Haugli, T. & Martnes, M. (Eds.). (2025).
Perspectives on Children, Rights, and Vulnerability.
Scandinavian University Press.
DOI: https://doi.org/10.18261/9788215069500-25-13

12. Rethinking Children's Competence through Children's Rights: Giving Professionals Space for Supporting Children

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Abstract Children have a Convention on the Rights of the Child (CRC) right to be supported in the exercise of their capacities. In this chapter, interviews with a range of UK practitioners working with children (e.g., nurses, doctors and lawyers) are analysed. It emerges that professionals engage frequently with questions around children's competence, whether or not they are required to officially assess it. The professionals interviewed were deeply supportive of children's competence, but are operating in systems which frequently provide little space to increase children's competence – this may make children more vulnerable.

Keywords children's competence | capacity support | Gillick case | UN Convention on the Rights of the Child

12.1 INTRODUCTION

On a daily basis, professionals work in various roles supporting children's interests. Children's understanding and competence on various issues will undoubtedly arise for these professionals for various reasons. Children may communicate differently than adults, and they may see the world in different ways, which may have consequences for communication between adult and child. Because childhood is (to a large extent) defined legally by an absence of a presumption of capacity, issues such as consent to medical treatment can be challenging. In circumstances like this, children's autonomy rights depend on an assessment of their competence.

The most common competence question tends to be in the realm of medical law, because medical consent is treated with great seriousness.[1] The perceived

1 Priscilla Alderson, "Researching Children's Rights to Integrity," in *Children's Childhoods: Observed and Experienced*, ed. Berry Mayall (London: The Falmer Press, 1994), 45–62.

competence of children under the age of 18 years will depend on whether they can consent to medical treatment. In England and Wales, in the Gillick case ([1986] AC 112), it was established that doctors could provide contraceptives to those under age 16 where they were determined by the doctor to have "sufficient understanding and intelligence" to "understand fully what is proposed" (at 253). The term "competence" is now used interchangeably with "capacity" in England and Wales, seemingly because of the introduction of the Mental Capacity Act (MCA) 2005 – the statutory framework in England and Wales for adults whose capacity to make specific decisions is in doubt. I will continue in this chapter to refer to competence, however, because of the persisting prevalence of the Gillick competence standard.

There has been much written resisting the legitimacy of the competence/capacity framework. It can be argued that the human condition is too complex for competence to be measured accurately or that it is in the eye of the beholder, in that an assessment depends on the understandings and values of the assessor. Herring highlights, however, that an accurate assessment of competence can be important:

> First, you could be assessed to lack capacity when you do not […] You lose control over your life. But second, you could be assessed to have capacity when you do not have it. You could suffer harms and injuries and you would be told that that was your choice …[2]

As competence issues are so prevalent, one would think that professionals and academics alike would have broad knowledge of the issues inherent in children's competence. One would also expect that there would be extensive efforts to define it. Yet this is far from the case at present. How professionals should understand and define competence is little understood,[3] and assessment of competence appears to be done very intuitively rather than in accordance with set rules or guidance.[4]

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2 Jonathan Herring, *Vulnerable Adults and the Law* (Oxford: Oxford University Press, 2016), 55.

3 Irma M. Hein, Pieter W. Troost, Robert Lindeboom, Imke Christiaans, Thomas Grisso, Johannes B. van Goudoever and Ramón J. L. Lindauer, "Feasibility of an Assessment Tool for Children's Competence to Consent to Predictive Genetic Testing: A Pilot Study," *Journal of Genetic Counselling*, vol. 24(6) (2015): 971–977; Gerison Lansdown, *The Evolving Capacities of the Child* (Florence: UNICEF Innocenti Research Centre, 2006).

4 Aoife Daly, "Assessing Children's Capacity: Reconceptualising our Understanding through the UN Convention on the Rights of the Child," *The International Journal of Children's Rights*, vol. 28(3) (2020): 471–499; Hein et al., "Feasibility of an Assessment Tool."; Emma Cave and Zenon Stavrinides, *Medical Practitioners, Adolescents and Informed Consent: Final Report* (University of Leeds, 2013).

I argue elsewhere that it is important to consider competence in light of the Convention on the Rights of the Child (CRC) through CRC-informed concepts of autonomy, evidence, support and protection:

> The intuitive approach is generally satisfactory but it is important that it is informed by the CRC. This, it has been argued here, should specifically require: an appreciation of autonomy, because this is so valued in the liberal democracy; evidence, because this will ensure that childhood is properly understood; support, because capacity is not static but can be maximised; and protection, because it must be emphasised that with childhood comes relative vulnerability.[5]

Yet this is not the framework in which professionals appear to generally work, nor the one on which domestic law appears to rely.

"Vulnerability" is frequently understood to apply to under-18s as opposed to adults. It is regularly relied upon as a reason why children should not enjoy various rights.[6] Although there is an obvious power imbalance between children and adults, vulnerability is a fluid state. Support, information and education will make a difference and will in turn increase competence. Individualist notions of vulnerability place the onus on the individual rather than on the question of how professionals and institutions may increase children's vulnerability by keeping them uninformed.[7] Providing the means to children to increase their competence on matters such as their medical or legal situation can therefore render them less vulnerable.

