Adolescent Access to Abortion Care in Canada: Age, Capacity and Parental Consent

Accès aux services d'avortement pour les adolescentes au Canada : âge, capacité et consentement parental

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Abstract

For adolescents seeking abortion care in Canada, clear information about age and parental consent requirements is not always available. This article details the state of age of consent law and policy across Canada, focusing on access to abortion care. It identifies three key concerns, namely, challenges with unclear or contradictory information, obstacles presented by having additional requirements for minors' consent and difficulties posed by restrictions that require parents and/or guardians to be involved in decision making. The article concludes with recommendations to reduce these barriers to care.

Résumé

Les adolescentes qui veulent obtenir des services d'avortement au Canada n'ont pas toujours accès à des renseignements clairs sur l'âge et les exigences en matière de consentement parental. Cet article décrit en détail l'état des lois et des politiques sur l'âge du consentement à travers le Canada, en mettant l'accent sur l'accès aux services d'avortement. On y relève trois préoccupations principales, à savoir les défis liés à des renseignements ambigus ou contradictoires, les obstacles que représente l'imposition d'exigences supplémentaires en matière de consentement pour les mineures et les difficultés posées par l'obligation que les parents ou les tuteurs participent à la prise de décision. L'article se termine par des recommandations qui visent à réduire ces obstacles.

Introduction

There continues to be a relatively small number of adolescents in Canada – people who have not yet reached the age of majority in their province or territory – who become pregnant each year and who may face significant challenges in procuring abortion care. More than 80% of pregnancies among adolescents are unintended (Black et al. 2015), with approximately 1,500 to 2,200 people under the age of 17 successfully procuring an abortion in Canada each year (CIHI 2015–2024). While there are many documented barriers that people experience in seeking abortion care (Hukku et al. 2022), adolescents face additional challenges, including, but not limited to, the uncertainty of familial and social supports, confidentiality concerns and limited access to resources as well as unclear information (Assifi et al. 2020; Downie and Nassar 2008).

Since the 1988 Supreme Court decision in *R v Morgentaler*, consent to abortion in Canada is subject to the same legal requirements as other medical interventions and is largely under the purview of provincial and territorial governments (Jackman 2000; Shaw and Norman 2020). Consequently, the age of consent for abortion is the same as other health services and subject to the same laws and policies. Yet, available information varies widely: some websites indicate that anyone in Canada over the age of 12 can access abortion care; others state that there is no age of consent, and it is also relatively rare to find details about differences between jurisdictions or clear information about when parent (or guardian) consent is required. Confusion about the age of consent is particularly concerning because abortion care is time-sensitive and often stigmatized; hence, adolescents seeking care may be doing so covertly or under stress. It is critical that adolescents have access to clear and effective information about how to obtain abortion care.

Age of Consent for Abortion Care Across Canada

There is significant variation across Canada in how the age of consent to medical treatment is governed. Many provinces do not have a specific age of consent, operating instead on the presumption that patients – regardless of whether they have reached the age of majority – can consent as long as they can reasonably understand the nature of their treatment and its consequences. In each of these jurisdictions – Nova Scotia, Ontario, Prince Edward Island, Saskatchewan and the Yukon – there is specific legislation that defines capacity for medical treatment, although healthcare providers can rebut the presumption of capacity if they have reasonable grounds to determine that the patient cannot consent (Table 1) (Coghlin 2018).

Other provinces have their own statutory provisions to aid in determining capacity in minors, and within them, the common law's mature minor doctrine typically governs how the provisions are interpreted by the courts. The mature minor doctrine in the common law recognizes that people under the age of majority can consent to medical treatment but that their consent may require particular scrutiny to assess whether they are able to consent in a specific context. In New Brunswick, for example, patients who are younger than 16 must demonstrate to their healthcare provider that they understand the nature of the treatment, and their healthcare provider must believe that the treatment is in their best interest. Similarly, in British Columbia, a minor can consent to care without the involvement of a parent or guardian, but the healthcare provider must believe that the minor understands the treatment and its potential benefits and risks, and the healthcare provider must also have taken "reasonable efforts" to determine that the decision is in the patient's best interest. The legislation in both British Columbia and New Brunswick does not, however, clearly set out what a decision in the child's best interest means. Furthermore, in the Northwest Territories and Nunavut, there is no legislation addressing consent to treatment and no specific minimum age for consent. It is likely that in the absence of legislation, questions of consent to treatment in these territories, if considered by courts, would rely on the mature minor doctrine.

