Responding to Adolescent Mental Health Difficulties: Irish Law Through a Gendered Lens

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1. Introduction

Given that adolescence[1] is a time of profound psychological disruption (Blakemore, 2008; 2012), it is no surprise that it is also a time when mental health difficulties emerge or increase (Patton et al, 2016). The World Health Organisation ('WHO') estimates that 10-20% of adolescents worldwide experience 'mental disorders'[2] in any given year (WHO, 2018), with the median age for onset being 14 years for anxiety and 11 years for personality disorder (OECD, 2014). In Ireland, prevalence figures are higher. A UNICEF Report found that 22.6% of adolescents (aged 15-19 years) reported two or more mental health symptoms more than once a week (UNICEF, 2017) while a National Study of 6,085 12-19 year olds found that 22% had mild/moderate depression and 8% had severe/very severe depression (Dooley and Fitzgerald, 2012: 25). The more wide-ranging (although smaller sample size[3]) PERL study found that 15.4% of Irish 10-13 year olds were experiencing a mental disorder at the time interviewed and that 31.2% had experienced a mental disorder at some point in their lives; of young adults aged 19-24 years, 19.5% were experiencing a mental disorder at the time interviewed and 56% had experienced a mental disorder at some point in their lives (Cannon et al, 2013).

Where prevalence studies include a gender breakdown, it clearly emerges that adolescent mental health difficulties are experienced in a gendered way. It would seem that broadly similar numbers of adolescent boys and girls experience mental health difficulties (Dooley and Fitzgerald, 2012; NHS, 2018, although compare Lawrence, 2015). However, there are differences in the kinds of difficulties reported (Dooley and Fitzgerald, 2012; Lawrence, 2015; NHS, 2018). Reflecting similar patterns in the adult population (Pigott, 1999; Kuehner, 2003; WHO, 2004; Seedat et al, 2009), prevalence studies suggest that adolescent girls are more likely to experience depression and eating disorders and that adolescent boys are more likely to experience schizophrenia, personality disorders and drug related mental illness (Thapar et al, 2012; Lawrence, 2015; Patton, 2016; NHS, 2018; van Droogenbroeck, 2018). There is also evidence that adolescents who identify as transgender/trans* or as gender non-conforming experience higher rates of mental illness, including suicidal ideation, than cisgender adolescents (Clark et al, 2014; Olson et al, 2015; Connolly et al, 2016; Reisner et al, 2016).

[1] 'Adolescence' is understood in this article in accordance with the WHO definition as occurring between the ages of 10 and 19. The terms adolescent boy/girl is used, rather than male/female (to reflect the focus on gender rather than biological sex). The term 'child' is used when this is the term in legislation.

[2] The term 'mental disorder' is used in this article where this is the term use in the report/study cited or the applicable legal standard. Otherwise, the looser term 'mental health difficulties' is employed so as to capture the broader picture.

[3] The PERL Study sample size was 212 in the 10-13 year old category and 169 in the 19-24 year old category.

As the Lancet Commission notes, '[l]aws have profound effects on adolescent health and wellbeing' (Patton et al, 2016: 2424). Yet, adolescents have been largely absent from contemporary discussions of mental health laws. There is some, albeit limited, scholarship regarding legal responses to adolescent mental health difficulties (Hale and Fortin, 2015), but there is none (to the author's knowledge) with a focus on the interrelationship between gender and law in this context. Given the evidence that adolescents experience mental health difficulties in a gendered way, there would seem to be a case for such an analysis. Inevitably, there are challenges in developing this analysis. A comprehensive picture of laws relevant to adolescent mental health extends well beyond the neat boundaries of mental health legislation and the applicable laws are likely to vary, sometimes considerably, between jurisdictions. Cultural and social factors also play a role. For this reason, it seems most useful to start with a jurisdiction-specific analysis which can draw on a multifaceted understanding of the range of relevant laws as well as the details of the cultural and social context.

In light of this, the goal of this article is to identify ways in which gender is implicated in the response of Irish law to adolescents with mental health difficulties and to present the problems and gaps which emerge in attempting to develop an analysis of these. It is hoped that in doing this, the article may provide a possible methodology for engagement with this question in other jurisdictions as well as a basis for further investigation of the specifics of the Irish context. The article begins with the applicable mental health legislation, the Mental Health Act 2001 ('MHA 2001'). This has a direct impact on only a small number of adolescents, although like all legal measures which facilitate compulsory admission, it can have a profound indirect impact. The article then turns to the other legal measures which affect the delivery of adolescent mental health care. Particular emphasis is placed on the common law structures around 'voluntary' admission and treatment; the use of 'special care' orders from the legal framework for child protection to supplement the MHA 2001 framework; and the lack of legal mechanisms to address the overriding problem of lack of access to appropriate treatment. The gendered impact of each will, insofar as is possible, be ascertained and analysed.

