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# Competence and consent to treatment in children and adolescents

Mike Shaw

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English law on young people's consent to treatment and competence is complex and can even appear contradictory. For example, competent minors can consent, but their refusal can be overruled by the consent of a person with parental authority or by the court. This paper is an attempt to make sense of the topic for clinicians. It includes a discussion of the law and the small body of relevant research evidence. There are clinical case examples, check-lists and guidelines for good practice. However, it is not a substitute for legal advice, which should be sought wherever doubt remains.

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## Competence

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### *Developmental perspectives*

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The law imposes a dichotomy (competent *v.* incompetent) on what, from a developmental perspective, is a spectrum of ability. Weithorn & Campbell (1982) compared decision-making in four age groups (9, 14, 18 and 21 years) using healthy subjects and hypothetical situations. The 14-year-olds showed a level of competence similar to that of the two adult groups. There were deficits in the 9-year-olds' understanding and reasoning, but their conclusions were very similar to those of the other groups.

Alderson (1993) interviewed 120 young people (aged 8–15 years) undergoing elective orthopaedic surgery; she also spoke to their parents and health professionals. Surgery was being undertaken for relief of chronic pain, disability or deformity, and

on average the patients had already had five operations. 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 very 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 than boys and their parents (girls: 13.1 years; girls' parents: 12.8; boys: 15.0; boys' parents 14.9).

Alderson also asked 983 ordinary school pupils (aged 8–15 years), "At what age do you think someone is old enough to decide with their doctor about surgery, without their parents being involved?" They gave a slightly older age than the orthopaedic group (mean of 15–17 years, compared with 14). It seems likely that past exposure to treatment decisions made the orthopaedic group more confident, suggesting that young people can be prepared for making treatment decisions.

In response to the question "Children vary greatly, but what is around the youngest age you think some of your patients could be trusted to make sensible, wise, mature decisions about proposed surgery?", health professionals recommended a mean age of 10.3 years, much younger than their patients or the parents. This suggests that these health professionals were in danger of expecting too much of their young patients.

Only a few young people in the orthopaedic group wanted to be the 'main decider' (21 out of 120). Asked what they might do if they disagreed with their parents over the decision on surgery, relatively few said they would try to get their own way (22%

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of boys, 11% of girls). This suggests that conflict of this sort was relatively unlikely.

McCabe (1996) provides an excellent review of young people's cognitive and social development in relation to decision-making, while Reder & Fitzpatrick (1998) draw attention to the influence of emotional factors. Reviewing what research can contribute to our understanding of competence, Rutter (1999) concludes:

"Often there is a wish, by courts and by researchers, that there be a suitable simple criterion or measure of competence that could be applied in a standardised fashion. Unfortunately, not only is no such test available but ... it is highly unlikely that such a test could be devised. That is because 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."

## The law

The concept of competence is central to the law's approach to consent. The Gillick decision (see below) defines competence as the ability to understand information about the proposed treatment. This includes the treatment's purpose, nature, likely effects and risks, chances of success and the availability of any alternatives. The patient may weigh the information differently from the doctor, and unwise choices are permitted. Also, understanding does not imply that a decision is made on a rational basis. In fact, many critical decisions in our lives, such as whom we marry or which car we buy, are based on 'gut feelings' rather than rational analysis.

In practice, the level of understanding required is affected by the risk-benefit ratio of the proposed treatment. If the treatment is simple, effective and relatively risk-free, a high-level criterion will be selected and a patient who refuses is more likely to be deemed incompetent. Alternatively, where the treatment is dangerous and the benefits speculative, a lower criterion is selected, to protect the patient's autonomy.

