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Assessing Children's Capacity

Reconceptualising our Understanding through the UN Convention on the Rights of the Child

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Abstract

This article seeks to reconceptualise approaches to assessing children's capacity, particularly in light of Article 5 of the CRC, which enshrines the principle of the evolving capacities of the child. Professionals regularly assess children's capacity, for example when doctors treat children, or when lawyers represent child clients. They usually do this assessment intuitively however, as there is little guidance on how assessment should work in practice. Medical law in England and Wales serves as a case study to examine law and practice as well as challenges in the area. It is concluded that it may not necessarily be possible objectively to measure children's capacity, and it may need to be done intuitively. Yet it should be done via a process which is rights-based. An approach to children's capacity is proposed through four concepts based on the UN Convention on the Rights of the Child: Autonomy, Evidence, Support and Protection.

Keywords

children's capacity – *Gillick* competence – best interests – medical law – autonomy – due weight – developmental psychology

1 Introduction

There are many areas of law and practice in which the capacity of children (that is, under-18s) comes into question. Capacity may be considered in an everyday context to establish that children understand a medical procedure or

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another process affecting them. Or it may concern a significant point of law and therefore come to court. Capacity issues can arise in relation to such matters as deprivation of liberty for children with mental health problems (see *In the matter of D* (*A Child*) [2019] UKSC 42); where a child wishes to instruct her own lawyer (*S v* SBH (*Appeal* FPR *16.5: Sufficiency of Child's Understanding*) [2019] EWHC 634); or where a child's capacity to consent to medical treatment is in question (*An* NHS *Foundation Trust v A & Others* [2014] EWHC 920).

In the everyday context, professionals make the decisions necessary in order to work in children's interests. In England and Wales the '*Gillick* competence' standard ostensibly guides these processes. Yet it remains the case that what children's capacity actually entails is little understood – it has proven notoriously hard to define (Hein, *et al.*, 2015[a]; Lansdown, 2005; Alderson and Montgomery, 1996: 11). To a large extent, those working with children and/or relevant laws work around capacity – applying experience and instinct – acknowledging capacity without knowing much about relevant research or theory. This intuitive approach is generally satisfactory and, in most cases, adults make a judgment about a child's capacity and problems do not arise (in the medical context see further e.g. Hein *et al.*, 2015[a]; Cave and Stavrinides, 2013: 12).

Capacity is the point on which many of children's rights and responsibilities turn, however, as sometimes a definitive capacity/no capacity judgment is required on a given matter. One important consideration in this area is that approaches to understanding and assessing capacity should be guided by the primary international children's rights instrument, the UN Convention on the Rights of the Child (CRC). Article 5 states that parents and other responsible adults are to guide children in the exercise of their rights 'in a manner consistent with the evolving capacities of the child'. Yet despite the influence of the CRC, and despite the everyday nature of children's capacity issues, little thought has been given by theorists, lawyers and others to understanding how and whether children's capacity can be assessed in a rights-based way via the CRC.

This article seeks to reconceptualise approaches to assessing children's capacity, particularly in light of Article 5 of the CRC. Law and practice in England and Wales, and particularly medical law, serve as a case study through which to examine what capacity means in relation to children. After considering some relevant points of law and practice in this area, it is argued that efforts by professionals, theorists and others to understand capacity should be done via a process which is explicitly rights-based. The CRC after all represents the 'hard-won consensus of the global community' (Lundy, 2007: 933) and should therefore be at the forefront of law and practice concerning children, particularly in

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areas as ill-understood, contested and fundamental to the exercise of rights as capacity. An approach to children's capacity is proposed through four concepts based on the CRC: Autonomy, Evidence, Support and Protection.

2 The Complex Terrain of Children's Capacity in Medical Law

Many commentators in the past decade have criticised the binary approach to capacity, that is, the idea that one has capacity or not (see e.g. Herring, 2016; Donnelly, 2010; Foster, 2009). There have also been critiques of the fact that efforts to understand children's capacity tend to position rational adulthood as the ultimate goal in child development (Cordero Arce, 2015). Nevertheless, in some cases a yes or no answer is required to determine, for example, whether or not a child can directly instruct a lawyer, or consent to treatment. Therefore sometimes children's capacity must be assessed, because their autonomy rights depend on it. Herring argues powerfully why an accurate assessment of capacity is important:

> First, you could be assessed to lack capacity when you do not … You lose control over your life. But second, you could be assessed to have capacity when you do not have it. You could suffer harms and injuries and you would be told that that was your choice … (Herring, 2016: 55).

Medical law has served as the main vehicle through which children's capacity has been examined because medical consent is treated with great seriousness (Alderson, 1994: 46); it is linked to the right to bodily integrity – a 'powerful principle which states that, except in a few situations, one person cannot touch another person' (Herring, 2016: 45). This article centres around medical consent in England and Wales therefore, as children's capacity has been considered in this area by courts and commentators to an extent unseen in other areas such as family law (Daly, 2018: 310).

The term "capacity" (sometimes used interchangeably with "competence"[1]) is used colloquially to refer to one's cognitive abilities, i.e. mental processes such as knowing, judging and evaluating. This will be the definition of capacity for the purpose of this article unless otherwise indicated. However, it is important

1 The term "competence" to denote the legal standard has decreased in use in recent years, presumably because of the introduction of the Mental Capacity Act 2005 which uses the term "capacity". Confusingly regarding the legal standard in the case of children, the term "*Gillick* competence" is still used, although not exclusively. In *X.* (*A Child*) [2014] EWHC 1871: para. 12, for example, it was referred to as "*Gillick* capacity".

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to note that there are two elements of capacity – 1) *legal capacity*, referring to the standard for someone to make legally effective decisions; and 2) *mental capacity*, which refers to judgments about decision-making skills (Ruck-Keene *et al.*, 2019: 58), denoting more of a sliding scale than a legal standard.

"Legal capacity" is used in the legal sphere to denote the standard for someone to make legally effective decisions, for example under the Mental Capacity Act (MCA) 2005 – the statutory framework in England and Wales for adults whose capacity to make specific decisions is in doubt – or "*Gillick* competence" for children under 16 years where they understand fully the matter at hand. Childhood in England and Wales has been defined as those under 18 years (General Medical Council, 2015). Adults are assumed to *have* capacity, and under-18s are generally legally assumed to *lack* it, on the basis that they ostensibly do not have the cognitive abilities to make decisions.

There are exceptions to this, of course. In the medical arena alone, obvious exceptions are evident – the age of consent to medical treatment in England and Wales is 16 (Family Law Reform Act 1969, s. 8), and the MCA applies to 16- and 17-year olds. However, in reality under-16s also need medical treatment, and they may need it independent of parental guidance. To deal with this reality, *Gillick* competence is relied upon to determine whether under-16s can themselves consent to treatment. *Gillick* has also become the standard for questions of children's capacity in other areas of the law such as decision making in the context of public and private family proceedings (*S v.* SBH, para. 51); and has had significant influence in other common law jurisdictions (Cave, 2014: 114).

