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Skeleton Keys to Hospital Doors: Adolescent Adults who Refuse Life-Sustaining Medical Treatment

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We consider how the sufficiency of young adults' autonomy is judged in light of biological, social and psychological evidence that adolescence can continue into the mid 20s. Until then, adolescent adults are prone to developmental immaturity which can affect risk taking, impulsivity, and independence in decision making. Some areas of law are starting to accommodate the impacts of adolescence into adulthood, and this article considers how they do so and whether and if so how the law relating to medical treatment refusals in England and Wales might similarly adapt. We argue that the right to full decision-making about medical treatment refusals at 18 based on the adult status of the individual should accommodate greater sensitivity to individual developmental attributes and set out three ways in which that might be achieved.

INTRODUCTION

Not all medical treatment decisions command respect. Not only are some desired options unavailable to patients,[1] but where choices exist, they must be sufficiently autonomous. This article is concerned with decisions to refuse treatment that others consider to be in the patient's best interests and without which the individual will suffer significant harm or die. In England and Wales, various legal mechanisms exist to determine when a treatment refusal is insufficiently autonomous, in which case it might be overruled. One mechanism separates minors under 18 and adults,[2] who gain protections of their right to decide and lose certain welfare-based protections. At 18, an adult with mental capacity who seeks to refuse life-sustaining medical treatment generally has the right to make a determinative decision.[3] This article posits that the law can and should better differentiate between young adults who are still going through adolescence, and older more mature adults.

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1 *N* v *ACCG* [2017] UKSC 22 at [35].
2 Family Law Reform Act 1969, s 1. The United Nations Convention on the Rights of the Child 1989, Art 1 says 'a child means every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier'.
3 *In re T (Adult: Refusal of Treatment)* [1992] EWCA Civ 18, [1993] Fam 95 at [3] per Lord Donaldson MR.

We consider the case for adaptation of the current approach in light of biological, social and psychological evidence that adolescence can extend to the mid 20s until which time it can impact on autonomous decision making. Biological research demonstrates the potential effect of physiological developments of the brain on risk appreciation and self-control and social research indicates changes in dependence on others which can in turn impact on voluntariness in decision making. Psychological tools have potential to show the impact of adolescence on the particular decisions of individuals, demonstrating where developmental immaturity is evident and its effect on the decision making process.

Posited law reflects the duty to protect vulnerable people from their own harmful decisions, but defining which decisions and what evidence of agential impediment justify a welfarist approach is controversial.[4] The two principal legal mechanisms relevant to treatment refusals are the Mental Capacity Act 2005, which deals with people aged 16 and over who lack mental capacity, and the inherent jurisdiction of the court.[5] According to the former, an exception to the rule that adult decisions are determinative applies if the presumption of capacity set out in section 1(2) of the Mental Capacity Act 2005 is rebutted. In an exercise of soft paternalism, others can make decisions in the person's best interests if the person is reasonably considered unable to make a capacitous decision. This is true even if the incapacitated person desires a different course of action, though their view will be taken into consideration.[6] The latter – the inherent jurisdiction – applies in relation to adults who are vulnerable and lack voluntariness.[7] Separately, the inherent jurisdiction also applies to children who are protected on the basis that they are inherently vulnerable by virtue of being under the age of 18. Accordingly, children's capacitous and voluntary medical treatment refusals can sometimes be overridden in their best interests.[8] In *Re X (A Child) (No 2)*[9] (*Re X*), Sir James Munby suggested that even if minors are assessed as having mental capacity, they have an inferior sort of autonomy to capacitous adults.

We aim to show that it is possible to better protect vulnerable adolescent adults through consistent application of established legal principles.[10] We do not seek to challenge the legal definition of adulthood and nor do we suggest

4 See for example Emma Cave, 'Protecting Patients from their Bad Decisions: Rebalancing Rights, Relationships and Risk' (2017) 25 *Medical Law Review* 527.

5 We do not consider the Mental Health Act 1983, which deals with the assessment and treatment of people with mental health disorders.

6 Mental Capacity Act 2005, s 4(6).

7 *DL* v *A Local Authority* [2012] EWCA Civ 253, discussed below.

8 *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 (*Re R*); *In re W (A Minor) (Medical Treatment: Courts Jurisdiction)* [1993] Fam 64 (*Re W*).

9 *Re X (A Child) (No 2)* [2021] EWHC 65 (Fam) at [117], discussed below.

10 We acknowledge Martha Fineman's theory of universal vulnerability (Martha Fineman, 'The Vulnerable Subject and the Responsive State' (2010) 60 *Emory Law Journal* 251; Martha Fineman, *The Autonomy Myth* (New York, NY: New Press, 2004) and Beverly Clough's related argument that the capacity / incapacity binary can result in the restriction of paternalistic state intervention to the incapacitous, which in turn is used to justify harmful non-intervention in relation to vulnerable people with capacity (Beverly Clough, 'Disability and Vulnerability: Challenging the Capacity/ Incapacity Binary' (2017) 16 *Social Policy and Society* 469, 471-772 and more generally, Beverly Clough, *The Spaces of Mental Capacity Law: Moving Beyond Binaries* (Abingdon:

that adolescent adults should be treated as children.[11] Whilst it is trite to note that no physiological change occurs on a person's 18th birthday, the line that divides childhood and adulthood gives rise to predictable decisions and limits subjective interpretations. Bright line rules prioritise clarity and certainty over occasional harsh and unjust results, as in the designation of the organism at one end of the birth canal a fetus and at the other a baby. Nonetheless, there is a moral imperative to mitigate harsh effects where injustice is known to result, as is achieved by legal recognition of the rights of children born alive to legal remedies even though the harm occurred when they were in utero.[12] Accordingly, we endorse the legal definition of adulthood but seek ways to undermine the dominant binary approach regarding the consequences that flow from being assigned child or adult status, where it leads to harm resulting from the person's vulnerability by virtue of their adolescence. The UN Committee on the Rights of the Child recognised in 2016 that 'Generic policies designed for children or young people often fail to address adolescents in all their diversity and are inadequate to guarantee the realization of their rights'.[13] In the context of health, George Patton et al call for better recognition of adolescence across the minor adult divide, where current failures result in barriers to health flowing from their inexperience, reliance on parents or carers, sensitivity around confidentiality breaches, stigma and practical difficulties such as lack of access to their own transport.[14]

We endorse the legal requirement that capacitous, voluntary, sufficiently informed treatment refusals made by adults should be respected, even if they are harmful and irrational. However, we challenge the current application of the tests for capacity and voluntariness. Our claim is that evidence of insufficient autonomy in young adults is currently overlooked and should be taken more seriously. We show how this might be achieved without straying into hard paternalism through the development of psychological assessment tools. We demonstrate how a comparable approach has been successfully adopted in criminal sentencing to take into account the effect of adult adolescence on culpability. We consider potential barriers to our proposed approach and how they might be resolved.

Routledge, 2021)). These arguments lend support to our problematisation of the current legal approach in England and Wales. However, because our focus is on how improvements might be achieved within the current legal framework in England and Wales, we depart in this article from their thinking in relation to perceived solutions.

11 In a different context, the suggestion that a 22-year-old with a severe learning disability should be treated as a child for the purposes of upholding a parental right to decide whether he should receive a COVID-19 vaccination was firmly (and we would suggest quite rightly) rejected in *TN* v *An NHS ICB & Anor* [2022] EWCOP 53 at [22] per Hayden J.

12 Congenital Disabilities (Civil Liability) Act 1976, s 1.

13 UN Committee on the Rights of the Child, *General Comment No 20 on the Implementation of the Rights of the Child During Adolescence* (CRC/C/GC/20, 2016), para 3. Note the Committee's focus was on adolescent minors, but the principle is also relevant to adolescent adults.

14 George C. Patton, Susan M. Sawyer, John S. Santelli et al, 'Our Future: A Lancet Commission on Adolescent Health and Wellbeing' (2016) 387 *Lancet* 2423. Discussed further below.

REFUSAL OF LIFE-SUSTAINING TREATMENT

The legal definition of adulthood at 18 has contributed to an all or nothing attitude in terms of paternalistic protection. In *Re W*, in which the Court of Appeal overruled a refusal by a 16-year-old to admission for specialist treatment, Nolan LJ said: '[T]he present state of the law is that an individual who has reached the age of 18 is free to do with his life what he wishes, but it is the duty of the court to ensure so far as it can that children survive to attain that age.'[15]

Minors' refusals can be vetoed in their best interests. After some years of doubt as to the compliance of this position with human rights, it was recently reviewed and confirmed. The requirements for a minor to give consent differ according to the child's age. Under the age of 16, the *Gillick* competence test is used to determine whether a minor has the requisite understanding and maturity to make the treatment decision. According to section 8 of the Family Law Reform Act 1969, the consent of a 16- or 17-year-old minor to medical treatment is 'as effective as it would be if he were of full age'. From the age of 16, most of the provisions of the Mental Capacity Act 2005 also apply. But for both those aged 16-17 and those under 16, their refusals of life-sustaining treatment can be overruled to protect their welfare interests. In *Re X*,[16] Sir James Munby accepted that a 15-year-old Jehovah's Witness's refusal of blood products to treat a crisis relating to sickle cell syndrome was *Gillick*[17] competent, but considered her views merely relevant, and not determinative.[18] McFarlane LJ in the Court of Appeal in *E & F (Minors: Blood Transfusion)* (*E & F*) confirmed the court's power to veto minors' capacitous medical treatment refusals: 'In our view, this approach remains good law. It survives the Human Rights Act 1988 and the Mental Capacity Act 2005, and it has not been overtaken by subsequent decisions, by the passage of time, or by the evolution of societal values.'[19] He went on to say: 'Once a young person becomes an adult, decisions about whether to accept or reject medical treatment become theirs absolutely, but before that age the court must act upon its objective assessment of the young person's best interests, even where this conflicts with sincere and considered views.'[20]

