > Public information campaign: A public information campaign aimed at children and adults needs to take place to raise awareness of the right of the child to be heard.
- > Training: Child development, children's rights and appropriate ways to communicate with children of all ages and stages of development should be incorporated into the training of all health professionals. This should also address the role of parents in this process.
- > Protocols and best practice: Protocols need to be developed between all health professionals, establishing best practice and shared approaches to communicating with children.
- > Research: Further research should be undertaken into the extent to which children are listened to in the healthcare setting. In particular, the experiences of teenagers and children and young people with disabilities should be taken into account.¹³ The report also usefully outlined best practice in communicating with children regarding healthcare as involving the following factors:
 - > The child must be involved in treatment decisions as far as possible, bearing in mind his/her capacity to understand and willingness to be involved.
 - > The patient's parents or carers must be involved in treatment decisions.
 - > The views of children must be sought and taken into account.
 - > The relationship between health professional and child should be based on truthfulness, clarity and awareness of the child's age and maturity.
 - > Children must be listened to and their questions responded to, clearly and truthfully.
 - > Communication with children must be an ongoing process.
 - > Training in communication skills with children is an essential component of appropriate professional education.¹⁴

These factors will provide welcome guidance for professionals in order to ensure a rights-based approach to best practice is being followed as regards hearing children and taking their views into account in the area of medical treatment.

12 ibid 6.
13 ibid 6.
14 ibid 4-5.

A crucial issue relating to the participation of children in healthcare decisions is that of the right to consent to medical treatment. Law and practice in Ireland does not at present provide clear guidelines on consent for professionals, and it has been reported that this results in inconsistent professional practice. It is also of concern that the existing mechanism through which children may consent to medical treatment is the Non-Fatal Offences Against the Person Act, 1997, which provides a medical professional with a defence when facing prosecution for assault. This is a criminal statute unsuitable for the vindication of children's healthcare rights.¹⁵ It does not provide a rights-based approach to children's consent and legislation should be drafted which deals in particular with this matter. The Law Reform Commission has made a number of recommendations as regards consent to medical treatment in the report *Children and the Law: Medical Treatment*.¹⁶

There is evidence that children can be dissuaded from seeking medical advice if confidentiality is not observed.¹⁷ Therefore it seems preferable for legislation to be introduced specifying that it be lawful for a health care professional to provide treatment to a person aged under 16 on the condition that the child has the capacity to understand the nature and consequences of the treatment.

Another vital issue is the right of children to refuse medical treatment. The Non-Fatal Offences Against the Person Act, 1997, does not provide guidance on whether children of 16 years of age have a right to refuse medical treatment. The issue of the right to refuse treatment in Ireland therefore remains vague as regards children aged 16 to 18 years. This issue is particularly important for children in the care of the State, who are without parents to guide them in this respect. The same issue also arises as regards persons under the age of 16. If children under 16 were to have the right to consent to medical treatment under such circumstances as recommended above, then logically they should also have the right to refuse such treatment. Clear guidelines should therefore be set out to address the matter of whether children under the age of 18 years have the right to refuse to consent to medical treatment.¹⁸

Recommendations

- > **Regular participatory consultations should be conducted with children in Ireland in order for children's views and experiences to contribute to the design of health interventions and programmes.**

15 Law Reform Commission, *Children and the Law: Medical Treatment* (Law Reform Commission, 2009) 221.

16 ibid 219.

17 Children's Rights Alliance, *Submission to the Joint Committee on Child Protection* (Dublin, 2006) <http://www.childrensrights.ie/sites/default/files/submissions_reports/files/SubJointOirCommChildProt0806_0.pdf> Accessed 14 July 2015.

18 This has also been provisionally recommended by the Law Reform Commission. Law Reform Commission, (n 15) 220.

- > **The recommendations made in the report of the Office of the Minister for Children, *The Child's Right to be Heard in the Healthcare Setting*, should be implemented. These recommendations include an awareness-raising campaign for the general public, training for all relevant professionals and the development of relevant protocols and research into the area. The best practice guidelines in the report should be made widely available to all.**
- > **Legislation should be drafted which deals in particular with the right of children to consent to treatment as the Non-Fatal Offences Against the Person Act, 1997 is unsuitable for this purpose. It should be lawful for a health care professional to provide treatment to a person under 16 years without parental consent on the condition that the child has the capacity to understand the nature and consequences of the treatment being provided.**
- > **Clear guidelines should be set out to address the matter of whether children under the age of 18 years have the right to refuse to consent to medical treatment.**

4.2 MENTAL HEALTH

General Comment 15 emphasises the serious nature of mental health problems for children and young people and the need to tackle

'behavioural and social issues that undermine children's mental health, psychosocial wellbeing and emotional development'.¹⁹

The lack of provision in this regard in the Irish context has been well documented. The Shadow Report to the Committee on the Rights of the Child, for example, highlights the absence of comprehensive, rights-based legislation in Ireland for addressing children's health needs; the lack of counselling services for children and the fact that children cannot access counselling without parental consent, despite the fact that the problems which many children experience will derive from issues in the home.²⁰ Adequate provision for children's mental health services will require greater resources and political will in Ireland.

In my Fourth Report as Special Rapporteur on Child Protection, I engaged extensively with the issue of the right to be heard of children with mental health difficulties.²¹ It was

highlighted that the Mental Health Act, 2001 operates in a context of uncertainty as regards children and medical consent, and that this can lead to situations whereby parents make decisions in respect of their children that otherwise the children would make for themselves. Although the age of consent for medical treatment is 16 years under the Non-Fatal Offences Against the Person Act, 1997, under the Mental Health Act, 2001 the age of consent for mental health treatment is 18 years. In order to account for the vulnerable position of children in this regard, it was recommended, amongst other things, that the Mental Health Act, 2001 should be amended to include a separate section which clarifies the rights of children in relation to that Act. The uncertainty and inconsistency as regards consent to treatment for mental health problems still persist for children in Ireland despite the serious rights issues involved.

A recent report by Children's Mental Health Coalition highlights the urgent need for a more joined-up system to address the mental health needs of young people who have experienced care and the youth justice system.²² The report acknowledges that, while there are some undoubtedly positive developments underway which aim to improve services for these children (for example, the establishment of the Child and Family Agency and the Assessment, Consultation and Therapy Service for the mental health needs of children in detention, special care and high support units), many problems remain which challenge the enjoyment by these children of the right to the highest attainable standard of health. The report emphasises that children, and particularly those with mental health problems, should not be involved with the youth justice system but instead be diverted towards community services that address their needs. In particular the fact that many such children require support 'to address trauma, neglect or abuse they may have experienced'²³ is emphasised.

A clear theme of the research is the need of children for stability and continuity in care, two factors which the report showed as notably missing from their lives. It is stated in the report that 'the overwhelming message is that if they could develop a single trusting relationship, the impact would be enormous'.²⁴ The report identifies the need for a coherent and comprehensive national strategy which would address the mental health needs of young people in care and those in the youth justice system. This strategy should involve input planning, development and delivery of services by the young people themselves as they are experts by virtue of their own experiences. The report also highlights the crucial nature of inter-agency co-operation and emphasises evidence that a piece meal approach to improving the system will not be successful.²⁵ The main recommendations of the report are as follows:

19 UN Committee on the Rights of the Child (n2) 7.

20 Children's Rights Alliance, *From Rhetoric to Rights: Second Shadow Report to the UN Committee on the Rights of the Child* (Children's Rights Alliance, 2006).

21 Geoffrey Shannon, *Fourth Report of the Special Rapporteur on Child Protection* (Dublin, 2010) <<http://www.dcyu.gov.ie/documents/publications/Rapporteur-Report-2010.pdf>> accessed 14 July 2015.

22 Children's Mental Health Coalition, *Someone to Care: the mental health needs of children and young people in the care and youth justice system* (Dublin, 2013).

23 *ibid* 8.

24 *ibid*.

25 *ibid* 20.

- > Listen to the voice of the child: involve young people in planning service developments, education and consultation;
- > Issue a national policy statement and national strategy to address the mental health needs of children and young people in the care of the State;
- > Establish a common assessment framework and ongoing monitoring of children's and young people's mental health needs;
- > Provide stability for children and young people in the care and in youth justice systems;
- > Provide adequate, equitable access to services;
- > Establish mandatory protocols for inter-agency work;
- > Develop training programmes in identifying and understanding psychological well-being issues as an integral part of professional development for all professionals;
- > Provide legislative protection for children leaving care and detention, and homeless children.²⁶

Recommendations

- > **Comprehensive, rights-based legislation should be drafted in Ireland for addressing children's health needs. Increased counselling services should be established, and children should be permitted to access counselling without parental consent. Greater resources should be ringfenced in Ireland to provide for children's mental health services more generally.**
- > **The recommendations from the Fourth Report of the Rapporteur on Child Protection should be carried out, in particular the Mental Health Act, 2001 should be amended to include a separate section which clarifies the rights of children in relation to that Act.**
- > **The recommendations from the recent report of the Children's Mental Health Coalition should be carried out, in particular the drafting of a national strategy to address the mental health needs of children and young people in the care of the State and in the youth justice system.**

4.3 OBESITY

The General Comment stipulates that states must tackle obesity in children, because of the negative effects of this health condition including 'hypertension, early markers of cardiovascular disease, insulin resistance, psychological effects, a higher likelihood of

²⁶ *ibid* 21.

adult obesity, and premature death'.²⁷ Levels of overweight and obesity among Irish children are high compared to other Northern European countries and these levels are on the increase.²⁸ If this increase is not reversed it will have a significant impact on quality of life, life expectancy and healthcare costs in Ireland.²⁹ This is a vital child protection issue and a challenge to implementation of the right of children to the highest attainable standard of health in Ireland.