It is not always easy to define exactly what "capacity" entails in practice, however. To turn to the MCA, it requires that an individual understands information but also retains, uses, weighs it; and communicates a decision (section 3[1]). Many theorists have written about the MCA and the challenges of pinning down exactly what capacity (in the case of adults) might be and how to assess it (see, e.g. Banner, 2013: 74–76; Donnelly, 2010: 142; Foster, 2009). Of ascertaining what capacity entails, Herring notes: 'This is clearly not a straightforward issue. The courts have avoided issuing general guidance' (2016: 46).

Similarly, there is a lack of elaboration beyond *Gillick* as to what *children's* capacity involves (Lansdown, 2005: xi). In the *Gillick* case (*Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 112) it was determined in England and Wales that doctors could provide contraceptive treatment to girls where they were deemed by the doctor to have 'sufficient understanding and intelligence' to 'understand fully what is proposed' (at 253). In *An* NHS *Foundation Trust Hospital v. P*, the court described *Gillick* competence as 'having a state of maturity, intelligence and understanding sufficient to enable her to

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take a decision as to medical treatment for herself' ([2014] EWHC 1650 (Fam): para. 12).

This appears to require a high level of understanding of what is involved in the matter in question. In *Gillick* the court elaborated that many factors beyond the medical advice would have to be understood for a child to have legal capacity to consent to such treatment. She would have to understand 'moral and family questions, especially her relationship with her parents, long-term problems associated with the emotional impact of pregnancy and its termination.' In *Re H* (*A Minor*) (*Role of Official Solicitor*) the court pointed to a similarly high level of understanding to instruct a lawyer: a child must have sufficient understanding to participate as a party in the proceedings which means much more than instructing a solicitor. It may also mean giving evidence and being cross-examined ([1993] 2 FLR 552: 554H).

There persists a lack of clarity surrounding the application of *Gillick* in practice, however. It seems that professionals are not always clear as to what exactly capacity for children entails, whether it be in the area of medicine (Cave, 2014; Cave and Stavrinedes, 2014: 16; Ashteka *et al.*, 2007: 632); in family law (Cashmore and Parkinson, 2009: 20–21); or social work (Thomas and O'Kane, 1998: 151). Yet for the most part the ability of children to consent to medical treatment is determined implicitly (Hein *et al.*, 2015[a]); 'day in and day out … as part of routine' (Appendix to *A* (*A Child*) [2014] EWFHC 1445 (Fam.)). Indeed, *Gillick* refers to the discretion of the clinician to treat children and to refrain from contacting parents (174B-D) – so it is ultimately about enabling professional discretion rather than offering a clear means for assessing capacity.

Although implicit assessment generally suffices, the lack of clarity about what capacity entails can sometimes pose a problem. Disagreements can arise between patients and doctors about treatment, though this may not reach the public eye (Cave and Stavrinides, 2013: 5). There can then be differences of opinions between professionals as to whether the child in question actually *has* capacity (note disagreements between clinicians in *An* NHS *Foundation Trust Hospital v P*: para. 9; and *A* (*A Child*) [2014]: para. 8; and between lawyers in *S v.* SBH).

3 Considering What Capacity Entails

It seems that there is no quick-fix definition for professionals, then, of what capacity is, whether in the mental capacity or the legal capacity sense. Yet one can look to guidance from various quarters. In Ontario, Canada, a presumption

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of capacity applies to adults *and* children. A single test for capacity exists under the Health Care Consent Act 1996, section 4(1), that is, whether:

> the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

The key points seem to be about understanding information and consequences. Practice guidance advises nurses to use 'professional judgment and common sense to determine whether the client is able to understand the information' (College of Nurses of Ontario, 2017: 9).

In England and Wales, the MCA (section 3[1]), as noted above, reflects the test involving four elements which is often relied upon when the question arises as to whether an adult's capacity is in doubt (see Hein *et al.*, 2015[a] and Grisso *et al.*, 1997). It requires that an individual understands information but also retains, uses, weighs it and communicates a decision. Even when it comes to clarifying what the standards are for adults, 'there is surprisingly little discussion in the theoretical and empirical literature' on what a procedurally rational decision-making process would look like (Banner, 2013: 74–76). The courts set out what the *inability*, rather than the *ability* entails (see consideration of the case law in Donnelly, 2010: 142). The case law is strikingly focused on impairment, as this must be present for incapacity to be determined under the MCA (section 2). Therefore, MCA case law is not well suited for a more constructive consideration of children's capacity outside of the impairment context. The MCA is noted by the court to be 'hardly of direct relevance' in relation to a child instructing a lawyer in *S v.* SBH (para. 62), although the section 3(1) factors are briefly considered. (see also the comparison in *S* (*Child as Parent - Adoption - Consent*) [2017] EWHC 2729 (Fam)).

An increasing number of tools have been developed to bring greater objectivity to assessments of decision-making abilities for consent to treatment and clinical research in adults, such as the MacArthur Competence Assessment Tool for Treatment (MacCAT, see Dunne *et al.*, 2006). The research of Hein *et al.* (2015[a] and [b]) sought to determine whether a tool for assessing "competence to consent" to medical treatment could be used with children. The tool requires that the assessor assign numerical scores when examining the four elements of capacity: (1) understanding information; (2) reasoning about choices; (3) appreciation of consequences; and (4) expressing a choice. There is little empirical research data on their efficacy, however. One study determined that the MacCAT, modified for children, was feasible (Koelch *et al.*, 2010) but also that clinicians were more likely to determine capacity without

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reference to the tool than if they applied it. This points to the tool failing to capture something which a less clinical (and more personal, holistic) interaction does (Hein *et al.*, 2014). These tools do not seem to provide much clarity, therefore, on what capacity entails in practice, and perhaps the tools facilitate assessments of capacity on paper, but reduce conclusions that children have capacity.

Recent jurisprudence is another source of guidance on children's capacity. In *S v.* SBH [2019] the court outlined (at para. 64) the main factors relevant to the assessment of whether a child can directly instruct a lawyer in a family law case, rather than being assigned a guardian to instruct the lawyer on the child's interests: i) intelligence; ii) emotional maturity; iii) factors which might undermine their understanding such as their emotional state; iv) their reasons for wishing to instruct a solicitor directly; v) potential undue influence; vi) their understanding of the process of litigation; vii) the risk of harm to the child from participation. These points are, of course, quite specific to instructing a lawyer. They are also, perhaps, demanding much from a child (and certainly more than is required from an adult wishing to instruct a solicitor) in order to reach the requisite standard of capacity.

