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RECONCILING CONFLICTING APPROACHES TO CHILDREN'S DECISION-MAKING CAPACITY IN AUSTRALIAN HEALTH AND CRIMINAL LAW

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ABSTRACT

Children's decision-making is intricate, influenced by factors like cognitive development, maturity, upbringing, and circumstances. In Australia, health law recognizes children's autonomy, allowing mature minors to consent to beneficial medical treatment, yet it restricts them from making life-altering decisions against their best interests. Conversely, criminal law adopts a punitive stance, holding older children (aged 14 and above) fully accountable for their actions as adults, without considering developmental maturity or contextual factors. This creates a conflict: health law protects children's vulnerability, while criminal law imposes adult-level responsibility. This article examines whether these divergent approaches to assessing children's decisional capacity in Australian law can be reconciled. It critiques the mature minor principle in health law, which balances autonomy and protection, and contrasts it with the criminal law's rigid age-based thresholds, such as the presumption of doli incapax for younger children. By analyzing these frameworks from a socio-legal perspective, the paper highlights inconsistencies and proposes aligning legal approaches to better reflect children's developmental immaturity, ensuring fairer treatment across both domains.

Keywords: *children; decision-making; capacity; criminal responsibility; health law; criminal law*

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1. INTRODUCTION

The process of decision-making in children is multifaceted and influenced by a variety of factors, including cognitive abilities, developmental maturity, intelligence, psychological well-being, and individual circumstances (Re Alex, 2004). The complexity arises because children develop at varying rates, and their capacity to make informed, rational choices depends on the nature of the decision. For instance, a child may grasp the necessity of pain relief but struggle to comprehend the implications of refusing life-sustaining medical treatment (Hunter and New England Area Health Services v A, 2009). This variability makes it challenging to establish a universal age at which children can be deemed capable of making decisions. Setting an arbitrary age for decision-making capacity can undermine a child's autonomy by assuming incapacity until adulthood, disregarding their individual maturity. However, allowing children to make all decisions independently could expose them to risks, particularly when their choices conflict with their best interests. This tension creates significant challenges for policymakers and courts in determining how to appropriately involve children in decisions that affect them.

In the realm of health law, Australian legal frameworks strive to balance children's autonomy with their vulnerability. The mature minor principle, derived from the landmark UK case Gillick v West Norfolk and Wisbech Area Health Authority (1986), known as Gillick competency, has been adopted in Australia to address this balance. This principle recognizes that children with sufficient maturity and understanding can consent to beneficial healthcare decisions without parental involvement (Gillick v West Norfolk and Wisbech Area Health Authority, 1986). By focusing on a child's developmental stage rather than a fixed age, the mature minor principle acknowledges the complexities of children's decision-making capacities. It allows children who demonstrate adequate comprehension to have a say in their medical treatment, reflecting respect for their autonomy. However, this framework has limitations, particularly in cases involving life-altering decisions or refusals of treatment, where courts often prioritize a child's best interests over their autonomous wishes. These limitations will be explored in detail to highlight the nuances of applying this principle in practice.

In contrast, Australia's criminal law takes a markedly different approach to children's decision-making. It assumes that children aged 14 and older possess the same decisional capacity as adults, holding them fully accountable for their actions without considering factors such as maturity or contextual influences (Moritz & Tuomi, 2022). For younger children, aged 10 to 13, a rebuttable presumption of doli incapax applies, meaning they are presumed incapable of criminal responsibility unless the prosecution can prove otherwise (RP v The Queen, 2016). This presumption evaluates whether a child understood their actions were seriously wrong, but it often fails to account for developmental nuances or environmental factors, such as peer pressure or socioeconomic disadvantage, that influence decision-making. The criminal law's

approach is thus more punitive, treating older children as fully responsible, in stark contrast to the protective mechanisms of health law.

The conflicting approaches of health and criminal law create a dichotomy in how children's decisional capacity is assessed in Australia. Health law seeks to protect children by limiting their ability to make decisions that could harm them, even when they demonstrate maturity, while criminal law imposes adult-level accountability without regard for developmental immaturity. This inconsistency raises questions about fairness and the appropriate recognition of children's evolving capacities. When the law disregards children's views or fails to assign appropriate weight to their maturity, it risks violating human rights obligations, such as those outlined in the Convention on the Rights of the Child (1990), which emphasizes that children capable of forming views should have those views considered in decisions affecting them (United Nations Convention on the Rights of the Child, 1990).

This article examines these divergent legal frameworks through a socio-legal lens, drawing on interdisciplinary perspectives to analyze how Australian law addresses children's decision-making (O'Donovan, 2016; Freckelton, 2013). It focuses specifically on health and criminal law due to their contrasting approaches to children's autonomy and responsibility. Health law's mature minor principle offers a nuanced, individualized assessment of capacity, while criminal law's reliance on age-based thresholds overlooks developmental complexities. The analysis explores whether these conflicting approaches can be reconciled to create a more consistent legal framework that respects children's evolving capacities while protecting their best interests.

The article is structured into five key sections to address this issue comprehensively. Section 2 delves into the mature minor principle within health law, examining its application and limitations. It highlights the factors influencing children's decision-making, the arbitrariness of fixed age thresholds, and the prioritization of best interests over autonomy in healthcare decisions. This section underscores the protective yet autonomy-respecting nature of health law, which contrasts sharply with criminal law's approach. Section 3 explores criminal law's treatment of children's decision-making, focusing on the age of criminal responsibility and the doli incapax presumption. It critiques the punitive nature of holding older children to adult standards and reviews proposed reforms, such as raising the age of criminal responsibility or extending capacity assessments (Crofts, 2015; Fitz-Gibbon & O'Brien, 2019). Section 4 analyzes the conflicts between health and criminal law approaches from a socio-legal perspective, arguing that it is inconsistent to restrict mature children's healthcare decisions while holding them fully accountable for criminal actions. It proposes that a more cohesive approach, incorporating individualized capacity assessments, could address this discrepancy. Finally, Section 5 concludes by evaluating whether these divergent approaches can be reconciled to better align with children's developmental realities and human rights obligations.