Research conducted on behalf of the Minister for Children and Youth Affairs, based on the *Growing Up In Ireland* Longitudinal Study, indicates that 75% of nine-year-olds in the study were of healthy body mass index (BMI), 19% were overweight and 7% were obese.³⁰ Girls were more likely to be overweight or obese, as were children from semi and unskilled social class households. Low levels of physical exercise were found in the research to be far more closely linked than diet to the risk of being overweight or obese. It was also found that parents underestimated the extent to which their child's weight was a problem.³¹

The report conducted on behalf of the Minister for Children and Youth Affairs includes a number of important recommendations. It is recommended that height and weight measures are routinely included in GP visits and school visits by public health nurses. It is recommended that sports policy include national standards for exercise in schools but also that a holistic approach is taken in that all those involved in sports are included. Because children from semi and unskilled social class households were found to have worse diets and less physical exercise, it was recommended that resources for interventions should be heavily targeted at relevant schools and communities. However, it was emphasised that the structural reasons for the higher levels of overweight and obese children among semi and unskilled social class households must be tackled through a cross agency approach in a manner similar to that adopted for 'poverty proofing' in accordance with the National Anti-Poverty Strategy.³²

Low levels of exercise is a particular problem in relation to girls, and therefore greater efforts must be made to make regular exercise more accessible to this group. Dance is consistently reported by girls to be a preferred form of exercise, although it is one of the more expensive options.³³ Research is needed to establish how to make exercise more

²⁷ UN Committee on the Rights of the Child (n 2) 12.

²⁸ Richard Layte and Cathal McCrory, *Growing Up in Ireland: Overweight and Obesity Amongst Nine-Year-Olds* (Minister for Children and Youth Affairs, 2011).

²⁹ *ibid*.

³⁰ *ibid*.

³¹ *ibid*.

³² *ibid*.

³³ See National Heart Alliance, *Physical Activity, Young People and the Physical Environment: Summary of Evidence* (National Heart Alliance, 2006) 13. <http://www.irishheart.ie/iopen24/pub/positionstatements/summary_of_evidence_physical_activity_young_people_the_physicalenvironment.pdf> accessed 14 July 2015.

accessible to girls, in particular on how to make the medium of dance more accessible to girls.

Breastfeeding is closely correlated with lower levels of obesity.³⁴ Data from the *Growing Up in Ireland* study indicates that children who are breastfed for three to six months are 38% less likely to be obese at nine years of age compared to children who have been exclusively formula-fed.³⁵

However, as outlined below, levels of breastfeeding in Ireland are very low. The link between breastfeeding and lower levels of obesity further highlights the need to increase levels of breastfeeding in Ireland. One way in which this could be done would be to highlight this link in information campaigns on breastfeeding.

The Committee on the Rights of the Child makes the point that the exposure of children to sugary drinks and 'fast foods' high in fat, sugar or salt contributes to obesity and that 'the marketing of these substances – especially when such marketing is focused on children – should be regulated and their availability in schools and other places controlled'.³⁶ The Broadcasting Authority of Ireland has issued General and Children's Commercial Communications Codes which include rules on commercial communications for High Fat, Salt and Sugar food directed at children, most recently updated in 2013. However the Institute of Public Health in Ireland states that the Codes do not go far enough, and recommends:

- > the adoption of the Nutrient Profiling Model (a 'simple scoring' system used in the UK, where points are allocated based on the nutritional content in 100g of a food or drink) to limit the exposure of the children to advertising of a product high in fat, sugar and salt;
- > a 'co-regulation' approach whereby both producers and a statutory agency have joint responsibility for certifying a product as a food high in fat, sugar and salt;
- > restrictions on the advertising of foods high in fat, sugar and salt between 6am and 9pm;
- > a monitoring system be established in order to evaluate the effect of measures adopted.³⁷ There is a clear link between advertising and consumption of fast food by children,³⁸ therefore standards need to be strengthened in this regard in Ireland to tackle rising obesity levels and comply with General Comment No. 15.

34 Muiris Houston, 'Feeding the Debate', *Irish Medical Times* (8 June 2012) <<http://www.imt.ie/opinion/2012/06/feeding-the-debate.html>> accessed 8 Dec 2013.

35 Layte and McCrory (n 28).

36 UN Committee on the Rights of the Child (n 2) 12.

37 Institute of Public Health in Ireland, *Submission to Broadcasting Authority of Ireland Children's Commercial Communications Code* (14 October 2011) <<http://www.publichealth.ie/sites/default/files/FINAL%20BAI%20ChildrensCode%20HMcA14Oct%2011%20VX.pdf>> accessed 14 July 2015.

38 See Jason Halford et al., 'Effect of television advertisements for foods on food consumption in children' (2004) 42 *Appetite* 221.

Recommendations

- > **Implement the recommendations of the report conducted on behalf of the Minister for Children and Youth Affairs. These include recommendations to have more height and weight measures for children, to take a holistic approach to sports policy, and to take a cross agency approach to tackling the obesity problem in semi and unskilled social class households.**
- > **Conduct research into increasing opportunities for girls to engage in exercise, with a particular emphasis on dance for girls.**
- > **Place greater emphasis on the link between breastfeeding and lower levels of obesity in children.**
- > **Implement the recommendations of the Institute of Public Health in Ireland to adopt of the Nutrient Profiling Model, a 'co-regulation' approach, restrictions on the advertising of foods high in fat, sugar and salt between 6am and 9pm and the establishment of a monitoring system.**

4.4 Breastfeeding

The Convention on the Rights of the Child stipulates that states must

'ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in... the advantages of breastfeeding...'³⁹

The Committee emphasises in the General Comment the importance of breastfeeding for the health of children, citing the recommendation of the World Health Organisation that infants should be exclusively breastfed to six months of age and that breastfeeding 'should continue alongside appropriate complementary foods preferably until two years of age, where feasible'.⁴⁰ States have obligations in this area to 'protect, promote and support' breastfeeding.⁴¹ States are required, for example, to implement the International Code on Marketing of Breast-milk Substitutes, which includes a requirement to forbid the advertising of baby formula.⁴²

39 Article 24(2)(e).

40 UN Committee on the Rights of the Child (n2) 11, citing WHO and United Nations Children's Fund (UNICEF), *Global Strategy for Infant and Young Child Feeding* (Geneva, 2003).

41 WHO and United Nations Children's Fund (UNICEF), *Global Strategy for Infant and Young Child Feeding* (Geneva, 2003).

42 See Health Service Executive, 'International Code of Marketing and Breast-Milk Substitutes Factsheet' (HSE) <<http://www.breastfeeding.ie/uploads/files/factsheet09.pdf>> accessed 14 July 2015.

The health benefits of breastfeeding for both mother and baby are well known,⁴³ and breastfeeding reduces respiratory, ear and gastrointestinal infection in infants as well as ensuring health benefits which endure into adulthood.⁴⁴ It is estimated that exclusive formula feeding costs at least €12 million annually due to extra health care costs for the treatment of infections in infancy in Ireland.⁴⁵ Yet in 2010, Ireland had the lowest breastfeeding rate of 14 European countries.⁴⁶ 56% of mothers in Ireland currently initiate breastfeeding compared to 81% in the UK and over 90% in Scandinavian countries.⁴⁷ Though breastfeeding duration rate figures are not collected at national level in Ireland research studies indicate that less than 10% of infants are still breastfed at age six months.⁴⁸ At international level a clear link has been made between breastfeeding and human rights obligations to children; therefore it is vital that significant efforts are made in Ireland to improve these figures and therefore the health of children.

Attempts have been made to implement policy in Ireland to increase breastfeeding rates, however there does not appear to have been sufficient efforts to follow-up on these efforts. Policy changes were recommended in the 2005 Five-Year Strategic Breastfeeding Action Plan in order to increase rates of breastfeeding in Ireland.⁴⁹ The targets included an infant feeding Data Collection System to be developed to include demographic indicators known to influence breastfeeding, the appointment of ten regional breastfeeding co-ordinators and an increase in the national breastfeeding initiation rate of 2% per year. It was stated in the Plan that an interim report and final report would be published, however neither have been produced.⁵⁰ Rates of breastfeeding in Ireland at hospital discharge had increased by almost 7% by 2010,⁵¹ however an Economic and Social Research Institute study found that existing policy

initiatives had at best a limited role in the increase in breastfeeding. Most of the increase had occurred because the characteristics of mothers changed. The average age of mothers had increased and more non-Irish national mothers were giving birth in Ireland, and both factors increase the rate of breastfeeding.⁵² In any case, Ireland still has an unacceptably low rate of breastfeeding compared to other countries.

Although detailed analysis of the causes of such low rates of breastfeeding in Ireland is beyond the scope of this report, there are some obvious points which can be made. An inadequate number of trained professionals exist in Ireland to assist women with breastfeeding. In one study, 54% of GPs and only 32% of practice nurses felt sufficiently skilled to provide breastfeeding support.⁵³ This is unfortunate as on the HSE breastfeeding website the emphasis is on accessing support from midwives and GPs who do not specialise in breastfeeding.⁵⁴ Lactation consultants, however, are professionals (usually midwives) who specialise in supporting mothers with breastfeeding. It is mentioned on the website that 'A Lactation Consultant (IBCLC) may also be available'.⁵⁵ There is no guarantee that a mother who requires assistance will have access to this professional. The Association of Lactation Consultants in Ireland states that there is a shortage of lactation consultants. At Cork University Maternity Hospital, for example, there were almost 9,000 births in 2008, with only one lactation consultant employed at the hospital.⁵⁶ There was still only one lactation consultant employed at the hospital in 2013. Clearly better training for health care staff generally, as well as an increase in the number of available lactation consultants should be the first step in attempting to increase breastfeeding rates.

The lack of a breastfeeding culture in Ireland also needs to be tackled. The National Infant Survey found in 2008 that by three to four months, only 53% of mothers who were breastfeeding had breastfed in public.⁵⁷ Increased health promotion strategies are one way in which breastfeeding should be promoted in line with State obligations. Research in Ireland has indicated that such strategies should be targeted at young people before they initiate pregnancies, and that girls should be made aware of the generally positive attitudes of boys to breastfeeding.⁵⁸ Attitudes of others have a great

43 American Academy of Pediatrics, 'Section on breastfeeding: Breastfeeding and the use of human milk' (2005) 115 (2) Pediatrics 496; Chessa Lutter et. al., Quantifying the benefits of breastfeeding: A summary of the evidence (The Food and Nutrition Programme 2002).

44 The Economic and Social Research Institute, 'Breastfeeding in Ireland 2012: Consequences and Policy Responses' <https://www.esri.ie/news_events/latest_press_releases/breastfeeding_in_ireland_/index.xml> accessed 2 Dec 2013.

