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THE CAPACITY CONUNDRUM: AN INVESTIGATION OF ASYMMETRICAL TRENDS OF LEGAL CAPACITY WITHIN THE ADOLESCENT JUSTICE AND MEDICAL FIELDS

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Abstract

Scientific developments are increasingly challenging the justness of holding children and young adults responsible for criminal acts on the basis that they face developmental obstacles to their capacity. Concurrently, in the medical sphere, children are being permitted to undergo gender-affirming treatments with seemingly no questions raised about their capacity to consent. This paper investigates whether these asymmetrical trends in legal capacity are reconcilable. The starting point is a closer examination of mental capacity in the context of decision making. This finds that the age at which an adolescent possesses adequate mental capacity for decision making differs depends on the nature of the decision and the environment in which the decision takes place. Adolescents making decisions in controlled medical environments have decision-making capacity younger than adolescents reacting to emotional stimuli, such as in the commission of a crime. In this way, situational differences in mental capacity go some way towards justifying the asymmetries in legal capacity. However, mental capacity is only part of this puzzle. This paper proceeds to examine the rights and policy factors which must be considered when setting legal capacity. These rights and policy factors support the asymmetry in capacity exposed in the context of mental capacity, thus justifying differing standards of legal capacity in law. The final part of this paper examines the wider applicability of this finding. It suggests that this paper be used as a model for further exploring inconsistencies in capacity across the law.

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Subjects and Topics

Youth Justice Reform, or
Gender-Affirming Treatment, or
Capacity.

I Introduction

Standard interpretations of the concept of "legal capacity" assume that it applies equally and without modification to both the situation of being a duty bearer and that of being a rights-holder.[1] In keeping with this interpretation, legal capacity means the same thing both in the context of personal decision making as in the context of responsibility for criminal acts.[2] This belief leads to the assumption that changes to our understanding of capacity in the context of one field, require a re-evaluation of capacity in the context of another.[3] Suppose, for instance, that capacity was qualitatively uniform across all areas of law. It follows that if the law does not allow children to make their own healthcare decisions, "the criminal justice system [has] little entitlement to hold them responsible for acts that transgress the criminal law" and vice versa.[4] This presumption in favour of uniformity across the various measures of legal capacity seems, at first instance, intuitive.[5]

This paper argues that we must resist the presumption that capacity ought to be symmetrical across different fields within the law, despite the attraction of this approach. This is because a presumption of symmetry fails to account for a number of complex moral, political and scientific considerations, which justify the differences in standards for legal capacity developing across the legal system. In developing this argument, this paper draws on three case studies—the first two concern recent challenges to the notion of capacity in the field of criminal justice. Presently, in New Zealand, the minimum age of criminal responsibility is ten years old.[6] Some believe that this age is too low, and there has been increasing support for campaigns to raise this age. This movement saw some recent success with the commissioner for Children, Judge Andrew Becroft, expressing his approval at raising the

[1] Jillian Craigie "Against a singular understanding of legal capacity: Criminal responsibility and the Convention on the Rights of Persons with Disabilities" (2015) 40 International Journal of Law and Psychiatry 6 at 6.

[2] At 6.

[3] At 6.

[4] Barry Lyons "Dying to be responsible: Adolescence, autonomy and responsibility" (2010) 30 Legal Studies 257 at 278.

[5] At 279.

[6] Crimes Act 1961, s 21.

age to fourteen.[7] A separate but related matter focuses on increasing the age of penal majority, or age before which the criminal justice system considers someone to be an adult.[8] Advocates for raising this age beyond eighteen have also experienced recent success, with the Porirua district court trialling an approach implementing a range of more youth focussed justice procedures, formerly reserved for under eighteen-year-olds, to offenders up to age twenty-five.[9] Both campaigns derive support from recent scientific advancements which indicate that the brains of young adults continue developing into their twenties, challenging previous age-based divisions in criminal procedure.[10] The third case study examines the provision of gender-affirming medical care to people younger than sixteen. This presents a counter view to the first two case studies, in that it depicts a situation where the people being found to have legal capacity and benefitting from treatment are getting younger over time.

After setting out these three case studies, this paper will justify the asymmetries in capacity across our law, first by reference to the scientific developments in this field before examining the rights and policy factors involved in determining capacity. It goes on to weigh up the strengths of these factors before making recommendations for how to progress. This thesis finds that these diverging standards of legal capacity, can and should coexist. Furthermore, this distinction is essential in the context of other legal matters and cannot be ignored any longer.

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[7] Office of the Children's Commissioner *Children with offending Behaviour* (24 August 2020) at 6.

[8] Nessa Lynch "Towards a Principled Legal Response to Children Who Kill" 2018 18:3 Youth Justice 211 at 226.

[9] Judge John Walker "Court to develop new approach to young adults" (press release, 29 August 2019).

[10] Arnett, Jeffrey and Jensen Emerging adulthood: A theory of development from the late teens through the twenties (2000) 55:5 American Psychologist 469 at 474-475 and Lynch, above n 8, at 226.

II Capacity

There are two different types of capacity which are important in the legal context.[11] Understanding the distinction between the two is vital to understanding why, and in what instances, there may be diverging measures of capacity across the law.

The first type of capacity is mental capacity. This encompasses the idea that someone is capable of making a decision or should be held accountable for their action because they possess a sufficient level of understanding about the nature of that decision or action.[12] This is distinct from the notion of legal capacity, which refers to the fact that an entity may enjoy legal rights and duties, such as the right to make a medical decision or the duty not to engage in criminal behaviours.[13]

These concepts are closely related. For instance, in the area of children's rights, a central argument for why children should not hold the same rights or be subject to the same duties as adults, that is, be found to have legal capacity, focuses on their reduced mental capacities.[14] This argument is pervasive to the extent that we are oftentimes unaware that we invoke it. [15] It is almost beyond question that children cannot vote nor make complex medical decisions.[16] This state of affairs is reinforced in international law, with many of the rights in the United Nations Convention for the Rights of the Child (CRC), couched in discretionary terms, allowing the right to be adjusted to account for varying levels of mental capacity.[17]

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[11] Alison Douglass *Mental Capacity: Updating New Zealand's Law and Practice* (Report for the New Zealand Law Foundation, 2014) at 1A.

[12] Bridgit Diamond *Legal Aspects of Mental Capacity* (Blackwell Publishing, Oxford, 2008) at 1 and A Douglass, G Young and J McMillan *A Toolkit for Assessing Capacity* in A Douglass "Mental Capacity: updating New Zealand's Law and Practice" (Report for the New Zealand Law Foundation, July 2016) at 4.

[13] Lucy Series "Relationships, autonomy and legal capacity: Mental capacity and support paradigms" (2015) 40 International Journal of Law and Psychiatry 80 at 80.

[14] Mhairi Cowden *Children's Rights: From Philosophy to Public Policy* (Palgrave MacMillan, New York, 2016) at 25.

[15] At 25.

[16] At 25.

[17] Convention on the Rights of the Child 1577 UNTS 3 (1990), arts 5, 14 and 40.

Unlike mental capacity, which is a scientific measure, determining legal capacity is a normative judgement.[18] While considerations of mental capacity are generally central to such a determination, policy and rights factors must also be considered. This is explained by the Committee for the Rights of Persons with Disabilities, which, in the context of disability rights, stated that "perceived or actual deficits in mental capacity [alone] must not be used as justification for denying legal capacity".[19] Clearly, something more is needed.

A further issue with current conceptions of legal and mental capacity is that both are closely linked to age eighteen, New Zealand's de facto age of majority. From age eighteen, an individual is presumed to have capacity in law.[20] However, the reality is that eighteen has little bearing on the mental capacity of an individual and is instead the result of a number of socio-historical factors. For example, historically, the age of majority was determined by a male's ability to bear arms and was set at age fifteen, before moving up to twenty-one based on medieval rules of land tenure and military service.[21] The age of eighteen was only settled on following a spate of societal changes which took place in the 20th century.[22] Scientific measures of capacity were not central (or even centrally relevant) to any of these determinations. This paper considers that it is time to bring nuance to this field. In so doing, it relies on scientific developments to decouple capacity from the age of de facto majority, before making the case that both scientific and rights factors lead to the conclusion that legal capacity should vary depending on the nature of the situation.

[18] Irma M Hein and others "Informed consent instead of assent is appropriate in children from the age of twelve: Policy implications of new findings on children's competence to consent to clinical research" (2015) 16:70 BMC Medical Ethics 76 at 78.

[19] Committee on the Rights of Persons with Disabilities *General Comment No. 1 (2014)* CRPD/C/GC/1 (19 May 2014) at 13.

[20] Diamond, above n 12, at 1 and Douglass Young and McMillan, above n 12, at 3.

[21] Rodney C Roberts "The Idea of an Age of Majority" (2017) 31:2 International Journal of Applied Philosophy 217 at 217.

[22] At 218.

III Responsibility

Another foundational element of this paper is the notion of responsibility. Mental capacity has particular relevance to the criminal justice system through its relationship to responsibility. In the adversarial western criminal justice system, considerations of autonomy underpin both responsibility and capacity.[23] This is because an agent is only construed as morally responsible, and therefore liable for punishment by the state, to the extent that they act voluntarily.[24] Legal responsibility is, in most cases, to be construed as congruent with moral responsibility. However, like capacity, legal responsibility is complex. As Joel Feinberg points out:[25]

> Determining legal responsibility in problematic cases often comes down to the questions of who ought to pay or who ought to be punished and how much. These questions are rendered problematic by conflicting interests and principles of justice, and the answers to them usually depend on what the judge takes to be the "ends" or "purposes" of compensation or punishment.

Despite these difficulties in determining who is to bear legal responsibility in practical contexts, for this paper, it suffices to consider that condemnation and punishment only attach to acts for which one is morally and legally responsible.[26] These are actions which are intentional, voluntary, and epistemic, and where there is concurrence with the harm caused by the defendant.[27] This is recognised throughout the criminal law, but perhaps most clearly in the framework around insanity.[28] Insanity, while not nullifying the offender's culpability, exculpates them from moral blame because they did not lack the mental capacity to act voluntarily and act based

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[23] Hanna Pickard "Choice deliberation, violence: Mental capacity and criminal responsibility in personality disorder" (2015) 40 International Journal of Law and Psychiatry 15 at 17.

[24] Angelo J Corlett *Responsibility and Punishment* (Springer, Dordrecht, 2009) at 11.

[25] Joel Feinberg *Doing and Deserving* (Princeton University Press, Princeton, 1970) at 27.

[26] HLA Hart *Punishment and Responsibility: Essays in the Philosophy of Law* (Clarendon Press, Oxford, 1968 at 22-23.

[27] Corlett, above n 24, at 17.

[28] Hart, above n 26, at 152.

on an external factor. In these circumstances, the offender may see a reduction in sentence or improvement of conditions to reflect this lack of responsibility. This theory of responsibility also has applicability in the context of personal decision making. For instance, when a person rationally deliberates and makes a decision, having understood the nature and risks of the decision before them, we intuitively feel that their decision is to be respected, no matter how unwise it seems to others.[29] On this basis, the question of whether someone has mental capacity bears relevance on whether someone ought to be punished or not for an act they have committed or whether they should be allowed to bear the consequences of an action they are yet to commit.

This view is not without criticism.[30] While our criminal law insists on the importance of free will in order to hold someone criminally responsible and legitimise punishment, arguably socio-economic and power disparities are more central to the "decision" to commit a crime than any notion of free choice.[31] It is not within this paper's scope to outline the substantial criticisms of the Choice Theory of Responsibility. It suffices to recognise that foundational to the modern western criminal justice system is the notion that someone should only be punished for actions they have freely taken. Lack of mental capacity poses issues in this regard.

