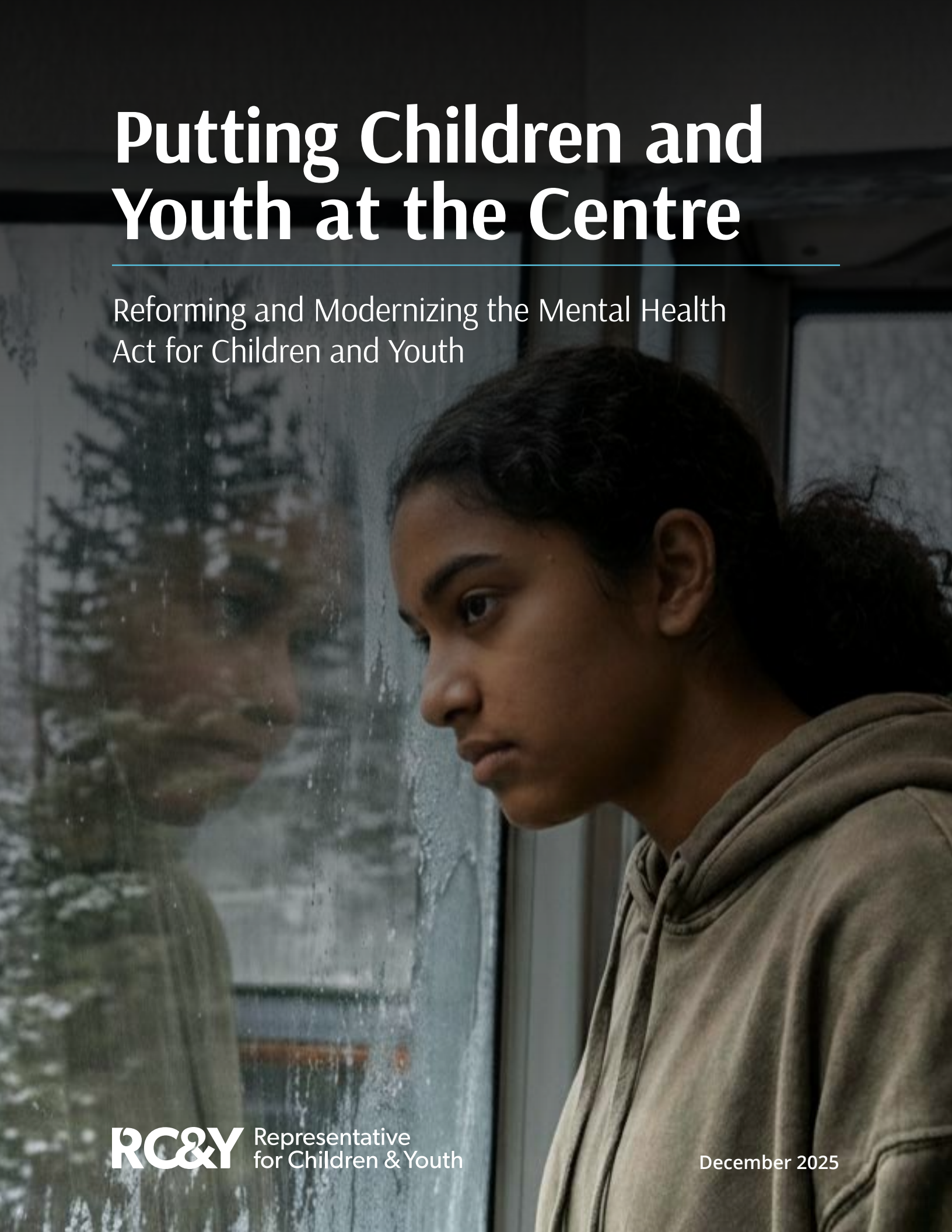
Putting Children and Youth at the Centre

Reforming and Modernizing the Mental Health Act for Children and Youth



RC&Y Representative for Children & Youth

December 2025

The Representative and staff, working throughout the province, would like to acknowledge that we are living and working with gratitude and respect on the traditional territories of the First Nations peoples of British Columbia.

We specifically acknowledge and express our gratitude to the keepers of the lands on the traditional territories of the Lheidli T'enneh peoples (Prince George) and the Lekwungen (place to smoke herring) people of the Songhees and Xwsepsum (Esquimalt) Nations (Victoria) where our offices are located. We also acknowledge our Métis and Inuit partners and friends living in these beautiful territories.

December 12, 2025

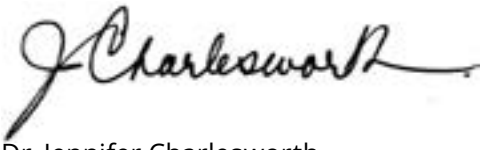
The Honourable Raj Chouhan
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, BC, V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the report, entitled *Putting Children and Youth at the Centre: Reforming and Modernizing the Mental Health Act for Children and Youth,* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 20 of the *Representative for Children and Youth Act,* which gives the Representative authority to make a special report to the Legislative Assembly if the Representative considers it necessary to do so.

Sincerely,



Dr. Jennifer Charlesworth
Representative for Children and Youth

pc: Ms. Kate Ryan-Lloyd
Clerk of the Legislative Assembly

Rohini Arora
Chair, Select Standing Committee on Children and Youth

Amelia Boultbee
Deputy Chair, Select Standing Committee on Children and Youth

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Introduction

In the wake of the Vancouver Lapu Lapu festival tragedy in April 2025 that left 11 dead and many more injured, the Premier said there would be a review of the province's mental health legislation – the *Mental Health Act*[1] – to ensure it is working the way it is intended.[2] The terms of reference of that review have yet to be announced.

Prior to that, the province had appointed a chief scientific advisor for psychiatry, toxic drugs and concurrent disorders,[3] Dr. Daniel Vigo, who subsequently issued a guidance document to doctors and psychiatrists in March 2025, to provide clarification on how the *Mental Health Act* can be used to provide involuntary care for adults when they are unable to seek it themselves.[4] Government also previously announced the development of highly secure facilities for adults with long-term concurrent mental-health and addiction challenges under the *Mental Health Act* and in correctional facilities,[5] the first two of which were implemented in 2025,[6] which was followed several months later by an announcement of the development of two more facilities.[7]

It is notable that these commitments and initiatives almost entirely relate to adults[8] in the context of public and political concerns about crime, public disorder, encampments, the intersection of mental health and addictions with the toxic drug supply, and, in particular, involuntary care. Organizations such as the BC Division of the Canadian Mental Health Association,[9] Health Justice,[10] the Community Legal Assistance Society (CLAS) and others[11] have, however, championed a comprehensive review and modernization of the Act from a very different perspective, which relates to significant concerns about the inadequate attention in the legislation to the rights of individuals who are involuntarily detained such that BC has been characterized as "the most regressive jurisdiction in Canada for mental health detention and involuntary psychiatric treatment".[12]

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1 RSBC 1996, Chapter 288. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96288_01

2 *BC premier announces review of mental health legislation in wake of Vancouver festival tragedy*, CBC News, April 30, 2025. https://www.cbc.ca/news/canada/british-columbia/b-c-premier-reviews-mental-health-legislation-1.7523191

3 *Advisor appointed to improve care for people with complex mental-health, addiction challenges,* British Columbia News, June 5, 2024. https://news.gov.bc.ca/releases/2024MMHA0028-000873

4 *BC improving care for people with mental-health, substance-use challenges*, British Columbia News, March 12, 2025. https://news.gov.bc.ca/releases/2025HLTH0015-000202. This was followed by the release of a similar guidance document respecting children and youth on December 5, 2025; see, New guidelines on *Mental health act* will help keep young people safe, December 5, 2025 https://news.gov.bc.ca/releases/2025HLTH0057-001209#:

5 *Province launches secure care for people with brain injury, mental illness, severe addiction*, British Columbia News, September 15, 2024. https://news.gov.bc.ca/releases/2024PREM0043-001532

6 *New beds improve care for people with complex mental-health disorders*, British Columbia News, June 3, 2025. https://news.gov.bc.ca/releases/2025HLTH0053-000534

7 CBC News, *Mixed reaction to BC premier's announcement of new involuntary care facilities*, September 27, 2025. Mixed reaction to BC premier's announcement of new involuntary care facilities | CBC News

8 In September 2024 government did commit to making changes to the law in the next legislative session "to provide clarity and ensure people, including youth, can and should receive care when they are unable to seek it themselves" (*supra*, note 4). The next legislative session began in February 2025 but the proposed legislative changes have yet to be introduced.

9 Canadian Mental Health Association, BC Division*, Involuntary Care Already Exists in BC, But Is It Working?* September 18, 2024. https://bc.cmha.ca/news/page/3/

10 Health Justice, *Framework for a review of the Mental Health Act*, 2025. https://www.healthjustice.ca/mhareview

11 *Open Letter from Community Groups on BC Mental Health Act Law Reform*, June 27, 2019**.** https://clasbc.net/our-work/law-reform/mental-health-law-reform/

12 Johnston, L. (2017, November 29). *Operating in darkness: BC's Mental Health Act detention system.* Community Legal Assistance Society, November 29, 2017, p.6. https://clasbc.net/operating-in-darkness-bcs-mentalhealth-act-detention-system/

With the exception of the recent release of Dr. Vigo's follow-up guidance document on how the *Mental Health Act* can be used for involuntary detention of children and youth, which will be discussed later, these commitments and initiatives almost entirely relate to adults. The unique needs and circumstances of children and youth[13] have been largely ignored, even though epidemiological research estimates that almost 100,000 children and youth in the province experience a mental disorder at any given time (see text box), more than 30,000 children and youth are served each year through the Ministry of Children and Family Development's (MCFD) Child and Youth Mental Health (CYMH) services[14] and as we will discuss, there are more than 4000 hospitalizations of children and youth under the *Mental Health Act* each year, more than half of which involve involuntary detention.[15] This lack of attention to children and youth echoes the provisions of the current *Mental Health Act* which, as we will also discuss, scarcely even recognizes children and youth and when that legislation does specifically address the unique circumstances of this especially vulnerable population, the provisions are severely wanting.

In the nearly five years since the Representative released her report on mental health hospitalizations of children and youth under the *Mental Health Act* – entitled *Detained, Rights of children and youth under the Mental Health Act*[16] ("Detained") – little progress has been made by government in implementing the recommendations in that report relating to improvements that will better respect the rights and interests of children and youth who are detained.[17] More generally, the Representative's follow up on government's responses to recommendations arising from ten previous RCY reports indicates that mental health services are the most frequent subject area for recommendations, yet it is the service area where government has been the least responsive to RCY recommendations.[18]

Prevalence of Mental Health Disorders Amongst Children

Children's mental health is crucial for the well-being of individuals and of populations. Yet rigorous epidemiological studies show high disorder prevalence with nearly 12.7% or 95,000 children aged 4–18 years being affected at any given time in British Columbia (BC). These studies also depict stark service shortfalls …

– Children's Health Policy Centre, Simon Fraser University, 2020, p.4[19]

As a follow-up to a key theme of the *Detained* report – listening to the voices of children and youth and promoting their active participation in processes that affect them – the Representative commissioned a series

[13] Unless otherwise specified, throughout this report "children and youth "and the shorter form "child" both mean persons under the age of 19 years, which is the age of majority in BC

[14] Ministry of Children and Family Development. The MCFD Reporting Portal states:
> A conservative estimate of the 2024/25 fiscal year total number of children and youth served including … (those) … not using CRIS is estimated at 31,000 provincially.

[15] To be discussed; see Figure 1 in the following section on Hospitalizations and Involuntary Detentions.

[16] Representative for Children and Youth. *Detained: Rights of children and youth under the Mental Health Act.* January 2021. https://rcybc.ca/reports-and-publications/detained/

[17] Representative for Children and Youth. *Detained: Rights of children and youth under the Mental Health Act RCY Annual Review Year 2*. Date Published: February 26, 2024 (amended March 25, 2024). rcybc.ca/wp-content/uploads/2024/04/2024.03.25-Detained-Year-2-Progress-Assessment-FINAL.pdf

[18] Representative for Children and Youth. *Annual Summary of Recommendations Monitoring Report 2023/24*.March 31, 2024. https://rcybc.ca/wp-content/uploads/2024/03/27.03.2024_FINAL_Annual-Monitoring-Summary_V6.pdf

[19] *Public Data Sources for Monitoring Children's Mental Health: A Research Report.* Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University, 2020. https://childhealthpolicy.ca/wp-content/uploads/2020/12/Waddell-Datasets-2020.12.08.pdf

of reports from the Society for Children and Youth of BC ("SCY") relating to child and youth capacity and participation in legal and administrative proceedings, including healthcare decisions and the voluntary and involuntary civil detention of children and youth under mental health legislation. Three of those inter-related reports are appended to this report and are concurrently released on the SCY website.[20] These reports examine child participation rights and children's capacity primarily through the lens of the *United Nations Convention on the Rights of the Child* ("UNCRC")[21] and other international human rights instruments, review the relevant legal, social science and health science literature, and consider related legislation and select case law. These reports, the key findings of which will be briefly summarized below, are essential reading as they describe key elements of the framework, foundational principles and considerations that must inform reform of the *Mental Health Act* for children and youth. That reform, in the Representative's view, requires a comprehensive review and revision that creates either separate, stand-alone mental health legislation for children and youth in BC, or a separate and distinct part of a comprehensively reformed *Mental Health Act* that specifically addresses the rights, unique needs and circumstances of children and youth.[22]

The *Mental Health Act*

The *Mental Health Act* is the law in BC governing mental health interventions, allowing for voluntary admissions to a designated mental health facility as well as involuntary admissions and treatment of individuals, including children and youth, with a "mental disorder" under specific legislated criteria. The Act provides a framework for involuntary care while also outlining certain patient rights, including the rights to medical examinations, access to legal counsel, the ability to request a hearing with a review panel to challenge involuntary detention, and the right to meet with an independent rights advisor.

[20] https://scyofbc.org/. The remaining two reports on child participation and capacity in, respectively, family law and child protection proceedings are expected to be released in the near future.

[21] *United Nations Convention on the Rights of the Child*, United Nations 1989. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

[22] This report is prepared under the authority of section 20 of the *Representative for Children and Youth Act*, RSBC, Chapter 29. Section 6 of the *RCY Act* describes the functions of the Representative, which include individual advocacy, reviews and investigations of deaths and critical injuries, and monitoring of designated or reviewable services and programs under the Act that are provided under an enactment or provided or funded by government. Section 1 of the Act includes mental health services to children, which are funded by government and in part are governed by the *Mental Health Act,* as designated and reviewable services. The Representative routinely provides individual advocacy services and receives reports of and reviews critical injuries and deaths in relation to mental health services for children, and monitors those services and programs. Section 20 of the *RCY Act* enables the Representative to make a special report to the Legislative Assembly if the representative considers it necessary. See, *British Columbia (Representative for Children and Youth) v British Columbia (Attorney General)*, 2019 BCSC 1888.

Highlights of the SCY Reports

Society for Children and Youth of BC

The Society for Children and Youth of BC is a provincial not-for-profit charity. Since 1974, the Society has focused on providing a strong voice representing children and youth. Its mission is to improve the well-being and resilience of children and youth in BC through the advancement of their civic, political, economic, social, cultural and legal rights. Using the UN Convention on the Rights of the Child as a foundation, SCY has a track record of creating and delivering programs that have motivated change in research, legislation, policy, and practice in Canada. The organization is comprised of three programming areas: the Child and Youth Legal Centre, Child and Youth Friendly Communities, and Child Rights Public Awareness.

SCY's approach to the commissioned research on child and youth capacity and participation in administrative and legal proceedings consisted of three stages. The first stage involved a literature review – predominantly from law, the social sciences, health sciences, and other disciplines – about child capacity, as well as legislation and select case law relevant to child capacity. The second stage involved interviews with children and youth about their experiences of capacity generally and as they related to the specific legal areas of inquiry, a survey of a larger number of children and youth, and hosting facilitated listening circles with groups of children and youth using key research questions. The final stage consisted of consultations with stakeholders and subject matter experts.

Children's Rights

The *United Nations Convention on the Rights of the Child (UNCRC)*, is a comprehensive, international human rights treaty adopted by the UN in 1989 that protects and promotes the rights of all children under 18. It recognizes children as individuals with their own rights and prescribes their civil, political, economic, social, health, and cultural rights, requiring signatory governments to ensure these rights are realized for all children, without discrimination. Having been ratified by almost every country, including by Canada in 1991, the UNCRC is the most widely ratified human rights treaty in the world.

The SCY reports embrace the UNCRC as a foundation, in particular Article 12 which states:

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.[23]

The first SCY report – entitled*, Capacity: A Principled, Rights-Based Approach to Child Participation: Research Report on Child Capacity*[24] – is a primer on the research related to child capacity and participation and serves as a foundational review to inform the ensuing reports on child and youth capacity and participation in specific types of legal and administrative proceedings. SCY's key findings from this research are:

- There is no universally agreed upon definition of capacity although there are recurring themes throughout social science.

- Age alone is not a reliable indicator of capacity. Decision makers should not use age as the sole determinative factor of children's capacity.

- All children should be presumed to have capacity to express their views and preferences. Great harm is done to children who are not permitted to exercise their capacity to be heard in matters affecting them.

- Capacity can be understood as both a function of cognition, as well as an ability or a right one possesses. What it is varies depending on its context or function. Capacity can be a legal right.

- Capacity encompasses a variety of factors and develops at different rates. Children may possess more or less capacity in different contexts. The capacity to be heard is not the same as the capacity to be the decision maker.

- The UNCRC provides that a child need only be capable of forming a view in order for their view to be heard and considered. There is no further test of cognition or capacity that should stand in the way.

- Children and youth must be equitably supported to express their views and desires on matters affecting them, using methods that meet their level of capacity.[25]

The Representative notes in particular, the findings that all children should be presumed to have capacity to express their views and preferences and that great harm is done to children who are not permitted to exercise their capacity to be heard in matters affecting them. In contrast, the report notes that a growing body of evidence demonstrates that meaningful participation from children in decision-making promotes improved outcomes and well-being, even when the decisions made are not ultimately

[23] *Ibid.*
[24] Society for Children and Youth, *Capacity: A Principled, Rights-Based Approach to Child Participation: Research Report on Child Capacity,* 2024.
[25] *Ibid*, p.8.

in accordance with the child's views.[26] Another key finding of particular note is that the capacity to be heard is not the same as the capacity to be the decision maker, i.e., expressing a view should be differentiated from making a decision/choice.

Engagement with mental healthcare is, of course, a healthcare decision. The second appended SCY paper – entitled, *Child Capacity and Participation in Healthcare Decisions*[27] – specifically addresses child and youth capacity and participation in the context of decisions about healthcare by exploring the interplay of legal principles, provincial statutes and international conventions.

A key aspect of child and youth capacity and participation in a healthcare context is the "mature minor" doctrine, which has flowed from the common law, is reflected in BC's *Infants Act,*[28] and largely aligns with the provisions of the UNCRC. The mature minor doctrine recognizes the evolving capacity of children to make decisions for themselves, granting that autonomy to children and youth who are considered sufficiently mature to make their own choices about treatment, even when those choices do not align with their parent's/guardian's views. In BC, there is not a stipulated age for a child to be deemed to have the capacity to consent to healthcare. Instead, the *Infants Act* provides that a child may consent to their own healthcare if the healthcare provider is satisfied the child has the capacity to "understand the nature and consequences and reasonably foreseeable benefits and risks of the healthcare" and has concluded that the healthcare is in the child's best interests.[29]

Key findings from the SCY's report on child and youth capacity and participation in healthcare decisions are:

- Regardless of their decision-making abilities, all children and youth have a right to be heard and to express their views in decisions concerning their healthcare.
- As in adults, capacity of children and youth encompasses a variety of factors and develops at different rates. It is an evolving trait that may be more or less present in different contexts and can be assessed through a variety of models available to healthcare providers.
- Healthcare must be patient-centred, with the views and interests of the young patient meaningfully considered in the provision of services. The onus must be on the healthcare provider to find an effective strategy to communicate and connect with their child or youth patient.
- Dismissal and invalidation by healthcare providers, parents, and other adults contributes to significant negative impacts on children and youth including reduced self-esteem and confidence in their treatment plans.
- Children and youth would greatly benefit from neutral, third-party support in medical settings that focuses only on their interests, needs, and views.
- For many children and youth, making healthcare decisions can be an empowering experience, helping them develop individual agency.[30]

[26] *Ibid*, p.17
[27] Society for Children and Youth, *Child Capacity and Participation in Healthcare Decisions,* April 2024
[28] RSBC, c.223
[29] *Ibid*, section 17.
[30] *Supra,* note 25, p.8.

The Representative notes in particular the findings in relation to the negative effects of dismissal and invalidation of children's views, the benefits of independent support for children and youth, and the benefits for children and youth that flow from making healthcare decisions for themselves.

The third SCY report – entitled, *Child Capacity and Participation in BC's Mental Health System*[31] – examines the involuntary and voluntary civil detention of children and youth in BC under the *Mental Health Act*, as well as previous proposals to expand the scope of involuntary civil detention, and how the current and proposed legislative frameworks do or do not accord with the UNCRC and various other international treaties to which Canada is a signatory. The key findings from this report are:

- Although a child or youth's mental or cognitive capacity may fluctuate depending on the nature of their mental illness or disability, this does not impact their legal capacity. Their legal rights do not go away because of their perceived lack of cognitive or mental capacity.
- While children and youth with mental illness may not always make decisions deemed "good" by decision-makers and healthcare providers, their right to participate in decision-making through the expression of their views should not be ignored.
- It is important to work with a child and youth's capacity – meeting them where they are at rather than assuming they lack capacity.
- When a child or youth's capacity is denied or taken away, it can create a negative cycle that impacts their ongoing ability to make decisions for themselves and to maintain a sense of autonomy.
- It is important for children and youth to express their capacity to be heard; to share their opinions and views on their treatment. A legislative framework that presumes a lack of capacity is not consistent with a child's legal right to be heard.
- To respect a child or youth's capacity, it is essential that decision makers and care providers share appropriate information with them about their rights and communicate adequately with them about their treatment. This helps a child or youth to be able to understand, to the best of their abilities, the situation at hand and to use this information to form views and make appropriate decisions about their care.
- Institutionalization can harm the physical, mental, and cognitive development of children and youth, with lasting effects into adulthood. Involuntary mental health detention should be used sparingly, for the shortest time possible, and in select cases.
- Any proposed legislation and legislative amendments, such as the *Mental Health Amendment Act and Safe Care Act*, require thorough scrutiny for their impact on children and youth.[32]

[31] Society for Children and Youth, *Child Capacity and Participation in BC's Mental Health System,* 2025.
[32] *Ibid*, p.'s 8-9

The SCY's research included consultations with young people who had experience with the mental health system and who consistently reported ill-effects of their treatment during mental health detention or stabilization. Echoing the findings of the Representative's 2021 *Detained* report, the SCY report states:

> The voices of children and youth consistently highlight the negative impact of involuntary detention, revealing limitations in their ability to participate meaningfully in their mental healthcare. They report being ignored, disempowered, and stripped of decision-making capacity. Instances of isolation, fear, and inadequate communication with family members further compound their distress. The negative repercussions impact their education, violating fundamental rights and placing vulnerable populations at heightened risk.[33]

The report further concludes:

> The predominant finding of this paper concerns the current mental health framework which, while potentially beneficial for select individuals, is deeply flawed, proving to be traumatizing, harmful, disempowering, and disabling for many of the children and youth it affects. In addition, it operates in discordance with international treaties, notably the UNCRC, and other fundamental principles of justice and administrative law.[34]

These important themes will be explored from the Representative's perspective in more detail below.

[33] *Ibid*, p.39
[34] *Ibid*, p.39

The Detained Report: A Follow Up

The Representative's 2021 *Detained* report examined the administration of the system for involuntary detention of children and youth under the *Mental Health Act*, seeking to better understand how that legislation functions and to identify ways to strengthen safeguards, enhance opportunities for young people to have a say in their treatment and improve the experience and outcomes for children and youth.

The report utilized several sources of information, including RCY and external data, a review of the legislation, regulations and guidelines, interviews with key partners and, notably, in-depth engagement of young people who had experienced detention under the *Mental Health Act* to amplify the voices of youth with lived experience. The report was grounded on the provisions of the UNCRC and other international human rights instruments such as the *United Nations Convention on the Rights of Persons with Disabilities*[35] and the *United Nations Declaration on the Rights of Indigenous Peoples*[36] (UNDRIP), in particular that young people have the right to participate in making decisions about their care, to the extent that they are able.

The report was also grounded on the premise that given their immaturity and state of dependency, children and youth should have enhanced protections of their rights when they are facing deprivation of liberty, as is the case in the youth criminal justice system, which is matter we will explore in more depth in this report. This need for enhanced protection is even more crucial in a mental health context since the capacity of children and youth to understand and exercise their rights may be diminished by their mental state at the time of admission.

The report notes that while the intention of mental health detention is to keep young people in severe distress safe by providing effective stabilization and treatment, involuntary admission to secure facilities that at times can and do employ restraints and seclusion, is an extraordinarily powerful tool of the state that can be misused and cause unintended harm. Sometimes it is used well and indeed can be life-saving, but it should not be assumed that detention is always therapeutic and beneficial, as was sadly evident in the stories of detained young people who participated in the report. The fear and confusion expressed by youth who described their experiences in involuntary detention is troubling to read.

Although the *Mental Health Act* has some, albeit limited, protective safeguards – such as requiring the provision of information about rights, notification of a near relative, the opportunity to request a second medical opinion, periodic re-assessments, Mental Health Review Board hearings and access to legal counsel for those hearings – the report found that young people were apparently not being informed of nor supported to exercise their (limited) rights under the Act. As the report stated:

> Most of the young people who participated in this report were surprised to learn that they had rights; they did not remember hearing about or seeing forms explaining their rights. Young people weren't aware they could request second medical opinions or access a lawyer for support to review their detention. They recalled forced medication, not being involved in treatment decisions and a lack of

[35] United Nations, 2006. Convention on the Rights of Persons with Disabilities | OHCHR
[36] United Nations, 2007. UN Declaration on the Rights of Indigenous Peoples | OHCHR

> attention to the underlying reasons for their pain. They recalled scary periods of isolation and restraint. Indigenous young people recalled racism and an absence of culturally relevant treatment. Data reviewed for this report supports the young people's memories, and reveals that children and youth are not exercising their rights under the Act. It is not clear to the Representative that children's voices are routinely considered with regard to certification, treatment and discharge under the *Mental Health Act*, all of which are decisions that intimately impact their lives. (p.5)

The report also observed that while the involuntary detention of First Nations, Métis, Inuit and urban Indigenous children and youth under the *Mental Health Act* may be intended for their safety and protection, it can be seen and experienced as another link in a long chain of oppression imposed by the state on Indigenous peoples. This is exacerbated by the significant concerns about racism in the healthcare system[37] as well as the lack of culturally safe and relevant services and supports.

The *Detained* report found that the number of children and youth who were involuntarily committed to mental health facilities increased alarmingly in the 10 years between 2008/09 and 2017/18, almost tripling from 973 to 2,545 admissions. This increase for children and youth (162%) was also almost triple the rate of increase for involuntary committals of adults (57%) in the same time period.

The *Detained* report made 14 recommendations to a number of public bodies. To its credit, government has moved forward in implementing a key recommendation relating to providing independent rights advice to children and youth (and adults). In June 2022, amendments to the *Mental Health Act*[38] were passed by the Legislature, although those amendments and accompanying changes to regulations were only very recently brought into force.[39] These amendments enable the Attorney General to establish an independent rights advice service and require the director of a mental health facility to inform an involuntarily detained patient, including children and youth, to be informed of the availability of an independent rights service and to facilitate private contact with a rights advisor.

The independent rights service is being implemented in three phases. Prior to bringing the amendments into force, the Ministry of Attorney General established the independent rights service administratively by funding the Canadian Mental Health Association, BC Division (CMHA BC) to develop and implement the service, which has been active since February 2024. Staff from the service, who are lay individuals with lived experience, provide some outreach education to staff and patients at mental health facilities about the role and availability of the service, which is to explain rights under the *Mental Health Act* (see text box). Some youth-friendly rights advice educational materials have been developed. As well as adults, youth who have been involuntarily detained are eligible for the service, as are children and youth under the age of 16 who have been "voluntarily" admitted to a hospital or facility after their parent or guardian requested it under section 20. Meetings are typically requested online and held by video conference. Right advisors are not lawyers: they cannot advise on what children and youth should do, nor represent them at Mental Health Review Board hearings.

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[37] See, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Healthcare*, 2020. In-Plain-Sight-Addressing-Indigenous-specific-Racism-and-Discrimination-in-BC-Health-Care.pdf

[38] Bill 23 – 2022: Mental Health Amendment Act, 2022. https://www.bclaws.gov.bc.ca/civix/document/id/bills/billsprevious/3rd42nd:gov23-3

[39] BC Reg 456/2025 was authorized on October 2, 2025 and brought the amendments into force on December 3, 2025, while accompanying regulation changes are brought into force in stages on December 3, 2025 and March 18, 2026. See, Helping people understand their rights under the *Mental health act*, December 3, 2025, https://news.gov.bc.ca/releases/2025AG0070

Independent Rights Advice Service

Rights Advisors can

- Explain your rights under the *Mental Health Act* and answer any questions you might have.
- Explain the Mental Health Review Board review panel process. If you would like to request a review of your involuntary status and detention, a Rights Advisor can also help you apply.
- Tell you your options if you have concerns about your treatment. They can also help you ask for a **second medical opinion** on your treatment.
- Give you information about how to find a lawyer or other legal support.
- Help you find out if you are eligible for legal aid.

Rights Advisors cannot

- Represent individuals at a Mental Health Review Board hearing or court proceeding.
- Give legal advice or recommendations about what someone "should" do.[40]

This new rights advice service has been infrequently accessed by children and youth to date. Data provided by the CMHA BC indicates that in the 19-month period between February 2024 and September 2025, there were 48 rights advice meetings requested by young people under 19 years old, 44 of which were attended, i.e., less than 3 per month in the context of an average of more than 200 involuntary hospitalizations per month[41] of children and youth. Youth under 19 years represented 4 per cent of the total number of (adult and youth) meetings requested and 5 per cent of the meetings attended.

The small number of children and youth accessing the rights advice service may be a function of recent start up[42] and unfamiliarity, which may improve over time. Importantly, the second phase of implementation should promote more frequent access. On December 3, 2025, the amendments to the *Mental Health Act* came into force, creating a statutory obligation for staff of mental health facilities to inform patients of the availability of the independent right advice service, which will also be set out in statutory forms notifying patients of their rights under the *Mental Health Act*. While this will be another step forward, it is noted that there is no mandatory training of healthcare staff to better support effective implementation. In the Representative's view, there should be mandatory training of relevant healthcare staff. Evidence of this need is illustrated by data provided by the independent rights advice service indicating that several facilities across the province that have dedicated, specialized units for children and youth have not referred children and youth to the service at all or in any meaningful numbers.[43]

[40] Independent Rights Advice Service, https://irasbc.ca/what-to-expect/

[41] Ministry of Health reports an average of 218 involuntary hospitalizations of children and youth in 2023/24 and an average of 204 in 2024/25.

[42] CMHA BC data indicates that there no requests for meetings by children and youth in the first five months of the new service in 2024. In the first half of FY 2025/26 (April – September), there were still only a small number of meeting requests by children and youth, averaging 5 requests per month for a meeting with a rights advisor.

[43] CMHA BC, email communication, October 17, 2025

Even with a statutory requirement to inform involuntary patients of their rights, including the right to independent rights advice, the independent rights advice service is and will remain essentially reactive insofar as it responds to children and youth who reach out after they have been informed by mental health facility staff of the availability of the service. As such, the effectiveness of the system is dependent on hospital staff informing children and youth of their rights (including access to the rights advice service), on the child or youth understanding the need for rights advice and deciding to reach out to the service and request advice, and on the child understanding and acting on that advice. That seems a lot to ask of, for example, a 14-year-old with mental health challenges, especially one who does not have an independent advocate who, in addition to providing information, can walk along side of and directly support and assist them.

The third, prospective stage of implementation of the rights advice service involves automatic scheduling of meetings of eligible patients with a rights advisor (which can be waived by the patient). This third administrative stage is, however, subject to future funding approval in 2027, and is not guaranteed at this point. The Representative agrees that this proactive and assertive approach to rights advice is necessary, especially for immature young people with mental health challenges, and urges government to support funding, and to go even further by building into modernized legislation a requirement for a rights advice meeting to be scheduled at the outset of involuntary detention of children and youth,[44] In any event, access to this service by children and youth is a matter that warrants ongoing monitoring and future evaluation.

Mental Health Review Board

The Mental Health Review Board is an independent tribunal established under the *Mental Health Act*. The Review Board conducts review hearings on the involuntary admission of patients under the *Mental Health Act*, including children and youth.

In another step forward, the Mental Health Review Board ("the review board") has been very responsive to the Representative's recommendation to improve the hearing process for children and youth. Following an exemplary consultation process and advice from an advisory council, the Board developed, and in 2023 implemented, a detailed plan which included information and communication materials for young people and their families, a revised youth-centred hearing process, a training program, and established a Navigator position to act as a point person for all communications and coordination of hearings involving children and youth.[45]

The *Detained* report found that very few children and youth exercised their right to have their detention reviewed by the review board: in 2017/18, in the context of 2,545 cases of detained children and youth, there were only 21 hearings involving children and youth. By comparison, recent data indicates these numbers have remained minuscule: in the context of 2,447 involuntary hospitalizations of children and youth in 2024/25, there were only 12 review board hearings involving children and youth.

[44] The young person could, of course, choose to waive the automatically scheduled meeting.
[45] British Columbia Mental Health Review Board, *Practice Direction- Children and Youth Hearings*. May 1, 2023 mhrb-rules-of-practice-and-procedure.pdf

Table 1 describes the total number of review board hearings and those involving children and youth between 2017/18 and 2024/25. The number of review board hearings involving children and youth has been consistently very small throughout the time period, comprising an average of only about 2 per cent of all hearings. The number (12) and percentage (1.2%) of review board hearings involving children and youth actually reached its lowest point in 2024/25, the first full year of operation of the new independent rights advice service.