Subject to the operation of the Mental Health Act 1983 and the court's inherent jurisdiction, once a person is 18, the courts will not overrule their capacitous treatment refusals. The decision becomes 'theirs absolutely'. A 17-year-old who refuses a blood transfusion for religiously motivated reasons might conceivably have their decision vetoed by the High Court in their best interests. At 18 their decision is unlikely even to be brought before the court. Consider *Re E (A Minor) (Wardship: Medical Treatment)*[21] (*Re E*) where

15 *Re W* n 8 above, 94, cited in *Re G (Children: Religious Upbringing)* [2012] EWCA Civ 1233 at [81] per Munby LJ, and *Re X* n 9 above at [21] per Sir James Munby.
16 *Re X ibid* at [77].
17 *Gillick* v *West Norfolk and Wisbech Area Health Authority* [1986] AC 112.
18 n 9 above at [25]. And see *DV (A Child)* [2021] EWHC 1037 (Fam).
19 *E & F (Minors: Blood Transfusion)* [2021] EWCA Civ 1888 at [57].
20 *ibid* at [73].
21 *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.

a 15-year-old minor was required to have a blood transfusion to help treat his leukaemia, against his wishes and religious beliefs. At the age of 18 he relapsed and refused the transfusions keeping him alive. He died thinking he had committed an ungodly act. The case has often been referenced to challenge the differential treatment of children when compared to adults with similar agential capacities.[22] In light of the recent judicial confirmation that this position does not, as a matter of posited law, breach minors' human rights, the next sections will argue that cases like *Re E* might equally be illustrative of a failure of the law to adequately protect the welfare of young adults.

The legal position in England and Wales with respect to adults follows John Stuart Mill's theory on the Liberty of Will, whereby 'The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. … Over himself, over his own body and mind, the individual is sovereign'.[23] On this account, hard paternalism, that is compulsion to protect the individual making an autonomous decision from harm, is tyrannical. For those judged to have sufficient autonomy to make a medical treatment decision, that decision should be respected, however unwise it might appear to others.[24]

Mill restricted his Harm Principle to 'human beings in the maturity of their faculties'.[25] For Mill, those who 'require being taken care of by others, must be protected against their own actions as well as against external injury'.[26] Accordingly, where there is good reason to doubt that a decision represents the will of the individual, and respecting the decision will cause the person significant harm, then a soft paternalistic stance might be justified.[27] Some would go further and argue that a failure to intervene would not take seriously the rights of vulnerable people to protection.[28] If, as Mill would have it, some adolescent adults are no more 'in the maturity of their faculties' than those a few years their junior, then a failure to give their immaturity consideration in cases where serious consequences to the young adult will follow is morally problematic.

The binary distinction between minors and adults is ingrained in law, medicine and society to such an extent that we would hypothesise that factors that might lead to an assessment of capacity in an older adult, which could potentially lead to a conclusion that they lack capacity, might be overlooked in a younger adult. This is particularly so if, as in *Re E*, refusals of the same treatment or procedure by the young person apply both sides of the bright line of legal adulthood. The legal position that at 18 the decision is 'theirs absolutely' might in clinical practice make it difficult to move from a position where capacity is

22 See for example Margaret Brazier and Emma Cave, *Medicine, Patients and the Law* (Manchester: Manchester University Press, 2016) 468.

23 John Stuart Mill, *On Liberty* (London: Thinker's Library Edition, Watts & Co, 1929) 12. And see for example *Nottinghamshire Healthcare NHS Trust* v *RC* [2014] EWHC 1317 (COP) at [8] per Mostyn J.

24 On the fallibility of paternalistic interference see Mill, *ibid*, 94.

25 *ibid*, 12. Later described as 'human creatures of ripe years', 94.

26 *ibid*, 12.

27 Joel Feinberg, *Harm to Self* (Oxford: OUP, 1986) 12.

28 See Catriona Mackenzie, 'Relational Autonomy, Normative Authority and Perfectionism' (2008) 39 *Journal of Social Philosophy* 512; Jonathan Herring, *Vulnerable Adults and the Law* (Oxford: OUP, 2016). And see the discussion below of *DL* v *A Local Authority* n 7 above at [67] per McFarlane LJ.

merely relevant but uncontested at 17, to one where capacity is determinative but contested at 18. There is evidence that in some of the cases overruling minors, questions as to their capacity were finely balanced or even overlooked. In *Re W*, for example, there was doubt as to the child's competence.[29] And in *NHS Foundation Hospital* v *P*,[30] Mr Justice Baker was not convinced that a 17-year-old minor who had refused treatment for drug overdose lacked capacity within the meaning of section 3 of the Mental Capacity Act 2005. The 'extremely limited' information available to the court in this urgent case was conflicting. Baker J was able to sidestep the issue by making an order under the inherent jurisdiction. But having done so in circumstances where capacity was assumed, a young adult might raise concerns that a finding of incapacity at 18 in relation to the same proposed treatment is driven by the outcome (namely serious harm or death), rather than their ability to make a decision, which would be contrary to the 2005 Act.[31] It is not unlawful to find that a 17-year-old who was assumed to have capacity but was overridden in their best interests lacks capacity to make a similar decision at 18, but in light of the statement that at 18 the decision is 'theirs absolutely', we suggest that it would be an uncomfortable conclusion to draw, and that this might lead to a failure to assess mental capacity when on the facts an assessment is warranted.

ADOLESCENCE

A key challenge to the binary nature of childhood and adulthood comes from discourses on adolescence. It was not until the twentieth century that adolescence emerged as a field of study. In 1904, G. Stanley Hall referred for the first time to the 'storm and stress' of the transition phase between childhood and adulthood, often evidenced by conflict with parents, mood disruptions and risky behaviour.[32] Biological, psychological and social explanations for adolescence and its impact abound. Erikson, for example, argued in 1968 that adolescence is turbulent due to crises regarding 'identity formation': ever-narrowing decisions they must make that commit to an adult identity.[33]

The very recognition of a period of turbulence poses risks. It could be used to assert authoritarian controls to curb socially undesirable manifestations or, conversely, it might lead to downplaying the impact of turmoil, based on an assumption that it will naturally resolve as the adolescent matures.[34] It can also lead to a focus on the negative connotations of adolescence, obscuring the proclivity for skill development, creativity and exploration.[35] However, evidence

29 *Re R* and *Re W* n 8 above, discussed in *Re X* n 9 above at [59].
30 *NHS Foundation Hospital* v *P* [2014] EWHC 1650 (Fam).
31 Mental Capacity Act 2005, ss 1(4), 2, 3.
32 G. Stanley Hall, *Adolescence: Its Psychology and Its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education* (New York, NY: D Appleton & Co, 1904), cited in Jeffrey Jensen Arnett, 'Adolescent Storm and Stress, Reconsidered' (1999) 54 *American Psychologist* 317.
33 Erik H. Erikson, *Identity: Youth and Crisis* (New York, NY: W. W. Norton, 1968).
34 Arnett, n 32 above, 324.
35 See for example Nancy Lesko, *Act Your Age: A Cultural Construction of Adolescence* (New York, NY: Routledge, 2012) Introduction.

that adolescents can lack the full moral agency of mature adults can also lead to better mechanisms to confer responsibilities and culpabilities in ways that are responsive to the variable impact adolescence has on individuals and the opportunities it presents.

Today there is widespread recognition of adolescence and its impact on minors up to the age of 18. There is, for example, evidence of the impact of puberty on decision making in early adolescence, and mounting recognition of vulnerability to social media influences in mid adolescence between 14-17.[36] Adolescence beyond the age of 18 is more contentious. A transition into adulthood in common parlance is naturally assumed to end when adulthood begins,[37] on the basis of which adolescence would cease at 18. But this view is contested in light of biological characteristics, social influences and psychological factors that are now known to impact on decision making beyond the age of 18.

It is uncontroversial to suggest that the process of maturity does not stop at 18. But, as we explore in the following sub-sections, there is also an increasingly strong evidence base suggesting that the turbulence associated with transition to adulthood – adolescence – can for many young adults continue into the mid 20s.[38] Social and biological evidence suggests that some of the factors that lead to the label of 'adolescent' in minors are often still pertinent in early adulthood, and that the impact of adolescence on the agential qualities of decision making in minors also has relevance to some young adults.

In this article, we do not seek to define the end point of adolescence, but rather to assert that it is indefensible to claim that adolescence is always complete by the age of majority, and subsequently to set out how those affected can be identified and to consider what might be done in law as a result. In place of a definition of adolescence based purely on chronological age, we argue that law and policy should better accommodate social and scientific evidence that adolescence is variable and can extend into legal adulthood.

Biological indicators of adolescence

Physiological research examines the chemistry and physics that control the body's functions. It applies a scientific method to standardise the definition of adolescence through analysis of the brain's structure over time. Developments in neuroimaging indicate that the adolescent brain continues to develop into the 20s.[39] From the onset of puberty to around the age of 25, waves of 'synaptic

36 L. Steinberg, 'A Behavioral Scientist Looks at the Science of Adolescent Brain Development' (2010) 72 *Brain and Cognition* 160.