In this chapter, semi-structured interviews with a range of practitioners working with children are analysed. It emerges that professionals engage frequently with questions around children's understanding or competence, whether or not they are required to officially assess competence. The professionals interviewed were deeply supportive of children and their needs and for the most part recognised that competence can be increased, and vulnerability decreased, through information and support. It seems, however, that they are operating in systems which frequently provide little time, space or training for them to engage with children in a way that facilitates them to increase children's competence.

5 Daly, "Assessing Children's Capacity."

6 Jonathan Herring, "Vulnerability, Children, and the Law," *Law and Childhood Studies: Current Legal Issues*, vol. 14 (2012): 243–263.

7 Aoife Daly, Rachel Heah and Kirsty Liddiard, "Vulnerable Subjects and Autonomous Actors: The Right to Sexuality Education for Disabled Under-18s," *Global Studies of Childhood*, vol. 9(3) (2019): 235–248.

Although the research is based in England and Wales as a jurisdiction, the findings will have relevance for work with children in other jurisdictions.

12.2 WHAT IS COMPETENCE AND HOW CAN IT BE SUPPORTED?

12.2.1 When Child Competence Arises in England and Wales

The term "competence" is far from straightforward. Historically, it appears to have been the preferred term to outline the concept of children adequately understanding something. In England and Wales it was encapsulated by the Gillick case ([1986] AC 112), a case relating to a legal conundrum whereby girls have to be protected when having sex under the age of consent. In this case it was established that doctors could provide contraceptives to girls in this situation, without parental involvement, where the girl was determined by the doctor to have "sufficient understanding and intelligence" to "understand fully what is proposed" (at 253). Presumably due to a lack of any other guidance in the area, the Gillick case ultimately proved very formative across laws relating to children beyond the area of contraception.[8] It has even proved influential outside the jurisdiction of England and Wales, into other common law countries[9] which were similarly confounded by how to deal with the paradox that children are legally defined by their lack of competence but there are certain areas in which their competence has to be assessed (often to protect their own interests). That the author was researching for over a decade in the system of England and Wales provided a rich opportunity to examine the workings of Gillick in practice.

In spite of the usefulness of the Gillick judgement, many questions and problems persist. First, in England and Wales the introduction of the MCA has presented some questions that have yet to be answered. Because of the importance and influence of this legislation, the term "capacity" is now for the most part used interchangeably with "competence"[10] when it comes to children, although this is apparently no longer the case when it comes to adults in England and Wales. The word used in that context is now "capacity", because of the influence of the MCA.

8 *CS* v *sbh* [2019] EWHC 634, (Appeal *fpr* 16.5: Sufficiency of Child's Understanding), para. 51.

9 Emma Cave, "Goodbye Gillick? Identifying and Resolving Problems with the Concept of Child Competence," *Legal Studies*, vol. 34(1) (2014): 103–122, 114.

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

The persisting importance of Gillick, however, means that the word "competence" sits alongside the word "capacity" for children, and either term may or may not refer to an actual legal standard. Conceptual confusion about competence abounds – as to whether it is a legal standard, and educational ideal, or something else.[11]

When the terms "competence" and "capacity" are used colloquially, they refer to one's cognitive abilities, i.e., mental processes such as knowing, judging and evaluating. For clarity, "competence" in this chapter will denote this colloquial meaning unless otherwise indicated. However, when one refers to "Gillick competence", this enters the realm of denoting an actual legal standard of competence for children. It is perhaps not equivalent to, but certainly is along the same lines as, the term "legal capacity", which is used in the legal sphere to refer to the standard for someone to make legally effective decisions, for example under the MCA. Yet the divide between adult and child is not clear-cut in this area – the MCA includes 16- and 17-year-olds, and in at least one England and Wales case has been deemed relevant even to those under the age of 16. This is perhaps unsurprising as it gives a level of guidance as to what capacity is in a way that the Gillick test does not (although the MCA 2005 requires impairment for incapacity to be present, whereas Gillick does not).

It is not always easy to define exactly what "capacity" entails in practice, however. The MCA requires that an individual understands information and that they can retain it, use it, weigh it, and communicate a decision (section 3[1]). It is challenging to pin down exactly what capacity for adults might be under the MCA,[12] and Herring notes: "This is clearly not a straightforward issue. The courts have avoided issuing general guidance".[13] As outlined above, there is a lack of clarity around defining "capacity" and applying the Gillick standard.[14] For the most part the capacity of children to consent to medical treatment is determined by professionals implicitly[15] "day in and day out … as part of routine"[16]. They use their skills and experience to make a person-to-person judgement about a child's capacity.

11 Jo Moran-Ellis and E. Kay M. Tisdall, "The Relevance of 'Competence' for Enhancing or Limiting Children's Participation: Unpicking Conceptual Confusion," *Global Studies of Childhood*, vol. 9(3) (2019): 212–223.