An NHS *Foundation Trust v. A & Others* [2014] highlights the court's *ad hoc* approach to capacity in a medical law context. It concerned the medical treatment of a 16-year old girl ("A") whose life was in immediate danger because of her disordered relationship with food. Two psychiatric reports established that the girl lacked capacity to make decisions about medical treatment and the court relayed the evidence as follows:

> It was concluded that A struggled to make decisions about her own care and presently suffered from a disorder of mind or brain … In Dr G's analysis there was no evidence that any further time would alleviate the problem or effectively assist in aiding A's understanding (paras. 14–15) … [She] had shown no capacity to focus on her emotional feelings or the 'powerless nature of her own situation'. Dr G told me that A presented as a much younger girl, sometimes petulant and child like … she lacks a real appreciation that unless immediate action is taken that she will die (para. 41).

The court did not consider *Gillick* competence,[2] it instead expressed that A's wishes were important (para. 12), particularly since use of force was being

2 Neither did the court refer to *Gillick* when making an order for treatment on a 12-year old in *X Health Authority v. D* [2019] EWHC 2311 (Fam.). In *F (Mother) v. F (Father)* [2013] EWHC 2683 (Fam.) in which the court made an order to inoculate adolescent girls against their wishes,

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sanctioned by the court. The court referenced the MCA although acknowledged it would not be applied in her case, presumably because she was under 18, although the fact that the MCA applies to 16- and 17-year olds was not mentioned in the judgment (bearing in mind A was 16 years old).[3] The elaboration of why she does not have capacity is somewhat vague and subjective, referring, for example, to perceived immaturity ('petulan[ce]').

In another 2014 case, *A* (*A Child*) [2014] EWFHC 1445 (Fam), the question was whether a 13-year old had the capacity to consent to a termination. This time *Gillick* competence *was* explicitly considered. A psychiatrist again provided evidence and, on this occasion, convinced the court that the girl had capacity to consent, although other doctors involved were in doubt (para. 8). She was deemed by him to have capacity as:

> [S]he fully understood the implications of the options; the risks … she was able to explain to him that her wish was to terminate the pregnancy as she felt that she could not cope with its continuance … the decision that was reached by A was hers alone and was not the product of influence by adults in her family (paras. 13–14).

In *An* NHS *Foundation Trust v. A & Others*, it is outlined that the 16-year old does not understand the consequences of refusing treatment. In *A* (*A Child*) it is outlined that the 13-year old does understand. Some convincing reasons are provided for these conclusions. Nevertheless, a somewhat *ad hoc* approach to considering capacity is evident in such judgments, in that the court does not have a standard approach. It does not rely upon any kind of checklist, for example. *Gillick* competence may or may not be explicitly mentioned. Elements of the MCA 2005 may or may not feature.

It seems very difficult, therefore, to ascertain how a professional is to apply an objective and standardised approach in an informal assessment of a child's capacity. This is particularly the case when we bear in mind that in both of these cases – *An* NHS *Foundation Trust v. A & Others* and *A* (*A Child*)) – expert psychiatrists were introduced and therefore the assessments could be described as formal,[4] and yet a fairly ad hoc approach to assessing capacity is

neither the words "competence" nor "capacity" were even explicitly referenced. Nor is *Gillick*.

3 In *An NHS Foundation Trust Hospital v. P* [2014] EWHC 1650, however, the court *did* apply the MCA when making an order for treatment on a 17-year old.

4 This reliance on experts appears to generally occur in only the most serious of medical law cases (although in the most acrimonious family law cases, psychologist and other expert evidence is very occasionally introduced, see Daly, 2018: 299).

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evident in the judgments. Some such cases show that experts may even be in disagreement with each other as to whether a child has capacity (see *An* NHS *Foundation Trust Hospital v. P*; *A* (*A Child*); and *S v.* SBH), demonstrating all the more how difficult it may be for a non- psychology/psychiatry expert to make such a determination.

Consider also the difficulties in defining capacity for adults, as well as the fact that standardised tests such as the MacCAT do not provide a definitive objective measure of capacity. It is telling that the courts in *S v.* SBH, after outlining elements to consider when determining a child's capacity to instruct a lawyer, stated that '[i]nevitably the evaluation is more an art than a science and the weight to be given to each component cannot be arithmetically totted up' (para. 80). It seems that perhaps an intuitive assessment of a child's capacity (based on experience and impressions) is inevitable in some practice contexts, and that attempting to quantify or to be overly rigid in defining capacity is unhelpful. Or perhaps it is possible to apply a solid definition but one has not yet been established to a satisfactory degree. In any case, professionals would benefit from a framework in which to work when assessing or understanding a child's capacity, and it is important that this framework is based in children's rights.

4 Considering Children's Capacity Rights

One important source for better understanding capacity is the CRC. The term "evolving capacities" in Article 5 implies the CRC's recognition and appreciation of the sliding scale of capacities that children move through as they grow to adulthood. Although 'the evolving capacities of the child' is not defined in the Convention, the Committee on the Rights of the Child ("the Committee") opines that it refers to 'processes of maturation and learning whereby children progressively acquire knowledge, competencies and understanding, including acquiring understanding about their rights and about how they can best be realized' (General Comment No. 7: para. 17).

Article 5 is a ground breaking provision of the CRC. Lansdown points out that traditionally, it was assumed that adults were the primary agents for protecting children, and that children were seen as mere recipients; but that 'the reality is more complex, involving a dynamic process that recognises children's capacities to contribute towards their own protection and allows them to build on their strengths' (Lansdown, 2005: 41). It is highly significant then that Article 5 positions parents not as owners or even solely protectors of their children but, similar to the *Gillick* case, as holders in trust of children's rights.

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The parental role will change as the child matures and develops abilities and desires to exercise rights on her own behalf. Article 5 then 'transforms the role of the parent from primary rights-holder over their child, to duty-bearer to their child in the child's exercise of her rights under the UNCRC' (Varadan, 2019: 320).

Article 5 may place emphasis on the position of parents but it envisages a balancing of children's autonomy and protection rights in accordance with their capacities (Lansdown 2005). We can infer from this that children themselves have "capacity rights" under Article 5 in that, on relevant matters, the extent of their capacity must be considered and they should be given the freedom to make their own decisions to the extent possible.

Whilst acknowledging that what constitutes capacity is a contested matter, and that there are no quick-fix definitions of capacity, it can be said that efforts to understand it should be grounded in the CRC. With the intuitive, informal approach to assessing children's capacity in mind, I am therefore proposing a rights-based model, based on the CRC, to guide assessment or understanding of a child's or children's capacity in a rights framework.