In Manitoba and Newfoundland and Labrador, there is a presumption in legislation that persons under the age of 16 cannot consent, although in both cases, this presumption can be rebutted with "evidence to the contrary" (*Advance Health Care Directives Act* 1995; *The Health Care Directives and Consequential Amendments Act* 1992). In Alberta, the approach is similar, but it is policy established by Alberta Health Services (rather than legislation) that sets out a presumption that those under the age of 18 cannot consent to treatment, although this "presumption of incapacity can be rebutted" if the patient is deemed to be a mature minor (AHS 2020).

In Quebec, those younger than 14 require consent from their parent or legal guardian to access abortion care. Minors aged 14 and over also require consent from their parent or legal guardian "if care entails a serious risk for the minor's health" (CCQ 1991, art 17).

TABLE 1. Minimum age of consent to treatment in legislation/policy by province/territory

	Province/territory	Minimum age of consent to treatment	Legislation/policy
No minimum age for consent; same tools to assess consent for everyone	Nova Scotia	None. All persons must understand the nature of treatment and its consequences.	*Personal Directives Act*, SNS 2008, c 8.
	Ontario		*Health Care Consent Act* SO 1996, c 2 (Sch A), s 4.
	Prince Edward Island		*Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2, ss 3–10.
	Saskatchewan		*The Health Care Directives and Substitute Health Care Decision Makers Act*, SS 2015, c H-0.002, s 2(1).
	Yukon		*Care Consent Act*, SY 2003, c 21 (Sch B), ss 5–6.
No minimum age for consent; additional precautions to assess consent in minors	New Brunswick	None. Minor must understand the benefits and risks and healthcare provider must conclude that healthcare is in the best interests of the minor.	*Enduring Powers of Attorney Act*, SNB 2019, c 30, s 2; *Medical Consent of Minors Act*, SNB 1976, c M-6.1, s 3.
	British Columbia		*Infants Act*, RSBC 1996, c 223, s 17.
	Northwest Territories[a]	None. Mature minor doctrine.	None.
	Nunavut[a]		None.
Rebuttable presumption that minor cannot consent	Alberta	Rebuttable presumption that person under 18 cannot consent.	Alberta Health Services, "Consent to Treatment/ Procedure(s): Minors/ Mature Minors" (last modified January 16, 2020) at 1.
	Manitoba	Rebuttable presumption that person under 16 cannot consent.	*The Health Care Directives and Consequential Amendments Act*, SM 1992, c 33, s 4(2).
	Newfoundland and Labrador		*Advance Health Care Directives Act*, SNL 1995, c A-4.1, s 7.
Minors require parental permission	Quebec	Persons 13 and under require consent from parent or legal guardian. Minors 14 and over require parental consent if care entails "serious risk."	Civil Code of Quebec, CQLR 1991, c CCQ-1991, arts 14–18.

a Given that there is no legislation in Northwest Territories and Nunavut, additional precautions may be taken in assessing a minor's ability to consent to treatment.

It is important to note, however, that the legislative approaches (and policy in the case of Alberta), as detailed above, have been addressed by a body of case law that addresses consent to medical treatment for minors. Importantly, in *A.C. v. Manitoba* (SCC 2009), the Supreme Court found that those under 16 in Manitoba can indeed rebut the presumption of incapacity in the legislation if they are sufficiently mature. In this case, the Supreme Court also found that the degree of scrutiny applied to a minor's decision making should be aligned with the extent to which "a treatment decision is likely to seriously endanger a child's life or health." Since abortion care is generally very safe (and indeed much safer than continuing a pregnancy), the level of scrutiny would be low. Some of this case law has also found that determining the "best interests" of an adolescent patient might occur with help of other adults who know them rather than engaging with parents, although others have found that taking "reasonable efforts" to determine an adolescent's best interest may – in cases where the child themselves are not capable of consent – require consultation with their parents (*Ney v. Canada* [Attorney General] 1993).

Ultimately, legislation and policy do not provide the last word on consent to care, and where abortion care is denied to adolescents, the case law suggests that there is a good chance that the courts would find in their favour (see discussion in ARCC 2017; *J.S.C. and C.H.C. v. Wren* 1986; SCC 2009). Yet, when adolescents are seeking information about abortion care, they are unlikely to encounter case law, but rather sources online – clinic websites, legislation, policy and other sources – that may contradict one another, making it unclear whether they will need parental approval or whether they may have to rebut the presumption that they are incapable of consent.