Table 1 Mental Health Review Board Hearings

Fiscal Year	Hearings of Under 19 Years	Total Hearings	% Under 19 Years
2017/18	21	878	2.4%
2018/19	12	820	1.5%
2019/20	16	811	2.0%
2020/21	21	970	2.2%
2021/22	15	990	1.5%
2022/23	21	946	2.2%
2023/24	22	937	2.3%
2024/25	12	990	1.1%

Source: Mental Health Review Board

Table 2 describes a similar picture with respect to applications by detained children and youth for legal representation from the Mental Health Law Program,[46] i.e., in every year of the time period, children and youth comprise less than 2 per cent of all applications for legal representation by persons detained under the *Mental Health Act*.

Table 2 Applications for Mental Health Law Program Representation

Fiscal Year	Under 19 Years	Total	% Under 19 Years
2017/18	8	831	0.96%
2018/19	11	1,336	0.82%
2019/20	22	1,389	1.58%
2020/21	26	1,538	1.69%
2021/22	25	1,696	1.47%
2022/23	18	1,658	1.09%
2023/24	26	1,891	1.37%
2024/25	27	1,890	1.43%

Source: Community Legal Assistance Society

[46] These are applications only, not actual representation. The number of applications are an indicator of awareness of rights. The number of applications is higher than the number of review board hearings because not every application for legal assistance is followed by a review board hearing. Involuntary patients may, for example, be decertified before the hearing or they may cancel their hearing for a variety of reasons, which may include agreement with the treatment team, that they find the hearing process too stressful, or other personal reasons.

The establishment of the rights advice service and improvements to the review board process are welcome steps forward. Nonetheless, the low rates of access to the rights advice service by children and youth and the continuing low rates of exercise of those rights evidenced by very small numbers of review board hearings is troubling. This is an area that, in the Representative's view, speaks to the need for more fulsome services and supports to inform children and youth of their rights and to exercise those rights, and to consideration of amendments that would, as recommended in *Detained*, statutorily mandate automatic scheduling of rights advice meetings and, similarly, mandate automatic early reviews and automatic periodic reviews thereafter by the review board rather than solely relying on the young person to take the initiative in making an application.[47]

Otherwise, a 2024 review by the Representative[48] indicated no progress or only some progress on the remaining 12 recommendations from the *Detained* report which, in brief, included:[49]

- Identify why involuntary mental health detention for children and youth is increasing and opportunities to reduce these admissions.
- Require the collection and reporting of standardized key data, including Indigeneity, pertaining to children and youth admitted under the *Mental Health Act*.
- Review and reconcile the section of the *Mental Health Act* that allows a child under 16 to be admitted on a voluntary basis at the request of their parent or guardian with the mature minor doctrine.
- Develop a process to enable a First Nations, Métis or Inuit child or youth to notify their community or Nation of their involuntary admission.
- Develop new informational materials provided to children and youth detained under the *Mental Health Act* that explain what is happening, their rights and options
- Ensure First Nations, Métis or Inuit children and youth who are detained under the *Mental Health Act* are offered services by staff who assist Indigenous patients.
- Amend the *Mental Health Act* to allow children and youth who are detained to retain personal items that do not pose a risk to their safety or the safety of others.
- Ensure First Nations, Métis, Inuit and urban Indigenous children and youth detained under the *Mental Health Act* receive trauma-informed, culturally safe and attuned mental health services
- Amend the *Mental Health Act* to ensure that for children and youth who are detained, the use of isolation (seclusion) and restraint are only used as a last report and in accordance with specified legislative or regulatory criteria.
- Conduct a review of the effectiveness of extended leave for children and youth who are detained and if effective review the need for additional legislative or regulatory criteria and oversight mechanisms.

[47] Statutorily mandated periodic reviews by the review board would not remove agency from the young person as long as the young person is also afforded the right to waive a mandated review.

[48] Representative for Children and Youth, 2024. *Detained: Rights of children and youth under the Mental Health Act RCY Annual Review Year 2*. 2024.03.25-Detained-Year-2-Progress-Assessment-FINAL.pdf

[49] For brevity, the detailed *Detained* recommendations are summarily described.

- Amend the *Mental Health Act* to create mandatory periodic reviews by the Mental Health Review Board of children and youth who are involuntarily detained and children under 16 who are admitted at the request of their parent, to ensure such reviews do not depend on the child or youth's knowledge or ability to request a review.

It is noted that several of the outstanding recommendations listed above involve amendments to the *Mental Health Act* which, in the Representative's view, should inform the development of separate, stand-alone mental health legislation for children and youth in BC, or a separate and distinct part of a comprehensively reformed *Mental Health Act* that specifically addresses the rights, unique needs and circumstances of children and youth.

Other outstanding recommendations from the *Detained* report are administrative in nature. The Representative notes in particular the lack of progress in collecting standardized data, including Indigeneity. For the *Detained* report, the Ministry of Health informed the Representative that it believes Indigenous children and youth are disproportionately involuntarily detained but was unable to verify the extent of the disproportionality with data. For the purposes of this report, the Representative requested updated data (discussed below) from the Ministry of Health, including the Indigeneity of children and youth admitted under the *Mental Health Act*. That data is still not available. It is unacceptable that five years after the Human Rights Commissioner's report on the need for disaggregated data on Indigeneity[50] as well as the *Detained* report, the urging of the First Nations Leadership Council,[51] and the In Plain Sight report on racism and discrimination in the healthcare system, there is still no data identifying the numbers of First Nations, Métis, Inuit and urban Indigenous children and youth who are detained under the *Mental Health Act*.

[50] Office of the Human Rights Commissioner, *Disaggregated demographic data collection in British Columbia: The grandmother perspective*, September 29, 2020. Disaggregated demographic data collection in British Columbia: The grandmother perspective | BC's Office of the Human Rights Commissioner

[51] First Nations Leadership Council, January 19, 2021. *Treatment Over Detention: Immediate Changes Required Regarding the Use of Involuntary Detentions for Youth under the Mental Health Act.*

Hospitalizations and Involuntary Detentions

Children and youth may be admitted to a designated mental health facility on a voluntary or involuntary basis. There are, in effect, two statutory regimes governing hospitalization of children and youth, one for those who are 16 years or older and the other for children under 16 years of age.

For youth who are 16 years or older, the rules for voluntary and involuntary admission are the same as they are for adults:

- **Voluntary admission**: A person aged 16 years or older may be voluntarily admitted to a mental health facility if they request admission and the director is satisfied that the person has been examined by a physician or nurse practitioner who is of the opinion that the person has a mental disorder.[52] A "voluntary" patient who is 16 or older must be discharged at the patient's request.[53]

- **Involuntary admission**: A person aged 16 years or older may be involuntarily admitted to a mental health facility if a physician or nurse practitioner who has examined the person issues a medical certificate certifying that the person:
  - has a mental disorder,
  - requires treatment in or through a designated facility,
  - requires care to prevent the person's mental or physical deterioration or for the protection of the person or others, and
  - cannot suitably be admitted as a voluntary patient.[54]

If a person, including a child, is involuntarily detained, treatment authorized by the director is deemed to be given with the consent of the patient.[55] This means that treatment, such as medications, may be administered to involuntary patients without assessing a patient's capacity to make their own treatment decisions and without consulting a substitute decision-maker. BC is only province in the country with such "deemed consent" provisions, which is a matter that is currently subject to a challenge before the BC Supreme Court on the grounds that these provisions infringe on liberty rights under the Canadian Charter of Rights and Freedoms.[56]

Bill 32 – the *Mental Health Amendment Act* (No.2), 2025 – was passed in the Legislative Assembly on December 2, 2025, in response to the pending court decision and is expected to be brought into force in the near future. Although these amendments repeal the deemed consent provisions and offer healthcare workers greater protection against liability in administering mental healthcare, they do not make any significant changes to the healthcare consent rights of involuntarily detained persons[57].

[52] A "Person with a mental disorder" is defined in section 1 *Mental Health Act* as "a person who has a disorder of the mind that requires treatment, and seriously impairs the person's ability to (a) react appropriately to the person's environment or (b) associate with others."
[53] Section 20 *Mental Health Act*
[54] Section 22 *Mental Health Act*
[55] Section 31 *Mental Health Act.* The deemed consent provisions also apply to persons who are discharged from hospital to the community on "extended leave", which is a form of release with stipulated conditions that are enforceable by requiring return to a designated mental health facility..
[56] Health Justice, May 27, 2025.*Charter challenge to deemed consent in BC: What does this mean?* Charter challenge to deemed consent in BC: Health Justice's intervention — Health Justice
[57] Health Justice, New *Mental health act* amendments: What you need to know, December 3, 2025. https://www.healthjustice.ca/blog

The only substantive provision of the *Mental Health Act* that differentiates children and youth from adults relates to voluntary admissions. Under section 20, a child under the age of 16 years who is assessed as having a mental disorder may be admitted to a mental health facility at the request of their parent or guardian as a "voluntary" patient, without the child's consent.[58] These provisions are starkly described in a revised form, which was recently authorized by Order-in-Council and was brought into force on December 3, 2025, notifying children under 16 years who are "voluntarily" admitted to a mental health facility of their rights:

FORM 14

NOTIFICATION TO PATIENT UNDER AGE 16, ADMITTED BY PARENT OR GUARDIAN, OF RIGHTS UNDER THE MENTAL HEALTH ACT.

REASONS FOR ADMISSION

You were admitted at the request of your parent or guardian and a medical doctor who examined you is of the opinion that

(a) you are a person with a mental disorder that seriously impairs your ability to react appropriately to your environment or associate with other people, and

(b) you require psychiatric treatment in a designated facility.

You do not have a choice about staying here. The staff may give you medication or other treatment, to which your parent or guardian has consented, for your mental disorder even if you do not want to take it.[59] (emphasis added)

In addition to being statutorily deemed incapable and subject to being detained with the consent of their parents/guardians, the liberty of children and youth under 16 is less protected than older persons insofar as:

- The two criteria for admission of children under 16 years described above are far less stringent than the four criteria described earlier for involuntary detention.
- Detention of an involuntary patient beyond 48 hours requires a second medical certificate[60] but that is not required with section 20 admissions of children and youth under 16 years.
- Persons who are involuntarily detained under section 22 have a right to request a second medical opinion, but children and youth who are admitted under section 20 do not have that right.
- The duration of initial detention of an involuntary patient is limited to one month unless the authority for detention is expressly renewed for further periods[61] whereas the similar period for children

[58] If a parent or guardian does not consent to "voluntary" admission under section 20, a child under 16 years can still be involuntarily detained by applying the involuntary committal provisions of section 22 described above.

[59] BC Reg 456/2025; effective December 3, 2025. Order in Council 456/2025. It is accurate to say that these children do not have a choice about staying in hospital. It may be an over-statement, however, to suggest that all children admitted under section 20 may be required to take medication that their parent has consented to. The "deemed consent" provisions of section 31 of the *Mental Health Act* do not apply to children admitted under section 20 and in absence of any other provision addressing consent to treatment by this young age group, the provisions of the *Infants Act* governing the capacity of children to consent to healthcare should apply. Form 14.1 , which set out rights, including private access to a rights advisor, is also provided .

[60] Section 22(2) *Mental Health Act*.

[61] Section 24 *Mental Health Act*.

under 16 years is longer (two months).[62]

The absence of a requirement for a second medical certificate to authorize detention beyond 48 hours as well as the lack of an option to request a second medical opinion means that the only recourse for a child under 16 years admitted under section 20 is application for a hearing before the review board, which must be held within 14 days. This means that there is, in effect, no recourse for the first two weeks of detention and the recourse that is available through the review board is, as noted earlier, rarely exercised.

Persons who are involuntarily detained are eligible to apply to have their detainment reviewed by the Mental Health Review Board, as are children under 16 years who are voluntarily admitted with the consent of their parent under section 20. The fact that children under 16 who are admitted with parental consent are eligible to apply for review amounts to an acknowledgment that these "voluntary" admissions are in fact involuntary.[63] These provisions under section 20, in effect, statutorily deem children under 16 years to be incapable chattel of their parents or guardians and are obviously incompatible with the provisions of the UNCRC, the mature minor doctrine and the *Infants Act*. In the Representative's view, these anachronistic provisions must be amended and brought into the 21st century. This is not to suggest that involuntary detention under the *Mental Health Act* should not be used for children under 16, which is obviously necessary in some circumstances. Those circumstances should, however, be conditioned by the principles set out in the UNCRC, the mature minor doctrine, and criteria that clearly set out appropriate grounds for involuntary detention, with appropriate safeguards to limit use to cases where involuntary detention is the only appropriate option and with timely and supported recourse to reviews of detention status.

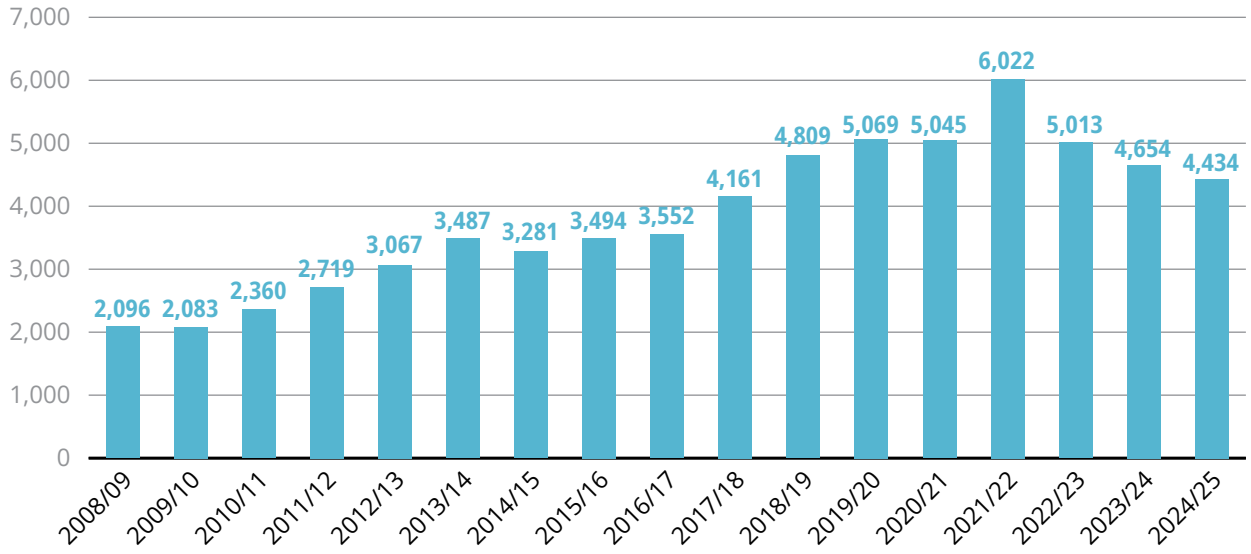
Figure 1 describes the total number of hospitalizations[64] under the *Mental Health Act* of children and youth between 2008/09 to 2024/25. These data include voluntary and involuntary hospitalizations combined. About one-half (52%) of the total hospitalizations involved children under 16 years; more than one in ten (11%) involved children under 12 years. There is a seemingly anomalous peak in hospitalizations in 2020/21 (a COVID year) and some decrease in the past two years. Otherwise, Figure 1 indicates that there has been far greater use of mental health hospitalizations of children and youth over the past seven years, as compared to the preceding decade; total hospitalizations in 2024/25 were more than double (112%) the number in 2008/09.

[62] Section 22(2*) Mental Health Act.*

[63] See section 21 *Mental Health Act*, which states that review panel proceedings apply to persons voluntarily admitted under section 20 " as though the patient had been admitted under section 22", which are the provisions for involuntary detention.

[64] These are hospitalizations, based on discharges during the course of a fiscal year. Note that the same unique individual may be admitted and discharged during the course of a year. Data does not include admissions to two MCFD -operated mental health facilities – the Maples Adolescent Treatment Centre ("Maples") and the Youth Forensic Psychiatric Services Inpatient Assessment Unit ("IAU"). Youth are admitted to IAU though the Youth Criminal Justice Act, whereas Maples is referral treatment centre that accepts voluntary admissions, with few exceptions.

Figure 1 Youth Mental Health Hospitalizations by Fiscal Year

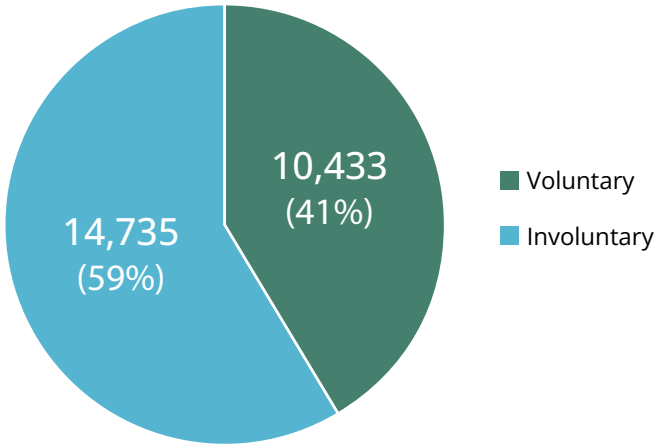


Source: BC Ministry of Health
"Youth" includes all patients under the age of nineteen years.

Turning to the critical issue of involuntary hospitalizations under the *Mental Health Act*, as noted, the *Detained* report described an alarming increase – 162% – in involuntary detentions between 2008/09 and 2017/18. This was a far greater rate of increase than the increase in voluntary hospitalizations of children and youth (+44%) and the increase in involuntary hospitalizations of adults (+57%) during the same period. Unfortunately, due to substantive changes in legal status data collection by the Ministry of Health, data on involuntary detentions for 2018/19 and 2019/20 is not available and the data for the most recent five years cannot be reliably compared to data preceding 2018/19, i.e., comparable long term trend data on involuntary hospitalizations of children and youth is no longer available.

Figure 2 describes the total number of voluntary and involuntary hospitalizations of children and youth in the past five years. Involuntary hospitalizations comprised the substantive majority (59%) of hospitalizations during that five-year period, which averaged 2947 involuntary hospitalizations per year. It should be noted that the numbers of truly involuntary hospitalizations are under-represented in these data and the number of truly voluntary hospitalizations are over-represented to an unknown degree, due to the anomalous provisions of section 20 *Mental Health Act* described earlier wherein a child under 16 years can be "voluntarily" admitted to a mental health facility without their consent. An indicator of this under-representation in truly involuntary status is found in the differences in involuntary detention rates for the two age groups: there is greater reliance on involuntary detention amongst youth who are 16 to 18 years old than those under 16 years – 64% versus 54% – presumably because de facto involuntary hospitalization of children under 16 years can be accomplished by way of a "voluntary" admission under section 20 with parental consent.

Figure 2 Voluntary and Involuntary Youth Mental Health Hospitalizations FY2020/21 to 2024/25 Totals



Source: BC Ministry of Health
"Youth" includes all patients under the age of 19 years.

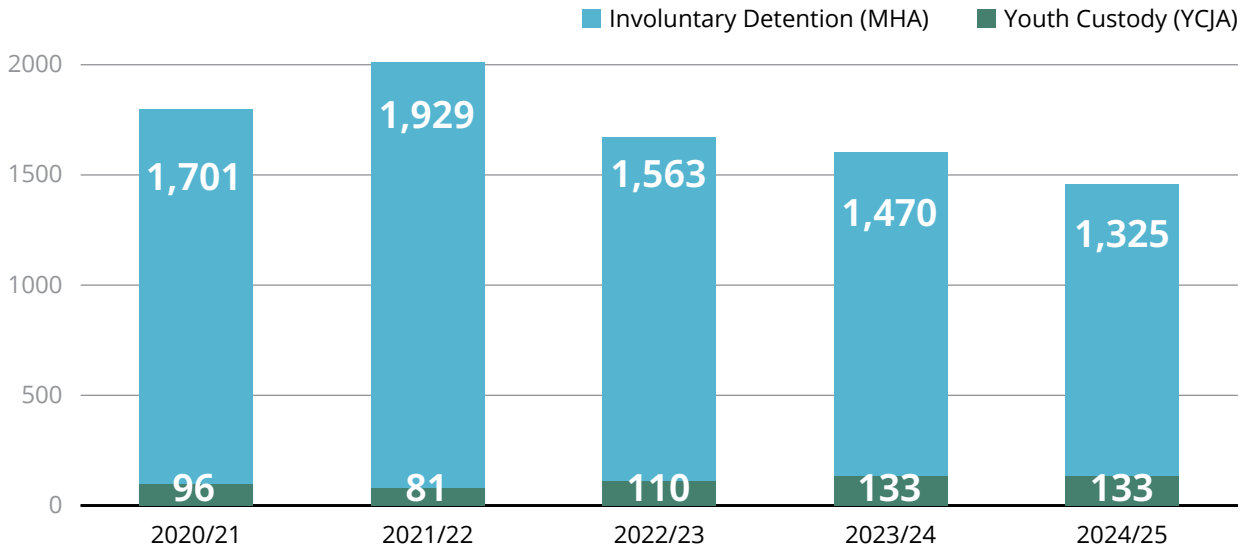
Involuntary detention under the *Mental Health Act* is perhaps the most intrusive measure the state can impose on an individual insofar as it deprives the person of their liberty, deprives the involuntary patient of the right to refuse treatment, and can lead to the use of restraints and seclusion in some circumstances while in detention. The only other legislative means of depriving young people of their liberty in BC is through the criminal justice system, specifically the federal *Youth Criminal Justice Act* (YCJA), which can result in a young person being committed to pretrial detention or sentenced to custody.[65] This raises a question about how these two legislative instruments for the deprivation of liberty of young people compare with respect to frequency of use. These data are available and presented in Figure 3, which compares the number of unique youth who have been involuntarily detained under the *Mental Health Act* to the number of unique youth who were committed to (pretrial or sentenced) custody under the YCJA in BC in each of the past five years. A unique youth is an individual youth who was admitted to mental health detention or to youth custody at least once during the year.[66] Since the age jurisdiction of the federal YCJA (12 to 17 years[67]) is different from the age jurisdiction of the provincial *Mental Health Act* (under age 19), children under the age of 12 and 18-year-olds have been removed from the mental health involuntary detention data, to make the two populations comparable in age groupings.

[65] S.C. 2002, c. 1. This is federal legislation that is administered by provinces, and has jurisdiction over a young person between the age of 12 and 17 years who is alleged to have committed or been found guilty of a Criminal Code or other federal statute offence In theory, a young person could also be committed to youth custody under the provincial *Youth Justice Act* (SBC 2003, Chapter 85), which has jurisdiction over provincial statute offences such as driving infractions, however, custody committals under that legislation do not occur in practice.

[66] Some youth from both population groups were admitted more than once during the year, however, they are only counted as one unique youth.

[67] Due to delays associated with police investigations and court processes, there are some youth over the age of 17 who are admitted to youth custody, however, as a matter of law they must have committed the alleged offence while under the age of 18.

Figure 3 Unique Youth (12-17) Involuntarily Detained (MHA) and Admitted to Youth Custody (YCJA) FY 2020/21 to 2024/25



As Figure 3 illustrates, the number of unique youth (12 to 17 years old) involuntarily detained under the *Mental Health Act* dwarfs the number committed to custody in every year. Throughout the entire five-year period, the total number of unique youth involuntarily detained under *the Mental Health Act* was fourteen (14.4) times the number committed to youth custody under the YCJA. Again, it should be noted that the number of youth who are truly involuntarily detained under the *Mental Health Act* is likely under-stated in these comparisons, given that admissions of youth under the age of 16 years under section 20 of the *Mental Health Act* are considered "voluntary" admissions. In short, the *Mental Health Act* is, by far, the principal mechanism for the deprivation of the liberty of children and youth in the province.

Locking Up Young People: A Comparison of Two Statutes

The fact that the *Mental Health Act* is, overwhelmingly, the primary legislative instrument for the deprivation of liberty of children and youth raises the question about how well that statute accords with the principles and safeguards set out in international human rights instruments respecting children and youth. The appended report by the Society for Children and Youth assesses how BC's mental health system aligns with the relevant requirements of the UNCRC as well as other international treaties, rules and guidelines such as the *United Nations Convention on the Rights of Persons with Disabilities*, the *United Nations Convention on the Rights of Indigenous Peoples*, the *United Nations Rules for the Protection of Juveniles Deprived of their Liberty, the International Covenant on Civil and Political Rights* and World Health Organization guidance. That analysis will not be repeated here but regarding summary the report concludes that BC's mental health system for children and youth, " ... operates in discordance with international treaties, notably the UNCRC, and other fundamental principles of justice and administrative law."[68] The report further states:

> In summary, this paper underscores the urgent need for a comprehensive reevaluation and reform of the current mental health framework in British Columbia, emphasizing the importance of aligning with international standards and safeguarding the rights and well-being of the children and youth it affects.[69]

Moving beyond the international sphere, the comparison of rates of utilization of involuntary detentions of young people under the *Mental Health Act* and custody committals under the YCJA also invites a comparison of the key features, including the recognition of rights and safeguards for young people, in these two domestic statutes. Like the disparate rates of utilizations, the contrasts between two statutes are stark, the highlights of which are briefly described below:

Youth Specific:

The YCJA is separate legislation that is solely applicable to youth (12 to 17 years), establishing principles, criteria and procedures that are distinct from the adult system. In contrast, under the *Mental Health Act* young people are subject to the same criteria and processes as adults with the sole substantive exception of section 20 "voluntary" admissions of children under 16 to hospital with the consent of the parent.

Moreover, there are requirements in law to separate youth from adults in youth-specific pretrial detention and sentenced custody facilities,[70] which is not a requirement under the *Mental Health Act*. Children and youth are administratively separated from adults only in locations where there are child and youth specific designated facilities.[71]

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[68] *Supra*, note 31, p.39
[69] *Ibid.*
[70] Sections 30(3) and 84 YCJA.
[71] There are designated facilities at BC Children's Hospital in Vancouver, the Maples Adolescent Treatment Centre in Burnaby (operated by MCFD), Queen Alexandra Hospital in Victoria and specialized psychiatric units in Surrey, Kelowna and Prince George.

Recognition of Rights

The YCJA contains both a Preamble and a Declaration of Principle that applies throughout the Act. The Preamble to the YCJA expressly states:

> WHEREAS Canada is a party to the United Nations Convention on the Rights of the Child and recognizes that young persons have rights and freedoms, including those stated in the *Canadian Charter of Rights and Freedoms* and the *Canadian Bill of Rights*, and have special guarantees of their rights and freedoms[72] (emphasis added)

Further, the Declaration of Principle states the system must emphasize:

> … enhanced procedural protection to ensure that young persons are treated fairly and that their rights, including their right to privacy, are protected.[73] (emphasis added)

In contrast, the *Mental Health Act* does not similarly recognize the rights of young persons, nor provide special guarantees of rights and procedural protections in recognition of their state of development and maturity.

Agency and Participation

The YCJA states:

> young persons have rights and freedoms in their own right, such as a right to be heard in the course of and to participate in the processes, other than the decision to prosecute, that lead to decisions that affect them, and young persons have special guarantees of their rights and freedoms …[74]

In contrast to the *Mental Health Act*, the YCJA statutorily deems a young person to be capable of making their own decisions, independent of their parent or guardian. As examples, a 12-year-old can instruct counsel, enter a plea or apply for reviews of their sentences, independent of their parent or guardian.

Representation by Counsel

The YCJA guarantees in law the provision of publicly funded counsel at any stage of proceedings,[75] whereas publicly funded counsel is only provided in mental health proceedings if a young person is before the Mental Health Review Board, which, as noted earlier, is very infrequently accessed.

Consent to Treatment

In contrast to the "deemed consent" provisions of the *Mental Health Act* respecting consent to treatment and section 20 "voluntary" admissions to hospital of children under 16 years, the YCJA provides that in respect of sentences imposed on a young person, "…. nothing …. abrogates or derogates from the rights of a young person regarding consent to physical or mental healthcare"[76]

[72] YCJA, Preamble
[73] Section 3(1)(b)(iii) YCJA
[74] Section 3(1)(d)(i) YCJA
[75] Section 25 YCJA
[76] Section 42(8) YCJA

Principles of Minimum Intervention

The YCJA incorporates the principles of minimal intervention and the use of custody only as a last resort by establishing strict legislative criteria limiting the use of pretrial detention and sentenced custody,[77] while also providing that the court "shall not impose a custodial sentence .... unless the court has considered all alternatives to custody raised at the sentencing hearing that are reasonable in the circumstances, and determined that there is not a reasonable alternative"[78]

In contrast, the *Mental Health Act* is silent with respect to the use of involuntary detention as a last resort.

Community-Based Measures

The YCJA sets out a variety of non-custodial, community based options and promotes their use as alternatives to custody. In contrast, the *Mental Health Act* is almost entirely focused on hospitalization and is silent with regard to community based measures, with the exception of extended leave, which is a conditional release to community, or transfer to an approved home, which are only available to persons after they have been involuntarily detained.[79]

Role Of Parents

Although a young person is deemed to be capable of making decisions independent of their parent or guardian, the YCJA's Declaration of Principle states that, " ... parents should be informed of measures or proceedings involving their children and encouraged to support them." The Act further defines the role of a parent in respect of receiving notices, reports, and having the opportunity to participate in proceedings such as sentencing and review. In contrast, the *Mental Health Act* only speaks to the role of parents/guardians in respect of consenting to "voluntary" admissions under section 20, payments for care (section 11) and advice to "near relatives" (section 34.2), which includes a parent.

Seclusion and Restraint

Section 32 of the *Mental Health Act* provides that patients, including children and youth, who are detained, are subject to the "direction and discipline of the director and members of the staff of the designated facility", but is otherwise silent in defining and limiting the circumstances under which the most extreme forms of discipline and control can be exercised, i.e., the use of physical restraints and seclusion rooms. While there are administrative standards and guidelines for the use of seclusion, those standards do not, for example, do not specify a maximum limit on the duration of seclusion. In contrast, the *Youth Custody Regulation*, which has the force of law, provides a statutory right of review of disciplinary consequences, including hearing the views of the youth, defines and limits the use of physical restraints, and defines and limits, including duration, the use of seclusion (known as separate confinement).[80]

[77] See section 29(2) YCJA in respect of pretrial detention and section 39(1) in respect of sentencing to custody.

[78] Section 39(2) YCJA. Section 38(2)(d) YCJA also states "all available sanctions other than custody that are reasonable in the circumstances should be considered for all young persons, with particular attention to the circumstances of aboriginal young persons", while section 38(2)(e) requires the court to consider the "least restrictive sentence".

[79] See, sections 37 and 38 *Mental Health Act*.

[80] *Youth Custody Regulation*, BC Reg. 137/2005. Sections 12.1, 15 and 15.1. While statutory requirements may provide greater definition and assurances of compliance, it does not guarantee compliance. See, for example, a report by the Office of the Ombudsperson on misuses of separate confinement in BC youth custody centres, *Alone: The Prolonged and Repeated Isolation of Youth in Custody*, June 15, 2021. The regulations set a maximum cumulative limit of 72 hours, albeit that maximum may be extended with the approval of the Provincial Director.

The youth justice system affords youth specialized and distinct legislation with special guarantees of rights and enhanced procedural protections precisely because of their state of development and greater vulnerability than adults, and because their liberty is at risk. Yet the mental health system detains children and youth in vastly greater numbers without similar special legislation, guarantees and enhanced procedural protections. In fact, the converse is the case: under the *Mental Health Act*, youth who are 16 years or older are subject to the same provisions as adults, whereas children under the age of 16 actually have fewer rights and procedural safeguards than older persons.

The summary comparison of the two statutes described above illustrates how inadequate the Mental *Health Act* is with respect to addressing the unique needs, circumstances and rights of children and youth, and how anachronistic that legislation is, given that the YCJA was introduced into the Canadian Parliament nearly a quarter-century ago.[81] These comparisons should not be taken to suggest that the specific provisions of a (largely) judicial decision-making process can be transposed onto an administrative decision-making process like mental health proceedings, however, the relevant principles, rights and enhanced procedural protections certainly could and should be included in reformed and modernized mental health legislation for children and youth.

[81] The YCJA was introduced into Parliament as Bill C-7 in February, 2001 and brought into force on April 1, 2003.

Expanding Involuntary Care

Reform and modernization of the *Mental Health Act* will inevitably include consideration of broadening the criteria for involuntary care of both adults and youth, principally as a response to the tragic outcomes of the toxic drug crisis. While the declaration of the overdose crisis as a public health emergency is nearly a decade old, the debate about a broader legislative capacity – either by way of separate legislation or changes to the *Mental Health Act* – to protect and treat children from harms such as addiction and sexual exploitation through "secure care" or "safe care" has been a recurring and controversial theme for decades, at least since the Report of the Secure Care Working Group in 1998.[82]

In more recent years, government introduced the *Mental Health Amendment Act*[83] in 2020, which provided for involuntary "stabilization care" for young people under 19 years who had experienced substance use overdoses but this proposed legislation was withdrawn in the face of opposition from a variety of fronts, such as the Union of BC Indian Chiefs, BC Civil Liberties Association, Health Justice, RCY[84] and others.

In September 2024, government committed to making changes to the law in the next legislative session "to provide clarity and ensure people, including youth, can and should receive care when they are unable to seek it themselves".[85] The next legislative session began in February 2025 but the proposed legislative changes have yet to be introduced.

The recently released guidance by Dr. Vigo for physicians on the treatment of children and youth with substance disorder under the *Mental health act* is clearly intended to administratively broaden the use of involuntary detention and parent-authorized involuntary committals of children under 16 years under the current provisions of the legislation, without need for resort to amendments.[86]

In light of the likelihood that these guidelines will lead to expanded use of involuntary care of young people, or amendments promised by the Premier that may further promote greater use of involuntary care, it is necessary for the Representative to re-state and expand upon her position on this matter, which was initially set out in a statement in 2020 outlining significant concerns about the proposed *Mental Health Amendment Act.*[87]

To be clear, the Representative is not opposed to involuntary care of youth under the *Mental Heath Act*, which is obviously necessary in the right circumstances and under the right conditions, nor is she opposed to clarifying the grounds for involuntary care of youth in appropriate cases of concurrent mental health and substance use where there is imminent

[82] Secure Care Working Group (1998). *Report of the Secure Care Working Group*. BC: Minister of Children and Families. A brief history (up to 2019) by the British Columbia Law Institute describing legislative proposals for safe care in BC can be found at https://www.bcli.org/analysis-of-the-bc-safe-care-act-bill/. The *Secure Care Act* [SBC 2000, Chapter 28) received Royal Assent on July 6, 2000, but was never brought into force.