While the article primarily focuses on Australian law, it draws on international perspectives, particularly from the United Kingdom, to provide comparative context and demonstrate the broader applicability of its findings (Gillick v West Norfolk and Wisbech Area Health Authority, 1986). The UK's adoption of the mature minor principle and its approach to criminal responsibility, including the abolition of doli incapax in some contexts, offer valuable insights into similar legal trends (Crime and Disorder Act, 1998). By referencing these international frameworks, the article highlights the global relevance of reconciling children's decisional capacity assessments. Ultimately, it aims to contribute to the ongoing discourse on how legal systems can better reflect the complexities of children's decision-making, ensuring fairness and protection across different legal domains.

2. HEALTHCARE DECISION-MAKING

The framework governing children's decision-making in healthcare is complex, shaped by the interplay of parental responsibility, legal protections, and the recognition of children's evolving autonomy. Historically, children were viewed as extensions of their parents, akin to property, with parents holding near-absolute authority over their decisions (Freeman, 1992). However, contemporary legal and social perspectives have shifted dramatically, recognizing children as individuals with their own rights. This evolution reflects a move away from parent-centric control toward a model of parental responsibility that prioritizes the child's well-being (Bridgeman, 2007). In Australia, parental responsibility encompasses the duties, powers, and authority legally conferred upon parents to make decisions in the best interests of their children (Family Law Act 1975 (Cth), s 61B). This framework assumes that children, particularly younger ones, lack the capacity to make informed decisions, necessitating parental oversight to safeguard their welfare (Secretary, Department of Health and Community Services v JWB and SMB, 1992).

The concept of parental responsibility is rooted in the principle that parents are best positioned to determine what is in their child's best interests, particularly in healthcare contexts. The best interests standard, as articulated in the Convention on the Rights of the Child (1990, art 3), emphasizes protection and care necessary for a child's well-being. However, this paternalistic approach can sometimes conflict with a child's autonomy. Mullin (2014) argues that overriding a child's autonomy in the name of best interests may not always serve their overall well-being, as it can stifle their ability to develop decision-making skills and self-determination. This tension between protection and autonomy is a central challenge in healthcare decision-making for children, as the law seeks to balance respecting their growing independence with safeguarding their vulnerability.

Children's autonomy is a cornerstone of human rights law, particularly under the Convention on the Rights of the Child (1990). Convention mandates that children capable of forming their own views should have the opportunity to express them freely, with those views given due weight according to the child's age and maturity (United

Nations Convention on the Rights of the Child, 1990). This principle underscores the importance of involving children in decisions that affect them, even if their views do not ultimately override those of parents or legal authorities. Krappman (2010) highlights that even young children can articulate preferences and contribute to decision-making processes, provided their capacity is appropriately assessed. However, the weight given to a child's input varies depending on their age, maturity, and the specific legal framework in place, as well as the nature of the decision itself (Alderson et al., 2022).

In healthcare, children are generally presumed to lack decisional capacity, a concept known as presumptive decisional incapacity (Harvey, 2003). Unlike adults, who are presumed competent unless proven otherwise (Re MB, 1997), children must demonstrate their capacity to make informed decisions. Capacity in this context refers to the ability to understand the nature, consequences, risks, and benefits of a decision (Re C, 1994). This presumption of incapacity can be rebutted through the mature minor principle, a legal doctrine originating in the United Kingdom and adopted in Australia, which allows children with sufficient maturity and understanding to consent to certain medical treatments without parental involvement (Gillick v West Norfolk and Wisbech Area Health Authority, 1986).

The mature minor principle, often referred to as Gillick competency, emerged from the landmark case of *Gillick v West Norfolk and Wisbech Area Health Authority* (1986). In this case, the UK House of Lords addressed a dispute over whether medical practitioners could provide confidential contraception advice to children under 16 without parental consent. The Department of Health and Social Security's memorandum at the time encouraged doctors to involve parents but prioritized the child's ability to seek medical advice independently, arguing that requiring parental consent might deter children from accessing necessary care. Mrs. Gillick challenged this policy, asserting that it undermined her parental rights to control her daughters' medical decisions. The House of Lords ultimately ruled that children with sufficient understanding and intelligence to comprehend the proposed treatment could consent to it independently, establishing the mature minor principle (Gillick v West Norfolk and Wisbech Area Health Authority, 1986). This decision marked a significant shift toward recognizing children's autonomy in healthcare, acknowledging that maturity, rather than chronological age, should guide decision-making capacity.

In Australia, the mature minor principle was formally adopted in *Secretary, Department of Health and Community Services v JWB and SMB* (1992), commonly known as *Marion's case*. This case involved a child with severe intellectual and physical disabilities, whose parents sought authorization for a sterilization procedure. The High Court of Australia clarified that children could consent to medical treatment if they were Gillick competent meaning they possessed sufficient intelligence and understanding to make informed decisions or if the Family Court authorized the procedure (Secretary, Department of Health and Community Services v JWB and SMB,

1992). The Court emphasized that capacity varies depending on the individual child's maturity and the complexity of the decision, aligning with psychological and developmental research. The ruling also acknowledged the challenges of assessing capacity in children with disabilities, noting that intellectual impairments do not uniformly preclude decision-making capacity. This individualized approach ensures that children's unique circumstances are considered, avoiding blanket assumptions about their abilities.