12 See, e.g., Natalie F. Banner, "Can Procedural and Substantive Elements of Decision Making Be Reconciled with Assessments of Mental Capacity?," *The International Journal of Law in Context*, vol. 9(1) (2013): 71–86; Mary Donnelly, *Autonomy, Capacity and the Limitations of Liberalism: An Exploration of the Law Relating to Treatment Refusal* (Cambridge: Cambridge University Press, 2010).

13 Jonathan Herring, *Vulnerable Adults*, 46.

14 Daly, "Assessing Children's Capacity". See also Cave, "Goodbye Gillick?," 103–122.

15 Hein et al., "Feasibility of an Assessment Tool," 971–977, 852.

16 *Appendix to A (A Child)* [2014] EWFHC 1445 (Fam.)

It has been widely expressed that the Gillick competence standard is vague and subjective. To have "sufficient understanding and intelligence" to "understand fully what is proposed" does not provide much guidance to a professional trying to understand a child's competence. It seems that it will be difficult for professionals working with children to have a clear definition of what children's competence entails.

The issue may also arise in England and Wales where children may be required to instruct a lawyer. In this context, the case of S v. SBH[17] provides some guidance. It was outlined (at para. 64) when assessing whether a child can directly instruct a lawyer in a family law case, one must consider: i) intelligence; ii) emotional maturity; iii) factors which might undermine their understanding such as their emotional state; iv) their reasons for wishing to instruct a solicitor directly; v) potential undue influence; vi) their understanding of the process of litigation; and vii) the risk of harm to the child from participation. These points appear sensible and intuitive when considering the competence of a child. They are, however, demanding a lot of a child compared to what is required from an adult wishing to instruct a solicitor.[18] Many adults, for example, may be low in cognitive ability and emotional maturity, and yet they will be assumed capable of instruction.

Of course, children's competence is very relevant in the area of children and criminal culpability. Minimum ages of criminal responsibility are public policy issues which are decided seemingly more by political factors than by objective evidence about a child's development. In England and Wales it used to be the case that between the ages of 10 and 14 there was a rebuttable assumption that a child could not commit a crime (*doli incapax*). This was removed via section 34 Crime and Disorder Act 1998 in the wake of a case of boys aged 9 and 10 kidnapping and killing a toddler (Jamie Bulger) in Liverpool in 1992. This particular case so shocked the nation that it seemingly set the context for the removal of the assumption of *doli incapax.* This means that the age of criminal responsibility in England and Wales is now 10 years. In contrast, the age of criminal responsibility in Sweden, Finland and Denmark is set much older, at 15 years.

These examples indicate that laws and policies concerning children and their competence in the legal arena are driven seemingly by adult assumptions and by politics rather than clear evidence about child development. A tension also appears to be playing out between perceptions of children's autonomy on the one hand and vulnerability on the other. Note, for example, inclinations towards holding children accountable in criminal law, and protective approaches in other areas

17 S v SBH [2019] EWHC 634 (Appeal FPR 16.5: Sufficiency of Child's Understanding).

18 See further Daly, "Assessing Children's Capacity".

of the law. There is strong evidence that when children from middle childhood or older receive time and support, their decision-making is equivalent to adults. In Greenberg Garrison's research, children's decisions in hypothetical scenarios around arrangements for children on family breakdown were examined. The research indicated that nine-year-olds were objectively "as rational" in their reasons for decision-making as adults.[19] Hein et al. conducted research indicating that children of 11.2 years and above appeared to generally have the mental capacity necessary to consent to medical treatment.[20] This is confirmed by modern neuroscience, which likewise indicates that thickening of the area of the brain which is used for judgement and planning peaks at around age 11 in girls and age 12 in boys.[21] On the other hand, research indicates that when children are making decisions under circumstances which may be stressful and involve peer pressure, their decision-making will not be as objectively "good".[22] Yet frequently laws, instead, require very high levels of capacity from children for personal decision-making to be respected, and on the other hand can hold very young children criminally responsible for their actions. Laws then tend to be punitive in the areas where children are most vulnerable.

12.2.2 Competence and the Framework of the CRC

The UN CRC is an international instrument outlining the basic rights of children around the world – it is the most ratified treaty in existence. Yet on this very fundamental issue of children's competence, it too is lacking in guidance. There are some vital provisions in the CRC to consider – in particular, Article 12, the right of children to be heard in all matters affecting them; Article 3, the obligation to consider children's best interest as a primary consideration in all matters affecting them; and, perhaps most importantly, Article 5, the principle of the evolving capacities of the child (as children mature they should increasingly exercise their own rights).

However, the lack of understanding about children's competence has an impact on the exercise of children's rights. Le Borgne and Tisdall emphasised that "One of the most persistent adult concerns is whether children are competent enough

19 Ellen Greenberg Garrison, "Children's Competence to Participate in Divorce Custody Decisionmaking", *Journal of Clinical Child Psychology*, vol. 20(1) (1991): 78–87, 78.