[83] BILL 22 – 2020, *Mental Health Amendment Act,* 2020 Legislative Session: 5th Session, 41st Parliament First Reading.

[84] See, Media Advisory of Press Conference: Bill 22 Stands to Increase the Opioid Crisis and Youth Deaths; Bill 22 Must be Withdrawn - UBCIC

[85] *Supra*, note 5

[86] *Supra*, note 4.

[87] Representative for Children and Youth, *Representative's Statement in response to government's proposed changes to the Mental Health Act*, June 23, 2020. Representative's Statement in response to government's proposed changes to the *Mental health act* | Office of the Representative for Children and Youth - RCYBC

and serious risk to the health and safety of young people and there is no other less intrusive means for effectively addressing that serious risk of harm.

In the Representative's view, however, expanding the scope of authority to detain youth under the *Mental Health Act*, whether administratively or through future legislative amendments, should only occur if four over-arching conditions are met, including:

A Robust and Accessible System of Voluntary Services

A robust and accessible system of voluntary, culturally appropriate, trauma-informed and evidence-based community -based treatment services must be the cornerstone of a system that incorporates involuntary care at the far end of the spectrum of care. A robust system with timely access is essential so that resort to involuntary care can be minimized rather than becoming the only available (and expensive) default mechanism in the absence of other alternatives, thereby avoiding or minimizing the potential anger, loss of trust and diminished likelihood of seeking help in future that can arise from forced treatment. Importantly, it is critical that a robust system of community-based supports for young people who are discharged from involuntary care be in place so they are well supported in their recovery, that gains made during treatment are not lost, or worse still, greater harms do not arise. In the latter regard, research has indicated that in some cases, involuntary treatment of persons with substance use disorders has been linked to negative health outcomes, such as increased risk of overdose or death post discharge.[88]

This begs the question: is there a robust and accessible array of community-based mental health services for children and youth currently in place in BC? Hardly so. Since the release in 2019 of government's ten-year plan for systemic enhancements to the mental health and substance use service system – known as *A Pathway to Hope*[89] – some strides have been taken to improve services to children and youth, especially with respect to Foundry programs[90] and school-based Integrated Child and Youth (ICY)[91] teams. Foundry centres and ICY teams are both integrated, multi-disciplinary services created to address gaps in the mental health and service system for children and youth, especially for cases of mild-to-moderate acuity that were previously unable to be well served. Foundry centres offer services to young people aged 12-24 and their families while ICY teams are based in school districts and serve children from 0 to 19 years. Foundry and ICY services are welcome steps forward, however, they are not systemically available.[92] At present, there are 19 active Foundry centres across the province, a virtual service, and announced plans to expand to a total of 35 service centres,[93] whereas there are active ICY teams in less than one-third (18 out of 60) of the province's school districts, noting that not all communities within those 18 school districts are served, two additional teams in the early phase of implementation.[94]

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[88] Canadian Centre on Substance Use and Addictions, *Evidence Brief: Involuntary Treatment for Severe Substance Use*, January, 2025. https://www.ccsa.ca/sites/default/files/2025-02/Involuntary-Treatment-Evidence-Brief-en.pdf

[89] June 25, 2019, BC Ministry of Mental Health and Addictions, *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia.* June 25, 2019.

[90] See, https://foundrybc.ca/about-foundry-services/

[91] See, BC Ministry of Health, *BC's Integrated Child & Youth Teams, Last updated on June 5, 2025. BC's Integrated Child & Youth Teams - Province of British Columbia*. Even in the largest urban centres, there are no ICY's in Vancouver and Victoria and one team planned for Surrey.

[92] See, https://foundrybc.ca/about-foundry-services/

[93] Ministry of Mental Health and Addictions, *Youth benefit from significant increase in mental-health, addiction care.* Updated March 4, 2024, https://news.gov.bc.ca/releases/2024MMHA0009-000280

[94] *Supra*, note 92. Supplementary information provided by MCFD, December 10, 2025.

Child and Youth Mental Health (CYMH) services, which principally involves community-based outpatient mental health services that are operated and/or funded by MCFD, are systemically available across the province. MCFD data indicates that there are large numbers of children and youth who are wait-listed for services, and for considerable periods. On December 31, 2024, there were 1,771 children and youth across the province who were wait-listed for CYMH services, with an average waitlist duration of more than four months (130 days). In the Northern region, the average waitlist duration was more than six months (194 days). Moreover, the average wait time across the province for the highest priority cases – described as "moderate risk of harm to self or others and-or high levels of distress, complexity and functional impact" – was more than three months (94 days). The average wait-time for these highest priority cases on Vancouver Island was more than seven months (219 days). Moreover, the average wait time to a first CYMH service in 2024/25 was slightly longer than in 2017/18, i.e., before the advent of *A Pathway to Hope.*[95]

Another critical service is "step up/step down" resources, which are staffed community residential resources[96] with appropriate clinical supports that can be an alternative to hospitalization in the first place or, importantly, can offer intensive support to transition from hospital to the community. The inadequacies – indeed, near absence – of dedicated mental health step up/step down community residential resources for youth has been the subject of reports, recommendations and plans in BC for more than twenty years,[97] with minimal to no progress during that time. A commitment to the establishment of step up/step down beds was made in government's plan, *A Pathway to Hope*, in 2019 and re-iterated with an investment of $13.4 million in the 2021 BC budget,[98] but there has been little follow through with the establishment of dedicated and readily available staffed residential resources.[99] It is noted that through RCY's individual advocacy function RCY Advocates routinely deal with cases of young people in hospital who are either held back in hospital due to a lack of appropriate placements or discharged to an inadequate community placement, an ongoing concern that has been underscored by recent discussions with representatives from BC Children's Hospital who describe children and youth, including those with mental health and complex needs, languishing in hospital due to a lack of community placements.

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[95] Data derived from MCFD Estimates Notes. The average number of days to first CYMH service in 2017/18 was 59.2 days compared to 59.8 days in 2024/25 (to December 31); the average number of days in the four years preceding 2024/25 were also greater.

[96] It is recognized that intensive non-residential services such as Assertive Community Treatment (ACT) teams and day programs can also be construed as a part of a continuum of step up/step down resources, however, the focus here is on community residential services.

[97] Examples of gaps in the availability of community residential step up/step down resources and recommendations or plans for improvement can be found in:
- Ministry of Children and Family Development*, Child and Youth Mental Health Plan for British Columbia*, February 2003
- A. Berland, *Promises Kept, Miles to Go: A Review of Child and Youth Mental Health Services in BC.,* Ministry of Children and Family Development, 2008
- Ministry of Health and Ministry of Children and Family Development, *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia*, 2010
- The Federation of Community Social Services of BC and the Ministry of Children and Family Development, *Residential Review Project: Final Report*, 2012
- Representative for Children and Youth, *Missing Pieces: Joshua's Story*, 2017

[98] See, BC Ministry of Mental Health and Addictions, *A Pathway to Hope Progress Report*, August 2021

[99] MCFD reports that the Maples Adolescent Treatment Centre has established some short term, step up/ step down live-in treatment services with severe and enduring mental health needs. Up to five bed satellite services were established in Prince George and Vernon in 2024, serving 29 youth between November 29, 2024 and November 29, 2025. These services are obviously not systemically available. For context, there were 4434 hospitalizations of children and youth in 2024/25 in health authorities, excluding admissions to the Maples.

In recent years, the Representative has also documented in detail the inadequacies of mental health assessment and treatment services for highly vulnerable sub-populations of children and youth, specifically children in care[100] (2022), children and youth with neurodevelopmental conditions[101] (2023). and gender diverse youth[102] (2023). Little to no progress has been made in improving the service shortfalls and better addressing the needs of these highly vulnerable young people since release of those reports.

It is also noted that the ten-bed Carlisle Centre in North Vancouver for 13- to 18-year-olds, which was the only dedicated tertiary care treatment program in the province for adolescents with concurrent mental health and substance use disorders, was permanently closed in 2024 due to medical staff shortages.[103]

Enhanced Procedural Safeguards

This report, and the accompanying report by the SCY, have detailed the many shortcomings of the *Mental Health Act* in protecting the rights of children and youth, including insufficient procedural safeguards to ensure that the involuntary committal and deprivation of liberty of children and youth is limited to cases where it is necessary and for the shortest duration possible, with effective recourse to challenge detention decisions. If consideration is to be given to expanding or clarifying the criteria for involuntary detention of children and youth, or to undertake a wholesale modernization of the legislation, it is essential that much stronger safeguards be included, such as:

- Recognize and support the right of children and youth to participate in decisions affecting them and to be heard.
- Limit section 20 admissions by way of parental consent (without the consent of the child) only to circumstances where a child does not have the capacity to consent in accordance with the *Infants Act* and, similarly, to consent to treatment after admission, with advocacy and system navigation supports in place to better support the exercise of those rights.
- Establish criteria for involuntary detention that are no less stringent than the criteria for adults, incorporating the principles of least intrusive measures, for the shortest duration necessary, and requirements to consider all available alternatives.
- Require that detention can be extended beyond 48 hours only on the basis of a second medical opinion.
- Provide for automatic and immediate scheduling of access to the independent rights advice service upon admission.
- Provide for automatic scheduling and early hearings before the review board, with a statutory guarantee of publicly funded counsel, and periodic, automatically scheduled hearings thereafter.

[100] Representative for Children and Youth, A Parent's Responsibility: Government's obligation to improve the mental health outcomes of children in care, September 2022. https://rcybc.ca/wp-content/uploads/2022/09/RCY-ParentsResponsibility-Sept2002.pdf

[101] Representative for Children and Youth, Toward Inclusion: The need to improve access to mental health services for children and youth with neurodevelopmental conditions, April 2023. https://rcybc.ca/reports-and-publications/reports/toward-inclusion-the-need-to-improve-access-to-mental-health-services-for-children-and-youth-with-developmental-conditions/

[102] Representative for Children and Youth, The Right to Thrive: An Urgent Call to Recognize, Respect and Nurture Two Spirit, Trans, Non-Binary and other Gender Diverse Children and Youth, June 2023. https://rcybc.ca/reports-and-publications/right-to-thrive/

[103] Vancouver Sun, *During a toxic drug crisis, health authority is closing unique facility for Vancouver area youth with addictions,* February 15, 2024. https://vancouversun.com/health/exclusive-during-a-toxic-drug-crisis-this-unique-lifeline-for-youth-with-addictions-is-closing

- Narrowly define and limit the use of restraints and seclusion to circumstances where it is necessary for the prevention of serious and imminent harm, and the duration of the same, with appropriate review, oversight and reporting.

Indigenous Consultation and Support

Sadly, the legacy of colonization and residential schools has resulted in the most coercive powers of the state being applied to Indigenous children and youth to a vastly disproportionate degree.

An Indigenous child is about 19 times more likely to be brought into care than a non-Indigenous child.[104] Even though Indigenous youth comprise less than ten per cent of the general population, about one-half of the youth custody population is Indigenous.[105] Unfortunately, similar data is not available with respect to involuntary mental health hospitalizations but, as noted, the Ministry of Health has previously acknowledged probable disproportionality.

A broadening of the scope of authority to involuntarily detain under the *Mental Health Act* will undoubtedly have an outsized impact on Indigenous children and youth, and their families and communities.

The *Declaration on the Rights of Indigenous Peoples Act* requires the province, in consultation and cooperation with the Indigenous peoples in British Columbia, to take all measures necessary to ensure the laws of British Columbia are consistent with the *United Nations Declaration on the Rights of Indigenous Peoples (*UNDRIP*).*[106] It is noted that UNDRIP provides that all Indigenous

[104] Ministry of Children and Family Development, *2025/26 – 2027/28 Service Plan*, March 2025.
[105] Data provided by MCFD, October 24, 2025.
[106] SBC (2019] CHAPTER 44, section 3.

individuals have the right to the full enjoyment of all human rights and fundamental freedoms recognized in international human rights law, which would include the UNCRC, to which Canada is a signatory.

A Commitment to Research and Evaluation

As noted earlier, the *Detained* report documented a remarkable increase in involuntary hospitalizations of children and youth while as described earlier, total hospitalizations and involuntary detentions have remained at high levels in the ensuing years. Although the *Detained* report recommended that the Ministry of Health take steps to identify the conditions contributing to that increased use, that work has not been done. Involuntary detention of children and youth under the *Mental Health Act* is, overwhelmingly, the principal legislative instrument that deprives children and youth of their liberty, yet we know little – beyond simple frequency measures and some demographics – about, for example: how it is being used, why there have been changes in use, amongst which types of demographic and clinical sub-populations it is being used, where detained young people go after discharge, and what the outcomes are, including in particular, for involuntarily detained children and youth who have a substance use disorder. In the Representative's view, expansion of the use of involuntary detention requires much further research and evaluation.

It is noted that there is limited evidence on the effectiveness of involuntary treatment of persons with severe substance use disorders; most studies lack scientific rigour and most do not show significant improvement in reducing substance use.[107] If the state is going to deprive individuals of their liberty and commit considerable resources to involuntary detention, it is vital that we determine whether those measures are effective. As well, it is critical that there be ongoing monitoring and evaluation of the application and exercise of procedural safeguards to ensure that such intrusive measures are being fairly and appropriately applied.

It is also imperative that health authorities routinely report critical injuries (e.g., suicide attempts, overdoses) and deaths of youth people who have been in receipt of mental health and substance use services to the Representative for Children and Youth so the Office is better positioned to monitor, review and, as necessary, investigate service provision to these young people. Although the Representative for Children and Youth Act has been in place since 2006 and reporting of critical injuries and deaths has been legally required since that time, health authorities have not complied with this legal requirement. The Representative has taken active administrative steps for the past eight years to promote reporting which, unacceptably, have resulted in little progress.

[107] *Supra*, note 86.

Concluding Remarks and Recommendations

The Representative fully agrees with the SCY's conclusions that the provisions of the *Mental Health Act* for children and youth are deeply flawed and fail to accord with Canada's obligations under the UNCRC and other international treaties, and simple procedural fairness. Due to their state of development and greater vulnerability, children and youth need greater procedural protections than adults but they currently actually have fewer protections, which in turn are inadequate for adults in the mental health system. We can and must do better.

The proposed review and modernization of the *Mental Health Act* presents an opportunity for British Columbia to move from being a laggard to a leader by either creating a separate *Mental Health Act* for children and youth, or a separate and distinct part of modernized mental health legislation that addresses the rights, unique needs and circumstances of children and youth. While this report focuses on rights and procedural safeguards, which are obviously vital, there are other key elements that should be incorporated into modernized mental health legislation for children and youth. The current legislation is almost entirely focused on hospitalization and is silent about the role and function of mental health services writ large and the intersections of those services with other child- serving systems. New legislation needs to address key aspects of the system of services such as mental health promotion, prevention, early intervention, and voluntary community-based services. As well, the Representative's July 2024 report, *Don't Look Away – How one boy's story has the power to shift a system of care for children and youth,*[108] underscored the need for cross-ministry and cross-service collaboration and communication to better support social and cultural determinants of health, which should be reflected and supported in new legislation.

It is noted that government is currently engaged in planning to transfer the administration of community-based CYMH services from MCFD, a child and family focused ministry, to the Ministry of Health and health authorities.[109] While this prospective change may have benefits such as better integration and coordination of mental health services for children and youth with other health services, especially youth substance use services, and more seamless transition from youth to adult mental health services, there are risks that child and youth mental health services will be subsumed and subordinated in a much larger adult mental health and health service system, with CYMH services becoming more adultified in nature. Separate and distinct mental health legislation for children and youth may help to buffer that dynamic.

The Representative recommends:

> The Ministry of Health include in the terms of reference of the forthcoming review and modernization of the *Mental Health Act,* a requirement that legislative proposals be considered that would establish either stand-alone mental health legislation for children and youth or a separate and distinct part of a modernized *Mental Health Act* that addresses the rights, unique needs and circumstances of children and youth.

[108] Representative for Children and Youth, *Don't Look Away – How one boy's story has the power to shift a system of care for children and youth,* July 16, 2024. https://rcybc.ca/hfaq/dont-look-away/

[109] See, Mandate Letter, Honourable Jody Wickens, January 16, 2025. https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet-mlas/minister-letter/mandate_letter_jodie_wickens.pdf. There is parallel instruction to the Minister of Health.

Child Capacity and Participation in BC's Mental Health System

The Society for Children and Youth of BC

SOCIETY FOR children and youth OF BC

REPRESENTATIVE FOR CHILDREN AND YOUTH

Mental Health

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Acknowledgements

We would like to recognize the generosity of all youth and contributors in sharing their experiences and insights throughout the project. We thank you for allowing us to hear your stories across the various mediums in which your words were shared. Thank you to all stakeholder experts who provided their knowledge and wisdom for each project topic, providing our research team with invaluable information that shaped the emergent themes and key findings. This project began with the convening of community stakeholders at an initial roundtable, and we would like to give our thanks to the folks who joined us. Finally, thank you to everyone who provided guidance and feedback throughout the duration of this project.

The Society for Children and Youth of BC would like to acknowledge that we live and work on the traditional territories of the First Nations peoples of British Columbia. Our office is located on the Unceded Territory of the xʷməθkwəy̓əm (Musqueam), sḵwx̱wú7mesh (Squamish) and səl̓ilwətaʔɬ (Tsleil-Waututh) First Nations. We express our sincerest gratitude to the custodians of these lands and beyond across BC. We also wish to recognize the specific impacts on Indigenous Peoples and communities that are a result of the systems that are the focus of these papers. We invite readers to critically engage with the themes and key findings presented using this lens as well as an intersectional approach to take action.

Finally, we would like to acknowledge the invaluable contribution of the Office of the Representative for Children and Youth in facilitating this research. Their expertise, insights, and guidance throughout the research process were instrumental in shaping this work.

We would like to express our sincere gratitude to our Project Coordinator and Youth Engagement Lead, Simran Sarwara, for her invaluable contributions to this project. We would also like to thank Lisa Bellano for her extraordinary research leadership and report writing, as well as Sara Hernandez for her exceptional design of the report layout. We are also grateful to Suzette Narbonne KC for her legal research expertise and leadership in editing the final report, and to Mina Macdonald, Daniela Davies, and Naz Kousha for their contributions and assistance in bringing the report to completion.

The British Columbia Representative for Children and Youth funded this report.

Photo by Alejandra Lugo on Unsplash

About The Society for Children and Youth of BC

The Society for Children and Youth of BC (SCY) is a provincial not-for-profit charity. Since 1974, the Society has focused on providing a strong voice representing children and youth. Our mission is to improve the well-being and resilience of children and youth in BC through the advancement of their civic, political, economic, social, cultural and legal rights. Using the UN Convention on the Rights of the Child as a foundation, SCY has a track record of creating and delivering programs that have motivated change in research, legislation, policy, and practice in Canada. This year, we proudly celebrate 50 years of advocacy for child and youth rights. The organization is comprised of three programming areas: The Child and Youth Legal Centre, Child and Youth Friendly Communities, and Child Rights Public Awareness.

The Child and Youth Legal Centre (CYLC), established in 2017, provides free support to young people experiencing issues related to Family Law, Child Protection, human rights violations, and other legal matters. The Legal Centre is made up of Lawyers, Intake Workers, Child and Youth Advocates and a Social Worker. The Legal Centre has seen significant growth since its inception, and in 2023 supported 1125 young people across 90+ Communities in British Columbia.

SCY's Child and Youth Friendly Communities (CYFC) program supports child-friendly community-building with young people. Over the past eight years we have worked in collaboration with various Metro Vancouver municipal planning teams to ensure that children and youth have a stronger voice in their community's planning initiatives. Our aim is to ensure that public engagement is a deep and meaningful experience for

young people. Some of our projects include the Walking School Bus, School Streets, Play Streets, and Urban Explorers.

The Child Rights Public Awareness Campaign began in 2006 when SCY, the Representative for Children and Youth, and the Institute for Safe Schools of BC came together to envision a plan for raising awareness of child rights. Throughout the years, the campaign has engaged in numerous activities including roundtables on children's rights, the creation of a child rights network, a multimedia campaign, community and youth engagement activities, and the development and dissemination of child rights resources across the province, including multilingual resources.

Drawing from our experiences over the past several decades across different sectors advocating for child and youth rights, SCY conducted a Child Capacity Research Project as commissioned by the Representative for Children and Youth of B.C. This work aims to highlight the importance of child participation rights by way of research papers on child capacity in the context of four key areas: 1) family law, 2) child welfare and adoptions, 3) decisions about healthcare, and 4) mental health and involuntary civil detention. We are pleased to present this report series as it reflects a culmination of comprehensive literature analysis and multi-faceted youth engagement specific to each area. It is our hope that the key findings identified within each paper will support systemic action and facilitate cross-sectoral collaboration within B.C.

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Child Capacity and Participation in BC's Mental Health System

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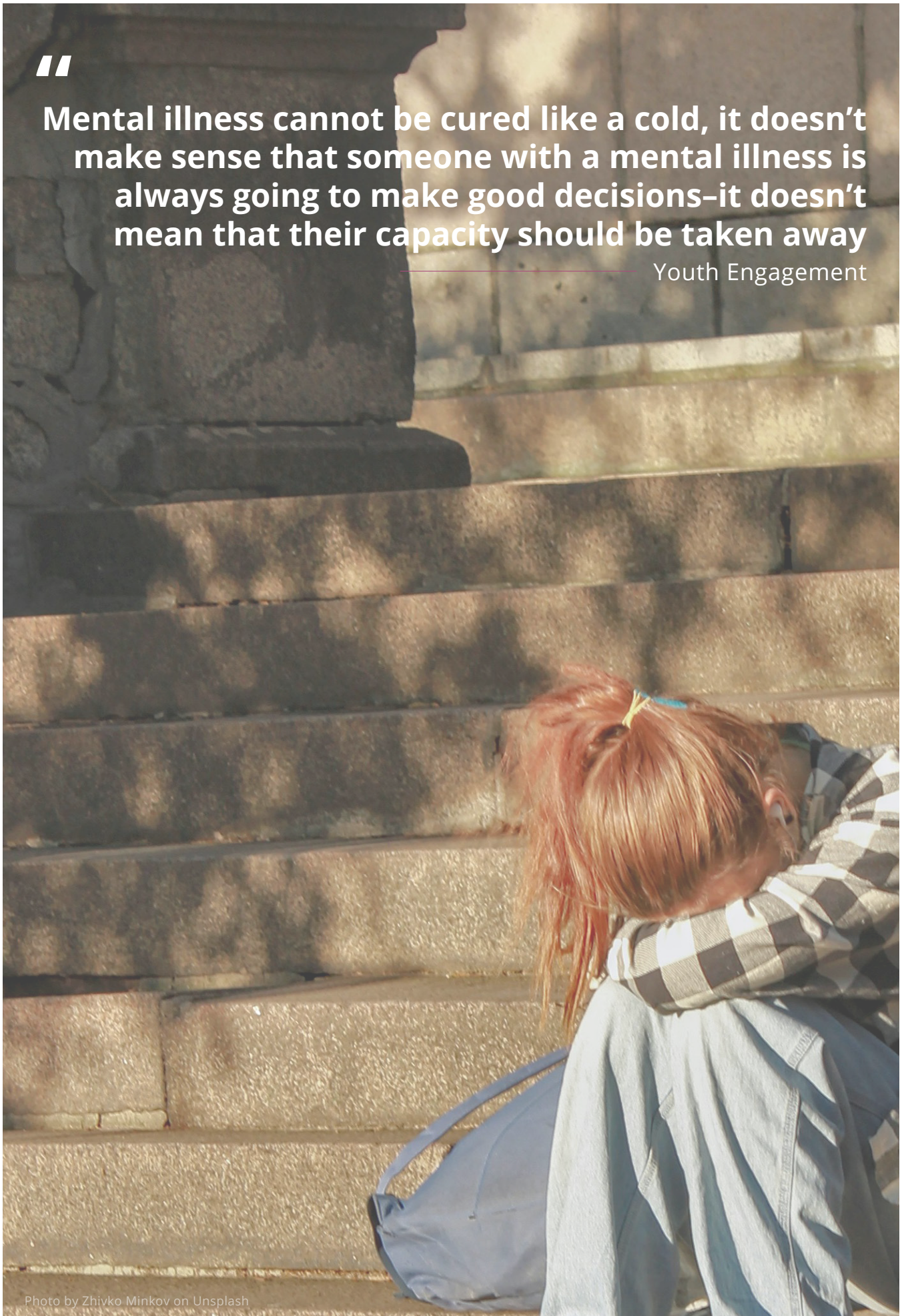

> **Mental illness cannot be cured like a cold, it doesn't make sense that someone with a mental illness is always going to make good decisions–it doesn't mean that their capacity should be taken away**
>
> Youth Engagement

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A. Executive Summary

This paper is part of a series on the topic of child capacity in relation to child participation rights. Throughout this collection of papers, we focus on the following areas: a broader socio-legal discussion on child capacity; family law; child welfare and adoptions; mental health and involuntary civil detention; and decisions about health care.

In 2021, the Representative for Children and Youth (RCY) reported a 162% increase in forced confinement of youth in BC over the last decade, rising from 973 in 2008-2009 to 2,545 in 2017-2018, with adult admissions rising at only 57% over the same period (RCY, 2021). Given the proposal of safe care legislation under the *Safe Care Act* (Bill M202 - 2024), which seeks to provide an additional framework for the involuntary detention of children and youth deemed "at risk" by decision-makers and care providers, it is a critical time to examine the impacts of institutionalization on children and youth in British Columbia, and to look at their experience of capacity and participation within the mental health context.

We begin with a discussion of capacity; the legal framework operating both internationally and provincially to detain children and youth for mental health care; the reported experience of detained children and youth both internationally and in British Columbia; and finally, we conclude with a summary of the key conclusions arising out of this discussion.

The key findings of this paper are derived from a review of relevant literature, legal analysis, and youth engagement. Youth engagement included surveys, interviews, and listening circles with young people on their experiences of capacity and participation in the context of mental health. The Society for Children and Youth of BC wish to acknowledge the courageous young people who spoke candidly about often difficult subjects. Their voices are critical to the research and key findings.

Key Findings

1. Although a child or youth's mental or cognitive capacity may fluctuate depending on the nature of their mental illness or disability, this does not impact their legal capacity. Their legal rights do not go away because of their perceived lack of cognitive or mental capacity.

2. While children and youth with mental illness may not always make decisions deemed "good" by decision-makers and health care providers, their right to participate in decision making through the expression of their views should not be ignored.

3. It is important to work with a child and youth's capacity—meeting them where they are at—rather than assuming they lack capacity.

4. When a child or youth's capacity is denied or taken away, it can create a negative cycle that impacts their ongoing ability to make decisions for themselves and to maintain a sense of autonomy.

5. It is important for children and youth to express their capacity to be heard; to share their opinions and views on their treatment. A legislative framework that presumes a lack of capacity is not consistent with a child's legal right to be heard.

6. To respect a child or youth's capacity, it is essential that decision-makers and care providers share appropriate information with them about their rights and communicate adequately with them about their treatment. This helps a child or youth to be able to understand, to the best of their abilities, the situation at hand and to use this information to form views and make appropriate decisions about their care.

7. Institutionalization can harm the physical, mental, and cognitive development of children and youth, with lasting effects into adulthood. Involuntary mental health detention should be used sparingly, for the shortest time possible, and in select cases.

8. Any proposed legislation and legislative amendments, such as the *Mental Health Amendment Act* and *Safe Care Act*, require thorough scrutiny for their impact on children and youth.

B. Background and purpose of report

The purpose of this paper is to discuss child capacity and participation rights in the context of the involuntary and voluntary civil detention of children and youth in British Columbia under the *Mental Health Act* (1996), with a focus on mental health admission to hospitals and other care facilities. We also consider proposed stabilization care measures under the *Mental Health Amendment Act* (Bill 23-2022), and *Safe Care Act* (Bill M202 - 2004). In particular, the paper considers how these legislative schemes impact the participation rights of children and youth in British Columbia, and how the current and proposed legislative frameworks do or do not accord with the United Nations Convention on the Rights of the Child (UNCRC) (1989) and various other international treaties to which Canada is a signatory. This research project was funded by the Office

of the Representative for Children and Youth (RCY) of British Columbia.

This paper is part of a larger research project exploring the interplay between child capacity and child participation in legal proceedings in Canada with a focus on the experience of children in British Columbia. Capacity and participation are considered through the lens of the United Nations Convention on the Rights of the Child (UNCRC) (1989), to which Canada is a signatory, and the Canadian Charter of Rights and Freedoms.

C. Discussion

Capacity

> *"Taking away capacity was used as a method of care, and it is not a method of care. Working with someone's capacity is important, if someone would have worked with me, it would have been better. The Mental Health Act is overused. I do not think that I had a lack of capacity, but I needed someone to work with me. I had the capacity to make decisions, I was just making bad decisions."*
>
> Youth Engagement

Our rights tradition is premised on the notion of capacity; that is participation rights are granted to those deemed "capable" by decision-makers. If a child is deemed "incapable", they are effectively prevented from having their voices heard (Narbonne, Child Capacity and Participation in Family Law, 2025). It is important, therefore, to understand what capacity is and the distinction between capacity to make a decision versus the capacity to exercise one's legal rights and to participate in decision-making.

Capacity is an evolving, context-dependent trait, and varies depending upon the developmental stage of the child or youth in question. This is explored in more detail in the paper "Capacity: A Principled, Rights-Based Approach to Child Participation" (Bellano, 2024). Further explained in this paper is the distinction between cognitive, mental, or developmental capacity and legal capacity. A basic definition of cognitive capacity is the ability to understand a situation, and to make a decision based on an assessment of that situation that evidences a sound mind and decision-making process. Legal capacity refers more specifically to a person's legal right "to make a particular decision, engage in a particular undertaking, or have a particular status" (Anderson et al., 2023 p. 2), it is often considered together with legal personhood, which refers broadly to a person's capacity to have rights and duties within a legal system.

This distinction is particularly important in the context of mental health, because while a child or youth with a perceived or actual mental impairment may be deemed by decision-makers or care providers to lack mental capacity, their legal capacity—a protected, socio-legal status to be able to exercise and have protected their legal rights—remains intact. That is, their legal rights do not go away because of their perceived lack of cognitive or mental capacity.

Additionally, the dominant view of capacity as evolving, and the commentary of the UNCRC, make clear that even children and youth with mental illness can be considered capable. They still have a right to be heard in all matters affecting them (Article 12, UNCRC), including mental health proceedings such as a Mental Health Review Board hearing, and when decisions are being made about their care plans. Many of the young people with whom we spoke shared that when they were in the mental health system they did in fact have capacity to make decisions, but that the decisions they made were ones that adults deemed unacceptable or suspect due to their mental illness; or, alternatively, that they did not feel they had the capacity to make certain decisions, but that they still had the capacity to express themselves and sought to exercise their right to have their views heard.

Bach and Kerzner (2010) argue for supporting people with disabilities in their decision-making where appropriate, to ensure and protect their fundamental legal capacity (i.e. their protected social and legal status). We may extrapolate from this to youth and children generally as well—that is, an approach whereby a child's fundamental legal capacity is respected and their ability to exercise that capacity is supported as needed.

In a mental health care setting, care providers and decision-makers often deem that children or youth lack the mental capacity to, for example, make a decision, because of the impairment or mental health illness with which the individual is diagnosed. Additionally, mental health challenges and addictions "are often cyclical, meaning a person with a mental health disability or addiction may be capable at one time, but not another" (*K (Re)*, 2009; Ontario Human Rights Commission [ONHRC], 2014, p. 105). Irrespective of whether a child or youth is capable of making a decision that an adult decision-maker or care provider deems to be sound, they have not lost their rights to exercise and have protected their fundamental legal capacity, meaning their protected social and legal status.

Too often, children are described as not having capacity when their decisions do not align with those of adults in the mental health system. Many of the young people we interviewed reflected on the fact that their capacity was called into question precisely because their decisions were perceived to be wrong by professionals.

> *"It became reenforcing, I would ask a question and because I asked, I was told that I have no capacity. I had no say in I how I was perceived. Every time that I tried to say anything it was flipped against me. Capacity was a weapon used against me. 'They' kept saying that I had no capacity, and then I wasn't involved. They felt that I did not understand. I feel that it wasn't me not understanding, it was like they did not want to tell me. The onus should have been on them to explain to me what was going on, they didn't and then when I did not know, they said that I did not know."*
>
> Youth Engagement

The youth with whom we spoke also repeatedly spoke to the negative effects of decision-makers and care providers assuming they lacked capacity.

> *"When capacity is taken away, it starts a cycle, I felt like what I was doing was being controlled. The more my capacity was taken away, the less that I knew how to use capacity. I would have benefited if I spent less time in the hospital. I was living in an institution, and it warped my sense of life. My sense of capacity was hindered by being in the hospital. The Mental Health Act and capacity are different, there were times when I was under the Mental Health Act and I could make decisions and sometimes when I was not under the Mental Health Act, that I could not make decisions. There were times when I had capacity, but I could not make decisions because I was under the Mental Health Act. "*
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> Youth Engagement

Involuntary civil detention and personal liberty

The involuntary civil detention of children and youth engages their right to personal liberty. Personal liberty is distinct from the broadly understood right to liberty and encompasses the "freedom of bodily movement in the narrowest sense" (Nowak, 2020, p. 5). The distinction is not based upon a fundamental difference but can be demonstrated by the degree or intensity of detainment. The involuntary detention of children and youth interferes with their right to personal liberty by restricting their movement to institutions, or a "narrowly bounded location, which he or she cannot leave at will" (Nowak, 2020, p. 6).

