Consent to Treatment in Children (Mental Capacity and Mental Health Legislation)

See also the separate Consent To Treatment (Mental Capacity and Mental Health Legislation) article.

Children and young people should be involved as much as possible in decisions about their care, even when they are not able to make decisions on their own.[1]

General principles[2]

- When obtaining consent, the doctor must establish whether the child is legally competent (in legal terms, 'has capacity' to give consent).
- All people aged 16 and over are presumed in law to have the capacity to consent to treatment unless there is evidence to the contrary.
- If the child is deemed not legally competent, consent will need to be obtained from someone with parental responsibility, unless it is an emergency.
- Emergency treatment can be provided without consent to save the life of, or prevent serious deterioration in the health of, a child or young person.
- The legal position differs, depending on whether the young person is aged over or under 16 (see below).

Assessing competence[1]

- Just because a person is aged over 16, this does not, as with adults, necessarily mean that the person is competent. A competent person:
  - Is able to understand and retain the information pertinent to the decision about their care, ie the nature, purpose and possible consequences of the proposed investigations or treatment, as well as the consequences of not having treatment.
  - Is able to use this information to consider whether or not they should consent to the intervention offered.
  - Is able to communicate their wishes.
- It should not be assumed that children with learning difficulties are unable to take competent decisions, which can be aided by presenting them with information in an appropriate way.
- If a child is deemed not competent, a person with parental responsibility would need to give consent.
- If a child lacks the capacity to consent and consent from someone with parental responsibility is required, only one individual needs to be approached.[3] However, it is good practice to involve all those close to the child if possible. If parents cannot agree and disputes cannot be resolved informally, seek legal advice about whether you should apply to the court.
- Once an individual has reached the age of 18, no one can give consent on their behalf. If they are not competent, clinicians can provide treatment and care, providing this is in their best interests.[2]

Parental responsibility[4]

- Parental responsibility includes the right of parents to consent to treatment on behalf of a child when the child is unable to provide valid consent for himself or herself, provided the treatment is in the interests of the child.
- Those with parental responsibility have a statutory right to apply for access to their children's health records, although if the child is capable of giving consent, he or she must consent to the access.
- The Children Act 1989 outlines who has parental responsibility. This includes:[5]
  - A mother always has parental responsibility for her child.
  - A father only has this responsibility if he is married to the mother when the child is born or has acquired legal responsibility for his child by:
    - Jointly registering the birth of the child with the mother (since December 2003).
    - A parental responsibility agreement with the mother.
    - A parental responsibility order, made by a court.
  - The child's legally appointed guardian - appointed either by a court or by a parent with parental responsibility in the event of their own death.
  - A person in whose favour a court has made a residence order concerning the child.
  - A local authority designated in a care order in respect of the child (but not where the child is being looked after under section 20 of the Children Act, also known as being 'accommodated' or in 'voluntary care').
  - A local authority or other authorised person who holds an emergency protection order in respect of the child.
- Foster parents, grandparents and indeed parents under the age of 16 do not automatically have parental responsibility. In the latter case, the individual needs to be deemed Gillick competent (see 'Children under the age of 16', below) before they can give consent on behalf of their child.
Children who are wards of court will need to have their 'important steps' approved by the court. It is helpful to keep a copy of the ward papers with the medical records, as this will act as a guide as to what routine treatment can be offered without reference to the court.

Where doctors believe that parental decisions are not in the best interests of the child, it may be necessary to seek a view from the courts, whilst meanwhile only providing emergency treatment that is essential to preserve life or prevent serious deterioration.

In England, Wales and Northern Ireland there remains some uncertainty in common law as to the situation where a competent child under the age of 16 disagrees with the views of those who have parental responsibility. Recent cases have retreated from the Gillick ruling, particularly where treatment refusal by the young person has occurred. Doctors confronted by such a situation should take legal advice.

In Scotland, the rights of people under the age of 16 to consent to treatment is governed by the Age of Legal Capacity (Scotland) Act 1991. This states quite clearly that a competent person under the age of 16 can consent on their own behalf to medical treatment, providing they are capable of understanding the nature and consequences of the treatment.

All parents (including adoptive parents) have a legal duty to support their child financially, whether they have parental responsibility or not.

**Children aged 16 and 17**[^3]

Once children reach the age of 16, they are presumed in law to be competent. In many respects they should be treated as adults and can give consent for their own surgical and medical treatment. The Department of Health recommends that it is nevertheless good practice to encourage children of this age to involve their families in decisions about their care, unless it would not be in their interests to do so.

If a competent child requests that confidentiality be maintained, this should be respected unless the doctor considers that failing to disclose information would result in significant harm to the child. A child aged 16-18 cannot refuse treatment if it has been agreed by a person with parental responsibility or the Court and it is in their best interests. Therefore, they do not have the same status as adults.

**Children and young people who lack the capacity to consent**[^1]

If a child lacks the capacity to consent, you should ask for parental consent. It is usually sufficient to have consent from one parent. If parents cannot agree and disputes cannot be resolved informally, you should seek legal advice about whether you should apply to the court.