The model below proposes that in order for professionals to take a rights-based approach to assessing or understanding the capacity of a child or of children generally, they should consider the following concepts:

1. Autonomy (Article 12): Children have autonomy rights, and to deny them their wishes should be considered a matter of seriousness.
2. Evidence (Article 2): Decision-makers should have basic knowledge about childhood including psychology and other relevant theories.
3. Support (Article 5): Capacity can be increased through appropriate support, guidance and information.
4. Protection (Article 3): Children are a group who are in a unique position of relative vulnerability and adults are obliged to offer them protection from harm.

All of these concepts have been specifically situated in this model via various 'cross-cutting standards' (Hanson and Lundy, 2017: 301) or provisions of the CRC. It must be borne in mind that CRC rights are indivisible and interdependent, however, so there will be overlapping elements to these points. Some further sub-headings have been included to assist assessment – under concept 1. *Autonomy*, 'accord due weight to views' is instructed, for example. These points are not intended to be exhaustive however, as each capacity assessment will need to be tailored to the specific context, such as a determination of capacity to consent to medical treatment, to participate in legal proceedings, and so on.

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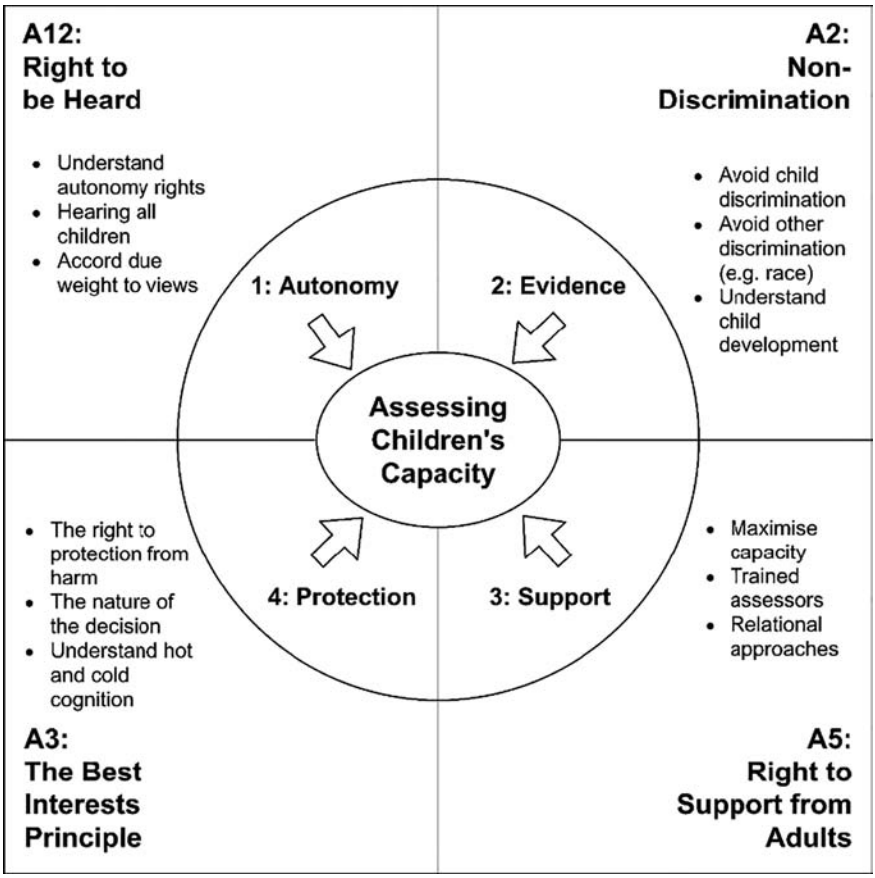


FIGURE 1 Children's Capacity Rights

4.1 *Autonomy* (*Article 12 Right to be Heard*)

4.1.1 Understand Autonomy Rights

When assessing or understanding a child's capacity, it is important to be aware of the importance of autonomy to all individuals, including children (see *X Health Authority v. D*: para. 12 and *S v.* SBH: para. 63). Autonomy – the ideal that we should decide our own destiny to the extent possible – is the most valued characteristic for the individual in a liberal democracy (see Daly, 2018). Evidence indicates that it is inherently good for wellbeing. Greater autonomy has been found to be correlated positively with a variety of outcomes for children, particularly where they make decisions together with adults (Bindman, Pomerantz and Roisman, 2015: 775). There are laws upholding autonomy and social policies based around it.

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Capacity is often the gateway to autonomy. For example, being determined *Gillick* competent may permit you to access the treatment you wish to have. Assessing capacity therefore requires an understanding that denying children autonomy should be taken seriously, as it is for adults (Daly, 2018). This requires that capacity assessment contains an understanding that a child is supported to understand the matter at hand before they are deemed to lack capacity (see further 3.3 below). It also requires that the *nature* of the decision is considered – less serious issues will likely require lower levels of understanding for children to be deemed capable of making decisions (see further 3.4 below).

There has been resistance to an overly-individualistic liberal notion of the autonomous individual in medical law (see e.g. Donnelly, 2016: 322; Herring, 2016; Foster, 2009). Yet a relational approach can be taken to autonomy which can provide a more holistic and less individualistic approach to it. There are various accounts of relational autonomy. Donnelly (2016: 322) opines that a useful unifying concept is that advanced by Christman (2004: 147): a conception of autonomy is uniquely relational when 'among its defining conditions are requirements concerning the interpersonal or social environment of the agent'. Understandings of children's autonomy and capacity, therefore, requires acceptance that we are all defined through our relationships with others and through the environments in which we are operating (see further 3.3 below).

4.1.2 Hearing All Children

Article 12 of the CRC requires that states 'shall assure' to children the right to be heard (Article 12[1]), and in particular children should be 'provided the opportunity' in proceedings affecting them (Article 12[2]). Although autonomy is not explicitly mentioned in the CRC, Article 12, taken together with Article 5, can be interpreted as meaning that children should have autonomy to the extent possible. When assessing a child's capacity, hearing what they have to say will be crucial. This will provide information about whether a child has made a decision, what their wishes are, and of course give indications as to their mental capacity. The Committee also makes the point that states should not just ensure children are heard, but also positively *encourage* children to provide views (General Comment No. 12: para. 11). Communication for the purpose of assessing capacity should therefore be encouraged.

There are different opinions on the age at which it is appropriate to hear children's views, but even young children can form views and express wishes. There is no age limit set by Article 12 for extending to a child the right to be heard; the text refers solely to the child 'capable of forming his or her own

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views' without designating a specific cut-off point. Therefore children must be assumed capable of forming views (this is not the same as assuming that a child has legal capacity), and children must be informed about the fact that they are in possession of this right to be heard (*ibid*, para. 20). The Committee defines 'young children' as those up to eight years of age, and states that their participation rights mean that adults must 'show patience and creativity by adapting their expectations to a young child's interests, level of understanding and preferred ways of communicating' (General Comment No. 5: para. 11[c]). Even children who clearly do not have capacity can potentially provide views through communication such as play or art (see General Comment No. 12: para 21; and Daly, 2018: 49).