These institutions by their very nature have certain characteristics, including "isolation, lack of control over one's life and decisions affecting it, blanket rules with little flexibility related to individual needs, lack of autonomy, separation from families and the wider community, and lack of bonding and affectionate relationships" (Nowak, 2020, p. 9).

The right to personal liberty is "one of the oldest human rights" (Nowak, 2020, p. 5) and falls within the overarching section 7 Charter right to life, liberty and security of the person. Specifically, liberty and security interests provide protection from physical detainment, personal autonomy, and the right to control bodily integrity without state interference.

Under the Charter, interference with a patient's liberty interests may be permitted where there are fair procedural protections for their section 7 rights. (*PS v Ontario* 2014 ONCA 900 ; *Fleming v Reid* [1991] OJ No. 1083 (CA)). "The greater the effect on the life of the individual by the decision, the greater the need for procedural protections to meet the common law duty of fairness and the requirements of fundaments justice" (*Suresh v. Canada (Minister of Citizenship and Immigration*, 2002 SCC 1 at para.118).

Doctrine of minimal limitation

The right to personal liberty is not an absolute right, however Article 37(b) of the UNCRC makes clear that children shall only be arrested, detained, or imprisoned as a measure of last resort and for the shortest appropriate period of time. States are required to apply non-custodial measures when dealing with children. In short, "children shall only be detained if all other non-custodial measures have failed or are expected to fail" (Nowak, 2020, p. 10).

This minimal limitation doctrine "applies in even stronger terms to children who are still in their formative stages of development" (Nowak, 2020, p 10). States have a positive obligation to ensure that children who have been involuntarily detained are still able to enjoy all other human and children's rights enshrined in the UNCRC, including "the rights to privacy, education, health care and protection from any form of violence, neglect and exploitation" (Nowak, 2020, p.10).

International Conventions and Declarations

> *"When you are in an involuntary admission, I think there's a limit on your preferences. You had the option to ask for a second opinion, to ask for a panel. Those were good things they had. But I learned a lot more about my rights after I was out of there. I learned from others. It would be nice in the institution where you are held against your will you are given an explanation of your rights."*
>
> Youth Engagement

Throughout our youth engagement, a consistent theme was that children in the mental health system were given limited opportunities to understand and enforce their legal rights. By silencing them and telling them that they didn't have capacity, rather than including their views in their treatment plans, the system prevented them from participating in decision-making. As the discussion below shows, all human beings have legal rights that must be respected, regardless of their personal circumstances. And unless we recognize and support a child's capacity to participate in decision making, we will risk harm to that child.

United Nations Convention on the Rights of the Child (1989)

The UNCRC explicitly defines a "child" as every human being below the age of eighteen years. This definition serves as the foundation for the entire Convention, emphasizing that children are individuals entitled to distinct rights and protections, including those related to mental health and liberty (UNCRC Article 1).

Article 37 of the UNCRC is of particular significance when considering the involuntary civil detention of children. It protects the child from arbitrary detention, protects the child's legal rights while they are in detention, and unqualifiedly asserts that a child

should only be detained as a last resort and for the shortest appropriate period of time. Where a child has been detained, they have the right to legal assistance to challenge that detention. Nowak asserts that the phrase "shortest appropriate period of time, calls for periodic judicial review of every deprivation of liberty of children" (Nowak, 2020, p. 11).

In circumstances where a child has been detained in conformity with the law, that child is entitled to be "treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances" (Article 37(c)). This respect for the right to humanity and the inherent dignity of the person is particularly relevant in the mental health context.

When a child has been deprived of their liberty, Article 37(d) provides the child with the right to legal assistance to challenge the legality of their deprivation. This right applies irrespective of the reason for the deprivation and includes access to habeas corpus proceedings. As Nowak (2020) explains,

> Every child deprived of liberty, for whatever reason, shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action (p.11).

United Nations Declaration on the Rights of Indigenous Peoples (2007)

Indigenous children and youth in British Columbia have unique rights in the context of mental health matters, particularly in light of the province's commitment to the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) through legislation in 2019 (Legislative Assembly of British Columbia, 2019).

I. Indigenous participation in decision-making

One of the core principles of UNDRIP is that Indigenous peoples, including children and youth, have the right to participate in decision-making in all matters affecting their rights. This includes decisions related to their mental health care and involuntary civil detention. The recognition of this right signifies a commitment to involving Indigenous children and youth in decisions that directly impact their lives.

II. Access to traditional medicines and health practices (Article 24(1))

Article 24(1) of UNDRIP specifically affirms the right of Indigenous peoples to their traditional medicines and the preservation of their health practices, including the conservation of vital medicinal plants, animals, and minerals. For Indigenous children and youth, this right recognizes the value of their cultural and traditional healing

practices in maintaining their mental and emotional well-being. Article 24(2) confirms their "equal right to the enjoyment of the highest attainable standard of physical and mental health".

Convention on the Rights of Persons with Disabilities (2006)

I. Deprivation of liberty and disability rights

The UN Special Rapporteur on the Rights of Persons with Disabilities has expressed concerns about the British Columbia *Mental Health Act's* broad criteria for involuntary admissions and the potential for forced treatments, including medication and electroconvulsive therapy, without free and informed consent (RCY, 2021, p. 114). Under Article 14(1)(b) of the Convention on the Rights of Persons with Disabilities (CRPD), the existence of a disability shall in no case justify a deprivation of liberty. This principle is particularly significant for children with disabilities who may be at risk of being placed in special institutions. Under Article 14(2) States Parties "shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation".

II. Best interests provision (UNCRC 3(1)) and last resort principle (Article 37(b))

To fully appreciate the rights of children with disabilities in the context of involuntary civil detention, it is essential to interpret Article 14 of the CRPD in conjunction with the UNCRC. UNCRC Article 3(1) emphasizes the best interests of the child as a primary consideration in all actions concerning children. Similarly, UNCRC Article 37(b) underscores the principle of using deprivation of liberty as a measure of last resort. When applied to children with disabilities, these provisions highlight the need to prioritize their well-being and consider alternatives to involuntary detention.

III. Legal capacity and equality before the law

CRPD Article 12 reaffirms the rights of persons with disabilities, including children under 16 with disabilities, to recognition as persons before the law. Article 12(2) says that "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life." This provision explicitly rejects any restrictions on legal capacity solely based on disability.

IV. Access to support and safeguards

CRPD Article 12(3) further emphasizes the need for appropriate measures to provide access to the support that persons with disabilities may require in exercising their legal capacity. Children with disabilities may need additional support to make informed decisions about their mental health care.

"Canada interprets Article 12 as securing supported decision-making as a right while ensuring that availing oneself of supports does not undermine his/her full legal capacity" (Bach and Kerzner, 2010, p 29).

V. Safeguards to prevent abuse

CRPD Article 12(4) outlines a comprehensive set of safeguards to protect the rights and interests of persons with disabilities, including children, in the exercise of their legal capacity. These safeguards include ensuring that measures respect the person's rights, will, and preferences, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible, and are subject to regular review by competent, independent, and impartial authorities or judicial bodies.

Article 12(4) specifically provides the following:

> States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests (CRPD, 2006).

In the context of mental health and involuntary civil detention, international disability rights standards—as enshrined in the CRPD—provide a robust framework for the protection of the legal capacity and rights of children with disabilities. These standards emphasize the importance of avoiding deprivation of liberty based on disability, prioritizing the best interests of the child, and ensuring equal access to legal capacity. Additionally, the safeguards outlined in Article 12(4) of the CRPD underscore the need for careful and individualized consideration of children's rights, will, and preferences in mental health decisions.

International Covenant on Civil and Political Rights (1966)

Article 9 of the ICCPR prohibits arbitrary and unlawful arrest and detention, while granting states some discretion in defining their laws related to deprivations of personal liberty.

In accordance with Article 10(1) ICCPR, persons deprived of liberty, including children, must be treated with humanity and with respect for the inherent dignity of the human person. UN General Comment No. 8 (1982) emphasizes that Article 9 of the ICCPR is applicable to "all deprivations of liberty," including those related to mental illness

(para. 1). In UN General Comment No. 35 (2014) the Committee again confirmed that "deprivation of liberty" includes involuntary hospitalization (para. 5). This broad interpretation ensures that the rights and protections under the ICCPR extend to children facing involuntary detention for mental health reasons. Read together, Articles 9 and 10 of the ICCPR reflect the need for careful consideration and protection of children's rights in all institutional settings, including mental health settings, and highlight the importance of providing compassionate and dignified care to children subjected to involuntary civil detention for mental health reasons.

Rules for the Protection of Juveniles Deprived of their Liberty (1990) (Havana Rules)

Article 11(b) of the Havana Rules defines deprivation of liberty as "any form of detention or imprisonment or the placement of a person in a public or private custodial setting, from which the person is not permitted to leave at will, by order of any judicial, administrative or other public authority." Under Article 13, the General Assembly confirms that children who are deprived of their liberty are nonetheless entitled to their "civil, economic, political, social [and] cultural rights."

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World Health Organization (WHO) Guidance on community mental health services ("WHO Guidance")

The WHO Guidance, published in 2021, promotes a person-centered and rights-based approach to mental health care.

A. Person-centered approaches

The WHO Guidance emphasizes the importance of person-centered approaches in mental health services. These approaches prioritize the individual's voice, preferences, and agency in decisions about their care. When applied to children in mental health settings, it highlights the need to engage them actively in decisions concerning their treatment, while considering their evolving capacity and best interests.

B. Rights-based approaches

The WHO Guidance underscores the significance of rights-based approaches in mental health care. This entails recognizing and upholding the rights of children, including their right to personal liberty, dignity, and informed consent. Rights-based approaches prioritize the protection of these rights and emphasize the need to minimize restrictions on personal liberty unless it is genuinely in the child's best interests.

Civil detention in Canada

Civil detention in Canada is a legal process that allows individuals who have been diagnosed with mental illness and who meet certain criteria to be temporarily admitted to designated psychiatric facilities for medical treatment, care, or supervision. Jurisdiction over mental health law falls within provincial and territorial domains, resulting in variations in legislation and procedures across different regions of Canada. According to Anand, "civil commitment represents the most significant deprivation of liberty without judicial process that is sanctioned by society today" (Anand, 1979, p. 251).

I. Civil detention framework overview

Civil detention involves the temporary confinement of individuals, with the well-being of the person detained and the safety of others being the primary concerns. The process can be initiated voluntarily or involuntarily and is carried out through legal procedures (Ambrosini & Jonas, 2013; Winick, 2005).

Ambrosini & Jonas (2013) assert that "following due process is essential to ensure that individuals' rights will be respected in civil commitment procedures" (p. 1030). They note that the fact that a person has been diagnosed with a mental illness does not automatically lead to the conclusion that they are unable to make "capable and autonomous choices" (p. 1029). The impact on those who are involuntarily detained can include "feelings of being unduly detained and isolated from the greater community"

(p. 1029). It is important, therefore, to ensure that a person's legal rights are respected throughout the civil detention process.

II. Balancing liberty and treatment

Civil detention engages several key principles:

A. Least restrictive alternative principle

As mentioned previously, involuntary civil detention should be a last resort. It is only employed when a patient refuses voluntary admission and other admission criteria have been satisfied. These criteria vary across Canadian jurisdictions from a "perceived danger standard of physical or bodily harm" to a "broader concept of dangerousness, that includes the risk of serious mental, emotional, social or financial harm" (Ambrosini & Jonas, 2013, p. 1037). For example, section 22(1)(3)(c) of BC's *Mental Health Act* specifies the need for involuntary admission, among other criteria, "to prevent the person's or patient's substantial mental or physical deterioration or for the protection of the person or patient or the protection of others." The notion of protection is broadly encompassing and "necessarily involves the notion of harm" (*McCorkell v. Riverview Hospital* [1993] BCJ No. 1518, p. 45).

The least restrictive alternative principle is embedded in most provincial and territorial mental health acts. It dictates that all reasonable alternatives must be explored before admitting someone to a psychiatric hospital, prioritizing the least restrictive form of care. Notably, BC's *Mental Health Act* does not explicitly reference this principle (Ambrosini & Jonas, 2013).

B. Canadian *Charter of Rights and Freedoms* (1982)

Mental health legislation must conform to the Canadian *Charter of Rights and Freedoms*. This includes rights such as "the right to counsel, to remain silent, to communicate with others, to receive visitors, to object to certain forms of seclusion and restraint, to request reasonable treatment, to refuse unreasonable treatment, to declare treatment preferences, and to access medical records" (Ambrosini & Joncas, 2013, p. 1031; Winick, 2005).

C. Legal protections

While some protections under the Canadian *Charter of Rights and Freedoms* do apply to those detained under the *Mental Health Act,* they do not have the same effect as those detained for criminal purposes (see CB v. Sawadsky, 2006).

III. Determining capacity

A significant challenge in civil detention is assessing the capacity or incapacity of individuals with mental illness. Different definitions of mental capacity exist across

Canadian jurisdictions, complicating the determination process. As Bach and Kerzner note, "there are as many different operational definitions of mental (in)capacity as there are jurisdictions" (2010, p. 18).

The Supreme Court of Canada (SCC) case *Starson v. Swayze* (2003 SCJ No. 33) highlights the delicate balance between autonomy and effective medical treatment. While autonomy generally prevails in medical decision-making, the law may intervene when an individual lacks the capacity to make decisions about their care, or where their decisions will cause harm to others. In *Starson v. Swayze*, the Court confirmed that "the right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy. This right is equally important in the context of treatment for mental illness" (para. 75). The court acknowledged that "in some instances the well-being of patients who lack the capacity to make medical decisions depends upon state intervention" (para. 75). Citing *Re Koch*, Justice Major explained,

> The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake (para. 76).

IV. The mature minor principle

The mature minor principle recognizes that children, although not endowed with the same decision-making rights as adults, possess a degree of decision-making autonomy reflective of their "evolving intelligence and understanding" (*A.C. v. Manitoba (Director of Child and Family Services)*, [2009] 2 SCR 181, para. 46).

This principle provides that children have the capacity to give informed consent to medical treatment when they demonstrate the required level of maturity. This principle aligns with the recognition that youth should not automatically forfeit their right to make decisions regarding their medical treatment solely based on their age. Instead, the right to make such decisions should vary in accordance with the young person's level of maturity.

A. Informed consent

According to this principle, a child who has been assessed and determined to be a mature minor possesses the capacity to make decisions about their medical treatment. This includes the right to give informed consent to treatment, or to decline to consent to treatment, subject to the condition that they receive comprehensive information concerning the associated risks and available options. This ensures that the consent given is genuinely informed consent, mirroring the standards expected of adults in analogous situations.

B. Extraordinary circumstances

The mature minor principle does not categorically prevent the court from intervening

in situations where a child's life is in jeopardy. In such cases, the court may exercise its parens patriae jurisdiction, prioritizing the child's welfare while affording greater weight to the child's perspectives as their maturity level increases. As the Court explains in *A.C. v. Manitoba (Director of Child and Family Services)*,

> […][M]ature minor status at common law will not necessarily prevent the court from overriding that child's wishes in situations where the child's life is threatened. In such cases, the court may exercise its parens patriae jurisdiction to authorize treatment based on an assessment of what would be most conducive to the child's welfare, with the child's views carrying increasing weight in the analysis as his or her maturity increases (2009, para. 56).

While health care practitioners should first determine a child's capacity to make decisions about their mental health treatment, most of the young people with whom we spoke were simply told that they had no capacity rather than being assessed on a case-by-case basis.

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Civil detention in British Columbia

Notably, BC stands out as the only Canadian province where capable, involuntary patients lack the right to make psychiatric treatment decisions, setting it apart from Ontario and Alberta, which offer more safeguards for patients (CLAS, 2017, p. 77). A comparative analysis of BC's approach to civil detention reveals variations and disparities in patient rights' protection across provinces.

A 2017 Community Legal Assistance Society report concluded that "BC is considered the most regressive jurisdiction in Canada for mental health detention and involuntary psychiatric treatment" (p. 6). Further, the Ministry of Health reported to RCY that "Indigenous children and youth are disproportionately represented in involuntary detentions under the Mental Health Act" (RCY, 2021, p. 23).

Mental Health Act (1996) and Mental Health Regulation (1999)

The *Mental Health Act* and *Mental Health Regulation* provide the legislative authority for civil detention in British Columbia. The traditional purpose of the *Mental Health Act* and *Mental Health Regulation* in BC, as interpreted in *McCorknell v Riverview* Hospital, is "the treatment of the mentally disordered who need protection and care in a provincial psychiatric hospital" (p.41). Section 1 of the *Mental Health Act* defines a person with a mental disorder as someone with "a disorder of the mind that requires treatment, [whose disorder] seriously impairs their ability to [...] react appropriately to their environment or [...] associate with others."

While the traditional purpose has been characterized as "protective" and "remedial," recent commentary and cases have affirmed that these purposes must be balanced with the principle of autonomy and specifically the right to medical self-determination (Dhand and Joffee, (2020), Starson v Swayze (2003)). The dual objectives of the *Mental Health Act* and *Mental Health Regulation* in British Columbia can be understood to support child capacity and participatory rights in mental health care, as well as stabilization of those with mental disorders.

I. Involuntary admission process

Section 22 of the *Mental Health Act* governs involuntary admissions. Certification under the *Mental Health Act* requires one physician or nurse practitioner to complete a certificate for the director to detain a patient for up to 48 hours, and a second physician to complete a certificate to continue detention for up to one month. After this, certification must be renewed for further detention. (It can initially be renewed for up to 3 additional months, with any further extensions to detention being for an additional 6 months). In light of the importance of detention being for the shortest period of time possible, coupled with what we know about the negative impact of prolonged detention on children in particular, it is concerning that there are no requirements for shorter times between reviews of a young person's detention under the mental health legislation.

The medical certificate must confirm four criteria are met:

a. The physician has examined the patient and opines that the patient is a person with a mental disorder;
b. The physician has specified reasons for their opinion;
c. The person requires treatment by a designated facility;
d. The person requires care, supervision and control to prevent substantial mental or physical deterioration, or for their protection or that of others; and
e. The person cannot suitably be admitted as a voluntary patient.

II. Consent and treatment

> *"I really didn't feel valued, it is hard to think of a time when I felt valued. My opinion on my treatment was not valued, there were times when I was working with great people but still my opinion was still not valued. Even when I was not under the mental health, I was treated like I was. Nothing that I had to say mattered..."*
>
> Youth Engagement

Once a person has been involuntarily detained under the *Mental Health Act*, a care provider is generally no longer required to obtain their consent to treatment (Standards for Operators and Directors of Designated Mental Health Facilities, 2020, p. 20). Under s.31 of the *Mental Health Act*, an involuntary patient is "deemed" to have consented to treatment regardless of their capacity to decline treatment.

This raises important ethical considerations surrounding capacity and the participatory rights of children.

III. Safeguards for children admitted under section 22 of the Mental Health Act

> *"In the mental health system, I was told that I could not discern between right and wrong. I was given involuntary treatment. I had things done to me, rather than with me, or decided by me"*
>
> Youth Engagement

The Canadian Charter of Rights and Freedoms (s. 7 and s. 10), the *Mental Health Act*, and *Mental Health Regulation* provide safeguards which protect the participatory rights of children who are involuntarily admitted.

Involuntary patients must be notified of:

a. The facility's name and location (s. 34(2));
b. Their rights under s. 10 of the Charter including seeking legal counsel (s. 34(2)(b));

c. The reasons for their detention;
d. The right to challenge the detention through an independent panel or court;
e. The right to a second medical opinion on authorized treatment (s. 31(2)).

Additionally, close relatives must be notified of the patient's circumstances and facilities must complete specific forms explaining these patient rights (see *Mental Health Regulation*, RCY Report, p. 19).

IV. Voluntary admission for children 16 and older

Youth aged 16 or older may be voluntarily admitted to a mental health facility if examined by a physician and requesting admission. A "voluntary" patient who is 16 or older must be discharged at the patient's request (*Mental Health Act*, s. 20(6)(b)).

V. Children under 16 admitted Under section 20 of the Mental Health Act

A. "Voluntary" admission

> *"There was a time when I was being taken to the psych ward and I had no idea that that is what [my guardian] was doing, I had no idea what was happening. I did not know why I was at [the hospital], no one talked to me."*
>
> Youth Engagement

A child under 16 is deemed to be "voluntarily admitted" if the child's parent or guardian requests that they be admitted, and the facility director is satisfied that the examining physician or nurse practitioner believes that the child has a mental disorder. This is considered "voluntary" because the *Mental Health Act* recognizes the legal rights of parents to make decisions on behalf of their children; children, however, may feel quite differently. Although the mature minor doctrine dictates that the capacity of a child under 16 to consent to or decline treatment must be considered, the *Mental Health Act* has not been updated to ensure that it conforms with BC's constitutional obligations.

B. Safeguards for admission

On admission, a child must be informed of the reason for their admission and notified of their rights set out in Section 10 of the Canadian *Charter of Rights and Freedoms* to talk to a lawyer and to challenge the detention before an independent hearing by the Mental Health Review Board or court (*Mental Health Act*, 1996, s. 34.1). Under section 7 of the *Charter*, a child has the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

The child must be examined within each of the first two months after the date of admission, within three months of the second examination and, after that, within six-month periods. If the physician concludes at any of these examinations that the child

does not have a mental disorder, the child must be discharged (*Mental Health Act*, 1996, s. 20). The child must also be discharged at the request of the parent or guardian, unless the facility director is satisfied that the child would meet all the conditions for involuntary detention (*Mental Health Act*, 1996, s. 20).

C. Consent and treatment for mature minors who are voluntarily admitted

Physicians have no legal right to treat a child even if they consider treatment to be in the child's best interests; instead, they must seek parental consent for treatment. However, if the child is considered a mature minor, the parents cannot override the views of the child and ignore their decision-making capacity. Only a court order may authorize treatment against the child's will (*A.C. v. Manitoba (Director of Child and Family Services)*).

Infants Act (1996)

The *Infants Act* allows a child who has been assessed as being a mature minor (a child or youth capable of making their own decisions) to consent to treatment when:

- A health care provider has explained the nature, consequences, benefits and risks of the treatment;
- The health care provider is satisfied that the child understands;
- And the health care provider has concluded that the treatment is in the child's best interests.

Section 17 allows a mature minor to provide consent for treatment, and inversely a physician can obtain this consent to provide treatment. Notably, the provision does not allow for physicians to treat a mature minors who has refused to provide their consent (RCY Report, p. 51).

Notwithstanding, as noted in *A.C. v. Manitoba (Director of Child and Family Services),* a Court may overrule a mature minor's decision respecting treatment if the Court determines that the decision is not in a child's best interests.

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VI. Capacity

> *"I am grateful for the mental health act because it did save my life, but **at times my capacity was judged as being lower than it was**. If I had been able to make more decisions the road would have been less traumatic."*
>
> Youth Engagement (emphasis added)

The Representative for Children and Youth (RCY) reports that children and youth require increased protection in the mental health context, as their "capacity to understand and exercise their rights may be diminished by their mental state at the time of admission" (2021, p. 5).

Some authors have questioned whether physicians are appropriately trained to make capacity assessments, particularly with respect to children and youth who are struggling with addiction.

> Physicians receive little education about addiction and less about assessing capacity. Minors struggling with addiction, whose main impairment is an ability to say no to substance use (or yes to treatment) are not being assessed to determine if they actually have capacity to refuse treatment (Hamilton et al., 2020, p. E121).

In *Starson v. Swayze*, the Supreme Court of Canada held that:

> While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental "condition", the patient must be able to acknowledge the possibility that he is affected by that condition…As a result, a patient is not required to describe his mental condition as an "illness", or to otherwise characterize the condition in negative terms… [N]onetheless, if the patient's condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision (2003, para.79).

Safe Care Act (2024)

The *Safe Care Act* (Bill M202 - 2024) is a private member's bill that would permit the involuntary confinement of children and youth with severe substance misuse issues, or those being sexually exploited. This proposed legislation would establish a legal process that would enable a court to authorize the placement of these children and youth in a safe setting for a period of time in order to stabilize their emotional and physical health while allowing time to assess their needs and develop a community plan.

Safe care raises several concerns in terms of efficacy and the potential for further rights violations. In short, "existing evidence suggests that mandatory addiction treatment

does not lead to significant improvements in substance use outcomes and can be destabilizing, increasing the risk of subsequent overdose" and "coercive approaches to substance use risks undermining trust and our ability to connect youth who live with intergenerational, childhood or institutional trauma with the health and social services they need most" (Pilarinos et al., 2018, p. E1219).

There is also concern regarding assessment of capacity, given that addiction tends to by its nature affect individuals' autonomy and ability to make decisions:

> Further, addiction impairs autonomy. Autonomy is typically defined as self-determination free from both controlling interferences by others and personal limitations preventing meaningful choice (e.g., inadequate understanding or faulty reasoning). If we know anything about addiction at all, it is that it impairs autonomy in some way. Loss of control—in some manner and to some degree—over drug-seeking and consuming behavior is a defining feature of addiction, as it is popularly and scientifically conceived (Hamilton et al., 2020, p. E121).

Thus, it is important to acknowledge the fact that children and youth in these situations may lack or have adversely impacted their capacity to refuse treatment.

> The issue of involuntary treatment concerns the *capacity of youth to refuse treatment*. A major barrier to the treatment of youth with substance use disorder and concurrent mental health conditions is their inability to understand their substance use is problematic (emphasis added, Hamilton et. al, 2020, p. E121).

VII. Rights notification

A. Legal requirements for rights notification

> *"There were times when I was made aware of my rights, but in emergency situations I was not made aware. Consistently, I was not informed. I felt like I was being told that I didn't have the capacity, in moments of intense crisis, I was not made aware.* ***I think that my rights should have been explained to me as soon as I could understand****. I was definitely not informed as things were happening, especially in moments of crisis."*
>
> Youth Engagement (emphasis added)

Rights notification is one of the "most important procedural safeguards in the *Mental Health Act*" (RCY, 2021, p. 51). When children are notified of their participatory rights in the mental health care context, this empowers an understanding of their legal capacity to make decisions when they have been detained. Yet, the BC Ombudsperson has identified systemic failures in terms of BC's rights notification generally and in relation to detained children—being "cause for significant alarm" (RCY, 2021, p. 48).

At the time of involuntary admission and at other critical stages such as detention

renewal, detention facilities are legally required to provide patients with information about their rights under the Canadian *Charter of Rights and Freedoms* and the *Mental Health Act* (s. 34 MHA).

The patient must be informed of their right to:

1. The hospital's name and location;
2. Reasons for the admission;
3. Consult a lawyer or advocate promptly;
4. Regular examination by a doctor to determine if involuntary detention remains necessary;
5. Apply to the Mental Health Review Board for a hearing to determine the potential for discharge;
6. Make a habeas corpus application to have the legality of the detention determined by the court;
7. Appeal the doctor's decision to detain you in the hospital; and
8. Request a second medical opinion on the appropriateness of treatment (RCY, 2021, p. 46).

Children under age 16, admitted as a voluntary patient, following a parent or guardian's request must also be provided with rights information (s.34.1, s.34.2 MHA). In addition, if a patient "does not, or appears not to, understand the rights information upon admission, it must be repeated as soon as the person is capable of understanding the content" and a second copy of the forms explaining their rights must be provided (Ministry of Health, Guide to the Mental Health Act, 2005, p. 41).

The opportunity to receive rights advice, can be distinguished from the rights notification process which provides only rights information. In practice, the same health care providers that administer treatment to patients will provide them with blanket information about patient rights upon admission or detention renewal (CLAS, 2017, p. 59). Rights advice goes a step further. It typically involves youth meeting with an independent adviser, who can explain their rights, answer questions, and provide the options on possible courses of action. Only a lawyer can provide legal advice regarding the best course of action in a patient's personal circumstances.

As important as the rights notification process is to children and youth, the Representative for Children and Youth states that children face "distinct vulnerabilities" and thus require developmentally appropriate and accessible rights advice (RCY, 2021, p. 48).

As RCY explains,

> Knowing what their rights are and how they apply is an important step toward a young person's participation in the important decisions made about them, particularly decisions that affect their bodily integrity and personal autonomy. In order to access their rights, young people must be

able to contact legal counsel or another advocate, requiring access to a telephone or computer and the privacy to use them (2021, p. 48).

Mental Health Amendment Act (2022)

> *"There were no legal advocates, I was not told I had rights.* ***The biggest issue was lack of knowledge****. I had no idea what the consequences were, I was in trouble for using the phone to call my parents, and then the phone rights were taken from me, so I couldn't even call my friends. There was* ***no relatability to youth.****"*
>
> Youth Engagement (emphasis added)

The *Mental Health Amendment Act* allows the government to establish an independent rights-advice service for those who have been detained under the *Mental Health Act* and are being administered treatment involuntarily (s. 22) and those under 16 years old who have been "voluntarily" admitted following a parental request (s. 20) (IRAS, undated; British Columbia Ombudsperson, 2022). The bill was introduced as a private member bill and underwent its first reading on April 28, 2022 as Bill 23 – 2022: Mental Health Amendment Act, 2022. It proceeded through further readings and the committee process, and received Royal Assent on June 2, 2022.

The rights-advice framework developed by these amendments, aims to assist children and youth by providing them information about their rights, and how they may exercise or seek to have these rights respected. Accordingly, the newly established Independent Rights Advice Service provides services complementary to the rights notification process, providing a meaningful opportunity to explain patient rights, options, and information about how to connect with a lawyer.

It is yet unclear whether the current *Mental Health Amendment Act* may positively impact children and youth, and whether the Independent Rights Advice Service, will be required to adapt in an appropriate way to the children and youth whom it serves. By this, we mean that any rights-advice service should use language that is appropriate to each child. It is critical that this information be provided in a manner that children and youth may understand and requires adaptation to each individual child, in accordance with their own evolving level of capacity. It is important to note that Independent Rights Advisors are not lawyers. They cannot provide legal advice on what children "should" do, nor provide representation at review hearings or court proceedings (Independent Rights Advice Service, undated). This limits the guidance and support that rights advisors can provide to children navigating mental health detention. Connecting children and youth with lawyers ensures that children are aware of their participatory rights and able to enforce those rights.

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Impact of institutionalization and civil detention on children and youth

UN Global Study on Children Deprived of Liberty (2019) by Manfred Nowak

The goal of this study, conducted by Manfred Nowak—former UN Special Rapporteur on Torture—was to review settings of deprivation of liberty for which states bear direct or indirect responsibility—i.e., any form of institution under some control of state authority. It provides a detailed legal analysis of the principles of "measure of last resort" and "shortest appropriate period of time" in respect of the detention and imprisonment of children.

In short and in very strong language, Nowak asserts that *children deprived of liberty are in effect deprived of their childhood*—the impacts of detention, even if of therapeutic benefit, can be drastically harmful to children and youth. These findings, which include the negative impacts of mental health detention, are supported by our youth engagement.

I. As reported by children

Globally, the rights of children who have been detained or institutionalized are not protected. Many children who were interviewed in Nowak's study felt that in decision-making, it was difficult for their voice to be heard or taken seriously. Many reported that they experienced isolation, loneliness, fear, and felt unsafe after experiencing physical and emotional harm during detention. Many also reported that they also experienced

discrimination based on their ethnicity, economic status, (dis)ability, sex, or sexual orientation (Nowak, 2020, pp. 18-19).

Some children reported they were denied information about their detention. For example, they were not informed about how long they would be detained or what the next steps were in the process. Some children received information, but without resources to ensure their understanding. (Nowak, 2020, p. 19).

Many children had difficulties being able to have contact with their families. They reported that they were able to receive visits for only short durations, or only when they "behaved well." Children with families who lived far from their detention facility, experienced further challenges in having family contact (Nowak, 2020, p. 19).

Many children also reported that they struggled to find resources to support them with the process of leaving detention facilities and felt unprepared to return to their communities (Nowak, 2020, p. 19).

II. Health and developmental impacts of deprivation of liberty

Deprivation of liberty—even if for ostensibly therapeutic reasons—impacts the health and development of children in critical ways. There are two primary reasons that deprivation of liberty negatively impacts children's health:

> (1) It is "inherently distressing and potentially traumatic," thus impacting children's mental health (potentially, exacerbating any mental health crisis that led to mental health detention); and
>
> (2) Detention conditions which restrict interactions and movement can impact physical wellness and cognitive development, and receiving medication can have negative and long-term effects. When children are institutionalized, especially early in life, this hinders growth of their physical and mental health, and cognitive skills (Nowak, 2020, pp. 21-22).

It is important to recognize that "deprivation of liberty might be associated with improvements in some aspects of health at least for some children" (Nowak, 2020, p.22) For example, deprivation of liberty of children for therapeutic reasons where appropriate psychiatric treatment in a least restrictive environment can be beneficial. Nowak cautions, however, that "evidence suggests that therapeutic institutions can also have negative health consequences, such as anxiety and depression" (Nowak, 2020, p. 22).

III. Detention of children with disabilities

Children with disabilities are detained to provide them with access to services that should be delivered in the community. Due to ongoing stigma and misconceptions surrounding their disabilities these children experience unique deprivations of liberty (Nowak, 2020, p. 24).

As Nowak explains,

> On the basis of the existence or the presumption of having an impairment, these children are systematically placed in institutions, involuntarily [detained in] mental health facilities, detained in forensic facilities or detained at home and other community settings, where they are confined in a particular space or room often in deplorable conditions...[and] these practices occur across a range of states that differ in economic and social status or legal tradition (2020, p. 24).

The consequence of this is that *children with disabilities are significantly overrepresented in mainstream settings of deprivation of liberty* (emphasis added). It is estimated that one in three children in institutions is a child with a disability (Nowak, 2020, p. 24).

Children with disabilities—particularly female children—are at a heightened risk of harm. Often, too, children and youth with physical or mental health disabilities, are erroneously assumed to lack capacity to make and implement decisions (ONHRC, 2014).

III. Gender and sexuality-related disparities

Nowak's research also found that there are significant gender disparities in children who have been detained. Globally, 94% of all detained children identify or are identified as boys. Although boys are overrepresented in detention, children identified as girls are more likely to experience gender-based discrimination.