Some feel that young people who refuse treatment should demonstrate a greater degree of understanding than those who consent. Pearce (1994) argues:

"The consequences of withholding consent to treatment are usually much more significant and potentially dangerous than simply giving consent... A more stringent test should therefore be applied when assessing a child's ability to refuse consent than when assessing competence to consent." (p. 713)

He goes on to talk about striking a delicate balance:

"There is a danger of using 'in the best interests of the child' as an excuse for poor communication and

for failing to take the necessary time to explain the proposed treatment properly. At the same time there is also a risk of placing an unacceptably high level of responsibility on the child which can release parents from their own duty of care." (p. 715)

However, it is difficult to define a level of understanding that is adequate. Understanding can only be inferred and not observed directly, it is influenced by the quality of information given, and the ability to understand is not the same as actual understanding.

Judgements about competence are seldom neat. Roth *et al* (1977) say,

"The search for a single test of competency is a search for a Holy Grail... In practice, judgements of competency go beyond semantics or straightforward applications of legal rules; such judgements reflect social considerations and societal biases as much as they reflect matters of law and medicine." (p. 283)

The clinician's preference for a treatment may cloud his or her assessment of the patient's competence. This, as Devereux *et al* (1993) put it, is revealed in

"the catch 22 by which patients whose competence is in doubt will be found rational if they accept the doctor's proposal but incompetent if they reject professional advice." (p. 1460)

## Guidelines

The legal test for competence is set out in Justice Thorpe's decision in *Re C (Adult: Refusal of Medical Treatment)* (C was a patient at Broadmoor Hospital suffering from schizophrenia who refused amputation of his gangrenous foot), describing it as:

"first comprehending and retaining information, secondly, believing it and thirdly, weighing it in the balance to arrive at a choice". (p. 36)

The same test has since been applied to a young person in *Re C (Detention: Medical Treatment)*.

The Department of Health's (DoH; 1999a) guidance emphasises the decision in *Re MB (Caesarean Section)*, which repeats and expands on the advice given in *Re C*, but adds two further elements (MB was a pregnant woman who was declared incompetent when a needle phobia led to her refusing a caesarean section). In her judgment Lady Justice Butler-Sloss drew attention to:

"The 'temporary factors' mentioned by Lord Donaldson MR in *Re T (supra)* (confusion, shock, fatigue, pain or drugs) may completely erode capacity but those concerned must be satisfied that such factors are operating to such a degree that the ability to decide is absent.

Another such influence may be panic induced by fear. Again careful scrutiny of the evidence is necessary

**Box 1 Recommendations on competence  
(British Medical Association & the Law  
Society, 1995)**

**Assessments of competence should consider  
a young person's:**

**Ability to understand that there is a choice  
and that choices have consequences**

**Willingness and ability to make a choice  
(including the option of choosing that  
someone else makes treatment decisions)**

**Understanding of the nature and purpose of  
the procedure**

**Understanding of the procedure's risks and  
side-effects**

**Understanding of the alternatives to the  
procedure and the risks attached to them,  
and the consequences of no treatment**

**Freedom from pressure**

because fear of an operation may be a rational reason for refusal to undergo it. Fear may also, however, paralyse the will and thus destroy the capacity to make a decision." (p. 224)

Specific guidance on young people is included in guidelines drawn up jointly by the British Medical Association & the Law Society (1995). Their recommendations are outlined in Box 1.

Judgements about competence can only be made case by case, taking account of the individual, the type of decision and the particular circumstances (see Box 2). In complex cases it is best practice for an independent clinician to advise on competence. It is vital to document carefully all the factors contributing to a judgement of competence. Finally, it is important not to set a higher standard for competence than would be expected for adults.

**Case example 1**

A 14-year-old boy with tourette syndrome has received clonidine for many years. He has become unhappy and hostile since it emerged that his mother was having an affair. Biological symptoms of depression responded to antidepressants. But after a row with his mother he stops the medication, claiming that he does not want his mood 'artificially' improved.

**Case example 2**

A 12-year-old girl with anorexia nervosa is refusing all food and drink and she appears withdrawn and perplexed. She understands that all living things need energy and water to survive, but claims she does not want to become incapacitated or die.