IV Age Limits in Criminal Justice

A Overview of Current Age Limits:

The field of criminal justice in New Zealand is a confusing patchwork of varying age limits and categories. Although some practical confusion has been addressed in recent years due

[29] Pickard, above n 23, at 17.

[30] Marie-Eve Sylvestre "Rethinking Criminal Responsibility for Poor Offenders: Choice, Monstrosity, and the Logic of Practice" (2010) 55 McGill Law Journal – Revue de droit de McGill 771 at 771.

[31] At 772.

to significant reforms, it is still doubtful that these age limits follow any principled scheme.[32]

Presently, there are two categories of youth offender in New Zealand. The first is the category of children. The Oranga Tamariki Act 1989 defines "child" as someone younger than fourteen.[33] However, children under ten years of age cannot be convicted of a criminal offence, and ten is therefore known as the minimum age of criminal responsibility.[34] The second category is that of "young person", defined by the Oranga Tamariki Act as someone older than fourteen but younger than eighteen.[35] Eighteen thereby represents the age of penal majority or age after which the criminal justice system considers someone to be an adult, thus precluding the possibility of accessing youth justice procedures.[36]

The difference between the categories is that there is a presumption against child criminality.[37] This means that only children accused of certain serious or persistent offending can be charged in the youth court.[38] In theory, young persons do not benefit from this presumption; however, it is worth noting that the vast majority of offences involving young people are dealt with through diversion.[39] Further complicating the matter is that several offences, including murder, manslaughter, robbery in possession of a weapon and instances in which the accused has elected trial by jury, fall outside Youth Court jurisdiction irrespective of age.[40] This could theoretically lead to someone as young as ten facing the full force of the criminal law for a murder charge. However, this has not occurred at least since the commencement of the Oranga Tamariki Act.[41] Both the minimum age of

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[32] Nessa Lynch *Youth Justice in New Zealand* (3rd Edition, Thomson Reuters, Wellington, 2019) at 26 and 28.

[33] Oranga Tamariki act 1989, s 2.

[34] Crimes Act 1963, s 21.

[35] Oranga Tamariki Act 1989, ss 2 and 272.

[36] Lynch, above n 8, at 226.

[37] Lynch, above n 32, at 191.

[38] At 191.

[39] At 21.

[40] Office of the Children's Commissioner *It's time to stop criminalizing children under 14* Position Brief (September 2019) at 2 and Oranga Tamariki Act 1989, s 274.

[41] Lynch, above n 32, at 191.

criminal responsibility at age ten and age of penal majority at eighteen are based on historical, societal factors rather than on principled consensus.[42] Despite this lack of principle, these ages have stood the test of time. However, mounting challenges threaten this status quo.

B Challenges to the Current Paradigm:

1 Brain Development:

A significant impetus for challenging how youth offenders are treated within the current paradigm are changes to our understanding of adolescent brain development and mental capacity. To illustrate this change, it is useful to examine the history of science in this field. Doing so demonstrates the arbitrary nature of the current conceptions of legal capacity.

The concept of adolescence is a recent phenomenon.[43] Until the turn of the twentieth century, society was divided into children, beings requiring special care, and adults, those who knew better.[44] It was during this time that the minimum age of criminal responsibility was set at seven years old.[45] The Crimes Act 1961 raised this age to ten.[46] Adolescence, as a stage distinct from adulthood, was "discovered" only in 1904 by G. Stanley Hall, who published a book detailing his findings, titled "Adolescence: Its Psychology and Its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education".[47] Hall characterised adolescence as a period lasting approximately ten years, from fourteen to twenty-four, during which "young people go through some degree of

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[42] Johanna Winkelman-Krupp "Age of Criminal Responsibility -Criminally Responsible at the Age of Twelve Years? A Comparison between New Zealand and Germany" (LLM Dissertation, Victoria University of Wellington, 2009) at 4.

[43] Kevin Lapp "Young Adults and Criminal Jurisdiction" (2019) 56:2 American Criminal Law Review 357 at 361.

[44] At 361.

[45] Emily Watt "A History of Youth Justice in New Zealand" (paper commissioned by Youth Court Judge Andrew Beacroft, January 2003) at 2.

[46] A survey of Hansard from the period preceding introduction of the Crimes Act indicates that there was no discussion in Parliament about the specific reasons for this adjustment and no evidence that it took account of scientific measures of mental capacity.

[47] G Stanley Hall *Adolescence: Its Psychology and Its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education Volume One* (Volume 1, D. Appleton & Company, New York, 1904).

emotional and behavioural upheaval before establishing a more stable equilibrium in adulthood".[48] It is noteworthy that Hall himself believed that adolescence lasted until the mid-twenties.

Hall's discovery was significant. Following the publication of his research, the fields of education, healthcare, social services and law all shifted to address the particular needs of this emerging class.[49] However, the founders of these systems disagreed with Hall's proposal, that adolescence lasted until age twenty-four and instead saw the cut off at the eighteen-year mark. There is no evidence to suggest that this decision was made following a scientific or rights principled consensus on capacity. Instead, the political climate, the availability of resources and the need for conscription to assist war efforts, likely each played a role.[50]

While social and political conceptions of adulthood and adolescence remained static over much of the last century, research on human development has continued. Notably, in the previous twenty years, research into brain development has begun to change how science understands mental capacity in young adults.[51] Conclusions reached by the scientific community include that brain development, and maturation continue into the early twenties with studies placing the age of complete development at twenty-five.[52] Specifically, how the mental capacity of young adults is affected by these cognitive factors is explored in greater detail later in this paper. At this stage, it suffices to recognise that young adult aged eighteen to twenty-four are cognitively more similar to adolescents than to adults beyond

[48] Jeffrey Jensen Arnett "G. Stanley Hall's Adolescence: Brilliance and Nonsense" (2006) 9:3 History of Psychology 186 at 186.

[49] Lapp, above n 43, at 361.

[50] At 363.

[51] Alex A Stamm "Young Adults Are Different, Too: Why and How We Can Create a Better Justice System for Young People Age 18 to 25" (2016) 95 Texas Law Revue 72 at 74.

[52] David P Farrington, Rolf Loeber & James C Howell, "Increasing the Minimum Age for Adult Court" (2017) 16:1 Criminology & Public Policy 83 at 85 and Nancy Ginsburg "Reimagining the Role of Defense Counsel for Adolescents in the Adult Criminal Court System: Bringing the Community and Policymakers into the Process to Achieve the Goals of Gideon" (2014) 35 Cardozo Law Review 1117 and 1121.

this range and have a heightened propensity to engage in risky behaviour.[53] This puts pressure on the criminal justice system because it suggests that young adults are less responsible and therefore, less culpable for offences they commit.[54]

Research into brain development further puts into doubt whether traditional types of prisoner treatment are able to achieve the penological goals this treatment was designed to occasion. Section 7 of the Sentencing Act 2002 recognises several purposes of punishment. The nine purposes laid out there may be summed up by reference to four general aims, namely retribution, incapacitation, rehabilitation and deterrence.[55] Where an offender acts not due to volition on their part but rather due to developmental factors, punishment will not act as a deterrence, and both rehabilitation and long-term incapacitation may be unnecessary.[56] Furthermore, retribution in such circumstances is unjust, given that the actor is not responsible for the crime.[57]

2 Increased Understanding about Disabilities and Traumas:

Another development, challenging how the justice system deals with youth offenders, is research into disabilities, atypical processing, and trauma. Between 50 and 70 per cent of youth involved in the justice system meet diagnostic criteria for at least one mental or substance use disorder.[58] A 2018 study conducted on children in custody in Western Australia found 89 per cent had "at least one severe neurodevelopmental deficit"; that is dyslexia or a similar learning disability, language disorder, attention deficit hyperactivity

[53] David P Farrington, Rolf Loeber & James C Howell "Young Adult Offenders: The Need for More Effective Legislative Options and Justice Processing" (2012) 11:4 Criminology & Public Policy 729 at 741.

[54] Laurence Steinberg "A social neuroscience perspective on adolescent risk-taking" (2008) 28 Developmental Review 78 at 79.

[55] Julian J Roberts "Sentencing Reform in New Zealand: An Analysis of the Sentencing Act 2002" (2003) 36:3 the Australian and New Zealand Journal of Criminology 249 at 256.

[56] Mike C Materni "Criminal Punishment and the Pursuit of Justice" (2013) 2 British Journal of American Legal Studies 263 at 289.

[57] Antony Duff and Andrew von Hirsch "Responsibility, Retribution and the "Voluntary": A Response to Williams" 1997 56(1) Cambridge Law Journal 103 at 103.

[58] Peter Gluckman *It's never too early, never too late: A discussion paper on preventing youth offending in New Zealand* (Office of the Prime Minister's Chief Science Advisor, June 2018) at 9.

disorder, memory impairment or motor coordination disorder.[59] A further 36 per cent of children could be diagnosed with a foetal alcohol spectrum disorder, leading to impaired cognitive functioning.[60] Dr Ian Lambie, Chief Science Advisor for the Justice Sector, suggests that these levels mirror those found in New Zealand.[61]

> Such conditions impair development, ensuring that children and young people may have a developmental age and mental capacity many years younger than their biological age.[62] In this way, trauma and disability exacerbate the issues posed by a lack of development and further threaten to compromise the fairness of a trial. It may be desirable in these circumstances to raise the minimum age of criminal responsibility or age of penal majority to ensure that the accused has reached their maximum mental capacity or at minimum, a higher level of mental capacity before appearing in court. Moreover, a court process which identifies disabilities and traumas, thus allowing measures to be put in place to account for such bars to mental capacity, could reduce reoffending, which is currently as high as 80 per cent for youth offenders in the ten years following their first offence.[63] Such a process is more likely to occur with youth court rather than standard court procedures. Therefore, the desire to accurately identify hurdles to capacity forms another basis on which to call for a higher age of penal majority.[64]

3 *Human Rights Developments:*

In addition to the emerging science around brain development, advancements in human rights scholarship are further lending support to the mounting challenges to current youth

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[59] Meg Perkins "Science and Raising the Age of Criminal Responsibility" (28 August 2019) Amnesty International Australia <www.amnesty.org.au>.

[60] Perkins, above and Ian Lambie *What were they thinking? A discussion paper on brain and behavior in relation to the justice system in New Zealand* (Office of the Prime Minister's Chief Science Advisor, January 2020) at 93-94.

[61] Jan-Marie Doogue and John Walker *Proposal for a Trial of Youth Adult List in Porirua District Court* at 5 and Lambie, above, at 93.

[62] Perkins, above n 59.

[63] Above.

[64] Judge John Walker "When the Vulnerable offend — whose fault is it?" (Address to Northern Territory Council of Social Services Conference, Darwin, 27 September 2017).

and young adult justice procedures. Catalysts include the United Nations Standard Minimum Rules for the Administration of Juvenile Justice in 1985 ("The Beijing Rules"), the CRC in 1989, Committee on the Rights of the Child General Comment No.24 2007 and the Council of Europe's 2003 and 2008 recommendations.[65] These international standards emphasise the values of diversion, minimum intervention, education, restorative justice and other constructive measures in the context of youth offending.[66] Promulgation of these values was accompanied by a significant reduction of juvenile crime across Europe and as such, instituting rehabilitative measures to young adult offenders has become the norm there.[67]

Many of these rights instruments indirectly draw on arguments concerning mental capacity. By way of example, the Council of Europe's 2003 recommendations included the following provision:[68]

> Reflecting the extended transition to adulthood, it should be possible for young adults under the age of 21 to be treated in a way comparable to juveniles and to be subject to the same interventions, when the judge is of the opinion that they are not as mature and responsible for their actions as full adults.