2. Adolescents in the Mental Health Act 2001

The MHA 2001 establishes a distinct legal framework for the involuntary admission of children to an 'approved centre'[4] and for their treatment while admitted. A 'child' is defined as a person under the age of 18 years other than a person who is or has been married (MHA 2001, s. 2(1)). The MHA 2001 framework is used infrequently in relation to children. The Mental Health Commission ('MHC') records 28 involuntary admissions (out of 441) in 2017; 12 (out of 506) in 2016; 14 (out of 503) in 2015; and 15 (out of 436) in 2014 (MHC 2018; 2017; 2016; 2015). The low numbers reflect the prevailing view that every effort should be made to avoid the stigma of involuntary admission for adolescents (Hale and Fortin, 2015). Unfortunately, there are no publically available gender disaggregated data on involuntary admissions. Even if there were, because the number of such admissions is limited, it would be difficult to reach definitive conclusions regarding the role of gender. Thus, perhaps the main 'story' of the MHA 2001 is how little we can learn about how gender is implicated by looking solely at mental health legislation. Nonetheless, even here, there are some insights to be found.

[4] An approved centre is a registered hospital or psychiatric facility which is subject to the oversight of the Inspector of Mental Health Services.

2.1 The MHA 2001 Framework for Involuntary Admission

The basis for the involuntary admission of a child (and indeed of an adult) under the MHA 2001 is that s/he suffers from a 'mental disorder.'[5] For a child to be admitted, it must also be established that s/he requires treatment which s/he is unlikely to receive unless an order for admission is made (MHA 2001, s. 25(1)). Certain conditions are specifically excluded from the category of mental disorder and therefore cannot, of themselves, be the basis for involuntary admission. These conditions are personality disorder; social deviance; and/or addiction to drugs or intoxicants (MHA 2001, s. 8(2)). As discussed further below, these exclusions are more likely to impact on adolescent boys.

The MHA 2001 places the involuntary admission of children at an intersection of child protection law and mental health law (Ralston, 2014a; 2014b). This plays out in a variety of ways. First, all applications for involuntary admission of a child must be made by the Health Service Executive ('HSE') (the public health and social care provider in Ireland) (MHA 2001, s. 25(1)). This contrasts with the admission of adults, where an application for admission may be made by a range of people (MHA 2001, s. 9) and, most typically, is made by a spouse or relative (MHC, 2017). Secondly, an application for the involuntary admission of a child must be approved and reviewed by the District Court (the lowest court in the hierarchy of Irish courts). This mirrors the way in which child care proceedings are dealt with under the Child Care Act 1991 ('CCA 1991')) and diverges from adults, where admission is reviewed by a specialist Mental Health Tribunal. Moreover, unlike in the adult context, the child being admitted is not automatically a party to the application (CCA 1991, s. 25) and does not have a statutory right to independent legal representation (although the District Court may - and routinely does - make an order to this effect). Thirdly, the procedural requirements around admission are derived from both the MHA 2001 and the CCA 1991 and the Court must regard the welfare of the child as the 'first and paramount consideration' and in so far as is practicable, must give due consideration, having regard to his or her age and understanding, to the wishes of the child (CCA 1991, s. 24).

This system has evident flaws. These include the absence of a statutory right to legal representation and the splitting of the legal framework over two acts (the MHA 2001 and the CCA 1991) (Expert Group, 2015). Questions also arise about the suitability of the District Court as an oversight mechanism. The District Court model has been shown to be problematic in the context of child care proceeding (O'Mahony et al, 2016; Burns et al, 2017)) and it would seem reasonable to assume that similar problems arise for involuntary admission. More empirical work is needed to identify the gendered consequences of these flaws in the system. However, based on what we do know (limited specialised training of judges; insufficient time; and enormous variation in practice (O'Mahony et al, 2016)), it would seem clear that the current structure lacks any meaningful mechanisms to address concerns such as gender role stereotyping in involuntary admission decisions.

[5] This is defined as meaning mental illness, severe dementia or significant disability where because of the illness, dementia or disability, there is a serious likelihood of the person causing immediate and serious harm to him/herself or other persons or that because of the severity of the illness, dementia or disability, the judgment of the person is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment which could only be given on such admission and the admission would be likely to benefit or alleviate the person's condition to a material extent: MHA 2001, s. 3(1).