45 *ibid.*

46 EURO-PERISTAT Project, SCPE EUROCAT, EURONEOSTAT European Perinatal Health Report (EURO-PERISTAT Project 2013).

47 The Economic and Social Research Institute (n44).

48 http://www.breastfeeding.ie/support/what_help_is_available#before (last visited 8 Dec 2013).

49 Department of Health and Children, 'Breastfeeding in Ireland: A five-year strategic action plan' (National Committee on Breastfeeding/ Department of Health and Children 2005) <<http://www.breastfeeding.ie/uploads/files/ACTIONplan.pdf>> accessed 14 July 2015.

50 Australian Government, Department of Health, 'An International Comparison Study into the implementation of the WHO Code and other breastfeeding initiatives: Republic of Ireland' (Australian Government, Department of Health, 2012). <<http://www.health.gov.au/internet/publications/publishing.nsf/Content/int-comp-whocode-bf-init-int-comp-whocode-bf-init-ico-int-comp-whocode-bf-init-ico-ireland>> accessed 1 Dec 2013.

51 The Economic and Social Research Institute, 'Breastfeeding in Ireland 2012: Consequences and Policy Responses' <https://www.esri.ie/news_events/latest_press_releases/breastfeeding_in_ireland_/index.xml> accessed 20 Dec 2013.

52 Aoife Brick and Anne Nolan, 'Explaining the increase in breastfeeding at hospital discharge in Ireland, 2004–2010' (2013) 183 (3) Irish Journal of Medical Science 333.

53 Barbara Whelan, 'An Exploration of Health Professional Support for Breastfeeding' Unpublished Thesis <<http://arrow.dit.ie/cgi/viewcontent.cgi?article=1090&context=sciendoc>> accessed 8 Dec 2013.

54 <http://www.breastfeeding.ie/policy_strategy> accessed 8 Dec 2013.

55 *ibid.*

56 Gary Culliton, 'Ireland needs more lactation consultants' Irish Medical Times, (Dublin, 19 March 2009) <<http://www.imt.ie/news/public-health/2009/03/ireland-needs-more-lactation-consultants.html>> accessed 14 July 2015.

57 Louise Gallagher, *National Infant Feeding Survey* (Health Service Executive, 2008) <http://www.breastfeeding.ie/uploads/files/National_Infant_Feeding_Survey_2008.pdf> accessed 14 July 2015.

58 Claire Connolly, 'Attitudes of Young Men and Women to Breastfeeding' (2013) 106 Irish Medical Journal 9. 59 Gallagher (n 57).

bearing on the likelihood of a mother to breastfeed,⁵⁹ and therefore nationwide campaigns to the general public and not just mothers will be of huge importance in increasing breastfeeding rates.

The marketing of baby formulas is also an area which could be improved in Ireland. Formula advertisements have been found to influence mothers' feeding choices. In one study, mothers who recalled an infant formula advertisement message were found to be twice as likely to feed their babies formula.⁶⁰ Ireland is subject to EU regulations as regards the control of advertising of such products.⁶¹ The Regulations detail, amongst other things, restrictions on the advertising of infant formulas (for those under six months) and 'follow-on formulas' (for those under 12 months). However the regulations do not apply to the full range of products covered by the International Code of Marketing of Breast-milk Substitutes of the World Health Organisation. Such products include all breast-milk substitutes, bottles and teats and bottle-fed complementary foods. There are many improvements which could be made to the standards around infant formula and related products in Ireland. Furthermore there is no indication that there has ever been action taken for a breach of the advertising codes, despite evidence that such breaches have occurred.⁶² Therefore more stringent policing of the implementation of the regulations is needed.

Recommendations

- > Greater training should exist for GPs and nurses in relation to support for breastfeeding.
- > A greater number of lactation consultants should be appointed in Ireland immediately.
- > Recommendations of the 2005 Five-Year Strategic Breastfeeding Action Plan should be implemented, in particular:
 - o Establish an infant feeding Data Collection
 - o Appoint ten regional breastfeeding co-ordinators
 - o Conduct and publish a review of the implementation of the 2005 Five-Year Strategic Breastfeeding Action Plan

- > There needs to be greater emphasis on health promotion strategies regarding breastfeeding. Such strategies should be targeted at the general public, and at young people before they initiate pregnancies. Girls should be made aware of the generally positive attitudes of boys to breastfeeding.
- > Legislation should be introduced which goes beyond EU regulations to ban the advertising of baby formula outright.
- > The regulation of advertising should apply not just to baby formula itself, but also to related products.
- > More stringent policing of the implementation of the regulations should be implemented.

60 Howard Sobel *et. al.*, 'Is Unimpeded Marketing for Breast milk Substitutes Responsible for the Decline in Breastfeeding in the Philippines? An Exploratory Survey and Focus Group Analysis' (2011) 73 *Social Science and Medicine Journal* 1445. See also Suleiman, A, 'A study on marketing and its effects on infant feeding practices' (2001) 56 *Medical Journal Malaysia* 23.

61 The most recent is Regulation (EU) No 609/2013 of 12 June 2013 on food intended for infants and young children, food for special medical purposes, and total diet replacement for weight control.

62 Australian Government, Department of Health (n 117).

Spotlight on Consent to Healthcare

Professor Deirdre Madden

4A.1 IMPORTANCE OF CHILD-CENTRED APPROACH IN HEALTH LAW

In the health and social care context in any matter relating to children, it is generally accepted that the child's best interests are of paramount importance. Such an approach involves putting the interests and wellbeing of the child at the centre of all decisions and ensuring that the child's own voice is heard and respected as far as possible. This does not mean that the interests and views of parents will be displaced, as in most instances the child's interests will be best represented by his or her parents, although their interests are not the same. However, respect for the autonomy of the child entails the facilitation, wherever possible, of the child's right to make his/her own decisions.

Involving children in decision making may be different from obtaining consent in the adult context due to the age or capacity of the child to understand and participate in the decision and the role of the parents in decision making. However, even where children are unable to give a valid consent for themselves, they should nonetheless be as involved as possible in decision making as even young children may have opinions about their healthcare and have the right to have their views taken into consideration by giving their assent to the proposed treatment or service. This principle is in keeping with legal and international human rights standards and ethical guidance which provide that the child's wishes should be taken into account and, as the child grows towards maturity, given more weight accordingly.¹

4A.2 ROLE OF PARENTS AND LEGAL GUARDIANS

Parents and legal guardians are generally considered best placed to safeguard the health and wellbeing of their children. Legal guardianship refers to the right of a parent to be involved in all major decisions affecting the welfare and upbringing of a child including decisions relating to education, health, religious, moral and monetary concerns.

In Ireland, there has been for some time inconsistency in health and social care practice as to whether one or both parents/legal guardians' consent was required prior to commencement of medical treatment and/or social care intervention. On the one hand it was argued (and some health and social care services such as child vaccination

programmes required) that the consent of both parents/legal guardians is required prior to treatment of the child on the basis of the rights of the parents/legal guardians in keeping with Article 41 of the Constitution, which recognises the family as the natural primary and fundamental unit group of society, and the Guardianship of Infants Act, 1964. However, it was also recognised by service providers that seeking joint parental consent sometimes caused delays in children receiving services and potential logistical difficulties in ensuring that all forms are co-signed, for example when parents/legal guardians are working abroad. In addition the requirement for joint consent may be perceived by those parents/legal guardians not in dispute to be bureaucratic.

It was therefore argued that seeking the consent of only one parent/legal guardian should be recognised in health and social care practice as more practical for safe, timely and effective service provision in the best interests of the child. It is generally accepted in other jurisdictions from a legal perspective that, in protecting health professionals from an action in battery, the consent of one parent (or in their absence, that of the court) is sufficient. The acceptance of consent of one parent/legal guardian assumes that the child's welfare is paramount, which is in line with the Child Care Act 1991 and the Children Act 2001, and that the health and social care professional is proposing treatment/intervention in the child's best interests. It also assumes that both of the parents/legal guardians are concerned with the child's welfare.

The provisions of the Irish Constitution 1937 acknowledge the important role and responsibility that all parents have to safeguard the welfare of their children in relation to decisions in many different contexts, including health, social development and education. As a corollary to the rights given to parents as legal guardians of their children, there are also duties imposed on them to act in the best interests of their children. In the health and social care context this requires parents to engage with health and social care service providers to ensure that the child receives the best possible care and services. Such involvement by parents should be encouraged and facilitated by service providers as much as possible.

In 2013 the Health Service Executive (HSE) published a National Consent Policy for all health and social care services provided by or on behalf of the HSE.² In trying to accommodate both of these positions outlined above – the protection of the welfare of the child as well as respect for the rights of both parents – the policy advises that where both parents have indicated a wish and willingness to participate fully in decision making for their child, this must be accommodated as far as possible by the service provider. This also imposes a responsibility on the parents to be contactable and available at relevant times when decisions may have to be made for the child.

1 Convention on the Rights of the Child (adopted and opened for signature, ratification and accession on 20 November 1989) 1577 UNTS 3 (UNCRC) art 3; Medical Council, Guide to Professional Conduct and Ethics for Registered Medical Practitioners (7th edn, 2009) para 43.

2 Health Service Executive, *National Consent Policy* (HSE 2013) pt 2 <http://www.hse.ie/eng/services/list/3/nas/news/National_Consent_Policy.pdf> accessed 20 January 2014.

The policy advocates that even where both parents have not clearly indicated their wish to be involved in decision making, if the decision will have profound and irreversible consequences for the child, both parents should be consulted if possible. The policy does not attempt to catalogue what is included in the meaning of 'profound and irreversible consequences' as it was felt that this should be left to the discretion of the clinician based on his/her best clinical judgement of the child's situation and that attempts to pre-determine what such consequences might be would not allow for sufficient flexibility to ensure adequate protection of the child. If urgent care is required and the second parent cannot be contacted despite reasonable efforts to do so, the service provider has a paramount duty to act in the best interests of the child.