Children and youth identifying as LGBTQ+ are likewise globally overrepresented in health-related institutions (Nowak, 2020 p. 28).

Engagement with children and youth in British Columbia

> *"The staff didn't see a young person suffering in pain, they saw an addict. I've heard many similar stories from those in my life who've been through or are currently struggling from addictions, It's heartbreaking and frightening. We are human beings who deserve the trust and belief to be taken seriously."*
>
> Youth Engagement

The Society for Children and Youth of BC's (SCY) engagement with children and youth in BC emphasized many of the same points as articulated by Manfred Nowak in the UN Global Study on Children Deprived of Liberty. Hearing from the young people directly, we are left with a disturbing image of the reality of their lived experiences within British Columbia's mental health system.

Young people consistently reported ill-effects of their treatment during mental health detention or stabilization. At best, their ability to meaningfully participate in their

mental health care was limited; more often their capacity to both make decisions and participate was ignored by decision-makers and care providers.

The children and youth shared that they were often not told what was happening, nor why. They were often not informed of their rights, for example to consult with legal counsel. Young people shared that they were ignored; that their voices were not heard; that despite numerous attempts, care providers would not consider their views or preferences. Many reported that once they were deemed to be a person with a mental disorder and admitted to a mental health facility, this determination was used as a basis for care providers and decision-makers to make decisions for children and youth without any regard for their capacity.

I. Disregard for capacity and exclusion from decision-making

> *"I think that having my opinion valued would have helped in general. I think it would have helped me process all the things going on externally. It would have helped me make treatment decisions differently, I would not have had to go against it. If I had more of a role, I would not have ended up in such emotional distressing situations."*
>
> Youth Engagement

One of the most consistent themes among the youth with whom we spoke or surveyed pertained to their decision-making capacity and their awareness that while mental impairments or illness may impact their capacity, it does not mean that it is entirely lacking.

Specifically, our participants shared the following as part of their experience within the mental health system:

- The recognition that individuals with mental illness may not always make good decisions, but their capacity should not be taken away entirely.
- The importance of working with a person's capacity rather than assuming they lack it.
- Acknowledgment that involuntary mental health treatment should be used sparingly and in select cases.
- The potential negative cycle that occurs when a person's capacity is repeatedly taken away.

The young people expressed how their exclusion from decision-making left them feeling frustrated and powerless. Few shared positive experiences of being heard, but those who did reflected on how empowering this was and how it helped them feel respected and valued.

Direct quotes from children and youth highlight the importance of being heard and involved in their care:

- *"In the hospital, I was never part of the meetings about me. I have pulled my records from the hospital. There were people making decisions about me that I have never met. I was always meeting with the residents, and it seemed like they were incompetent. The MRP never charted on me, only the resident did. There was no reasoning given to me, why I could not go to school. There was no de-briefing, no eye contact. It was very top down, very authoritative. No one checked in with me about how I was feeling. The system decided I was a manipulator, the health care system, MCFD."*
- *"In psychiatry you lose an element of your humanity, and you don't get to make decisions. They try to give you the illusion of choice, but you learn quickly that you don't get to make decisions."*
- *"I had one nurse who listened to me, and I don't know how I would have survived without her. There is such a safety element with capacity, as a youth you don't know if you can trust. You have been hurt by the system before, so you don't know if you can even say anything."*
- *"During all of my treatment, what I wanted, what I had to say was never taken into consideration. Perhaps superficially my opinion was taken into consideration when a professional needed to validate something. There were times when I had questions they were answered, yet other times they were never answered. At times I was told that if I knew what was going it would cause me to deteriorate, which I never understood. I always want to know what is going on, I am someone that needs know all the information, and it never happened. I felt like capacity was being set up, I was never given the chance to demonstrate that I have capacity, and then it is used as proof that I can't make good, safe decisions. Professionals were never comfortable giving me decision making power, but I was never given the chance."*

II. Lack of transparency and information-sharing

Another key theme that emerged from our youth engagement related to the lack of information-sharing and adequate communication between children and youth and relevant decision-makers and care providers.

Young people spoke about:

- Inadequate communication and lack of information-sharing during moments of crisis.
- The need for timely and comprehensive explanations of rights, especially during emergency situations.
- Instances where individuals were not informed about their whereabouts and the reasons behind their transfers between hospitals.
- Lack of legal advocacy and understanding of their rights.

> *"In [the institution] the whole thing is so strange, there were weird inter hospital transfers. They would move me around from hospital to hospital. I was always scared. I was scared to be shipped all over the place, I would ask why and no one would tell me. I would try to go to other hospitals, because they felt safer but they would never let me go. I was never told why, it was really weird. I could not make sense of it, they would send me to another hospital. They never told me why, I did not want to move. It was strange. I would present at one hospital, and then be moved. They fail to give you information about what certification means, they sugar coat it when you are a youth. As a youth you didn't even know that you were certified. I have no memory of being told what it meant. I was stripped of my rights and at the same time I did not know what my rights were. It was so muddled. You get made to be more ill because of what they are doing to you."*
>
> Youth Engagement

III. Emotional isolation and disconnection from family

The children and youth reported that while in detention under the *Mental Health Act* (1996), they were often isolated, afraid, and removed from friends and family. Many talked about not being able to contact or see family members, and said that their families were not told what was happening to them.

> *"I was told that my parents could not see me. A physiatrist told me I couldn't see them, they were trying hard to help, I was told that I could never see them. I was screaming and crying to see them, I told my doctors I wanted to see them, and I was never allowed to see them. I was treated like a mini adult but with no voice."*
>
> *""I was never told why my parents were not coming. My parents were asking about my care, and they were told that they were bad for me and they did not know how to communicate with the hospital. My parents were never told the legal implications, they were never informed, they were never told what their role was. They had no awareness of the Mental Health Act, they didn't understand certification. At the time there were no resources for them. We did not sit down and have anything explained to me, neither did my parents."*
>
> Youth Engagement

IV. Undermined consent and bodily autonomy in medical treatment

Young people reported that they were medicated without being informed of the name or type of medication, or why it was required. They expressed frustration at not being included in meetings and decisions about their treatment. Many youth described experiencing adverse effects from being medicated and receiving punishment by health care providers for refusing to take medication, such as being placed in an isolation

room or being forcibly medicated. They expressed concerns about the seriousness and long-term consequences of being medicated and the lack of information that was provided to them about the medication's purpose or side effects.

> *"When I was taking medications I was given no information, no choices, I was being treated for insomnia when I was 7 and then I started having explosive melt downs, and I had more medications prescribed. Again, I had no idea what they were, what they were doing me. I didn't even know what I was being treated for. I was told that I was being treated for anxiety, and I wasn't. I didn't even know what I was on, I had no idea, no on explained it to me. I didn't know that the side effects, I didn't know what I was being treated for. It took me three weeks to get off of it, because I didn't quit cold turkey."*
>
> *"At one point, I was given pills and I asked the nurse what the pills were and she just said the doctor said to take them, so I took them. I was given different pills at breakfast, different pills at lunch and different pills at dinner. I knew that if I didn't take them I would be in trouble. I wanted to stop taking them, but I knew if I didn't I would be forced to take them."*
>
> Youth Engagement

Some reported bodily harm specific to their gender and sexuality and that they wanted, but were not offered, gender-appropriate care settings to increase their feeling of safety.

> *"I wasn't even told that I was transferring to adult care at 17, I wasn't made aware of my own trajectory. I was scared, I went from adolescent care to adult care, and I did not even know what the rules were. I wasn't even told about consent in relation to my body. I was on wards with men (staff), they were injecting me with needles, and I didn't even know that I could not consent... there was no female centred care."*
>
> Youth Engagement

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V. Disruption of education and developmental harm

Young people spoke, as well, about the negative impact of institutionalization on their education. These children and youth were taken out of school, sometimes for months at a time, and were not provided with any replacement education while effectively incarcerated. This is contrary to a child's right to education.

> *"I was in the hospital for three weeks, and I missed three months of school. I can see missing one month, but three was too much. I am academic, school is the only place that I felt safe, no one in the decision took my voice into consideration. I was screaming from the roof top that I wanted to be back in school, and no one took it into consideration. I had to end up playing a game with them to get back to school. With reasoning, it was like they were on the North Pole and I was on the South Pole."*
>
> *"There are no teachers to help with education, I lost my education. Everyone can name a teacher that guided them, but at my hospital there wasn't that teacher. I had no teachers that cared about me or my education."*
>
> Youth Engagement

VI. Long term psychological impact

The young people with whom we consulted talked about the lasting emotional and psychological impact of forced medicalization; the feeling of having years stolen due to the traumatic experiences they endured during treatment.

> *"It was mostly pretty awful. It is always something that you carry with you, you have to process. You have to liberate yourself from the shame. I feel like the years were stolen from me."*
>
> Youth Engagement

VII. Youth recommendations for change

The children and youth were clear about their recommendations for mental health reform in BC:

- *"Things needs to be explained in ways that kids can understand them."*
- *"Youth need to be informed of what is happening and why, irrespective of their adjudged capacity level."*
- *"Health care providers and decision-makers should be transparent and honest with youth about the decisions that are being made and why."*

- *"In medical settings, we need a neutral third party. Children and youth need advocates from someone who is not directly involved."*
- *"Shared decision-making—involving youth in decisions being made about them."*
- *"To have someone with lived experience be a part the process, have someone be there to be part of what you need, someone to help them see."*
- *"Informing everyone of their rights, people need care and compassion. Ask youth what they need, what would help them. You need someone with lived experience, you need a compassion support person. A team needs to be there, people need to feel like they are human beings. You need self-care and you are not even allowed that."*

A primary takeaway from these consultations is that although forced mental health care can be useful for select individuals, the way in which the current mental health framework operates in British Columbia can also be traumatizing, harmful, and disempowering to children and youth in the way it impacts on their capacity and ability to participate in their mental health treatment.

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D. Conclusion and Summary of Key Findings

The predominant finding of this paper concerns the current mental health framework which, while potentially beneficial for select individuals, is deeply flawed, proving to be traumatizing, harmful, disempowering, and and disabling for many of the children and youth it affects. In addition, it operates in discordance with international treaties, notably the UNCRC, and other fundamental principles of justice and administrative law.

The voices of children and youth consistently highlight the negative impact of involuntary detention, revealing limitations in their ability to participate meaningfully in their mental health care. They report being ignored, disempowered, and stripped of decision-making capacity. Instances of isolation, fear, and inadequate communication with family members further compound their distress. The negative repercussions impact their education, violating fundamental rights and placing vulnerable populations at heightened risk.

Specifically, the disproportionately high rates of admission for children with disabilities, behavioural difficulties, substance use disorders, and the overrepresentation of Indigenous children suggest a systemic bias within the mental health scheme. Moreover, research underscores the detrimental effects of institutionalization on the physical, mental, and cognitive development of children, with lasting consequences into adulthood.

The experiences recounted by children and youth in British Columbia starkly contrast with international conventions, notably Article 37(b) of the UNCRC, which mandates detention as a measure of last resort and for the shortest appropriate period. Non-custodial options, as advocated by these conventions, are often overlooked, with forced confinement taking precedence. The positive obligations outlined in the UNCRC, including the right to education and protection from neglect, are frequently disregarded in the lived experiences of these youth.

Fundamental principles of justice and administrative law emphasize the need for protections during detention, Mental Health Review Board hearings, and the right to be informed, heard, and to contact a lawyer. However, the accounts of children and youth in British Columbia indicate gaps in these safeguards. It remains to be seen to what extent the *Mental Health Amendment Act* may address the right to be informed and to contact a lawyer.

In summary, this paper underscores the urgent need for a comprehensive reevaluation and reform of the current mental health framework in British Columbia, emphasizing the importance of aligning with international standards and safeguarding the rights and well-being of the children and youth it affects.

1. Although a child or youth's mental or cognitive capacity may fluctuate depending on the nature of their mental illness or disability, this does not impact their legal capacity. Their legal rights do not go away because of their perceived lack of cognitive or mental capacity.

2. While children and youth with mental illness may not always make decisions deemed "good" by decision-makers and health care providers, their right to participate in decision making through the expression of their views should not be ignored.

3. It is important to work with a child and youth's capacity—meeting them where they are at—rather than assuming they lack capacity.

4. When a child or youth's capacity is denied or taken away, it can create a negative cycle that impacts their ongoing ability to make decisions for themselves and to maintain a sense of autonomy.

5. It is important for children and youth to express their capacity to be heard; to share their opinions and views on their treatment. A legislative framework that presumes a lack of capacity is not consistent with a child's legal right to be heard.

6. To respect a child or youth's capacity, it is essential that decision-makers and care providers share appropriate information with them about their rights and communicate adequately with them about their treatment. This helps a child or youth to be able to understand, to the best of their abilities, the situation at hand and to use this information to form views and make appropriate decisions about their care.

7. Institutionalization can harm the physical, mental, and cognitive development of children and youth, with lasting effects into adulthood. Involuntary mental health detention should be used sparingly, for the shortest time possible, and in select cases.

8. Any proposed legislation and legislative amendments, such as the *Mental Health Amendment Act* and *Safe Care Act*, require thorough scrutiny for their impact on children and youth.

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Youth Engagement Methodology & Data

The Child Capacity Research Project sought to embed key values and principles in the research process that in turn shaped the research methodology, community engagement, and analysis of the results. These values and principles pertained to striving for accessibility, highlighting intersectionality, valuing lived and living experiences, and others crucial for meaningful engagement and research.

It was this approach, as well as the calls to action from participants, that allowed for the recognition that while the project was intended to look at four key topics with complex systems of their own, they are also interconnected in many ways. In addition, it was noted throughout the youth engagement that it was sometimes difficult for participants to speak to one system without describing the impact of another. Thus, we advise readers to recognize the intersectionality of the lived experiences reflected in the information below and that also has contributed to the richness of qualitative data that emerged.

ENGAGEMENT METHODS:

Three distinct engagement methods were utilized to provide accessible opportunities for contribution from youth and young people, primarily below the age of 30, with lived and living experiences in relation to the research topics. All three options were offered to every participant prior to written consent being provided:

Survey:

- An anonymous, online survey consisting of 3 questions was made available during the entire duration of the project
- The nature and structure of the questions allowed for participants to respond based on the experience they deemed relevant to contribute

Interviews:

- 1-hour virtual Zoom sessions with a participant and two members of the CCRP team
- Discussion questions* were provided in advance
- Follow-up interview opportunity offered

Listening Circles:

- 1-1.5 hour virtual Zoom sessions with existing youth advisories, councils, and other programming groups
- Sessions were coordinated in collaboration with group/organization leads, coordinators, and/or supporting staff
- Discussion questions* were provided in advance
- Follow-up session and/or interview with interested participants offered

***Note:** The following three questions were used in all methods of engagement and were specified (in Listening Circles and interviews) based on the topic participants wished to address. However, it is crucial to note that while these were the primary questions asked, discussions often built on what was shared in the session. The evolving conversations differed per group / participant, and as a result, the extent of questions that organically emerged were not able to be included in the list below.

Discussion Questions:

1) How do you define "capacity"? Based on your understanding, do you feel you have had capacity to make decisions, or the opportunity to use your capacity to participate in decisions?

2) Can you tell us about a time [in a family law / mental health / healthcare decision / child protection matter] when you felt like your opinion was valued and taken into consideration?

3) Based on your experience [in a family law / mental health/ healthcare decision / child protection matter], how do you think things could be improved so that your capacity to make decisions and be heard is better respected?

Stakeholders & Subject Matter Experts:

- Stakeholders and subject matter experts across sectors were invited to provide feedback on the draft outlines for all four research papers at a virtual roundtable held during the earlier stages of the project
- Individuals part of community networks were also selectively invited to provide feedback on research paper drafts as they were developed by topic

Outcomes:

- 78 participants across all methods of the youth engagement contributed their feedback by sharing their lived and living experiences
- An analysis of themes from the youth engagement by topic can be found below

Note: While the project sought to uplift intersectional experiences of young people across all four topics, there are limitations to those reflected in this paper. It is recommended that future research initiatives dedicate efforts to highlight the specificities of identities of young people that may uniquely inform the nature of their experiences with respect to the four topics examined in this project (e.g. gender and sexuality).

THEME CODE	THEME:	DETAILS/VARIANCES
1	Presumed lack of discernment	• Determined by practitioners to be **unable to determine what was 'right' and 'wrong'** • Lack of shared understanding (e.g. what is considered 'safe') contributed to **perceived inability to make decisions** • Cyclical and assumptive **treatment based on previous documentation**
2	Disenfranchisement	• Young people treated only as **recipients of treatment** • **Lack of consultation, being made aware** (e.g. of legal rights, consequences of actions, access to family/friends), or **informed during decision-making** • Assumption that **being informed would worsen health** • **Onus should be on practitioners** to find most appropriate method to inform young people • Opinions only **taken into consideration "superficially"** (e.g. when a professional needed to validate something) • Capacity being taken away in mental health system resulting **in lack of opportunity to develop and exercise capacity** generally • Recognition that some situations call for more intervention but also that the lack of statutory criteria in the Mental Health Act framework **often results in inaccurate assessments of capacity** in the clinical setting • The involuntary treatment framework **should not be contingent on determining presence of capacity** (perceived or actual) • **Overuse/reliance on Mental Health Act** in providing care • Recognition that ability to exercise capacity is **sometimes taken away "pre-emptively" and as a "method of care"** • **Use of 'best interests'** reasoning to make decisions without informing/consulting
3	Invasive / unsafe experiences	• Trauma resulting from **forced procedure and actions** (e.g. forced feeding) • Hesitancy due to **mistrust of systems** impacting future accessing of medical services

		• Young people **assumed by some to be exaggerating** emotion, behavior, experience, etc. • **Shifted between different institutions / treatments** (e.g. location, adolescent vs. adult facility) **without consent** of young person
4	Interconnections with other systems	• **Foster homes, social workers, etc. created toxic circumstances** leading to admission into mental health system • Compounding impacts due to **guardianship being attributed to entities that young people do not trust** • Assessment of perceived lack of capacity in one system resulted in **harm occurring in another** • Recognition of how **experience in one system normalized experience of not being valued**, capacity considered, involved, etc.
5	Weaponization of efforts for agency	• **Questioning of invasive methods weaponized** as justification for young people's lack of capacity • **Feedback loop effect of questioning utilized as rationale** for assessment of lack of capacity • **Lack of opportunity** to demonstrate capacity resulted in assumption of **lack of ability**
6	Need to improve professional practice	• Need for practitioners to **approach work with an open mind** • Need for young people to **receive opportunity for a second opinion** • Need for someone to **work with the level of capacity a young person has in a situation** • **Lack of transparency and honesty** from practitioners to young people • Medical practitioners / adults recognized as **lacking ability to connect or relate with youth** • **Need for people with lived experience** in mental health system to be a third-party advocate/ support for young person
7	Valuing young people's experiences	• Recognition of **the need to value lived experiences** of young people • Recognition that being informed or valued would have **led young people to make better decisions and less resistance against treatment**

		• **Lack of check-ins** with young people regarding their emotional wellness regarding decisions, treatments, etc. • **Contradictory experience of being perceived as "mature"** while also not afforded any autonomy, decision-making ability, or engaged as an independent person • **Treated as an 'adult' in situations without receiving the respect or rights** afforded to adults • **Recognition of poor communication from practitioners to young people** (e.g. illusionary sense of agency, "sugar-coated" explanations) • Approach to treatment reflected internalized sentiment that young people have **"done something wrong"**
8	Relationship between capacity and decision-making	• Problematic **conflation of presence of capacity with ability to make 'correct' decisions** consistently
9	Long-term impacts	• Recognition of time spent institutionalized significantly impacted youth **beyond the experience in the system** • **Prone to being more ill** identified as a consequence • Multi-faceted impacts recognized as staying with youth as they get older including **need to do own healing and recovery from system**
10	Performing to navigate system	• Young people expressed feeling the need to **"perform" a certain way to avoid** trouble and not be forced, or even to be listened to and to leave the system • Lack of being perceived a certain way resulted in **misdiagnosis and treatment that caused harm**

Capacity: A Principled, Rights-Based Approach to Child Participation

The Society for Children and Youth of BC

SOCIETY FOR children and youth OF BC

REPRESENTATIVE FOR CHILDREN AND YOUTH

Child Capacity

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Acknowledgements

We would like to recognize the generosity of all youth and contributors in sharing their experiences and insights throughout the project. We thank you for allowing us to hear your stories across the various mediums in which your words were shared. Thank you to all stakeholder experts who provided their knowledge and wisdom for each project topic, providing our research team with invaluable information that shaped the emergent themes and key findings. This project began with the convening of community stakeholders at an initial roundtable, and we would like to give our thanks to the folks who joined us. Finally, thank you to everyone who provided guidance and feedback throughout the duration of this project.

The Society for Children and Youth of BC would like to acknowledge that we live and work on the traditional territories of the First Nations peoples of British Columbia. Our office is located on the Unceded Territory of the xʷməθkwəy̓əm (Musqueam), sḵwx̱wú7mesh (Squamish) and səl̓ilwətaʔɬ (Tsleil-Waututh) First Nations. We express our sincerest gratitude to the custodians of these lands and beyond across BC. We also wish to recognize the specific impacts on Indigenous Peoples and communities that are a result of the systems that are the focus of these papers. We invite readers to critically engage with the themes and key findings presented using this lens as well as an intersectional approach to take action.

Finally, we would like to acknowledge the invaluable contribution of the Office of the Representative for Children and Youth in facilitating this research. Their expertise, insights, and guidance throughout the research process were instrumental in shaping this work.

We would like to express our sincere gratitude to our Project Coordinator and Youth Engagement Lead, Simran Sarwara, for her invaluable contributions to this project. We would also like to thank Lisa Bellano for her extraordinary research leadership and report writing, as well as Sara Hernandez for her exceptional design of the report layout.

The British Columbia Representative for Children and Youth funded this report.

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About The Society for Children and Youth of BC

The Society for Children and Youth of BC (SCY) is a provincial not-for-profit charity. Since 1974, the Society has focused on providing a strong voice representing children and youth. Our mission is to improve the well-being and resilience of children and youth in BC through the advancement of their civic, political, economic, social, cultural and legal rights. Using the UN Convention on the Rights of the Child as a foundation, SCY has a track record of creating and delivering programs that have motivated change in research, legislation, policy, and practice in Canada. This year, we proudly celebrate 50 years of advocacy for child and youth rights. The organization is comprised of three programming areas: The Child and Youth Legal Centre, Child and Youth Friendly Communities, and Child Rights Public Awareness.

The Child and Youth Legal Centre (CYLC), established in 2017, provides free support to young people experiencing issues related to Family Law, Child Protection, human rights violations, and other legal matters. The Legal Centre is made up of Lawyers, Intake Workers, Child and Youth Advocates and a Social Worker. The Legal Centre has seen significant growth since its inception, and in 2023 supported 1125 young people across 90+ Communities in British Columbia.

SCY's Child and Youth Friendly Communities (CYFC) program supports child-friendly community-building with young people. Over the past eight years we have worked in collaboration with various Metro Vancouver municipal planning teams to ensure that children and youth have a stronger voice in their community's planning initiatives. Our aim is to ensure that public engagement is a deep and meaningful experience for

young people. Some of our projects include the Walking School Bus, School Streets, Play Streets, and Urban Explorers.

The Child Rights Public Awareness Campaign began in 2006 when SCY, the Representative for Children and Youth, and the Institute for Safe Schools of BC came together to envision a plan for raising awareness of child rights. Throughout the years, the campaign has engaged in numerous activities including roundtables on children's rights, the creation of a child rights network, a multimedia campaign, community and youth engagement activities, and the development and dissemination of child rights resources across the province, including multilingual resources.

Drawing from our experiences over the past several decades across different sectors advocating for child and youth rights, SCY conducted a Child Capacity Research Project as commissioned by the Representative for Children and Youth of B.C. This work aims to highlight the importance of child participation rights by way of research papers on child capacity in the context of four key areas: 1) family law, 2) child welfare and adoptions, 3) decisions about healthcare, and 4) mental health and involuntary civil detention. We are pleased to present this report series as it reflects a culmination of comprehensive literature analysis and multi-faceted youth engagement specific to each area. It is our hope that the key findings identified within each paper will support systemic action and facilitate cross-sectoral collaboration within B.C.

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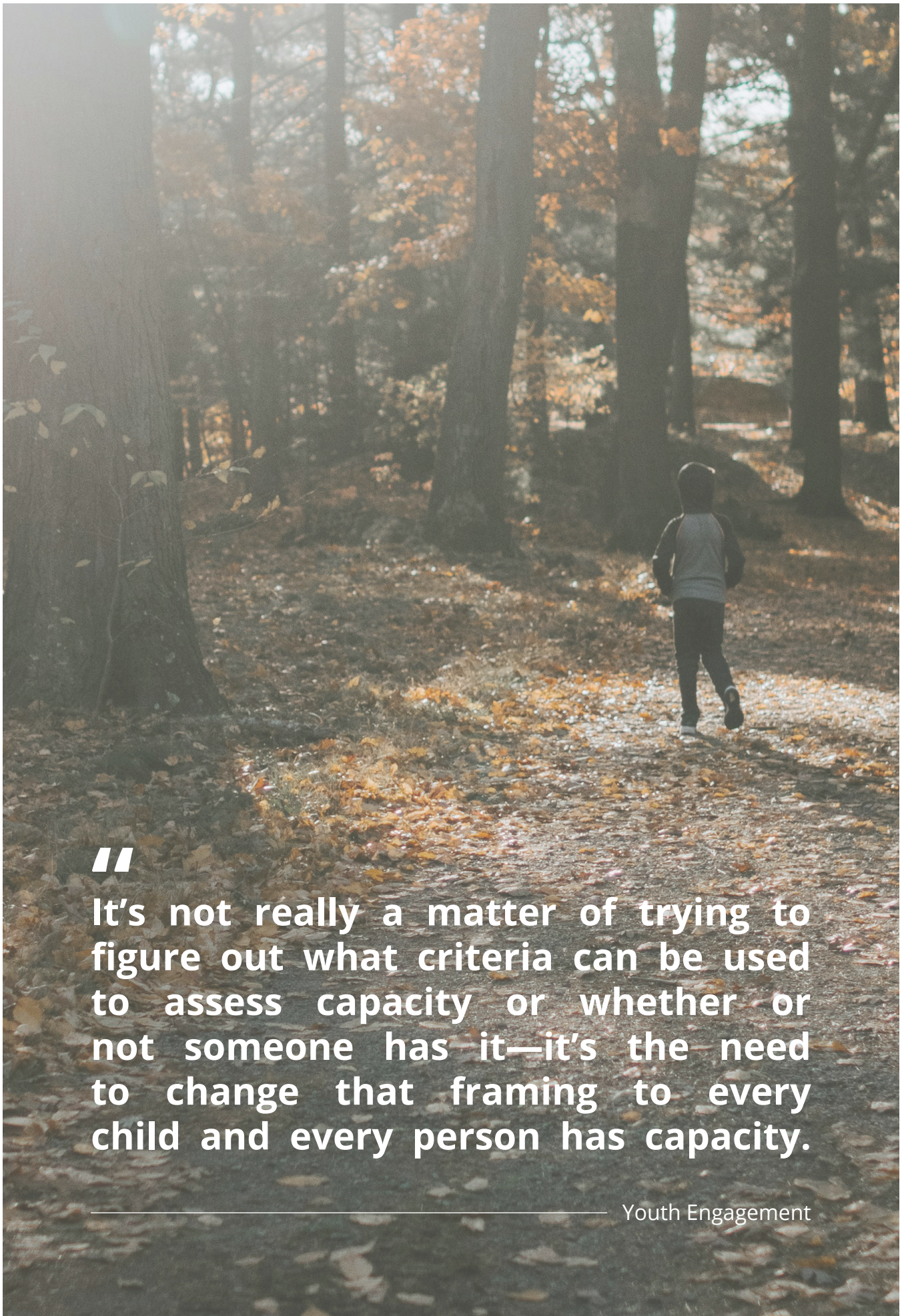
Capacity: A Principled, Rights-Based Approach to Child Participation

Research Report on Child Capacity

Society for Children and Youth of BC
Lisa Maria Bellano



"It's not really a matter of trying to figure out what criteria can be used to assess capacity or whether or not someone has it—it's the need to change that framing to every child and every person has capacity.

Youth Engagement

A. Executive Summary

This research project explores child capacity in a participatory context in legal and administrative proceedings in Canada with a focus on British Columbia in the areas of family law; child welfare and adoptions; mental health and involuntary civil detention; and decisions about health care. Capacity is considered through the lens of the United Nations' Convention on the Rights of the Child (UNCRC) (1989), to which Canada is a signatory.

Key Findings

1. There is no universally agreed upon definition of capacity although there are recurring themes throughout social science.

2. Age alone is not a reliable indicator of capacity. Decision makers should not use age as the sole determinative factor of children's capacity.

3. All children should be presumed to have capacity to express their views and preferences. Great harm is done to children who are not permitted to exercise their capacity to be heard in matters affecting them.

4. Capacity can be understood as both a function of cognition, as well as an ability or a right one possesses. What it is varies depending on its context or function. Capacity can be a legal right.

5. Capacity encompasses a variety of factors and develops at different rates. Children may possess more or less capacity in different contexts. The capacity to be heard is not the same as the capacity to be the decision maker.

6. The United Nations Convention on the Rights of the Child provides that a child need only be capable of forming a view in order for their view to be heard and considered. There is no further test of cognition or capacity that should stand in the way.

7. Children and youth must be equitably supported to express their views and desires on matters affecting them, using methods that meet their level of capacity.

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B. Background and purpose of report

The purpose of this report is to summarize research findings on the topic of child capacity, largely in the context of child participation rights. This research was funded by the Office of the Representative for Children and Youth (RCY) of British Columbia and was undertaken to generate greater clarity on (a) the definition and scope of child capacity, (b) factors influencing the development and exercise of capacity, and (c) the impact of trauma or neurodiverse conditions on the same.

Specifically, this research considers child capacity in the context of four key legislated areas:

- family law;
- child welfare and adoptions;
- mental health and involuntary civil detention;
- decisions about health care.

Each of these legislated areas comprise their own, separate forthcoming paper.

The current paper offers a summary of the key findings emerging from research in the topic of child capacity in a participatory context. It provides a primer on the topic of child capacity and a discussion of the multiple definitions of child capacity, key themes emerging from research on capacity, and criticisms and limitations of the capacity concept. The paper ends with suggesting examples of models to support effective child participation consistent with Article 12 of the UNCRC.

C. Scope of Review and Methods

The scope of this review is limited to the legislated areas of family law, child welfare and adoptions, mental health and involuntary civil detention, and decisions about healthcare. There are other significant legal domains within which child capacity is a live issue, including but not limited to immigration and refugee hearings, criminal or youth justice proceedings, educational matters (such as disciplinary hearings), and labour and employment (many youth under the age of majority are employed). While these areas are not directly discussed in this paper, they are nonetheless important to the lives of children and youth in British Columbia and may warrant separate investigation.

The approach to this research consisted of three stages. First, we reviewed literature—predominantly from law, psychology, anthropology, health sciences, and other disciplines—about child capacity, as well as legislation and select case law relevant to child capacity in the four key legal areas. The second stage consisted of community engagement. At this stage, we interviewed children and youth on their experiences of capacity generally and as they relate to the specific legal areas of inquiry, and from these interviews generated key conclusions and recommendations for reform. Part of this stage included distributing a survey to a larger number of children and youth to strengthen our key conclusions. The engagement stage also included hosting facilitated listening circles with groups of children and youth using key research questions. The third and final stage consisted of stakeholder consultations, during which time this research was presented to stakeholders and subject matter experts, and reviewed by them to ensure accuracy, clarity, and soundness—particularly of our key findings.

Our approach to this research has been to adopt an intersectional framework, while also recognizing the challenges inherent in writing about a legal and scholarly tradition rooted in imperial and colonial assumptions of children, childhood, and human rights. We have endeavoured to move beyond looking only at age as a factor in our capacity discussion, including also variations in children's experience pertaining to their class, ethnicity, race, religion, gender, sexuality, social background, ability, and the intersection of these elements (Adami, 2023). Given our regional and historical context, we have also paid specific attention to the experience of Indigenous children and youth in British Columbia.

D. Discussion

Definition of child

The UNCRC defines a child as a human being below the age of 18, unless national laws recognize an earlier age of majority (Article 1). In Canada, the age of majority is 18 in Alberta, Manitoba, Ontario, Prince Edward Island, Quebec, and Saskatchewan; and 19 in British Columbia, New Brunswick, Newfoundland, Northwest Territories, Nova Scotia, Nunavut, and Yukon.

Given that this is a British Columbia-specific paper focused on the UNCRC, we will define child as a human being below the age of 19.

Note that although we are using this definition for the purposes of this paper, the definition of child is—like capacity—without consensus. For example, independent children, child-headed households, and children at work are all exceptions to the accepted narrative and call into question our assumptions about the line between childhood and adulthood. Is a 17-year-old human being—who may be a mother to a child, the sole supporter of her family, employed, and making adult decisions for herself and her child—a child or an adult? Depending on one's cultural reference-point and legal framework, among other factors, the answer given will vary.

Connected to the above, there is cultural and regional variation in the definition of childhood. It is beyond the scope of this paper to discuss these variations; however, it is important to state that many scholars have criticized the UNCRC for the fact that it standardizes a universal, largely North American and Western European understanding of childhood that does not cohere with the experiences of children and youth in other countries. There is a trove of literature written on the experience of African youth and children in particular—see for example Twum-Danso (2008), who has specifically addressed the deficiencies of the UNCRC and its questionable efficacy for African children and youth.

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A brief history of capacity in children's rights

The relationship between capacity and human rights is one that can be traced to the origin of our rights tradition. Whether or not one is able to exercise a right as a legal actor is often seen as dependent upon that actor's ability or capacity to effectively exercise that right.

Only those deemed capable can benefit from the ability to exercise a right and to have that right respected. According to Federle, this can be found in the origin of our rights tradition, "which emphasizes autonomy and individuality, perpetuates hierarchy and exclusion by limiting the class of rights holders to those with capacity" (Federle 1993, p. 1028).