2.2 Decisions about Treatment

The MHA 2001 places primary control for decisions about treatment for a mental disorder in the hands of the consultant psychiatrist responsible for the adolescent's care (other than for the extremely rare instances of psychosurgery or electro-convulsive therapy, both which require the approval of the District Court (MHA 2001, s. 25(12), (13)). The consultant is required to make treatment decisions in the best interests of the child; to take account of any 'representations' made by the child; and to respect the child's right to dignity, bodily integrity, privacy and autonomy (MHA 2001, s. 4). There is also a requirement for authorisation by a second consultant psychiatrist after medicine has been administered to the child for three months (although the second consultant psychiatrist is chosen by the child's own consultant psychiatrist) (MHA, s, 61). There is no stated statutory requirement to obtain the consent of parents. However, the Irish High Court has identified the importance of consultation with parents, recognising the 'central role of parents when it comes to the taking of decisions in relation to their child' (*XY v HSE*, 2013). The legal position in respect of the consent/involvement of the child is less clear. There is ongoing uncertainty regarding the interaction between the MHA 2001, which defines a child as a person less than 18 years, and the Non-Fatal Offence Against the Person Act 1997, which states that the age of consent to medical treatment is 16 years (Whelan, 2009). The position in respect of refusal is more clear; the High Court has held that an adolescent may not refuse treatment for his or her mental disorder (*HSE v JM,* 2013).

In Ireland (and indeed in many other jurisdictions), there is a striking absence of case law in respect of treatment decisions following the involuntary admission of adolescents. This reflects the small number of such admissions and the problems likely to be encountered by any adolescent who has been involuntarily admitted in asserting legal rights. In this context, the linked cases of *HSE v JM* (2013) and *XY v HSE* (2013) provide useful insights into both the operation of the law and the possible impact of gender. The cases involve the same young woman (XY), who had been involuntarily admitted under the MHA 2001 to a Child and Adolescent Mental Health Services ('CAMHS') inpatient unit at the age of fifteen, following several suicide attempts and had been diagnosed with a bipolar affective disorder. XY had been prescribed the mood stabiliser drug, olanzapine, which she resisted and which had generally been administered to her intramuscularly involving the use of physical restraint. She subsequently began to take the medication orally but she stated to her legal representatives that this was only because she knew it would otherwise be administered forcibly. XY then began to withhold urine in what her doctors believed was an attempt to cause herself physical harm. At the time of the first case (*HSE v JM*, 2013), she appeared to have developed an infection as a result of this. Her doctors wished to take blood tests to determine if she had an infection and also to monitor the effect of the olanzapine. A court application for an order to this effect was made by the HSE.

In considering the matter, Birmingham J recognised that, under the MHA 2001, any decision taken in relation to XY must respect her rights to dignity, bodily integrity, privacy and autonomy. He also noted that the views of a minor of her age should 'most certainly' be treated with respect (*HSE v JM,* 2013: para 23). Nonetheless, he made the orders requested, offering several justifications for this decision. First, he found that XY did not have the requisite decision-making capacity; secondly, a distinction could be drawn between consent to treatment and refusal of treatment and the same standard did not have to apply to both; and, thirdly, the detention of a child under s. 25 of the MHA 2001 also served to authorise medical professionals to administer treatment to the child. He took comfort too from the fact that XY's parents were supportive of the decision.

The matter returned to court some 10 months later, this time at XY's instigation. XY was now 16 and half years old and was still an involuntary patient. A guardian ad litem[6] had been appointed for XY and he brought the proceedings on her behalf. XY's argument was that s. 25 of the MHA 2001 was unconstitutional and incompatible with the European Convention on Human Rights because it failed to provide adequate safeguards for children who wished to object to admission and to the forcible administration of medication. Birmingham J rejected this argument, finding that the plaintiff had underestimated the protective force of the Child Care Act 1991, which placed the welfare of the child as the 'first and paramount consideration', and the central role of parents in making decisions for their child. He side-stepped the issue of forcible treatment and found that there was 'every reason to believe that the regime to which XY is subject serves her best interests' and that she would have the opportunity to canvas any concerns when the matter of her detention came before the District Court again and that she would also have the opportunity to raise any issues regarding the appropriateness of her treatment (*XY v HSE*, 2013: para 40).

Viewed through a gendered lens, both XY's response to her treatment and the Court's response to her response is noteworthy. The cases evince very forceful opposition to treatment on XYs part; both in her physical resistance and in the assertive way in which she engaged with the legal system. On the account presented by the Court, she was both determined and resourceful. Yet, at no point are these presented as positive features but rather only as indications of the seriousness of her mental illness. While the Court does state that XY's views should 'most certainly' be treated with respect (*HSE v JM,* 2013: para 23), this is a lone statement, out of line with rest of the judgments which do not demonstrate any commitment to actually taking any account of these views. From a gendered perspective, the question which arises is whether XY's conduct (decidedly non-compliant) played any role in the Court's response. There is a sizeable body of scholarship which identifies the impact of conduct which is contrary to gender role expectations on judicial responses to situations (Elvin, 2010; Cook and Cusack, 2011; Langer, 2016). XY's conduct is clearly contrary to the established stereotype of the 'good' (compliant) girl and the view of girls as inherently less 'agentic' than boys (Hentschel et al, 2019). It is, of course, not possible to reach a definitive conclusion on this point. XY was, by all accounts (except her own, which was not sought by the Court) very unwell. Nonetheless, it is plausible that the fact that XY's conduct contradicted the stereotypical female response to her situation played at least some role in the Court's response.