The mature minor principle has been codified in some Australian jurisdictions, complementing the common law framework. In South Australia, for instance, children aged 16 and older are presumed to have the capacity to make medical decisions as effectively as adults (Consent to Medical Treatment and Palliative Care Act (1995). This applies to a broad range of healthcare services, including diagnosis, maintenance, and treatment of physical or mental conditions. However, children under 16 in South Australia must rely on the common law Gillick test to establish their capacity. Similarly, in New South Wales, children aged 14 and older are deemed competent to consent to medical treatment, but parental consent remains an option for those under 16 (Minors (Property and Contracts) Act (1970). These legislative provisions reinforce the mature minor principle by setting age-based thresholds for presumed capacity while maintaining flexibility for younger children to demonstrate competence through individual assessments.

The mature minor principle has transformed healthcare decision-making by empowering children to participate in decisions that affect their health, provided they meet the requisite threshold of understanding. This approach contrasts sharply with historical views of children as parental property, emphasizing their agency and evolving capacities (Montgomery, 1988). However, the principle is not without limitations. As a common law doctrine established nearly four decades ago, it struggles to address contemporary healthcare issues, such as those involving emerging medical technologies or complex ethical dilemmas (Telfer et al., 2018). Thomson (2001) argues that the Gillick framework lacks clarity in defining what constitutes sufficient understanding and intelligence, creating challenges for healthcare practitioners tasked with assessing children's competency. In clinical settings, time constraints and the subjective nature of assessing maturity can complicate the application of the principle, potentially leading to inconsistent outcomes (ibid.). Moreover, the principle is rarely applied outside healthcare contexts, limiting its broader utility in recognizing children's decision-making capacities in other legal domains (Young, 2019).

Three critical themes emerge from the mature minor principle and related health law commentary, which are central to understanding children's decisional capacity in healthcare and provide a foundation for comparing it to criminal law approaches:

1. **Factors Influencing Children's Decision-Making**: Children's ability to make rational, informed decisions is shaped by a multitude of factors, including their neurological development, psychological state, social environment, and the

specific context of the decision (Dickey & Deatrick, 2000). These factors create a complex landscape that requires individualized assessments rather than uniform standards.

2. **Arbitrariness of Prescribed Decision-Making Ages**: Setting fixed age thresholds for decision-making capacity is problematic, as it fails to account for the variability in children's developmental trajectories and can undermine their autonomy or expose them to harm (Freckelton & McGregor, 2016).
3. **Best Interests Overriding Autonomy**: Despite recognizing children's autonomy, health law prioritizes their best interests, often overriding their decisions when they conflict with medical or judicial assessments of what is beneficial (Willmott et al., 2018). This protective approach limits the scope of children's decision-making authority, particularly in high-stakes situations.

These themes are explored in depth below to elucidate the nuances of children's healthcare decision-making and highlight the contrasts with criminal law approaches.

2.1. Factors Influencing Children's Decision-Making

The complexity of children's decision-making capacity in healthcare stems from the interplay of developmental, psychological, and social factors. As Dickey and Deatrick (2000) note, rational decision-making is inherently multifaceted, and determining when children can make sound healthcare choices requires a comprehensive approach. No single perspective whether legal, medical, or social can fully capture the nuances of a child's capacity, and disagreements among stakeholders often arise due to differing interpretations of competence. The High Court of Australia, in *Marion's case* (1992), recognized that a child's legal capacity to make decisions is not fixed but varies based on the decision's gravity and the child's maturity (Secretary, Department of Health and Community Services v JWB and SMB, 1992). This variability underscores the need for individualized assessments that consider the child's unique circumstances.

Neurological development plays a significant role in shaping children's decision-making abilities. Research indicates that adolescents undergo significant brain development, particularly in areas responsible for impulse control, emotional regulation, and risk assessment (Grootens-Wiegers et al., 2017). From around age 12, children may exhibit competence in decision-making, but their ability is moderated by the early development of the brain's reward system and the delayed maturation of control mechanisms. This developmental asymmetry makes adolescents particularly susceptible to impulsive or emotionally driven decisions, especially in high-pressure or peer-influenced contexts (Steinberg, 2009). For instance, adolescents are more likely to engage in risk-taking behaviors when surrounded by peers, a tendency that diminishes as they mature into adulthood due to changes in brain development (Blakemore & Robbins, 2012; Steinberg, 2007; Reyna & Farley, 2006).

Psychosocial factors further complicate children's decision-making. Adolescents are more sensitive to peer pressure, have less developed self-regulation skills, and are

less oriented toward long-term consequences compared to adults (Steinberg, 2009). These factors are particularly pronounced in "hot" contexts situations involving high emotional arousal where adolescents may act impulsively due to underdeveloped emotional regulation (Blakemore & Robbins, 2012). In contrast, "cold" contexts, where decisions are made deliberately and without emotional pressure, allow for more rational decision-making, though adolescents still lag behind adults in cognitive maturity (Steinberg & Icenogle, 2019). Pubertal changes also contribute to impulsive and sensation-seeking behaviors, further complicating adolescents' ability to make informed choices (Moritz & Christensen, 2020; Galvan et al., 2007). These developmental realities highlight the need for legal frameworks that account for the dynamic nature of children's decision-making capacities.

The case of *Application of a Local Health District; Re a Patient Fay* (2016) illustrates the spectrum of capacity in healthcare decision-making. The court emphasized that capacity exists on a continuum, influenced by the decision's significance and the individual's understanding (Application of a Local Health District; Re a Patient Fay, 2016). This spectrum applies to both adults and children, but children face a higher burden to demonstrate competence due to their presumed incapacity (Re MB, 1997). The individualized nature of capacity assessments in healthcare ensures that decisions are tailored to the child's developmental stage, but it also underscores the challenge of applying uniform standards across diverse cases.