Problems with the legal landscape of age of consent around abortion

While the requirements for consent to abortion in all Canadian jurisdictions are the same as other health services, there are three important concerns that the review of the legislation (and policy) above raises in relation to adolescent access to abortion care. First, information about the circumstances in which adolescents can access abortion care in their province or territory may be unclear or contradictory. Some clinics provide very clear information online about access and age, but there are also some that establish a more restrictive minimum threshold for parental consent than their provincial or territorial law. Furthermore, the legislation (and policy) in some provinces (i.e., Alberta, Manitoba and Newfoundland and Labrador) that presumes that minors cannot consent without evidence to the contrary stands in contrast with information on clinic websites stating that they do not restrict access on the basis of age and/or that parental consent is not required (e.g., Kensington Clinic, Women's Health Clinic) as well as the relevant case law. Contradictions between the language of the relevant legislation (and policy) and clinic policy introduce unnecessary uncertainty about how consent processes will go and whether the legislation (and policy) will be an impediment to care (ARCC 2017).

Second, the requirements for minors to demonstrate a capacity to consent that does not exist for others inherently works to make access to treatment more difficult. The presumption of incapacity in some legislation puts an onus on young patients to actively rebut the presumption and to prove that they are capable of consenting to treatment. These extra steps are not inherently problematic, insofar as healthcare providers typically work hard to ensure that minors seeking any form of care understand and can agree to their treatment. However, it is possible that extra consent requirements may delay or otherwise impede adolescents seeking already difficult-to-access treatment. Abortion care needs to be obtained in a timely manner, and extra requirements can have negative physiological and mental health impacts (Foster 2021; Jerman et al. 2017).

Finally, there is potential harm associated with consent laws that require parental/guardian consent. Requirements for parental consent to abortion are problematic for a variety of reasons, including that they may deter people from accessing care entirely, or people may feel a need to travel elsewhere to seek care (with or without the resources to do so), or they may engage in self-induced abortions. For people who are in abusive family relationships, the requirement to access parental consent can also result in "serious physical injury or emotional harm" (ARCC 2017).

Reducing barriers to access

While Canada is often understood as having no legal restrictions that limit access to abortion, our analysis presents a more nuanced view. Adolescents seeking abortion care may be impeded by unclear information about the age of consent and/or parental consent requirements as outlined in legislation and policy that contradicts case law or clinic policy. This is true both of procedural abortions and medication abortions, although there may be additional concerns in the case of medication abortions in some settings where adolescents are tasked with getting a prescription filled.

There are a number of ways to reduce these potential barriers to care. Most importantly, in jurisdictions where there is a presumption of incapacity in the legislation or policy, or where the legislation indicates additional precautions are needed, provinces should revisit their legislation to reflect both the case law and clinical practice. Given anti-abortion and "parental rights" mobilization advocating for increased parental intervention in consent to healthcare for adolescents, including abortion care (*CBC News* 2018; The Canadian Press 2015), it is especially critical that information about what services are provided, to whom and in what circumstances (including when parental consent is required) is accurate, up to date, consistent and accessible.

Healthcare providers and policy makers should also work to ensure that assessments of capacity do not create delays or undue barriers to care. Again, healthcare providers are typically committed to ensuring that patients understand and can agree to their treatment in a timely manner, but the additional provisions in legislation and policy around determining consent in jurisdictions such as British Columbia, New Brunswick, Alberta, Manitoba and

Newfoundland and Labrador may add extra steps to consent processes that introduce more opportunities for scrutiny, delays in care and the denial of services.

Finally, and wherever possible, requirements for parental involvement in consent processes should be removed, namely in Quebec, where the legislation is clear that there is a need for parental consent for those under the age of 14. While most adolescents involve a parent or guardian willingly, some may be driven away from seeking care by this requirement, or they may feel the need to travel for care or may seek unsafe alternatives (ARCC 2017). The conditions requiring parental consent in Quebec for those under the age of 14 should be reconsidered.

Ultimately, capacity to consent matters and it is critical that healthcare providers continue to be given the discretion to determine whether someone seeking care can consent to their treatment. Yet, the persistence of unclear and contradictory information about the circumstances in which adolescents in many jurisdictions can consent to abortion services, and requirements for parental consent, collectively introduce uncertainty about access and, as a result, unnecessary obstacles to care.

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