

Consent to Treatment Policy and Procedure

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Consent to Treatment

Policy and Procedure

1 Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) offers a range of mental health assessments and treatments to patients and by their very nature a patient's active participation is vital to the process. It recognises that consent and voluntary choice are a fundamental principle of the work of the Trust.

In order that a patient can confidently participate in assessment and/or treatment, the Trust fully acknowledges the fundamental legal and ethical right of patients to determine what happens to them during the course of their care. Clinical staff at the Trust are responsible for ensuring that patients are provided with sufficient information on which to base a valid decision as to whether or not they wish to participate in assessments and treatments.

The Trust does not require a formal consent form to be signed by the patient, however, in all cases the clinician must be confident that the patient has actively agreed to participate in treatment and had been provided with suitable and sufficient information on which to make that decision. The process for obtaining consent is set out at section 7.

2 Purpose

This policy and procedure describes the principles and process of obtaining valid consent to treatment. It highlights the need to ensure that sufficient information is given to allow valid consent to be made and it sets out how 'best interests' decisions need to be made for those lacking capacity (Mental Capacity Act 2005).

This policy is written to ensure that the Trust meets legal, NHSLA and CQC standards of good practice relating to consent in healthcare. It is based on Department of Health Guidance 2009 and sets out the procedures for obtaining and recording consent that operate in the Trust. It is written with regard to the type of clinical work that the Trust undertakes.

3 Scope¹

This policy and procedure is applicable to all clinical staff, including; permanent staff, clinical trainees, locums, and honorary clinical staff, seeing patients in the Trust.

The principles and processes of consent in the policy apply specifically to treatment of patients, but the principles of choice of participation also apply to the assessment phase of care.

The policy does not cover consent for participation in a research study; staff should refer to the NHS guide on research consent, (see reference section 10).

4 Definitions

The following definitions apply in this policy:

Term	Definition in this policy
Capacity	Applies to persons 16 years and over and is a legal term from the Mental Capacity Act 2005, it means the ability to understand and give legal consent to an action or arrangement.
Competence	Is the equivalent legal term to capacity from the Children Act 1989 and applies to young people under 16 years, it refers to a young person's ability to understand information about the proposed treatment and make a decision based on that understanding
Presumption of capacity to consent	For anyone over 16 there must be a presumption that the person has a capacity to consent unless it is positively shown that they lack capacity
Right to refuse/ withdraw consent	<ul style="list-style-type: none">• Consent can be withdrawn at any time.• Persons over 18 with capacity to consent have the legal right to withdraw consent and or refuse treatment without the need to offer reasons for their decision.

¹ **Notes on scope:**

1. The Trust does not provide any compulsory treatments under the Mental Health Act. (1983), however 'approved' Psychiatrists in the Adolescent and CAMHS Directorate may be requested to carry out assessments under the Mental Health Act (as Section 12 approved doctors). Formal consent for such an examination is not required.

2. A number of specialist departments provide a court reporting service. In the case that the Court Orders that a report be prepared, the individual concerned is under a legal obligation to cooperate and taking consent is not applicable.

5 Policy Statements

The Trusts accepts the following position on consent for Treatment by trust staff:

Capacity to consent:

- For those aged 16 years or over capacity to make informed decisions is presumed.
- If a clinician is doubtful about the capacity of an individual then the clinician must prove that the individual lacks capacity.

Valid Consent:

Consent is a patient's voluntary agreement to receive a particular treatment. For consent to be valid, the patient must:

- have the capacity (for persons 16 years or over) or competence (for young people under 16) to take the particular decision
- have received sufficient information about the nature , purpose, likely effects and risks of a particular treatment as well as received information and/or had a discussion about alternatives (including no treatment)
- not be acting under duress or the influence of another person
- be able to express their decision to the clinician, either verbally or in writing

Right to refuse treatment and/or withdraw consent

A patient has the legal right to withdraw consent and or refuse consent for treatment without the requirement to explain his actions

6 Duties and responsibilities

Medical Director

The Medical Director has overall responsibility for this policy and procedure and for ensuring that all clinicians understand the procedure. The Medical Director will ensure that the content of this procedure is part of clinical induction for all new staff. The Medical Director is accountable to the Board of Directors on matters relating to patient consent and is lead for the CQC standard on consent (Standard 5).

Clinical Staff

Clinicians are responsible for ensuring that they obtain consent from each patient and that the patient has sufficient information on the benefits, risks and alternatives of the proposed treatment on which to make an informed decision. Clinicians are responsible for recording that consent has been discussed and the outcome recorded, and for ensuring that records of any concerns relating to consent are kept up to date.

7 Procedure for obtaining consent

7.1 Consent for Assessment

A patient can be offered one or a series of appointments at the Trust for the purpose of conducting an assessment to determine which, if any, of the treatment options available from the Trust would best meet the needs of the patient.

The Trust does not seek formal consent of the patient to undergo an assessment. Consent is implied by the fact the patient chooses to attend the offered appointment and engages with the clinician so that information can be gathered in order to make an assessment. A patient is able to withdraw from the assessment process at any time.