In order to assess children's capacity, professionals must engage in communication in 'a child friendly manner' (Day of General Discussion on the Right to be Heard, para. 40). There are now guidelines in many areas of practice as to how to communicate with children, for example in legal proceedings (see e.g. the Council of Europe Guidelines on child-friendly justice, 2010).

4.1.3 According Due Weight to Views: Participation Without Full Capacity

Part of facilitating children's autonomy rights is to ensure not just that children are heard, but that what they say is given due weight. The Committee states that 'simply listening to the child is insufficient', but that the views of the child have to be seriously considered (General Comment No. 12: para. 28). There are also obligations to provide children with feedback and information on the position of their views in the outcome of decisions (*ibid*, para. 45). There must therefore *always* be some level of weight accorded to their views (Daly, 2018). Even if hearing a child indicates that she is not *Gillick* competent, her views should still be given due weight in accordance with Article 12.

Participation has become a key notion associated with Article 12 – the right to be heard means that children should enjoy participation in an all matters affecting them (General Comment No. 12: 86). The notion of participation is highly relevant to children's capacity, as the principle of the evolving capacities of the child means that children have a right to participate to the extent possible – the level of their of involvement will accord with their mental capacity. Children should not simply be "assessed", however, they should be supported to participate, as is outlined in section 3.3 below. This should be the case for even young children who can have sophisticated knowledge of their medical condition, particularly if they have had a serious illness for some time. In these circumstances they may develop decision-making capacities that far exceed expectations of children of their age group (Alderson and Montgomery, 1996).

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4.2 *Evidence* (*Article 2 Non-Discrimination*)

4.2.1 Refraining from Discriminating Against Children as a Group

Article 2 of the CRC requires states to ensure that rights are secured: 'to each child within their jurisdiction without discrimination of any kind', noting characteristics such as race, colour, sex, 'or other status'. The emphasis here is often on characteristics such as race but 'other status' can also be interpreted to include age, that is, the status of the child as a child.

There are strong non-discrimination movements in the areas of disability rights, gender and race, but the unfair treatment of children on the basis that they are under 18 years is little examined, considered or discussed in the sphere of children's rights (Daly, 2018), though the Committee has on occasion emphasised discriminatory attitudes against adolescents (General Comment No. 20, para. 21). In efforts to understand capacity, greater attention must be given to the part played by adult attitudes to children and how this affects perceptions of the capacity of individual children, as well as children generally.

Contemporary scholarship provides evidence that children are not undeveloped adults. They are complete entities who are deserving of respect. Childhood, of course, has a biological component. Yet it is now accepted, due to scholarship rooted in childhood studies, that childhood is to some extent constructed. Such constructions have tended to underestimate children's capacity and ability to exercise agency in their own lives (Prout and James, 1990: 7–33). Alderson and Montgomery state that the greatest obstacles to children's capacity likely arise from prejudices about children, and beliefs that it is unwise to listen to children (1996: 58). Children's relative inexperience does render them vulnerable and they require special protections. However, they are frequently denied opportunities for decision making in accordance with their evolving capacities (Lansdown, 2005: 31).

Non-discrimination in capacity assessment will therefore involve awareness of and resistance to discriminatory attitudes against children as a group. Koh-Peters (2018), in her work representing children in child protection proceedings, poses questions "to keep us honest" such as: if one is treating this client or patient differently because she is a child, then why is that? Is it justifiable? A positive example of non-discrimination in the specific context of consideration of children's evolving capacities is noted in New Zealand by Lansdown (2005: 53). There the Ministry for Youth Affairs developed guidelines for government departments and public bodies when considering age-limits in law and policy. Various prompting questions are encouraged, including: 'Does the age-limit discriminate against young people?' noting that '[i]t is not acceptable to treat young people differently just because of their age.'

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Applying the principle of non-discrimination when considering a child's capacity also means refraining from an overly conservative application of *Gillick* and other standards of assessment of capacity. Being 'fully' informed, as *Gillick* requires, is beyond the requirements for an adult, who simply needs to be aware in broad terms of the nature of the treatment (*Rogers v. Whitaker* [1992] 175 CLR 479, 489 see also *S* (*Child as Parent - Adoption - Consent*) [2017], para. 60). The court in *S v.* SBH advocates 'a shift away from a paternalistic approach in favour of an approach which gives significantly more weight to the autonomy of the child in the evaluation of whether they have sufficient understanding' (para. 63). Careful consideration should be given to a child's capacity in circumstances such as obtaining consent for medical treatment. Yet one should avoid an overly stringent interpretation of what a child's understanding entails.

4.2.2 Supporting Marginalised Children

Lundy (2007: 934–935) emphasises that participation rights should not be afforded only to articulate and literate children. The Committee provides evidence of the particular need to guarantee the participation of children with disabilities. This is important when it comes to assessing capacity, as adults may have difficulty accepting that a child with disabilities might have capacity (1997, para. 334). It is also the case that children with language barriers: 'minority, indigenous and migrant children and other children who do not speak the majority language' (General Comment No 12: para. 21) may struggle to have their capacity taken seriously, for example in the context of immigration cases.

It is not simply the case that the capacities of children may be underestimated; there may also be less sense of a duty to support and maximise the capacity of these groups. Lansdown points to the fact that children from minority groups may experience negative assumptions about their capacity and their ability to learn (2005: 30). Yet there are particular obligations to ensure that groups are supported to have their views and understandings made clear. The Committee states that children with disabilities have a right to 'any mode of communication necessary to facilitate the expression of their views' and also that particular efforts must also be made to support children with language issues (General Comment No 12: para. 21).

4.2.3 Understand Child Development: Theory and Unknowns

It is important to remain critical of the notion that children's capacity can be measured in a straightforward way considering the fraught and contested nature of the concept of capacity in the case law and literature outlined above. Yet the Committee states that professionals working with children should have

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the relevant training, including on children's capacities (General Comment No. 20: para 37[e]). It is therefore useful to consider briefly what claims are made within developmental psychology and in empirical research about children's evolving capacities, in order to determine the relevance of those claims and findings for how the law approaches and treats children. This section does not aim to provide a comprehensive analysis of what psychology and neuroscience can tell us about capacity, but rather serves to provide an overview of relevant evidence from these fields of study.