2.2. Appropriate Decision-Making Ages

Assigning a fixed age for decision-making capacity is inherently problematic, as it fails to reflect the variability in children's developmental trajectories. Lord Scarman, in *Gillick v West Norfolk and Wisbech Area Health Authority* (1986), acknowledged the appeal of fixed age limits for their legal certainty but cautioned against their rigidity, which can obstruct justice and fail to account for the continuous process of human development (Gillick v West Norfolk and Wisbech Area Health Authority, 1986, p. 186). A prescribed age of majority, while administratively convenient, does not align with the scientific understanding of brain development, which shows that children mature at different rates (McLean, 2000). Some children may exhibit adult-like decision-making capacities at a young age, while some adults may lack the maturity typically associated with adulthood (Freckelton & McGregor, 2016).

The mature minor principle addresses this issue by focusing on individual assessments rather than arbitrary age thresholds. By evaluating a child's understanding and maturity, the principle allows for flexibility in determining when a child can consent to medical treatment (Gillick v West Norfolk and Wisbech Area Health Authority, 1986). This approach aligns with the developmental literature, which highlights the gradual nature of cognitive and emotional maturation (Steinberg & Icenogle, 2019). However, legislative frameworks in some jurisdictions, such as South Australia and New South Wales, still rely on age-based thresholds for presumed capacity, which can limit the flexibility of the mature minor principle for younger

children (Consent to Medical Treatment and Palliative Care Act 1995 (SA); Minors (Property and Contracts) Act 1970 (NSW)).

The arbitrariness of age-based thresholds is particularly evident when considering the neurological evidence. Delmage (2013) notes that scientific absolutes, such as the stages of brain development, do not easily translate into legal absolutes, creating a disconnect between science and law. For example, a child's capacity to understand the implications of a medical decision may vary significantly from their ability to navigate complex social or legal consequences, yet age-based laws often fail to account for these differences (McLean, 2000). The mature minor principle mitigates this issue by prioritizing individual assessments, but its application remains limited to healthcare contexts, leaving other areas of law, such as criminal justice, reliant on rigid age thresholds.

2.3. Children's Best Interests

The concept of best interests is a cornerstone of healthcare decision-making for children, guiding parents, healthcare practitioners, and courts in determining appropriate outcomes. Best interests encompass a range of factors, including physical, emotional, psychological, and socio-cultural considerations, but the concept is inherently subjective and context-dependent (Re B and B: Family Law Reform Act, 1997). Willmott et al. (2018) note that best interests are typically associated with treatments that cure or improve a child's health, supported by medical evidence regarding diagnosis, prognosis, or treatment efficacy. However, the subjective nature of best interests can lead to varying interpretations, as different stakeholders may reach different conclusions based on the same circumstances (Director Clinical Services, Child and Adolescent Health Services and Kiszko, 2016).

In healthcare, parents are generally considered the primary decision-makers for their children, as they are presumed to act in the child's best interests (Gillick v West Norfolk and Wisbech Area Health Authority, 1986). However, this authority is not absolute. The Supreme Courts of Australia exercise *parens patriae* jurisdiction to protect individuals, including children, who cannot protect themselves (Carseldine v Department of Children's Services, 1974). This jurisdiction allows courts to override parental or child decisions if they are deemed contrary to the child's best interests, such as in cases involving special medical procedures like sterilization (Secretary, Department of Health and Community Services v JWB and SMB, 1992) or disputes over treatment for conditions like gender dysphoria (Jowett & Kelly, 2021; Kelly et al., 2022).

The *parens patriae* jurisdiction reflects the law's protective stance toward children, prioritizing their vulnerability over their autonomy. Even when children demonstrate maturity, courts may intervene to ensure decisions align with their best interests, particularly in high-stakes cases (Royal Alexandra Hospital for Children v J, 2005). This approach contrasts with adult decision-making, where autonomy is paramount, even for decisions that may lead to adverse outcomes (Brightwater Care Group v

Rossiter, 2009). For children, the law's protective mechanisms often override their autonomous wishes, especially in cases involving refusal of treatment.

The distinction between consenting to beneficial treatment and refusing treatment is critical. Consent to treatments like contraception or pain relief typically involves lower stakes and requires a lower threshold of understanding (Hunter and New England Area Health Services v A, 2009). In contrast, refusing life-sustaining treatment carries significant consequences, necessitating a higher level of capacity (Bell v Tavistock, 2020). Australian courts are particularly reluctant to allow children to refuse treatment that conflicts with their best interests, even when they demonstrate Gillick competency (X v Sydney Children's Hospital Network, 2013). For example, in *Mercy Hospitals Victoria v D1* (2018), a 17-year-old pregnant child was deemed incapable of refusing lifesaving blood products, despite being close to adulthood, because her decision was not in her best interests (Mercy Hospitals Victoria v D1, 2018; Moritz & Ebbs, 2021). This case illustrates the courts' cautious approach to granting children full decision-making authority in high-stakes scenarios.

The reluctance to allow children to refuse treatment often stems from their perceived vulnerability and ongoing developmental immaturity. Courts recognize that even mature children may not fully appreciate the long-term implications of their decisions due to incomplete brain development (Freckelton & McGregor, 2016). This protective stance is particularly evident in cases involving religious objections, such as those by Jehovah's Witness families, where children may refuse blood products based on deeply held beliefs. In such cases, courts prioritize preserving life over respecting the child's autonomy, reflecting the state's interest in protecting vulnerable individuals (Mercy Hospitals Victoria v D1, 2018).

The health law framework thus creates a delicate balance between acknowledging children's autonomy and protecting their best interests. While the mature minor principle empowers children to consent to beneficial treatments, it does not extend to decisions that could harm them, particularly refusals of life-sustaining care. This protective approach contrasts sharply with the criminal law's punitive treatment of children, which holds older children fully accountable without considering their developmental limitations. The following sections will explore these differences in greater detail, highlighting the need for a more consistent approach to children's decision-making across legal domains.