20 Hein et al., "Feasibility of an Assessment Tool," 971–977, 852.

21 Jay N. Giedd, "Structural Magnetic Resonance Imaging of the Adolescent Brain," *Annals of the New York Academy of Sciences*, vol. 1021(1) (2004): 77–85.

22 Sarah-Jayne Blakemore, *Inventing Ourselves: The Secret Life of the Teenage Brain* (London: Black Swan, 2019).

to participate."[23] They emphasise that competency can be used as an exclusionary principle – children deemed incompetent are excluded from participation. This is due, the authors continue, to an emphasis by adults on the perceived deficit associated with children rather than a focus on the responsibilities and potential shortcomings of adults: "Adults perceive children as having limited or lesser competence than adults, with the concentration on children's lack of competence to participate rather than adults' lack of competence in enabling children to participate."[24]

I have argued elsewhere that efforts to understand competence should be grounded in the CRC. I demonstrated how considering children's best interests is crucial, because children still require protection under the age of 18. I also highlighted how autonomy – a feeling of power and choice over one's life – is very important for children, and therefore capacity must be considered in that context. I also emphasised the principle of non-discrimination, because those working with children and their capacity should operate on the basis of *evidence* in whatever area is in question, rather than relying on personal assumptions about children. I also highlighted the importance of Article 5, the right of children to exercise their own rights in accordance with their evolving capacities. This is crucial because it is not always well understood that capacity is not simply a quality to be found in a child – children's competence can be increased with time and support by adults and others. I argue that "[t]hese points are not intended to be exhaustive however, as each capacity assessment will need to be tailored to the specific context, such as a determination of capacity to consent to medical treatment, to participate in legal proceedings, and so on."[25]

12.2.3 Can Competence Be Increased through Support?

Post-structuralist theorists have long criticised the liberalist construction of the universal, autonomous, rational subject.[26] Feminist theorists have emphasised that instead we should turn our attention to our common vulnerabilities, which are universal to the human condition.[27] Where this socially created vulnerability is recognised in children, we should emphasise the huge potential for enhancing children's competence rather than assuming that competence is something to be found in the individual child. Le Borgne and Tisdall, for example, argue

23 Carine Le Borgne and E. Kay M. Tisdall, "Children's Participation: Questioning Competence and Competencies?," *Social Inclusion*, vol. 5(3) (2017): 122–130.

24 Ibid.

25 Daly, "Assessing Children's Capacity".

26 Joan Copjec, ed., *Supposing the Subject* (New York: Verso, 1994).

27 Martha Fineman, *The Autonomy Myth* (New York: The New Press, 2004).

"that competence is situationally and socially constructed rather than a set and individual characteristic."[28]

The notion of relational competence views the quality as originating from social interactions and relationships: "capacity is not something that simply appears but something that develops through communication, explanation and interaction with others."[29] Competence is not a quality which sits inside a person but rather a social ability which can be promoted and learned.[30] Autonomy support – a concept from psychology – can and should be applied to children in legal contexts to enhance their decision-making abilities in matters affecting them.[31] Autonomy support involves developing children's psychological needs, interests and values through helping them to understand their environment and to solve their own problems.[32] Children are regularly assumed to defer to undue influence from others,[33] yet it is important to remember that children and adults are not entirely different in this way, and there may be more overlap than one assumes – "adults largely defer their moral judgements to what are widely shared moral standards."[34]

"Scaffolding" is a term that was first coined by developmental psychologist Vygotsky (1978). He described the process as one that allows children to develop their current level of understandings to a more advanced one, supporting children to undertake activities that they would otherwise not be able to without the assistance of those around them. The social element of competence has been elaborated even further in recent years in relevant literature, including in relation to the legal arena. As Stalford and Hollingsworth outline, legal matters (family law proceedings and so on) will be enormously foundational in the development of children, and there is therefore a duty on those in the legal profession to consider the ways in which they could and should nurture children's development

28 Le Borgne and Tisdall, "Children's Participation," n872.2.

29 Katharina M. Ruhe, Eva De Clercq, Tenzin Wangmo and Bernice S. Elger, "Relational Capacity: Broadening the Notion of Decision-Making Capacity in Paediatric Healthcare," *Bioethical Inquiry*, vol. 13(4) (2016): 515–524.

30 Eva De Clercq, Katharina Ruhe, Michel Rost, Bernice Elgar, "Is Decision-Making Capacity an 'Essentially Contested' Concept in Pediatrics?," *Medicine, Health Care and Philosophy*, vol. 20(3) (2017): 425–433.

31 Aoife Daly, *Children, Autonomy and the Courts: Beyond the Right to be Heard* (Leiden: Brill, 2018).

32 See, for example, Wendy S. Grolnick, *The Psychology of Parental Control: How Well-Meant Parenting Backfires* (New York: Lawrence Erlbaum Associates Publishers, 2003).

33 Christopher Joseph An, "Participation, Not Paternalism: Moral Education, Normative Competence and the Child's Entry into the Moral Community," *Educational Philosophy and Theory*, vol. 52(2) (2020): 192–205.