Classes of rights-holders traditionally excluded from being able to exercise their legal rights based on incapacity arguments include children, youth, women, racialized groups, Indigenous persons, disabled folks, and other marginalized groups.

> *"I feel like people always assumed I wasn't capable of making good decisions because I was young, which was very frustrating and made me feel like I was too stupid or like I didn't know anything. I don't think this was the case, people just didn't want to listen to me."*
>
> Youth Engagement

In terms of socio-legal theory, the antecedents of this view—that capacity and legal rights are linked—are social contrarianism (Hobbes, Locke, Rousseau), utilitarianism (Bentham, Mill), and legal positivism (Hart). Each of these philosophies, which have informed the formation of rights-talk in Canadian law, "exclude children entirely from the class of rights holders because of their incapacities" (Federle, 1993, p. 1028). So too do natural law theories (Kant, Hegel, Rawls) limit the legal participation of children under a protectionist framework, even while recognizing that children are moral beings possessing their own, distinctive wants and needs separate from adults (Federle, 1993). A protectionist framework is one which emphasizes the vulnerability of children and the need to protect them from harm, rather than seeing them as empowered.

These theories more often view children not as human-beings, but "human-becomings" (Alderson & Goodwin, 1993, p. 6). The ability, then, for children to exercise rights is tied to their perceived competencies—and these theories tend to purport either that children "do not have the requisite will to obligate others", or that children's interests are insufficient, warranting protection, or otherwise characterized "in ways that promote their incapacities" (Federle, 1993, p. 986).

Given this relationship between capacity and rights, Federle and others have deemed it "essential...to recognize the centrality of capacity as an organizing principle in our rights talk" (1993, p. 1028). Other legal scholars, such as Gary Melton, have provided

similar such statements on competency as capacity; “competency is the overriding issue in the law affecting children” (as cited in Federle, 1993, p. 1011). In the words of Bruce Hafen, the “law has ‘long assumed the necessity of competency’” (as quoted by Federle, 1993, p. 1012).

More pointedly, Federle asserts:

> As long as we premise rights upon ability and view children as undeveloped or underdeveloped beings evolving into adulthood, we can discuss individual rights only in terms of hierarchy and exclusion. To speak of children’s rights, however, means to hear children’s voices without the filtering influence of our preconceived notions about children’s incompetencies. To hear children’s voices requires us to look beyond our status-based relationships and to set aside the power that we have. We need to acknowledge that rights have value because of their power to eliminate hierarchy and exclusion, but as long as capacity plays a role in defining rights, we minimize value. Reconceiving rights means reconceiving our sameness; this we can accomplish only if we cast capacity aside as an organizing principle in our rights discourse (Federle, 1993, p. 1028).

Theorists Richard Farson and John Caldwell Holt further argue that given the issues in drawing the line between competency and incompetency, it ought to be presumed that children have capacity; that is, children have the “same political and legal rights held by adults because children are competent” (Federle, 1993, p. 1012). Federle maintains that there are significant negative consequences to applying a stringent or exclusive definition of capacity. “[T]he exclusion of the child from greater political participation signifies a deeper consequence of capacity: incompetency does not merely limit rights; it denies them entirely” (Federle, 1993, p. 995).

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Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child (UNCRC) is a human rights treaty adopted on November 20, 1989 by General Assembly resolution 44/25. It has been signed and ratified by almost every country in the world, including Canada.

Its basic principles pertain to non-discrimination of children, making decisions in the best interests of children, respecting the child's right to life and development, and child participation in all matters affecting them. Articles 5 and 12 of the UNCRC are most often engaged when a child's capacity and participatory rights are considered.

Article 5 provides that "States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, **in a manner consistent with the evolving capacities of the child**, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention" (emphasis added).

The UNCRC does not provide a definition of capacity. Henderson-Dekort and colleagues (2022) note:

> Within specific articles within the United Nations Convention on the Rights of the Child (1989), it is clear that there is frequent uncertainty surrounding the term capacity. It remains a difficult concept to assess with certainty, especially in the case of children. This is concerning considering how frequently the term is used or eluded to [sic] in matters that pertain to the participation or rights of children (p.3).

"Evolving capacity," as it is used in Article 5 of the UNCRC, refers to a child's progressive ability to exercise his or her rights (Canadian Bar Association, CBA, 2023). This is distinct from the view that capacity is a fixed trait; rather, it is a "fluid and evolving response to various situations"—it is situation and context-dependent (Henderson, 2022, p.6). More to this point, "evolving capacities recognizes children as active agents in their own lives entitled to be listened to, respected and granted increasing autonomy in the exercise of rights, while also being entitled to protection in accordance with their relative immaturity and youth" (Lansdown, 2005, p. ix).

Article 12(1) of the UNCRC stipulates that States Parties provide a child capable of forming his or her own views the right to express those views freely in all matters affecting the child, and that the child's views be given due weight in accordance with the child's age and maturity (emphasis added). Article 12(2) further states that the child be provided an opportunity to be heard in any judicial and administrative proceedings affecting him or her, either directly or through a representative, in a manner consistent with the procedural rules of national law. Again, this Article references a developmental view of capacity, providing that as children develop and acquire capacity, they shall become entitled to higher levels of responsibility in areas that affect them (UN General Comment No. 12, 2009, para. 85).

UN General Comment No. 12 and the UNCRC make it clear that the child should be presumed to be capable of expressing his or her own views, rather than incapable. The General Comment states that "it is not up to the child to first prove her or his capacity" (para. 20, emphasis added). The General Comment does not define capacity but does define maturity within the context of Article 12 as being "the capacity of a child to express her or his views on issues in a reasonable and independent manner," and "the ability to understand and assess the implications of a particular matter" (para. 30).

All that is required to demonstrate that a child is "capable" under Article 12 is a "formulation of a view, absent any understanding by the young person of how or why they formed the view, the basis of the view, or the consequences of voicing the view or acting on it" (CBA, 2023; Mol, 2019). Article 12 likewise reflects a view of capacity as evolving, as it provides that the child's views be given due weight in accordance with his or her age or maturity, suggesting greater weight is given as the child ages and becomes more mature (CBA, 2023; UN General Comment No. 12, paras. 20-21).

Other notable sections of the UNCRC referring to capacity are Article 40(3)(a) (children may lack capacity and thus require special protection, here in the context of young children and regarding minimum age for criminal responsibility); Articles 9, 12, 26, 37, and 40 contemplate participation and representation of the young person in various processes and proceedings (e.g. sharing views, providing informed consent, applying for benefits); and Article 21 ("persons having the right to consent to an adoption, including a young person being considered for adoption, have a right to 'informed consent'", implying "both participation and capacity on the part of the young person as informed consent can only be given by someone who has capacity; that is, an understanding of what they are consenting to") (CBA, 2023).

Best Interests

> *"If you wanted my best interests, you could have just asked me."*
>
> ——Youth Engagement

There is some tension within the UNCRC—and in child participation generally—between the rights afforded to children and youth to express their views and have those views taken seriously, and the notion of best interests. Article 3(1) of the UNCRC provides that in all actions concerning children, the best interests of the child shall be a primary consideration. On the face of the UNCRC, it is unclear what ought to occur in a situation where the views of a child or a child's exercise of his or her capacity is at odds with what is deemed to be in that child's best interest. It is also unclear what constitutes best interests (Henderson-Dekort et al., 2021).

Certain scholars, like Daly, have argued that judges should adopt a children's autonomy

principle in legal decisions wherein the best interests of the child is the primary consideration. In such cases—and in accordance with Article 12—children should get to "choose, if they wish, how they are involved (process autonomy) and the outcome (outcome autonomy) unless it is likely that significant harm will arise from their wishes" (Daly, 2017, p. 115). However, this does not resolve the question of whether a child's views or their "best interests" is deemed primary when in contest. "Best interests" language has been adopted and incorporated into various laws in British Columbia (for example, the Family Law Act). Practice and case law suggest that "best interests" considerations, while important, have in some cases been used to devalue the views expressed by a child or otherwise preclude a child from meaningful participation in matters affecting them. It is important that there is appropriate balancing between "best interests" and a child's right to be heard; they are separate yet overlapping rights.

In the context of health care decisions, the issue of best interests is again engaged in situations where a child or youth's treatment decision is at odds with that of a parent, guardian, or healthcare provider. For instance, section 17 of the Infants Act (British Columbia) explicitly provides that a healthcare provider—in assessing a child or youth's capacity—determine that the healthcare is in the child's best interests. In situations of conflict between views, which should prevail: the decision of a child or youth for a particular course of treatment, or that of an adult who may oppose the child or youth's decision? The concern is that the language and principle of best interests may be used to undermine a child or youth's decision-making capacity. From SCY's engagement with children and youth in British Columbia, a recurring theme that emerged was that the best interests model was sometimes used to reflect the best interests of the adults, rather than the interests of the child or youth. As one youth put it, "parents do not have to live with it, yet they are ones who make the decisions, they are deferred to." Another young person said:

> *"It is a two-edged weapon, your best interests, it is a way for your guardian to use/assert power. Like in child custody, a child may not have the capacity to make decisions, but they should still have the opportunity to feel like their opinion is still valued. If they do not feel like their opinion is valued, then it may cause problems later in life"*
>
> Youth Engagement

It is important to note that hearing from the child and acting in their best interests are not inherently at odds. Rather, children's meaningful participation is a clear part of the determination of their best interests. The UN Committee on the Rights of the Child states in their General Comment 14 Article 3(1) "the concept of the child's best interests is aimed at ensuring both the full and effective enjoyment of all the rights recognised in the Convention and the holistic development of the child". That a child's views may be contrary to what an authority deems to be in their "best interests" should not be used as a reason to exclude their meaningful participation in the decision-making process, which should be central in most cases. A growing body of evidence

demonstrates that meaningful participation from children in decision making promotes improved outcomes and wellbeing, even when the decisions made are not ultimately in accordance with the child's views.

Multiple definitions of capacity

The term capacity in the context of child participation, and in children's rights generally, encompasses at least the following two core concepts: (1) legal personhood or legal capacity, and (2) mental, cognitive, or developmental capacity. It is the latter which is most dominant in discussions of child capacity, which focus not on the legal capacity of the child and the nature of being a legal rights-holder, but instead on the child's cognitive, mental, or developmental capacity—that is, their (perceived) ability to exercise a right (see Bach & Kerzner, 2010).

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How children define capacity

Throughout our youth engagement, several themes emerged regarding how children and youth themselves define capacity. Particularly for younger children, capacity is a kind of feeling—you know how you feel about a situation, you know when something feels wrong for you. It is about the ability to decide for oneself, to make decisions in one's life. Most shared that it was present when they were young, but in a different way. This is aligned with the developmental or evolving view of child capacity—that it develops over time and develops in complexity.

For example, during a youth listening circle, a participant shared the following about their understanding of capacity as a younger child:

> "As a child making decisions about who you live with, who you feel safe with, you don't know a lot about the technical things, you just know something is wrong, you just don't feel safe. As a small kid it is a lot based on feeling out what you want to feel."

During a one-on-one interview, another youth shared their sense of capacity as they have grown older:

> "Now, I feel that my self-awareness guides whether or not I have capacity".

Capacity was also defined by the children and youth we spoke with as the ability to make decisions, to be aware of your rights, to understand what you want, and to understand the direction that you want your life to go:

> "I think sometimes the idea of capacity is caught up in whether the person's decision is a good decision."

Others shared that capacity was also something that at times could be lacking. For example, one participant said that there were times when her mental health struggles impaired her ability to make proper decisions for herself. She felt like during these periods, she needed guidance and support that she did not receive. Conversely, she said that when she felt she did have capacity and her mental health felt secure, she was not given the opportunity to be heard or to have her desires respected in the context of an involuntary hospitalization.

Photo owned by SCY

Other aspects of capacity stood out during our one-on-one interviews with children and youth, demonstrating some of the adverse consequences of assuming that a child lacks capacity:

> *"The more my capacity was taken away, the less that I knew how to use capacity.*
>
> *"I do not think that I had a lack of capacity, but I needed someone to work with me.*
>
> *"Capacity was a weapon used against me.*

Developmental approach to child capacity

The developmental psychology approach to child capacity is most dominant in the literature surveyed. Capacity is viewed not as a fixed trait, but a fluid and evolving context-dependent process. It is multidimensional: to assess a child's capacity, one must consider the physical, cognitive, relational, and emotional factors, with reference to a child's religious, cultural, racial, economic, community, and familial contexts—and the interplay between them (Henderson-Dekort et al., 2022; Kinniburgh et al., 2005). Appropriate assessment of capacity is thus a comprehensive, multidimensional process.

The developmental approach proceeds from the basis that there are certain developmental stages through which children pass as they acquire knowledge and understanding of the world around them. Jean Piaget is the psychologist often credited with popularizing the developmental stage model. His theory was that children experience four distinct developmental stages that inform the way they conceive of the world and impact their cognitive abilities: sensorimotor (birth to 2); preoperational (2-7); concrete operational (7-11); formal operational stage (11 and up).

It is important to note that Piaget's approach, while foundational, has since been refined by subsequent, contemporary theories—and criticized by others. For example, in Tisdall et al., (2018):

> Research and theory now recognise that children are far more competent than Piaget's classic tests showed, depending on the situation and contexts …Literature now documents how all people are in the process of "becoming" and development is inherently social, scaffolded by others and interfacing with meso and macro influences (e.g. Donaldson, 1978; Bronfenbrenner, 1979; Rogoff, 1998). We thus have considerable research that competence is situated and relational but that finding is largely ignored by the assessments and judgments about "capacity" in the UNCRC's General Comment No. 12 and "age and maturity" (p. 176).

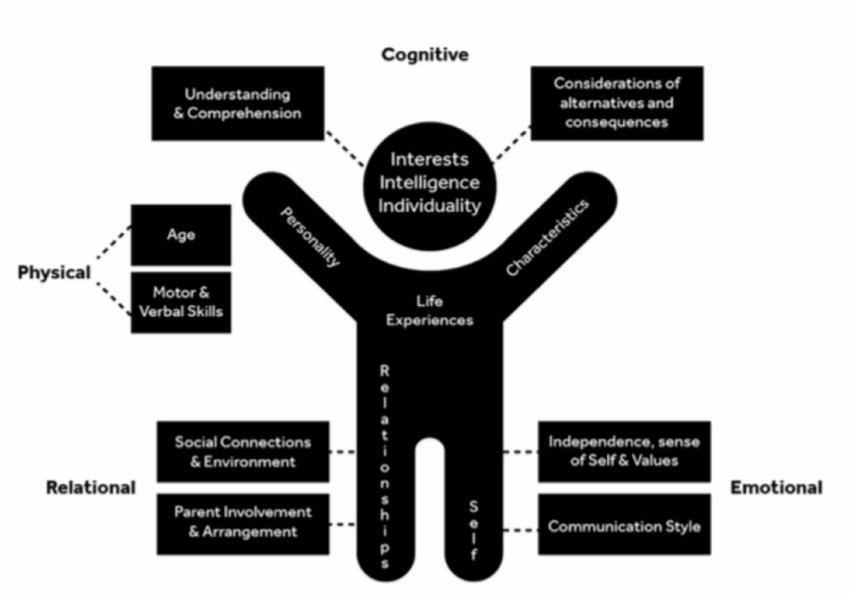
In their critical literature review provided by Zana Babakr and colleagues, the authors noted that Piaget's developmental theories may underestimate infant's capacity, and that the theories may likewise underestimate the significance of cultural and social factors to the development of children's cognitive abilities (Babakr et al, 2019). Likewise, there is contention within the field of developmental psychology as to whether developmental stages exist (see Orlando M. Lourenço, 2016, for a critical review of developmental stages).

Despite the shortcomings of his theory, Piaget's developmental stages remain the foundation of much of the current thinking on child development.

Henderson-Dekort and colleagues (2022) conducted an extensive interdisciplinary literature review on the topic of child capacity in the context of meaningful participation, with a focus on literature emerging from developmental psychology. According to their review, there are four primary domains or core elements to the capacity concept. These are:

- Physical capacity (age, motor development, and verbal communication);
- Cognitive capacity (understanding, intelligence, comprehension, ability to consider alternatives and consequences);
- Relational capacity (social connections and environment, parental involvement and attachment, sense of others); and
- Emotional capacity (independence, sense of self and set of core values and beliefs, communication style and delivery of voice, views, and preferences).

Figure 1.
The Four Primary Domains of Capacity (Henderson-Dekort et al., 2022)



It is important to consider physical elements of capacity at the outset, as these are primary, and subsequently consider cognitive, relational, and emotional domains (Henderson-Dekort et al., 2022).

Physical capacity—age, motor development, and verbal communication

There are large variations in the age at which a child should be deemed capable, thus age cannot be the sole consideration of capacity. Other physical considerations of capacity are the child's ability to verbalize and their motor skills (e.g. languages, accents, speech production, the use of physical voice, articulation, and pronunciation). Verbal abilities of the child are critical to consider for their active participation, since "[c]hildren may lack the necessary vocabulary to describe their thoughts and perspectives though they possess a deep understanding" (Einarsdottir et al., 2009, as cited in Henderson-Dekort, 2022, p. 9). For this reason, it is important to meet children at their verbal level.

Motor skills are not necessarily relevant to capacity level but are "simply another layer of the child's abilities and experiences, which can provide insight into a child's basic composition" (Henderson-Dekort, 2022, p. 9). If a child has a physical disability, they will "require appropriate methods of accessibility in order to display their capacities in other ways" (Henderson-Dekort et al., 2022, p. 9).

Cognitive capacity—understanding, intelligence, and comprehension; ability to consider alternatives and consequences

A child must possess basic intelligence and comprehension to enable them to understand what is happening around them (Alderson & Goodwin, 1993), where understanding means the ability to "grasp the fundamental meaning of the information communicated" (Appelbaum, 2007, p. 1836). Understanding does not necessarily mean that a child can proficiently express their comprehension of a matter verbally (Henderson-Dekort et al., 2022,). That is, while a child may understand something, they may not have the ability to explain their understanding "in the expected verbal method" (Henderson-Dekort et al., 2022, p. 9).

Developmentally typical children often follow basic patterns (Brown et al., 2020). However, the capacity of children with developmental delays or atypical patterns of development will be unique to each child's specific developmental pattern (Brown et al., 2020). Capacity for such a child can be ascertained after "gathering information [specific to] that child's development level or atypical patterns of development" (Henderson-Dekort et al., 2022, p. 9).

A key concept emerging from the literature is that children demonstrate their understanding in different ways, distinct from adults, and that it is essential to allow children to display their own unique understanding. Tisdall et al. (2018) calls for a paradigm shift in family law proceedings, where we move away from exclusion of children based on the age and competence bias, and instead focus on creating the necessary environmental and social supports that allow children to develop and communicate their views.

Consequential thinking is understood to mean the ability of a child to identify and understand potential consequences, outcomes, and alternatives in a situation that will significantly impact a young person's life, such as in a custody proceeding (Henderson-Dekort et al., 2022, citing Grisso et al., 1997). It is imperative to identify and discuss these potential outcomes, alternatives, and consequences with a child in such a situation.

Comparative thinking "involves having the child develop ideas and identify potential outcomes of each, which they then contemplate and compare. Comparing alternative options to any other preferences is also crucial, and is known as comparative thinking" (Henderson-Dekort et al., 2022, p. 9, citing Grisso et al., 1997). Consequential and comparative thinking are viewed by the literature as central to understanding child capacity: "A 'capable' child will be able to formulate a perspective that is followed by a logical explanation of alternatives and consequences in order to convey comprehensive reasoning for the preference"—that is, "rather than just stating their views, thoughts must also include consequences to show alternatives were considered and the thinking process was thorough" (Henderson-Dekort et al., 2022, p. 9-10, citing Grisso et al, 1997).

However, it is important also not to set an inordinately high standard for children—one that would be higher than that required for adults.

Relational—social connections and environment; parental involvement and attachment; sense of others

The relationships with important people in their lives and the life experiences of a child will impact that child's capacity, and while "children are [...] now seen to be more competent earlier than previously thought, [...] adults still tend to underestimate children's capacities" (Parkinson & Cashmore, 2008, p. 4). The capacity a child exhibits depends on the context, on supports that facilitate the development of capacity, and on how much a child is given the opportunity to be part of decision-making.

Bronfenbrenner's Ecological Systems Theory advocates for understanding the way in which various contexts surrounding children impact a child's development. This theory "views children within the multiple, complex, interconnected, and layered contexts in which they live" (Henderson-Dekort et al., 2022, p. 10, citing Bronfenbrenner, 1986). These contexts or systems include friends, family members, teachers, cultural and social contexts (informing a child's development and worldview), family dynamics, caregivers, and educational experiences. The child's family and other important social systems affect how the child develops socially, physiologically, and behaviourally, and this in turn directly impacts their capacity (Henderson & Dekort et al., 2022).

Emotional independence; sense of self and set of core values and beliefs; communication style and delivery of voice, views, and preferences

Core values refer to basic beliefs guiding feelings, actions, or thoughts. Stable values likely correlate with stability in voicing preferences or displaying decisional capacity (Lansdown, 2005). According to numerous scholars, it is critical that a child "possess

a stable set of core values" in order to have functional capacity (Henderson-Dekort et al., 2022, p. 7, citing Applebaum, 2007; Dunn et al., 2006; Grisso & Applebaum, 1988; Lansdown, 2005).

Children "acquire lasting values from very early ages and these values will be unique and distinct for each child" (Henderson-Dekort et al., 2022, p. 11, citing Alderson, re1992; Fidler & Bala, 2010). Family practices and cultural beliefs will have a significant impact on a child's core values. Additionally, it is necessary to look at a child's sense of self to ascertain their values (Henderson-Dekort et al., 2022).

Regarding communication style (delivery of voice, views, and preferences), it is critical to maintain children's rights to be provided with the appropriate space, voice, audience, and influence, to have their voice heard as aligned with Lundy's model of participation, which we discuss later in this paper. There are a variety of ways in which a child may express and communicate (Henderson-Dekort, 2022, citing Grover, 2004)—for example, a child may use drawings, dolls, narrative creation, or other methods to demonstrate their understanding (Christensen, 2004).

Summative statements

Some summative statements about capacity from a developmental perspective are as follows:

- "Across the literature, central concepts of capacity include understanding, independence, assessing and appreciating risk, possessing values, and expressing choice" (Henderson-Dekort et al., 2022, p. 6, citing Applebaum, 2007; Dunn et al., 2006; Grisso & Applebaum, 1988; Lansdown, 2005).
- "Generally speaking, capacity involves a basic level of understanding and communication, consideration of alternatives, expression of preferences, and providing concerns and questions" (Henderson-Dekort et al., 2022, p. 6-7).
- "Understanding, appreciation, reasoning, and self-expression are four critical elements of capacity highlighted in the literature" (Henderson-Dekort et al., 2022, p. 7, citing Henderson-Dekort et al., 2022, p. 7, citing Applebaum, 2007; Dunn et al., 2006; Van Rooyen et al., 2015).
- "Understanding what is being discussed, appreciating the situation at hand, reasoning to form views and thoughts, and communicating those views are all important elements...[as is] an ability to consider the benefits, risks, and consequences" (Henderson-Dekort et al., 2022, p. 7).
- "When developing opinions, thinking of alternatives as well as considering the positive factors and negative factors of each thought is critical to display that the thought was contemplated to its fullest" (Henderson-Dekort et al., 2022, p. 7).

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Legal capacity

While the above discussion refers to the components of capacity from a developmental perspective, there is another, less discussed component of capacity which refers to the child's legal capacity.

Legal capacity refers to a person's authority under law to make a particular decision, engage in a particular undertaking, or have a particular status (Anderson et al., 2023). It is often considered together with legal personhood, which refers broadly to a person's capacity to have rights and duties within a legal system. Legal capacity refers to a socio-legal status, in which "people may have a right to but may not be able to exercise in full or in part" (Anderson et al., 2023, p. 2).

The UN Convention on the Rights of Persons with Disabilities (CRPD) and UN Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) define legal capacity as people's capacity to have rights, and to have the capacity to act on those rights on an equal basis with others without discrimination on the basis of gender or disability. It is a recognized status.

The International Disability Alliance's legal opinion on the CRPD describes legal capacity as consisting of two components: the capacity to hold a right and the capacity to act and exercise the right. This is reflected in international human rights law (Bach & Kerzner, 2010).

Legal capacity is recognized internationally as a term but not commonly used in Canadian law—instead, capacity is often used and defined as an ability to understand information relevant to making a decision and an ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision. "In this sense, capacity refers to the cognitive requisites considered necessary for exercising one's right to legal capacity, and having it respected by others" (Bach & Kerzner, 2010, p. 17).

Why does the concept of legal capacity matter? As Bach and Kerzner (2010) explain,

> The concept of legal capacity is significant because it represents a shift in the understanding that many members of the legal community have attributed to it. A common understanding of legal capacity law in Canada views it in relation to a person's cognitive functioning[...] thus, having the status of being considered legally capable is determined based on a person's own ability to understand information and assess consequences of making a decision. Legal capacity, in this sense, is attached to the attributes of a person. In contrast, legal capacity as it is used in the [CEDAW] and CRPD is a social and legal status accorded independent of a person's particular capacities (p. 17-18).

Based on their analysis of the laws in Canada and international conventions, Bach and Kerzner state that "legal capacity does not reflect an individual's ability to make decisions" but instead "reflects an individual's ability to make decisions and have those decisions respected" (2010, p. 18). This is a social model approach to defining and understanding disability and it defines legal capacity by focusing not on the individual's attributes or relative limitations, but rather on "the social, economic and legal barriers a person faces in formulating and executing individual decisions, and the supports and accommodations they may require given their particular decision-making abilities" (Bach & Kerzner, 2010, p. 18).

Bach and Kerzner (2010) argue for supporting people with disabilities in their decision-making where appropriate, in order to ensure and protect their fundamental legal capacity (i.e. their protected social and legal status). We may extrapolate from this to youth and children generally—that is, an approach whereby a child's fundamental legal capacity is respected and their ability to exercise that capacity is supported as needed.

Participatory and decisional capacity

Capacity can be further divided into two distinct applications: (1) the capacity to participate, and (2) the capacity to make a decision (Henderson-Dekort et al., 2022).

Participatory capacity refers to a child's ability to "engage with other people around issues that concern their individual and collective life conditions" (Malone & Hartung, 2009, p. 27).

Decisional capacity is "the ability of an individual to make their own decisions; this could be regarding medical decisions, the ability to stand trial in a court of law, or make decisions relating to personal care" (Henderson-Dekort et. al. 2022, p. 4 citing Dunn et al, 2006). In children, decisional capacity is associated with the ability to make relatively independent choices without adult direction or control.

One young person from our youth engagement said:

> "I understand my ability to have capacity as whether I can make a decision, in my rational brain or my emotional brain."

The question of "capacity to do what?"

The literature reviewed and youth engagement conducted by SCY suggest that the definition of capacity shifts depending on the situation at hand. Accordingly, there "should not be a universal test for capacity" because capacity is "not a global condition but rather domain and/or decision-specific; hence, the requirement to ask, 'capacity to do what?'" (CBA, 2023).

The answer to this question determines the context and the corresponding capacity required (CBA, 2023). "Consideration of the full bundle of the child's rights is required to ensure the developmental, participatory and protective elements of the child's evolving capacities are respected" (CBA, 2023).

The Canadian Bar Association provides the following non-exhaustive list of situations that engage a child's capacity:

- Consent to/refuse release of records;
- Consent to/refuse medical treatment;
- Consent to/refuse treatment for mental disorders;
- Consent to/refuse consent to evaluation or assessment;
- Consent to/refuse testing;
- Consent to doctor-assisted death;
- Admit/refuse admission to hospital;
- Enter a solicitor-client relationship;
- Waive solicitor-client privilege;
- Instruct counsel;
- Testify/give evidence;
- Stand trial;
- Register in school;
- Determine the school in which to register;
- Make access arrangements with a non-residential parent;
- Open a bank account;
- Apply for a driver's licence;
- Enter into a contract: (a) to buy a car; (b) to buy a cell phone); (c) to rent an apartment;
- Travel as an unaccompanied minor;
- Enter a foreign country as a refugee;
- Consent to sexual activity;
- Consent to marry; and
- Vote

(CBA, 2023).

Different levels of capacity may be required, relative to the decision that is being made. For example, in the medical decision-making context, a child's capacity is defined as their ability as a patient to "understand information relevant to a treatment decision

and to appreciate the reasonably foreseeable consequences of a decision or lack of decision" (Coughlin & Canadian Paediatric Society, 2018, p. 138). The level of capacity required will scale depending upon the seriousness of the condition or treatment at hand.

Age alone is not a reliable indicator of capacity

Numerous scholars have stated that age alone is not a reliable indicator of capacity; instead, age is viewed by many as a "reductive categorization of a child's development and cognitive function" (Martinson & Tempesta 2018).

To deny a child's "fundamental rights on the basis of a perceived, arbitrary age or maturity level fundamentally undermines the UNCRC framework and perpetuates a blanket standard that young people under the age of eighteen are unable to rationalize their legal interests in particular" (emphasis added, Jackson & Martinson et al., 2020, p. 2, citing Grover, 2015).

Age is useful as one indicator of capacity and can provide information about the developmental stages in that child's life but using it as a sole or as a primary indicator of capacity is inconsistent with the results of our literature review and youth engagement. That research shows that youth at varying ages—and indeed adults and people generally—develop and maintain various capacities at varying rates depending on multiple factors, because capacity is a multi-dimensional, multi-factorial construct.

One youth shared that at a young age (8-years-old) they possessed the capacity to understand and decide which parent they wanted to live with during a custody dispute, stating that:

> *"I want to live with my mom, full time. I know that my dad will be angry, but for me, it makes sense for me to live with my mom. My dad is always angry, so it does not matter where I live, he will be angry anyway."*
>
> Youth Engagement

UN General Comment No. 12 (2009) to the UNCRC states that a child is **"able to form views from the youngest age, even when she or he may be unable to express them verbally"** (emphasis added). Thus, to fully implement Article 12, children may require alternative forms of expression, such as non-verbal forms of communication like "play, body language, facial expressions, drawing, and painting" (Adami et al., 2023, p. 139).

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Capacity as "present or not"

Traditionally in legal settings, child capacity has been viewed as either present or not, "meaning the child either has the capacity to make a sound decision or they do not" (Henderson-Dekort et al., 2022, p 4, citing Parkinson and Cashmore, 2008). This binary approach of capable or incapable is not supported by current developmental psychology research (Tisdall, 2018). It is also contrary to the notion of capacity as evolving and fluid.

There is an argument that capacity should be presumed present, rather than absent, in family law proceedings (Henderson-Dekort et al., 2021; Tisdall, 2018). We expand this to refer more broadly to matters affecting children. This is supported by UN General Comment No. 12 and the UNCRC, which (as noted earlier) presume that a child is capable of expressing his or her own views, rather than incapable. The General Comment states that **"it is not up to the child to first prove her or his capacity"** (para. 20, emphasis added).

This approach is further supported by the experiences of children and youth. Their experiences consistently highlight that when they were assumed incapable, and thus prevented from being heard or otherwise participating in matters affecting them, they experienced great harm—they felt isolated, unheard, violated, and disempowered. These experiences caused them to experience mistrust of authorities and the legal system. This is particularly true of Indigenous children and youth, and those who are marginalized and vulnerable, whose experience with and view of authorities is poor as a starting point.

From an interview with a youth participant:

> "It's not really a matter of trying to figure out what criteria can be used to assess capacity or whether or not someone has it—it's the need to change that framing to every child and every person has capacity, it's just a matter of the medium to really engage that capacity or support someone to exercise that capacity."

The development of capacity and the impact of Adverse Childhood Experiences

> *"Everyone needs one safe person, someone who will listen*
>
> Youth Engagement

Another theme emerging in the literature is the way in which trauma, or Adverse Childhood Experiences (ACEs) during a child's early life, impacts their capacity. It is important to note at the outset that although a child or youth may have multiple ACEs present, this does not in and of itself eliminate their ability to possess or exercise capacity, just as it does not for adults. The presence of ACEs cannot be used as justification for deeming that a child or youth is incapable, or otherwise serve as a barrier to their meaningful participation in matters affecting them. Instead, the presence of ACEs should alert one to specific challenges or differences that may (or may not) be present in how a child or youth is able to possess or exercise capacity in a variety of contexts, and correspondingly, to offer appropriate, context-specific support to that child or youth in their ability to exercise their capacity.

ACEs are defined as potentially traumatic events occurring in childhood, and include:

- Experiencing violence, abuse, or neglect;
- Witnessing violence;
- The death of a family member;
- Exposure to adults with substance use or mental health problems;
- Instability due to parental absence;
- Lack of adequate food or housing;
- Discrimination;
- and many others

(Centers for Disease Control and Prevention, 2023)

Children experiencing ACEs may ultimately develop a "low sense of self-efficacy—where self-efficacy is the belief that we can be agents in improving our own lives—which is needed to engage in planning, goal-oriented behaviours" (Center on the Developing Child, 2016, p. 8), thus impacting the development of a child's capacity.

Conversely, positive early experiences with adults—even the presence of only one supportive, stable adult—will help a child adapt to and ultimately overcome early adverse experiences. Positive early experiences with adults provide the foundation of what is referred to as "resilience".

Children with disabilities

The literature provides that children with disabilities should be considered capable, but that their participation should be scaled or altered to meet their capacity level. Children with "low intelligence, a disability, learning difficulties, or poor relational/ attachment with parental figures...[should] be included and considered as primarily capable as well, but their participation must be altered to meet their capacity level. [...] [E]ach child must be given ample opportunity to display their abilities, in whichever manner works most efficiently for them" (Henderson-Dekort et al., 2021, p. 12).

The literature suggests that "even...children...with intellectual disabilities benefit when granted autonomy with enhanced protections and support in decision-making" (Jackson & Martinson, 2020 p. 2, citing Saaltink et al., 2012).