It is important to emphasise, as the Committee does, that 'age alone cannot determine the significance of a child's views' and that other factors such as experience will also be significant (General Comment No. 12: para. 29). Much of the thinking around children's decision-making abilities, however, revolves around what children should be expected to do within their particular age range. Piaget's "stage theory" (see e.g. Piaget and Inhelder, 1969) is prevalent within developmental psychology. Piaget worked on developing early IQ testing with Alfred Binet (an intelligence quotient [IQ] is a score based on standardised tests to assess human intelligence). Piaget noticed that children of approximately the same age have a tendency to engage in similar behaviours. Piaget's work was novel, and increased perceptions that children's cognition was worth understanding. However, he has been criticised as underestimating children's abilities, and later theorists such as Vygotsky (1978) and Bronfenbrenner (1979) have placed greater emphasis on the importance of the environment of the child as opposed to particular stages of development. There is continued acknowledgement, nevertheless, that ages and stages are important in understanding the cognitive development of children (Gay Hartman, 2000: 1285). Rutter and Rutter (1993: 195) make the point that no amount of training or environmental fine-tuning will enable a four-month old baby to walk.

Since Piaget, many researchers have further examined what children can generally do at certain ages. Empirical research and advances in neurobiology have added to the body of evidence (see also Kilkelly in this special issue). In general, the evidence paints a complex picture and it is important to remember that developmental psychology is theory rather than fact. However, there are some trends in the findings that we can point to. It is also important to acknowledge that the question, 'what can children be expected to know/decide at a particular age?' is very common, as we tend to have a preoccupation with age. This inescapable question therefore requires a response, and the response should involve both available evidence, and an appeal for balance, in that factors besides age must also be considered.

From birth to age two, Piaget stated that children are in the "sensorimotor stage" whereby they experience the world through movement and their senses.

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Babies are conscious and active agents who alter environments, families, relationships (Alderson and Montgomery, 1996). Their experiences are to be taken seriously but they are not going to have capacity to consent to medical treatment, for example. The "preoperational" stage continues from age two to seven whereby there is an increasing ability to use and represent objects through words and images ("symbolic thinking"). Mental reasoning (that is, solving problems and making decisions) is developing. It is thought, however, that children are expected to think in "egocentric" terms, that is, to have difficulty in considering the viewpoints of others, although they are increasingly gaining these skills. "Cognitive control" – that is, controlling your behaviour in line with your goals – is thought to be weak in children of this age (Kidd *et al.*, 2013) although more recent research (e.g. Murray *et al.*, 2016; Blakemore, 2019: 149–154), points to the influence which environment, assistance and support has on the ability of children (and all individuals) to make more objectively "good" decisions.

Seven years appears to be a developmental turning point, and children from this age are considered, for example, capable of assenting (i.e. actively agreeing) to medical research (see e.g. Hein *et al.*, 2015[b] and Varadan, this special issue). Children are developing metacognitive skills, that is, a more abstract and complex idea of identity and interests. Piaget, identifying a "concrete operational stage" from 7 to 11 years, pointed to the ability to think logically about concrete events from age 7, though he argued that children may still be unable logically to consider all outcomes.

The research indicates another leap in development *within* this stage, at age nine. The research of Hein *et al.* indicates that those between 9.6 and 11.2 years are in a period of transition; they are developing important abilities but their maturity is not yet "effective" (2015[a] and [b]). Their research estimates that children of 11.2 years and above generally seemed to have the mental capacity necessary to consent to medical treatment, while children of 9.6 years and younger generally did not. Other research has been even more positive about abilities at this age. In Greenberg Garrison's research examining children's decisions in hypothetical scenarios concerning arrangements for children on family breakdown, it was found that nine-year olds were as rational as adults in their reasons for decision-making (1991: 78).

"Adolescence", then, is usually defined as puberty (around age 12) to age 18, which is the age of majority for most purposes. At some time around age 12, Piaget argued, children enter the "formal operational stage", and abstract thought starts to become sophisticated. Individuals reason logically, draw conclusions from available information and apply to hypothetical situations all of these processes. Neuroscience likewise indicates that the thickening of the

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part of the brain involved in judgment and planning peaks at approximately age 11 in girls and age 12 in boys (Giedd, 2004). There is a consequent development of cognitive skills facilitating greater ability to develop hypothetical solutions, and the development of the means to choose the best one (Broome, 1999). Within this stage, 14 years appears to be a significant turning point for decision-making abilities (see e.g. Bosisio, 2008: 290). Some research indicates that 14-year olds' ability to make decisions is as advanced as that of adults, when considering their understanding of the facts, their processes of decision making and their understanding of potential outcomes of choice (see e.g. Greenberg Garrison, 1991: 78).

Other research points, however, to cognitive limitations which persist in adolescence. It indicates that the frontal lobes, which govern executive functions (cognitive processes in the brain responsible for reasoning and problem solving, helping us to prioritise, think ahead and regulate emotion), matures in our early to mid-twenties (Lipstein *et al.*, 2013). This has led to a new developmental period explored by researchers: "emerging adulthood". Evidence points to an important transition between 15 and 19 years (Scott *et al.*, 1995). Weijers and Grisso (2009: 64) argue that the 'lesser maturity of adolescents' decision-making capacities may be linked to brain structures that also have not yet reached adult maturity'. This has led to theories that adolescents make riskier decisions than adults, even in medical treatment (see e.g. Lipstein *et al.*, 2013). It is important to remember, however, that this does not write off all under-18s in terms of reasoning tasks: 'It is not that these tasks cannot be done before young adulthood, but rather that [in adulthood] it takes less effort, and hence is more likely to happen.'[5] Individual differences will dictate a lot – some individuals are risk-takers, whilst others are not (Blakemore, 2019: 134).

Even when considered through the lens of developmental psychology then, the difficulties with measuring and defining capacity have to be acknowledged. Commentators question whether developmental psychology is objective and neutral, and the legitimacy of focusing on children reaching particular stages at particular times (Cordero Arce, 2015). Furthermore, it must be emphasised that capacity cannot be understood as located solely in the individual; it is highly dependent on the environment in which an individual is operating, and particularly whether they are receiving support to maximise capacity.

5 Massachusetts Institute of Technology, *Young Adult Development Project*. Available at http://hrweb.mit.edu/worklife/youngadult/changes.html (last accessed 2 Jul. 2020).

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4.3 *Support* (*Article 5, The Evolving Capacities of the Child*)

4.3.1 Maximising Capacity

Providing children with support and information will boost capacity. The level of assistance and support which children receive will likely be far more important than their decision-making abilities *per se*: 'Children's capacities are very much an interactive and relational process of dialogue, determined as much by the "hearing" and "scaffolding" capacities of the adults they engage with as their own expressive capacities' (Cashmore, 2011: 520).