34 Ibid.

and positive way.[35] Buss refers to the "child-rearing function" law can have.[36] This is particularly important considering how much more relational children are as compared with adults – children are more reliant on adults for basic survival, for example. They are also going to benefit more from social interaction, learning experiences and so on that legal proceedings and other key interactions such as medical treatment provide to them.

There is therefore a basic duty to provide children with the care and support they need during foundational life experiences such as those relating to legal proceedings and to medical treatment. There is also the enormous learning potential that arises from such experiences. This is theory which is not often placed in the sphere of attempts to understand children's competence in decision-making about themselves; however, an amalgamation of developmental psychology and law relating to children's rights is clearly necessary in an area which appears to have confused and perplexed lawyers and lay persons alike for some time.

12.3 METHODOLOGY

This research involved a small-scale, independent qualitative study which took place between November 2019 and August 2021. The research explored two main research questions for professionals working in various roles with children: *1. What are their views on, and experiences of, how and whether the competence of a child arises for them? 2. What are the consequences of their views and approaches for practice?*[37]

A purposive sample of UK professionals working with children was invited to participate in the research. Professionals working as closely as possible with children, and with issues relating to competence/understanding, were sought. This was to ensure that all professionals had the necessary experience to inform their perspective on children's competence. A total of 33 individuals took part – these included 19 lawyers, eight medical professionals (four doctors and four nurses), three psychologists, a school counsellor, a pharmacist, and one member of support staff for an asylum-seeker charity.

35 Helen Stalford and Kathryn Hollingsworth, "'This Case Is about You and Your Future': Towards Judgments for Children," *Modern Law Review*, vol. 83(5) (2020): 1030–1058.

36 Emily Buss, "What the Law Should (and Should Not) Learn from Child Development Research," *Hofstra Law Review*, vol. 38(13) (2009): 13–68.

37 An article focusing solely on how these professionals tend to assess competence is also available – Aoife Daly, "What Is 'Competence' for Children in Legal Matters?—Views of UK Professionals," *Irish Journal of Family Law* 92, vol. 26(4).

The data was collected through semi-structured interviews with professionals. Ethics approval was secured from the ethics committee at the University of Liverpool. Participants were engaged in an informed consent process, and their names are not included in this chapter. Some of the data has been further anonymised to avoid identification.

The data was coded using an informal thematic coding framework. Thematic analysis was used to identify themes and patterns of meaning in relation to the research questions of the project within the data and across the different professions. Consultation was conducted with Liverpool's youth advisory board – a board consisting of adolescents living in Liverpool who provide advice and guidance on research relating to children. They provided their views on the research project and influenced the questions asked of interviewees, as well as the analysis of the data. They are paid a wage for this work.

Research participants were sought from amongst the contacts of the researcher. This related to organisations and professionals ranging from legal firms and hospitals with whom the researcher had engaged in the past through other children's rights work. Some "snowball sampling" was involved whereby existing study participants recruited future participants from among their colleagues and other contacts. The sample of professionals was based in England and Wales, although one practitioner who was primarily based in Scotland was also included. His inclusion was justified due to his expertise on the issue. Although it was useful to limit geographically those interviewed, his inclusion appeared to outweigh the fact that he was not based in the England/Wales legal jurisdiction.

Because participants were not selected from a sampling frame, the data was subject to some bias. Those professionals particularly interested in competence, and possibly those most interested in and open to research, were undoubtedly more likely to respond to the email invitation to participate in the study. Because of the relatively small sample size, quantitative information on responses is not provided. Instead, the primary themes that emerged and which were most commonly touched upon are presented and analysed.

12.4 PROFESSIONALS' UNDERSTANDINGS OF WHAT CONSTITUTES COMPETENCE

Amongst the professionals interviewed in this study, they were trying to ascertain the level of understanding of children, whether they understood the many complexities of the situations in which they found themselves, whether it was in a criminal law, and asylum law, or a medical context. As this solicitor put it, "But from day one, the young person's competence is in issue, because the very moment

you meet them, you're having to try and explain the asylum process. So you're instinctively and professionally trying to determine if this young person can actually understand" (Interview 21: Asylum law solicitor in Midlands and East).

The passion of all professionals for their work with children was very evident from the interviews. This extended into the issue of competence – most professionals felt very strongly that competence was an incredibly important issue in their work, whether or not it was a day-to-day issue for them, and whether or not they felt they had a strong understanding of it. The importance placed on it by professionals is evident in this surgeon's views: "This is something I feel you know quite a lot of passion about … I've spent the last few years sort of giving lectures and presentations to my colleagues, to sort of try and say this is our consent policy and you know here is the provision for the fact that some children should actually be making these decisions themselves" (Interview 18: Consultant paediatric surgeon in the North West).

For lawyers, the question of whether they would consider or assess competence depended on the area of the law. Most lawyers in non-criminal law proceedings were in a situation where they may have to consider whether a child could directly instruct them, rather than taking instruction from a children's guardian or a professional – usually a former social worker – whose job it is to represent the children's wishes and best interests. It was to the forefront of the minds of barristers, although it is the instructing solicitor who makes the determination as to whether a child has competence to instruct.