7.2 Consent for Treatment

The principles for obtaining valid consent to treatment are that the patient is provided with sufficient information with which to make an informed decision whether to undergo the proposed treatment. This information should include:

- Details of proposed treatment
- Benefits of the treatment
- Risks of the treatment
- Alternatives to treatment proposed (including the option of no treatment)
- informing patients about the use of their confidential data and to record their objections, consent or dissent;
- how access to a patient's data to other relevant professionals is provided securely and only where there is a legal and appropriate basis to do so.

Due to the nature of the services offered different approaches to practice that operate in the four directorates local procedures apply and these are detailed in Appendices as shown below:

- Appendix 1: Procedure for obtaining valid consent in for people aged under 16
- Appendix 2 Procedure for obtaining valid consent for people aged 16-18.
- Appendix 3 Procedure for obtaining valid consent for people aged 18 and over
- Appendix 4 Procedure for obtaining valid consent for patients with a Learning Disability
- Appendix 5 Summary guide for clinicians on who can hold 'parental responsibility'
- Appendix 5 Guidance for all Clinicians on Competence, Consent, Refusal of Treatment and Confidentiality for Children and Young People

7.3 **Consent and patients whose first language is not English**

Patients and or clinical staff can approach PALS for help and support. If language is an issue and the PALS service can liaise with clinical staff on behalf of those inquiring. PALS can make arrangements for patients to have access to a translator if required.

7.4 **Recording consent discussions and decisions**

In all cases, consent discussion and decisions must be recorded by the clinician in the record. There is a specific section in the Assessment Summary to record consent. In services that do not use the Assessment Summary a narrative around consent discussions and outcome should be included in the case file. Patients are not required to sign a 'consent form'

8 Training Requirements

Training on consent is part of on-going professional development training for all clinical staff, with support being provided both by formal training and through case supervision. Occasional in-house training sessions will be provided as needs are identified.

9 Process for monitoring compliance with this Procedure

Compliance with this procedure will be monitored and assured in the following ways:

- **Documentation of consent** will be audited as part of the annual records audit and reported to the Clinical Audit lead and a copies of any audit report produced will also be provided to relevant directors. Any issues with non-compliance will be escalated to the relevant director. Assurance that this process is working will be provided by the Patient Safety and Clinical Risk work stream lead to the Clinical Quality Safety and Governance Committee (CQSG) Committee who will monitor any action plans agreed to address deficiencies.
- **Patient Feedback on consent will be** will be collated as part of the annual review of patient feedback prepared by the Patient Experience lead to the Patient Experience and Care Quality work stream. Any issues with non-compliance will be escalated to the relevant clinical director. Assurance that this process is working will be provided by the Patient Safety and Clinical Risk work stream lead to the Clinical Quality Safety and Governance (CQSG) Committee.
- **Review of incidents, complaints and claims** for evidence of issues relating to consent will be undertaken 6 monthly by the Governance and Risk Adviser and reported to the Patient Safety and Risk Work stream. Any issues with non-compliance will be escalated to the relevant director. Assurance that this process is working will be provided by the Patient Safety and Clinical Risk Work stream lead to the Clinical Quality Safety and Governance (CQSG) Committee.

10 References

General guidance *Reference guide to consent for examination or therapy*: provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies may be accessed via the web at www.dh.gov.uk/consent. See http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643 for the most up to date guidance (2009).

Specific guidance, incorporating both the law and good practice advice, is available for professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available on the internet at www.dh.gov.uk/consent.

There are specific requirements in relation to **consent for research**. The general requirements can be found from the National Research Ethics Service's website <http://www.nres.npsa.nhs.uk/>.

11 Associated documents²

Procedure for the Prescribing and Administration of Medicines

Procedure for obtaining consent to make live electronic recordings of patient sessions

Leaflet: *Your personal information and how it is used*

² For the current version of Trust procedures, please refer to the intranet.

12. Equality Impact Assessment

1. Does this Procedure, function or service development impact affect patients, staff and/or the public? **YES**

2. Is there reason to believe that the Procedure, function or service development could have an adverse impact on a particular group or groups? **NO**

This is a policy and procedure that will be applied equally to all patients dependant on their capacity to consent. For patient who has a disability that impairs their capacity to consent specific additional safeguards and arrangements are in place to protect the interest of this group. Special legally binding arrangements are in place to protect the interests of children under this policy.

Age – especially younger and older people *No: protected arrangements in the policy*

Disability – people with impairments *No: protected arrangements in the policy*

Race – people of different ethnic groups *No: protected arrangements in the policy for those whose first language is not English*

3. If you answered **YES in section 2**, how have you reached that conclusion? (Please refer to the information you collected e.g., relevant research and reports, local monitoring data, results of consultations exercises, demographic data, professional knowledge and experience) *na*

4.. Based on the initial screening process, now rate the level of impact on equality groups of the Procedure, function or service development:

Positive impact: Medium

(i.e. likely to promote, or does have some positive impact on equality of opportunity)

Date completed 8.11.11 reviewed November 2014, no change

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Appendix 1 : Procedure for obtaining consent for people aged under 16

Clinicians are referred to Appendix 5 which provides detailed guidelines on considerations that should be made when taking consent from a child and/or young person

Consent to Treatment

Treatment of children and young people is complicated by the fact that it is often adults (parents or carers) who are concerned about the young person's symptoms or behaviour and consider them to need help. The young person themselves may not actively want help. The child and young person's understanding of what assessment and treatment entails may be at a different level from the understanding of parents / carers.