Delving deeper into the applicability of the UN Convention on the Rights of Persons with Disabilities (CRPD) to child capacity, scholars note that Article 12 of the CRPD "creates a new model of legal personality and legal capacity" (Tisdall, 2018 p. 165, citing Series, 2015). That Article provides: (1) States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law; (2) States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life; and (3) States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity (emphasis added).

According to Series (2015), "this new approach treats a person's agency as shaped or even constituted by their environment and relationships with others. Instead of casting 'mental incapacity' as an individual deficit, resulting in a loss of legal capacity, it calls for the provision of whatever support is necessary to ensure that disabled people are able to exercise full legal capacity on an equal basis with others, and addressing discriminatory attitudes and barriers that might limit the recognition and exercise of legal capacity by disabled persons" (p. 79, emphasis added). This is a support model; that is, individuals should be supported in exercising their legal capacity and expressing their views.

However, scholars have questioned how to reconcile such an approach with the best interests paradigm. Tisdall (2018) opines that the support model in effect rejects the best interests model. The General Comment 2014 on Article 12 further considers best interests determinations as "inconsistent with the support paradigm, giving insufficient respect to an individual's will and preference" (Tisdall, 2018, p.166, citing General Comment 2014, para. 21).

While the General Comment (2014) insists that there are "no permissible circumstances under international human rights law in which a person may be deprived of the right to recognition as a person before the law, or in which this right may be limited" (para. 5), it nevertheless qualifies this right for children in paragraph 36. The reason cited for this is the "developing capacities" of children. In short, "the General Comment itself demonstrates a competence bias" (Tisdall, 2018, p. 166).

> *"I have capacity because of lived experience*
>
> Youth Engagement

Mature minor doctrine

Another aspect of capacity in practice is the mature minor doctrine. The mature minor doctrine recognizes the capacity of some children to make decisions for themselves, especially medical decisions, even when contrary to their parents' positions. The doctrine arises from Gillick v. West Norfolk and Wisbech Area Health Authority and another (1985 3 All ER 403, [Gillick]).

The Gillick case is viewed as "fundamental to the modern understanding of how law can include considerations of the capacities of children and has had a massive influence on efforts to establish what this may look like in practice. Gillick has also evolved to a standard for questions regarding children's capacity across various legal proceedings such as family law proceedings" (Henderson-Dekort et al., 2022, p. 5).

In Gillick, the Court found that "parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision" (Gillick, 1985, p. 421-422).

The test of "sufficient understanding and intelligence" to consent to the matter in question, however, has led to confusion about the level of understanding children should have and in which context (Cave, 2014), and there is a lack of consistency regarding its application (Daly, 2020).

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Criticisms and limitations of capacity concept

Many of the myths and assumptions underpinning modern notions of capacity are rooted in what scholars have termed "childism".

Childism is "prejudice against children that leads to structural discrimination and oppression against [them]" (Adami, 2023 p. 127). It "characterizes children as defined by their lack of adult abilities and, therefore, as inferior to adults" and on this basis children are "assigned or denied certain perceived abilities, skills, or character traits" (Adami, 2023, p. 128). Adami likens this to discrimination on any other grounds—racism, sexism, ableism. It pertains to the discrimination of children (below 18 years) and occurs when a person is "treated less favourably because of age (0-18), including age stereotyping" (Adami, 2023, p. 128).

Childism is critical to identify and name in the realm of child participation, because a child's "perceived lack of ability or capacity relative to that of adults, risks leading to a poor realization of their rights as set forth in the UNCRC" (Adami, 2023, p. 134). Put more directly, when children are deemed incompetent due to prejudice, they are prevented from exercising their legal rights. The global maltreatment of children and unaddressed human rights violations against them has been termed a "silent pandemic" (Adami, 2023, p. 134).

Under this framework, adultism is a "power structure[...]maintained through adult and ableist normativity" (Adami, 2023, p. 144). This perspective also calls into question the best interests framework, if it is the case that the child's best interests are determined by adults and not the child themselves.

It is important to consider the social context and cultural beliefs about the nature of childhood when asking the capacity question (Gaylin & Macklin, 1982; Kopelman & Moskop, 1989). Asking this question reveals a number of myths and assumptions giving rise to childist views.

Alderson and Goodwin note:

> Twentieth century Western notions of childhood are dominated by developmental theories which implicitly perceive children as partly formed human-becomings rather than as human-beings capable of full experiences and relationships as critically reviewed by the Stainton Rogers (1992). Beyond associating childhood with incompetent ignorance and folly, such notions take incompetence as the definitive and essential nature of childhood, the distinguishing feature from adulthood. A few interviewees in the consent study accepted this dichotomy, assuming that `children can't possibly decide for themselves until they grow up/ leave home/ have done A-level biology'. They dismissed the possibility of the competent child, or felt troubled or threatened by it. Most interviewees did not identify competence with age and believed that children could be competent. Yet influential ethicists (Buchanan and Brock 1989) and lawyers continue to accept simplistic status

definitions of competence and assert that most minors do not have the cognitive and moral maturity to evaluate complex decisions.

Anthropologists argue that the vague concept of the competent person is mainly defined negatively, by classifying certain groups as `incompetents' (Young 1990). Then adults, for example, do not need to question their own abilities, and can rest assured that they fit comfortably within the status of competent adulthood. Children's rights are far more than an intellectual matter; the unease and anger aroused during talk of children's autonomy indicate that such discussion deeply threatens adults' convenience, power and beliefs about the moral order. As discussed in the next section, if children are defined by their incompetence, ignorance and folly, then `children's rights' is essentially a contradictory term (1993, p.6).

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E. Models for Supporting Child Participation

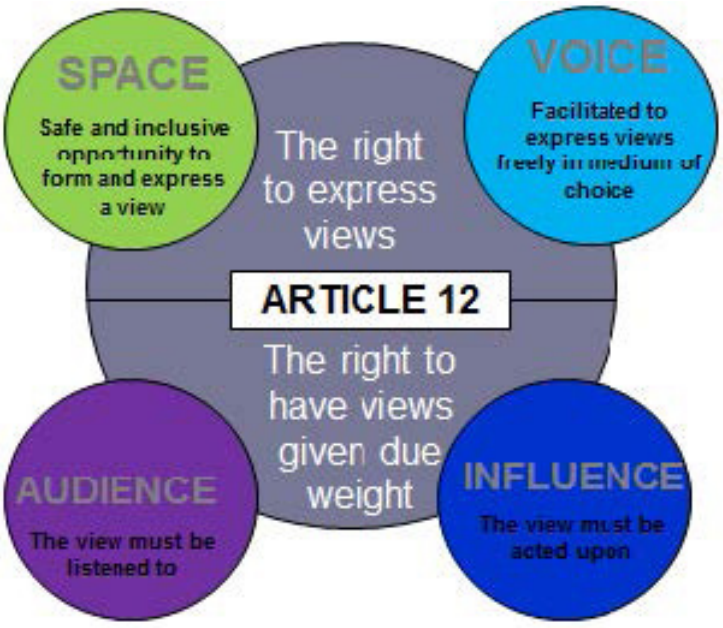
Moving forward and implementing the above research on child capacity, we look to some examples of models for child participation. Two models in particular--the Lundy Model of Child Participation (Byrne & Lundy, 2019) and the Circle of the Child Model (Morgan, 2018) -- provide robust examples.

Lundy Model of Child Participation

The Lundy Model was created by Professor Laura Lundy and has been adopted internationally by various national and international organizations, agencies, and governments (Byrne & Lundy, 2019).

The purpose of the Lundy Model is to assist duty-bearers in meaningfully involving children in decision-making, in compliance with Article 12 of the UNCRC (Byrne & Lundy, 2019), which provides that "State parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child".

The model, also called a Voice model, includes four key factors: (1) space; (2) voice; (3) audience; and (4) influence (Byrne & Lundy, 2019). Decision-makers, those working with children and youth, and those involved in matters affecting children, should consider these four key factors to ensure that the children and youth are able to effectively participate and exercise their capacities.



Space

The space factor provides that it is essential to children's participation to provide a safe and inclusive space for children and young people to express their views.

Voice

The voice factor provides that it is essential to provide the necessary information and support to children and young people so that they may express their views; that is, that children are given the opportunity to be heard and to use their voice.

Audience

The audience factor provides that it is essential to ensure children and young people's views are communicated to the right people, or the right audience.

Influence

The influence factor provides that it is essential that children and young people's views are taken seriously and acted upon, wherever possible—that is, the views that they have shared are given appropriate weight and have influence in matters affecting them.

Circle of the Child Model

The Circle of the Child Model was developed by Hélène (Sioui) Trudel, a lawyer and member of the Wendat First Nation, in partnership with pediatrician Dr. Gilles Julien (Morgan, 2018). It is rooted in Indigenous perspectives and is a mediation tool that has been used in the child welfare context—particularly when attempting to determine what may be in the child's best interests. The model is based on an integrated social medicine approach and focuses on the needs, interests, and rights of children in vulnerable circumstances.

The Circle of the Child Model empowers children to be heard and to create a process that reflects their interests (Morgan, 2018). The circle is designed by the child. The child may decide who to invite, how to arrange the seating plan, and who they would like to participate and to what degree. The process includes in-depth discussions around the needs of the child and how best to meet those needs, with the discussion always being centred around the child. During the circle, the participants may share a meal and the focus is on a collaborative approach to designing an action plan that reflects the child's needs and objectives.

F. Summary of Key Findings

To summarize some of the key findings emerging from the literature surveyed and youth engagement:

1. There is no universally agreed upon definition of capacity although there are recurring themes throughout social science.

2. Age alone is not a reliable indicator of capacity. Decision makers should not use age as the sole determinative factor of children's capacity.

3. All children should be presumed to have capacity to express their views and preferences. Great harm is done to children who are not permitted to exercise their capacity to be heard in matters affecting them.

4. Capacity can be understood as both a function of cognition, as well as an ability or a right one possesses. What it is varies depending on its context or function. Capacity can be a legal right.

5. Capacity encompasses a variety of factors and develops at different rates. Children may possess more or less capacity in different contexts. The capacity to be heard is not the same as the capacity to be the decision maker.

6. The United Nations Convention on the Rights of the Child provides that a child need only be capable of forming a view in order for their view to be heard and considered. There is no further test of cognition or capacity that should stand in the way.

7. Children and youth must be equitably supported to express their views and desires on matters affecting them, using methods that meet their level of capacity.

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Youth Engagement Methodology & Data

The Child Capacity Research Project sought to embed key values and principles in the research process that in turn shaped the research methodology, community engagement, and analysis of the results. These values and principles pertained to striving for accessibility, highlighting intersectionality, valuing lived and living experiences, and others crucial for meaningful engagement and research.

It was this approach, as well as the calls to action from participants, that allowed for the recognition that while the project was intended to look at four key topics with complex systems of their own, they are also interconnected in many ways. In addition, it was noted throughout the youth engagement that it was sometimes difficult for participants to speak to one system without describing the impact of another. Thus, we advise readers to recognize the intersectionality of the lived experiences reflected in the information below and that also has contributed to the richness of qualitative data that emerged.

ENGAGEMENT METHODS:

Three distinct engagement methods were utilized to provide accessible opportunities for contribution from youth and young people, primarily below the age of 30, with lived and living experiences in relation to the research topics. All three options were offered to every participant prior to written consent being provided:

Survey:

- An anonymous, online survey consisting of 3 questions was made available during the entire duration of the project
- The nature and structure of the questions allowed for participants to respond based on the experience they deemed relevant to contribute

Interviews:

- 1-hour virtual Zoom sessions with a participant and two members of the CCRP team
- Discussion questions* were provided in advance
- Follow-up interview opportunity offered

Listening Circles:

- 1-1.5 hour virtual Zoom sessions with existing youth advisories, councils, and other programming groups
- Sessions were coordinated in collaboration with group/organization leads, coordinators, and/or supporting staff
- Discussion questions* were provided in advance
- Follow-up session and/or interview with interested participants offered

***Note:** The following three questions were used in all methods of engagement and were specified (in Listening Circles and interviews) based on the topic participants wished to address. However, it is crucial to note that while these were the primary questions asked, discussions often built on what was shared in the session. The evolving conversations differed per group / participant, and as a result, the extent of questions that organically emerged were not able to be included in the list below.

Discussion Questions:

1) How do you define "capacity"? Based on your understanding, do you feel you have had capacity to make decisions, or the opportunity to use your capacity to participate in decisions?

2) Can you tell us about a time [in a family law / mental health / healthcare decision / child protection matter] when you felt like your opinion was valued and taken into consideration?

3) Based on your experience [in a family law / mental health/ healthcare decision / child protection matter], how do you think things could be improved so that your capacity to make decisions and be heard is better respected?

Stakeholders & Subject Matter Experts:

- Stakeholders and subject matter experts across sectors were invited to provide feedback on the draft outlines for all four research papers at a virtual roundtable held during the earlier stages of the project
- Individuals part of community networks were also selectively invited to provide feedback on research paper drafts as they were developed by topic

Outcomes:

- 78 participants across all methods of the youth engagement contributed their feedback by sharing their lived and living experiences
- An analysis of themes from the youth engagement by topic can be found below

Note: While the project sought to uplift intersectional experiences of young people across all four topics, there are limitations to those reflected in this paper. It is recommended that future research initiatives dedicate efforts to highlight the specificities of identities of young people that may uniquely inform the nature of their experiences with respect to the four topics examined in this project (e.g. gender and sexuality).

THEME CODE	THEME:	DETAILS/VARIANCES
1	Decision-making ability	• **Action** and **process-oriented** • Ability related to decisions and providing consent as contingent upon being **informed** • Ability as characterized by **autonomy with limited to no coercion** • Ability as characterized by **appropriateness and ethicality** of the decision ("best" decision, "correct" decision, "right" decision) • Ability as aligned with **"best interest"** • Ability as characterized by **participation** • Ability as related to **emotional regulation** • **Lack of decision-making** ability **equated to lack of capacity**
2	Comprehension	• Ability to **receive and process information** • Ability to **provide input based on understanding** a situation • Understanding **consequences as an indicator of comprehension** • Understanding **reasons and process to make decisions** including assessment • Awareness and understanding of **rights, desires, and self-interests**
3	Quality of flexibility	• Capacity **shifts over time and based on circumstance** • Nature of **decisions differ with age** but **existence of capacity remains consistent**
4	External factors	• **Lived experiences shape variances** in capacity amongst young people • **Systemic contexts play a significant role** in the ability to exercise capacity • **Ageism impacts ability to exercise capacity in multi-faceted** ways (e.g. having to 'prove' maturity) • **Opportunities** to build capacity contingent upon **systemic privilege** • **Potential consequences** impact how individual capacity is exercised
5	Early development	• Children **involved in decision-making earlier** supports long-term capacity-building
6	Purpose	• Capacity to be **consulted** differs from capacity to **engage in decision-making**
7	Cultural context	• **Many Indigenous cultural practices reflect systems/models that are inclusive of youth** and bringing all people together – differs significantly from colonial government's perception of children
8	Intuitive	• Capacity as reflected by **intuition and emotional awareness** (i.e. "gut sense")
9	Basis for assessment	• Assessment of capacity (if any) must occur on an **individual and contextual basis** • Need to **shift framing (and onus) of 'capacity assessment' to 'best engagement method'** • Capacity as **subjective** and possibly in **opposition to that as perceived by 'adults'**
10	Relationship to age	• Age as a **factor not a defining characteristic** • **Inconsistent and arbitrary** as related to age
11	Predisposition of individual	• Having capacity as related to **state of mental and emotional well-being** • Recognizing that one's understanding of "capacity" is **informed by their understanding of the world**

Child Capacity and Participation in Healthcare Decisions

The Society for Children and Youth of BC

SOCIETY FOR children and youth OF BC

REPRESENTATIVE FOR CHILDREN AND YOUTH

Health Care

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Acknowledgements

We would like to recognize the generosity of all youth and contributors in sharing their experiences and insights throughout the project. We thank you for allowing us to hear your stories across the various mediums in which your words were shared. Thank you to all stakeholder experts who provided their knowledge and wisdom for each project topic, providing our research team with invaluable information that shaped the emergent themes and key findings. This project began with the convening of community stakeholders at an initial roundtable, and we would like to give our thanks to the folks who joined us. Finally, thank you to everyone who provided guidance and feedback throughout the duration of this project.

The Society for Children and Youth of BC would like to acknowledge that we live and work on the traditional territories of the First Nations peoples of British Columbia. Our office is located on the Unceded Territory of the xʷməθkwəy̓əm (Musqueam), sḵwx̱wú7mesh (Squamish) and səl̓ilwətaʔɬ (Tsleil-Waututh) First Nations. We express our sincerest gratitude to the custodians of these lands and beyond across BC. We also wish to recognize the specific impacts on Indigenous Peoples and communities that are a result of the systems that are the focus of these papers. We invite readers to critically engage with the themes and key findings presented using this lens as well as an intersectional approach to take action.

Finally, we would like to acknowledge the invaluable contribution of the Office of the Representative for Children and Youth in facilitating this research. Their expertise, insights, and guidance throughout the research process were instrumental in shaping this work.

We would like to express our sincere gratitude to our Project Coordinator and Youth Engagement Lead, Simran Sarwara, for her invaluable contributions to this project. We would also like to thank Lisa Bellano for her extraordinary research leadership and report writing, as well as Sara Hernandez for her exceptional design of the report layout. We are also grateful to Margie Sanderson and Suzette Narbonne, KC for their leadership in editing the final report and Daniela Davies for her contributions and assistance in bringing the report to completion.

The British Columbia Representative for Children and Youth funded this report.

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About The Society for Children and Youth of BC

The Society for Children and Youth of BC (SCY) is a provincial not-for-profit charity. Since 1974, the Society has focused on providing a strong voice representing children and youth. Our mission is to improve the well-being and resilience of children and youth in BC through the advancement of their civic, political, economic, social, cultural and legal rights. Using the UN Convention on the Rights of the Child as a foundation, SCY has a track record of creating and delivering programs that have motivated change in research, legislation, policy, and practice in Canada. This year, we proudly celebrate 50 years of advocacy for child and youth rights. The organization is comprised of three programming areas: The Child and Youth Legal Centre, Child and Youth Friendly Communities, and Child Rights Public Awareness.

The Child and Youth Legal Centre (CYLC), established in 2017, provides free support to young people experiencing issues related to Family Law, Child Protection, human rights violations, and other legal matters. The Legal Centre is made up of Lawyers, Intake Workers, Child and Youth Advocates and a Social Worker. The Legal Centre has seen significant growth since its inception, and in 2023 supported 1125 young people across 90+ Communities in British Columbia.

SCY's Child and Youth Friendly Communities (CYFC) program supports child-friendly community-building with young people. Over the past eight years we have worked in collaboration with various Metro Vancouver municipal planning teams to ensure that children and youth have a stronger voice in their community's planning initiatives. Our aim is to ensure that public engagement is a deep and meaningful experience for

young people. Some of our projects include the Walking School Bus, School Streets, Play Streets, and Urban Explorers.

The Child Rights Public Awareness Campaign began in 2006 when SCY, the Representative for Children and Youth, and the Institute for Safe Schools of BC came together to envision a plan for raising awareness of child rights. Throughout the years, the campaign has engaged in numerous activities including roundtables on children's rights, the creation of a child rights network, a multimedia campaign, community and youth engagement activities, and the development and dissemination of child rights resources across the province, including multilingual resources.

Drawing from our experiences over the past several decades across different sectors advocating for child and youth rights, SCY conducted a Child Capacity Research Project as commissioned by the Representative for Children and Youth of B.C. This work aims to highlight the importance of child participation rights by way of research papers on child capacity in the context of four key areas: 1) family law, 2) child welfare and adoptions, 3) decisions about healthcare, and 4) mental health and involuntary civil detention. We are pleased to present this report series as it reflects a culmination of comprehensive literature analysis and multi-faceted youth engagement specific to each area. It is our hope that the key findings identified within each paper will support systemic action and facilitate cross-sectoral collaboration within B.C.

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Child Capacity and Participation in Healthcare Decisions

Society of Children and Youth of BC
Lisa Maria Bellano


"
The biggest issue was that no one would listen to me. No one. There was no one listening.

A. Executive Summary

This paper is part of a series on the topic of child capacity in relation to child participation rights. Throughout this collection of papers, we focus on the following areas: a broader socio-legal discussion on child capacity; family law; child welfare and adoptions; mental health and involuntary civil detention; and decisions about health care.

The key findings of this paper are derived from a literature review, legal analysis, and youth engagement. The youth engagement included surveys, interviews, and listening circles with children and youth regarding their experiences of capacity in the context of decisions about healthcare. The Society for Children and Youth of BC want to acknowledge the thoughtful young people who spoke candidly about their lived experiences. Those voices are critical to the research and key findings.

Key Findings

1. Regardless of their decision-making abilities, all children and youth have a right to be heard and to express their views in decisions concerning their healthcare.

2. As in adults, capacity of children and youth encompasses a variety of factors and develops at different rates. It is an evolving trait that may be more or less present in different contexts and can be assessed through a variety of models available to healthcare providers.

3. Healthcare must be patient-centred, with the views and interests of the young patient meaningfully considered in the provision of services. The onus must be on the healthcare provider to find an effective strategy to communicate and connect with their child or youth patient.

4. Dismissal and invalidation by healthcare providers, parents, and other adults contributes to significant negative impacts on children and youth including reduced self-esteem and confidence in their treatment plans.

5. Children and youth would greatly benefit from neutral, third-party support in medical settings that focuses only on their interests, needs, and views.

6. For many children and youth, making healthcare decisions can be an empowering experience, helping them develop individual agency.

B. Background and purpose of report

This paper provides an overview of the legal framework governing children and youth's capacity and participation in healthcare decision-making within Canada, contextualized within a broader children's rights framework informed by the United Nations Convention on the Rights of the Child (UNCRC), particularly Articles 5 and 12. Focused primarily on the jurisdiction of British Columbia, this paper explores the interplay of legal principles, provincial statutes, and international conventions, providing an overview of the way in which these elements interact to shape healthcare decision-making processes for minors. By contextualizing legal principles within a children's rights framework informed by the UNCRC, this paper seeks to contribute to a deeper understanding of the complex dynamics shaping healthcare decision-making processes for minors and the importance of upholding children's participatory rights in healthcare contexts.

This paper is part of a larger research project exploring the interplay between child capacity and child participation in legal proceedings in Canada with a focus on the experience of children in British Columbia. Capacity and participation are considered through the lens of the United Nations Convention on the Rights of the Child (UNCRC) (1989), to which Canada is a signatory, and the Canadian Charter of Rights and Freedoms.

C. Discussion

Legal framework and concepts

> *"I don't think age had anything to do with capacity. I will say our age has something to do with what other people think of our capacity. I know minors are not exactly allowed to make certain decisions. I felt like my age had something to do with the first time. I felt the second time I should speak up, because I am older."*
>
> Youth Engagement

In Canada, the framework for children or youth to exercise their capacity to make healthcare decisions is complex, in large part due to the interplay between common law principles, provincial and territorial legislation, child protection laws, legal precedents, and international conventions.

- The mature minor doctrine, which recognizes the capacity for children to make health care decisions for themselves, grants some autonomy to mature children and youth to make their own treatment choices, even when those choices don't align with those of their guardians.
- Some provincial and territorial laws set specific ages at which children can consent to medical procedures, although many do not provide specific ages and instead offer factors for consideration.
- Child protection legislation allows agencies to seek court orders for treatment if consent is refused by the child or parent, prioritizing the child's well-being.
- Legal precedents guide the interaction of these laws, shaping healthcare decision-

making for children and youth across Canada.

- The United Nations Convention on the Rights of the Child intersects with Canada's legal framework for children's healthcare decisions by reinforcing the rights of children to participate in matters concerning their health and well-being, while the Nuremberg Code provides the fundamental basis for the right of a person to consent to medical treatment. The World Health Organization provides guidance on the topic of child and youth capacity in the context of healthcare decisions.

The Evolving Trait of Capacity

> *"I think of capacity as my ability to do something, taking into account my resources and support. When I make a decision, I have the capacity to do so if my resources and support allows me to. This can be as simple as having a safe space to sit and think something through, or talk a decision out with someone."*
>
> Youth Engagement

Capacity is widely recognized as an evolving rather than fixed trait; that is, a "fluid and evolving response to various situations" (Henderson, 2022, p.6). This further supports the premise that children are also "active agents in their own lives entitled to be listened to, respected and granted increasing autonomy in the exercise of rights, while also being entitled to protection in accordance with their relative immaturity and youth" (Lansdown, 2005, p.ix; Bellano, 2024, p. 14).

In their toolkit for health care providers, the World Health Organization (WHO, 2021) provides a guide for assessing and supporting young people's capacity to make decisions in health care. Some of the definitions of the key concepts are:

A) **Competence:** WHO defines competence as a legal concept "referring to the right to make an autonomous decision (i.e. a decision taken without authorization by a third party, e.g. parents or guardian)" (2021, p. v). Whether a person is considered to be legally competent is determined by the laws of each nation. WHO notes that in some countries, "minor adolescents are considered competent as long as, in a given situation, their health-care providers consider that they are capable of decision-making" (2021, p. v). In other countries, competence is more strictly defined by the age of the young person.

B) **Decision-making capacity:** WHO distinguishes between competence and decision-making capacity. According to WHO, competence is a legal concept; decision-making capacity, conversely, is a "clinical concept that refers to the individual psychological or cognitive ability to make a decision" (2021, p. v). WHO outlines four separate dimensions that constitute decision-making capacity: (1) how a person understands information pertaining to their condition and the available treatment options; (2) how a person compares treatment options by "balancing risks and benefits", and their ability to discuss the "potential consequences" of any given decision; (3) how a person "discusses the relevance of the options for

their own situation"; and (4) how a person expresses a choice and argues for it in "light of previous discussions" (2021, p. v).

C) **Evolving capacity:** Consistent with the UNCRC, WHO advances an overall definition of child and youth capacity as evolving. This refers to the evolving or changing capacity of an adolescent to "understand matters that affect changes in their life and health with age and maturity" (2021, p. v). Specifically, "the more an adolescent knows, has experienced and understands, the more the parent, legal guardian or other persons legally responsible for him or her can transform direction and guidance into reminders and advice, and later into exchange on an equal footing" (2021, p. v). In the healthcare context, evolving capacity means that as a child or youth matures, their views are accorded increasing weight in healthcare choices. Neither age nor vulnerability (such as having a disability or belonging to a minority group) prevent a child or youth from exercising their evolving capacity—these are not appropriate bases to "deprive them of the right to express their views, nor does it reduce the weight given to the adolescent's views in determining their best interests and, hence, choices on aspects of care" (2021, p. v).

D) **Informed choice:** WHO defines informed choice as one made "on the elements of [one's] care", including "treatment options, follow-up options, refusal of services" and arising "as a result of adequate, appropriate, clear information for understanding the nature, risks, alternatives to a medical procedure or treatment and their implications for health and other aspects of the adolescent's life" (2021, p. vi). In a situation where there are multiple possible courses of action for a health condition, or in the presence of treatment uncertainty, then "the advantages of all possible options must be weighed against all possible risks and side-effects" (2021, p. vi). In all cases, the views of the child or youth "must be given due weight according to his or her age and maturity" (2021, p. vi).

E) **Informed consent:** Informed consent is defined by WHO as "a documented (usually written) agreement or permission based on full, clear information on the nature, risks and alternatives of a medical procedure or treatment and their implications, before the physician or other [healthcare provider] begins the procedure or treatment" (2021, p. vi). After this information is received, the child or youth, or third party authorized to give informed consent, may either consent to or refuse the procedure or treatment. As WHO explains, laws vary state-by-state in terms of which procedures or treatments require informed consent. Once again aligning with the UNCRC, WHO provides that an adolescent "should be supported to make an informed choice and give assent if they wish" (2021, p. vi).

As noted above, WHO notes that competence must be differentiated from capacity: competence pertains to a legal concept respecting "the right to provide an opinion or make an autonomous decision", while capacity refers to a "clinical concept of individual

psychological and cognitive ability to understand information, reason and reflect to make a decision" (2021, p. 6). Both are "task- and context-specific" (WHO, 2021, p. 6), meaning that the competence and capacity that are required shift according to the task or context at hand. In terms of children and youth, WHO explains that a potential difficulty is the fact that "capacity for autonomy is a continuous variable (evolving degree of capacity), but determination of competence is dichotomous (yes or no)" (2021, p. 6). This means that capacity is a shifting or evolving variable, but competency either is or is not required for a task or situation.

WHO further notes that, since capacity is "specific to each task and context specific, adolescents may have adequate capacity for a given decision but diminished or absent capacity for another medical decision" (2021, p. 6).

Capacity is also widely referenced in the UN Convention on the Rights of the Child (the UNCRC). Article 5 of the UNCRC states that "States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, **in a manner consistent with the evolving capacities of the child**, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention" (emphasis added).

The UNCRC does not provide a definition of capacity. According to Henderson-Dekort and colleagues (2022):

> Within specific articles within the United Nations Convention on the Rights of the Child (1989), it is clear that there is frequent uncertainty surrounding the term capacity. It remains a difficult concept to assess with certainty, especially in the case of children. This is concerning considering how frequently the term is used or alluded to in matters that pertain to the participation or rights of children (p. 3).

"Evolving capacity," as it is used in Article 5 of the UNCRC, refers to a child's progressive ability to exercise his or her rights (Canadian Bar Association, CBA, 2023). This is distinct from the view that capacity is a fixed trait. Instead, the evolving capacity viewpoint provides that capacity is not fixed, but rather is a "fluid and evolving response to various situations"—it is situation and context-dependent (Alderson & Goodwin, 1993). More to this point, evolving capacities recognizes children as "active agents in their own lives, entitled to be listened to, respected and granted increasing autonomy in the exercise of rights, while also being entitled to protection in accordance with their relative immaturity and youth" (Lansdown, 2005, p. ix).

Article 12(1) of the Convention stipulates that States Parties provide a child **"capable of forming his or her own views the right to express those views freely in all matters affecting the child"**, and that the **child's views be given due weight in accordance with the child's age and maturity** (emphasis added). Article 12(2) further states that the child be provided an "opportunity to be heard in any judicial and administrative proceedings" affecting him or her, "either directly, or through a representative...

in a manner consistent with the procedural rules of national law". Again, this article references a developmental view of capacity, providing that as children develop and acquire capacity, they shall become entitled to higher levels of responsibility in areas that affect them (UN General Comment No. 12, 2009, para. 85).

Further, The Nuremberg Code (1947) serves as a fundamental framework for consent in healthcare decisions, emphasizing voluntary participation and informed, uncoerced agreement. Though not explicitly mentioning children and youth, its principles apply to them implicitly, affirming their right to make informed healthcare choices (Annas & Grodin, 1992). It defines consent as the voluntary, informed agreement of an individual to participate in medical procedures, stressing the importance of safeguarding individuals from coercion or exploitation.

Presumption of Capacity or Competence

While adults are legally presumed to be competent unless proven otherwise, children and youth are "still too often presumed not to be competent, and their competence must be assessed in order to be recognized" (WHO, 2021, p. 7). Internationally, a plethora of legal frameworks exists for such a task: some countries set an age limit at which minors may make healthcare decisions; most countries do not and instead leave the task of assessing competence to healthcare providers.

Likewise, UN General Comment No. 12 and the UNCRC say that the assumption should be that a child is capable of expressing his or her own views, rather than incapable. The General Comment states that "it is not up to the child to first prove her or his capacity" (para. 20, emphasis added). The General Comment does not define capacity but does define maturity within the context of Article 12 as being "the capacity of a child to express her or his views on issues in a reasonable and independent manner," and "the ability to understand and assess the implications of a particular matter" (para. 30).

Other commentary suggests that the use of the term "capable" in Article 12 does not seem to mean "having capacity" to form a view (CBA, 2023; Mol, 2019). All that is required is a "formulation of a view, absent any understanding by the young person of how or why they formed the view, the basis of the view, or the consequences of voicing the view or acting on it" (CBA, 2023). Article 12 likewise reflects a view of capacity as evolving, as it provides that the child's views be given due weight in accordance with his or her age or maturity, suggesting greater weight is given as the child ages and becomes more mature, as this implies a greater degree of understanding on the part of the child and the nature and consequences of their articulated view (CBA, 2023; UN General Comment No. 12, paras. 20-21).

UN General Comment No. 20 on the Implementation of the Rights of the Child During Adolescence recommends that "States review or introduce legislation recognizing the right of adolescents to take increasing responsibility for decisions that affect their lives" (WHO, 2021, p. 7). It also provides that the right to give medical consent is distinct from "confidential medical counselling and advice, and should not be subject to any age

limit" (WHO, 2021, p. 7). Article 39 provides that adolescents may access counselling and advice without the consent of a parent or guardian, regardless of age (WHO, 2021). WHO says that "consideration should also be given to a legal presumption that adolescents are competent to seek and have access to preventative or time-sensitive sexual and reproductive health commodities and services" (WHO, 2021, p. 7).

It is important to stress the confidentiality of counselling services. Lack of confidentiality, whether perceived or actual, was a consistent concern expressed by many of the youth we engaged with through our research. As one young person shared:

> *"There were many things that I stated to my therapist that I thought were confidential, and the therapist would blab everything to my guardian. Professionals repeatedly act in the best interest of what the parents want."*

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Mature minor doctrine: "Gillick competence"

> *"My capacity to make healthcare decisions was quite strong. I had the intellectual ability and understanding. And also something I wanted to do for myself. I felt empowered to be in control of my healthcare decisions and what was happening to me. But in other areas of my life, maybe I wasn't as confident."*
>
> Youth Engagement

The mature minor doctrine addresses the capacity of children to make decisions for themselves—especially in medical matters—even when those decisions are contrary to their parents' positions. The doctrine arises from the House of Lords decision in *Gillick v. West Norfolk and Wisbech Area Health Authority and another* (1985).

In *Gillick*, the Department of Health and Social Security (DHSS) had issued guidance to doctors indicating that in certain cases a doctor could legally prescribe contraception for a girl under 16 years old without the consent of her guardian. Mrs. Gillick, who was the mother of 5 daughters, objected to this and instituted legal proceedings seeking a declaration from the Court that the guidance given by the DHSS was unlawful.