37 See Oxford English Dictionary, Cambridge Dictionary, Marriam-Webster Dictionary definitions. Note, however, that it originates from the Latin *adolescere*, which means to mature.

38 See Jay N. Giedd, Michael Stockman, Catherine Weddle et al, 'Anatomic Magnetic Resonance Imaging of the Developing Child and Adolescent Brain' in Valerie F. Reyna, Sandra B. Chapman, Michael R. Dougherty and Jere Confrey (eds), *The Adolescent Brain: Learning, Reasoning, and Decision Making* (Washington, DC: American Psychological Association, 2012), 15-35.

39 Jay N. Giedd, Jonathan Blumenthal, Neal O. Jeffries et al, 'Brain Development During Childhood and Adolescence: A Longitudinal MRI Study' (1999) 2 *Nature Neuroscience* 861; Susan M. Sawyer,

pruning' in the amygdala, nucleus accumbens and prefrontal cortex remove unused connections in the brain and facilitate the abilities to control risk and emotions.[40] During this phase, neuronal plasticity occurs, whereby adolescents can learn and adapt to a range of environments and situations to develop as independent individuals, but can also render them vulnerable 'to making improper decisions because the brain's region-specific neurocircuitry remains under construction, thus making it difficult to think critically and rationally before making complex decisions'.[41]

There is evidence that changes to the limbic system affect self-control, emotions, risk-taking and decision making.[42] The under-developed prefrontal cortex is linked to a vulnerability in adolescence to impulsive decisions,[43] the weak amygdala impacts on harm avoidance and the nucleus accumbens results in a strong reward system.[44] This 'triadic model' helps to explain typical adolescent behavioural motivation,[45] as well as the variable impact of adolescence on decision making. Betty Jo Case et al consider that the differential development of the limbic system relative to top-down control systems in adolescence results in 'dynamic interplay' between cortical and subcortical brain regions. This results in non-linear changes in behaviour as brain development brakes and accelerates.[46]

Social indicators of adulthood

Sociological concepts of adulthood and its phases have received little attention relative to the focus on the transition to legal adulthood at 18.[47] Nilsen laments the absence of a 'sociology of adulthood' to correspond to the sociologies of childhood and youth:[48] 'The very notion of a transition to adulthood can suggest that upon arrival all movement and motion stop and life becomes a series of routines and obligations.'[49]

Peter S. Azzopardi, Dakshitha Wickremarathne and George C. Patton, 'The Age of Adolescence' (2018) 2 *The Lancet Child & Adolescent Health* 223.

40 Chief Medical Officer, *Our Children Deserve Better: Prevention Pays: Annual Report of the Chief Medical Officer 2012* (London: Department of Health and Social Care, 2013) ch 8, 3; Miriam Arain, Maliha Haque, Lina Johal et al, 'Maturation of the Adolescent Brain' (2013) 9 *Neuropsychiatric Disease and Treatment* 449.

41 Arain, Haque and Johal et al, *ibid*.

42 *ibid*, 450. Larger longitudinal neuroimaging analysis studies support these findings: Jay N. Giedd, Jonathan Blumenthal, Neal O. Jeffries et al, 'Brain Development During Childhood and Adolescence: A Longitudinal MRI Study' (1999) 2 *Nature Neuroscience* 861.

43 Steinberg, n 36 above, 160. Elizabeth S. Scott, 'Judgment and Reasoning in Adolescent Decision Making' (1992) 37 *Villanova Law Review* 1607.

44 Monique Ernst, Daniel S. Pine and Michael Hardin, 'Triadic Model of the Neurobiology of Motivated Behavior in Adolescence' (2006) 36 Psychol Med 299.

45 *ibid*.

46 B. J. Casey, Rebecca M. Jones and Leah H. Somerville, 'Braking and Accelerating of the Adolescent Brain' (2011) 21 *Journal of Research on Adolescence* 21.

47 Jane Pilcher, 'Where is a Sociology of Adulthood?' (2012) at https://www.janepilcher.me.uk/2012/02/where-is-a-sociology-of-adulthood/ [https://perma.cc/EQY4-Y4HU].

48 Ann Nilsen, 'Independence and Relationality in Notions of Adulthood Across Generations, Gender and Social Class' (2021) 69 *The Sociological Review* 123, 125.

49 *ibid*, 125.

There is, however, a strong sociological contribution to defining the ambits and consequences of youth, which amply demonstrates that a focus on physiology and psychology alone will miss important influences such as work, culture, family, institutions and the norms and values of society.[50] In many high income countries, one aspect of this is a well-documented phenomenon of generations taking ever longer to attain the independence, stability and self-reliance that, from cognitive, emotional and behavioural perspectives, signal the onset of adulthood.[51] These milestones can vary across time periods, gender and class.[52] In England and Wales in 2021, for example, the average age of first-time home buyers rose to 32,[53] from 25 two decades ago.[54] The 'key to the door' now handed to 18-year-olds is a skeleton key that opens many metaphorical doors, but this rarely includes their own front door. It is increasingly normal for single young adults in their 20s to live with their parents.[55] The relationship between detachment from parents and adolescent autonomy is complex and we merely touch on the literature. A high degree of attachment in a positive parent-adolescent relationship can be indicative of enhanced *emotional* autonomy,[56] but it can also result in increased financial and emotional dependence, impacting on behavioural autonomy.[57]

Evidence of delayed social adulthood has resulted in dilemmas regarding the name of the interim adult phase. Given the broadly accepted definition of adulthood at 18, Frank Furstenberg et al, for example, use the term 'early adulthood'[58] to distinguish young adults from mature adults. Jeffrey Arnett opts for 'emerging adulthood'.[59] More recently, in light of biological evidence of adolescence into the mid-20s, some, such as Laurence Steinberg, prefer the term

50 See Alan France, Julia Coffey, Steven Roberts and Catherine Waite, *Youth Sociology* (London: Red Globe Press, 2020) 3.

51 Jeffrey Jensen Arnett and Susan Taber, 'Adolescence Terminable and Interminable: When Does Adolescence End?' (1994) 23 *Journal of Youth and Adolescence* 517; Kennan Cepa and Frank F. Furstgenberg, 'Reaching Adulthood: Persistent Beliefs about the Importance and Timing of Adult Milestones' (2021) 42 *Journal of Family Issues* 27.

52 Nilsen, n 48 above.

53 Department for Levelling Up, Housing and Communities, *English Housing Survey Headline Report* (London: Gov.UK, 2021), para 1.38.

54 Miles Brignall, 'Young Britons Believe Dream of Owning Home is Over, Survey Says' *The Guardian* 31 July 2019.

55 Katherine Hill, Donald Hirsh, Juliet Stone and Ruth Webber, *Home Truths: Young Adults Living with their Parents in Low to Middle Income Families* (Edinburgh: Standard Life Foundation, 2021).

56 Teresa Fuhrman and Grayson N. Holmbeck, 'A Contextual-Moderator Analysis of Emotional Autonomy and Adjustment in Adolescence' (1995) 66 *Child Development* 793.

57 Rowan Arundel and Christian Lennartz, 'Returning to the Parental Home: Boomerang Moves of Younger Adults and the Welfare Regime Context' (2017) 27 *Journal of European Social Policy* 276. The reason for these social changes is beyond the scope of this paper.

58 Frank F. Furstenberg, Sheela Kennedy, Vonnie C. McCloy et al, 'Between Adolescence and Adulthood: Expectations about the Timing of Adulthood' *The Network on Transitions to Adulthood Research Network Working Paper 1* at https://www.researchgate.net/profile/Frank-Furstenberg-2/publication/237234266_Between_Adolescence_and_Adulthood_Expectations_about_the_Timing_of_Adulthood/links/5755a11108aec74acf5801da/Between-Adolescence-and-Adulthood-Expectations-about-the-Timing-of-Adulthood.pdf.

59 Jeffrey Jensen Arnett, *Emerging Adulthood: The Winding Road from the Late Teens through the Twenties* (New York, NY: OUP, 2004).

'adolescence' that we adopt in this article.[60] There is agreement neither as to nomenclature nor the start- and end-points of adolescence, but for our purposes what is useful is to consider the impact of the broad agreement that, sociologically, full or mature adulthood will rarely coincide with legal adulthood at 18 and may occur considerably later.

One potential impact is on the normative authority of the young adult's view which may be dependent on the opinions of others in a way that we have traditionally assigned to minors. Andrew Franklin-Hall has argued, for example, that welfarism with respect to adolescents can be justified on the basis of their stage-of-life.[61] Focusing on their educational phase, he argues that they are not yet stable in their views and values and are justifiably protected (and are thus freed from) certain difficult decisions that have long-term, potentially very harmful, consequences.[62] Susan Sawyer et al argue that social changes such as extensions to education completion and delays in settled partnerships and having children result in an often extended adolescence, and that consequently a more appropriate and inclusive definition of adolescence is required. Sawyer argues that the period of adolescence should encompass the ages between 10 and 24 years of age.[63]

Psychological indicators of maturity

So far, we have briefly set out a tension between the legal definition of adulthood based on chronological age, and social and biological evidence of prolonged transition phases, which we have referred to as 'adolescence'. Psychology offers an additional assessment that focuses not on the drivers of variation, but on its impact on the psychological maturity of the individual.[64]

Psychological research demonstrates the effects of biological and social factors on behaviour. Sara Johnson et al build on physiological research showing that the adolescent brain continues to develop beyond the teenage years and associate this finding with impacts on judgement and decision making.[65] We do not attempt to offer comprehensive coverage of the many impacts this might contribute to, but Mariam Arain et al have associated changes to the limbic system and underdevelopment of the prefrontal cortex with susceptibility to drink

60 Laurence Steinberg, *Age of Opportunity: Lessons from the New Science of Adolescence* (New York, NY: Houghton Mifflin Harcourt, 2014).