While the child/ young person may not be in a position to provide active consent to psychotherapeutic treatment, it is important to establish that they do not actively dissent.

Written consent is not required for a child or young person but the basis for believing that the young person /or the parent acting on behalf of a child not competent to consent for themselves should be written in the file. The Trust has included a section on the Assessment form to record the consent process

Consent for use of medication:

On occasions consultant child and adolescent psychiatrists will prescribe medication for a child/young person and may carry out baseline checks of height/weight/blood pressure and pulse following best practice guidelines (e.g. NICE Guidelines for management of ADHD)

The same principles of consent to treatment apply.

Appendix 2 : Procedure for obtaining consent for people aged 16-18

Clinicians are referred to Appendix 5 which provides detailed guidelines on considerations that should be made when taking consent from a child and/or young person

Opt-In policy for Assessment of young people over 16

It is the Trusts usual practice to write to young people, who have not self-referred, asking them to opt-In and confirm that they would like to be seen here. The Adolescent Department then gives a deadline of one week for the young person to make contact. If no response is received after the first week, a reminder letter is sent with a copy to the referrer and a further week given to await contact.

To minimise the waiting time, the young person has a choice of contacting the Adolescent Department, Referrals Coordinator by telephone or by returning the Opt-In form which is enclosed with the original letter and prompt letters.

If there is no further response after the second letter, the case is closed on the system and the referrer is written to advising them of the outcome.

Young People's Rights to Consent to Treatment

Adults over the age of 18 attending the adolescent department are presumed to have the capacity to consent to treatment

Young persons aged 16 -17 attending adolescent services are regarded as having capacity to give consent to treatment, in line with the Mental Capacity Act, however in practice adolescents vary greatly in their level of maturity and it is important therefore that when clinicians have any concern about the capacity to consent in a young person aged 16-17 that with the patient's permission the patient/carer may be engaged to participate in the decision. It is usual practice that a different clinician is assigned to carers /parents if they are also being seen at the Trust.

For children **under 16**, under the law clinicians may assess patients and determine whether they have sufficient understanding of what is to be offered, both its risks and benefits, and alternatives to treatment, and if a patient has sufficient understanding then they can consent to treatment. This is referred to as 'Gillick' or 'Frazer' competence.

For under 16's who are deemed competent it is recommended practice in the Adolescent Directorate for parents of children under 16 to be seen at least once during the course of assessment This is usually discussed with the young person.

If a **child under 16 is not considered competent** to give consent then a parent or legal guardian may consent on behalf of the patient.

Providing information and recording consent

Once it has been determined that the young person has the capacity (over 16) or competence (under 16) to consent to treatment then the basic principles for obtaining valid consent are to be followed i.e.: the therapist must provide the patient with sufficient information on which s/he can decide whether s/he wants to accept the offer of treatment.

This information must include:

- Proposed treatment
- Benefits of the Treatment
- Risks of the treatment (including the possibility that the situation might get worse before it gets better with as issues they find difficult to think about are opened up in the sessions)
- Alternatives to the proposed treatment (including no treatment)

Recording Consent

Following this discussion if the young person wishes to proceed to treatment their consent must be documented in the file by the clinician completing the Consent section in the Assessment form

For young people who are not competent to consent

In the event that an Adolescent Patient has been assessed as not competent to consent for him/herself then the clinician should obtain consent for a parent/guardian on behalf of the patient. This is to be documented on the Assessment Form

Appendix 3 : procedure for obtaining consent for people aged 18 and over

The principles that guide taking consent from adults are set out below. It is the responsibility of each clinician offering adult patients the opportunity for treatment to ensure that their patient has sufficient information and time to make a decision as to whether they wish to accept this offer.

Capacity to Consent

All adult patients attending the Trust are normally deemed to have capacity to agree to assessment and consent to treatment. (Certain rare exceptions may apply to patients seeking voluntary treatment but who are subject to a treatment plan the Mental Health Act or to those patients with severe learning difficulties³). That said, capacity to consent may be temporarily impaired by trauma or severely disabling emotional responses or physical illness and clinicians must always be aware of this possibility and take it into account if present.

'Consent' to assessment

The Trust does not take formal consent for assessment, however for an assessment to be effective a patient must agree to attend sessions and participate in the assessment process

Consent to treatment

If, following assessment the clinician recommends a course of treatment, which may be individual, group, family or couple therapy, it is the responsibility of the clinician to provide the patient with information on which to base a decision to proceed.