While the recommendations refer to the maturity and responsibility of the offender, they are ostensibly built more on the practical experience of those working within the youth and young adult justice sectors than on any specific developmental science.[69] This is important because, while science has the potential to change as new information is uncovered,

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[65] Sibella Mathews, Vincent Schiraldi and Lael Chester "Youth Justice in Europe: Experience of Germany, the Netherlands, and Croatia in Providing Developmentally Appropriate Responses to Emerging Adults in the Criminal Justice System (2018) 1:1 Justice Evaluation Journal 59 at 64.

[66] At 64.

[67] F Dünkel "Juvenile Justice and Human Rights: European Perspectives" in H. Kury, S.Redo and E. Shea (Eds.) *Women and Children as Victims and Offenders: Background, Prevention, Reintegration Suggestions for Succeeding Generations Volume 2* (Springer, Cham, 2016) 681 at 713 and Mathews, above n 65, at 64.

[68] Council of Europe Committee of Ministers *Recommendation Rec (2003) 20 of the Committee of Ministers to member States concerning new* ways *of dealing with juvenile delinquency and the role of juvenile justice* (2003) at 11.

[69] At 1.

experience establishes that young adults benefit from a range of more youth-friendly justice procedures. Therefore, even if differences in mental capacity between young adults and adults older than twenty-five were determined to be less significant than present science indicates, there could still be a reason to implement changes to young adult justice procedure to mitigate yet unidentified differences between young adults and adults who have reached developmental maturity.

C Raising the Minimum Age of Criminal Responsibility:

New Zealand's low minimum age of criminal responsibility has been subject to building controversy.[70] Although, as mentioned, children generally only appear in court (Youth, District or High Court) in a limited number of situations, such cases are certainly not unheard of. In the year from 2019 to 2020, 30 children (below fourteen years of age) had charges finalised in court.[71] While this number may seem insignificant to some, others question whether a child of this age should be subject to the criminal justice system and whether they have sufficient mental capacity for the imposition of legal capacity and responsibility.[72] Furthermore, the number of children who had contact with the criminal justice system but were diverted without receiving a formal criminal record is not covered in these statistics. As such, the number of young children who have contact with the justice system before age fourteen could be many times higher.

Questions around the matter of child criminality mounted, culminating in a report, published in August 2020 in which New Zealand's Children's Commissioner outlined his support for raising the age of criminal responsibility to 14 years.[73] His advice follows a recommendation by the Modernising Child Youth and Family Expert Panel, which was in 2015 tasked with reviewing New Zealand's Child, Youth and Family Framework, to

[70] Georgie Forrester "As countries look to raise the age of criminal responsibility, should NZ too?" *Stuff* (New Zealand, 1 November 2019).

[71] Ministry of Justice *Children and Young People in Court* (2020) at 3.

[72] Lynch, above n 32, at 191.

[73] Office of the Children's Commissioner *Children with Offending Behavior: Supporting children, 10-13 year olds, who seriously offend and are referred under s 14(1)(e) of the Oranga Tamariki Act* (August 2020) at 5.

increase the age of criminal responsibility to twelve.[74] It also follows analogous developments in Australia, where, in 2019, the Council of Attorneys-General Age of Criminal Responsibility Working Group was tasked with considering submissions relating to raising the minimum age of criminal responsibility from ten to fourteen with the view to making a recommendation at the end of this process.[75] Similar changes are also being called for across various American jurisdictions.[76] These various campaigns have received the support of the United Nations Committee on the Rights of the Child (the Committee), which in 2007, released guidance recommending that twelve years was, in the Committee's opinion the "absolute minimum age" acceptable for criminal responsibility.[77] Furthermore, the Committee recommended that state parties should "under no circumstances reduce the minimum age of criminal responsibility if its current penal law sets the age above fourteen.[78] Moreover, the Committee, writing now on the application of youth justice systems "notes with appreciation that some States parties allow for the applications of [youth justice procedures] to persons 18 and older".[79]

These calls to action, both in New Zealand and abroad cite the matter of incomplete brain development until age twenty-five as a significant factor in their calls for change.[80] In these circumstances, fourteen as the minimum age of criminal responsibility is a significant compromise, reflecting the entrenched-ness of the current low minimum age of criminal responsibility.[81] The efforts of these campaigns to bring greater visibility to developing

[74] Modernising Child, Youth and Family Expert Panel *Expert Panel Final Report: Investing in New Zealand's Children and their Families* (Ministry of Social Development, Expert Report, December 2015) at 30.
[75] Perkins, above n 59.
[76] Raise the Age – New York about the Campaign (2020) <https://cdfny.org> and John Kelly "In Another Big Year for "Raise the Age" Laws, One State Now Considers All Teens as Juveniles" *The Imprint* (online ed, 26 June 2018).
[77] Committee on the Rights of the Child *General Comment No.24 (201x), replacing Comment No.10 (2007) Children's rights in juvenile justice* CRC/C/GC/24 (September 18 2019) at 9.
[78] At 9.
[79] At 3.
[80] Office of the Children's Commissioner, above n 73, at 9.
[81] Perkins, above n 59, and Office of the Children's Commissioner, above n 40, at 2.

science have also contributed to further calls to raise the age of penal majority beyond eighteen.[82]

D Raising the Age of Penal Majority:

In August of 2019 New Zealand Chief District Court Judge, Justice John Walker, announced that a new justice approach for young adults aged between eighteen and twenty-five was being developed for the Porirua District Court.[83] A lack of information about specifics of the proposal persists even though a trial of the scheme is underway.[84] At the heart of the proposal lie two factors discussed earlier in the paper but which are set out briefly again for ease of reference.[85] Firstly, that the brains of under twenty-five-year-olds display a "demonstrably different brain architecture [to] adults" and secondly that a large proportion of young people who come into contact with the court suffer from a range of childhood disabilities and traumas, which "do not have an expiry date".[86]

In light of these challenges, the proposal recommends making basic changes to procedural justice by adopting a "universal vulnerability" approach.[87] Universal vulnerability aims to treat all people as though they are vulnerable in the interaction, thus challenging commonly held societal views about offenders; that they are tough and prey on the weak.[88] In a court setting, the vulnerability approach involves using plain language, open-ended questions and asking people to translate information into their own words.[89] In this way, it ensures that communication is more effective and fairer than it would be in standard court procedure. Furthermore, the proposal splits the process of dealing with young defendants

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[82] Kelly, above n 76.

[83] Walker, above n 9.

[84] Judge John Walker "Trial of Young Adult List court officially launched in Porirua" (press release, 31 July 2020).

[85] Above.

[86] Elise White and Kimberly Dalve "Changing the Frame: Practitioner Knowledge, Perceptions, and Practice in New York City's Young Adult Courts" (Center for Court Innovation, New York, 2017) at 14 Doogue, above n 61, at 1.

[87] Doogue, above n 61, at 10.

[88] Nina A Kohn "Vulnerability Theory and the Role of Government" (2014) 26:1 Yale Journal of Law and Feminism 2 at 7.

[89] Doogue, above n 61, at 10.

into several phases.[90] In the first phase, information is harvested about the defendant from existing court records and screening tools. This facilitates a process that accounts for the particular characteristics of young people and enables the court to be alert to the disabilities of the particular offender. This additional information also allows the language and procedure of the court to be modified to account for an offender's specific needs.[91] It can also be considered at sentencing.[92]

In the proposal, Judge Walker mentions a desire to ensure that New Zealand continues to lead the way in "developing a comprehensive, consistent and effective youth justice system".[93] He mentions several nations which he considers co-pioneers of this approach.[94]

In Europe, these co-pioneers include the Netherlands, Croatia and Germany, each of which permit offenders over age eighteen to be treated similarly to youth offenders in specified situations. In the Netherlands, young adults between ages eighteen and twenty-three can be sentenced under juvenile justice procedures if the court finds reason for this "in the personality of the offender or the circumstances of the case".[95] Germany adopted a similar approach, allowing those between eighteen and twenty-one to be dealt with under either the juvenile justice system or adult jurisdiction at the court's discretion.[96] At present, 67 per cent of offenders in this range are dealt with using juvenile justice measures.[97] Finally, Croatia has set up a general "young adults" category, which operates distinct procedures for everyone under age twenty-one, regardless of the circumstances of the alleged offence.[98]

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[90] At 13.
[91] At 15.
[92] At 15.
[93] At 12.
[94] At 11.
[95] Ton Liefaard and Maryse Hazelzet *Alternatives to Custody for Young Offenders National Report on Juvenile Justice Trends* (International Juvenile Justice Observatory, 2014).
[96] Mathews, above n 65, at 65.
[97] At 66.
[98] At 75.

It is not only European nations that have been looking to recent scientific developments to make changes to their young adult justice procedure. In the USA, several court systems have joined this wave. The processes developed vary state by state and at times, even borough by borough.[99] A non-scientific survey reveals that boroughs of New York and the justice systems of California, Connecticut and Vermont are among the first to implement procedural changes aimed at young adult offenders.[100] These examples demonstrate the widespread acceptance for the notion that young adults lack sufficient mental capacity to be held liable for criminal actions and emphasise the need to re-evaluate the current framework of legal capacity.

V Age Limits in Medical Law

While research into mental capacity has led to doubts arising about the justness of holding young adults responsible for their actions, thus challenging current formulations of legal capacity in the context of youth and young adult justice, developments in medical law flout this trend. This is particularly the case for gender-affirming treatments. Many of these treatments result in more desirable outcomes for the individual undergoing them if administered at a young age.[101] This encounters tension in that such treatments are not entirely risk-free and can lead to unintended consequences. Ostensibly, such decisions are best made by individuals with fully developed brains, who have sufficient mental capacity; something, advocates in the youth justice context argue, adolescents lack. If the nature of mental capacity is the same across the medical and youth justice fields, this situation poses an issue.

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[99] Doogue, above n 61, at 11.

[100] At 12 and Dannel P Malloy "Gov. Malloy Introduces Juvenile Justice Reform Legislation Legislative Proposal Raises the Age of Juvenile Justice Jurisdiction; Expands Opportunity for Youthful Offenders to Lead Productive Lives" (press release, 20 March 2018), Anita Chabria "Offenders under 21 would be automatically tried as juveniles under new California bill" *Los Angeles Times* (Los Angeles, 20 January 2020) and Kelly, above n 76.

[101] Samantha M. Busa, Scott Leibowitz and Aron Janssen "Transgender Adolescents and the Gender-Affirming Interventions: Pubertal Suppression, Hormones, Surgery, and other Pharmacological Interventions" in A Janssen and S. Leibowitz (eds) *Affirmative Mental Health for Transgender and Gender Diverse Youth* (Springer International Publishing, New York City, 2018) 49 at 50.

A Capacity in the Medical Field:

The current legal scheme around the age of consent for medical procedures, just like age limits in youth justice, is complex and lacks a strong foundation in research or principle. Furthermore, the law in this area has not always linked up with the realities of contemporary medical treatment, resulting in blind spots over the years.