3. CRIMINAL LAW

The approach of Australian criminal law to children's decision-making stands in stark contrast to the protective and nuanced framework of health law. Criminal law adopts a punitive stance, particularly for older children, holding them accountable for their actions with little regard for their developmental maturity, vulnerability, or the contextual factors influencing their behavior. This approach is particularly evident in the clear legal thresholds established for determining children's criminal responsibility across Australia's states and territories. Unlike health law, which seeks to balance

autonomy with protection, criminal law imposes rigid age-based standards that often fail to account for the complexities of children's cognitive and emotional development.

In Australia, the minimum age of criminal responsibility is set at 10 years across all jurisdictions, with the Australian Capital Territory (ACT) committing to raise this threshold to 12 starting in 2023 (ACT Government, 2022). Children under 10 are deemed incapable of possessing the mental capacity to understand the moral or legal implications of their actions, thus exempting them from criminal liability (Goldson, 2013). This age threshold is grounded in the recognition that very young children lack the cognitive ability to distinguish between right and wrong in a manner sufficient to warrant criminal responsibility (Delmage, 2013). However, once children reach the age of 10, the law begins to hold them accountable, albeit with certain protections for younger children within the 10–13 age range.

For children aged 10 to 13, Australian jurisdictions apply the principle of *doli incapax*, a rebuttable presumption that they lack the capacity for criminal responsibility unless proven otherwise (C v DPP, 1995). This presumption requires the prosecution to demonstrate that the child knew their actions were seriously wrong, beyond mere naughtiness, at the time of the offense (RP v The Queen, 2016). The application of *doli incapax* varies across jurisdictions, with four distinct capacity thresholds: actual knowledge that the behavior was "seriously wrong" (RP v The Queen, 2016); actual knowledge that the behavior was "wrong"; capacity to know the conduct should not occur; and capacity to know the conduct was "seriously wrong" (Criminal Code Act Compilation Act 1913) (Moritz & Tuomi, 2022). These variations reflect differing standards for assessing a child's understanding, but all aim to evaluate whether the child had the requisite moral and cognitive awareness to be held criminally liable.

The *doli incapax* presumption serves as a protective mechanism, theoretically shielding young children from the full weight of the criminal justice system. Courts assess the child's understanding at the time of the alleged offense, considering factors such as the nature of the offense, the child's criminal history, their upbringing, and expert evidence, such as psychological or developmental assessments (Crofts, 2018). For example, a child who commits a serious offense, like vandalism, may be evaluated based on whether they understood the act's moral gravity, as opposed to simply being mischievous. However, in practice, *doli incapax* is often ineffective in diverting children from the criminal justice system. The prosecution bears the burden of rebutting the presumption, but defense teams frequently find themselves needing to raise and substantiate it, particularly in regional areas where magistrates and lawyers may lack expertise in applying the principle (Fitz-Gibbon & O'Brien, 2019). Consequently, *doli incapax* is rarely a significant barrier to prosecution, and many children as young as 10 face criminal charges and potential sentencing outcomes (Atkinson, 2018).

For children aged 14 and older, the criminal law imposes an adult standard of responsibility, treating them as fully accountable for their actions without any presumption of incapacity (Moritz & Tuomi, 2022). This approach disregards

developmental factors, such as ongoing brain maturation or psychosocial influences, that may impair a child's decision-making. Unlike the health law's mature minor principle, which assesses capacity on an individual basis, criminal law assumes that children 14 and above possess the same cognitive and moral capacity as adults, regardless of their maturity or circumstances. To avoid culpability, these children must establish a legal defense or excuse, such as mental impairment or duress, which places a significant burden on them to prove their incapacity (Rye v The State of Western Australia, 2021). This rigid framework fails to account for the neurodevelopmental evidence that children's brains continue to develop into early adulthood, affecting their ability to make reasoned decisions, particularly in high-pressure or emotionally charged situations (Mendelson, 2014).

The criminal law's approach to capacity assessment is fundamentally different from that in health law. In jurisdictions like Queensland, Western Australia, and Tasmania, the prosecution must prove that a child aged 10–13 had the capacity to know their conduct was wrong to rebut *doli incapax* (Rye v The State of Western Australia, 2021). However, this assessment is not a comprehensive evaluation of the child's understanding of the decision's nature and consequences, as in health law. Instead, it applies an objective standard based on what a reasonable adult would understand, which is problematic given that neurodevelopmental research indicates children cannot achieve adult-level cognition due to incomplete brain maturation (Mendelson, 2014). For instance, the prefrontal cortex, responsible for impulse control and long-term planning, continues to develop into the early 20s, making it unrealistic to expect children to exhibit adult-like decision-making (Steinberg & Icenogle, 2019). Despite this, *doli incapax* is frequently rebutted, often through factors like prior offending or admissions of guilt, which do not necessarily reflect a child's true understanding at the time of the offense (Crofts, 2018).

The failure to consider developmental maturity in older children is particularly concerning. Criminal law's imposition of adult responsibility on children aged 14 and above ignores the influence of external factors, such as peer pressure, socioeconomic disadvantage, or emotional impulsivity, which can significantly affect decision-making (Steinberg, 2009). McDiarmid (2013) argues that criminal capacity is not a simplistic concept tied solely to knowing right from wrong but involves a complex interplay of psychological development and lived experiences. For example, a 14-year-old who commits a theft under peer pressure may not fully comprehend the moral or legal implications of their actions due to their developmental stage, yet the law holds them fully accountable. This approach contrasts sharply with health law's protective stance, which restricts mature children from making harmful decisions to safeguard their well-being (Gillick v West Norfolk and Wisbech Area Health Authority, 1986).