61 A. Franklin-Hall, 'On Becoming an Adult: Autonomy and the Moral Relevance of Life's Stages' (2013) 63 *Philosophical Quarterly* 223.

62 *ibid*, 246.

63 Sawyer, Azzopardi, Wickremarathne and Patton, n 39 above. And see Barbara M. Newman and Philip R. Newman, *Theories of Adolescent Development* (London: Elsevier, 2020) 2: 'Adolescence is a period of biological change that is taking place over the years from approximately age 10 to 24.'

64 See for example Arnett, n 59 above.

65 Sara B. Johnson, Robert W. Blum, and Jay N. Giedd, 'Adolescent Maturity and the Brain: The Promise and Pitfalls of Neuroscience Research in Adolescent Health Policy' (2009) 45 *Journal of Adolescent Health* 216.

driving, social maladjustments, drug abuse and offensive crimes.[66] Another example is the high incidence of injury-related deaths between the ages of 15 and 24. In the UK, injury accounts for 52.47 per cent of deaths between the ages of 15 and 24, but only 13.24 per cent of deaths between the ages of 35 to 54 (a 39.23 per cent decrease).[67]

Assimilating biological, social and psychological research, Steinberg[68] argues that adolescence lasts longer than ever previously acknowledged. He argues that the plasticity of the brain in late adolescence, particularly in the pre-frontal cortex which controls advance thinking, reasoning and self-control presents opportunities as well as threats. Better insight and acknowledgement of biological change and its psychological impact can, he argues, be used to help young adults to cultivate self-control, particularly when risk-taking reaches its height around the age of 18.

The start and end point of adolescence and the phases of adulthood are widely contested, but the impact of sociological and biological developments provide strong grounds for challenging the adequacy of legal adulthood at 18 as a proxy for developmental maturity. In 2012, Susan Sawyer et al called for greater recognition that the boundaries of adolescence are changing: that the age of puberty is decreasing and 'the age at which mature social roles are achieved is rising'.[69] Policy makers are increasingly taking these factors into consideration. A 2016 *Lancet* commission on adolescent health and wellbeing defines adolescence as the period between 10-24 years old. It recognises 'new understandings of adolescence as a critical phase in life for achieving human potential'.[70]

In conclusion, biological, social and psychological advances recognise the relevance of a transition period that extends into legal adulthood. We have referred to this as 'adolescence' in recognition of the underlying biological mechanisms that can impact on psychological or developmental maturity in late childhood and early adulthood. Adolescence can result in increased risk-taking, impulsivity and peer-orientation and limited ability to take into account both the long- and short-term consequences of a decision.

DEFINING CHARACTERISTICS OF DEVELOPMENTAL IMMATURITY

Recognition of agential impediments in some adolescent adults only takes us so far. The requirement in section 1 of the Children Act 1989 to make minors' welfare the paramount consideration does not apply to adult adolescents. Moreover, there are stark warnings from historical application of biological evidence

66 Mariam Arain, Maliha Haque, Lina Johal et al, 'Maturation of the Adolescent Brain' (2013) 9 *Neuropsychiatric Disease and Treatment* 449.

67 World Health Organisation, *Mortality Database* (2019) at https://www.who.int/data/data-collection-tools/who-mortality-database [https://perma.cc/9YCP-HPLK].

68 Steinberg, n 60 above.

69 Susan M. Sawyer, Rima A. Afifi, Linda H. Bearinger et al 'Adolescence: A Foundation for Future Health' (2012) 379 *Lancet* 1630.

70 Patton, Sawyer and Santelli et al, n 14 above. And see The Association for Young People's Health which works to meet the particular health needs of 10-25 year olds at https://ayph.org.uk/.

of disruption to the brain to justify control. There is evidence, for example, that lobotomy, electro-convulsive therapy and intense medication of psychosis has sometimes been used to socially control individuals rather than to serve their best interests.[71] Vulnerability does not denote universal impact or serve as a reason to medicalise adolescence. A blanket assumption of insufficient autonomy would be incompatible with the ethos of the Mental Capacity Act and would result in hard paternalism. Only if adult adolescents can be demonstrated to have insufficient autonomy to make a decision are welfare-based protections relevant, and the proof and degree of insufficiency are highly contentious. Reliable mechanisms are needed to determine both the factors impeding autonomous decision making and their impact on a particular decision.

In relation to the impact of physiological factors, the science is in its infancy, and, as we have acknowledged, social and environmental factors also contribute to a person's ability to make mature judgments. Furthermore, maturity is likely to fluctuate over time and will vary according to the subject matter. Thus, adolescence may entail a tendency to immature decision making, but is not of itself sufficient evidence of an inability to make mature decisions, and an adolescent 20-year-old will have very different capabilities to an adolescent 12-year-old.

If age combined with the harmfulness of the decision were sufficient to justify an assessment of capacity, however, tools might be developed to more accurately assess the impact of developmental maturity, which in turn would be relevant to the capacity assessment. We come to the legal test below and focus in this section on the potential to develop such a tool.

Psychologists have developed tools which can be used to determine the individual's 'developmental maturity',[72] lack of which may entail poor risk perception, lack of future perspective and susceptibility to influence,[73] as well as impulsivity and lack of responsibility and perspective.[74] Core characteristics of developmental maturity have been developed through psychological empirical research. They focus on (i) autonomy, including ability to incorporate and re-evaluate, (ii) cognitive capacities such as the ability to switch goals and make cost-benefit analyses, and (iii) emotional skills such as clear priorities, delayed gratification, psychological insight, identify formation and realistic expectations of self.[75] Tools and scales have been designed to assist clinical assessment of developmental maturity. For example, Randall Salekin and Anne-Marie Iselin have developed a measure that encompasses all three areas of autonomy,

71 Jason Luty, 'Controversial Treatments in Psychiatry' (2017) 23 BJPsych Advances 169.

72 Randall T. Salekin, Emily A. M. MacDougall and Natalie A. Harrison, 'Developmental Maturity and Sophistication-Maturity: Learning More About Its Purpose and Assessment' in Kirk Heilbrun, David DeMatteo and Naomi E. S. Goldstein (eds), *APA Handbook of Psychology and Juvenile Justice* (Washington, DC: American Psychological Association, 2016) 405-442.

73 Elisabeth S. Scott, Thomas Grisso, 'Evaluating Adolescent Decision-Making in Legal Contexts' (1995) 19 *Law and Human Behavior* 221.

74 Laurence Steinberg and Elizabeth Cauffman, 'Maturity of Judgment in Adolescence: Psychosocial Factors in Adolescent Decision Making' (1996) 20 *Law and Human Behavior* 249.

75 Salekin, MacDougall and Harrison, n 72 above.

cognitive skills and emotional skills,[76] and Laurence Steinberg and Kathryn Monahan have developed a short self-report measure to assess independence.[77]

Further research would be needed to adapt existing tools for use in the context of medical treatment decisions. As part of a mental capacity assessment, this might simply reassure those concerned that the assumption of capacity should not be rebutted. Sometimes, however, an assessment of psychological maturity might be relevant to a finding that the decision is not capacitous. The aim should be to give the minor, clinicians and family insight into any impediments to the young adult's agency and give that person support to make a capacitous decision, even if that decision is to refuse the life-sustaining treatment. If that is not possible at the time the decision is needed, then the decision might be overruled if that is in the person's best interests. The potential for such a tool is not mere conjecture, as we discuss in the next section.

RECOGNITION OF ADULT ADOLESCENCE IN CRIMINAL LAW

Recognition of adult adolescence in the courts is rare, but there are signs of increasing judicial willingness to recognise the distinct needs of young adults. In the context of immigration law, for example, domestic courts have recently been willing to move from their original position that Article 8 was not engaged outside relationships between spouses and minor children. It has recently been acknowledged that 'family life' can incorporate young adult children: 'A young adult living with his parents or siblings will normally have a family life to be respected under Article 8. A child enjoying a family life with his parents does not suddenly cease to have a family life at midnight as he turns 18 years of age'.[78]

In family law, some provisions now recognise that young adults have particular needs flowing from vulnerability or dependency, notwithstanding their having reached the age of majority. For example, Part 5 of the Children and Families Act 2014 provides for foster care to extend to the age of 21 in certain circumstances, and Part 3 sets out provisions for both children and 'young people' with special educational needs or disabilities. Section 83 defines a 'young person' as someone over compulsory school age but under 25.

In criminal law there is more explicit recognition of adult adolescence and specialist tools have been developed to assess the impact of adult adolescence on responsibility.[79] Before we describe the legal developments, we must first establish that the criminal model is a relevant comparator to adolescent medical treatment refusals. In that regard we accept Barry Lyons' argument that there

76 Randall T. Salekin, A. M. Iselin, 'The Risk-Sophistication Treatment Inventory' (2010) unpublished, as cited in Salekin, MacDougall and Harrison, n 72 above, 426.

77 Laurence Steinberg and Kathryn C. Monahan, 'Age Differences in Resistance to Peer Influence' (2005) 43 *Developmental Psychology* 1531.