The boy's rejection of antidepressants is inconsistent with continuing to take clonidine, and it appears

motivated by anger with his mother. Although he is behaving irrationally, there is no suggestion that his capacity to understand is impaired. By contrast, it is doubtful whether the girl appreciates the physical dangers of not eating. Although she may be able to comprehend and retain the relevant information, she is unable to believe it (in the sense of seeing how it applies to her) or weigh it in the balance. (If this girl needs to be treated against her wishes, the Mental Health Act 1983 will go further than the Children Act to protect her rights – see Refusal below.)

## Consent

### *The law*

Other than for emergencies or in the circumstances described in Part IV of the Mental Health Act 1983,

**Box 2 A competence checklist**

**Young people are more likely to be competent  
and contribute to decision-making:**

**In the presence of**

- a supportive and affectionate parent–child relationship
- trust and confidence in the doctor–patient relationship
- adequate information presented in an appropriate way

**If free from**

- pressure
- panic
- pain
- other 'temporary factors' that could impair judgement

**Understanding**

- that there is a decision to make
- that decisions have consequences
- the nature of the illness
- the nature of the recommended intervention and any alternatives
- risks and benefits of interventions or no intervention
- longer-term consequences of each option

**If able to**

- retain an understanding
- appreciate its importance
- see how it applies to them
- weigh the issues in the balance
- arrive at a decision

consent is a necessary prerequisite for the treatment of any young person. The DoH's Code of Practice Mental Health Act 1983 (DoH & Welsh Office, 1999) gives the following definition of consent (15.3):

“‘Consent’ is the voluntary and continuing permission of the patient to receive a particular treatment, based on an 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 unfair undue pressure is not ‘consent’.”

The recent General Medical Council guidance (1999) on consent places particular emphasis on providing patients with adequate information and freedom from pressure.

Table 1 gives a summary of who can consent. An adult having parental responsibility (including a local authority having a care order) can give consent on behalf of a young person (before the 18th

**Table 1 Who can consent?**

	Consent	Consent of others	Best interests	Refuse
<b>Adults</b>				
Competent	Yes Consent is the only basis on which treatment of a competent adult can occur	No No one else can give consent on behalf of a competent adult	No A competent adult's best interests are irrelevant	Yes Refusal may be rational, irrational or groundless
Incompetent	No No incompetent person can give a valid consent	Yes Court can consent on behalf of an incompetent adult	Yes Incompetent adult can be treated in his or her best interests	No No incompetent person can withhold consent
<b>16- and 17-year-olds</b>				
Competent	Yes Without need for consent from a person with parental responsibility	Yes 1. Persons with parental responsibility 2. High Court jurisdiction 3. Specific issues order	Yes Welfare of child is court's main consideration (Children Act), but court's authority is needed	No Competent minor who withholds consent can be overruled by court or person with parental responsibility
Incompetent	No No incompetent person can give a valid consent	Yes 1. Persons with parental responsibility 2. High Court jurisdiction 3. Specific issues order	Yes Welfare of child is court's main consideration (Children Act), but court's authority is needed	No No incompetent person can withhold consent
<b>Under-16-year-olds</b>				
Competent	Yes But if possible also with consent of person with parental responsibility	Yes 1. Persons with parental responsibility 2. High Court jurisdiction 3. Specific issues order	Yes Welfare of child is court's main consideration (Children Act), but court's authority is needed	No Competent minor who withholds consent can be overruled by court or person with parental responsibility
Incompetent	No No incompetent person can give a valid consent	Yes 1. Persons with parental responsibility 2. High Court jurisdiction 3. Specific issues order	Yes Welfare of child is court's main consideration (Children Act), but court's authority is needed	No No incompetent person can withhold consent

birthday). However, this power is subject to a number of qualifications.

### Sixteen- and seventeen-year-olds

The Family 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) says:

“the consent of a minor who has attained the age of sixteen ... shall be as effective as it would be if he were of full age; and where a minor has ... given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian”.