The punitive nature of criminal law's approach to children has significant consequences. Engagement with the criminal justice system can lead to adverse outcomes, including poor educational attainment, reduced employment prospects, and

increased likelihood of recidivism (Bernburg & Krohn, 2003). Goldson (2013) argues that the focus should shift from assessing children's criminal capacity to preventing their entry into the criminal justice system altogether, as exposure to this system often exacerbates harm rather than rehabilitates. For instance, children from disadvantaged backgrounds, particularly Indigenous children, are disproportionately affected by the criminal justice system, facing higher incarceration rates and systemic biases (Crofts, 2015). These outcomes highlight the need for a more nuanced approach that considers children's developmental limitations and vulnerabilities.

Reforming Criminal Responsibility

The shortcomings of the current criminal law framework have prompted extensive discussion and proposals for reform aimed at better aligning legal standards with children's developmental realities. These proposals seek to balance the need to hold children accountable for harmful actions with the imperative to protect them from the punitive consequences of a system designed for adults. Key reform options include raising the age of minimum criminal responsibility, extending the *doli incapax* presumption to older children, removing criminal responsibility entirely for children, and implementing more rigorous capacity assessments (Crofts, 2015; Fitz-Gibbon & O'Brien, 2019; Pillay, 2019; Delmage, 2013).

One prominent proposal is to raise the age of minimum criminal responsibility to 12 or 14, reflecting the growing consensus that children under these ages lack the cognitive maturity to be held criminally liable (Crofts, 2015). The RaiseTheAge campaign in Australia has gained significant traction, advocating for this change due to the overrepresentation of Indigenous children in the justice system, the high recidivism rates associated with early criminal justice involvement, and the detrimental effects of incarceration on young people (Raise the Age, n.d.; Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory, 2017). For example, Indigenous children are incarcerated at significantly higher rates than their non-Indigenous peers, often due to systemic socioeconomic disadvantages (Richards, 2011). Raising the age of criminal responsibility would reduce these disparities and align with international human rights standards, as seen in jurisdictions like Scotland, which has raised its minimum age to 12 (Crofts, 2015).

Efforts to raise the age of criminal responsibility have met with mixed success in Australia. Queensland and New South Wales have explored increasing the threshold to 14, citing alignment with neurodevelopmental research and human rights principles, but these proposals have not been implemented (Crofts, 2015). The ACT's commitment to raising the age to 12 in 2023 represents a step forward, but broader adoption across jurisdictions remains elusive due to community resistance and concerns about accountability for serious offenses (ACT Government, 2022). The United Kingdom's experience provides a cautionary tale: despite retaining a minimum age of 10, the UK abolished *doli incapax* in 1998 following public outcry over high-profile cases, such as the murder of James Bulger by two 10-year-olds (Crime and Disorder Act, 1998;

Young, 1996). This abolition increased children's exposure to criminal liability, highlighting the challenges of balancing victim protection with child welfare (Bandalli, 1998).

Another reform proposal is to extend the *doli incapax* presumption to older children, up to the age of majority (Fitz-Gibbon & O'Brien, 2019). This would ensure that all children, regardless of age, benefit from a rebuttable presumption of incapacity, requiring the prosecution to prove their understanding of the wrongness of their actions. Such an approach could protect older children who lack maturity due to developmental delays, disadvantaged backgrounds, or other factors, preventing them from facing adult-level consequences. However, the practical challenges of *doli incapax*—such as inconsistent application and the burden on defense teams—would persist, potentially limiting its effectiveness (Fitz-Gibbon & O'Brien, 2019).

Delmage (2013) proposes a "defense of developmental immaturity" as an alternative, which would apply a rebuttable presumption of incapacity to children aged 14–15 (prosecution's burden) and 16–17 (defense's burden). This defense would require a more comprehensive assessment of a child's developmental stage, similar to the mature minor principle in health law, ensuring that only children with sufficient maturity face criminal liability (Delmage, 2013). McDiarmid (2016) similarly advocates for a developmental immaturity defense that considers a child's understanding of the consequences and wrongfulness of their actions, rather than relying solely on age or prior offending. These proposals aim to integrate neurodevelopmental evidence into legal assessments, acknowledging that children's decision-making is influenced by ongoing brain development and external factors (Pillay, 2019).

A more radical reform option is to remove children from the criminal justice system entirely, managing their behavior through alternative mechanisms focused on rehabilitation rather than punishment (Pillay, 2019). Neurodevelopmental research highlights that children respond differently to high-arousal situations due to underdeveloped emotional regulation, particularly in "hot" contexts involving peer pressure or impulsivity (Steinberg & Icenogle, 2019). Diverting children to social services or community-based programs could address underlying issues, such as trauma or socioeconomic disadvantage, without the harms associated with criminal justice involvement (Kerig et al., 2016; Abram et al., 2004; McNair et al., 2019). For example, programs that provide counseling, education, or family support could reduce recidivism and promote positive outcomes, particularly for vulnerable populations like Indigenous children (Richards, 2011).

The criminal law's current approach, with its reliance on age-based thresholds and limited capacity assessments, fails to align with the nuanced, protective framework of health law. By holding older children to adult standards and inadequately applying *doli incapax* for younger children, the system overlooks the developmental realities that influence decision-making. Reforms that incorporate individualized capacity

assessments, raise the age of criminal responsibility, or divert children from the justice system could create a more equitable framework that respects children's vulnerabilities while addressing their accountability.