Apart from the circumstances outlined above and in keeping with the prioritization of the best interests of the child, the policy provides that the consent of one parent/legal guardian will provide sufficient authority in respect of any health or social care intervention in relation to a child. Despite efforts to find a middle ground position that prioritises the welfare of the child, it is possible that this policy may be legally challenged in the courts on the grounds that it fails to give due regard to the rights of both parents equally. This would raise a clash of constitutional principles, for example between the principle that the courts must always act on the basis that the child's welfare is paramount and the principle that each parent or legal guardian has equal standing in decision making for their child in the absence of indications to the contrary.

In 2013 the Irish High Court dealt with a case involving a five-year-old boy whose parents were in dispute about whether he should get vaccinations. The boy's parents were not married but were in a ten year relationship which broke down in 2009. When the child was born, he was immunised without dispute and with no adverse reactions reported. But after the parents' relationship broke down in 2009, the mother left the family home with her son, who was due to receive a further two vaccination injections provided under the public health programme to children. A dispute arose between the parents on the issue. The HSE and the boy's father supported him getting the vaccinations but the mother was opposed. The High Court held that both mother and father were clearly loving parents and that, even though the mother was the primary carer, the court did not accept a hierarchy of authority could exist in cases where unmarried guardians have disagreements as to the medical treatment for their children. In other words, the judge rejected arguments that the mother as primary carer has a stronger voice than the father. The court had to decide the matter on the basis of what was in the child's best interests. This was upheld by the Supreme Court which agreed that the mother did not have superior constitutional rights requiring that her opposition to the vaccinations of the child take priority over the father's support for them.³ Her claim of an effective veto would, if upheld, set at naught the father's rights and status as his son's legal guardian, according to MacMenamin J. The court was not obliged to give

precedence to either parent, as the welfare of the child is their first and paramount consideration.⁴

It is difficult to anticipate the outcome of further litigation on this issue and it is not best practice to have each individual case referred to legal resolution as this may cause delay in treatment for children which is contrary to their best interests. However, in the absence of legislation on the issue, it is hoped that the National Consent Policy will form the basis of best practice safeguarding the welfare of the child in medical decision making.

4A.3 MINORS AND CONSENT TO MEDICAL TREATMENT

Under the Irish Constitution, the rights of children flow from the rights of every individual person to life, liberty, education etc. These rights are independent of the rights of the parents as such. Therefore, an unqualified acceptance of absolute parental authority would unduly restrict the exercise by older minors of their legal and constitutional rights, their rights under the European Convention of Human Rights, and the United Nations Convention on the Rights of the Child. These rights include rights to liberty, bodily integrity, the freedom to communicate with others and to follow their own conscience.

There is no single age in Ireland at which a person is entitled to all the rights and responsibilities of adulthood. The law instead sets various thresholds such as 16, 18 and 21 years at which the young person gradually moves from childhood to adulthood. For example, at 16 some restrictions on employment are lifted and young people may choose to leave school whereas the Age of Majority Act, 1985 provides that a person becomes an adult for the purposes of civil law at 18 years. This marks an important point as the person loses many of the protections of childhood at that point.

The Non-Fatal Offences Against the Person Act, 1997 provides in section 23(1) that in the context of criminal law only, consent to medical treatment by a person aged over 16 has the same status as if he or she was an 18 year old. This means that although Section 23 of the Act provides a defence to a criminal charge of assault against a health care professional who provides treatment to a 16 or 17 year old, it does not provide a defence to a civil action. However, in terms of health care practice, 16 is largely accepted as the age of consent to medical treatment in Ireland. This means that a person aged 16 years can in practice choose their own doctor, obtain a Medical Card or consent to an operation. In general, young people are not treated in paediatric hospitals once they reach 16.

3 C.O's. & Anor. v Her Honour Judge Alice Doyle & Ors. [2013] IESC 60.

4 Mary Carolan, 'Challenge to son's vaccination fails' The Irish Times (Dublin, 20 December 2013). <<http://www.irishtimes.com/news/crime-and-law/courts/challenge-to-son-s-vaccination-fails-1.1633545>> accessed 20 January 2014.

Section 23 does not make any reference to those under the age of 16. There are various possible interpretations of this. One interpretation is that the Act provides for consent by a person over 16 without necessarily preventing those under 16 from giving consent. Another interpretation is that the Act prevents those under 16 giving consent. It has been consistently recommended by legal commentators as well as the Law Reform Commission and the Ombudsman for Children that the law should be clarified on this matter.⁵

There have not been any clear judicial decisions on the capacity of young persons to give consent to or refuse healthcare interventions in Ireland. However, some guidance may be drawn from a handful of cases in the general healthcare context. For example, in *McK v The Information Commissioner*⁶ the Supreme Court held that in a health care setting the views of a young person aged 17 are very relevant and may override a parent's presumed entitlement to access health care information about their children under the Freedom of Information Acts, which applies until the age of 18.

In the *D* case in 2007, the High Court acknowledged that a 16- or 17-year-old can give consent in certain circumstances without parental involvement.⁷ The young person in this case was 16 years old when she became pregnant (she was 17 when the case came before the court). A scan revealed that the foetus had anencephaly and would not survive. She decided to go to England for a termination of the pregnancy. For different reasons the HSE obtained an interim care order which meant she was under the care of the HSE. The HSE took the view that she should be prohibited from travelling to England for a termination, although it is not clear whether her welfare or indeed her own views were taken into account in this decision. *D* applied to the High Court for a declaration that she had a right to travel. McKechnie J took the view that she had displayed good moral judgement, courage, integrity and maturity following the discovery of her baby's condition and he made the declarations sought.⁸

The courts have generally taken the view that as a young person approaches 18, their decision making capacity increases and the decision making capacity of their parents decreases. However, there is no definitive legal framework that clarifies the rights of those under 18 and the health care professionals treating them. In practice it appears that many doctors in Ireland have adopted the mature minor test put forward in the English case of *Gillick v West Norfolk and Wisbech Area Health Authority* (1985), and in particular the 'Fraser Guidelines' set out in that case.⁹ This case is very significant in setting out the legal relationship between parents and children, though of course it

must be remembered that the constitutional framework in Ireland may result in a different outcome here. In the *Gillick* case a mother of five daughters under the age of 16 challenged the legality of guidance issues to health authorities. This guidance was to the effect that if a doctor was approached by a girl under the age of 16 for contraception he should try to persuade her to involve her parents but that in exceptional cases the decision of whether or not to prescribe the contraception was a clinical one for the doctor. Mrs Gillick complained that this breached her parental rights.

The House of Lords held by majority that the guidance was lawful and that parental rights recede as the child grows in maturity. They concluded that a strict age rule would not take account of the growing maturity and capacity of the child. Therefore capacity to consent should not be determined by a fixed age limit but should be determined according to the maturity, understanding and intelligence of the child in relation to what is proposed. The guidelines proposed in this case by Lord Fraser are that the doctor will be justified in proceeding without parental consent or knowledge if the girl who is under 16 understands the medical advice given; the doctor cannot persuade her to inform her parents; the girl is very likely to begin or continue sexual intercourse without contraception; unless she receives contraception, her physical or mental health are likely to suffer; and her best interests require the doctor to give such contraception.

The first of these tests is often referred to as the test of Gillick competence. It is consistent with international standards in the area of adolescent autonomy such as Article 12 of the UN Convention on the Rights of the Child as well as the Irish Child Care Act, 1991. It is also reflected in the Age of Legal Capacity (Scotland) Act 1991 which states that a person under the age of 16 'shall have legal capacity to consent on his own behalf to any surgical, medical or dental treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.'¹⁰ The absence of a best interests requirement seems to suggest that a young person who is deemed mature enough to understand the nature of their treatment can make healthcare decisions even if these are not in their best interests.

Existing practice in Ireland has therefore taken the view that although the 1997 Act applies to criminal law only, it is seen as setting the correct approach with regard to 16- and 17-year-olds having the capacity to give their own consent to medical treatment generally. The Medical Council which regulates the conduct of registered medical practitioners in Ireland has given guidance to registered medical practitioners in this area in its Guide to Professional Conduct and Ethics which reflects the general law.¹¹ It recommends that where a person under the age of 16 years seeks to make a healthcare decision, the doctor should encourage the patient to involve their parents in the

5 Law Reform Commission, *Children and the Law: Medical Treatment* 2011 (LRC 103 - 2011).

6 [2006] IESC 2, [2006] 1 IR 260.

7 *D v Ireland* App no 26499/02 (ECtHR, 27th June 2006).

8 <<http://www.rte.ie/news/2007/0509/88757-abortion/>> accessed 17 January 2014.

9 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

10 Age of Legal Capacity (Scotland) Act 1991 Section 2 subsection 4.

11 Medical Council (n 1).

decision, bearing in mind the doctor's paramount responsibility to act in the patient's best interests.¹²

The National Consent Policy states that while currently there are no legal provisions in Ireland for minors under 16 years to give consent on their own behalf, it is nonetheless good practice to involve the minor in decisions relating to them and listen to their wishes and concerns in terms of their treatment and care.¹³ It acknowledges that the *Gillick* case and other similar cases elsewhere do not have any application in Ireland although they may be of persuasive authority in the event of a judicial determination on this issue. The policy acknowledges that in health and social care practice it is usual to involve parent(s)/guardian(s) and seek their consent when providing a service or treatment to a minor under 16. However, the minor may seek to make a decision on their own without parental involvement or consent. In such circumstances it is best practice to encourage and advise the minor to communicate with and involve their parents or guardians. It is only in exceptional circumstances that, having regard to the need to take account of an objective assessment of both the rights and the best interests of the person under 16, health and social care interventions would be provided for those under 16 without the knowledge or consent of parent(s) or guardian(s).

It is unclear whether, in the absence of a finding that there has been a failure by the parents to provide for their child, Articles 41 and 42 of the Constitution would allow medical treatment to be given to a 15-year-old without the consent or knowledge of the parents or their right to decide what is in the best interests of their child. It is possible that an Irish court would draw a distinction between contraceptive treatment (or decisions in relation to termination of pregnancy) on the one hand and ordinary medical treatment on the other as the former may be seen as in keeping with the right of family to make moral/ social decisions in relation to children in the family under Article 42. The latter form of decision might lend itself to increased judicial willingness to adopt the mature minor approach in this jurisdiction. Although the courts have been clear in stating that constitutional rights extend to children, it may be argued that it would only be lawful to interfere with the authority of the family in its decision making over the medical welfare of the child as a member of the family unit, if legislation were introduced to specifically deal with the question of medical treatment and intervention in a way that is consistent with Articles 41 and 42.