Until the 1960s there was uncertainty about who could consent to treatment.[102] This resulted on one occasion in a nineteen-year-old man not being given a blood transfusion because, despite him having consented to the procedure, his parents had not.[103] At the time, Auckland Hospital's legal advisors thought it best to treat the nineteen-year-old as someone who lacked legal capacity to consent to a transfusion, because he was not yet an adult in law.[104] Parliament quickly responded with an amendment to the Guardianship Act of 1968, the governing statute to this time.[105] Today, it is beyond doubt that those who have reached de facto legal majority at age eighteen, possess requisite legal capacity to consent to medical treatment.[106]

For those younger than eighteen, the situation is more complicated. The care of Children Act 2004 creates restrictions on the ability of sixteen to eighteen-year-olds to consent to medical treatment. Section 36(1) provides that those over the age of sixteen shall be treated as if they were of full age, so long as the medical, surgical or dental treatment or procedure contemplated is carried out for the "benefit" of that child, by someone "professionally qualified to carry it out".[107] The qualification that treatment must be carried out to the benefit of a child is not a substantive restriction because it is not qualified by the term "health". This means that theoretically, any perceived benefit can be considered.[108] Furthermore, the concept of a "benefit" has proven extraordinarily malleable in other

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[102] Peter Skegg *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) at 235.
[103] At 235.
[104] At 235.
[105] At 248.
[106] At 248.
[107] Care of Children Act 2004, s 36(1).
[108] Skegg, above n 102, at 238.

medico-legal contexts making it likely that this term will not substantially inhibit the ability of sixteen-year-olds to consent to treatment.[109] Finally, the requirement that the treatment is administered by someone "professionally qualified to carry it out" is unlikely to pose issues for gender-affirming treatment.[110]

Turning to those under sixteen. Statute is silent on the legal capacity of people under sixteen to consent to medical treatment.[111] The answer is instead found in the common law. The leading case on common law capacity is *Gillick v West Norfolk and Wisbech Area Health Authority*.[112] In this case, the House of Lords accepted that minors are not incapable of consenting to medical treatment by reason only of their age.[113] Instead, the court must be satisfied that the young person contemplating treatment "has sufficient understanding and intelligence to give [his or her] consent".[114] In this way, the House of Lords appears to link legal capacity to consent to medical treatment directly to mental capacity and ignores rights and policy decisions which may affect this determination. This poses an issue in that the call to raise legal capacity in the criminal justice context is supported chiefly by claims that adolescents lack mental capacity to understand the nature of their actions. Can both of these measures of mental capacity be true at the same time and what does this mean for legal capacity?

Before examining mental capacity more closely it is necessary to chart the applicability of *Gillick*. The extent to which *Gillick* is admissible in New Zealand, especially given that statute does not deal with the capacity of people younger than sixteen, is in theory still unsettled.[115] While the United Kingdom equivalent of the Care of Children Act 2004 contains a savings provision, preserving common law rules concerning capacity, the savings provision in the New Zealand Care of Children Act is more equivocal.[116] It does

[109] At 238.
[110] At 238.
[111] At 239.
[112] At 240.
[113] *Gillick v West Norfolk and Wisbech* AHA [1985] UKHL 7 at 174.
[114] *R v D* [1984] AC 778 at 806.
[115] Skegg, above n 102, at 241.
[116] Family Law Reform Act 1969 (UK), s 8(3).

not address situations where treatment is to be administered to a person under sixteen, where the consent of the child alone may suffice.[117] However, this obstacle to capacity for under sixteen-year-olds has gone unmentioned by New Zealand courts, who have assumed that there are no obstacles to applying *Gillick*.[118] This is also the view shared by various state bodies, which refer directly to *Gillick* as a starting point for assessing a child's capacity.[119] *Gillick* has also been used to help determine capacity in the context of gender-affirming care in the Australian cases of *Re Lucy* and *Re Sam and Terry*.[120]

An understanding that sixteen-year-olds can consent to gender-affirming treatment is also supported by current practice in New Zealand. In a 2018 paper titled "Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa, New Zealand" the authors recommend that while a number of surgical procedures are best reserved until the patient has reached "the age of majority", treatments such as endocrine procedures may be initiated prior to the patient turning sixteen.[121] This mirrors the most recent recommendations from the Endocrine Society, that adolescents younger than sixteen should be eligible for gender-affirming hormone treatments.[122]

The view that those younger than sixteen can generally not consent to more intensive surgical procedures is reflected in the *Standards of Care* set out by the World Professional Association for Transgender Health (WPATH), referred to by the Ministry of Health in relation to eligibility for gender-affirming surgery and a range of other international clinical

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[117] Skegg, above n 102, at 242.

[118] At 242.

[119] Ministry of Justice *Guideline on Assessing Capacity to Make Decisions about Treatment for Severe Substance Addiction* (2017).

[120] Ana-Maria Bucataru "Using the Convention on the Rights of the Child to Project the Rights of Transgender Children and Adolescents: the Context of Education and Transition" (2016) 3:1 Queen Mary Human Rights Review 59 at 75.

[121] Oliphant J and others *Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young Persons and Adults in Aotearoa New Zealand* (Transgender Health Research Lab, University of Waikato, Hamilton, 2018) at 31.

[122] Busa, Leibowitz and Janssen, above n 101, at 58.

guidelines.[123] These take the view that sex reassignment is best reserved for individuals older than eighteen.[124] The WPATH Guidelines contemplate that other surgeries, however, including "top surgery", a term referring to both mastectomies and breast augmentations may be performed before the age of majority.[125] Furthermore, the Affirmative Mental Health Care for Transgender and Gender Diverse Youth Clinical Guide "increasingly recommends" such surgeries before age eighteen.[126]

B Gender-Affirming Treatments and Risks:

Before progressing further into the specific procedures available to adolescents and the risks, these procedures may pose, it is important to make clear that this is not a medical research paper. As such, the author does not purport to have expert medical knowledge. However, substantial research was done to ensure that the following statements are accurate, current and reflect the opinions of experts on these matters.

One endocrine procedure increasingly offered to people before age sixteen is puberty suppression. The physical changes wrought on a body during puberty may be difficult to reverse. The reasoning behind this procedure is that preventing a person from going through puberty can preserve their body in a more "gender-neutral" state, averting the potential need for invasive procedures later in life to bring their body into step with their gender. As such, puberty suppressants are considered a way of buying gender non-conforming young people who have not yet begun puberty, time to decide whether to progress with treatment or let natural puberty run its course.

A second procedure commonly available to gender non-conforming young people is gender-affirming hormone therapy. This treatment helps individuals to develop the secondary sexual characteristics which align with their gender identity. By way of

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[123] Eli Coleman and others *Standards of Care for the Health of Transsexual, Transgender, and Gender Non-conforming People* (World Professional Organisation for Transgender Health, 2012) at 105 and "Health care for transgender New Zealanders" Ministry of Health < www.health.govt.nz>.

[124] At 106.

[125] At 105.

[126] Busa, Leibowitz and Janssen, above n 101, at 59.

comparison, while puberty suppressants prevent someone from undergoing biological puberty, gender-affirming hormone therapy induces puberty or in some cases a second puberty to affirm an individual's gender and combat dysphoria.

The above described endocrine procedures are generally considered low risk and potentially reversible to an extent.[127] This is one factor that has made them a popular treatment option for adolescents who may be unable or unwilling to consent to more permanent measures. However, hormone-based procedures are not risk-free.

At the time of writing this paper, there is scant data on the long-term impacts of prolonged use of puberty-suppressing hormones on an individual's health. However, recent studies are raising concerns about the side effects such hormones may have on bone mineral density and bone mass.[128] There are also concerns about the impact puberty-suppressants may have on an individual's social and cerebral development.[129]

Gender affirming hormone therapy also presents risks. The first of these is that its effects are often not entirely reversible. [130] In particular, studies have raised concern about the fertility of individuals undergoing such treatment.[131] This, in turn, begs the question of whether adolescents are well suited to make complex decisions regarding their fertility.[132] To illustrate this point further, voice deepening occurs in male puberty at roughly the same time at which mature sperm can be harvested.[133] This puts some young gender-diverse people in the position of having to decide between developing a deeper voice and the accompanying dysphoria and the ability to have biological children. Furthermore, this

[127] At 54.

[128] Hembree WC and others "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline" (2017) 102:11 Journal of Clinical Endocrinology and Metabolism 38 at 69.

[129] Busa, Leibowitz and Janssen, above n 101, at 54.

[130] Oliphant, above n 121, at 30.

[131] At 28.

[132] MM Telfer and others *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents Version* (1.2, The Royal Children's Hospital, Melbourne, 2020) at 13.

[133] At 14.

decision must be made just before or in the early stages of puberty, which is commonly already a difficult time for adolescents.[134]

Another risk of allowing children to access gender-affirming treatments is that the child is not truly transgender and will need to undergo a second transition, also known as a "detransition" in future.[135] It is difficult to appraise the legitimacy of this risk, given the lack of research on detransitioning children and highly politicised discussion around this matter. Critics of gender-affirming treatment appear to be of the view that gender diversity is not only acceptable but trendy amongst modern adolescents and that social pressure could cause young people to undergo a medical transition despite feeling comfortable in their cisgender identities.[136]

At present, such a view does not appear to be supported by scientific evidence.[137] Studies indicate that the rate of regret following gender-confirming surgeries is low, at between 2.2 and 5 per cent.[138] The notion of regret is in itself amorphous and it is unclear whether it refers to the regret of medical transition altogether or regret around specific surgical procedures or timing.[139] Furthermore, this research was conducted in the context of surgical procedures rather than endocrine procedures. However, with a lack of research specifically on the matter of detransition following hormone treatment, it is impossible to discount the risk posed by such a detransition entirely. It is, in any case, desirable to ensure that young people are not exposed even to small risks.

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[134] Deborah Yurgelun-Todd "Emotional and cognitive changes during adolescence" (2007) 17 Current Opinion in Neurobiology 251 at 255.

[135] Alex Verman "Telling trans stories: Journalism about detrainsition is creating overblown moral panic among North American readers. Why reporters need to be more responsible in their reporting of trans communities" (2018) 52:2 This Magazine 14 at 14.

[136] At 14.

[137] Rowan Hildebrand-Chupp "More than 'Canaries in the gender coal mine': A transfeminist approach to research on detransition" (2020) 64:4 The Sociological Review 800 at 811.

[138] Cacilia Dhejne and others "An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960-2010: Prevalence, Incidence and Regrets" (2014) 43 Archives of Sexual Behavior 1535 at 1540 and Anne A Lawrence "Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery" (2003) 32 Archives of Sexual Behavior 299 at 305.

[139] Hildebrand-Chupp, above n 137, at 806-807.

Given the not insignificant nature of risks to young people's health in the context of gender-affirming treatments, care should be taken in determining the age for legal capacity to ensure that young people have sufficient ability to account for the above-described dangers.

VI Scientific Developments in Mental Capacity

Having set out the three case studies this paper draws on, the following section examines scientific measures of capacity in greater detail. This helps to decouple the notion of capacity from the age of majority and reveals that the nature of a decision can impact on whether or not the decision-maker has sufficient mental capacity to make it.

A Research on Capacity in the Youth Justice Context:

Adolescents are more likely than adults older than twenty-five to engage in binge drinking, drink driving, cigarette consumption and unprotected sex.[140] There are already large-scale education efforts underway to notify youth about the risks inherent in such activities in an attempt to modify these risky behaviours.[141] While these programmes are effective to a degree, most systematic research on health education indicates that even the best education programmes are more successful at changing an individuals' knowledge than altering behaviour.[142]

Further, recent studies have increasingly challenged several widely held-beliefs about adolescents.[143] These beliefs include that: (a) adolescents are irrational or deficient in their information processing, or that they reason about risk in a fundamentally different way than adults; (b) that adolescents do not perceive risks where adults do or are more likely to believe that they are invulnerable; and (c) that adolescents are less risk-averse than adults. Instead, research has consistently found that the logical reasoning and information processing abilities of sixteen-year-olds are comparable to adults and that adolescents are

[140] Laurence Steinberg "A social neuroscience perspective on adolescent risk taking" (2008) 21:1 Developmental Review 78 at 79.
[141] At 79.
[142] At 80.
[143] At 80.

no worse than adults at perceiving or estimating their vulnerability to risk.[144] This suggests that the cause of adolescent risk-taking and offending is the developing brains impact on the social and emotional processes of the adolescent mind, rather than on the risk perceiving portions. Put simply, adolescents can see the danger, yet choose to act anyway for the factors set out below.