3. 'Voluntary' Admissions

Irish inpatient admission statistics (which cover both voluntary and involuntary admissions) are disaggregated on the basis of gender. Because the vast majority of admissions are 'voluntary', these statistics give a reasonably accurate picture of the gendered nature of such admissions. As Table 1 shows, adolescent girls significantly outnumber adolescent boys in inpatient admissions (MHC, 2018).

[6] A guardian ad litem may be appointed in cases where a child is not party to child care/mental health proceedings where the Court is satisfied that it is in the interests of the child and the interests of justice to do so (CCA 1991, s. 26). The role of the guardian ad litem is to inform the Court of the child's views and to offer his/her professional opinion as to what is in the best interests of the child.

Table 1: All Inpatient Admissions

Children's Admissions to approved centres	2017	2016	2015	2014
Total	441	506	503	436
% Male	40%	36%	40%	33%
% Female	60%	64%	60%	67%

The most common grounds for admission of adolescents is depressive disorder (2017: 30%; 2016: 33%; 2015: 32%; 2014: 36%) followed by eating disorders (2017: 14%; 2016: 12%; 2015: 12%; 2014: 14%) (HRB, 2018; 2017; 2016; 2015).[7] As is evident in Table 2, young women are significantly more likely to be admitted for these conditions while young men substantially predominate in drug disorder-related mental illnesses and somewhat in schizophrenia and neurosis.

Table 2: Inpatient Admissions by Condition

% of admissions M/F	2017	2016	2015	2014
Depression	67% F	73%F	65%F	65%F
Eating Disorder	89%F	93% F	87%F	93%F
Mania	52% F	-	54%F	-
Drug Disorder	87% M	-	93%M	78%M
Schizophrenia	62%M	-	59%M	47%M
Neurosis	56%M	-	58%F	62%F

The predominance of girls/young women in admissions for depression and eating disorders reflects prevalence statistics. The National Study of Youth Mental Health in Ireland found that adolescent girls were more likely to experience depression. However, the proportionate difference between the genders is much less extreme than the admission statistics (for mild/moderate depression: 27% female/18% male; severe/very severe depression: 9% female/6% male (Dooley and Fitzgerald, 2012). The NHS Study (2018) also found that emotional disorders such as anxiety and depression were more common in girls (10% in girls as compared with 6.2% in boys). Both the Irish study and the NHS Study found that emotional disorders increased with age for girls. Thus for 17-19 year olds, 22.4% of adolescent girls had emotional disorders as compared with 7.9% of adolescent boys (NHS, 2018). The NHS Study also found eating disorders, although much less common, to be more prevalent in girls (0.7% as compared to 0.1% of boys). Once again, prevalence increased with age for girls (1.6% of adolescent girls aged 17-19 years had an eating disorder as compared to 0% of adolescent boys). Similar findings are reported in smaller studies from a range of different countries (Essau et al, 2010; van Droogenbroeck et al, 2018). The gender differences in a study of Australian children and adolescents were less pronounced. Girls were more likely to experience depression but by a smaller margin (3.1% in girls as compared to 2.5% of boys) and the prevalence of anxiety was the same in both genders (Lawrence, 2015).

[7] HRB statistics distinguish between all admissions and first admissions. All HRB data presented here refers to all admissions.

3.1 The Meaning of 'Voluntary'

The admissions data outlined in the previous section indicates that most 'voluntary' admissions in Ireland involve adolescent girls with depression and adolescent girls with eating disorders. Thus, any flaws in the voluntary admission system have a more marked impact on adolescent girls (with depressive disorders). For the main part, a 'voluntary' child inpatient is one who has been admitted by his or her parent/s. The legal validity of this form of voluntary admission has not been formally tested before the Irish courts. It was however upheld by the European Court of Human Rights ('ECtHR') in the controversial (Fortin, 2009: 101-102; Parker, 2016) decision in *Nielsen v Denmark* (1988). Here, the ECtHR found that the placing of a 12 year old boy in a psychiatric facility by his mother against his wishes was not a breach of the boy's Art. 5 right to liberty. More recently, in the English case of *Trust A v X* (2015) the 'voluntary' admission by parents of a boy with autism and challenging behaviour was found by the English High Court to lie within the 'zone of parental responsibility', although the reasoning of the Court has been doubted (Parker, 2016). The categorisation of parental admission as voluntary was criticised in the Expert Group Review of the MHA 2001 (2015). The Expert Group recommended that before the admission of a 16 or 17 year old could proceed on a voluntary basis, the child must consent to admission, or at least not object.