This Child and Adolescent Mental Health Service (CAMHS) nurse manager outlined that Gillick was very much a part of his daily work with children with mental health problems: "So the patient's journey, on admission, every patient would be assessed whether they were Gillick competent, usually specific around medication, so it would be recorded in their notes" (Interview 20: CAMHS nurse manager in the North West). He outlined that if a child were found not to be Gillick competent on a particular issue, consent to treatment would be sought from a parent or guardian instead. He also emphasised that in his area of medicine, he and his colleagues were dealing much more with the issue of Gillick competence than in other areas of medicine: "certainly we're dealing with it a lot more than the average, you know, in-patient type unit."

In criminal law, assessing children's competence was a prominent issue for them, because considering competence was crucial to considering whether children were competent to instruct and whether they understood the various elements of these important proceedings. This youth lawyer explained that competence is important in determining that children "understand the allegation against them, and that they are competent to give me instructions regarding

that" (Interview 27: Youth lawyer in London). The lack of attention to the issue of children's competence was particularly dominant in family law. This barrister outlined: "For me if … you know, I always feel like it's just confined in medical law because you often where you've got the [refusing crucial medical treatment] kind of issue. But we don't … I don't come across it, I don't think I have since I've been in practice if I'm honest with you" (Interview 26: Family law barrister in the South East).

Even medical professionals, dealing with consent day in and day out, felt that Gillick competence was something to be assessed very intuitively: "Does it give enough? I mean at the bottom line what does Gillick say? You're making a judgement call, you as an individual, you don't get somebody else in to help you. And a little bit of it is gut instinct isn't it, this child understands enough, versus no I don't think this child understands enough" (Interview 18: Consultant paediatric surgeon in the North West).

There was a strong sense that the informal way in which capacity is assessed is a problem. This solicitor particularly felt this was an issue in the case of the immigration context where English was not the child's first language. She felt that it would be better to "… assess that in a kind of more formal way rather than trying to do it on the hoof" (Interview 6: Solicitor with children's legal centre in London). This barrister emphasised three variables – age, ability, and issue:

> Well it's a balance because you know you've got the variable of age on one side, you've got the variable ability of the child and you've also got a third variable, which is the nature of the decision being made. So you're trying to adjust your decision-making and … applying a level of force to what the child is saying based on those three factors. (Interview 2: Public children law barrister in London)

There was a strong sense across all professionals that an important part of determining whether a child can understand something involved the child being able to explain back to them details of the situation or choices that had been explained to the child: "I would be looking to see if that child could repeat back to me things that I'd explained to him or her" (Interview 1: Family law barrister in London).

There was a striking sense amongst professionals that competence was something that was vague and a concept that needed further elaboration. This barrister expressed: "Yeah, but I'd encourage you to focus on that, because I think it can be broadened out from there. I think if I may say so, competence is the right question, it's just we only ask it in very defined circumstances, and that to me makes very little sense" (Interview 3: Criminal law barrister in the North of England).

This observation reflects the fact that competence appears only to arise in relation to a handful of discrete legal issues such as medical consent and instructing a solicitor.

12.5 SUPPORTING COMPETENCE

As outlined above, relational competence refers to the increase in our understandings and abilities which can arise from social interactions and relationships through for example communication and explanation.[38] Competence can be promoted and learned in this way. Therefore it was of interest to ascertain the extent to which a relational understanding of competence was part of the practice of the professionals interviewed for this research.

12.5.1 Professionals Supporting Competence

Medical professionals are aware that they needed not just to treat children's medical conditions but also to provide children with information and support to enhance their competence about their own conditions. As this doctor expressed: "it's not just about being given medication, it's about you know working with whoever you're seeing, about strategies and understanding you know how your condition might affect you!" (Interview 15: Paediatric specialist in the North West). This doctor expressed that in some situations where parent and child may disagree on the treatment options, she felt that it was her role to provide as much time and information as she could to help them come to an agreement about the way to proceed:

> I'm going to say, OK, we've discussed this, I know what you're thinking parents, and I know what you're thinking child and they don't agree but actually they're both important, and I don't think it's right that we rush to a decision. So you go away and think about it, perhaps chat about it at home and come back and meet me again. So that's my approach to that situation, unless it's something where we really need to make a decision to prevent harm coming to the child, this is a … we've got to keep talking about it until we can come to the compromise … (Interview 18: Consultant paediatric surgeon in the North West)

38 Katharina M. Ruhe, Tenzin Wangmo, Eva De Clercq, Domnita Oana Badarau, Marc Ansari, Thomas Küne, Felix Niggli, Bernice Simone Elger and Swiss Pediatric Oncology Group, "Putting Patient Participation into Practice in Pediatrics: Results from a Qualitative Study in Pediatric Oncology," *European Journal of Pediatrics*, vol. 175(9) (2016): 1147–1155.