1. Emotional Arousal

An important variable in the context of adolescent decision making is the decision maker's state of emotional arousal. Research indicates that when faced with a high degree of pressure or emotion, adolescents are more likely to make riskier decisions than in calmer situations. This difference in emotionality can be referred to as "hot" versus "cold" processing, where cold processing refers to an analytical decision made in a state of low emotional arousal, by a relaxed decision-maker, while hot processing, to a situation where the decision-maker experiences greater levels of pressure and emotion while making the decision.[145] Studies indicate that adolescents, but not younger children or adults exhibit a marked change in decision making based on the emotional intensity of the situation orchestrated by researchers, suggesting that adolescents are less able to suppress impulsive behaviours in the face of salient, emotional stimuli.[146]

2 Peer Pressure

The presence of peers and the social pressure this generates is particularly influential in predicting whether a young person will choose to engage in behaviours which they understand to be risky.[147] An existing relationship between the third party and the decision-

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[144] At 80.

[145] Ashley R. Smith, Jason Chien and Laurence Steinberg "Impact of socio-emotional context, brain development, and pubertal maturation on adolescent risk-taking" (2013) 64:2 Hormones and Behavior 323 at 325.

[146] At 330

[147] Ashley R. Smith, Jason Chien and Laurence Steinberg "Peers Increase Adolescent Risk Taking Even When the Probabilities of Negative Outcomes Are Known" (2014) 50:5 Developmental Psychology 1564 at 1567 and Jason Chien and others "Peers increase adolescent risk taking by enhancing activity in the brains reward circuitry" (2011) 14:2 Developmental Science F1 at F8.

maker is not necessary for this phenomenon to materialise.[148] Observation of the actor by unfamiliar peers was found even further to increase an adolescents' inclination to make riskier choices.[149] This correlation between peer presence and risk-taking has not been observed in adults over the age of twenty-four.[150]

3 Future Orientation

Another variable affecting the decision making of adolescents is their lack of future orientation.[151] Research has established that adolescents think less about the future, plan less before acting and anticipate future outcomes less than people older than their early - twenties.[152] As a result, adolescents worry more about short term consequences of their actions, rather than more distant risks or benefits.[153] While future orientation has been documented to increase generally from age twelve into adulthood, adults up until their twenties face developmental gaps in this regard and therefore are at a disadvantage in their long-term decision making.[154]

4 Sensation Seeking

The final factor identified as leading to higher rates of risky behaviours amongst adolescents is sensation seeking.[155] This is where an individual intentionally places themselves in dangerous situations, to experience something new and potentially exciting. This factor further reinforces the notion that adolescents understand the risks associated with certain behaviours yet elect to place themselves in such situations regardless of that

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[148] Smith, Chien and Steinberg, above n 147, at 1568 and Alexander Weigard and others "Effects of Anonymous Peer Observation on Adolescents Preference for Immediate Rewards" (2014) 17:1 Developmental Science 1 at 8.

[149] Smith, Chien and Steinberg, above n 147, at 1568.

[150] Margo Gardner and Laurence Steinberg "Peers Influence on Risk Taking, Risk Preference, and Risky Decision Making in Adolescence and Adulthood: An Experimental Study" (2005) 41:4 Developmental Psychology 625 at 635.

[151] Chi Meng Chu and James R.P. Ogloff "Sentencing of Adolescent Offenders in Victoria: A Review of Empirical Evidence and Practice" (2011) 19:3 Psychiatry, Psychology and Law 325 at 332.

[152] At 332 and Steinberg, above n 139, at 94.

[153] Chu and Ogloff, above n 151, at 332.

[154] At 332.

[155] At 333.

perceived risk. Evidence indicates that sensation seeking rises abruptly between the ages of twelve and fifteen before declining gradually thereafter.[156]

B Research Limitations:

It should be noted that a significant limitation in the research on capacity is that many of the studies disagree over where to draw the line between children, adolescents and adults, with different studies utilising different ages to guide their research.[157] For example, several developmental theorists writing on the matter of future orientation defined the term "adolescent" to mean a young person between the ages of thirteen and eighteen.[158] Therefore it was sometimes unclear to what extent young people in their twenties face similar challenges in this regard or whether there is a disagreement within the scholarship. Other studies depict adolescence and its related challenges as coming to an end only at around age twenty-five.[159] Because of this variation, more research should be undertaken into these factors influencing capacity to determine until which age precisely they are important in predicting how adolescents are likely to act. Furthermore, there would be a benefit in increased transparency within the existing literature, about why it defines adolescence as it does. Is it, for instance, a decision based on the de facto age of majority, eighteen years old, or is it an ex post facto distinction derived from the data itself?

Another factor which complicates the question of mental capacity is that the gender of the decision-maker may influence their decision-making ability.[160] It is unclear whether "gender" refers to natal sex or the gender identity as could be the case, especially given that the brain structure and activity of transgender adolescents has been found to be more consistent with the structure and activation patterns of their gender than with those of their

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[156] Laurence Steinberg and others "Age Differences in Sensation Seeking and Impulsivity as Indexed by Behavior and Self-Report: Evidence for a Dual Systems Model" (2008) 44:6 Developmental Psychology 1764 at 1774.

[157] Smith, Chien and Steinberg, above n 145, at 324.

[158] Chu and Ogloff, above n 151, at 331.

[159] Steinberg, above n 140, at 79.

[160] Michelle O'Reilly, Pablo Ronzoni and Nisha Dogra "Children's Capacity to Make Decisions" in *Research with Children: Theory and Practice* (SAGE Publications, New York, 2013) at 9.

birth sex.[161] The relationship between the gender of the decision-maker and their capacity to understand the nature of their choice is not yet sufficiently understood. I highlight the matter simply to mark it as a topic warranting further study.

C Interim Conclusion on Mental Capacity

There are several qualitative differences between the decision-making procedure around gender-affirming treatment and youth criminality, with regard to the factors set out above, which indicate that differences in mental capacity across these areas can be reconciled.

The first major difference is that unlike the decision to commit a crime, the decision to undergo treatment and potentially put one's interests at risk is unlikely to be a split second, emotionally charged decision.[162] In this sense, the decision to undergo gender-affirming procedures most closely resembles a cold reasoning situation. Furthermore, the decision to undergo treatment is made in the presence of a medical professional, which generally also precludes the presence of peers, who may influence the outcome. Moreover, studies have concluded that most children, regardless of age or disability, can express their views if appropriately supported and asked.[163] Providing children with appropriate information has been found to boost capacity, with some claiming that this factor is even more central to the matter of mental capacity than the decision-making abilities that a child possesses per se.[164] Therefore, a more drawn-out process including an extended period of consultation with experts and caregivers can help ensure that the decision-maker has all relevant information on the matter and is not being detrimentally affected by developmental hurdles to their mental capacity.

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[161] European Society of Endocrinology. "Transgender brains are more like their desired gender from an early age." (24 May 2018) ScienceDaily <www.sciencedaily.com >.

[162] Baudewijntje PC Kreukels and Peggy T Cohen-Kettenis "Puberty suppression in gender identity disorder: The Amsterdam experience" (2011) 7:8 Nature Reviews. Endocrinology 466 at 469.

[163] Christina Standhold Anderson and Anna-Stine Dolve "Children's perspectives in their right to participate in decision-making according to the United Nations Convention on the Rights of the Child article 12" (2014) 35:3 Physical & Occupational Therapy In Pediatrics 218 at 227.

[164] Aoife Daly "Assessing Children's Capacity: Reconceptualising our Understanding through the UN Convention on the Rights of the Child" (2020) 28:3 The International Journal of Children's Rights 471 at 489.

This conclusion is supported by studies investigating the mental capacity of children to consent to scientific research participation. Such studies found that children as young as eleven years old generally appeared competent to offer their informed consent to participate in research.[165] Children only slightly younger, at nine and a half, were not found to have sufficient capacity, indicating that mental capacity may develop quickly between the ages of nine and twelve.[166] Choosing to partake in scientific research is quite a different matter to electing to undergo gender-affirming procedures. Therefore the findings on mental capacity in one context cannot necessarily be directly transplanted to the other. Nonetheless, these studies underscore the fact that mental capacity in the context of medical situations can substantially differ from mental capacity in criminal situations.

There may still be some factors, such as an adolescent's lack of future orientation and their propensity to seek to experience new and diverse sensations which have the potential to impact on their decision making in both a medical or criminal context. This could be a basis for holding that that caregivers and experts should retain a level of input into adolescent decision making, while recognising that adolescents are capable of being and should be the primary actors.

In light of the discussion above, it is evident that mental capacity comprises two distinct situation dependant variants, namely the capacity to make decisions in hot versus cold situations. This understanding casts a shadow over other areas of the law, which have long assumed that capacity in all matters is reached at age eighteen.

VII Legal Capacity and the Children's Rights Framework

As mentioned, legal capacity is a normative judgement. This judgement depends in large part on considerations of mental capacity. Also important, however, in setting the age for legal capacity in various legal fields is a consideration of New Zealand's international

[165] Hein, above n 18, at 78.

[166] At 78.

rights obligations. Chief amongst these in the context of children's legal capacity is the CRC. Examination of the CRC further supports the development of diverging standards of legal capacity across the areas of medical and criminal law.

It is important to note that the CRC, strictly speaking, does not apply to the matter of raising the age of penal majority because it only applies to "children", who are defined as under eighteen years old.[167] However, the theory behind these rights applies equally to children as young adults if one considers that eighteen, is not a scientifically principled age limit. On this basis, although CRC rights may not exert a legalistic influence over the matter of raising the age of penal majority, such rights considerations are highly persuasive in laying out what the situation ought to be in this respect.

A CRC article 24:

Article 24 of the CRC provides for a child's right to access health services. Read in conjunction with CRC article 2, the right against discrimination; state parties undertake to ensure that the right to health is upheld without discrimination on the grounds of gender identity.[168] Where a child suffers from gender dysphoria art 24 may be a basis for arguing that states should ensure that treatment options are available. This could include the provision of counselling services, hormone therapy or surgery. Article 24 also has a bearing on how to interpret other aspects of the CRC.

B CRC Article 5

Article 5 provides that the rights and duties of parents or, where applicable, the family will be respected, to provide in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise of its rights. The term "evolving capacities" utilised in article 5 refers, in the opinion of the Committee on the Rights of the Child (the Committee), to the "process of maturation and learning" where a child's ability to have agency over their rights exists on a sliding scale alongside a child's ability to understand how these rights are best realised.[169] In this way, article 5 indicates that while

[167] Convention on the Rights of the Child 1577 UNTS 3 (1999), art 1.

[168] Bucataru, above n 120, at 75.

[169] Daly, above n 164, at 479.

parents have a duty to act as protectors of a child's right, this role is not monolithic and the say a parent can exercise of a child's rights should decrease with time.[170] Article 5 also supports the notion that where evidence of mental capacity indicates that adolescents are capable of understanding and consenting to a procedure, this should be respected.