This means that if a 16- or 17-year-old consents it is unnecessary to seek consent from a person with parental responsibility (but see Refusal below.)

### Under-sixteen-year-olds

As described above, the competence of a young person under the age of 16 years is considered in light of the Gillick decision. 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 the parents' permission. In his judgment Lord Scarman said:

“the parental right to determine whether or not their minor child below the age of sixteen 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” (Gillick *v.* West Norfolk and Wisbech Area Health Authority, 1986).

This ruling gives under-16-year-olds with sufficient understanding ('Gillick competent') an independent right to consent to treatment. However, even with a Gillick-competent young person (under the age of 16) it is good practice also to seek consent from a person with parental responsibility. 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. These are summarised as follows:

- 1 that the girl would understand the clinician's advice;
- 2 that the clinician cannot persuade her to tell her parents or to allow him to tell them that she is seeking contraceptive advice;
- 3 that she is very likely to begin or continue to have sexual intercourse with or without contraceptive treatment;
- 4 that unless she receives contraceptive advice or treatment her physical and mental health or both are likely to suffer;
- 5 that her best interests require the clinician to give her contraceptive advice, treatment or both without parental consent.

Although there is no lower age limit, Bailey & Harbour (1999) suggest it would rarely be appropriate for a person under the age of 13 years to consent to treatment without a parent's involvement. Boxes 3 and 4 present a consent checklist and guidelines for good practice on consent.

### Clinical practice

There are many reasons for informing children and gaining their cooperation over and above obtaining valid consent. Alderson (1993) cites: respect for the child; to answer questions and help the child know what to expect; to reduce anxiety; to help the child make sense of the experience; to warn about risks; to prevent misunderstanding or resentment; to promote confidence and courage; and to increase compliance.

Young people are not involved in treatment decisions as often they should be. Rylance *et al* (1995) looked at consent in an immunisation campaign for school children. They distributed a questionnaire concerning consent to 851 school pupils (11- to 15-years-old) within 21 days of the campaign; 513 (60%) were completed and returned. While 435 (85%)

#### Box 3 Consent checklist (adapted from Pearce, 1994)

##### *The child's stage of cognitive development*

Does the child have a satisfactory understanding of the following?

- the nature of the illness
- his or her own needs and the needs of others
- the risks and benefits of the treatment
- his or her own self-concept
- significance of time: past, present, future

##### *The parent-child relationship*

Is it supportive and affectionate?

##### *The doctor-patient relationship*

Is there trust and confidence?

##### *The views of significant others*

Whose opinion influences the child and how?

##### *The risks and benefits of the treatment*

What are the risks of treatment *v.* no treatment?

##### *The nature of the illness*

How disabling, chronic or life-threatening?

##### *The need for consensus*

Is more time or information needed?

Is a second opinion required?

**Box 4 Guidelines for good practice on consent (modified with permission from Shaw, 1998)**

- 1 Parents and young people (whether or not they are competent) need to be informed and involved as much as possible in treatment decisions.
- 2 Treatment can proceed with the consent of a person having parental responsibility and the incompetent young person's agreement, or the competent young person's consent.
- 3 If either the parent or young person refuses, treatment should be delayed for more discussion, modification of the treatment plan, or the help of an independent arbiter.
- 4 Treatment may proceed with the consent of one person having parental responsibility (Children Act, s2 (7)) even if there is opposition from another. The onus is on the latter to obtain a prohibited steps order under section 8.
- 5 If there is no person having parental responsibility willing to consent to a necessary action or treatment programme for a child who is not competent, consideration must be given to obtaining a specific issue order or asking the local authority to seek a care order.
- 6 Overruling the refusal of any young person (competent or not) should be considered only if:
  - (a) discussion and modification of the treatment have been exhausted;
  - (b) (and) the parents are in favour, or the authority of the court is obtained;
  - (c) (and) the young person is more likely than not to suffer significant harm without treatment.
- 7 Before treating a young person against his or her will:
  - (a) consider whether treatment under the Mental Health Act is indicated;
  - (b) alternatively, the decision should be confirmed by a second opinion;
  - (c) (and) a time limit set for reviewing the decision;
  - (d) (and) the reasons for the decision should be recorded in the notes.
- 8 If it is considered necessary to overrule the refusal of consent by a competent child, legal advice should be taken on whether to rely on the consent of a person having parental responsibility, if available, or whether to seek the authority of the court.
- 9 Parents or the young person can withdraw consent at any time.
- 10 Staff need to be aware of the service's policy on consent.
- 11 Staff will need training and ongoing support to achieve an appropriate balance between autonomy and protection.