For this doctor, the issue of spending time communicating with the child was crucial to helping them understand their condition and consenting to treatment. She, as with many other medical professionals, expressed that the position of parents was a difficult one, in that sometimes parents want to gatekeep information in a perceived effort to protect their child: "I think there is that need for families as well to control the information shared" (Interview 11: Palliative care consultant). She described struggling to find the time and opportunity to build the relationship with the child in a way that's necessary to understand their personality and level of understanding: "So you feel artificial, you're trying to set up a scenario where you can realistically and actively understand that child and who they are and what they are and what they're about, how much they've taken in and … But that's a whole week of work virtually" (Interview 11: Palliative care consultant). She also outlined that she felt medical professionals should be giving more information "in an understandable way, age-appropriate" to help children understand the medical situations: "So I think legal training just generally around capacity, consent, best interests, would be very powerful for medical professionals" (Interview 11: Palliative care consultant).

For those lawyers with experience of the Court of Protection, there was a sense that there was a disjoint between the approach to the competence of adults as opposed to that of children. This barrister, very accustomed to dealing with questions of adult capacity, was asked whether he felt that children's capacity could be supported. He considered how adults' capacity was treated, in that the MCA requires that capacity be supported, for example, question of residence options: "you actually have to be supplied with actual options to weigh and the pros and cons of each option, rather than would you like to live in a residential setting or would you like to live at home, because there are so many different types of residential setting …" (Interview 14: Barrister in Court of Protection and care proceedings in London). Therefore, when he considered that in light of children, he felt that an equivalent approach was definitely possible.

Unsurprisingly, many lawyers spoke about supporting their children to understand the proceedings in which they found themselves. This was not necessarily for the purpose of assessing competence, but for guiding children through proceedings. This is, of course, part of the role of the legal representative. This asylum law solicitor, for example, expressed it as follows: "I always explain that … it's really important that you feel empowered to make your own decisions, and I'm here to help you and guide you" (Interview 21: Asylum law solicitor in Midlands and East). Similarly, medical professionals felt strongly that part of their role was to guide patients through understanding their medical situation and understanding possible treatment options.

However, the ability of professionals to support children's competence appeared in many cases to be hampered by a lack of understanding of what exactly

competence is. Medical professionals who deal with consent tended to deal with the issue of Gillick competency more frequently and generally had received some element of training in it. However, even in this area, a lack of definition about what good competence is was prevalent, and likewise, training did not appear to be extensive in relation to children's competence. This child and adolescent mental health services nurse manager outlined that capacity training was available from his employer, but that was not specific to children (Interview 20: CAMHS nurse manager in the North West).

12.5.2 The Time Barrier to Supporting Competence

Time was also a key issue for this asylum law solicitor, who emphasised how, in spite of intense work and time pressures, she found ways to explain in detail to her child clients what their situation was and what the legal options were. She did this through innovative methods such as drawing:

> So … level of understanding is always an issue and I think that … I mean the way we tend to deal with that is just go slowly, go really slowly. The Home Office hates me, you know I do go slowly, but I have to act in a way that I can stand by and put in something that I believe that the young person understands is thorough, is detailed… So [I draw] one circle and you know arrows and stuff coming out, because it's easier for them to have something to see, rather than just listening to your words. … So I think a lot of those techniques you can use when just trying to talk to anybody in a vulnerable situation, just that idea of being very calm and centred yourself and … not letting any pressures you have with time or Home Office deadlines or court deadlines impact on that hour or hour and a half that you're sat with that client, and making sure that it's very much their space, their time to give you that information. (Interview 21: Asylum law solicitor in Midlands and East)

We can see in this quote a reference to the system – in this case facilitated by the Home Office – being clearly inclined away from supporting children's understanding and competence. This lawyer had to take the initiative herself to find ways and time to support the competence of her clients. She wished that there was more time, and that her approach was more facilitated by the system in which she worked, to ensure the children fully understood the system that they were in.

This barrister expressed the issue that professionals in recent years have less time to spend with children. This meant that they could not get their views, wishes, and other important information and relationship-building which is necessary in cases:

> The problem there is CAFCAS have introduced what they call a system of proportionate working, and you know that's dialect, that's code for don't do as much as you used to do. Because we can't afford it. And actually the work that's disappearing is the children's guardians spending time with the child. And if we don't do that then their voices won't be heard. (Interview 2: Public children law barrister in London)

This criminal barrister stated that she had built up much experience in psychiatric issues that might affect competence, but expressed her unease with her lack of formal training on such issues. She felt that a lack of time to spend with the client might compound this problem. Up until the cuts to legal aid that she expressed, every serious case had an assistant who would get to know the client well and be able to ascertain any issues relating to psychiatric disorders are competence, but now that was not the case:

> So defence lawyers have to be alert to these issues around and … we're not really trained how to do it.
>
> Do you think you should be?
>
> Yeah, it terrifies the bloody life out of me. And as Legal Aid gets stripped back … Now, everybody, even if you get a solicitor, is meeting the client for the first time, you've never met them before, or maybe you've done another case for them, but you don't have any relationship to speak of, you don't know what they're like.
>
> And so was that because … since Legal Aid cuts came in?
>
> Yeah. (Interview 3: Criminal law barrister in the North of England)

She expressed that this was particularly the case with children, who she did not feel confident that she would spot and understand such issues in relation to: "and I wouldn't … wouldn't trust myself at all, not at all, because they just present so differently, and I am not computing it. So who knows?" (Interview 3: Criminal law barrister in the North of England).