The passing into law of Article 42A of the Constitution, following the referendum on children's rights in 2012, may have an impact in this area in the future through the interpretation placed on the new constitutional provisions by the courts although the wording of the new provisions do not appear to directly affect the provision of healthcare. The provisions of the European Convention on Human Rights Act 2003 are

12 *ibid* para 43.5.

13 Health Service Executive (n 2).

also relevant in ensuring that the Convention rights are applied here as much as possible in keeping with the limitations on judicial function under the Constitution. In particular Article 8 of the Convention provides for the right to respect for private and family life which may have relevance in this context although the breadth of the right in the context under discussion is unclear.

4A.4 MENTAL HEALTH LAW AND MINORS

The Mental Health Act, 2001 defines a child as a person under 18 years. There is confusion as to the interaction between the Mental Health Act, 2001 and the Non-Fatal Offences Against the Person Act, 1997 discussed above as it is unclear whether the age of 16 years also applies to mental health treatment. The Law Reform Commission in its 2011 stated that:

The Mental Health Act 2001, however, does not engage with section 23 of the Non-Fatal Offences Against the Person Act 1997, which provides that a minor aged 16 years of age may consent to medical treatment. The uneasy relationship between section 23 of the 1997 Act and the 2001 Act raises questions over the status of consent or refusal given by a young person aged 16 years of age under the 2001 Act. This uncertainty also extends to issues of capacity and consent in respect of young people under 16 years of age.¹⁴

The Commission also pointed out that: 'The failure to recognise the capacity of children and young people, particularly those aged 16 and 17 years of age in respect of consent to mental health admission and treatment creates an arbitrary distinction between physical and mental health.'¹⁵ It recommended that the Mental Health Act, 2001 be amended to provide that a person who is 16 or 17 years of age is presumed to have capacity to consent to and refuse healthcare and medical treatment, including psychiatric treatment. It also stated that its recommendations concerning healthcare decision making by persons under 16 years of age should also be applied in the context of mental health, including decisions in respect of admission and treatment under the Mental Health Act, 2001. This means that there would be no distinction between physical and mental health for the purposes of recognising the young person's capacity to give consent.

The only parts of the Mental Health Act which refer to children are those which apply to involuntary detention so it may be argued that the only time the definition is relevant is in this context. This may be interpreted to mean that for clinical assessment and treatment in any other context such as outpatient treatment, the Act does not apply to

14 Law Reform Commission 2011 Report on Children and the Law: Medical Treatment, at para. 3.40.

15 *ibid* para 3.53.

limit the giving of consent to those over the age of 18. Therefore a person aged 16 years would have the legal capacity to give personal consent to their own mental health treatment in the same way as any other medical treatment.

Of some relevance in this context is *HSE v JM* in 2013,¹⁶ where a 15-year-old girl with bipolar disorder was refusing to comply with her treatment regime or to allow a blood sample to be taken from her to monitor her condition. She was assessed by a consultant adolescent psychiatrist as mature enough to understand the necessary information regarding her diagnosis and treatment, and as being at significant risk of suicide to the extent that her judgement was impaired and she was unable to make clear decisions about her future. The judge took the view that she lacked the capacity to refuse consent to the taking of blood samples. In discussing section 23 of the 1997 Act, Birmingham J stated that although the consent of a minor aged 15 years and 11 months would not provide a statutory defence to what would otherwise be a trespass, this is 'not at all to suggest that the views of a minor of that age ought not to be treated with respect, they most certainly should be'.

He went on to say:

I am not to be taken as being of the view that there are no decisions of a medical nature which X.Y. would not have the capacity to take. Neither am I laying down any general principle that young people aged 15 going on 16 should always be regarded as lacking capacity.¹⁷

In relation to the question of whether Gillick competence forms part of Irish law, the court noted that this approach had found favour in a number of common law jurisdictions but did not comment on whether it formed part of Irish law. The judge stated that even assuming for the purpose of this case only that the concept forms part of Irish law, X.Y. was not in fact Gillick competent. The relevance of the case here is that the judge was prepared to countenance that the Non-Fatal Offences Against the Person Act, 1997 does in fact apply to psychiatric treatment as advocated above.

The Mental Health Commission has recommended that persons under 18 should be allowed to consent to psychiatric treatment and it is understood that they intend revising their code of practice in this regard in light of the *JM* case mentioned above.

16 2013] IEHC 12.

17 *HSE v JM* [2013] IEHC 12 (Birmingham J 24).

Spotlight on Mental Health

Anne-Marie O'Sullivan BL

4B.1 INTRODUCTION

The prevalence of mental health problems among children and adolescents is well documented, as is the need to prioritise mental health care in childhood.¹ Recent studies also suggest that young people in Ireland may have a higher rate of mental health problems than similarly aged young people in other countries.² Unfortunately, this has not resulted in the required level of service provision or legislation.³ Failure to deal with the mental health needs of children can lead to mental health problems with lifelong consequences, undermining compliance with health regimes and reducing the capacity of societies to be safe and productive.⁴ Mental health problems do not occur in isolation and children who are exposed to risk factors such as homelessness, poverty, the care and youth justice system, and substance abuse have a greater likelihood of developing mental health difficulties.⁵ The cross cutting nature of mental health issues demands a multi-disciplinary approach to reform across the education, care and youth justice and asylum and immigration systems, both in terms of policy and legislative reform.⁶

4B.2 REVIEW OF RELEVANT INTERNATIONAL HUMAN RIGHTS AND CONSTITUTIONAL STANDARDS

International standards

Article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR) establishes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The ICESCR also provides for an overarching right to non-discrimination under Article 2(2).⁷ The right to health is also set out in Article

- 1 Department of Health and Children, *A Vision for Change - Policy Document* (2006) 85; Health Service Executive, *Fifth Annual Child & Adolescent Mental Health Service Report 2012 – 2013* (2014); Tony Bates and others, *Someone to Turn To, Someone to Talk To* (Headstrong 2009) 18; Barbara Dooley and Amanda Fitzgerald, *My World Survey: National Study on Youth Mental Health in Ireland* (Headstrong and UCD 2012).
- 2 Mary Cannon and others, *The Mental Health of Young People in Ireland: A report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group* (RCSI 2013) 7.
- 3 Health Service Executive, *Fifth Annual Child & Adolescent Mental Health Service Report 2012 – 2013* (2014).
- 4 World Health Organisation, *Caring for children and adolescents with mental disorders: Setting WHO direction* (2003) 25, appendix 1.
- 5 Department of Health and Children, (n 1) 85.
- 6 Rosaleen McElvaney and others, *Someone to Care: The Mental Health Needs of Children and Young People with Experience of the Care and Youth Justice Systems*, (Children's Mental Health Coalition Dublin 2013).
- 7 UN Economic and Social Council, 'CESCR General Comment No. 5: Persons with Disabilities' (9 December 1994) E/1995/22.

24 of the UN Convention on the Rights of the Child (CRC) which includes mental health. Article 23 of the CRC also specifically addresses the rights of children with disabilities to enjoy a 'full and decent life' as well as the right to 'special care' and 'assistance' while Article 27 of the CRC provides that every child has the right to a standard of living adequate for his or her physical, mental, spiritual, moral and social development. The CRC's four main guiding principles include the best interests of the child (Art 3 CRC), non-discrimination (Art 21 CRC), the right to survival and development (Art 6 CRC), and respect for the views of the child (Art 12 CRC). The Convention also contains a number of more specific rights of relevance to children with mental health problems, which will be discussed in more detail in the body of this section.

Ireland is also a signatory to the UN Convention on the Rights of Persons with Disabilities (CRPD).⁸ While the CRPD does not introduce any new rights, it seeks to 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity'.⁹ The CRPD moves towards a social model of disability¹⁰ and has been described as marking a 'paradigm shift' in attitudes and approaches to persons with disabilities, which includes persons who experience mental health problems.

Article 3 CRPD, which sets out the Convention's general principles, refers to the specific needs of children and requires respect for the evolving capacities of children with disabilities, while Article 4(3) requires States to closely consult with and actively involve children with disabilities and their representative organisations in the development and implementation of legislation and policies to implement the CRPD. Article 7 of the CRPD discusses the principle of 'best interests' and recognises the developing capacities of children. It states that 'in all actions concerning children with disabilities, the best interests of the child [...] be a primary consideration' (Art 7(2) CRPD) and that their views be given due weight in accordance with their age and maturity (Art 7(3) CRPD). This must be read in conjunction with Article 12 of the CRPD, which protects equality before the law for all persons regardless of age. The UN Committee on the CRPD has provided clarification on Article 12 in its first General Comment and in relation to children has stated that parties must examine their laws to ensure that the will and preferences of children with disabilities are respected on an equal basis with other children.¹¹ In light of this approach and the evolving interpretation of Article 12 of the CRPD, there is a need

for greater clarity and guidance from the CRC Committee in relation to concepts of best interests, the voice of the child and the evolving capacity of the child as they relate to mental health, particularly. There remains a gap in international commentary on the position of children under the CRPD and further consideration and guidance is necessary on this developing issue. In particular, further thought must be given as to how the principles of autonomy, self-determination and the promotion of a child's decision making abilities might be balanced alongside the exercise of parental responsibilities and the child's best interests.¹²

The *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*¹³ were adopted by the UN in 1991 to provide useful guidance on the human rights of people experiencing mental health problems. The Principles have to a large extent been superseded by the CRPD, however they emphasise the right to care and treatment in the community¹⁴ and to the least intrusive treatment in the least restrictive environment in accordance with an individually prescribed treatment plan.¹⁵

Regional standards

The European Convention on Human Rights (ECHR)¹⁶ contains a number of provisions relevant to the treatment and detention of children with mental health problems. These include Article 2 ECHR (right to life), Article 3 ECHR (prohibition of torture, inhuman and degrading treatment or punishment), Article 8 (right to respect for private and family life, including a person's physical and psychological integrity) and Article 5 (right to liberty and security). The European Court of Human Rights' (ECtHR) jurisprudence in the area of mental health has primarily dealt with adults. In the context of children and mental health, the ECtHR found in *DG v Ireland* that Ireland was in breach of its obligation under the Convention for the temporary placement of a minor with a mental health problem in St. Patrick's Institution for Young Offenders without charge or conviction. The Court did not accept the argument that a high-support secure educational facility for 16-18 year olds was unavailable and held that such a facility was not lawful for the purposes of educational supervision and was a violation of D.G.'s rights under Article 5 ECHR.¹⁷

In 2004, the Council of Europe issued *Recommendation Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorders* (Rec (2004) 10). Article 10 requires the provision of hospital facilities with appropriate levels of security, as well as community-based services to meet the health needs of people with mental health problems involved in the criminal justice system. Article 29, paragraph (2) states that the

8 Ireland has yet to ratify the UN CRPD, which entered into force on 3 May 2008 and has been ratified by 126 countries. The Government has signalled its intention to ratify the Convention following the enactment of capacity legislation which it says is necessary. The Assisted Decision-making (Capacity) Bill 2013 was published in June 2013.