78 *Singh* v *The Secretary of State for the Home Department* [2015] EWCA Civ 630 at [24] per Sir Stanley Burnton.

79 David Pimentel, 'The Widening Maturity Gap: Trying and Punishing Juveniles as Adults in an Era of Extended Adolescence' (2013-14) 4 Tex Tech L Rev 71.

is significant overlap in the types of responsibilities when someone commits a crime and refuses medical treatment,[80] a view supported by guidance from the United Nations recognising 'a close relationship between the notion of responsibility for delinquent or criminal behaviour and other social rights and responsibilities'.[81] Additionally, as we shall see, recognition of adult adolescence in criminal sentencing was established in reliance on research arguing for a greater recognition of adult adolescence in health decisions.[82] On these grounds, we consider that the criminal law example is a useful comparator model providing both a reason to consider adult adolescence in medical treatment refusal decisions and an example of how adult adolescence might be detected and its effects mitigated.

The criminal law has developed incrementally and only relatively recently has taken into account the impact of adolescence on agency, even up to the age of 18. In the influential US Supreme Court case of *Roper* v *Simmons* (*Roper*), a 17-year-old was convicted of murder and sentenced to death. The court ruled that the execution of a minor was unconstitutional.[83] An amicus brief from the American Psychological Association, considered in the course of the judgment, argued that his developing adolescent brain reduced his culpability.[84] The Supreme Court acknowledged that 'the personality traits of the juveniles are more transitory, less fixed'.[85] In consequence, the impact of adolescence on mature decision making, risk-taking, impulsivity, peer orientation and the ability to take into account both the long- and short-term consequences of a decision were accepted as relevant sentencing considerations.[86]

The UK criminal justice system has for some time recognised that different approaches are needed depending on an offender's age.[87] Any decision to prosecute a youth offender under the age of 18 must take into consideration the circumstance and general character of the accused.[88] A special system of youth

80 Barry Lyons, 'Dying to be Responsible: Adolescence, Autonomy and Responsibility' (2010) 30 *Legal Studies* 257. For our purposes, we are interested in the comparative relevance of the responsibilities that need to be demonstrated for someone to be found responsible for a) committing a crime and b) refusing life-sustaining medical treatment. We do not comment on Lyons' argument that the similarity is such that the age for each should be the same, except to acknowledge criticism of this view in Jonathan Herring, 'The Age of Criminal responsibility and the Age of Consent: Should they be any Different?' (2016) 67 N Ir Legal Q 343 and to note recognition of the potential for different civil and criminal law tests for capacity to engage in sexual relations in *A Local Authority* v *JB* [2021] UKSC 52 at [106] per Lord Stephens.

81 United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) (UN, 1985) 4.1.

82 *R* v *Daniels* [2019] EWCA Crim 296 at [32] citing Sawyer, Azzopardi, Wickremarathne and Patton, n 39 above, discussed below.

83 543 US 551 (2005). And see *Graham* v *Florida* 560 US 48 (2010); *Miller* v *Alabama* 567 US 460 (2012); *Montgomery* v *Louisiana* USSC No 14-280, granted Certiorari 23 March 2015.

84 On the impact of this line of argument see Aliya Haider, 'Roper v Simmons: The Role of the Science Brief' (2006) 375 Ohio State J Criminal Law 369.

85 n 83 above, 16.

86 See *Brief for the American Psychological Association, and the Missouri Psychological Association as Amici Curiae Supporting Respondent in Roper v Simmons* 19 July 2004 at https://www.apa.org/about/offices/ogc/amicus/roper.pdf [https://perma.cc/844S-4DXP]. It was also considered that the same factors can make adolescents vulnerable to coercion and false confession.

87 See for example Rob Allen, 'Young Adults and the Criminal Justice System' (2010) 174 *Criminal Law and Justice Weekly* 416.

88 *R* v *Chief Constable of Kent and Another ex parte L, R* v *DPP ex parte B* [1991] 93 Cr App R 416.

cautions[89] and sentencing guidelines[90] apply. Referring to *Roper* in the case of *R (Smith)* v *Secretary of State for the Home Department* (*Smith*), Baroness Hale said 'the great majority of juveniles are less blameworthy and more worthy of forgiveness than adult offenders … [A]n important aim, some would think the most important aim, of any sentence imposed should be to promote the process of maturation, the development of a sense of responsibility, and the growth of a healthy adult personality and identity.'[91]

The defendants in *Roper* and *Smith* were minors. Recently, in light of the scientific developments referred to above, similar reasoning has extended to adolescent adults. In 2018, the UK Justice Committee reported a lamentable lack of progress in recognising the need for a distinct approach to young adults up to 25 'while the brain is still developing'.[92] A previous Justice Committee report in 2016 had found that: 'Those parts of the brain influencing maturity that are the last to develop are responsible for controlling how individuals weigh long-term gains and costs against short-term rewards. As the system to regulate "reward seeking" is still evolving this affects how young adults judge situations and decide to act, including consequential thinking, future-oriented decisions, empathy, remorse, and planning.'[93]

The Government responded to the 2016 report with a new screening tool for maturity which can then be considered when sentencing, and improved transition between youth and adult systems. The 2018 report reiterated the need for more significant change. The aim is not to absolve young adults of responsibility, but to recognise that their adolescence can impact on their safety, reform and rehabilitation and on the effectiveness and fairness of sentences. Shortly after the report was published, Lord Chief Justice Burnett of Maldon argued in *The Times* that sentencing of young adults should take into consideration their maturity.[94] The matter was subsequently tested in the courts. In *R* v *Clarke (Morgan)*[95] (*Clarke*), citing scientific research published in the Lancet[96] and referred to above, which links adolescence and agential capacities, Lord Burnett was clear that maturity is relevant to sentencing even in early adulthood. Subsequently, in *R* v *Daniels* the Court of Appeal said: 'No doubt science will in time tell us more about the development of the young adult brain and its impact on behaviour. But there will be cases and this, in our view, is one of them

89 Crime and Disorder Act 1998, ss 66ZA, 66ZB inserted by Legal Aid Sentencing and Punishment of Offenders Act 2012, s 135(2).

90 Sentencing Guidelines Council, *Definitive Guideline: Overarching Principles Sentencing Youths* (November 2009).

91 *R (Smith)* v *Secretary of State for the Home Department* [2005] UKHL 51; [2006] 1 AC 159 at [25].

92 House of Commons Justice Committee, *Young Adults in the Criminal Justice System* HC 419 (2018) at https://publications.parliament.uk/pa/cm201719/cmselect/cmjust/419/419.pdf.

93 House of Commons Justice Committee, *The Treatment of Young Adults in the Criminal Justice System* HC169 (2016) para 8 at https://publications.parliament.uk/pa/cm201617/cmselect/cmjust/169/169.pdf.

94 Frances Gibb, 'Immature Offenders Don't Deserve Jail, Says Law Chief' *The Times* 3 May 2018.

95 *R* v *Clarke (Morgan)* [2018] EWCA Crim 185. See David Emanuel, Claire Mawer and Laura Janes, 'The Sentencing of Young Adults: A Distinct Group Requiring a Distinct Approach' (2021) 3 *Criminal Law Review* 203.

96 Sawyer, Azzopardi, Wickremarathne and Patton, n 39 above.

where there is material available to the sentencing court which speaks about the maturity and developmental reality of the offender in question.'[97]

The reliance on the Lancet article in *Clarke* links the appropriate legal response to scientific evidence of extended adolescence which, we would argue, is also pertinent to young adults making life-limiting refusals of treatment contrary to their best interests. The comparison between criminal sentencing and medical treatment decisions should not, however, be overstretched. When adolescence is considered in sentencing it might result in an alternative or reduced sentence. In medical treatment decisions it could result in the person being overruled and required to have medical treatment they do not want. The analogy is, however, relevant insofar as it demonstrates initial judicial acceptance of scientific evidence of extended adolescence and recognises its potential impact on agency.

SOLUTIONS

So far, we have problematised the current legal approach to treatment refusals, arguing that it is insufficiently cognisant of the impacts of socially and physiologically extended adolescence and their impact on autonomous decision making. We have suggested that neglecting a class of vulnerable people with potential agential impediments which, through the development of psychological tools, could be discerned with some accuracy, when evidence of analogous impediments in other vulnerable groups triggers protection, is normatively problematic. We turn now to the legal interpretation required to bring about a change of approach.

Mental Capacity Act 2005

The Mental Capacity Act 2005 sets out a series of principles in section 1, including that a person must be assumed to have capacity unless it is established that they lack capacity, that a person is not to be treated as unable to make a decision unless all practical steps to help them to do so have been taken without success, and that a person is not to be treated as unable to make a decision merely because they make an unwise decision.[98] The test for incapacity is set out in part in section 2(1). It requires that: 'For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is *unable to make a decision for himself* in relation to the matter *because of an impairment of, or a disturbance in the functioning of, the mind or brain*' (our emphasis).

Section 3(1) provides that a person is 'unable to make a decision' if he is unable (a) to understand the information relevant to the decision, (b) to retain the information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate the decision. Article 8 of the

97 *R* v *Daniels* n 82 above at [32].
98 ss 1(2), 1(3), 1(4) respectively.