The Court declined to issue that declaration and instead ruled that a minor who is "capable of understanding what is proposed and of expressing his or her own wishes" should be found to have "the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises" (Gillick, 1985, p. 409).

In reaching that decision, the House of Lords explained that "...parental rights to control a child do not exist for the benefit of the parent. They exist for the benefit of the child" (Gillick, 1985 p. 410). In circumstances where a child reaches "sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decisions", a parent's right "yields to the child's right to make his own decisions" (Gillick, 1985 p. 422). The Court cautioned against the imposition of "fixed limits" on the process of growing up: "the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change" (Gillick, 1985 p. 421).

The *Gillick* case is "fundamental to the modern understanding of how law can include considerations of the capacities of children and has had a massive influence on efforts to establish what this may look like in practice. *Gillick* has also evolved to a standard for questions regarding children's capacity across various legal proceedings" (Henderson-Dekort et al., 2022, p. 5).

The test according to *Gillick* is, whether the child has "sufficient understanding and intelligence" to consent to the matter in question (1985, p. 422). However, the language of this test has led to confusion about the level of understanding children should have and in which contexts (Cave, 2014), and there is a lack of consistency regarding its application (Daly, 2020):

> 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 (p. 475).

It is important not to be overly strict in applying the Gillick or mature minor test. Daly (2020) argues,

> 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 (p. 485).

Informed consent laws

Each province or territory in Canada has its own legislation on healthcare decisions that differ to varying degrees from one another.

In British Columbia, the age of majority is 19 years, and there is no specified age of consent for medical treatment. According to the *Healthcare (Consent) and Care Facility (Admission) Act*, individuals who have reached 19 years of age are presumed to be capable unless proven otherwise. The *Infants Act* governs individuals under 19 years old, allowing them to consent to medical treatment—which is broadly defined as "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other heath related purpose, and includes a course of health care" - if they demonstrate capacity (s.17 *Infants Act* (1996)). However, consent is deemed invalid unless healthcare providers have taken reasonable steps to ensure treatment aligns with the minor's best interests.

Section 17 of the *Infants Act* stipulates that a child's consent is "effective and it is not necessary to obtain a consent to the health care from the infant's parent or guardian" only if:

17(3)... the healthcare provider providing the healthcare

> a) has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the healthcare and

(b) has made reasonable efforts to determine and has concluded that the healthcare is in the infant's best interests.

This determination of capacity is significant and relies on both legal standards and medical evaluations, and requires that healthcare providers appropriately assess the minor's capacity in order to ensure that the treatment is in their best interests.

For an overview and summary of Canada's provincial and territorial consent laws as they pertain to children and youth in the context of healthcare decisions, see Appendix 1 on page 34.

Informed Consent and its overlap with child welfare legislation

Across Canada, child protection laws allow provincial agencies to make treatment decisions for children when a parent's refusal threatens their health or life. This typically involves apprehending the child and obtaining a court order within a short time frame, with parents and sometimes the child entitled to notification and participation. However, the situation becomes complicated when a child is deemed a 'mature minor', otherwise capable of making their own treatment decisions.

In a pivotal case, the Supreme Court of Canada ruled that applying a best interests lens to the question of a young person's competence to refuse medical treatment was not a breach of the child's constitutional rights, as long as the child was given the opportunity to demonstrate their competence as part of the decision-making process (A.C. v. Manitoba (Director of Child and Family Services)). In this case, a 14-year-old refused a blood transfusion on religious grounds despite medical advice indicating there was an imminent, serious risk to her health and perhaps her life. Her parents supported her decision and refused to authorize a blood transfusion. The child was apprehended by the state.

Photo by Ana Klipper on Unsplash

The state argued that the relevant child welfare legislation allowed the court to authorize medical treatment that it considered to be in the best interests of the child if the child was under 16, without regard to the child's competence to otherwise consent to or refuse medical treatment. Justice Abella disagreed with such a strict reading of the legislation and instead found that "it is inherently arbitrary to deprive an adolescent under the age of 16 the opportunity to demonstrate sufficient maturity when he or she is under the care of the state" (para. 114). Any other interpretation of the legislation would likely be "...arbitrary and discriminatory. A rigid statutory distinction that completely ignored the actual decision-making capabilities of children under a certain age would fail to reflect the realities of childhood and child development" (para. 116).

In her decision, Justice Abella said:

> With our evolving understanding has come the recognition that the quality of decision-making about a child is enhanced by input from that child. The extent to which that input affects the "best interests" assessment is as variable as the child's circumstances, but one thing that can be said with certainty is that the input becomes increasingly determinative as the child matures. This is true not only when considering the child's best interests in the placement context but also when deciding whether to accede to a child's wishes in medical treatment situations (para. 92).

This 'sliding scale' approach, where the degree of deference to the child's decision increases with maturity, aligns with Article 12 of the UNCRC, which underscores the importance of considering children's views according to their age and maturity.

Cave (2014) argues that in its decision in *A.C. V Manitoba (Director of Child and Family Services)*, the Supreme Court of Canada moved closer to the view that "though the minors' views may not be authoritative, they are always relevant, because Article 12 of the UNCRC demands that all children are consulted about decisions made about them" (p. 116).

Case law

Subsequent cases have followed this approach in recognizing the importance of determining the proper balance between the child's views and the risks to the child.

In Alberta (*Child, Youth and Family Enhancement Act*, *Director) v. K.R.*, (2010) the Supreme Court of Canada held that decision-makers should use a "functional" approach when assessing a child's capacity to make decisions about their healthcare. This means that the focus should be on the child's ability to understand the relevant information and appreciate the consequences of their decision, rather than on their age or cognitive abilities.

In *C.C. v. Children's Aid Society of the Region of Peel,* (2012), the Ontario Superior Court of Justice held that children have the right to make their own healthcare decisions if they are capable of doing so. The Court emphasized that decision-makers should

take into account the child's wishes and opinions, and should only override the child's decision if it is necessary to protect their health or safety.

Assessment models

> *"It is so frustrating to realize that if I had known, I would have never went on it. It is so frustrating to me that no one explained it to me. When you are in the doctor's office, someone is always talking over you. The doctor does not listen. Doctors and parents go to medications as a solution when in reality the medications are the problems or at least exacerbated it. If I had not been drugged out of my mind, I would have been better."*
>
> Youth Engagement

Healthcare providers often do not have sufficient time in a patient appointment to fully assess a young person's capacity. This is notwithstanding the fact that the proper assessment of a child's capacity is critically important. If a child or youth is assessed as lacking capacity when this is not in fact the case, that child or youth "lose[s] control over [their] life"; by corollary, if a child or youth is assessed as having capacity when they do not, then they "could suffer harms and injuries and[...]would be told that that was [their] choice" (Herring, 2016, as cited in Daly, 2020, p. 473).

The following three assessment models are examples primarily used by healthcare providers to assess the competence or capacity of a child or youth to make their own decisions in healthcare. They are described here in summary, with more details provided in Appendix 2 on page 37.

MacArthur Competence Assessment Tool

The MacArthur Competence Assessment Tool (MacCAT) is a structured set of interview instruments developed by Grisso and Appelbaum in 1998 (Hein et al., 2015). The instrument focuses on assessing four areas of the patients' understanding, including information about their condition and recommended treatment, risks, benefits, nature of the situation, and the ability to express a choice.

Multidisciplinary-developed assessment model

This four-step assessment model developed by Michaud and others (2015) involves assessing the patient's understanding of their situation; evaluating their reasoning and application of logic; assessing their thinking regarding different options; and ensuring they are able to express a choice.

WHO 4-step assessment model

WHO provides another four-step assessment model involving joint exploration of the situation and options; coming to a common synthesis of the situation; deciding whether the patient has capacity to make an autonomous decision in the particular situation and given time; and providing a follow-up regardless of outcome.

Capacity to make healthcare decisions: specific considerations

Medical assistance in dying (MAID) for children and youth

In Canada, the regulations for medical assistance in dying (MAID) stipulate that applicants must be 18 years or older. Notwithstanding this, certain regions in Canada grant mature minors the authority to make significant decisions about their healthcare, including the ability to consent to or refuse life-saving medical interventions. Dying With Dignity Canada (DWDC) advocates for extending this autonomy within MAID, emphasizing the importance of robust eligibility criteria and safeguards to protect vulnerable individuals. DWDC (2021) proposes revising the current age requirement to include individuals "at least 12 years of age and capable of making decisions about their health" (para. 5), prioritizing capacity and maturity over strict age limits.

DWDC (2021) suggests that,

> Mature minors who might be seeking to access MAID in Canada would likely be very similar to the adults who seek to access MAID: individuals with a grievous and irremediable Medical condition who are facing significant suffering (para. 14).
>
> and
>
> Overall, a mature minor who might want to access MAID would likely be one who has been engaged in their healthcare over a sustained period, who expresses a deep understanding of the consequences of their decisions, who faces a condition that is irreversibly progressing, and who has spiritual, physical, psychological, and/or existential interests in contributing to a decision about their death and/or accessing an assisted death at the end of their life. Like all individuals accessing MAID, these decisions would not be easy, so it would be reasonable to presume that mature minors making these decisions would have a close social circle who were able to provide the person with support in making this important decision (para. 15).

DWDC emphasizes the need for informed consent from competent parents or guardians for minors aged 12 to 15 seeking access to MAID. For minors aged 16 and 17, DWDC suggests additional consultations between assessors and parents or guardians. It is essential to understand that the concept of a 'mature minor' varies and exists on a spectrum rather than a binary classification, encompassing different levels of decision-making capability across various contexts and over time. The precedent set by the *A.C.*

v Manitoba decision highlights that mature minors may possess legal capacity to make end-of-life decisions, depending on their understanding and ability to consent. Bill C-7, which received Royal Assent and underwent Parliamentary Review in 2023, brings significant changes to MAID, including provisions for mature minors and individuals with mental illness, as well as advance requests for MAID. Bill C-62 delays the expansion of MAID for three years from the current date, postponing broader access to MAID.

Transgender children and youth; the *Family Law Act* and *Infants Act*

> *"I'm transgender and when I was in the process of getting assessed for gender dysphoria, it was one of the few times where I feel like I was actually listened to. I shared my feelings, thoughts, and experiences, and my doctor wrote a report that reflected that he was really listening and thinking about what I told him. Because he took me seriously, I was able to get the help I needed as quickly as possible. This genuinely saved my life. I was very suicidal and wouldn't have gone much longer without help fast. He listened to what I wanted and was able to help me get it."*
>
> Youth Engagement

When speaking about the legal rights of transgender children and youth seeking medical care, barbara findlay, KC (2022), is unequivocal: "BC law regarding transgender youth consent to gender-affirming medical treatment is unambiguous: the youth has the exclusive right—provided certain conditions are met by their healthcare provider" (p. 65).

An important decision in this area is the case of *AB v CD* (2020), involving a transgender 13-year-old, assigned female at birth, who sought gender-affirming medical treatment. His doctor recommended puberty-delaying hormone therapy, which his father contested. The youth brought an application to court seeking a declaration that he was entitled to make his own medical decisions and that the treatment he sought was in his best interests. The father sought an injunction to prevent treatment.

The lower court dismissed the father's application for an injunction and held that his guardianship right to determine his child's medical care was limited by section 41(f) of the *Family Law Act* (2011), which is subject to section 14 of the *Infants Act*. Section 17 of the *Infants Act* provides that if a minor comprehends a proposed treatment and its implications, and if the medical provider determines the minor to be competent and the treatment to be in their best interest, then the minor holds the exclusive right to consent to the treatment. Accordingly, the court ruled that AB had the sole authority to consent, and his father could not intervene. This decision was upheld by the BC Court of Appeal.

The BC Court of Appeal outlined the duties of healthcare professionals when dealing with patients under 19 years old. It clarified how the *Infants Act* and *Family Law Act* apply in scenarios where there is disagreement between youth and parents regarding medical treatment. The court affirmed that healthcare providers, rather than parents,


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are responsible for assessing the capacity of minor patients to consent to treatment and determining the issue of whether the treatment is in the patient's best interest. If a healthcare provider deems a young person capable and concludes that the treatment is in their best interest, the youth alone has the authority to consent to or refuse treatment. Providers must adhere to the standards set by their professional bodies and human rights tribunals when providing healthcare to minors.

Subsequent cases have similarly allowed mature transgender minors to make their own decisions respecting gender affirming surgery.

In *A.M. v. Dr. F* (2021) a parent obtained an order to prevent a doctor from providing gender reassignment surgery for their child without advising the other parties that they were doing so. The court later set aside that order and dismissed the proceeding, with the court granting a subsequent order preventing the parent from relitigating.

And in *G.M.S. v. Dr. Z* (2021) a parent sought an injunction to prevent their gender dysphoric child from getting a gender affirming mastectomy. The court denied the injunction noting that the child was "mature enough to make his own medical decisions regarding gender affirming medical procedures" (para. 12). Citing these cases, barbara findlay, KC, concludes that "in BC, the law about consent to treatment by transgender youth is unambiguous" (2022, p. 66).

Disclosure of children's personal health information

Privacy legislation governs the collection, use and disclosure of personal health information in BC, including the personal health information of a minor.

The Personal Information Protection Act, SBC 2003, Ch.63 ("PIPA") regulates private sector organizations, businesses and not-for-profit organizations in the collection and use of the personal information of individuals while allowing an individual to access their personal information.

In the healthcare sector, the legislation protects personal information that is held by a private health care provider working in the community. Similarly, the Freedom of Information and Protection of Privacy Act , [RSBC 1996] Ch. 165 ("FOIPPA") "applies to health authorities, hospitals, and urgent care clinics, and to providers working within them" (Doctors of BC, n.d.).

Because many doctors work both in private clinics and in hospitals, their records may be covered by both pieces of legislation. Regardless of which Act applies, medical professionals are responsible to protect any personal information that they might have about a young person and to disclose it only in accordance with the legislation.

Both Acts allow an individual to request personal information, including personal health care information from their health care providers, and to control access to their personal health care information.

Can a guardian override a minor's consent to release of medical information?

When a minor is incapable of exercising their right to control access to their medical information, the Regulations allow a guardian who has the necessary guardianship powers to control those records, including requesting copies of medical records (PIPA Regulation 473/2003 s.2(2); FOIPPA Regulation155/2012 s.3(1) and (2)).

Determinations of whether a minor is "incapable" fall to the medical provider. Before a healthcare provider can release any information about that child to their guardian or adult representatives, they must conclude that a child is "incapable". The fact that the person seeking the information is a guardian is irrelevant unless the child is first found to be incapable.

In a case before the British Columbia Information and Privacy Commissioner, the father of a child made a request for personal information about their minor son under the Personal Information Protection Act (PIPA) to the Richmond City Baseball Association. The Association refused to disclose the information and the guardian sought a ruling from the Privacy Commissioner that would require the Association to provide that information to the guardian. The adjudicator ruled that a guardian would only be able to access his minor son's personal information under PIPA if all three of the following conditions were met:

1. The applicant is the son's guardian,
2. The son is a minor; and
3. The son is incapable of exercising his own access rights.

As there was no evidence that the young person was not capable of exercising his own access rights, the adjudicator declined to allow the parent's application. (Order P22-04; Richmond City Baseball Assn. (Re) [2022] B.C.I.P.C.D. No. 42, para 6-9).

The same legal test applies to requests for medical information about a minor, and a capable minor has the right to deny their parent access to their information, even if the parent is a legal guardian of the minor.

These Acts reinforce the importance of respecting the capacity of a mature minor to make decisions about their own healthcare and to control their personal information.

Consequences of forced treatment

> *"I was being medically abused. I was not given the opportunity to make any decisions about my medical care. There were cases when I if I was able to make decisions I would have made different choices. When I was 12, I was treated for scoliosis, and put in a full body brace. I was only given 15 minutes to think it over, if I was given all of the information, I would have made a different choice."*
>
> Youth Engagement

In situations where a child or youth's healthcare decision is not respected, or otherwise substituted for that of an adult, such as a parent, guardian, or healthcare provider, literature suggests that outcomes may be deleterious to that child or youth (Alderson & Goodwin, 1993). This is particularly the case in situations involving severe or prolonged treatment, a conclusion that is echoed by SCY's engagement with children and youth (see page 32).

Alderson and Goodwin (1993) explain, "The literature and law on consent to children's treatment tend to assume that almost any life-extending treatment is better than none, and that refusal of proposed medical treatment is inevitably incompetent, though the suffering this causes has been critically documented" (p. 5).

Specifically, in the case of severe or prolonged treatment, Alderson and Goodwin's (1993) review of the literature found that such treatment "can induce terror and despair in the child" (p. 4), and that this experience of terror can be tantamount to the reactions of torture victims:

> Children who perceive treatment as worse than the disease risk having similar reactions to those of torture victims. Torture is defined as `breaking down a person's sense of identity'. It is exacerbated when people are in a strange culture, such as a hospital ward. It arouses feelings of utter helplessness, being out of control of events and one's own body, inability to sleep, or concentrate, irritability, confusion between feeling bad and being bad, the disintegration of mind and body. `A perfect way to cope with torture and prison is to disassociate your feelings from your experience[...] If it becomes a habit, children become emotionally crippled (p. 4).

In the case of life-saving treatment, Alderson and Goodwin note: "It is very rare for children to refuse life-saving treatment, and[...]their response should then be taken very seriously. Such refusal can be deeply perturbing with competent adult patients yet is respected in law. Why should not informed, wise children receive the same respect in cases when health professionals are uncertain what is the correct choice?" (1993, p. 7).

D. Conclusion and Summary of Key Findings

Legislation may be complex, but the importance of upholding children's participatory rights in healthcare contexts is simple. Growing evidence from academic literature, legal analysis, and youth engagement all point to the positive benefits for young people to be heard and taken seriously when decisions are made about their healthcare. Throughout the course of research conducted, the following key findings emerged:

1. Regardless of their decision-making abilities, all children and youth have a right to be heard and to express their views in decisions concerning their healthcare.

2. As in adults, capacity of children and youth encompasses a variety of factors and develops at different rates. It is an evolving trait that may be more or less present in different contexts and can be assessed through a variety of models available to healthcare providers.

3. Healthcare must be patient-centred, with the views and interests of the young patient meaningfully considered in the provision of services. The onus must be on the healthcare provider to find an effective strategy to communicate and connect with their child or youth patient.

4. Dismissal and invalidation by healthcare providers, parents, and other adults contributes to significant negative impacts on children and youth including reduced self-esteem and confidence in their treatment plans.

5. Children and youth would greatly benefit from neutral, third-party support in medical settings that focuses only on their interests, needs, and views.

6. For many children and youth, making healthcare decisions can be an empowering experience, helping them develop individual agency.

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Youth Engagement Methodology & Data

The Child Capacity Research Project sought to embed key values and principles in the research process that in turn shaped the research methodology, community engagement, and analysis of the results. These values and principles pertained to striving for accessibility, highlighting intersectionality, valuing lived and living experiences, and others crucial for meaningful engagement and research.

It was this approach, as well as the calls to action from participants, that allowed for the recognition that while the project was intended to look at four key topics with complex systems of their own, they are also interconnected in many ways. In addition, it was noted throughout the youth engagement that it was sometimes difficult for participants to speak to one system without describing the impact of another. Thus, we advise readers to recognize the intersectionality of the lived experiences reflected in the information below and that also has contributed to the richness of qualitative data that emerged.

ENGAGEMENT METHODS:

Three distinct engagement methods were utilized to provide accessible opportunities for contribution from youth and young people, primarily below the age of 30, with lived and living experiences in relation to the research topics. All three options were offered to every participant prior to written consent being provided:

Survey:

- An anonymous, online survey consisting of 3 questions was made available during the entire duration of the project
- The nature and structure of the questions allowed for participants to respond based on the experience they deemed relevant to contribute

Interviews:

- 1-hour virtual Zoom sessions with a participant and two members of the CCRP team
- Discussion questions* were provided in advance
- Follow-up interview opportunity offered

Listening Circles:

- 1-1.5 hour virtual Zoom sessions with existing youth advisories, councils, and other programming groups
- Sessions were coordinated in collaboration with group/organization leads, coordinators, and/or supporting staff
- Discussion questions* were provided in advance
- Follow-up session and/or interview with interested participants offered

***Note:** The following three questions were used in all methods of engagement and were specified (in Listening Circles and interviews) based on the topic participants wished to address. However, it is crucial to note that while these were the primary questions asked, discussions often built on what was shared in the session. The evolving conversations differed per group / participant, and as a result, the extent of questions that organically emerged were not able to be included in the list below.

Discussion Questions:

1) How do you define "capacity"? Based on your understanding, do you feel you have had capacity to make decisions, or the opportunity to use your capacity to participate in decisions?

2) Can you tell us about a time [in a family law / mental health / healthcare decision / child protection matter] when you felt like your opinion was valued and taken into consideration?

3) Based on your experience [in a family law / mental health/ healthcare decision / child protection matter], how do you think things could be improved so that your capacity to make decisions and be heard is better respected?

Stakeholders & Subject Matter Experts:

- Stakeholders and subject matter experts across sectors were invited to provide feedback on the draft outlines for all four research papers at a virtual roundtable held during the earlier stages of the project
- Individuals part of community networks were also selectively invited to provide feedback on research paper drafts as they were developed by topic

Outcomes:

- 78 participants across all methods of the youth engagement contributed their feedback by sharing their lived and living experiences
- An analysis of themes from the youth engagement by topic can be found below

Note: While the project sought to uplift intersectional experiences of young people across all four topics, there are limitations to those reflected in this paper. It is recommended that future research initiatives dedicate efforts to highlight the specificities of identities of young people that may uniquely inform the nature of their experiences with respect to the four topics examined in this project (e.g. gender and sexuality).

THEME CODE	THEME:	DETAILS/VARIANCES
1	Limited understanding of Intersections of identity	• Medical practitioners unable to a**cknowledge complexities of situation specific to racial identity** • Need for **elimination of ageist-based dismissal** of young people's experiences
2	Power dynamics of decision-making	• Designated professionals with credentials **defaulted to over needs and interests of young people**
3	Self-advocacy	• Young people **feeling need to represent their own interests** on a long-term basis (i.e. long journey of self-advocacy) • **Greater autonomy** for young people **co-related with becoming older** • Need for young people to **be trusted to be able to decide their own need for care/treatment** • **Young people may 'give up' on getting support** (e.g. diagnosed) for conditions they have due to being repetitively dismissed and invalidated
4	Lack of proper practice	• **Poor transition planning and care** • **Lack of effective and coordinated communication** among medical practitioners • Consequence **of onus shifting to young people to determine course of action** • **Detrimental health and financial impacts** resulting from not being informed (e.g. going 'cold turkey' due to cost of expensive medication) • **Variance in experiences of assessment** practices at different institutions
5	Need for due diligence	• Medical practitioners noted to be **operating on assumptions** • Practitioners noted to **need more education and training** in providing care/service to young people and challenges they navigate • **Desire for medical practitioners/staff that have lived and/or living experiences** with the same mental health issues as patients being serviced

6	Need to demonstrate genuine care	• Medical practitioners **need to make efforts for active listening, consulting, and demonstrating belief** in young people's experiences • Young people may not disclose information due to **not being believed** • Meaningfully **listening to youth** noted to be reason that **immediate and life-saving treatment was made available** • Need to support young people to **express themselves**
7	Shifting priority from 'fixing' patients	• Need to **situate intervention in larger context** as opposed to fixating on what is 'wrong' with patient
8	Lack of meaningful consultation	• **Dialogue only existing between guardian/family and medical practitioners** • Young people's requests **being "heard" but not incorporated** into decisions • **Opportunity to express choice/preference not provided** even when multiple **options available**
9	Contradictory practice of 'best interests'	• **Lack of any 'interests' of the child** in practice of 'best interest'
10	Improving effective delivery of service	• **More funding** to allow greater availability of support and resources • **Need support from systems/practitioners in advocating for services** (e.g. gender affirming care for young people who are Trans*) • **Need to shift pace of service delivery** (i.e. young people not having to wait for extended periods of time)

Appendix 1:
Overview of Canadian laws on age of consent

PROVINCE/TERRITORY	LEGISLATION DETAILS
British Columbia	The age of majority is 19 years old. No specific age of consent for treatment is mentioned. The *Healthcare (Consent) and Care Facility (Admission) Act* presumes adults (19 years or older) to be capable unless proven otherwise. The *Infants Act* applies to those under 19 years old, allowing consent if capacity is demonstrated. Consent must also align with the minor's best interests.
	Healthcare (Consent) and Care Facility (Admission) Act, RSBC 1996, c 181
	Infants Act, RSBC 1996, c 223
Alberta	The age of majority is 18 years old. No specific age of consent for treatment is mentioned. Patients under 18 years old are presumed without capacity but can be assessed as 'mature minors' capable of consenting to treatment.
	Personal Directives Act, RSA 2000, c P-6
	Alberta Health Services, 'Consent to Treatment/Procedures Minor/Mature Minors' (PRR-01-03)
Saskatchewan	The age of majority is 18 years old. No specific age of consent for treatment is mentioned. Minors under 18 years old can consent to treatment if deemed capable ('mature minors').
	Healthcare Directives and Substitute Healthcare Decision Makers Act, 2015, SS 2015, c H – 0.0002
	Saskatoon Health Region 'Consent, Informed Consent' (Policy 7311050-002)
Manitoba	The age of majority is 18 years old. No specific age of consent for treatment is mentioned. Those 16 years or older are presumed to have capacity for healthcare decisions, while those under 16 years old are presumed not to unless proven otherwise.

	Healthcare Directives Act, CCSM, c H27
	Substitute Consent to Healthcare, Report #110 (2004) Law Reform Commission
Ontario	The age of majority is 18 years old. No specific age of consent for treatment is mentioned. The Healthcare Consent Act presumes all individuals capable of understanding treatment information. The Substitute Decisions Act presumes individuals 16 years or older capable of giving consent unless proven otherwise.
	Healthcare Consent Act, 1996 c.2
Quebec	The age of majority is 18 years old. Minors under 14 years old require parental or 'tutor' consent for treatment. Those 14 years or older can consent to necessary care. Court authorization is necessary for certain cases.
	Quebec Civil Code, Articles 14–18
	Act Respecting End-of-Life Care RSQ c S-32.0001
New Brunswick	The age of majority is 19 years old. No specific age of consent for treatment is mentioned. Minors 16 years old can consent to medical treatment like adults. Those younger than 16 years old can consent if capable and in their best interests.
	Medical Consent of Minors Act, SN.B 1976, c M-6.1
Nova Scotia	The age of majority is 19 years old. No specific age of consent for treatment is mentioned. Those with capacity can consent to treatment.
	Personal Directives Act, SNS 2008, c 8
Prince Edward Island	The age of majority is 18 years old. No specific age of consent for treatment is mentioned. Those capable may consent to treatment.
	Consent to Treatment and Healthcare Directives Act, RSPEI 1988,c C-17.2

Newfoundland & Labrador	The age of majority is 19 years old. No specific age of consent for treatment is mentioned. Those 16 years or older are presumed competent to make healthcare decisions.
	Advanced Healthcare Directives Act, SNL 1995, c A-4.1
Yukon	The age of majority is 19 years old. No specific age of consent for treatment is mentioned. Those capable may consent to care.
	Care Consent Act, SY 2003, c 21
Northwest Territories	The age of majority is 19 years old. No specific age of consent for treatment is mentioned. Adults can consent to treatment.
	Personal Directives Act, SNWT 2005,c16
Nunavut	The age of majority is 19 years old. No specific age of consent for treatment is mentioned. Adults are presumed capable unless proven otherwise.
	Guardianship and Trusteeship Act, SNWT (Nu) 1994, c 29

Appendix 2: Assessment Tools

The MacArthur Competence Assessment Tool (MacCAT)

The MacArthur Competence Assessment Tool (MacCAT) refers to a set of structured interview instruments. The MacCat-Treatment (MacCAT-T) instrument is used to evaluate competence in healthcare decision-making and was developed by Grisso and Appelbaum in 1998 (Hein et al., 2015).

As described by Henderson-Dekort and others (2022), "[t]his instrument aims to assess patients' capacity to make decisions surrounding treatment by assessing four areas of the patients' understanding:

(1) Information about their condition and recommended treatment;
(2) The potential risks and benefits of treatment options;
(3) The nature of their situation and consequences; and
(4) Their ability to express a choice" (p. 13, citing Grisso et al., 1997).

Many have adapted the MacCAT-T to assess a minor's competence (Michaud et al., 2015; Hein et al., 2015), as the instrument "employs both quantitative and qualitative elements to gather insight into a patient's capacity to make medical decisions" (Henderson-Dekort et al., 2022, p. 13).

Multidisciplinary-developed assessment model

The second model is offered by Michaud and others (2015). The framework advanced by this group of scholars arose out of a two-day summit of international healthcare professionals, psychologists, ethicists, and legal scholars, inter alia, for the purposes of providing policy guidance on assessing the capacity of minor adolescents for autonomous decision-making without a third party authorization.

According to Michaud and others (2015), the assessment of adolescent decision-making capacity includes the following six components:

(1) Reviewing the legal context in accordance with the principles enshrined in the UNCRC;
(2) Establishing an "empathetic relationship" between the adolescent and the healthcare professional or team;
(3) Respecting the adolescent's development stage and capacities;
(4) Including "relatives, peers, teachers, or social and mental health providers" with the adolescent's consent, if appropriate or relevant;
(5) Controlling for "coercion and other social forces" that may influence decision-making; and
(6) Utilizing a "deliberative stepwise appraisal" of the adolescent's decision-making process (p. 361).

In terms of the final component, a "deliberative stepwise appraisal" or approach involves "understanding the different facets of the given situation, reasoning on the involved issues, appreciating the outcomes linked with the decision(s), and expressing a choice" (Michaud et al., 2015, p. 361).

The specific approach devised by this group is informed by the above components and the MacCAT-T instrument, creating a four-step assessment model (Michaud et al., 2015, p. 364). The four steps are thus:

(1) "Assess the adolescent's understanding of the different facets of the situation".

a) Information about the disease or condition and recommended treatment should be comprehensive and provided by the healthcare provider in simple, accessible language (Michaud et al., 2015, p. 364). The adolescent should be asked to interpret what they have understood, speaking to the nature and prognosis of the condition, and the availability of treatment options (Michaud et al., 2015). The healthcare provider should specifically address the short- and long-term consequences of different treatment options.

(2) "Evaluate the adolescent's reasoning about [their] present situation, health condition, and therapeutic options".

a) The assessor should explore how the "young patient applies logic to clarify information, verifies facts, and justifies change or persistence in opinions and beliefs based on newly acquired or existing information" (Michaud et al., 2015, p. 364). These facets can be explored through asking questions, such as "What do you understand of the consequence of stopping treatment in your situation", or "What does it mean for you if you do not take any medication"? During this stage, it is appropriate to "explore how the adolescent feels about his parents' or relatives' views and preferences and how these opinions would impact on [their] choice" (Michaud et al., 2015, p. 364)

(3) "Assess the adolescent's thinking on various options".

a) It is important that an assessor "be very careful in accompanying the adolescent in the progression of [their] understanding of the situation" in light of the "specific difficulty of young adolescents[...]to foresee the long-term consequences of any choice, as the capacity to reason in an abstract and long-term perspective may be hampered because of neurodevelopmental limitations" (Michaud et al., 2015, p. 364). Questions that may assist in achieving this end are, "Can you explain why you prefer this option to another?", "Can you compare these two options and list the risks and benefits for each?". Michaud et al note that unless the situation at hand is urgent, the assessment should occur over a minimum of two separate occasions, and that healthcare providers should reassess the adolescent's understanding and reasoning capacities on multiple occasions (2015).

(4) Ensure that "the adolescent is able to express a choice".

a) After the above three steps, the assessor should then ask the adolescent to express their preferred choice and provide justifications for their decision.

> If the assessor is of the opinion that the adolescent has not understood the potential consequences and does not display an appropriate level of reasoning, then they may not be granted full competence and the healthcare provider may decide that the parents or another guardian should be involved in decision-making. There are also circumstances where an adolescent may themselves feel unable to make a decision and, consequently, may not be granted full competence.

WHO 4-step assessment model

WHO provides an additional four-step assessment model for assessing and supporting adolescent capacity (2021, p. 8).

(1) "Joint exploration of the situation and options"
a) The assessor or healthcare provider (these are often the same) should explore the important elements of decision-making and the overall situation. This should include "the adolescent's psychosocial life, risks, and resources" (WHO, 2021, p. 8). The healthcare professional's role at this stage is to "provide all the necessary information in appropriate language on the framework of care, the medical condition, and the options to help the adolescent in making a choice" (WHO, 2021, p. 8).

(2) "Common synthesis of the situation"
a) This stage involves the assessor summarizing the issues that arose in the first step to "ensure common understanding" (WHO, 2021, p. 8). In this analysis, the healthcare provider should "be particularly attentive to elements that are likely to alter a decision and address them as appropriate to allow deliberation with the adolescent and any relevant partners in order to reach a consensual decision" (WHO, 2021, p. 8). This may involve parents, legal guardians, or other relevant people.

(3) "Decision point"
a) At this stage, the healthcare provider or assessor decides whether the adolescent has the capacity to make an autonomous decision in a given situation at a given time.

(4) "Follow-up"
a) The healthcare provider should outline guidelines for follow-up, "whether or not consensus is reached on a decision" (WHO, 2021, p. 8).

WHO notes that these four steps are not designed as a "rigidly linear process", but instead should be used as an "integrated, dynamic approach" (WHO, 2021, p. 9). Less complex situations may not require all four steps, while more complex cases may require thorough scrutiny at each stage:

> Decisions, especially complex decisions, cannot be made without exploration of the adolescent's overall and psychosocial situation. They may be vulnerable in a number of ways that could either alter their decision-making capacity or threaten their healthy development if they make a particular decision. It is also essential to identify the resources that can help the adolescent in making decisions. (WHO, 2021, p. 9)

Contact Information

Phone
In Victoria: 250-356-6710
Elsewhere in BC: 1-800-476-3933

Text (children and youth)
1-778-404-7161

Chat (children and youth)
rcybc.ca/get-help-now/chat

E-mail
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RC&Y Representative for Children & Youth