9 Convention on the Rights of Persons with Disabilities (adopted on 13 December 2006) A/RES/61/106 art 1.

10 Article 1 CRPD defines the term 'disability' as including 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.'

11 UN Committee on the Rights of Persons with Disabilities, 'General Comment No. 1 (2014) Article 12: Equal recognition before the law' (11 April 2014) CRPD/C/GC/1, para. 32, 9.

12 Amnesty International Ireland, *Response to the Interim Report of the Steering Group on the review of the Mental Health Act 2001* (Dublin, November 2012) 46.

13 UN General Assembly, 'Principles for the Protection of Persons With Mental Illness and the Improvement of Mental Health Care' (17 December 1991) A/RES/46/119.

14 *ibid* Principle 7.

15 *ibid* Principle 9.

16 Incorporated into Irish law by means of the European Convention on Human Rights Act 2003.

17 Ursula Kilkelly, 'Children's Rights: A European Perspective' (2004) 4(2) *Judicial Studies Institute Journal* 68.

minor's opinion should be taken into consideration in decisions about placement and treatment and should have proportionate weight to the child's age and degree of maturity. It also requires that representatives should provide assistance to children who have been involuntarily placed¹⁸ and that minors should not be placed in a facility with adults unless it would benefit the minor.¹⁹

Constitutional Standards

The 31st Amendment to the Constitution was passed by referendum in November 2012 and following the Supreme Court decision in *Re: Referendum Act & re: Jordan v Minister for Children and Youth Affairs & ors*,²⁰ new provisions strengthening children's rights were inserted into the Constitution. While this amendment has been broadly welcomed as a positive step for children's rights, its impact in the area of children's mental health is regrettably limited. The 'best interests' principle and the right of the child to be heard under the amendment will only apply to matters concerning adoption, guardianship, custody or access and proceedings brought by the State. This means that it does not apply to the admission or treatment of children under the Mental Health Act, 2001 or proceedings arising under the Act. However, the amendment is an important first step and has the potential to bring about a fundamental change in the relationship between the State and children by affirming in children as rights holders under the Constitution and placing an obligation on the State to uphold those rights.²¹ It may also redress the imbalance between parental rights and children's rights, particularly where there is a disagreement between the child's wishes and those of the parent in relation to either treatment or admission under the 2001 Act.

4B.3 REVIEW OF IRISH LEGISLATION AND CASE LAW

Mental Health Act 2001

The Mental Health Act, 2001 is the primary legislation governing children with mental health problems and their access to mental health services. Even though the 2001 Act was only brought into effect in 2006, it is outdated and is not in line with Ireland's international human rights obligations, particularly as these relate to children.²² When the 2001 Act was first enacted, the CRC Committee welcomed its introduction but noted the lack of adequate programmes and services related to the mental health of children and their families in Ireland. The Committee also expressed concern that many children with mental health difficulties were unable to access existing programmes and services

for fear of stigmatisation and that some children were treated with adults in psychiatric facilities.²³ *The Programme for Government 2011* recognised this and committed to reviewing the 2001 Act in consultation with service users, carers and other stakeholders and in line by human rights standards. This review was recently completed with the publication of a *Report by the Department of Health's Expert Group on the review of the Mental Health Act 2001*, which contained a number of important recommendations relating specifically to children.²⁴

Separate section for children and young people and guiding principles

The provisions of the 2001 Act relating to children and young people are spread throughout the Act so the extent to which such provisions apply to children is unclear.²⁵ To make the 2001 Act user-friendly and to facilitate the introduction of a separate set of guiding principles specifically for children and young people, the Law Reform Commission (LRC) recommended the introduction of a separate section for people under the age of 18 into the Act.²⁶ The Expert Group has added to this recommendation by stating that the applicable provisions of the Child Care Act 1991 should be expressly included in the 2001 Act rather than being cross referenced.²⁷ The Expert Group also recommended that this separate section contain its own set of guiding principles.²⁸

Best Interests: The Expert Group has accepted that interventions under the 2001 Act must take into account the views of the child and that those should be given due weight in accordance with his/her age, evolving capacity and maturity. This doesn't go as far as the recommendation of the LRC, and the requirement of Article 3 of the CRC, that the best interests of the child be the first and paramount consideration in all decisions taken under the Act.²⁹ This should be clearly stated in the new guiding principles. On a more positive note, the Expert Group's Report does take into account the need to respect the evolving capacities of the child (Article 5 CRC) as well as their right to be heard and to participate in decisions affecting them (Article 12 CRC);³⁰ an approach that is reflected in the CRPD (Article 7 CRPD). In implementing the recommendations of the Expert Group, it is important that the legislature adopt a holistic approach when considering what is in the 'best interests' of a child in a mental health context. This should not be limited to the

18 Art 29(3).

19 Art 29(4).

20 *Re: Referendum Act & re: Jordan v Minister for Children and Youth Affairs & ors* [2015] IESC 13

21 Ursula Kilkelly, 'Ireland's Law and Policy: Moving towards a Children's Rights Based Approach' (Symposium to mark the 10th Anniversary of Ombudsman for Children's Office, Farmleigh House, 25 April 2014).

22 Mental Health Commission, *Response to the Law Reform Consultation Paper on Children and the Law: Medical Treatment* (2010) 24.

23 UN Committee on the Rights of the Child, 'Concluding Observations of the UN Committee on the Rights of the Child: Ireland' (29 September 2006) CRC/C/IRL/CO/2 para 46.

24 Department of Health and Children, *Report of the Expert Group on the Review of the Mental Health Act 2001*, (Dublin: Department of Health, 2015).

25 Department of Health and Children, *Report of the Steering Group on the Review of the Mental Health Act 2001*, (2012) 14.

26 Law Reform Commission, *Children and the Law: Medical Treatment 2011* (LRC 103 - 2011) recommendation 7.14.

27 Department of Health, *Expert Group Report* (n 24) 68. At present, a number of sections of the Child Care Act 1991 apply to proceedings under s. 25 of the 2001 Act making its application unnecessarily complex.

28 *ibid* 68.

29 Law Reform Commission (n 26) para 3.82, 132 -133.

30 Jean Zermatten, *The Best Interests of the Child, Literal Analysis, Function and Implementation* (Institut International Des Droits De L'Enfant, 2010).

medical best interests of the child but also recognise the child's life in the family or community. The best interests of the child should not be objectively assessed; instead there should be objective and subject elements to the definition of best interests. The subjective elements of best interests should include collective subjectivity (what is in the best interests of the child in the context of society at the time) and personal subjectivity.³¹ In order to facilitate such an assessment, the 2001 Act should contain a set of guiding principles or factors to be considered in determining what is in a child's the best interests.³²

Voice of the child: The 2001 Act does not provide for the voice of the child to be heard in relation to treatment or admission.³³ In a welcome move, the Expert Group has recommended that the child's right to be heard be included in the guiding principles of the child-specific part of the legislation and that consultation with the child is required at each and every state of diagnosis and treatment.

Capacity to Consent³⁴

The 2001 Act does not recognise the ability of a person under the age of 18 years to consent to admission or treatment for mental health problems. Instead parental consent is determinative of a young person's status as a patient (voluntary or involuntary) regardless of their age, maturity or ability to consent. This issue was recently highlighted by the High Court in *In re X.Y.: HSE v J.M. & Anor*³⁵ where a child aged 15 years and 11 months disagreed with her doctors and parents regarding the provision of medication and the taking of an ancillary blood test. The judge acknowledged that the views of a minor ought to be treated with respect but stated that a minor's consent could not provide a statutory defence in this matter.³⁶ The court did not rule out the possibility that the respondent could have the capacity to make certain decisions of a medical nature. The judge clarified this by stating that there was no general principle that young people aged 15 going on 16 should always be regarded as lacking capacity.

Children aged 16 and 17 years of age: Section 2 of the 2001 Act defines a child as a person under the age of 18³⁷ while the HSE's *National Consent Policy* confirms that the age of consent for treatment of a mental health problem is 18.³⁸ This contrasts with s. 23

of the Non-Fatal Offences Against the Person Act 1997, which provides that a young person can make decisions about his or her medical treatment from the age of 16. This inconsistency was recognised by the Expert Group which recommended that children aged 16 and 17 be presumed to have the capacity to consent or refuse healthcare and treatment under the 2001 Act. This approach is in line with Article 12 of the CRC which respects the evolving capacities of the child and gives due weight to his or her views in accordance with his or her age and maturity. Unfortunately, the Expert Group also introduced a requirement that where a *16- or 17-year-old* objects to treatment for a mental health problem, the case should be referred to a child friendly District Court. This undermines the presumption of capacity as the mere fact of a *16- or 17-year-old's* objection to admission or treatment is enough to bring his or her ability to consent into question and retains the existing discrimination.

To ensure compliance with the CRPD, there must not be any discrimination in the application of age limits, i.e. if there is a presumption of the ability to consent, it should apply to all children over the age of 16 equally, including those with mental health problems. Where this presumption exists, the child should have the full benefit of the principles of autonomy, self-determination, will and preferences as set out in relation to adults as well as support in making those decisions.³⁹ The CRPD creates an obligation to support such children to exercise their will and preferences and make decisions.⁴⁰

Under 16 years of age: The 2001 Act does not distinguish between children under the age of 16 years of age and those aged 16 and 17. The Expert Group recommended there should be no automatic presumption of capacity for children under the age of 16 but that the views of the child should be heard and given due weight in voluntary admission process.⁴¹ The situation regarding children below the age of 16 years is less clear than minors age 16 and 17 years as 'competence' is a matter of fact that can differ from child to child depending on the individual child's maturity.