European Convention on Human Rights (ECHR) is not violated if an adult is incapacitated by reason of mental incapacity and treated in their best interests.[99]

Is there potential for the presumption of capacity to be rebutted if an adult decision to refuse life-sustaining treatment could be shown to be impacted by developmental immaturity related to adolescence? At present this would be unlikely. We have argued that one reason for this is the legal recognition that legal adults are free to make unwise decisions and another is that, at present, tests to determine developmental immaturity are insufficiently advanced. An additional reason, which we explore further in this sub-section, flows from the current and outdated iteration of the Mental Capacity Act Code of Practice. The Code was set out in 2007, since when the case law has developed. A new draft Mental Capacity Act Code of Practice has recently been issued, subject to consultation.[100] In light of legal developments in criminal sentencing, recent case law on mental capacity, and the mounting evidence of adult adolescence and its impacts, we would suggest that there is good reason to reconsider the potential relevance of the 2005 Act to protect those adolescent adult patients who, through the development of psychological tools could potentially be shown to be unable to make an autonomous decision because of their developmental immaturity.

Based on *current* guidance, we would opine that developmental immaturity is unlikely to be relevant to a finding of incapacity and might not even trigger a capacity assessment. Let us begin by considering when capacity might be assessed. Practice guidance on medical treatment advises that where treatment is 'serious', 'special care and attention to the decision-making process' is needed.[101] This would suggest that a harmful decision by a developmentally immature young adult might trigger a capacity assessment. However, that is not inevitably the case due to the strong social and legal emphasis on the rights of 18-year-olds to make determinative decisions.

An assessment is more likely to be triggered under the new (currently draft) Code of Practice which sets out in more detail when an assessment is required. According to paragraph 4.5 an assessment would be relevant where '[t]he decision the person is proposing to take appears to be unwise, especially if they are putting either themselves or others at risk'. Paragraph 4.73 recommends a professional assessment of capacity whenever the decision would have serious consequences. The combination of this more detailed guidance and increasing recognition of the phenomenon of adult adolescence could increase the emphasis on assessing capacity if an adult adolescent refuses life-sustaining medical treatment against their best interests. Whilst the Act operates a presumption of capacity, it comes subject to the following proviso, set out in *Royal Bank of Scotland Plc* v *AB*:

> The presumption of capacity is important; it ensures proper respect for personal autonomy by requiring any decision as to a lack of capacity to be based on evidence.

99 *W* v *M* [2011] EWCOP 2443, [2012] 1 WLR 1653 at [95] per Baker J.

100 HM Government, *Draft Mental Capacity Act 2005 Code of Practice Including the Liberty Protection Safeguards* (March 2022).

101 *Applications Relating to Medical Treatment: Guidance Authorised by the Honourable Mr Justice Hayden, The Vice President of The Court of Protection* [2020] EWCOP 2 at [5].

> Yet the section 1(2) presumption like any other, has logical limits. When there is good reason for cause for concern, where there is legitimate doubt as to capacity, the presumption cannot be used to avoid taking responsibility for assessing and determining capacity. To do that would be to fail to respect personal autonomy in a different way.[102]

Once the assessment has been triggered, might a person with developmental immaturity be found to lack capacity? Before we consider the test for incapacity, two other barriers to such a finding must be considered. Section 2(3) provides that a lack of capacity cannot be made 'merely by reference to a person's age' and section 1(4) provides that 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision'. Whereas outcome is relevant in triggering an assessment of capacity, it will not drive its determination.[103] Peter Jackson J in *Heart of England NHS Foundation Trust* v *JB* said in another context: 'The temptation to base a judgment of a person's capacity upon whether they seem to have made a good or bad decision, and in particular on whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, expressed another way, to allow the tail of welfare to wag the dog of capacity.'[104]

Note, however, that sections 2(3) and 1(4) do not render the unwiseness of the decision or the age of the decision maker irrelevant. Rather they require that these are not the sole reasons for rebutting the presumption of capacity. In *A Local Authority* v *JB*, Lord Stephens recognised that the Act does not give individuals a right to make unwise decisions, if the unwise decision is not autonomous: 'Legal capacity depends on the application of sections 2 and 3 of the MCA together with the principles in section 1. It does not depend on the wisdom of the decision. Furthermore, an important purpose of the MCA is to promote autonomy. That purpose aids the interpretation of sections 2 and 3 of the MCA.'[105]

Having argued that sections 2(3) and 1(4) will not necessarily bar a finding that a person with developmental immaturity lacks capacity we can now consider the test for incapacity. The section 2(1) test set out above incorporates two elements. The current Code of Practice focuses on establishing impairment or disturbance of the mind or brain based largely on clinical diagnosis,[106] before going on to assess functional ability to make a decision.[107] On this understanding, a clinician arguing that a young adult is developmentally immature but who has no medical diagnosis pertinent to 'impairment' is unlikely to get past the first hurdle. But this interpretation is outdated. The Supreme Court in *A Local Authority* v *JB*[108] requires that the first step is to establish a functional inability to decide.[109] Once 'the matter' central to the decision is identified (in

102 [2020] UKEAT 0266_18_2702.
103 *R* v *Cooper* [2009] 1 WLR 1786 at [13].
104 [2014] EWHC 342 (COP) at [7].
105 *A Local Authority v JB* n 80 above at [51].
106 Department for Constitutional Affairs, *Mental Capacity Act Code of Practice* (London: TSO, 2007) para 4.12.
107 *Mental Capacity Act Code of Practice* 41, para 4.13.
108 *A Local Authority v JB* n 80 above.
109 *ibid* [67] and see *York City Council* v *C* [2013] EWCA Civ 478 at [37].

our case, refusal of a particular medical treatment), the court should turn to section 3(1)(a) to identify the 'information relevant to the decision', including information about the consequences of so deciding,[110] and consider whether the person can understand it. Section 3(1) sets out the factors relevant to an inability to make a decision. Many cases involve failures to use and weigh information under section 3(1)(c)[111] and this is likely to be the most relevant factor in the case of a person with developmental immaturity. Para 4.36 of the new draft Code offers guidance on assessment of a person's ability to use and weigh information. If the person understands the information but cannot use it or is led to making a decision without understanding or using the information they have been given, they might be found to lack capacity.

The bar for rebuttal of the presumption of capacity under section 3(1)(c) is high and is focussed on the ability to use and weigh not on how matters are weighed. In *Kings College Hospital NHS Foundation Trust* v *C & V,* MacDonald J said that: 'a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision making process'.[112]

This factor will help protect the current autonomy of adult adolescents who, due to their immaturity, make a decision they would, as mature adults, likely regret: it would not suffice to show that the adult's values would be likely one day to change. But if, as we have suggested, a psychological tool is developed to assess maturity and this is applied as part of the professional assessment of capacity, it could indicate where risk perception, independence or other factors impact on the decision to an extent that the court considers the person's ability to use and weigh renders the person unable to make a decision. In essence, the focus would be on the quality of the decision rather than its propensity to change.

If the person cannot make a decision, then the second part of section 2(1) is to address whether this is caused by 'an impairment of, or a disturbance in the functioning of, the mind or brain'.[113] The impairment need not be permanent,[114] or even a medical condition as such:[115] the new draft Code clarifies that a formal clinical diagnosis is not necessary for the purposes of establishing an impairment of the mind or brain.[116] The physiological evidence cited above, including waves of 'synaptic pruning' could, at this stage, potentially be considered sufficient, provided there is a causative nexus between the evidence of adolescence and the inability to decide. The relevance of developmental immaturity in criminal sentencing would be supportive.

110 *ibid* [69].
111 Alex Ruck Keene, Nuala B. Kane et al, 'Taking Capacity Seriously? Ten Years of Mental Capacity Disputes Before England's Court of Protection' (2019) 62 *International Journal of Law and Psychiatry* 56, para.4.9.
112 [2015] EWCOP 80 at [38].
113 *A Local Authority* v *JB* n 80 above at [78].
114 Mental Capacity Act 2005, s 2(2).
115 See Keene, n 111 above, para 4.7.
116 HM Government, *Draft Mental Capacity Act 2005 Code of Practice Including the Liberty Protection Safeguards* (March 2022), para 4.47.

Based on these arguments, hurdles to establishing incapacity where an adult suffers agential impediments as a result of developmental immaturity could potentially be overcome. In cases of doubt, application can be made to the Court of Protection by interested parties such as the hospital Trust or family under section 15 of the Mental Capacity Act for a declaration that the person lacks capacity and an assessment of their best interests.[117] Practice Guidance suggests that, in cases involving life-sustaining treatment, some cases *must* be put to the Court of Protection.[118] The cases falling into this category are set out in paragraph 8. The non-exhaustive list includes medical decisions that are finely balanced, involve a difference of medical opinion or a lack of agreement from those interested in the person's welfare or a potential conflict of interest amongst decision makers. As evidence of extended adolescence is better promulgated, understood and accepted, difference of medical opinion is increasingly likely. If such a case were to proceed to court, there would be an opportunity to issue specific guidance that would assist in future cases.

The court is likely to call upon expert evidence of understanding, risk appreciation and consideration of long- and short-term impacts, just as in the criminal courts where expert evidence relating to maturity is relevant to sentencing. The Court of Protection is not bound to follow expert evidence.[119] We would argue that pertinent to the consideration of whether to follow expert evidence would be consideration of how far experts are influenced by an outdated Code of Practice. If it is determined on the balance of probabilities that the individual lacks capacity then a decision can be made in their best interests under section 4. The relevant decision might be to uphold the adult's decision to refuse treatment.