This information must cover:

- Proposed treatment
- Benefits and risk of the proposed treatment
- Alternatives to this treatment (including no treatment)
- That the patient may withdraw his consent at any time

In the discussions about treatment the clinician should consider the following:

³ Refer to Appendix 5 re consent for patients with learning or complex difficulties

- Clinicians should be prepared to discuss any treatment offer in relation to current NICE Guidance and other current advice and should encourage their patient to seek additional information if they wish either from Trust publications or via MIND and other relevant organisations.
- Clinicians should always attend to patients concerns and help them to become verbalised and explicit. This includes taking care that so far as possible, the patient understands correctly. This process should begin during an assessment should also be the beginning of establishing the honesty and trustworthiness of the clinician and the Trust, as a basis for psychological treatment.
- Patients should be given time to consider the option of treatment and offered any support they may need to reach a decision

Recording consent

Written consent (i.e. on a consent form signed by a patient) is **not** required for the types of treatment that the Trust offers, however it is very important that the clinician records consent in the case file, a section in the Assessment Form provides space for this, additional notes can be made in the main record

Additional Advice for Clinicians re withdrawal of consent during treatment

Consent to psychotherapy is complicated by the fact that a patient who has consented to treatment may nevertheless feel ambivalent, anxious, resistant and hostile when faced with the reality of the psychotherapy treatment. If the clinician construes this, prematurely, as withdrawal of consent to treatment, the patient may feel rejected or uncontained.

Clinical judgement is required to gauge whether the patient has consented to treatment but is ambivalent, hostile and / or anxious, or whether the patient's attitude communicates a lack of, or withdrawal of consent to treatment.

Appendix 4 : Guidelines for Obtaining Consent for Treatment for patients with learning disabilities⁴

The guidance below has been informed by the principles and legal framework as underlined by the Mental Capacity Act (2005) and by the General Medical Council guidance notes 'Consent: patients and doctors making decisions together' (June 2008).

The principal aim of this guidance is to ensure and safeguard that vulnerable patients are enabled, to the best of their abilities, to make decisions relating to their health and welfare. Capacity must always be presumed. A patient can only be seen as lacking capacity if it is clear that, having been given all the appropriate help and support, they cannot understand, use or weigh up the information needed to make a decision.

Introduction

The [Lifespan Learning Disabilities and Autistic Spectrum Disorders Service](#) (LCDS) is a multidisciplinary assessment and intervention service and as such, it requires patients to voluntarily engage in the assessment and treatment process.

Practice protocol

The protocol for adults should be used as a guide when considering consent to treatment in adults with a learning disability. In addition, the following practice protocol should help in ensuring that valid consent/ agreement for treatment is obtained.

- 1.
2. The assessment process itself can act as an important tool in imparting information to the patient regarding the kind of experience he/she is likely to have in the context of therapeutic work and is therefore crucial in enabling patients to give **informed consent**. It is incumbent on the clinician to closely monitor the patient's response to this process, both in terms of verbal and non-verbal communication, to assess both the patient's wishes and their capacity

⁴Note: This appendix is also included in the Trust's Vulnerable Adults Policy - does this mean Safeguarding of Adults at Risk Policy and Procedure??

with regards to consent.

3. The assessment process must include clear and direct indication about a patient's capacity to consent and motivation for treatment; these must be clearly stated in the notes and in the relevant consent form. Wherever possible, written consent should be obtained, however oral statements and non-verbal communications regarding consent need to be recorded with equal status
4. If capacity to consent to treatment is established, treatment can then be offered as appropriate. If the patient is considered to be lacking in capacity to consent to treatment, under the terms of the Mental Capacity Act, a discussion with the referring network and those close to the patient needs to take place with regards to the course of action, which is considered to be in the patient's 'best interest'. Decisions regarding 'best interest' and any points of disagreement regarding this must be clearly recorded in the notes. As far as it is helpful to the patient, the patient should be involved as far as possible in the decision making process.
5. Consent to treatment is not a one off event; a patient may withdraw or give consent at any point during treatment; it is therefore important to be alert to this and to respond accordingly. Clinicians will need to make a judgment to whether a patient is expressing an ordinary degree of ambivalence, or is in fact withdrawing his/her consent.
6. The consent process is to be recorded on the Assessment form, with additional information recorded in the patient's case file **Appendix 5 : Short Guide to Parental Responsibility**

Introduction

In the event that a child is not considered to be old enough and/or mature enough to consent for treatment the trust will seek consent from a person with legal parental responsibility.