There are no data regarding the extent to which 'voluntary' admissions cohere with the wishes of the adolescent admitted in this way. It might be presumed that most of the time in reasonably functioning family relationships, there is a degree of an overlap between parental decisions and their adolescent children's views. However, the pressures imposed on parents by the possibility of involuntary admission initiated by the HSE should not be underestimated. Moreover, given that most 'voluntary' admissions are statistically likely to be adolescent girls with depression, there is also the question of how effectively these girls are able to assert their wishes. As described in Mathew Ratcliffe's phenomenological account of severe depression, the condition diminishes and ultimately extinguishes the sufferer's sense of agency and she 'experiences her situation *as* something she cannot act upon' (2015: 167).

A Report by the Ombudsman for Children of young people's experience of mental health services found that many young people who were inpatients experienced high levels of restriction as well as feelings of being 'institutionalised', bored and having very little to do all day (Ombudsman, 2018: 41). While the implications of this for the 'voluntariness' of these admissions are not clear, it does indicate that adolescent inpatient mental health services are experienced in a way which is clearly restrictive of adolescents' liberty and autonomy. Unfortunately for the discussion here, the Ombudsman's report does not provide a gendered breakdown of experiences of inpatient care and whether these restrictions are experienced differently depending on gender.

3.2 Admission to Adult Units

One of the most pressing current problems in Irish adolescent mental health care is the limited availability of CAMHS beds. Problems include the shortage of operational beds in dedicated child units and the fact that CAMHS services cannot admit after-hours (MHC, 2017). As a result, some adolescents are admitted to adult units. The experience of such admission is, not unsurprisingly, described by adolescents as 'traumatic' (Ombudsman, 2018: 40) and the practice of admitting to adult units has been condemned by the United Nations Committee on the Rights of the Child (CRC, 2016).

As Table 3 shows, over a three-year period adolescent boys have been more likely to be admitted to adult units (although the gender balance appears to be shifting). It is unclear whether this reflects the nature of the mental health difficulty experienced, possibly combined with the lack of an after-hours CAMHS service or gendered views that adult units are in some way less unsuitable for boys.

Table 3: Admission to Adult Units

Admissions to adult units	2017	2016	2015	2014
Total	82	67	96	93
% Male	48%	54%	64%	-
% Female	52%	46%	36%	-

Legislation attempting to protect children admitted to adult units has been (slowly) making its way through the Irish legislative process. The Mental Health (Amendment) Bill 2016 proposes to restrict the circumstances in which a child may be admitted to an adult unit and sets out post-admission requirements. If brought into force, the proposed legislative requirements would require substantial investment in adolescent mental health services, something which would be of benefit to all adolescents. However, because of the cost implications, ultimate delivery on the framework remains uncertain.

3.3 Treatment Decisions

The (limited) MHA 2001 oversight requirements do not apply to treatment decisions for 'voluntary' adolescent inpatients. However, there is a statutory requirement that all 'residents' in approved centres (which include all adolescent residents) must have an 'individual care plan' which, for children, must also include education requirements (2006: reg 15). This plan must be developed in consultation with the resident so far as practicable (MHC, 2012). When it comes to consent/refusal of treatment, the Non-Fatal Offences Against the Person Act 1997 states that 'the consent of a minor who has attained the age of 16 … shall be as effective as it would be if he or she were of full age' (1997: s. 23(1)). Although some doubts have been raised about the applicability of the 1997 Act outside of the criminal law context (Law Reform Commission, 2011), it is widely accepted that this establishes a general right to consent for adolescents over the age of 16 (HSE Consent Policy, 2016). The position in respect of young people under the age of 16 is less clear. The Irish courts have not (yet) approved a maturity-based standard for consent as, for example was adopted by the House of Lords in *Gillick v West Norfolk and Wisbech AHA* (1986). In contrast, there is clarity around the right to refuse and judicial confirmation that '[a] capacity or entitlement to refuse is not necessarily to be equated with a capacity or entitlement to consent to treatment' (*XY v HSE* 2013: para 25).

There are limited data on how treatment decisions for adolescents are made and a notable lack of data on the role of gender in this regard. In general, approved centres' compliance with the requirement for an individual care plan has been poor, with the main problem being the failure to involve the resident in the development of the plan (MHC, 2017: 12-13).[8] This exclusionary attitude is substantiated in the Ombudsman's Report where young people identified communication difficulties and lack of information around treatment decisions (2018: 40-41). A study of the experience of adolescents with mental health difficulties who were also in residential care reiterated

[8] These data are not divided between adults and children.

this view, expressing feeling forced into mental health care and being coerced to 'open up' to strangers (mental health professionals) without having had a chance to develop relationships of trust with them (Tatlow-Golden and McElvaney, 2015). A notable feature of this study is that 7 of the 8 adolescents who participated were girls. Thus, the study affirms the importance placed on relationships of trust by adolescent girls identified by Tan et al (2010). This study of 29 adolescent girls/young women found that feelings of trust (of parents and health professionals) was often more important to participants than freedom of choice.