The Committee stipulates that states must ensure that a child receives all necessary information and advice to make a decision in favour of her or his best interests (General Comment No. 12: para. 16). Adults have duties to maximise children's capacities, specifically because of the relative lack of experience of children: the Committee states that 'the child has a right to direction and guidance, which have to compensate for the lack of knowledge, experience and understanding of the child and are restricted by his or her evolving capacities' (*ibid*, para. 84), although the meaning of 'parental direction and guidance' under Article 5 has remained largely without definition (Varadan, 2019). The Committee points to duties on adults to support capacity: the more the child knows, has experienced and understands, the more adults must move from 'direction and guidance into reminders and advice' and later to an approach to important issues as equals. This will 'steadily increase' over time (General Comment No. 12: para. 84).

In cases where adult capacity is at issue, there is an MCA duty to support capacity (in section 1[3]), although Ruck-Keene *et al.* (2019) found that there is much more work to be done in achieving this. There is no comparable obligation in England and Wales in cases concerning children. In *F* (*Mother*) *v. F* (*Father*) [2013] EWHC 2683 (Fam.), for example, two adolescent sisters and their mother were resisting vaccinations sought by the father for the girls. The court noted that the girls did not have 'a rounded appreciation of the pros and cons of the vaccine'. Cave makes the points that the girls could have been given this information, and their capacity then considered (2014b: 639 see also *S* (*Child as Parent - Adoption - Consent*) [2017], para. 57 where information was to be provided to the 'child parent' about adoption).

4.3.2 Trained Assessors

Professionals should have some basic knowledge of theories around children, developmental psychology and capacity when working with children. The Committee states that when there are proceedings in relation to children, the capacity to form views has to be assessed (2009: para. 28) and that all personnel involved in proceedings regarding decision-making are to be trained in this

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regard (Day of General Discussion on the Right to be Heard: para. 41). Alderson suggests that a test should be required to determine whether *practitioners* understand children's competence and how to enhance it. She suggests that the test should enquire as to whether a professional is able: 'to understand all the relevant information; to retain and explain all the issues clearly and resolve misunderstandings; to assist children and parents in their reasoned choice-making; and to respect their decisions, putting no undue pressures on them?' (1994: 53).

I consider elsewhere how "autonomy support" can be used to assist children in decision-making – that they should be provided with non-controlling, impartial information and support to form and/or express views and decisions (Daly, 2018: 418). There are a wealth of resources on maximising capacity and providing support which could be adapted for maximising children's capacity. The UN Convention on the Rights of Persons with Disabilities enshrines an obligation to support exercise of capacity (Article 12) rather than assuming abilities can be measured. Consequently, decision-making support for those with cognitive disability has been incorporated into policy and legislation around the world.

Guidance is available, for example, for implementing support under the MCA 2005. The Office of the Public Guardian (2013) states that, to support someone to make a decision for themselves, one must ask, does the person have all the relevant information they need? Do they understand alternatives? And has communication of the information been conducted well? In medical practice research has been conducted on supporting decision-making by ensuring quality of communication (Hein, I. *et al.*, 2015[a]) and enhancing competence through various techniques such as breaking the process down into smaller but linked choices, and making the child feel valued (Larcher and Hutchinson, 2010: 309). Given the clear obligation under Article 5 of the CRC to support children's decision-making (Varadan, 2019: 329), it is crucial that professionals engage in supportive, capacity-maximising of this nature where capacity is being assessed.

A basic understanding of child development is not only necessary to understand how to assess children's capacity, it will also be important for understanding how to maximise the capacity of children of various ages through autonomy support. The Committee points out that '[c]onsideration needs to be given to the fact that children will need differing levels of support and forms of involvement according to their age and evolving capacities' (2009: para. 184) and assessors will have to have training in these points. This means that states have obligations to ensure training similar to that which is now common in the area of capacity support for people with cognitive disability.

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4.3.3 Relational Approaches

Available research on children's views indicates that they wish jointly to make decisions with parents and others rather than be the sole decision-maker (Alderson and Montgomery, 1996: 2). It is considered good practice to involve the child's family in the decision-making process, if the child consents to this (Department of Health, 2009: 33). Of course, children are particularly dependent on those close to them, socially, emotionally, financially and legally. It is important to ascertain that children are not under undue influence in the decision that they have made. This is complex, as choosing an option because it aligns with the interests of those close to you can still be "your own" choice. Helpfully, courts make a distinction between this and "parroting" the views of parents (see e.g. *S v.* SBH: para. 64).

Because of the relational nature of decision-making, there may legitimately be an element of "persuasion" to do the right thing. One can imagine scenarios in which this would be entirely appropriate. Consider, for example, where needle fear is preventing a child from accepting life-saving treatment which requires an injection (see e.g. *Re M. B.* (*An Adult: Medical Treatment*) ([1997] EWCA Civ. 1361 where the patient was an adult). A child may need to be persuaded to endure the discomfort of an injection in order to avoid much greater harm. Research indicates that children's attitudes to compulsion is more dependent on their relationship with parents and clinicians than the degree of compulsion (Tan *et al.*, 2010), highlighting the importance of communication, and the intimate connection of capacity to factors such as trust and positive relationships. There is a difference between providing information and persuading on the one hand and coercing on the other however, and professionals should be aware of the power dynamics between adults and children.

An assessment of capacity should include consideration of factors relating to the child's relationships, cultural context and his/her particular perspectives and experiences (Alderson 1993: 123). Having experienced a chronic illness for a number of years, for example, would clearly be relevant to a child's capacity for making decisions in relation to that illness. There is evidence that such experience is a more indicative factor than age in assessing capacity (Chico and Hagger, 2011: 161).

4.4 *Protection* (*Article 3: The Best Interest of the Child*)

4.4.1 The Right to Protection from Harm

The principle of the best interest as enshrined in Article 3 is many-faceted. It is, for example, a legal device for courts to ensure that children's interests are given due consideration in proceedings affecting them. It also has a protective

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function: Cave and Stavrinides make the point that, 'Article 3 places great responsibility on parents and public officials to protect the health and welfare interests of children' (2013: 13). This is reflected in domestic law in systems all over the world. The Children Act 1989 stipulates that, 'the child's welfare shall be the court's paramount consideration', although a child's wishes will form part of that consideration.

The basis for this paternalism is a recognition that children's capacities are still evolving and, therefore, they are owed a duty of protection from activities likely to cause them harm, although this paternalism should diminish over time (Lansdown, 2005: x). States have obligations to all citizens to engage in a balancing act between autonomy and protection. Where children are making a decision which is disastrous to their health, such as resisting life-saving treatment for religious reasons (see e.g. *Re E.* [1993] 1 FLR 386), then the state has an obligation to override their immediate decision as failure to do so would prevent children from developing into autonomous agents (Cave, 2014: 111). This can be argued to be the case even for those who are *Gillick* competent, on the basis that special protection is owed to under-18s. The reason why controversy has arisen in terms of the inability of children to refuse consent is because treatment will not be offered unless it is in the child's best interests (Cave and Stavrinides, 2013: 19). Therefore refusing is sometimes significantly different in outcome to consenting. It seems logical then that a difference is drawn between the two, and that autonomy must sometimes be overridden in favour of protection.