The following persons can have parental responsibility:

No order in force	<ol style="list-style-type: none">1. Biological mother of the child2. Biological father of the child if<ol style="list-style-type: none">a. Married to the mother at the time of birth orb. Married to the mother after the birth of the child orc. Is named as the father on the birth certificate (for births after
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	<p>1.12.2003) or</p> <p>d. Has a signed parental responsibility agreement (PRA) with the mother or</p> <p>e. Has obtained a parental responsibility order (PRO) or</p> <p>f. Has obtained a residence order</p> <p>3. Is a step parent and has signed a PRA or obtained a PRO</p>
Care Order	<p>1. Local authority (named social worker)</p> <p>2. Mother</p> <p>3. Father if he has a PR under the 'no order' rules above</p>
Residence order	<p>1. The person named in the residence order (RO) plus:</p> <p>2. As under 'no order' above</p>
Placement order	<p>1. Local authority (adoption agency)</p> <p>2. Birth parent(s)</p> <p>3. Prospective adopters (where the child is placed for adoption) NB if the child is subject of a placement order but NOT placed for adoption the foster carers DO NOT have PR</p>
Special Guardianship order	<p>1. The named special guardian(s)</p> <p>2. Anyone holding a RO</p> <p>3. The Local Authority if a care order is in force</p> <p>4. Others as per 'no order' above</p> <p>5. Local authority (adoption agency)</p> <p>6. Birth parent(s)</p> <p>7. Prospective adopters (where the child is placed for adoption) NB if the child is subject of a placement order but NOT placed for adoption the foster carers DO NOT have PR</p>
<p>Note (1) <i>In law if there are two people with parental responsibility (eg mother and father) consent is only required from one parent (and this is valid even if the other parent disagrees). If this situation arises, the clinician is advised to raise it with the course consultant and/or at supervision.</i></p>	
<p>Note (2) <i>It is the therapists responsibility to ensure that the person from whom consent is sought is authorised in law as holding parental responsibility</i></p>	

Appendix 5 : Guidance for Clinicians on Competence, Consent, and Refusal of Treatment for Children and Young People

Young people should be involved as much as possible in decisions about their health care. At the same time, a balance needs to be struck between autonomy and protection. Young people are entitled to privacy, information, and a level of decision making geared to their maturity. Most young people prefer to share treatment decisions with their parents, but some will wish to exclude their parents, or oppose their parents' and/or clinician's recommendations. Every effort should be made to reach a consensus, including providing more information and time, and the involvement of an independent second opinion. Where agreement is not possible, the law provides more than one approach to avoid deadlock. The challenge is choosing which legal framework is most appropriate to the circumstances of the particular case.

The following is an aid to clinicians supporting young people in their decision making. Good practice requires not only an understanding of the legal and ethical framework but also clinical sensitivity.

Competence

Key Points to consider

- 1. The consent of a young person under the age of 16 years is only valid if a clinician is satisfied that the young person is competent.*
- 2. Competence requires adequate information.*
- 3. The value of information is increased by an opportunity to ask questions and time to think.*
- 4. Competence requires young people to:*
 - understand fully what is proposed,*
 - retain an understanding,*
 - appreciate the importance of information and see how it applies to themselves,*
 - and weigh the information in the balance.*
- 5. The Level of understanding that is sufficient will vary with the complexity and gravity of the decision.*
- 6. Young people's competence can be:*
 - enhanced by support,*
 - impaired by adverse mental or physical states,*
 - and undermined by coercion,*

7. *Judgments about competence can only be made on a case-by-case basis.*
8. *In complex cases, it is best practice to involve an independent clinician.*

Introduction

Competence is central to the law's approach to consent. Only a competent person can give a valid consent. Adults enjoy a presumption of competence and in practice, a similar approach is taken to 16 and 17 year olds. The consent of a young person under the age of 16 years is only valid if a clinician is satisfied that the young person is competent. Competence is about the young person's level of understanding and ability to think about the issues. It varies with the complexity of the decision, the availability of information and time, and the presence of factors that enhance or impair the young person's decision making capacities.

Information and Time

Competence is only possible in the presence of adequate information. The value of information will increase with the opportunity to ask questions and proceed at the young person's own pace (in the absence of an overriding need to act). Translators may be necessary and adaptations made for young people with learning difficulties or deficits in symbolic thinking. Clinicians should make a record of what was shared with the young person and their family.

Understanding

Ruling in the Gillick Case (Gillick v. West Norfolk and Wisbech Area Health Authority), Lord Scarman linked competence to "sufficient understanding and intelligence" to allow a young person "to understand fully what is proposed". (As is well known, this case examined the circumstances in which it would be lawful to give contraceptive advice to a young person under the age of 16 years without parents' permission.) Understanding fully is generally taken to include understanding the nature of what is wrong, the treatment process, the treatment options, the likely risks and benefits of treatment, and the outlook with or without treatment. Alderson (1993) interviewed 120 young people (aged 8-15 years) undergoing elective surgery to relieve chronic orthopaedic pain disability or deformity, she also spoke to their parents. The young people were asked, "How old do you think you were or will be when you're old enough to decide?" (about surgery). Their parents were asked, "at what age do you think your child can make a wise choice?" The two groups gave a similar mean age (the young people said 14.0 years, the parents 13.9). But girls and their parents thought they would be ready to decide 2 years earlier (girls: 13.1 years, and girls' parents: 12.8, compared with boys: 15.0 years; boys' parents 14.9). However most young people wanted to share the decision with their parents, only a few wanted to be the "main decider" (21 out of 120).