Coercion can also be more immediately physical. Available evidence affirms that physical restraint is sometimes used to administer treatment to adolescents of both genders. The use of restraint to administer medication to XY was noted (without any indication of concern) by the Court in *JM/XY* and the use of restraint was approved by the High Court in delivering nasogastric feeding to an adolescent girl with anorexia nervosa (Carolan, 2018a). There is no indication from either case that the courts saw the use of force as a separate matter from the administration of medication/feeding. The MHC statistics on the use of physical restraint are disaggregated on both age and gender grounds (MHC, 2017b), although unfortunately, the two grounds are not cross-referenced. Statistics on the use of restraint in the inpatient population as a whole (adults and children) indicate that restraint is used slightly more often in relation to males than females (eg in 2016, 54% male; in 2015, 53% male: MHC, 2017b: 15). In age terms, 4% of inpatients under 18 were restrained in 2015 and 3% in 2016 (MHC, 2017b: 15). Being physically restrained can be traumatic for both genders (Bonner, 2002; Cusack, 2018). In the Ombudsman's Report, one adolescent (gender unspecified) describes as one of the 'challenges' of inpatient care, '[b]eing restrained and carrying around the place to be put into special care and being injected in the backside, held down crying and screaming' (2018: 44). However, emerging ethnographic studies indicate that there are additional gendered elements of the experience, especially where a girl/woman had previously experienced sexual abuse or violence (Wynn, 2004; Fish and Hatton, 2017).

3.4 Treatment Abroad

A notable feature of adolescent mental health care in Ireland is the lack of facilities to address certain mental health conditions. This has made it necessary to send some adolescents to the UK for specialist treatment. Statistics in this regard have only recently started to be recorded in the MHC Annual Reports. The 2017 Annual Report identifies 11 such instances (MHC, 2018). The MHC does not identify the gender of these adolescents. However, one of the most significant gaps relates to treatment for eating disorders and so it can be presumed that adolescent girls are mostly affected. From a legal perspective, the decision to send an adolescent abroad for treatment must be approved by the High Court. While the High Court rarely issues written judgments in these cases, there are newspaper reports of some of the hearings. From these, it is clear that the adolescents do not wish to go abroad for treatment; in one evocative case, the adolescent girl expressed her strong wish not to be sent abroad but if she had to go, her concern was to be able to bring her teddy bear with her (Carolan, 2019).

There has also been a practice of sending adolescents to the UK for treatment for personality disorders, which, as noted above, are expressly excluded from the definition of mental disorder under the MHA 2001. The order to send the adolescent abroad in this instance is sought

by the Child and Family Agency and is made under the inherent jurisdiction[9] of the High Court. These cases are typically also reviewed by the High Court in England and Wales. There is no available gender breakdown of the operation of the inherent jurisdiction in these cases. However, given the linkage with personality disorders, it might be presumed that more adolescent boys are sent abroad for treatment through this mechanism.

Sending an adolescent abroad for treatment, whether for eating disorder or for personality disorder is profoundly disruptive. As Tan et al have identified (2010), stable relationships are especially important in delivering effective treatment for eating disorders and the practice of removing an adolescent girl from her environment and her family/loved ones adds substantially to the pressures on relationships and thus on potential for recovery. The practice of sending adolescents abroad for treatment has been condemned by the President of the High Court (Carolan, 2018b). However, in the absence of suitable facilities in Ireland, applications continue to be approved.

4. **Special Care Orders**

Legislative provision for 'special care' orders were made by the Child Care (Amendment) Act 2011 which came into force in 2017 (2017 Order). This Order allows a child under the age of 18 years (and over the age of 11) to be detained in a 'special care unit' where s/he is to be provided with 'special care'.[10] This is defined as:

> Care which addresses
>
> (i) [The child's] behaviour and the risk of harm it poses to his or her life, health, safety, development or welfare; and
> (ii) [The child's] care requirements, and includes medical and psychiatric assessment, examination and treatment (2011, s. 23C).

An application for admission to special care must be made by the Child and Family Agency where it is satisfied that 'there is reasonable cause to believe that the behaviour of the child poses a real and substantial risk of harm to his or her life, health, safety, development or welfare' (2011, s. 23F(2)). The application for admission must be approved by the High Court (2011, s. 23H).