We end this section by noting that acceptance of the position we advocate, whilst arguable on the wording of the Act, subsequent case law and the new draft Code, is subject to significant cultural and historical barriers. In this regard, it is useful to compare two cases, though neither concerns medical treatment. In *Hull City Council* v *KF*,[120] Poole J assessed the capacity of KF, who was 34 and had a moderate learning disability, to engage in sexual relations with KW, who had previously seriously assaulted, coerced and controlled her. A previous decision had been made on an interim basis that she had capacity to engage in sexual relations but lacked capacity to make decisions about residence, care and contact with others. Poole J disagreed with the former conclusion. The expert evidence suggested KF lacked the functional ability to decide the matter based on her inability to use and weigh the risks and benefits of contact, due

117 It is unlikely in this context that healthcare professionals could rely on section 5 of the Mental Capacity Act, to override an adolescent adult's decision. Section 5 provides a general authority to treat a patient who lacks capacity in their best interests. Not only is the matter finely balanced, but the adult is likely to be in disagreement with the assessment. See *Applications Relating to Medical Treatment: Guidance Authorised by the Honourable Mr Justice Hayden, The Vice President of The Court of Protection* n 101 above at [8]-[9].

118 *Applications Relating to Medical Treatment, ibid* at [9].

119 *King's College Hospital NHS Foundation Trust* v *C and V* n 112 above. And see *ibid* at [39] on the non-determinative nature of expert evidence as to capacity.

120 [2022] EWCOP 33.

to her learning disability.[121] It was in her best interests that whilst she should be facilitated to meet KW under supervised conditions, and to kiss and cuddle him if she so desired, she should not be permitted to spend time alone with a man who had previously caused her significant harm in circumstances where she could not use and weigh information about the risk he posed to her.

Contrast this case with *London Borough of Islington* v *EF*.[122] EF was 18 at the time of the hearing and, as the judge, Mr Verdan QC, was at pains to make clear in his opening paragraph: 'She is therefore an adult'. It was accepted by the parties that, though vulnerable on account of mental illness and a troubled childhood, she had capacity to decide whether or not to travel to Brazil to be with her lover GH: a man 11 years her senior whom she first met in a chat room when she was 14; a man who was wanted for investigation by the police in England for possession of child pornography including images of very young children. The evidence relating to capacity was recited but not questioned by the judge who went on to consider whether the inherent jurisdiction might be invoked in light of the undue influence the court accepted GH exerted. We turn to this aspect of the case in the next section. For now, it is pertinent to note that the experts and the court accepted that 'EF found it difficult to understand the risk that GH posed',[123] and that her age was relevant to her decision insofar as 'like many young women her age, she is likely to prioritise [pursuit of the relationship] above her own needs and her own welfare'.[124] The accepted view was that the unwise decision was not incapacitous because it was not accompanied by 'any form of disordered thinking or the influence of her mental illness'.[125]

We would argue that the assessment of capacity in EF warranted closer judicial consideration. Her understanding of risk, the lack of a requirement to link incapacity to a medical diagnosis and the relevance of her potential developmental immaturity should, we would argue, have been given greater consideration. Whilst unwise capacitous decisions should not be overturned, upholding unwise decisions where the dangers are not understood or the long-term consequences appreciated risks doing a great harm to a vulnerable adolescent.

Inherent jurisdiction

A second, more tenuous position is that some adult adolescents might be considered vulnerable in which case the court might use its inherent jurisdiction to protect their welfare. In *Re SA*, Munby J (as he was then) was 'satisfied that, even though SA has now reached her majority, she needs some element of

121 *ibid* at [23].
122 [2022] EWHC 803 (Fam).
123 *ibid* at [66].
124 *ibid* at [69].
125 *ibid* at [68].

continuing protection by the court'.[126] In that case, Munby J described this aspect of the inherent jurisdiction thus:

> … the inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either
>
> i. under constraint or
> ii. subject to coercion or undue influence or
> iii. for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.[127]

David Lock KC accepts grounds (i) and (ii) on the basis that a legal wrong has been done to the person. However, he argues that the bar for establishing undue influence is high: that coercion should be shown,[128] though this begs the question as to why coercion and undue influence were set out as alternative relevant grounds in *Re SA*. We have examined above psychological research indicating that social adolescence increasingly extends into early adulthood and that this can result in emotional reliance on (particularly) parents in decision making. It is unlikely that this factor alone would be sufficient to establish a ground for the court to intervene. But where there is evidence of strong parental influence to accept or refuse treatment that goes beyond mere persuasion,[129] and given the 'fuzzy-edged'[130] nature of this aspect of the inherent jurisdiction, the combined impact of internal and external influences on the adolescent could be sufficient to trigger an assessment of voluntariness by the court. Where so, the focus would be on establishing the person's wishes rather than substituting an objectively rational decision for the influenced one.[131] Where the operation of the High Court's inherent jurisdiction is facilitative rather than dictatorial, the Court of Appeal has found that it 'enhances, rather than breaches, [the person's] ECHR Article 8 rights'.[132]

Lock is critical of ground (iii) except where the person lacks capacity.[133] In *A NHS Trust* v *Dr A*,[134] an Iranian doctor went on hunger strike when the UK

126 *Re SA (Vulnerable Adult with Capacity: Marriage)* [2006] 1 FLR 867 at [121].
127 *ibid* at [77]. And approved by the Court of Appeal in *DL* n 7 above at [54] per McFarlane LJ.
128 D. Lock QC, 'Decision Making, Mental Capacity and Undue Influence: Do Hard Cases Make Bad – Or at least Fuzzy-Edged Law?' [2020] *Fam Law* 1624, 1632, citing *Wingrove* v *Wingrove* (1885) 11 PD 81: 'For actual undue influence, coercion needs to be shown'.
129 On which see *In re T (Adult: Refusal of Treatment)* n 3 above at [37] per Lord Donaldson MR: 'In some cases doctors will not only have to consider the capacity of the patient to refuse treatment, but also whether the refusal has been vitiated because it resulted not from the patient's will, but from the will of others … If … his will was overborne, the refusal will not have represented a true decision. In this context the relationship of the persuader to the patient – for example, spouse, parents or religious adviser – will be important, because some relationships more readily lend themselves to overbearing the patient's independent will than do others.'
130 Lock, n 128 above, 1624.
131 *DL* n 7 above at [67] per McFarlane LJ; and see *LBL* v *RYJ* v *VJ* [2010] EWHC 2665 at [62] per Macur J.
132 *DL ibid* at [67] per McFarlane LJ.
133 Lock, n 128 above, 1632.
134 [2013] EWHC 2442 (COP).

Border Agency rejected his claim for asylum. Dr A was found to lack mental capacity. For reasons not pertinent to our argument, his treatment fell into a gap between the Mental Capacity Act 2005 and the Mental Health Act 1983, and Baker J found that, in such circumstances, and given Dr A's lack of capacity, the inherent jurisdiction could be invoked to protect his welfare.

Lock views the invocation of the inherent jurisdiction on ground (iii) in cases where people are capacitous but vulnerable as resting on 'unsound foundations': it risks paternalistic intervention in the decision making of vulnerable people where there is no proven legal wrong inflicted on them.[135] The case law, however, suggests that there is scope for advancing the inherent jurisdiction to protect vulnerable groups. In *Southend-on-Sea Borough Council* v *Meyers*[136] for example, Hayden J made an order that a 97-year-old man be initially prevented from living with his son, as he capacitously desired, given the squalid and unsafe conditions. Hayden J said:

> I instinctively recoil from intervening in the decision making of a capacitious adult. However well motivated the State may be in seeking, paternalistically, to protect people from their own unwise decisions, it is a dangerous course which has the potential to threaten fundamental rights and freedoms. … the inherent jurisdiction is not ubiquitous and should be utilised sparingly. Here Mr Meyers' life requires to be protected and I consider that, ultimately, the State has an obligation to do so.[137]

The inherent jurisdiction is used in this case in a quasi-dictatorial manner, in order to facilitate the well-being of a person with capacity.[138] In follow-up hearings a care package was arranged that allowed Mr Meyers to return home, absent his son.[139] Sir James Munby has since expressed criticism of the case and called for a more conservative interpretation of the 'great safety net', so that it is never used in a manner that potentially breaches Article 8 of the ECHR which, as we have briefly discussed and explore further below, protects the right of individuals with capacity to make their own decisions.[140]

Returning to *London Borough of Islington* v *EF*,[141] it is clear that Sir James's position is highly influential. There, the court accepted that GH was an undue influence on EF.[142] EF was vulnerable due to a serious life-long mental health

135 Lock, n 128 above, 1624.
136 [2019] EWHC 399 (Fam), and see *London Borough of Croydon* v *KR and Anor* [2019] EWHC 2498 (Fam) at [63] per Lieven J.
137 *Southend-on-Sea Borough Council* v *Meyers ibid* at [42].
138 See 29 Essex Chambers, 'Southend-on-Sea Borough Council v Meyers' at https://www.39essex.com/cop_cases/southend-on-sea-borough-council-v-meyers/ [https://perma.cc/4F9C-MC43]: 'Although intended to be facilitative, rather than dictatorial, in its approach, the great safety net of the inherent jurisdiction is capable of "facilitating" a vulnerable adult to move in one direction, by removing all other available choices.'
139 See 'Blind Care Row Veteran, 98, "Living Again" After Court Battle' BBC News 20 March 2019 at https://www.bbc.co.uk/news/uk-england-essex-47628084 [https://perma.cc/7SNX-KMHF].
140 J. Munby 'Whither the Inherent Jurisdiction? How Did We Get Here? Where Are We Now? Where Are We Going?' (2021) 51 Fam Law 215 (Part I); (2021) 51 Fam Law 365 (Part II); (2021) 51 Fam Law 508 (Part III).
141 n 122 above.
142 *ibid* at [90].

disorder, and had in the past expressed suicidal ideation,[143] though was at the time of the hearing mentally stable. She had a troubled family history. Travelling to Brazil with GH would be 'very unwise'.[144] But these factors were not considered sufficient to invoke the great safety net: 'Although the MCA does not apply I think … that I should assume EF is able to make her own decisions and should not be treated as being unable to merely because she is making unwise ones.'[145]

We agree that decisions should not be overturned merely because they are considered by others to be unwise. We would argue, however, that on an assessment of proportionality and necessity, overruling EF might be compatible with Article 8 on the basis of her vulnerability, the operation of undue influence and her failure to appreciate the risks. Where so, the aim should be to give her time and support to think through her decision and its consequences and make a voluntary decision. In exceptional circumstances, we consider there to be considerable value in Hayden J's recognition that a temporary dictatorial approach can facilitate an outcome that allows the individual to exercise their autonomy in relative safety, though of course there is no guarantee that time and support would lead to an objectively rational decision.