children felt they had sufficient understanding to make a decision regarding immunisation, only four (1%) considered the information leaflet to be directed at young people, and only 34 (7%) reported that they had been asked to give consent. Most did not believe that attending the immunisation session implied consent (333, 65%), or that health professionals should assume that they consented (300, 58%).

**Case example 3**

During a follow-up appointment a 15-year-old confides that she took 30 paracetamol a few days earlier. She told no one at the time and is still reluctant to tell her parents.

**Case example 4**

A mother gives permission for her 12-year-old son's admission to hospital but forbids staff to contact his estranged father, hinting that her former partner is likely to object and be litigious.

Under the circumstances envisaged by Lord Fraser, the young woman in case example 3 can be treated without her parents' consent (which would require them to be informed about the overdose). It is then a matter of judgement whether it is safer to encourage her to talk to her parents, respecting her decision if she chooses not to tell them, or to break her confidence.

In case example 4, admission may proceed with the consent of one person having parental responsibility (Children Act, s2 (7)) even if there is opposition from another. The onus is on the latter to obtain a prohibited steps order (Children Act, s8 (1)). Unmarried fathers do not have parental responsibility unless they have taken legal steps to acquire it. It is good practice to keep an absent parent informed, but a matter of judgement how far to pursue this under circumstances like this where there is conflict.

## Refusal

### The law

A competent adult has a right to refuse treatment "for reasons which are rational or irrational, or for no reason" (*Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital*, 1985). The Children Act explicitly gives competent under-16-year-olds the right to refuse assessment and treatment in the very limited circumstances of care proceedings (which can be overridden by the court). There are five provisions in the Act whereby a child of sufficient understanding to make an informed decision may refuse medical or psychiatric examination or other assessment: s38 (6), s43 (8), s44 (7) and paragraphs 4 (4) (a) and 5 (5) (a) of Schedule 3; and one provision where the child can refuse medical or psychiatric treatment: paragraph 5 (5) (a) of Schedule 3.

The Act and accompanying guidance and regulations place considerable emphasis on taking account of the child's views. But 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 child's views may be overruled in pursuit of his or her welfare.

Two further rulings by the Court of Appeal (*Re R (A Minor) (Wardship: Medical Treatment)*; *Re W (A Minor) (Wardship: Medical Treatment)*) have significantly curtailed a young person's right to refuse treatment. They concern R, a 15-year-old woman refusing antipsychotic medication, and W, a 16-year-old woman with anorexia nervosa refusing transfer to another treatment centre. In the case of R, Lord Donaldson argued that in the Gillick ruling:

"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 ceased to have a right of consent as contrasted with ceasing to have 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." (*Re W (A Minor) (Wardship: Medical Treatment)*)

In both cases the court ruled that treatment could lawfully proceed with the consent of either a competent young person or a person with parental responsibility, and that the consent of a person with parental responsibility would override the refusal of a young person. These rulings have effectively

made it impossible for a competent minor to refuse treatment and have led to controversy. In his judgment in *Re W*, Lord Justice Balcombe admitted:

"[I]n logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment."