12.5.3 Do Systems Facilitate Capacity Support?

In previous work, I have outlined the concept of autonomy support and how it could be employed to support professionals to enhance children's competence and

decision-making abilities.[39] However, the obvious problem is that no matter how determined a professional is to support a child's competence, they are frequently operating in systems – be they medical or legal – that incline against supporting competence.

Medical professionals interviewed considered that the systems in which they work could better work to provide children with information and support to boost their competence. As this doctor expressed, leaflets are not sufficient to do this well:

> … we're still working on that. I don't think … certainly in our service we're working on that for all of our bits, providing kind of age-friendly leaflets but also providing websites that are useful for them … Because often just providing leaflets for young people, they just kind of don't look at them … I don't know about you, I often put leaflets in my pocket and never look at them again! (Interview 15: Paediatric specialist in the North West)

This nurse also expressed that much of the building of competence in children about the medical treatment was left up to parents: "…if you went to A & E for instance, they would give you a parent information sheet of kind of what to do kind of if a child had broken an arm or something, but if a child's 12, 13, then why can't they have an information sheet to allow them to understand what's happened to them?... The onus is always put onto the parent, isn't it?" (Interview 12: Research nurse in the North West).

The frustration of this children/youth lawyer with the lack of support for young people accused of sexual offending also seemed relevant to this question of how systems support children. She expressed that, where children are accused of sexual assault, the system should be in place to have the time and care to support them back to a positive place in their behaviour. Instead, she seemed to emphasise, it attempts solely to punish them. She was of the opinion that the lack of effort to support children, and to help them understand their own proceedings, constituted detrimental treatment of children because this is a group that is so lacking in power:

> So if you think about your [European Convention on Human Rights] Article 6 right to a fair trial, that means that you've got to effectively participate in a trial, right? … It's not fair if you don't understand what's going on. Well why are we mucking around with it? Why are we not doing this? Well, because they're children, so they can't complain, they don't vote, so what do we care? You know it's … it's all inextricably linked. (Interview 27: Youth lawyer in London)

39 Aoife Daly, *Children, Autonomy and the Courts: Beyond the Right to be Heard.*

This point brings to the fore the crucial link between competence and vulnerability. Children are indeed generally more vulnerable compared with adults, not least because they are excluded from ways of exercising power, such as the right to vote. This vulnerability is compounded by a failure by systems to support competence, for example, when it comes to competence to understand one's own trial. Supporting competence, then, is clearly crucial to children's rights, and yet there remains a lack of focus on this across numerous services for children.

12.6 CONCLUSIONS

Professionals have guidance for how to assess adult capacity, but very little for children. The adults' conception of capacity for adults under the MCA 2005 gives greater guidance to professionals, whereas the reliance on Gillick competence means that there is less to go on. Guidance is definitely needed on what Gillick competence actually is in the same way that the MCA provides guidance, albeit very imperfect. This is linked to the fact that for adults, the MCA requires that capacity be supported for a determination to be made (on whether an adult actually has capacity). There is no such requirement for children, in spite of the wealth of literature that we now have on how support and information will enhance how competent someone is on a particular subject. The perceived vulnerability of children appears to be a factor in this. In the medical arena, for example, it is frequently left to parents to decide how much involvement children have in decisions. This is apparently due to a lack of time and a lack of familiarity with Gillick. However, children's vulnerability is, ironically, likely increased where there is a failure to provide enough information to children to be empowered in decision-making concerning themselves.

Of the legal professionals with whom I spoke, not many consider the actual question of how they could support competence. There was much more emphasis on how they could ascertain whether a child does have competence. In some ways this is unsurprising as it is the children's interests (medical, legal, etc.) that these professionals are there to support, rather than children's competence to make a decision *per se*. However, professionals were very aware that they needed to know more about the Gillick competence standard, about communicating with children, and so on. Again, training and time appeared to be strongly desired by these professionals. Lawyers appear to be working in an environment that was not as well disposed to supporting children's competence compared with medical professionals. The structures and procedures of law meant that lawyers felt compelled to focus on more immediate concerns such as what evidence to present, how to mitigate a sentence, and so on.

The data clearly points to professionals who are very passionate about supporting children and representing their interests. However, they are operating in systems that do not define competence adequately and do not appear to give professionals adequate training or sufficient time to support children's competence. Given what we know about the relational nature of competence, states and adults more broadly have obligations under the CRC to support children enjoying their Article 5 right to exercise their rights in line with their evolving capacities across different legal issues.

ACKNOWLEDGEMENTS

This research was funded by the Independent Social Research Foundation. I would like to thank those who provided invaluable feedback at various stages of drafting. These included Hedi Viterbo, Kay Tisdall and Rachel Heah, and the participants of a 2022 workshop at the University of Tromsø on children's rights and vulnerability.

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