Complexity and Gravity of the Decision

The level of understanding that is sufficient will vary with the complexity and gravity of the decision. Of particular importance are the relative benefits, risks and burdens of the treatment options (where the burdens are the demands, inconvenience or suffering a particular treatment is likely to be required). Greater understanding is expected if the burdens are heavy, the risks high, or the benefits uncertain. Similarly, a higher level of understanding is required if young people refuse treatment.

Building on Understanding

Lord Justice Thorpe's decision in *Re C (Adult: Refusal of Medical Treatment)* broadened the concept of competence established by Gillick. C was a patient at Broadmoor Hospital suffering from schizophrenia who refused amputation of his gangrenous foot. Ruling that C should decide for himself, the court defined competence as "first comprehending and retaining information, secondly, believing it and thirdly, weighing it in the balance to arrive at a choice". In this context believing means the young person appreciates the importance of information and sees how it applies to them. A young person may weigh the information differently from their parents or clinician, and unwise choices might be permitted. Pearce (1994) has argued that because: "the consequences of withholding consent are usually much more significant and potentially dangerous...a more stringent test should therefore be applied". On the other hand it may be more respectful to recognize that a young person is competent but over ride their decision on the basis of welfare (Shaw 2002) (see section on refusal below). Finally, when evaluating young people's competence it is important not to set a higher standard than would be expected for adults.

Enhancing Competence

Young people's competence will be enhanced if they feel loved and supported. As mentioned earlier most young people prefer to discuss important decisions with a family member or friend. Equally, discussion with health professionals will be more productive when the relationship is founded on trust and respect.

Threats to competence

Competence can be impaired by disordered mental or physical states. Ruling in the case of MB a woman who refused a caesarean section because of a needle phobia, Lady Justice Butler-Sloss cited "temporary factors...confusion, shock, fatigue, pain or drugs may completely erode capacity...another such influence may be panic induced by fear"

(Re MB (Caesarean Section)). Mental illness may render a young person incompetent; however, it is important not to assume that all (or even most) mentally ill people are incompetent. Finally, competence can be undermined by coercion (however well intentioned) from family, or even clinicians.

Assessing competence

Judgments about competence can only be made on a case-by-case basis. As Rutter (1999) points out "...there is no universally acceptable level of competence that applies to an individual child. Rather, the question is of a child's competence in a particular context, for a particular type of decision, given particular circumstances". When there is genuine doubt over competence it may be useful to get a second clinical opinion (something that is always required where Section 58 of the Mental Health Act 1983 pertains). In any event, clinicians must make a full record of the basis for any judgment about competence. The criteria are derived from Re C and it will be important to indicate whether the young person was not competent because he or she: "is unable to take in and retain the information material to the decision especially as to the likely consequences of having, or not having treatment"; or "is unable to believe the information"; or "is unable to weigh the information in the balance as part of a process of arriving at the decision". (chapter 15 of the Mental Health Act 1983 Code of Practice 1999).

Consent

Key points to consider

- 1. Outside of emergencies or the Mental Health Act 1983, consent is a prerequisite to treatment.*
- 2. Consent is a voluntary and continuing permission to receive a particular treatment, based on an adequate knowledge.*
- 3. Consent can be withdrawn at any time and patients are not bound by written consent.*
- 4. If a 16 or 17 year old consents, it is unnecessary to seek consent from a person with parental responsibility.*
- 5. A competent person under 16 has an independent right to treatment; however, it is good practice to also seek consent from a person with parental responsibility.*
- 6. Where a young person is not competent, treatment can proceed with the consent of a person with parental responsibility.*
- 7. Sometimes it may be necessary to seek consent from the High Court.*
- 8. The basis for believing that a young person gave valid consent should be recorded in the clinical record.*

The Requirement for consent

Other than for emergencies or in the circumstances described in part IV of the Mental Health Act 1983, consent is a necessary prerequisite to the treatment of any person. The Code of Practice for the Mental Health Act defines consent as “the voluntary and continuing permission of the patient to receive a particular treatment, based on adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Permission given under any undue pressure is not consent. Giving and obtaining consent is a process not a one-off event” (DoH 2001 Good practice on consent implementation guide). Consent can be withdrawn at any time and patients are not bound by written consent.

It is unlikely that the written consent of the patient will be required for routine assessment and treatment in the Child & Family Department. The Department of Health say “It is rarely a legal requirement to seek written consent, but it is good practice to do so if any of the following circumstances apply: the treatment or procedure is complex, or involves significant risks...; the procedure involves general/regional anaesthesia or sedation; providing clinical care is not the primary purpose of the procedure; there may be significant consequences for the patient’s employment, social or personal life; the treatment is part of a project or programme of research” (DoH Good practice in consent implementation guide 2001). However, the basis for believing that the young person gave valid consent should be recorded in the file. This will include that they were competent and gave consent: free of “unfair or undue pressure”; and “based on an adequate knowledge of the purpose, nature, likely risks of that treatment including the likelihood of its success and any alternatives to it”; and “the patient was invited to ask questions”; and that the patient has been “told that his or her consent to treatment can be withdrawn at any time” (chapter 15 of the Mental Health Act 1983 Code of Practice 1999).

Who can give Consent?