However, Mason & McCall Smith (1999) argue that the Court of Appeal was right in its interpretation of s8 (3) of the Family Law Reform Act 1969 as upholding the right of someone with parental responsibility to consent on behalf of a minor, as it says,

"Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted."

Where a competent young person withholds consent, it may still be advisable to obtain the authority of the court for treatment. In cases involving sterilisation or abortion the court's guidance should always be sought. If neither the young person nor any other person can give valid consent, the authority of the court should be sought, unless emergency treatment is required.

There are other situations where the competent young person can be overruled. When he or she is in care, the local authority has parental responsibility and can give consent (parents also retain responsibility and it is good practice to consult them). Young people who are wards can only receive treatment with the leave of the court (*Re G-U (A Minor) (Wardship)*), and the court can use its inherent jurisdiction to overrule a competent child (*Re W*).

The Children Act has no specific safeguards for young people whose refusal of treatment has been overruled. A competent young person could instruct a solicitor to seek a specific steps order, but this would require an unusual degree of initiative and understanding of the law. This contrasts with the strict safeguards governing restriction of liberty in the Children Act: a young person's liberty cannot be restricted for more than 72 hours in any consecutive 28 days without the authority of the court (Regulation 10(1)) and must have access to legal representation in any proceedings (S25 (6)).

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 goes further than the Children Act to protect the rights of young people treated against their wishes. However, there is still a stigma attached to being detained under the Mental Health Act. Where there is a choice between using the Mental Health Act or the Children Act, account may be taken of the family's preferences. My own view is that in situations where the Mental Health Act would normally apply, it should be

preferred. (For a full comparison of the two legal frameworks see: Williams & White, 1996; Bailey & Harbour, 1999.) The Mental Health Act is about to be revised and the inclusion of a test for capacity is one of the proposals being considered (DoH, 1999b).

In Scotland competent minors have an independent right to consent to or refuse treatment (the Age of Legal Capacity (Scotland) Act 1991).

Parents have a duty under the Children and Young Persons Act 1933 5(I) to obtain essential medical assistance for a child under the age of 16 years. The court needs to intervene if parents withhold treatment, the young person is either not competent or refuses to consent, discussion and modification of a treatment plan have been exhausted, or the young person is more likely than not to suffer significant harm without treatment. Where the parents' 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 the treatment can proceed with its consent. If the parents' care of the child is generally satisfactory and their objection to treatment is based on religious or other strongly held beliefs, it is possible either to ask the High Court to use its inherent jurisdiction to overrule the parents (Children Act, s100), or to apply for a specific issue order (Children Act, s8 (1)). (See Mason & McCall Smith, 1999, for an excellent exploration of the court's approach when parents disagree with medical advisors on prolonging life.)

On 2 October 2000 the Human Rights Act 1998 came into force, incorporating the European Convention on Human Rights into domestic law. Article 8 of the Act deals with the right to "private and family life" and could form the basis for a challenge to the court's existing approach to young people and refusal to treatment.

## Guidance

Gaining the trust, cooperation and consent of young people who have been abused poses particular challenges. In these circumstances it may be utterly inappropriate to use parental authority to override the young person's objections (in the last resort application to the court may be needed).

The young person will sometimes refuse treatment despite the most sensitive and skilled approach of staff and parents. Pearce (1994) suggests that

"[e]very effort should be made to reach a 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."

The British Medical Association (1993) has suggested that another health professional be asked to act as an independent arbiter and attempt to negotiate an agreement.

I believe no young people (competent or otherwise) should be treated against their will unless they are more likely than not to suffer significant harm without treatment. Even when overruling a young person's refusal it will often be possible to give limited choices.

The guidelines in Box 4 are based on the best features of the law and guidance in this area.

### Case example 5

A 12-year-old girl with poorly controlled insulin dependent diabetes has been to school for only a few days in the past 3 years. Her mother has a long history of depression and agoraphobia and the family is socially very isolated. Despite close liaison with the paediatric team and school over several years, the local child and adolescent mental health service has not managed to engage the family.