4. A PRACTICAL USE OF CAPACITY ASSESSMENTS

The approaches to children's decision-making in Australian health and criminal law reveal a profound inconsistency that undermines the equitable treatment of young individuals. Health law adopts a protective stance, carefully balancing children's autonomy with their vulnerability through individualized capacity assessments, particularly via the mature minor principle. In contrast, criminal law applies a punitive framework, presuming older children (aged 14 and above) possess adult-level decisional capacity and subjecting younger children (aged 10–13) to a rebuttable presumption of incapacity that is often easily overcome. This dichotomy results in a legal system that restricts mature children from making harmful healthcare decisions while holding potentially immature children fully accountable for criminal actions, regardless of their developmental limitations. This section explores the practical implications of these conflicting approaches, drawing on socio-legal perspectives to argue for a more cohesive framework that integrates comprehensive capacity assessments across both domains to better reflect children's developmental realities (O'Donovan, 2016; Freckelton, 2013).

Health law's approach to children's decision-making is grounded in the mature minor principle, established in *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) and adopted in Australia through *Secretary, Department of Health and Community Services v JWB and SMB* (1992). This principle allows children who demonstrate sufficient understanding and maturity to consent to beneficial medical treatments, recognizing their evolving autonomy (Gillick v West Norfolk and Wisbech Area Health Authority, 1986). However, this autonomy is curtailed when decisions, such as refusing life-sustaining treatment, conflict with the child's best interests. Courts, exercising their *parens patriae* jurisdiction, often override such decisions to protect children from harm, acknowledging their inherent vulnerability (Royal Alexandra Hospital for Children v J, 2005). For instance, in *Mercy Hospitals Victoria v D1* (2018), a 17-year-old was deemed incapable of refusing lifesaving blood products, despite her near-adult status, because her decision was not in her best interests (Mercy Hospitals Victoria v D1, 2018). This protective mechanism ensures that children's developmental immaturity does not lead to irreversible consequences, prioritizing their well-being over their autonomous preferences.

Criminal law, however, takes a starkly different approach. Children aged 14 and older are treated as fully responsible for their actions, with no routine assessment of their decisional capacity (Moritz & Tuomi, 2022). For children aged 10–13, the *doli incapax* presumption assumes they lack criminal responsibility unless the prosecution proves they understood their actions were seriously wrong (RP v The Queen, 2016). In practice, this presumption is frequently rebutted through factors like prior offending or

admissions of guilt, which do not necessarily reflect a child's true understanding (Crofts, 2018). Unlike health law's individualized assessments, criminal law relies on rigid age-based thresholds that fail to account for developmental variations, such as incomplete cognitive and emotional maturation (Mendelson, 2014). This approach disregards the neuroscientific evidence that children's decision-making is influenced by ongoing brain development, particularly in emotionally charged or "hot" contexts where impulsivity and peer pressure prevail (Steinberg & Icenogle, 2019).

The inconsistency between these frameworks is problematic. Health law acknowledges that even mature children may lack the capacity to make decisions with significant consequences, yet criminal law holds children accountable for reactive decisions made in high-pressure situations, often without considering their developmental stage. Delmage (2013) emphasizes the importance of developmental immaturity in assessing children's capacity, arguing that legal frameworks should account for individual circumstances, such as psychological development and environmental influences. A child's capacity is not solely a function of age but is shaped by their lived experiences, education, and socio-economic background (McDiarmid, 2016). For example, a 15-year-old from a disadvantaged community who commits a minor theft under peer influence may not fully comprehend the moral or legal implications of their actions, yet criminal law treats them as an adult offender. In contrast, health law would likely restrict the same child from refusing life-sustaining treatment, recognizing their developmental limitations.

This discrepancy can be contextualized through Hendrick's (1993) conceptual binary, which categorizes children as either victims or threats. Health law views children as victims requiring protection, ensuring their decisions align with their best interests to shield them from harm. This perspective is evident in cases where courts intervene to authorize treatments despite a child's objections, prioritizing their vulnerability (Minister for Health v AS, 2004). Criminal law, however, perceives children as threats to societal order, particularly when they engage in offending behavior. By imposing adult-level responsibility, criminal law disregards children's vulnerability, focusing instead on punishment and deterrence (Hendrick, 1993). This binary framing reflects an adult-centric approach to childhood, where decisions are made based on societal perceptions rather than the child's individual capacities (Mathews, 2003). The arbitrary age of majority, which marks the transition to adulthood, reinforces this construct, ignoring the gradual nature of developmental maturity (Bridgeman, 2007).

The adult-centric nature of legal decision-making is particularly evident in the role of parental responsibility. In health law, parents are entrusted to act in their child's best interests, but their authority is not absolute, as courts can intervene to protect the child (Family Court of Australia, 1975). Bridgeman (2007) critiques this model, noting that parental decisions may not always reflect the child's perspective, potentially undermining their autonomy. In criminal law, parental influence is largely absent once

a child enters the justice system, and the focus shifts to individual accountability. This shift leaves children vulnerable, as they lack the resources or advocacy to navigate complex legal processes (Moritz et al., 2020). Vulnerability, defined as an increased risk of harm due to diminished decision-making ability or external pressures, is a critical factor in health law but is overlooked in criminal law's treatment of older children (Byju & Mayo, 2019; Ruof, 2016).

The practical challenges of applying capacity assessments in criminal law further highlight the need for reform. In health law, capacity assessments are conducted by healthcare professionals, with courts intervening only in disputes or complex cases, such as those involving special medical procedures (Secretary, Department of Health and Community Services v JWB and SMB, 1992). This system is efficient, as it delegates routine assessments to practitioners while reserving judicial oversight for significant issues. In criminal law, however, assessing capacity for every child prosecuted would be resource-intensive, requiring trained professionals to evaluate developmental maturity at the time of the offense (Delmage, 2013). Police officers, as primary responders, are not ideally suited for this role, given their focus on law enforcement rather than psychological assessment (Police Service Administration Act, 1990). Social workers or child psychologists could potentially conduct these assessments, but implementing such a system would require significant investment in training and infrastructure.