As mentioned earlier in the paper, research indicated that providing children with appropriate information and support is hugely important to increasing mental capacity.[171] Hein and others in a 2015 study suggest that children are capable of autonomous decision-making in "shared" or "co-consent" models as early as 12 years of age.[172] Furthermore, the Committee on the Rights of the Child, in its General Comment No. 12 stipulated that states are to ensure that a child receives all necessary information and advice to make a decision in favour of its best interests.[173] In the English case of *F (Mother) v. F (Father) [2013]* the court held that two daughters who were resisting vaccination against their father's wishes did not have "a rounded appreciation of the pros and cons of the vaccine" and therefore ordered that they receive the MMR vaccine.[174] Cave makes the point that a more CRC compliant approach to this decision would have been to provide the girls with the relevant information before reconsidering their capacity.[175] This has parallels for gender-affirming treatment. In this way, especially in medical situations where "scaffolding" can be put in place before the decision is made, adults may have an obligation under the CRC to support mental capacity, thus helping to lower the age at which legal capacity can be found in these circumstances.[176]

This notion that states not only are to respect the rights of those responsible for the child but ensure that the child receives all necessary information to support their development of

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[170] At 493.

[171] At 489.

[172] Hein, above n 18, at 81.

[173] Committee on the Rights of the Child *General Comment No.12 The right of the child to be heard* CRC/C/GC/12 (July 1 2009) at 16.

[174] *F (Mother) v. F (Father)* [2013] EWHC 2683 (Fam) at 15.

[175] Emma Cave "Adolescent Refusal of mmr Inoculation: F (Mother) v F (Father)" (2014) 77:4 The Modern Law Review 619 at 639.

[176] Daly, above n 164, at 489.

capacity could have implications for the field of youth justice. This is because states might be less willing to see a child prosecuted for murder under the age of fourteen if the child's lack of capacity or hurdles to mental capacity (where capacity is determined to exist) are caused by failures by the state to support the development of such capacity. In these circumstances then, art 5 serves as a practical basis for arguing that the age of criminal responsibility ought to be raised.

C CRC article 3:

Article 3 provides that in all actions concerning children, undertaken both by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration. This has bearing both to the question of youth criminality as well as the question of whether or not gender diverse and transgender children should be able to access gender-affirming procedures and on what terms these services should be delivered.

Starting with the gender-affirming treatment scenario. The first question is whether "public or private social welfare institutions" encompasses hospitals or medical institutions which administer gender-affirming treatments. There is little guidance in the convention itself, or any subsequent guidelines, about what is to be understood by the term "welfare institution". Given this lack of clarity, it is likely to be construed widely such that it includes hospital and other medical services.[177]

While such institutions may have internal ethical guidelines (doctors, for instance, commonly observe the Hippocratic oath or an equivalent code of ethics) such codes do not mirror the child-specific obligations of the CRC. One such example is the New Zealand Medical Association Code of Ethics, which requires medical professionals to swear to consider the health and well-being of the patient as their number one priority.[178] The health and well-being of a patient is narrower than the best interests of a child, which encompasses

[177] Phillip Alston "The Best Interests Principle: Towards a Reconciliation of Culture and Human Rights" (1994) 8 International Journal of Law and the Family 1 at 4.

[178] New Zealand Medical Association Code of Ethics 2020, principle 1.

both issues of a medical nature and broader issues, such as a child's ability to have a secure and open future or a child's ability to have agency over its body. In these circumstances, art 3 supports the notion that a child's interest in undergoing medical procedures to change its gender, should be subject to the condition that practitioners consider that doing so is in the child's best interests. However, this must be balanced with art 24, the right to access health services. In this way it should be born in mind that where a child is in urgent need of relief from gender dysphoria, best interests may favour treatment even though this may harm other interests, such as the child's future reproductive ability. As such, art 3 does not speak to the fact that children under sixteen should not be able to access gender-affirming care. It does, however, impose a form of safety check requiring adults to consider the child's interests.

Similarly, in youth justice situations, the CRC art 3 also favours a more paternalistic and sheltering approach. As discussed, almost 80 per cent of young people who commit a crime end up reconvicted within ten years and are significantly less likely to finish school and get a job.[179] Therefore, it is not in the best interests of children to convict them for crimes. Instead, the focus should be on addressing the causes of their behaviour, as to do otherwise increases their risk of becoming involved in criminal activities and is detrimental to their interests.[180]

The best interests principle under art 3 is equivocal in that it provides that the best interests of the child are *a primary consideration* rather than *the primary consideration*.[181] Even so, where capacity is concerned, art 3 favours an approach that allows caregivers to act as a final line of protection to stop children from being held accountable for juvenile decisions. In these circumstances, from a policy standpoint art 3 could be seen to support younger provision of gender-affirming care, because it helps ameliorate potential gaps in capacity by ensuring a level of adult oversight.

[179] Perkins, above n 59.

[180] Committee on the Rights of the Child, above n 77, at 7.

[181] Alston, above n 177, at 13.

D CRC article 8:

Article 8 protects a child's right to preserve its identity, including nationality, name and family relations without interference. It requires states to help children regain aspects of that identity which have been stolen from them. Article 8 was originally added to the CRC in response to a series of events in Argentina, where children were removed from their families and deprived of information concerning their true identity.[182] Despite these origins, the wording of art 8 is broad and in the modern context might include a right to a gender identity.[183] This argument, although never brought directly before New Zealand courts, has been raised by the Irish Ombudsman for the Children's Office and the Scottish Children's and Young People's Commissioner.[184] Furthermore, there is nothing to suggest that gender identity is not included in the context of art 8.[185]

Because art 8 gives the child a right to *preserve* its identity, one may question how this relates to a procedure aimed at changing the physical expression of one's gender. However, suppose one considers that an individual's gender is mentally established by the time they seek to begin gender-affirming medical procedures. In that case, such a procedure may be seen as a preservation of the child's gender identity against the threat of their changing body.[186] Furthermore, when read in conjunction with art 24, which protects a child's right to health, it seems arguable that a right to access medical gender-confirming procedures fits within article 8.[187] Finally, the obligation under art 24 is to provide health services to the maximum extent of the state's available resources.[188] This means that relatively well-off nations, such as those where gender confirmation procedures generally are provided by

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[182] Jaap Doek, *A Commentary on the United Nations Convention on the Rights of the Child, Article 8 The Right to Preservation of Identity Article 9 The Right Not to Be Separated from His or Her Parents* (Martinus Nijhoff 2006) 7 and Bucataru, above n 120, at 63.

[183] Irish Ombudsman for Children's Office, "Advice of the Ombudsman for Children on the General Scheme of the Gender Recognition Bill 2013" (Advice document, October 2013).

[184] Above and Children and Young People's Commissioner Scotland "UNC Simplified Articles – Article 8: I have a Right to an Identity" Children and Young People's Commissioner Scotland < www.cypcs.org.uk>.

[185] Kirsten Sandberg "The Rights of LGBTI Children under the Convention on the Rights of the Child" (2015) 33:4 Nordic Journal of Human Rights 337 at 343.

[186] At 343.

[187] At 345.

[188] At 345.

the state, may have an obligation to extend such treatments to children.[189] In these circumstances, CRC art 8 supports children having access to gender-affirming therapies, irrespective of mental measures of capacity.

E CRC article 12:

Article 12 protects the child's right to express their views "on all matter's affecting [them]" and provides that their views will be given due weight in accordance with their age and maturity. The wording "all matters affecting the child" is broad and can refer to a range of issues and fields including matters relating to the child directly, matters in the "family setting, the local community level and national political level".[190] As such, this right encompasses situations where a child is subject to medical and youth justice procedures. As discussed in the context of mental capacity, studies have found that most children, regardless of age can express their views where appropriately supported.[191] It is beyond question then that states should ensure that virtually all children are at the very least consulted, in medical matters affecting them.[192] The next more difficult step is assessing the weight to be given to these views. The fact that age and maturity are identified as factors guiding the weight to be assigned to a child's views suggests that drafters of the convention anticipated an evidence-based analysis, rather than a limit based only on culturally relevant criteria.[193] In this sense, taking into account the discussion of mental capacity from earlier in the paper, art 12 lends support to the idea that children below age sixteen should be able to access gender-affirming treatments.

F Right to an Open Future

A right of potential application, outside the CRC framework, is the moral right to an "open future" as conceived by philosopher Joel Feinberg. This right is a classic of children's rights literature and despite not having its basis in the CRC, is commonly cited as a guiding

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[189] At 346.

[190] Fiona Ang and others *Participation Right of Children* (Intersentia, Antwerpen, 2006) at 16.

[191] Anderson and Dolve, above n 163, at 227.

[192] At 227.

[193] Daly, above n 164, at 490.

consideration in a diverse number of issues.[194] Feinberg, troubled by the fact that children's rights were held for them "in-trust" by adults, conceived of the right to an open future to protect the future autonomy of children to exercise these yet unattained rights when they came of age.[195] Feinberg believed that a parents duty is to "send [the child] out into the adult world with as many open opportunities as possible, thus maximising the child's chances at achieving self-fulfilment".[196] Such a right is particularly important where the adult's present right threatens to come into conflict with a right of the child that it is not yet able to exercise. Feinberg's original conception of the right was designed to, protect children from parental decisions, often in the name of religious expression or freedom of speech, which threaten to curtail a child's future rights. [197] In this way, it operates as a "rights shield".[198]

Subsequent legal theorists have questioned whether the right to an open future might include positive obligations, such as in a situation where a child's cancer treatment threatens to hamper a child's future reproductive possibilities. [199] In such a case one might consider that parents have an obligation when planning their child's treatment, not only to consider short term health outcomes but to weigh these up with future reproductive prospects and preserve these so far as possible.[200] This example carries parallels to the situation of gender non-conforming children contemplating treatment, as cancer treatment, like certain gender-affirming procedures, has the potential to impact on a young person's future fertility.[201]

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[194] Bernard G. Prusak "Not Good Enough Parenting: What's Wrong with the Child's Rights To an "Open Future"" (2008) 34:2 Social Theory and Practice 271 at 271 and Joseph Millum "The foundation of the child's right to an open future" (2014) 45:4 Journal of Social Philosophy 522 at 522.

[195] Joel Feinberg "The Child's Right To An Open Future" in *Freedom & Fulfilment* (Princeton University Press, Princeton, 1994) 76 at 77.

[196] At 84.

[197] Claudia Mills "The Child's Right to an Open Future?" 2003 34:4 Journal of Social Philosophy 499 at 500.

[198] At 500.

[199] Daniela Cutas and Kristien Hens "Preserving children's fertility: two tales about children's right to an open future and the margins of parental obligations" (2015) 18 Medicine, Health Care and Philosophy 253 at 253.

[200] At 253.

[201] At 253.

As with gender confirmation treatments, children poised to undergo chemotherapy often undergo counselling regarding fertility preservation procedures they may undertake. [202] However, it is important to remember that children in these difficult circumstances, likely, do not have fertility at the forefront of their minds or may have to delay lifesaving treatment if they wish to harvest viable gametes. [203] This is inevitably a stressful decision. Additionally, more could be at stake than fertility alone as evidenced by a 1984 study, which found that knowledge of a child's infertility may affect family dynamics and care given to a child, potentially influencing childhood development. [204]

In the context of fertility loss due to cancer treatment, Cutas and Hens conclude that the current weight of risks and interests do not support an obligation for parents to preserve their children's fertility under the right to an open future framework. [205] This conclusion follows a common thread of criticisms levelled against Feinberg's right of an open future; that the notion of an open future is amorphous and encounters practical issues. These are that, while the right generally assumes that an open future is in the child's best interest, it would be remiss in the interests of ensuring the "openness" of a child's future to discourage it from getting a head start in or securing something that it needs. [206] This is often put in terms of a child wanting to perfect one skill but being forced by its parents to try many different things, which it may be less passionate about, resulting in worse future prospects. While this is a common argument against the existence and applicability of such a right, this critique is misdirected. The right to an open future model conceives of rights being held in trust until one is of age to enjoy them. In the above example of a child learning a skill, it is difficult to see which "right-in-trust" is infringed upon, given that there exists no "right to success" per se. While no right to fertility or right to have children exists either, several rights across a range of instruments refer to rights parents may exercise over

[202] At 254.