Where a young person is competent, we would normally seek their consent. “Even where children are not able to give consent for themselves it is very important to involve them as much as possible in decision about their own health” (DoH 2001 Seeking consent: working with children). Alderson, (see section on competence above) cites: out of respect for the young person; to answer questions and help the young person know what to expect; to reduce anxiety; to help the young person make sense of their experience; to prevent misunderstandings or resentment; to promote confidence and courage; and increase compliance.

Where the young person is not competent, treatment can proceed with the consent of a person with parental responsibility (including the local authority with a care order). In exceptional circumstances, the High Court may be asked to consent on behalf of a young person. "It is good practice to involve all those close to the child in the decision making process" (DoH 2001 Seeking consent: working with children). Where one person with parental responsibility consents but their decision is opposed by another person with parental responsibility the onus is on the objecting parent to obtain a court order blocking treatment (Children Act 1989 s2 (7)).

It would normally be inappropriate for a parent who has abused a child to give consent on that child's behalf. Where the young person is not already in the care of the local authority (who will then hold parental responsibility), the High Court's authority should be sought. In the case of an unaccompanied minor unable to give valid consent, outside of an emergency the young person will need to be taken into care or the authority of the Court should be sought.

Those aged 16 or 17

The Law Reform Act 1969 lowered the age of majority to 18 years, and gave 16 and 17 year olds the same right of consent as adults (s8 [1]). This means that if a 16 or 17 year old person consents it is unnecessary to seek consent from a person with parental responsibility. (However, see the section on refusal, below.)

Those under 16

As described above, the competence of a young person under the age of 16 years is considered in light of the Gillick decision (see above). It gives under 16 year olds with sufficient understanding ("Gillick competent") an independent right to consent to treatment. In his ruling in the Gillick case, Lord Fraser set out five preconditions that would justify a doctor prescribing contraceptives to a young woman under the age of 16 years without her parents' consent:

- That the girl (although under the age of 16 years) will understand the doctor's advice.
- That the doctor cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice.
- That she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment.
- That unless she receives contraceptive advice or treatment, her physical or mental health or both is likely to suffer.
- That her best interests require the doctor to give her contraceptive advice or treatment, or both, without parental consent.

Clinical experience predicts that treatment will be less effective if parents are excluded. The principals of Lord Fraser's preconditions help delineate a small group of young people where treatment may still be appropriate. Although there is no legal age limit, Bailey and Harbour suggest that it would rarely be appropriate for a young person under the age of 13 years to consent to treatment without their parents' involvement

Refusing Treatment

Key Points to consider

- 1. Every effort should be made to reach a consensus, including providing more information and time, and the involvement of an independent second opinion.*
- 2. The Mental Health Act 1983 goes further to protect the rights of young people treated against their wishes.*
- 3. The consent of a person with parental responsibility will override the refusal of the young person.*
- 4. But the power to over-rule a competent young person's refusal should be used very rarely and it would be appropriate to seek legal advice before proceeding.*
- 5. And it would be inappropriate to use parental authority where young people have been abused or neglected by their parents.*
- 6. Occasionally the court needs to intervene where parents withhold treatment.*

Finding a way forward

Young people will sometimes refuse treatment despite the most sensitive and skilled approach of clinicians and parents. Pearce (1994) suggests that "every effort should be made to reach consensus, however protracted this process may be – so long as this does not involve taking unacceptable risks with the child's future health...It is usually better to delay treatment until attitudes and relationships have changed – which could just as easily be the professional's attitude as the patient's". Again, it may be useful to get a second opinion from an independent clinician and it is essential that the basis for any decision is fully recorded.

Where agreement is not possible, the law provides more than one approach to avoid deadlock. The challenge is choosing which legal framework is most appropriate to the circumstances of the particular case.

The Mental Health Act 1983

The Mental Health Act 1983 may be used to treat people of any age. With its requirement for a second opinion, time limited application and opportunity for independent review, the Mental Health Act 1983 goes further than common law (see below) to protect the rights of young people treated against their wishes. However, there is still a stigma attached to treatment under the Mental Health Act. Furthermore because treatment can proceed with the consent of a person with parental responsibility (see below) there are difficulties meeting the Mental Health Act 1983's requirement that "treatment...cannot be provided unless he is detained" (s3 (2) (c)). The new draft Mental Health Bill proposes that for 16 or 17 year olds "refusal to consent or resistance may not be overridden by the giving of consent by a person who has parental responsibility for him" (s202 (5)). Under 16 year olds are treated with parental consent but with various safeguards (part 6 Chapter 2).

Adults' right to refuse

Other than the circumstances described in part IV of the Mental Health Act 1983, once a person has reached the age of 18 years they have a right to refuse treatment "for reasons which are rational or irrational, or for no reason" (Sidway v. Board of Governors of Bethlem Royal Hospital and Maudsley Hospital).