The inherent jurisdiction is not a comprehensive safety net. It will not and should not provide a means by which decisions impacted by developmental immaturity can be routinely overruled. It has limited potential to protect adult adolescents, and that potential depends on wider acceptance of the new scientific evidence of the causes and impact of developmental immaturity, as well as evidence of its particular impact on the will of the individual in the circumstances and a recognition that whilst decisions should not be overridden merely because they are unwise, the unwiseness may be indicative of the influence under which they operate. Even then, it would also require evidence that on the particular facts, intervention might facilitate the agential capacities that are shown to be lacking in the initial decision.

Statute

We would favour an interpretation of the Mental Capacity Act to assess capacity where there are doubts as to the developmental maturity of young adults. We briefly raise an additional possibility before we conclude, namely the option of legislating to impose blanket protection on adult adolescents who refuse life-sustaining treatment.

Legislation, or potentially simply amendment of the Mental Capacity Act Code of Practice, could require formal assessments of mental capacity in all cases where a young adult refuses life-sustaining medical treatment. In theory this could incorporate a developmental maturity test similar to that applied in relation to criminal sentencing.

143 *ibid* at [23].
144 *ibid* at [110].
145 *ibid* at [95].

Alternatively, and in light of the approach taken in *EF* which indicates strong opposition to overturning harmful decisions when the agency of the adult is compromised, a more paternalistic stance would be to restrict young adults' powers to refuse life-sustaining treatment that is not in their best interests. There are examples of legislative restrictions that apply beyond the age of majority, denying the adult the requisite legal capacity to make a particular decision or act in a particular way. Section 51 of the Adoption and Children Act 2002 prevents an adult adopting a child until 21 and section 101 of the Road Traffic Act 1988 does not allow under 21s to drive heavy machinery. New legislation could potentially recognise the age of majority at 18 but restrict legal capacity[146] to make life-sustaining treatment decisions contrary to their best interests to the age of 21 or even 24. This way, the outcome of their decisions would be highly relevant whereas it is irrelevant to a finding of incapacity. The individual assessment of agency would be pertinent to best interests decision making so that the greater the evidence that the decision is autonomous, the more likely it is that the decision is in the person's best interests. A rebuttable presumption that a decision is in the young adult's best interests could allow healthcare professionals and others to challenge decisions where they believe agency is impacted by immaturity or limited risk appreciation, for example, even if those impediments were not sufficient to rebut the presumption of mental capacity.

Would such legislation be human rights compliant? The European Court of Human Rights has recognised the intrinsic value of self-determination which is protected by Article 8(1) of the ECHR.[147] Article 8 is a qualified right and, if engaged, is not violated if it is a necessary response to a pressing social need and is proportionate to a legitimate aim, such as the protection of health.[148] The Strasbourg Court grants States Parties a margin of appreciation in how this applies. There is authority from the Strasbourg Court that Article 8 does not pose a barrier to non-consensual treatment in a minor's best interests.[149] For adults, a higher bar has been established. Compliance with Article 8 could however rest on proof of developmental immaturity and its impact on the serious medical treatment decision.

There was found to be no breach of Article 3 with respect to treatment of minors against their wishes in *Re X*.[150] Article 3 is an unqualified provision protecting people from inhuman and degrading treatment. Strasbourg jurisprudence makes clear that Article 3 will not 'as a general rule' be violated in cases of medical necessity.[151] Whilst there is some suggestion that violation could occur if the person refusing treatment has capacity,[152] Sir James considered that, in principle, minors are not yet fully autonomous.[153] They are not 'in all

146 In Scotland, for example, the age of majority is 18 (Age of Majority (Scotland) Act 1969) and the age of legal capacity is 16 (Age of Legal Capacity (Scotland) Act 1991).
147 *Tysiac* v *Poland* App No 5410/03, 20 March 2007 at [107].
148 ECHR, Art 8(2). On necessity and proportionality see *K* v *LBX* [2012] EWCA Civ 79, [2012] 1 FCR 441 at [35] per Thorpe LJ.
149 See *Vavřiččka and Others* v *the Czech Republic* [GC] App Nos 47621/13, 3867/14, 73094/14, 19298/15, 19306/15 and 43883/15, 8 April 2021 at § [282].
150 *Re X* n 9 above at [109]-[121].
151 *Nevmerzhitsky* v *Ukraine* (2006) 43 EHRR 32 at [94].
152 *Aggerholm* v *Denmark* App 45439/18, 15 September 2020.
153 *Re X* n 9 above at [117].

circumstances autonomous in the sense that a capacitous adult is autonomous; nor, specifically, [is] a child … autonomous when it comes to deciding whether or not to accept life-saving medical treatment'.[154]

There is some ambiguity as to the normative justification for this position. If it flows from the availability of a hard paternalistic override, then the justification is subject to criticism on the basis that it would seem to rely on the fact that there is a judicial override to justify judicial override. Alternatively, the justification lies in the different quality of autonomy vis-à-vis a child with capacity and a mature adult with capacity based on their relative maturity and life experience. If so, then the justification relies on soft rather than hard paternalism: whilst a minor's capacitous decision can in law be overruled, it is a decision that is nonetheless not considered to be fully autonomous. A similar argument could be raised with respect to adult adolescents shown to be impacted by developmental immaturity.

CONCLUSIONS

In *AC* v *Manitoba*, the Supreme Court of Canada said in a case involving a minor refusing medical treatment: 'Many experts suggest that due to the very nature of adolescence, adolescent choices may be particularly prone to defects in decisional autonomy.'[155] The court opined that 'while many adolescents may have the technical ability to make complex decisions, this does not always mean they will have the necessary maturity and independence of judgment to make truly autonomous choices'.[156]

We have seen in this article that whilst the 'nature of adolescence' is still contested, there is gradual acceptance in law, policy and practice that the term rightfully extends to young adults in their early 20s.[157] Sawyer et al declare: 'Arguably, the transition period from childhood to adulthood now occupies a greater portion of the life course than ever before at a time when unprecedented social forces, including marketing and digital media, are affecting health and wellbeing across these years. An expanded and more inclusive definition of adolescence is essential for developmentally appropriate framing of laws, social policies, and service systems.'[158]

As the scope and impacts of adolescence described in this article gain broader acceptance, there is potential to advance the protection of the welfare and autonomy rights of both minors and young adults. For minors, it is already the case that compelling evidence that a treatment decision is autonomous can lead to the minor's view being determinative in the assessment of their welfare.[159] There is potential to develop psychological assessment tools that

154 *ibid* at [120].
155 *ibid* at [73].
156 *AC* v *Manitoba (Director of Child and Family Services)* 2009 SCC 30 at [71]. And see *Re X* n 9 above at [117].
157 Newman and Newman, n 63 above.
158 Sawyer et al, n 39 above.
159 *E & F* n 19 above at [66].

would articulate with greater finesse when and why a minor's decision is less autonomous than a mature adult's.

The focus in this article has been on adolescence in early adulthood where capacity and voluntariness are linked to the right to make a determinative decision. We accept the differential treatment of adults and minors but argue that this of itself does not prevent further differentiation between groups of adults if some groups can be shown to be vulnerable and deserving of protection.

The conventional wisdom is to uphold adult decisions notwithstanding potential defects in agency flowing from adolescence and accept this as an implication of the bright line approach separating minors and adults. Whilst this was acceptable historically when the agential defects that flow from adolescence were poorly understood, it is more controversial in light of advanced scientific and social understanding of adolescence and the potential to develop more accurate psychological measures of its effects. We have shown that other areas of law are increasingly cognisant of the impact of adolescence into adulthood and called for consistency.

Some will argue that the position taken in this article constitutes an unjustified attack on young people's valid and autonomous choices. We would counterargue that the law already recognises that neither age nor mental capacity are suitable proxies for the sufficiency of autonomy in decision making about life-sustaining treatment. Provided the defects in autonomy and its impacts can be identified with sufficient accuracy; that the primary aim is to facilitate a capacitous and voluntary decision; and that a failure to achieve that aim in the relevant timeframe leads to a best interests decision, the will of the adolescent can be balanced appropriately with their protection. This would require change within the existing legal framework: acceptance of a broader conception of adolescence, the development of a specific assessment tool, and a more flexible interpretation of the test for mental incapacity so that assessments of capacity are triggered by the unwiseness of a decision that would have a seriously harmful outcome.