The Law Reform Commission considered that the 2001 Act should provide that where it has been established that a child has the maturity and understanding to appreciate the nature and consequences of a specific healthcare treatment decision, they should be able to make healthcare decisions. The LRC has recommended inserting a set of factors to be taken into account when deciding whether a child has the ability to make a decision.⁴² These include having regard to whether the child has the maturity to understand the information and to appreciate its potential consequences; whether the child's views are stable and a true reflection of his/her core values and beliefs; the nature, purpose and utility of the treatment; the risks and benefits of the treatment and

31 *ibid.*
 32 Amnesty International (n 12) 46.
 33 Ursula Kilkelly, *Children's rights in Ireland: Law, policy and practice* (Tottel Publishing 2008) 177.
 34 In this section, reference to capacity refers simply to the legal capacity of children generally to make decisions, rather than 'mental capacity' or decision-making ability of a child by virtue of their disability or mental health problem. In recognising the evolving capacity of children to make decisions, it is important that this is differentiated from the 'decision making ability' of children. See AI, *Response to the Interim Report of the Steering Group*, at p. 48.
 35 *In re X.Y.: HSE v J.M. & Anor* [2013] IEHC 12.
 36 *HSE v J.M. & Anor* [2013] IEHC 12 para 23.
 37 The UN CRC also defines a child as anyone below the age of 18.
 38 Health Service Executive, *National Consent Policy* (HSE 2013).

39 Convention on the Rights of Persons with Disabilities (n 9) art 7(2).
 40 Amnesty International (n 12) 51.
 41 Department of Health, Expert Group Report (n 24) 71.
 42 Law Reform Commission (n 26) 102-103.

any other specific welfare, protection or public health considerations. However, the LRC also referred to the child's 'mental health' as a possible factor for assessing a child's decision making ability. A child's mental health problems should not be considered in relation to whether or not he or she is able to make a decision. Rather, appropriate supports should be put in place to ensure that the child can exercise his or her will and preferences.⁴³

Admission to age-appropriate approved centres

Article 37(c) of the CRC provides that 'every child deprived of liberty shall be separated from adults unless it is considered in the child's best interests not to do so'.⁴⁴ The UN Principles for the Protection of Persons with Mental Illness state that the environment and living conditions in mental health facilities must be as close as possible to those of the normal life of persons of similar age.⁴⁵

The 2001 Act does not require that children and young people be admitted to age-appropriate mental health facilities. As a result, children and young people are routinely placed in adult facilities, a practice that has raised concerns for the UN Committee on the Rights of the Child⁴⁶ and the Inspector of Mental Health Services.⁴⁷ In order to address this issue and phase out the admission of children and young people to adult centres, the Mental Health Commission introduced an addendum to its *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001*⁴⁸ which states that except in exceptional circumstances no child under 18 years is to be admitted to an adult unit in an approved centre from 1st December 2011.⁴⁹

The number of available child units has doubled from three units in 2008 to six in 2012, contributing greatly to the decline in the number of admissions of children to adult units. More CAMHS beds will be added to the system in 2015. However, the Inspector for Mental Health Services' Annual Report showed that levels of compliance under this Code for 2014 fell from 21% to 16% while compliance with the code of practice on admission, transfer and discharge to and from an approved centre fell by 11% from 30%

to 19% compliance.⁵⁰ Admissions of children to adult units continued in 2014 when there were 89 such admissions amounting to 20% of all child admissions. While this reflects a year-on-year decline of child admissions to adult units, progress on this issue must continue to ensure that all children receive the mental health services they require in an age-appropriate setting.⁵¹ In 2014, over 84% of the child admissions to adult units were on the basis that no CAMHS beds were available. However, there were in fact vacancies in at least one CAMHS unit on 98% of those occasions.⁵² Possible reasons include the geographical location of the CAMHS units, lack of out-of-hours availability of CAMHS beds or a parent unwilling to admit their child to a CAMHS unit some distance from their home. The lack of provision of emergency assessment by a CAMHS team also means that children presenting for admission during out-of-office hours may be admitted to adult units.⁵³

Admission of children and young people

Definition of a 'voluntary patient': Under the 2001 Act children receiving care and treatment on foot of their parent's consent are voluntary patients.⁵⁴ Section 2 of the 2001 Act defines a voluntary patient as a 'person receiving care and treatment in an approved centre *who is not the subject of an admission order or a renewal order*.' This definition does not contain any reference to consent, decision making ability or legal capacity. While the Expert Group proposes to amend this definition to reflect a person's ability to consent, there is no proposal to deal with children who have been detained 'voluntarily' on the basis of their parent's consent. The Mental Health Commission has stated that in spite of their voluntary status, these children would not be allowed to leave approved centre⁵⁵ and they do not have the protections or safeguards that flow from involuntary status under the 2001 Act. The Law Reform Commission believes that this practice is flawed and out of line with children's rights⁵⁶ and have recommended the introduction of a third category of 'informal admission' for children admitted under the 2001 Act by parental consent. The admission and treatment of this intermediate category of patients would be subject to regular review, in the same manner as involuntary patients and the proposed third category of 'intermediate' patient proposed by the Expert Group.

The failure to provide safeguards for 'voluntary' child patients has been observed by the Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading

43 Amnesty International (n 12) 51.

44 See also Council of Europe, 'White Paper on the protection of human rights and dignity of people suffering from a mental disorder, especially those placed as voluntary patients in a psychiatric establishment' DIR/JUR (2000) para 8.4 and UN Committee on the Rights of the Child, 'General comment No. 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child' (1 July 2003) CRC/GC/2003/4 29.

45 UN General Assembly, 'Principles for the Protection of Persons With Mental Illness and the Improvement of Mental Health Care' (17 December 1991) A/RES/46/119.

46 UN Committee on the Rights of the Child, 'UN Committee on the Rights of the Child: Concluding Observations, Ireland' (n 12) 11.

47 Mental Health Commission, *Annual Report 2009* (MHC 2010) 29.

48 Mental Health Commission, *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001* (2006).

49 Section 2.4.1 (c) of the *Addendum to the Code of Practice Relating to the Admission of Children under the Mental Health Act 2001*.

50 Mental Health Commission, *Mental Health Commission and Inspector of Mental Health Services Annual Report 2014* (MHC 2015) 8.

51 Mental Health Commission, *Annual Report 2012* p 28 and Health Service Executive, *Fifth Annual Child & Adolescent Mental Health Service Report 2012 - 2013* (2014) 46.

52 Mental Health Commission (n 50) 67.

53 *ibid.*

54 S 2 of the 2001 Act. See also Mental Health Commission, *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001* (MHC 2006) para 2.7, 13.

55 Mental Health Commission, *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001* (n 48) 15.

56 Law Reform Commission para 3.38, 119.

Treatment or Punishment (CPT).⁵⁷ It may also be in contravention of the CRC, which provides that no child should be deprived of his or her liberty unlawfully or arbitrarily. The CRC calls for detention to be in conformity with the law and used only as a measure of last resort for the shortest appropriate period of time.⁵⁸ Articles 14 and 17 of the CRPD take a similar approach and point out the general inappropriateness of detaining individuals for the purposes of treatment, while the Act's shortcomings in this respect may also infringe the ECHR.⁵⁹ In *XY (a minor) v Health Service Executive*⁶⁰ the plaintiff argued that the 2001 Act's failure to provide adequate safeguards for minors who objected to detention or forced treatment was unconstitutional and in breach of the ECHR. The plaintiff's argument addressed a number of potential shortcomings in the 2001 Act: the lack of review by Mental Health Tribunals; the fact that the District Court can and does act on the report of a single psychiatrist who may also be the treating psychiatrist and the lack of a statutory obligation to notify the Mental Health Commission of the making of an order under s. 25 of the Act. Unfortunately, the High Court rejected these arguments and did not make the declarations sought in relation to unconstitutionality and incompatibility.

Power of Gardai to remove children

The Expert Group's recommended clarifying the interplay between s. 25 of the 2001 Act and the relevant provisions of the Child Care Act 1991 by granting the Gardai the specific power to remove a child believed to be experiencing a mental health problem to an age-appropriate approved centre is welcome. However, this must be subject to the inclusion of safeguards for the child in such circumstances and the proviso that such Garda powers be exercised only in exceptional circumstances where all other avenues have been exhausted. Where such involvement is deemed necessary, trained personnel with experience of dealing with children should accompany the Gardai.

Review of admission and detention

At present, the District Court has jurisdiction to order the detention of children. Whereas adults who are involuntarily detained under the 2001 Act have the right to a review of their detention by a Mental Health Tribunal, no such automatic review is available to children. The Expert Group recommends retaining the role of the District Court in making admission orders and this is appropriate given the seriousness of depriving a child of her/his liberty. These proceedings should take place in camera and with

anonymous reporting. However, consideration should be given to ensuring that Courts have the necessary age appropriate focus and provide support. Where a child is involuntarily detained, she or he should have the right to an independent review of her or his detention by a child friendly Tribunal,⁶¹ with appropriate child expertise.

In addition, children should be provided with a legal representative and parents of detained children should have the right to attend the Tribunal hearing together with the child.⁶² In terms of the review of detention, the Act should review detention after 28 days, similar to the length of time which applies for the review of interim care orders under the Child Care Act 1991.

Child advocacy service

Advocates should be available to children and young people when making decisions prior to admission to mental health in-patient units, as well as for any subsequent decisions about care and treatment. Children and young people detained under s. 25 of the 2001 Act are particularly vulnerable and should be provided with information in a child-friendly and easy-to-read format.⁶³

Assisted Decision-Making (Capacity) Bill 2013

The Assisted Decision-Making (Capacity) Bill 2013 was published in 2013 and is the Government's first step towards ratification of the CRPD. The Bill does not refer to children or young people under the age of 18, again creating a discrepancy between the Bill, the 2001 Act and the Non-Fatal Offences Against the Person Act, 1997. However, the question of a child's decision-making ability is one that should be dealt with in great detail in light of the requirement to take into account the voice of the child and children's evolving capacities as outlined in the CRPD and the CRC. If the Bill is to deal with the matter of children and young people, it should do so in a separate section. This should contain its own set of guiding principles and overarching provisions to reflect international human rights law and standards. However, it would be more appropriate to introduce separate legislation dealing with the evolving legal capacity and decision-making ability of children and young people.