The Children Act 1989

The Children Act 1989 explicitly gives those who are under 16 years old and competent the right to refuse assessment and treatment in the very limited circumstances of care proceedings (s38 (6), s43 (8), s44 (7) and paragraphs 4 (4) (a) and 5 (5) (a) of Schedule 3). The Act and accompanying guidance and regulations place considerable emphasis on taking account of the young person's views. However, the central premise of the Children Act is that "the child's welfare shall be the court's paramount consideration" (s1 [1]). Unlike the competent adult, the competent young person's views may be overruled in pursuit of his or her welfare.

Decisions in *Re R & Re W* curtail a young person's ability to refuse treatment. Furthermore, two rulings by the Court of Appeal (*Re R (A Minor) (Wardship: Medical Treatment)* and *Re W (A Minor) (Wardship: Medical Treatment)*) significantly curtail a young person's ability to refuse treatment. They concern R, a 15 year old young woman refusing antipsychotic medication, and W, a 16 year old young woman with anorexia nervosa refusing transfer to another treatment centre. In both cases the Court of Appeal decided that treatment could lawfully precede with the consent of a person with parental responsibility effectively ignoring the refusal of a young person whether or not they were competent and even when they were over 16 years. In the

Gillick decision, Lord Scarman said: "the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed". In *Re R* Lord Donaldson argued that in Gillick "Lord Scarman was discussing the parent's right to determine whether or not their minor child below the age of 16 will have medical treatment...a right of determination is wider than a right of consent...I do not understand Lord Scarman to be saying that, if a child was "Gillick competent" ...the parents cease to have a right of consent as contrasted with ceasing to having a right of determination, i.e. a veto. In a case in which the "Gillick competent" child refuses treatment, but the parents' consent, that consent enables treatment to be undertaken lawfully".

As it stands, common law allows a competent young person to consent to treatment; but does not recognize refusal if consent can be obtained from a person with parental responsibility. Many commentators consider this contradictory, even Lord Balcombe ruling in *Re W* admitted: "in logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment". A challenge under Article 5 of the Human Rights Act 1998 "right to liberty" seems possible. However, some years ago the European Court of Human Rights upheld a mother's right to make decisions about psychiatric admission on her son's behalf under her Article 8 "right to respect of private and family life" (*Nielsen v Denmark*). The Department of Health recommend the "power to over-rule a competent child's refusal should be used very rarely" (2001 *Seeking consent: working with children*).

It would be appropriate to seek legal advice before using parental consent to treat a young person against their wishes (especially where they are competent and older). It may even be necessary to go to Court, for example, the British Medical Association (2001) recommends involving the Court where restraint or detention under parental consent is contemplated. As mentioned above it would normally be inappropriate for a parent who has abused a child to override a young person's refusal. Where such a young person is not already in the care of the local authority, the High Court's authority should be sought.

Parents who refuse treatment for their child

Parents have a duty under the Children and Young Persons Act 1933 5(1) to obtain essential medical assistance for a child under the age of 16 years. Occasionally the court needs to intervene in situations where parents withhold treatment. Where parent's refusal is part of a wider process of neglect or abuse, a care order may be appropriate. This gives the local authority parental responsibility, and treatment can proceed with their consent. Alternatively if the parents' care is generally satisfactory and their objection to treatment is on the basis of religious or other firmly held beliefs,

it is possible to ask the High Court to use its inherent jurisdiction to overrule the parents, or apply a Specific Issues Order of the Children Act 1989 (s8).

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References

Anderson P. Children's consent to surgery. Buckingham: open University Press, 1993.

Bailey P, Harbour A. The law and child's consent to treatment (England and Wales). *Child Psychol Psychiatry Rev* 1999; 4:30-4.

Bastable R, Sheather J. Mandatory reporting to the police of all sexually active under-13s. *BMJ* 2005; 331:918-919

British Medical Association. Consent, rights and choices in health care for children and young people. London. BMA, 2001.

Department of Health and Welsh Office. Code of practice: Mental Health Act 1983. London HMSO, 1999.

Gillick v. West Norfolk and Wisbech Area Health Authority [1986] AC 112

Nielsen v Denmark [1988] 11 EHRR 175

Pearce J. Consent to treatment during childhood: the assessment of competence and avoidance of conflict. *Br J Psychiatry* 1994; 165:713-6.

Re C (Adult: Refusal of Medical Treatment) [1994] 1 FLR 31

Re MB (Caesarean Section) [1997] 8 Med LR 217, (1997) 38 BMLR 175, CA

Re R (A Minor) (Wardship: Medical Treatment) [1992] Fam 11, [1991] 4 All ER 177, CA

Re W (A Minor) (Wardship: Medical Treatment) [1993] Fam 64, [1992] 4 All ER 627, CA

Rutter M. "Research and the family justice system: What has been the role of research and what should it be?". 3rd Annual Lecture of the National Council for Family Proceedings and reprinted in its newsletter (1999), pp2-6.

Shaw M. When young people refuse treatment: balancing autonomy and protection. In *Delight and Dole the Children Act 10 years on*. Eds Thorpe & Cowton. London. Jordon, 2002.

Sidway v. Board of Governors of Bethlem Royal Hospital and Maudsley Hospital [1985] AC 871