4.4.2 The Nature of the Decision

Many commentators emphasise that the same thresholds of capacity are not necessary for all decisions. The MCA's approach is that capacity is 'issue specific': the question is whether a person has capacity to decide *this* particular question (Herring, 2016: 45), not all questions. Moreover, capacity is not a single, one-off event (British Medical Association, 2010: 4) or definitive. Ruck-Keene *et al.*, for example, found that in 12.5 per cent of MCA cases, the individual in question was found to have capacity in relation to some issues but lacking capacity in relation to others. In one case referred to, for example, the person was found to have capacity for sexual relations and marriage, but not to litigate these issues (2019: 66 see also *S* (*Child as Parent - Adoption - Consent*) [2017], para. 17).

Likewise, in *D Borough Council v AB*, the court stated that: 'The terms of [*Gillick*] show clearly that the capacity in question is act and not person specific' ([2011] EWHC 101 (COP): para. 18). Cave opines that this means that a child's ability to understand will depend on the complexities of a particular decision (2014: 106). The Committee notes that the importance of the matter may mean

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that assessing maturity accurately becomes more important (2009: para. 30). This is reflected in the fact that in the cases where serious medical issues are at play, courts may engage the expert evidence of a psychiatrist (and in family law cases there is sometimes reliance on psychologists' evidence, see section 2 above).

The nature of the decision may also be significant not just for capacity, but to determine how much weight children's wishes should have. Lansdown suggests a principle of proportionality with a sliding scale of capacity in accordance with the seriousness of the decision. Low-risk decisions would mean that children could take responsibility without demonstrating high capacity levels. For a child's wishes to be overruled, one would have to demonstrate that the child does not understand the implications of the choice and the risk it poses to his/her best interests (Lansdown, 2005: x).

4.4.3 Understand Hot and Cold Cognition: The Consequences for Criminal Behaviour

The context of the decision will also be very relevant to considerations of capacity. This becomes particularly important in the context of children's criminal behaviour. The United Nations Standard Minimum Rules for the Administration of Juvenile Justice requires 'a close relationship' between children's responsibility for criminal behaviour and 'other social rights and responsibilities' (Official commentary on Article 4(1)). Yet this is rarely achieved – in England and Wales, for example, the age of criminal responsibility for serious crimes is 10 years (Children and Young Persons Act 1963, Section 16), yet the courts can overrule a child's refusal to consent to medical treatment up to the age of 18 years (*Re W* (*A Minor*) (*Medical Treatment: Court's Jurisdiction*) [1993] Fam. 64, [1993] 1 FLR 1). This is 'a dichotomy that appears not to have been subjected to detailed analysis' (Lyons, 2010: 258). Lyons argues that if children are to be denied responsibility for their healthcare decisions, then when they commit crimes, 'they should be dealt with … by agencies outside of the criminal law' (2010: 277).

Available research on children's capacities indicates that the context of the decision is crucial to whether adult-child differences will emerge for under-18s in their reasoning: '[i]n the heat of passion, in the presence of peers, on the spur of the moment, in unfamiliar situations' adolescents may not reason as well as an adults might (Reyna and Farley, 2006: 1). This is because the prefrontal cortex, which prevents us from acting on impulse, is not yet fully developed (Blakemore, 2019: 135). Where adolescents can consult others, however, and consider their options at a measured pace, their decision-making abilities can match maturity attained in adulthood (Steinberg, 2005). Children

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become more adept at problem-solving when they have practised solving problems with parents or older children (Gay Hartman, 2000: 1285; Vygotsky, 1978; Bronfenbrenner 1979). The difference in contexts has been described as "hot" cognition – making decisions in a heightened emotional state; and "cold" cognition – a more deliberative type of decision-making process in less stressful environments (Blakemore, 2019: 143–148; Albert and Steinberg, 2011).

This points clearly, therefore, to why children's capacity in different contexts should be treated distinctly; and why children should be considered to have greater potential for good decision-making in the medical law context as opposed to the criminal law context. The Committee astutely emphasises the need for 'recognition that competence and understanding do not necessarily develop equally across all fields at the same pace and recognition of individual experience and capacity' (General Comment No. 20: para. 20). The same child may have different abilities for decision-making in relation to a criminal matter and a medical law matter. Two children of the same age could have entirely different decision-making abilities in relation to the same matter because of individual differences. The context in which the decision is made, therefore, will likely have a major effect on how capacious a child will be.

5 Conclusion

It is important to remain critical of the notion that children's capacity can be measured in a straightforward way. However, law is often dichotomous in nature: guilty/not guilty; liable/not liable; rational/not rational (Lyons, 2010: 277), and judgment calls must sometimes be made about a child's capacity. In such a binary context it is difficult to operationalise the principle of the evolving capacities of the child. It is significant, however, that Article 5 emphasises the sliding scale of capacities that children move through as they grow to adulthood. Children's "capacity rights" therefore mean that, on relevant matters, children's capacity must be assessed, and this should be done in accordance with children's rights.

Although "*Gillick* competence" is supposed to be the standard for under-16s in England and Wales, the approach of the courts to assessing capacity can be vague and inconsistent. It is clear that children need a high level of understanding to be considered to have legal capacity in a certain area, and that they will have to demonstrate awareness of various risks and consequences (see e.g. *An* NHS *Foundation Trust v. A & Others*). It remains challenging, however, for professionals to understand how to assess capacity and what "*Gillick* competence" means in practice. The intuitive approach is generally satisfactory, but it

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is important that it is informed by the CRC. This, it has been argued here, should specifically require: an appreciation of autonomy, because this is so valued in the liberal democracy; evidence, because this will ensure that childhood is properly understood; support, because capacity is not static but can be maximised; and protection, because it must be emphasised that with childhood comes relative vulnerability.

In order to ensure that children's capacity rights are met, and particularly to ensure that adults have a rounded understanding of capacity, there will have to be significant efforts made by states to ensure that medical professionals, lawyers and others working with children are trained in children's rights and child development. This is going to require significant investment, but it is an obligation that states undertake when they ratify the CRC, which requires that the provisions of the treaty are made widely known and that relevant professionals are trained accordingly (General Comment No. 12: para. 135).

Although it may not necessarily be possible objectively and precisely to assess children's capacity, insisting on understanding capacity through a children's rights lens will at least prompt challenging questions which get to the heart of what it is to respect children as equals.

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