Because special care orders are a recent phenomenon, data on their operation is limited. The Child and Family Agency reported that, at the end of September 2018, 13 young people were resident in special care units, although it did not provide a gender breakdown or details of whether these young people had mental health difficulties. However, *Child and Family Agency v ML (orse G)* (2019) shows how special care orders can be used to address mental health difficulties which fall outside of the ambit of the MHA 2001. The case involved G, a 17 year old who had been born male and had identified as female since the age of 15. As described by the Court of Appeal, she 'had been born into a household of extreme depravity and domestic violence' and from an early age had been 'recruited' by her father in the abuse of her mother (2019, para 6). G had been in State care since she was 10 and during this time, she had instigated various forms of physical and sexual violence, especially toward women. G had reported suicidal thoughts and had also indicated a plan to take pain medication, call an ambulance, cut off her penis, and flush it down the toilet. The view of

[9] The inherent jurisdiction refers to the general power of the High Court to make decisions in the best interests of children and adults lacking decision-making capacity. The specific application is for an Art. 56 Brussels II bis order (under Council Regulation (EC) No 2201/2003 concerning jurisdiction and the recognition and enforcement of judgments in matrimonial matters and matters of parental responsibility).

[10] Prior to the legislation, these orderswere made through the inherent jurisdiction of the High Court.

experts was that G did not have a 'psychiatric illness' but that she exhibited several personality disorder traits. There was also scepticism about whether she had gender dysphoria. G strongly indicated that she did not wish the special care order to be made and that she wished to proceed with gender reassignment and ultimately move to Los Angeles to work in the adult porn industry. The Director of Oberstown Children's Detention Campus (where G had been detained following a violent attack on a female social worker) gave evidence that G did not require special care. Both G's guardian ad litem and her mother were supportive of the order being made. The High Court made the special care order, finding that there was a substantial risk of harm to G's life and safety. This decision was upheld by the Court of Appeal which found the order to be 'necessary, proportionate and validly made' (2019, para 175).

The complex and unusual nature of the case makes it difficult to draw general conclusions regarding the role of gender in the legal process for special care orders. Some comparisons with other relevant legal frameworks can, however, be made. The special care process appears to be more participative than the MHA 2001 and the (non-existent) process around 'voluntary' admissions. G was represented by a solicitor, Junior Counsel and Senior Counsel and also had a guardian ad litem. This level of representation was described by the Court of Appeal as 'clearly appropriate, having regard to the age, understanding and wishes of G, and the circumstances of this case' (2019, para 160). G also presented three letters to the Court and participated in the hearing by video link. This contrasts with the decisions in *JM v HSE and XY v HSE* discussed earlier. Notably, however, the more participative approach did not make any difference to the final outcome. The order was granted notwithstanding that the evidence regarding therapeutic benefit from 'special care' appears flimsy (not least because G had expressed her intention not to cooperate with any therapeutic interventions not linked to gender reassignment). Thus, the special care order bears some resemblance to preventive detention, [11] albeit with the hope that G might ultimately decide to co-operate. Either way, by December 2019, G would reach the age of majority and her time within the care system would come to an end. At that point, for good or ill, she would be beyond the ambit of coercion (unless the High Court were to find her to lack decision-making capacity, in which case an order for detention under the court's inherent jurisdiction could be made).[12]

5. Access Issues

Access problems are endemic in Irish adolescent mental health care. In 2017, there were 72 CAMHS inpatient beds and 69 CAMHS teams, of which three had a full complement of staff. There were 6,811 children and adolescents awaiting a primary care community-based psychology appointment, of whom 2,186 had been waiting more than one year. There were 2, 419 children and adolescents on a waiting list for CAMHS of whom 1,257 had been on a waiting list for more than 12 weeks and 317 for more than 12 months (Ombudsman, 2018: 9-10). These statistics are not disaggregated by gender. However, given the evidence that adolescent boys and men are less inclined to seek help for mental health difficulties (Chandra et al, 2006; Dooley and Fitzgerald, 2012; Cleary, 2017), it would seem reasonable to presume that a majority of adolescents on these waiting lists are female.

The access issue in respect of adolescent boys is more complex. International evidence suggests that adolescent boys respond to unmet mental health needs in different ways to adolescent girls (Rice, 2018). These include suicide, risky behaviour, conduct disorders, drug and alcohol abuse, and violence (Patton et al, 2018; Rice, 2018). Data from Ireland indicate a similar

[11] The Court of Appeal rejected G's argument in this respect but in so doing, it focussed on the procedural protections afforded rather than engaging with the substantive concept of preventive detention (2019, paras 140-154).