[203] At 254.

[204] Joyce B. Borelli and others "The meaning of early knowledge of a child's infertility in families with 47, XXY and 45, X children" (1984)14:4 Child Psychiatry and Human Development 215 at 221.

[205] Cutas and Hens, above n 199, at 258.

[206] Mills, above n 197, at 503.

children or to reproductive freedom, and therefore contemplate a model where a child's reproductive ability is preserved.[207] In these circumstances, the argument restricting a child's decision making to protect its future ability to shape its life is perhaps more justifiable. However, especially in medical situations, one must be careful when using this framework to consider whether the choices parents make to preserve the openness of their child's future, unduly threaten the prospect of the child having any future. On that basis, a precautionary approach is perhaps best employed.

The other argument against the right to an open future's applicability regarding fertility preservation is one of practicality in that it is not necessarily the case that undertaking fertility preservation measures keeps the future open.[208] Children who undergo treatment may still have to opt for gamete or embryo donation or pursue surrogacy as adults.[209] These options have issues of their own in that they may be prohibitively expensive or open the person to discrimination.[210] However, fertility is not the only issue that both people with cancer or recipients of gender-affirming therapy undergo as a result of their treatment. In these circumstances, other potential side effects must also be born in mind.

There is also a qualitative difference, particularly between fertility preservation in the context of treatment for an often-aggressive illness, such as cancer and gender affirmative procedures. Diseases such as cancer present a unique range of challenges. Cancer spreads and will generally, if left untreated eventually cause death. While it may be difficult to quantify how much time someone who has cancer has left before they die, the fact of the matter is that usually, unless treatment is begun, time is finite. This contrasts with gender dysphoria, which, although linked to suicidal ideation in some cases, is less directly terminal.

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[207] *Universal Declaration of Human Rights* GA Res 217A (1948), arts 25 and 26, Convention on the Rights of the Child 1577 UNTS 3 (1990), arts 2, 3, 4, 9, 7, 10 and 18 and *Beijing Declaration and Platform of Action* A/CONF 177/20 (1995).

[208] Cutas and Hens, above n 199, at 256.

[209] At 256.

[210] At 259.

On this basis, where a child is not in imminent danger, the openness of a child's future may be one consideration which parents must bear in mind when supporting a child's decision making around gender-affirming treatment.

Despite originating with Feinberg, a range of other academics have redefined the notion of the right to an open future. Among these is John Eekelaar, who proposes a formulation of the right in which all children:[211]

> should have an equal opportunity to maximise the resources available to them during their childhood (including inherent abilities) so as to minimise the degree to which they enter adult life affected by avoidable prejudices incurred during childhood.

This contrasting conception of the right offers an attractive counterpoint in that it proposes that the best custodian of a right is not necessarily the future adult, but rather the present child. This may better accord with the reality of the situation under the CRC, in that children have been granted a number of rights, some of which may prejudice their future, than the more aspirational conception of the right by Feinberg. In these circumstances then, the right to an open future might be viewed as empowering children to undergo gender-affirming procedures young to attain the best results.

It is not the purpose of this paper to elevate one conception of the right to an open future over the other. Both, however, should help inform the considerations of lawmakers, medical practitioners and family members who are chaperoning a child's decision-making process. Also, in these circumstances, CRC arts 3 and 12 must be borne in mind and a weighing up of future consequences conducted. It may be, for instance, that a promise made to a child that it can begin gender-affirming therapy in the near future is enough to prevent a child from harming its interests in the short term and allow fertility to be preserved, or risks relating to bone density to be

[211] John Eekelaar "The Emergence of Children's Rights" (1986) 6:2 Oxford Journal of Legal Studies 161 at 170.

overcome. On this basis, parents and medical professionals should consider the child's future to help overcome issues relating to children's lack of future orientation discussed in relation to mental capacity. On the other hand, the strength of a child's resolve or the severity of dysphoria may suggest that a child's future is more open where treatment is begun at a younger age. Furthermore, the amount that a child is permitted to participate may help ensure that parties can reach a compromise that maximises the benefit to all involved. Parents, caregivers and responsible government bodies must be aware of these complex and overlapping factors and take these into account when supporting the mental capacity of children.

In the Youth Justice context, the moral right to an open future is less complicated in that it favours minimal criminalisation of children and young people, regardless of which conception of the right is adopted. This is because raising the minimum age of criminal responsibility and age of penal majority better facilitates rehabilitation in that such measures preserve the rights of children to a future not determined by the consequences of their juvenile decisions.

G Interim Conclusion on Rights:

Having considered the rights which weigh in on the question of legal capacity, it is helpful to briefly sum up how these rights impact on the broader question of this piece, namely whether asymmetries in legal capacity across various legal frameworks can be justified.

Starting with the two youth justice case studies. On balance, the rights considerations under arts 5, 3 and under the right to an open future framework favour the minimum criminalisation of children and young adults on account of the developmental hurdles they face. Thus these rights considerations support formulating legal capacity to be in line with the developing science around mental capacity. Furthermore, while art 12 does not directly speak to the matter of whether young people should be criminalised or which court procedure should be applied, it does contemplate a situation whereby children's participation is limited by their age and maturity. Given then that science is increasingly challenging the mental capacity and maturity of children, one might wonder whether this

same logic that prevents children's opinions from being heard should not also prevent them from suffering the repercussions of their immature actions.

On the matter of gender affirmation, an analysis of the same rights leads us to a different conclusion, in that they favour an outcome in which children are, where possible, granted autonomy over their bodies and have their mental capacity supported. This is not to say that parents and state actors are to simply let children and young people do as they please in all circumstances. Instead, such actors have obligations in the way of protecting children from harm and taking particular care to support the development of mental capacity. Further, parents and the state may, under article 3 and the right to an open future, have an obligation to prevent a child from harming its future rights and interests. This may well be a difficult balance to strike. Whether parents are best suited for this role may be questioned. This paper will go on to discuss potential practical solutions for this issue in section IX.[212]

VIII Risks, Benefits and their Bearing on Legal Capacity

Important also to determining where to set the threshold for legal capacity is an assessment of the utility of a particular behaviour. In the case of *Re T,* the English Court of Appeal addressed the question of whether life-threatening circumstances were relevant to whether the patient's mental capacity was sufficient for their refusal to receive treatment to be respected.[213] The court held that the doctors were to consider whether at the time the claimant "had a capacity which was commensurate with the decision".[214] That is to say that where the consequences of an action are likely to be grave, the level of mental capacity required to make the decision increases. A number of philosophical commentators also recognise the necessity of such a measure of proportionality.[215] The reverse is also true, up to a point.[216] Namely that in circumstances where there is substantial utility in undergoing

[212] Commencing on page 49.
[213] *Re T (Adult: Refusal of Medical Treatment)* [1994] 4 All ER 649 at 50.
[214] At 19.
[215] Alec Buchanan "Mental capacity, legal competence and consent to treatment" (2204) 97:9 Journal of the Royal Society of Medicine 415 at 415.
[216] At 416.

a procedure or the consequences of refusal are less grave, the capacity required to make such a decision will be proportionally lowered.[217]

This idea is not only accepted in law, but also makes sense in the context of harm attribution theory. Where someone has a high level of mental capacity and makes a decision, we consider that they should be allowed to make this choice. To deny them this choice, would be to harm that person's autonomy.[218] Conversely, where a person has only low levels of mental capacity, such that they do not understand the nature of their risky decision, any potential harm to their autonomy may be offset by risk of harm inherent in the decision.

There are several risks in allowing young people to proceed with gender-affirming treatment, including risks relating to fertility, bone density, cerebral development and detransition. However, it is crucial to bear in mind also the therapeutic aspect of this decision for treating gender dysphoria.

Gender dysphoria is a condition where an individual experiences their gender identity as being detached from and incongruent with their biological gender.[219] For individuals living with gender dysphoria, this feeling of incongruence often begins in early childhood and may include displaying characteristics or behaviour's linked to their gender identity in their play, dress and social expression.[220] Such individuals also often express a desire to have the genitalia of the opposite sex or assert incorrectly that they already have them.[221] Not all children who exhibit these behaviours grow into transgender or gender diverse adults. A series of Dutch studies focusing on this very issue concluded that over 80 per cent of children exhibiting aspects of gender dysphoria came to identify as cis-gender and did not

[217] At 418.

[218] At 417.

[219] Cowden, above n 14, at 119.

[220] Alexander Korte and others "Gender Identity Disorders in Childhood and Adolescence: Currently debated Concepts and Treatment Strategies" (2008) 105:48 Deutsches Ärzteblatt International 834 at 834.

[221] At 834.

go on to seek treatment.[222] However, individuals who suffer from persistent and long-term untreated gender dysphoria often experience a range of emotional and behavioural problems.[223] These may include depression, anxiety or suicidal ideation, which as well as being damaging in and of themselves, may encourage adolescents to engage in risky behaviours, out of despair. [224] One UK study found that 67% of transgender individuals had considered suicide at some stage before transitioning, while only 3% continued to consider suicide following their transition.[225] While this study was not explicitly aimed at young people, it may give some indication of the heightened mental health risks transgender and gender diverse people face.

Furthermore, gender dysphoria is documented to get worse with age.[226] This is because puberty and an individual's development of secondary sexual characteristics further emphasises the differences between their biological gender and their gender identity, oftentimes leading to distress.[227] For this reason, it is generally considered that the earlier gender-affirming treatments are initiated, the more effective such therapies are in combatting dysphoria.[228] An individual who develops secondary sexual characteristics associated with their natal sex may also need to undergo expensive and invasive surgeries later in life. In addition to the risks associated with undergoing surgery in and of themselves, such surgeries may be prohibitively expensive, exposing the individual to another level of dangers as they negotiate balancing the need for treatment with their needs

[222] Julia Temple Newhook and others "A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children" (2018) 19:2 International Journal of Transgenderism 212 at 212.

[223] Cowden, above n 14, at 117.

[224] Kathleen Chung and others "Treatment Paradigms for Adolescents: Gender-Affirming Hormonal Care" in Michelle Forcier, Gerrit Van Schalkwyk and Jack L. Turban (eds) Pediatric Gender Identity (Springer, Cham, 2020) 187 at 191 and Kreukels and Cohen-Kettenis, above n 162, at 469.

[225] Bailey L, Ellis S, and McNeil, J "Suicide risk in the UK trans population and the role of gender transitioning in decreasing suicidal ideation and suicide attempt" (2014) 19:4 Mental Health Review Journal at 218.

[226] Cowden, above n 14, at 119-120.

[227] At 121.

[228] Busa, Leibowitz and Janssen, above n 101, at 50

for food, shelter, and safety.[229] Adolescents in this position may look to other ways of obtaining treatment which can lead to purchasing illegal and unsafe hormones or engaging in sex work to earn money for treatment.[230] This speaks to the fact that a full-scale ban on gender-affirming treatment for young people is undesirable. The benefits of gender-affirming care being available, when weighed against the risks of such a treatment, supports the notion that legal capacity should be formulated to extend to people below age sixteen. However, some risks or benefits may be more relevant in certain circumstances. Therefore, an analysis of risk/benefit proportionality, much like considerations under the right to an open future framework will involve a case by case analysis of an adolescent's circumstances.