The reactive nature of criminal law assessments poses another challenge. Unlike health law, where capacity is evaluated at the time of decision-making, criminal law assesses a child's understanding *after* the offense, often months or years later (RP v The Queen, 2016). This delay complicates the process, as a child's maturity may have evolved, or evidence of their state of mind at the time of the offense may be difficult to obtain. For instance, a 12-year-old who committed vandalism may appear more mature by the time their case reaches court, skewing the assessment of their understanding at the time of the act. The *doli incapax* presumption attempts to address this by focusing on the child's knowledge of wrongfulness, but its application is inconsistent, often relying on incidental factors like prior offending rather than a thorough evaluation of capacity (C v DPP, 1996; Freckelton, 2017).

The differences in decision-making contexts further underscore the need for alignment. Health law decisions are proactive, allowing children to weigh risks and benefits with guidance from professionals, often over time (Alderson et al., 2022). For example, a child with a chronic condition like congenital heart disease may develop a sophisticated understanding of their treatment options through ongoing medical consultations, enabling informed consent even at a young age. Criminal law decisions, however, are typically reactive, occurring in "hot" contexts where impulsivity, peer pressure, or emotional arousal dominate (Steinberg, 2009). A teenager who steals a car during a spontaneous group activity may not have considered the consequences, yet criminal law holds them fully accountable. This discrepancy highlights the inadequacy

of applying adult standards to children, whose psychosocial immaturity impairs their ability to make reasoned decisions in high-pressure situations (Monahan et al., 2009; Moritz & Christensen, 2020).

The absence of a best interests framework in criminal law exacerbates these issues. In health law, the best interests principle guides decisions, ensuring that children's welfare is prioritized even when their autonomy is restricted (Willmott et al., 2018). Criminal law, however, focuses on accountability and punishment, with mitigating factors like upbringing or disadvantage considered only at sentencing, not during the assessment of responsibility (Crofts, 2009). This approach is not only inconsistent with health law but also harmful, as involvement in the criminal justice system can lead to negative outcomes, such as reduced educational opportunities and increased recidivism (Bernburg & Krohn, 2003). Goldson (2013) argues that the focus should shift from assessing criminal capacity to preventing children's entry into the justice system, advocating for decriminalization or alternative interventions like rehabilitation programs.

A more consistent approach would involve adopting capacity assessments similar to those in health law. Delmage (2013) suggests that criminal law could benefit from individualized assessments, akin to the mature minor principle, to evaluate a child's understanding and maturity at the time of the offense. This would require moving beyond the *doli incapax* presumption, which is limited by its rebuttable nature and reliance on adult-centric standards. Instead, a comprehensive assessment would consider neurodevelopmental factors, such as the child's ability to regulate emotions or resist peer pressure, as well as environmental influences like family dynamics or socioeconomic status (Pillay, 2019). For example, a 13-year-old who commits a minor offense due to peer coercion could be evaluated for their developmental maturity, potentially diverting them to community-based interventions rather than prosecution.

Implementing such assessments would align criminal law with the protective principles of health law, ensuring that children's developmental immaturity is recognized across both domains. The Canadian Supreme Court's ruling in *AC v Manitoba (Director, Child and Family Services)* (2009) provides a relevant precedent, noting that the mature minor principle does not reclassify adolescents as adults for medical purposes, emphasizing the need for tailored assessments (AC v Manitoba, 2009). Applying this logic to criminal law would prevent the premature imposition of adult responsibility on children, acknowledging their unique developmental needs.

The integration of capacity assessments could also address the disproportionate impact on vulnerable populations, such as Indigenous children, who face systemic biases in the criminal justice system (Richards, 2011). By prioritizing rehabilitation over punishment, the law could mitigate the long-term harms of criminal justice involvement, promoting better outcomes for children and society. For instance, diversion programs that provide counseling or education could address underlying

issues like trauma or poverty, reducing recidivism and fostering positive development (Kerig et al., 2016).

Ultimately, the law must resolve the dichotomy between health and criminal law approaches to children's decision-making. A unified framework that incorporates individualized capacity assessments would ensure that children are neither denied autonomy in healthcare nor unfairly punished for criminal actions influenced by their developmental stage. This approach would align with human rights obligations under the *Convention on the Rights of the Child* (1990), which emphasizes the importance of considering children's views and capacities in decisions affecting them (United Nations Convention on the Rights of the Child, 1990). By recognizing the complexities of children's decision-making, the law can create a more equitable system that protects their vulnerability while fostering their growth into responsible adults.

5. CONCLUSIONS

The divergent approaches to children's decision-making capacity in Australian health and criminal law create a significant inconsistency that undermines fair treatment. Health law employs a protective framework, using the mature minor principle to assess children's capacity individually, balancing their autonomy with their best interests. This allows mature children to consent to beneficial treatments while restricting harmful decisions, acknowledging their developmental vulnerabilities. In contrast, criminal law adopts a punitive stance, holding children aged 14 and older fully accountable as adults and applying the *doli incapax* presumption for younger children in a manner that is often easily rebutted. This rigid, age-based approach fails to consider developmental immaturity, exposing children to harsh consequences without regard for their cognitive limitations.

Reconciling these frameworks requires integrating individualized capacity assessments across both domains, similar to those in health law, to ensure children's developmental stages are consistently recognized. Such assessments would evaluate a child's understanding, maturity, and contextual influences, preventing the premature imposition of adult responsibility in criminal law. Which mandates that children's views be given due weight based on their age and maturity. By adopting a cohesive framework, the law can protect children's vulnerability while respecting their evolving autonomy, reducing the adverse impacts of criminal justice involvement, such as recidivism and social marginalization. Reforms like raising the age of criminal responsibility or implementing developmental immaturity defenses could further support this goal, fostering equitable treatment and promoting positive outcomes for children.

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