[12] This has happened on several occasions when young people, having turned 18, were returning from treatment for personality disorders in the UK: *HSE v KW* (2015); *HSE v JB* (2015).

pattern. A survey from Oberstown Children's Detention Campus (where the vast majority of adolescents detained are male[13]) found that more than half the adolescents detained had a mental health need (Q1 statistics, 2017). Even more striking are the statistics relates to deaths by suicide in Ireland. Although not all deaths by suicide are because of mental health difficulties, these difficulties appear to be one of the most significant risk factors (Harris, 1997; Nock, 2010). At 10.3 per 100,000, adolescent suicide rates in Ireland are the fourth highest in the EU/OECD regions (UNICEF, 2017). The most recent gender disaggregated statistics on adolescent suicide in Ireland are from 2007-2015. These show that, over this period more than three times more boys (10-14 years) and young men (15-19 years) than girls and young women have died by suicide (NSRF, 2016). These statistics are notably out-of-line with international data. While WHO global data affirms that a majority of suicides in the category 10 -29 years are male, there is a much more equal gender breakdown; for 10-14 year olds, the breakdown was 55% male/44% female and, for 15-19 year olds, the male/female preponderance is reversed, with 48% male suicides and 52% female (WHO, 2018).

The challenges posed by access are political, social, cultural and economic. Irish law has offered little in addressing these. Like most jurisdictions, Ireland is party to international treaties (International Covenant on Economic, Social and Cultural Rights (1996); Convention on the Rights of the Child (1992); Convention on the Rights of Persons with Disability (2006)) which recognise the right to the highest attainable standard of health. However, these international law measures have had almost no impact on the resolution of matters under domestic law. This reflects the lack of status afforded to legally enforceable socio-economic rights under Irish law (O'Connell, 2012). The access gap has consequences for all adolescents with mental health difficulties, but most especially for adolescent boys, many of whom appear to fall outside the system as it is currently constituted.

6. Conclusion

As the Lancet Commission describes, adolescents have 'until recently been overlooked in global health and social policy' and have experienced 'fewer health gains with economic developments than other health groups' (Patton et al, 2016: 2423). In fact, some problems, including mental health difficulties and suicide, appear to be becoming more prevalent (Patton et al, 2016: 2441). The Lancet Commission points out that adolescent mental health difficulties 'have consequences for mental health across the life course, social adjustment and economic productivity' (2016: 2428). It is imperative therefore that states invest in delivering improvements to adolescent mental health. One important aspect of this is the development of appropriate and evidence-based legal and policy responses to adolescents experiencing mental health difficulties.

This article has sought to map the role of gender in law's engagement with adolescents experiencing mental health difficulties in Ireland. The picture presented is inevitably fragmented and incomplete. Perhaps the strongest conclusion to be drawn is that there is a great deal that we do not know about the relationship between gender, adolescents and mental health law. Nonetheless, there is sufficient evidence to conclude that there are gender-based differences in how the legal framework in Ireland applies. In brief, although oversight of admission is deficient for all adolescents, adolescent girls are most affected by the absence of oversight in 'voluntary' (i.e. parental) admission. It would also seem that adolescent girls are especially affected by delays in access to CAMHS services and by the lack of facilities to deal with complex adolescent eating disorders in Ireland. On the other hand, many adolescent boys appear to be falling outside the

[13] In 2017, of the 135 young people detained, 133 were male and 2 were female (Annual Report, 2018: 14).

system entirely, as evidenced by the high rates of suicide and the established link between mental illness and criminal detention. While there are many reasons for this, the specific exclusion of personality disorders and addiction to drugs or intoxicants from the definition of 'mental disorder' under the MHA 2001 may be a contributing factor.

More research is needed to understand the gendered implications of the Irish legal framework. Several gaps in available knowledge can be identified (which may or may not be replicated in other jurisdictions). First, there is a lack of data relating to the specific experience of transgender/trans* adolescents. There is no category in the available MHC or HRB statistics to reflect adolescents who do not identify as male or female. As a result, the needs of these adolescents are invisible to law and policy makers. Secondly, information about adolescents' experience of inpatient care needs to be expanded. Issues which need further investigation include adolescents' experience of restrictions on freedom; issues of communication and trust with health professionals; and the use and impact of restraint, including in the administration of treatment. Studies in this context should be gender-aware. Finally, the gendered aspects of access to treatment must be further investigated and the issue of access should be expanded beyond issues of delay (notwithstanding the importance of these) to include the broader concern of total exclusion from the mental health system.

This article enacted a gendered study using Irish law. As such, it provides some possible starting points for investigations in other jurisdictions. It shows that a focus on mental health legislation and on court decisions is likely too narrow to be helpful in identifying gender-related issues (although judicial narratives can provide a rich source for analysis from a gender perspective). Instead, a broader lens is needed which can take account of parental powers and 'voluntary' admissions as well as other legal avenues for decision-making in respect of adolescents, such as child care/child protection or the youth criminal justice system. The link with suicide, which is especially pronounced in Ireland, should also form part of an investigation. There are undeniable challenges in developing appropriate legal and policy responses to gender for adolescents with mental health difficulties. Simplistic responses run the risk of essentialism and of reinforcing gender stereotypes. Adolescents cannot be reduced to their gender; yet, a failure to acknowledge the role of gender results in an impoverished legal and policy framework. Assembling a solid evidence base is a necessary first step to developing frameworks that meet adolescents' needs

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