It is not only the benefits to the individual which must be considered. Public interest should also be taken into account when assessing at which age to set the threshold for legal capacity. Public interest in the matter of gender-affirming treatment supports the view discussed above, that treatment should be available from a young age. This is related again to the evidence that transgender and gender diverse young people are at a severely heightened risk of suicide and other damaging behaviours. The costs, both economic and emotional, that suicide inflicts on a community are massive.[231] Furthermore, especially among adolescents, suicide is documented as being socially contagious.[232] Therefore, public interest is served by a situation where gender-affirming care is available to young people, but where a framework exists to support capacity to offset possible side-effects and risks around detransition.

In the criminal justice context, a risk/benefit proportionality assessment favours raising the minimum age of criminality and penal majority. International studies have confirmed that sending young people to adult courts and prisons increases rather than decreases risk of

[229] Kreukels and Cohen-Kettenis, above n 162, at 469.

[230] At 469.

[231] Des O'Dea and Sarah Tucker *The Cost of Suicide to Society* (Ministry of Health, Wellington, 2005) at 7 and 36.

[232] Madelyn Gould, Patrick Jamieson and Daniel Romer "Media Contagion and Suicide Among the Young" (2003) 46:9 American Behavioral Science 1269.

recidivism and leads to more serious offending, that victimisation of juvenile offenders is common in adult institutions, and that rehabilitation measures are more prevalent in juvenile institutions.[233] In these circumstances the risk to young people through early criminalisation favours setting legal capacity for criminal acts later. Public interest also overwhelmingly favours raising both the age of criminal responsibility and penal majority. Through the aforementioned reduction of recidivism, such a move decreases both the quantity of crime the wider public is exposed to and the amount of public money spent on incarcerating young offenders.[234]

IX Conclusion on Legal Capacity and Recommendations for Reform

The question of when an adolescent should be found to have legal capacity is not easy. It involves not only an analysis of scientific evidence concerning mental capacity but also an assessment of the relevant rights and policy factors. A thorough consideration of these factors leads to the conclusion that the diverging trends of legal capacity across the medical and youth justice fields are reconcilable. This analysis also leads to the conclusion that the current framework for determining legal capacity is deficient. At present the case of *Gillick* is still the leading case on determining legal capacity in medical situations. However, as this paper demonstrates, the analysis in *Gillick* which directly equates legal capacity and mental capacity is over simplistic and fails to capture the true scope of determinations important to the matter of legal capacity. In these circumstances more stringent guidance is needed to ensure that legal capacity is properly understood and empowers rather than damages the interests of adolescents.

While this paper has established that adolescents under age sixteen are likely to have sufficient mental capacity to consent to gender-affirming care, there are a number of duties incumbent on caregivers and the state to support capacity in such circumstances. The first set of duties relate to the environment in which the decision-maker finds themselves. In order to support mental capacity, medical experts working with children should ensure that

[233] Farrington, Loeber and Howell, above n 53, at 85.

[234] At 85.

decisions are made in an emotionally neutral space or made over a period of time, so that the emotion of the situation is less of a factor, that peers do not influence the decision and that young decision-makers have sufficient information about the risks of their decision. This paper considers that a set of guidelines outlining these conditions is important in ensuring that capacity is uniformly supported. Important also is to recognise that while the CRC and right to an open future empower children to undergo gender-affirming treatment, such rights also place a number of obligations on parents, caregivers and the state to support development of an adolescents capacity. As such, comprehensive guidelines alerting parents and caregivers to their obligations under the CRC and right to an open future could help achieve the fulfilment of these objectives.

Moreover, CRC arts 3 and 5, the right to an open future and the notion of risk/benefit proportionality support the idea that parents, caregivers and state institutions should have some say in the outcome of the decision. This is to account for the level of risk inherent in the choice to undergo gender-affirming treatment and the fact that adolescents may still face some more minor hurdles regarding their lack of future orientation. Given the complex and emotionally charged nature of decisions in this area, this paper considers that the role of protecting a child's best interests and future is best performed by an independent third-party expert rather than by the parent or caregiver alone. Although caregivers share in the obligation to look out for the best interests of their child, their level of emotional investment in the outcome of a decision may prevent them from acting objectively. In these circumstances, this paper considers that an independent expert should convene with the child, parents and medical staff with the view of making a final determination on a child's legal capacity. This person would ideally be well versed in the CRC to ensure that legal capacity does not simply become a proxy of mental capacity and instead adequately accounts for a child's rights and the risks or benefits of the procedure.

Finally, although theoretically, an individual determination of mental capacity is unlikely to be necessary in every instance, when determining legal capacity, it may still be useful in particularly tricky cases where rights and risks/benefits are finely balanced. At present, there does not exist a detailed set of guidelines for evaluating children's capacity in New

Zealand.[235] The 1998 Conference on Consent in Child and Youth Health appears to be the most recent document on the matter and only provides basic guidance for health practitioners.[236] To ensure greater uniformity of approach and counter risks of diverging opinions within the medical profession, a more stringent set of guiding principles is required for conducting such an assessment.

A Other variables which Influence Decision Making:

Alongside the matters already discussed which contribute to the determination of legal capacity, there are several other variables which may influence decision making regardless of age. As such, strictly speaking, these factors do not affect the capacity of an individual but should still be considered and guarded against when formulating guidelines for when children can consent to receive gender-affirming treatment or be held liable for a criminal act.

It is well documented that the phrasing of a proposition impacts how it is perceived and acted on.[237] While there is no research to suggest that this effect is more pronounced in adolescents than in adults, the impact of phrasing may be more important in the context of adolescents who may for other reasons already be more susceptible to making risky decisions.[238] Framing of a proposition could be a factor in either a youth justice or a medical context as both may involve situations where an individual acts, following consultation with others. However, the problems this raises is more pronounced in medical contexts because in these situations, an individual may make a potentially risky decision, to receive or not receive treatment, as opposed to in a youth justice context, where the law is stepping in to ameliorate the effects of a risky decision that has already been made. Medical personnel working with adolescents should receive guidance on how to frame propositions to ensure that phrasing has minimal effect on the outcome.

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[235] Elaine Plesner and Megan Eddy *Performing Capacity Assessments: Information for GPs* (Hawke's Bay District Health Board, Guidelines).

[236] Ministry of Health *Consent in Child and Youth Health: Information for Practitioners (Ministry of Health, Wellington*, 1998) 3.

[237] NS Fagley and Paul M Miller "The Effects of Decision Framing on Choice of Risky vs Certain Options" (1987) 39:2 Organizational Behaviour and Human Decision Processes 264 at 276.

[238] At 276.

Another variable to consider is the neutrality of the advice-giver and how this affects the determination of capacity. A number of recent studies have indicated that doctors and researchers are more likely to consider a child to be competent in a medical context if the child's decision conforms to their own ideas about what outcome is in the child's best interests.[239] This indicates that medical professionals may influence the outcome of a child's decision even where the child has sufficient capacity, by declining to make a determination of capacity where the decision differs too substantially from their own. The reverse is also true. This further speaks to the fact that the final determination of legal capacity should be made by a third-party expert rather than a medical professional and that individual assessments of mental capacity are perhaps unnecessary in light of the trends observed in this paper. This will help ensure that medical outcomes are adequately weighed against rights and policy factors and that outcomes are not unduly influenced by the personal opinions of medical staff.

Finally, current assessments of competence may fail to account for value judgements underlying a decision. That is, although procedurally a young person may be classified as possessing capacity, their decisions will invariably be based on values which may change.[240] This, in turn, could lead someone to regret a decision based on early-life values if these change later in life.[241] This risk is not unique to children, and everyone is likely to change in some way throughout their life. While more research is required to understand the underlying basis on which people form values, so as to help differentiate between a "genuine value" and an "immature value", the notion that someone might act differently at a future time alone cannot stand in the way of finding children competent to consent to treatment or commit a crime.

[239] Hein, above n 18, at 73 and Rony E. Duncan and Susan M. Sawyer "Respecting Adolescents' Autonomy (as Long as They Make the Right Choice)" (2010) 47 *Journal of Adolescent Health* 113 at 113.
[240] Hein, above n 18, at 73.
[241] At 75.

X The Wider Applicability of this Understanding of Capacity:

The notion that asymmetries in capacity are not only justified but expected given the qualitative difference between making a pressurised split-second decision and making an adequately supported decision over a longer period has consequences for other areas of the law. While a "lack of capacity" is often deployed as a justification for restricting the rights of children, the applicability of this logic must be reconsidered in light of the above findings.[242] Several areas to which this novel understanding of capacity may apply are outlined below.

The first and most obvious example can be found in the context of other medical situations, such as immunisations, treatment with antibiotics or forms of elective surgery. While, from a policy standpoint, it may be desirable that parents or caregivers, rather than the adolescents themselves, can consent to such treatments, a recognition that children under sixteen are likely to have legal capacity where gender-affirming treatment is concerned indicates that adolescents in these diverse situations should be treated similarly. This is because the similarities of these situations mean that the factors influencing mental capacity as well as the rights considerations are likely to be the same.

A further matter to which this distinction in capacity has possible application is the movement to lower the voting age. An understanding that children can, if presented with adequate information and an emotionally neutral environment, make complex and long-term decisions, could persuade opponents to youth suffrage that adolescents should be allowed to partake in our democratic process. I note that a court challenge, alleging that the current voting age was discriminatory failed as recently as October of this year.[243] However, a greater understanding, particularly of different factors of mental capacity could help change the scope of this debate in the future. Suppose there was a more widespread understanding that children below age sixteen generally have the mental capacity to make

[242] Emily Buss "What the Law Should (And Should Not) Learn from Child Development Research" (2009) 38:1 Hofstra Law Review 13 at 13.

[243] *Make it 16 Inc v Attorney-General* [2020] NZHC 2630 at [118].

cold processing type decisions in emotionally neutral environments. This might shift the debate from a situation where proponents of the "Make it 16" campaign are arguing that adolescents have capacity to vote, to a situation where opponents of the change must justify not lowering the standard of legal capacity in the face of salient evidence regarding adolescents adequate mental capacity. Such an understanding could also result in practical measures around voter's education and voting itself to ensure that adolescents have their capacity adequately supported. More research is required to determine which age is the most appropriate for youth suffrage. However, given that puberty suppressants are likely to be administered around the onset of puberty, this may be a useful indication as to when the majority of young people will have sufficient capacity to make other important decisions such as voting.

A similar issue arises in the context of religion, schooling or access to certain educational programmes within schools such as sex-education. These choices are often presented as being out of the control of children except to the extent that parents or caregivers deign to incorporate children's opinions when making them. Application of the distinction between the two types of mental capacity alongside the rights and policy discussions set out above, may serve as a template for arguing that the age of legal capacity to make these sorts of decisions should shift, potentially helping to give children a greater say in these diverse areas of life.

XI Conclusion

Capacity is a term which, although appearing straightforward and familiar can mean different things in different contexts. A closer examination of recent scientific developments concerning mental capacity reveals that it is hugely context dependant and may be reached at varying ages depending on the decision at hand. These measures of mental capacity form the basis for building a principled schema of legal capacity. Legal capacity is more complex, however, and due to its nature as a normative judgement, requires investigation of several rights factors as well as an investigation of the risks of benefits inherent in a decision. These factors help add nuance to mental capacity, ensuring

that the framework of legal capacity is not only scientifically principled but also justifiable from a rights and harm attribution perspective.

Having conducted a thorough investigation of the schemes around legal capacity in both the youth justice and medical sphere, this paper, concludes that the seemingly opposite trends relating to youth criminality and provision of gender-affirming treatment can be neatly reconciled. The idea that the notion of capacity itself has a greater level of nuance than our current legal framework and language accounts for, cast's shadows on other areas of law, where strictly age-based and unprincipled conceptions of capacity still hold sway. It is hoped that this paper can act as a springboard for a fuller investigation into legal capacity and provoke a fuller examination of a number of rights from which children and young people are presently being excluded from.

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