Supported Decision-Making

The LRC has acknowledged that the level of support and encouragement that a child is given can have a significant impact on competence.⁶⁴ The CRC also favours giving

57 Council of Europe, 'Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)', (10 February 2011) CPT/Inf (2011) 3, 60.

58 UN Convention on the Rights of the Child (n 23) Art 37(b).

59 Mental Health Commission, *Response to the Law Reform Consultation Paper on Children and the Law: Medical Treatment* (2010) 9. See *Nielson v Denmark* (1988) 11 EHRR 175 and *Johanssen v Norway* (1996) 23 EHRR 33 paras 76-78. See also Ursula Kilkelly and Mary Donnelly, 'Child Friendly Healthcare: Delivering on the Right to be Heard' (2011) 19 (1) *Med Law Review* 27-54, p 49.

60 *X.Y. (a minor) v Health Service Executive* [2013] IEHC 490

61 Department of Health, Interim Report of the Steering Group (n25) 18.

62 Law Reform Commission (n 26) 18.

63 *ibid* para 3.109, 138.

64 *ibid* para 1.10. The LRC referred to an English Study (Priscilla Alderson, *Children's Consent to Surgery*, (Open University Press 1993) cited in Gerison Lansdown, *The Evolving Capacities of the Child* (UNICEF Innocenti Research Centre 2005) at 25.

children an increasing ability to make decisions that concern them as the child matures. While the parents' role in decision-making cannot be ignored, it is important, especially for adolescents to be able to rely on a support network beyond parents.⁶⁵

Policy Background and Children's Mental Health Services

Policy

In 2006, *A Vision for Change* called for fundamental reform of the Irish mental health system and included specific recommendations for a comprehensive system of mental health care for young people from infancy up to the age of 18 years from primary care to specialist mental health services, on a community, regional and national basis.⁶⁶ It proposed a new structure for specialised mental health services to respond to the needs of children at risk of mental health problems to be based in 'community mental health centres.' Such services were to comprise a range of supports, be delivered by multidisciplinary teams, including day hospitals and sufficient in-patient places and be available in all parts of the country. The Report also recommended that young people using mental health services, and their carers, should be facilitated in giving feedback on their experiences with a view to influencing future policy.

Services

The service model currently in place in Ireland to address the mental health needs of children spans a range of agencies and disciplines; from community-based supports and services designed to prevent the development of mental health problems, to tertiary level, specialist mental health services providing support for those with psychiatric disorders.⁶⁷ These services remain inadequate with complaints including the fragmented and under-resourced nature of financing and staffing as well as problems with the availability of assessments and long waiting lists. There remains a lack of clarity about which service providers should assess young people in situations where they have multiple needs.⁶⁸ The implementation of *A Vision for Change* has been 'slow and inconsistent' and no coherent framework for developing mental health specialties has been introduced. The total staffing of the 58 existing community mental health teams remains at 44.6% of the staffing level recommended in *A Vision for Change*.⁶⁹ A

comprehensive, time-lined and costed implementation plan as well as increased coherence in the development of community mental health services is necessary.⁷⁰

Child and Adolescent Mental Health Services (CAMHS) cater to a high level of need and provide a community-based, multi-disciplinary team service but remain underdeveloped and understaffed. The service has not been available on a consistent basis to 16-18-year-olds in many areas despite evidence that mental health problems increase in frequency and severity over the age of 15. On 4 September 2012, the HSE approved 'Access protocols for 16- and 17-year-olds to mental health services' and from 1 January 2014, all children up to their 18 birthday who require mental health assessment and treatment will be seen by CAMHS. The HSE made this a mental health service priority for 2014.⁷¹ Between October 2012 and the end of September 2013, of the 9,616 new cases seen, 1551 (16%) were 16 years of age and over. This was an increase of 446 (40%) compared with the previous year.⁷² Unfortunately, over a similar period the number of children on waiting lists for appointments with community CAMHS increased by 24%.⁷³ There also continues to be an inequitable variation in the distribution of CAMHS throughout the country.

While CAMHS teams were not brought within the scope of the Child and Family Agency (TUSLA), the Task Force for Tusla highlighted the current deficits in access to, and coordination between, specialist mental health services and other services for vulnerable children and families.⁷⁴ There is a clear need for effective inter-agency working, as well as a shared understanding of the mental health needs of young people.⁷⁵

A Vision for Change highlighted the absence of certain specialist services such as paediatric liaison services in most major hospitals, specialist services for eating disorders, mental health services for autism and autistic-spectrum disorders and dedicated child and adolescent forensic teams. There has been some limited progress in these areas with a National Forensic Hospital to include a 10 bed secure unit for adolescents due to open in 2017 as well as a 20 bed unit in the new National Children's Hospital that will include an 8 bed eating disorder service which is at initial planning stage.⁷⁶

65 Mona Paré, 'Of minors and the mentally ill: re-positioning perspectives on consent to health care' (2011) 29 *Windsor Yearbook of Access to Justice* 107, 123-125.

66 Department of Health and Children (n 1).

67 Rosaleen McElvaney, 96.

68 Ombudsman for Children, *Submission of the Ombudsman for Children to the Oireachtas Joint Committee on Health and Children Consultation on Primary Medical Care in the Community* (2008).

69 Health Service Executive, *Fifth Annual Child & Adolescent Mental Health Service Report 2012 - 2013* (2014), 6 and 19 and Figure 2.3(i). According to the HSE, Mental Health Division - Operational Plan 2015, 103, this will rise to 64 CAMHS teams in 2015.

70 Department of Health, *A Vision for Change - the Report of the Expert Group on Mental Health Policy Sixth Annual Report on implementation 2011* (Department of Health 2012) 3.

71 Health Service Executive, *Mental Health Division - Operational Plan 2014* (2014) 2.

<<http://www.hse.ie/eng/services/Publications/corporate/mentalhealthplan.pdf>> accessed 9 July 2015.

72 Health Service Executive (n 69) 7.

73 *ibid.*

74 Department of Children and Youth Affairs, *Report of the Task Force on the Child and Family Support Agency* (2012).

75 Mental Health Commission, *Response to Task Force Report on the Child and Family Support Agency* (2012) at 3. The MHC objected to the transfer of mental health services to the CFA, stating that mental health services should be treated like any other health service and the transfer of CAMHS to CFA could further stigmatize children with mental health problems while at the same time impeding referral and access to appropriate services. Rosaleen McElvaney, 155 and 177.

76 Health Service Executive, *Fifth Annual Child & Adolescent Mental Health Service Report 2012 - 2013* (2014) 52.

Headstrong currently provides adolescent mental health services at a community level through its 10 Jigsaw sites around the country. However there remains a need for a dedicated service on a national level. Community level supports can also be found in the education system but school-based mental health supports continue to be under-resourced. In addition, the *Guidelines for Mental Health Promotion and Suicide Prevention in Post-Primary Schools*,⁷⁷ which were a welcome development when published in 2013, do not provide a framework for multi-agency collaboration between various education agencies such as the National Educational Psychology Services, CAMHS, the Special Education Support Service and the National Education and Welfare Board.

Conclusion

Legislative change alone will not be sufficient to provide the sea-change necessary in the area of children's mental health services. The Government and the HSE have begun to invest in community-based mental health services for children and adolescents. However, the slow progress of policy implementation suggests that a stronger legislative basis is required to ensure that the rights of children and young people to mental health are respected and protected in line with Ireland's human rights obligations.

Recommendations

- > The 2001 Act should contain a separate section for children and young people with mental health problems.
- > This separate section of the 2001 Act should contain its own set of guiding principles tailored specifically to the needs of young people, including reference to best interests and the voice of the child.
- > 16- and 17-year-olds should be presumed to have the ability to consent or refuse healthcare and treatment under the 2001 Act.
- > Where this presumption exists, the child should have the full benefit of the principles of autonomy, self-determination, will and preferences.
- > The 2001 Act should be amended to provide that a child under 16 years of age can make a decision about his or her care or treatment where he or she has the maturity and understanding to appreciate the nature and consequences of a specific healthcare treatment decision.

- > The 2001 Act should set out factors to be taken into account when deciding whether a child has the ability to make a decision.
- > The 2001 Act should be amended to provide that no child under the age of 18 years should be admitted to an adult in-patient unit unless it is in his or her best interests to do so.
- > A third category of patients, 'informal patients' should be created for children admitted under the 2001 Act on the basis of parental consent.
- > The 2001 Act should provide safeguards for children who have been involuntarily or informally detained under the Act. Such safeguards would include automatic review of detention by a Mental Health Tribunal every 28 days and the automatic provision of legal representative.
- > The 2001 Act should be amended to provide Gardaí with the power to remove a child who is experiencing a mental health problem to an age-appropriate approved centre.
- > The 2001 Act should provide for specialised child advocacy and consideration should be given to the feasibility of providing for a form of peer-advocacy so that people aged 18-24 can provide advocacy support to children experiencing mental health problems.
- > Children and young people detained under s. 25 of the 2001 Act should be provided with child-friendly and easy-to-read information.
- > Separate legislation dealing with children's evolving legal capacity and decision-making ability should be developed and this should include decisions relating to health and mental health care. Such legislation should include provisions for supported decision-making.
- > There should be a comprehensive, time-lined and costed plan for the full implementation of *A Vision for Change* with emphasis on the coherent development of community mental health services for children and young people.⁷⁸
- > Inter-agency coordination is necessary in the provision of comprehensive mental health services to children and young people.
- > Funding must be allocated to ensure the establishment of further specialist and community CAMHS teams in line with the number of teams required in *A Vision for Change*.

77 Department of Education and Skills, *Well-being in Post-Primary Schools: Guidelines for Mental Health Promotion and Suicide Prevention* (2013).

78 Independent Monitoring Group for A Vision for Change, Department of Health, 2012 3.