### Case example 6

A 10-year-old boy is significantly handicapped by a combination of hyperkinetic disorder and oppositional defiant disorder. He and his mother were repeatedly threatened and physically assaulted by his substance-misusing father. His mother is now in a relationship with a non-violent partner, but continues to be troubled by post-traumatic stress disorder and bouts of depression. The family has been referred to a child psychiatric in-patient unit and, while the mother is very motivated to get help, the boy is adamant that he will not go into hospital and physically attacked staff on his first visit to the unit.

In case example 5, the mother's reluctance seems at least as important as her daughter's. A care order would give social services the authority to ensure that the girl attends school and medical appointments. If the situation does not improve the girl might have to be removed from home.

In case example 6, abuse has sensitised this boy to feeling coerced, and a battle of wills over admission is likely to provoke stubborn resistance. For admission to succeed considerable time and patience will be needed to engage this boy. An important step in that direction may be making him aware that he has a choice.

## Seeking legal advice

Some of the controversial issues surrounding the question of competency and consent are given in Box 4. Unfortunately, this is an area where legal



**Box 5 Controversial issues regarding competency and consent to treatment**

**There can be no single test of competency (Roth *et al*, 1977)**

**Withholding consent usually has consequences of greater importance and potential danger than giving consent (Pearce, 1994)**

**By a 'catch 22', patients whose competence is in doubt are deemed rational if they accept a doctor's proposal but incompetent if they reject it (Devereux *et al*, 1993)**

**The consent of a person with parental responsibility overrides a young person's refusal: thus, a competent minor cannot refuse treatment**

**In logic there can be no difference between an ability to consent to treatment and an ability to refuse it (Lord Justice Balcombe, in *Re W (A Minor) (Wardship: Medical Treatment)*)**

**The Children Act has no specific safeguards for young people whose refusal of treatment is overruled; their only recourse is to instruct a solicitor to seek a specific steps order**

**The Mental Health Act better protects the rights of young people treated against their wishes than does the Children Act, but detention under the Mental Health Act is stigmatising**

**Should any young person (competent or not) be treated against his or her will unless significant harm is likely to result from failure to treat?**

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advice can vary, so clinicians need to be sure of the support of their trust's solicitors and defence organisations. However, the Children's Legal Centre offers advice to professionals and families without charge (tel: 01206 873820; open 10.00–12.30 and 14.00–16.30, Monday–Friday).

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## Multiple choice questions

- The following can consent to treatment of a competent 14-year-old:
  - the young person to be treated
  - the court
  - a person with parental responsibility
  - the local authority with a care order.
- The following are relevant to assessing competence:
  - the patient realising that there is a choice
  - the patient comprehending and retaining information

- c whether or not the patient agrees with the doctor  
 d the patient's understanding of the effectiveness and risks of the treatment.
3. If a competent 16-year-old withholds consent:  
 a further discussion and a second opinion may be helpful  
 b it is important to seek legal advice  
 c someone with parental responsibility cannot consent on the young person's behalf  
 d the risk of significant harm gives grounds to seek to override the individual's objections.
4. When parents disagree about their young child's treatment:  
 a treatment can proceed with the consent of one person holding parental responsibility  
 b it is up to the objecting parent to mount a legal challenge  
 c unmarried fathers do not automatically have parental responsibility  
 d it is good practice to keep all parents informed.
5. Treating a 14-year-old without parental consent would be justified if:  
 a the individual is competent and gives consent  
 b involving the parents might increase the risk to the individual  
 c the individual refuses to allow the parents to be consulted  
 d the individual's health is likely to suffer without treatment.

## MCQ answers

1	2	3	4	5
a T	a T	a T	a T	a T
b T	b T	b T	b T	b T
c T	c F	c F	c T	c T
d T	d T	d T	d T	d T



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