Young people aged 16 and 17 years
The legal framework for the treatment of 16- and 17-year-olds who lack the capacity to consent differs across the UK:

- In England, Wales and Northern Ireland:
  - Parents can consent to investigations and treatment that are in the young person's best interests.
  - Treatment can also be provided in the young person's best interests without parental consent, although the views of parents may be important in assessing the young person's best interests.

- In Northern Ireland, treatment can be provided in the young person's best interests if a parent cannot be contacted, although you should seek legal advice about applying for court approval for significant (other than emergency) interventions.
- In Scotland, 16- and 17-year-olds who do not have the capacity to consent are treated as adults who lack capacity and treatment may be given to safeguard or promote their health.

Children under the age of 16
Children in this age group are not deemed to be automatically legally competent to give consent. The courts have determined that such children can be legally competent if they have 'sufficient understanding and maturity to enable them to understand fully what is proposed'.

This concept - now known as ‘Gillick competency’ - initially arose in the case of Gillick v West Norfolk and Wisbech Health Authority in 1986. The term ‘Fraser competency’ is also used in this respect (Lord Fraser was the judge who ruled on the case). Some authorities refer to Fraser competency when talking about contraception and Gillick competency when talking about wider areas of consent. In many cases the two terms are used interchangeably.

Much will depend on the relationship of the clinician with the child and the family and also on what intervention is being proposed. A young person who has the capacity to consent to straightforward, relatively risk-free treatment may not necessarily have the capacity to consent to complex treatment involving high risks or serious consequences.

Competency is something that can be developed over time by presenting the child with information appropriate to their age and level of education and this process may be a rewarding one in the management of children with long-term conditions that involve several therapeutic procedures or investigations. The emphasis is that the families of children in this age group should be involved in decisions about their care, unless there is a very good reason for not doing so.

If, however, a competent child under the age of 16 is insistent that their family should not be involved, their right to confidentiality must be respected, unless such an approach would put them at serious risk of harm.

If a young person refuses treatment
Parents cannot override the competent consent of a young person to treatment that you consider is in their best interests. But you can rely on parental consent when a child lacks the capacity to consent. In Scotland parents cannot authorise treatment a competent young person has refused. In England, Wales and Northern Ireland, the law on parents overriding young people's competent refusal is complex. You should seek legal advice if you think treatment is in the best interests of a competent young person who refuses.

You must carefully weigh up the harm to the rights of children and young people of overriding their refusal against the benefits of treatment, so that decisions can be taken in their best interests. In these circumstances, you should consider involving other members of the multidisciplinary team, an independent advocate, or a named or designated doctor for child protection. Legal advice may be helpful in deciding whether you should apply to the court to resolve disputes about best interests that cannot be resolved informally.

You should also consider involving these same colleagues before seeking legal advice if parents refuse treatment that is clearly in the best interests of a child or young person who lacks capacity, or if both a young person with capacity and their parents refuse such treatment.

Devolving parental responsibility
- Parents are not with their children 24 hours a day and there are times when parents might devolve the responsibility to consent to treatment to others - eg, grandparents or childminders - for certain interventions such as emergency care and treatment of minor illnesses.
- Such consent does not need to be in writing and the healthcare professional does not need to consult the parents, unless there is cause to believe parents’ views would differ significantly.
- Where there is no specific agreement between parents and a third party in any given situation, the third party can give consent, providing it can be justified as being in the best interests of the child. An example of this would be a teacher accompanying a child to the Accident and Emergency Department for urgent treatment required after an accident at school.
• The guidance concerning immunisation does not differ significantly from other interventions. Further details can be found in the Department of Health’s ‘Green Book’ - Immunisation Against Infectious Disease.

• Bringing the child for immunisation is seen as implied consent and devolved responsibility does not have to be in writing.

• Important issues that do need to be considered, however, include whether the consent is valid (ie based on sufficient information to give informed consent), whether there is a reason to believe that the parental views would differ from a third party bringing the child and whether consent has been obtained on each occasion an immunisation is given.

• Signing a consent form is not obligatory but a written record that the main issues have been covered does offer some insurance against future difficulties.

Special situations

No one is able to give valid consent

• Examples would be a child brought to hospital needing emergency surgery after a road accident, an unaccompanied asylum seeker, or a child of parents who were not deemed competent to give consent (eg, drug-dependent or drunk).

• In such cases, treatment can be given, providing it is in the child’s welfare and the child would come to significant harm if treatment were withheld.

The clinician disagrees with the parents

• In such cases an application should be made to the court to decide, particularly if life-saving treatment is required.

• An emergency decision can often be obtained. If this is not possible, the treatment should be given if it is life-preserving.

• The appropriate medical defence body should be consulted.

• The situation may be reversed in that parents may wish a child to have a treatment which the clinician may feel is inappropriate. Again, an application for a court decision should be made. In such cases, the court will sometimes attempt to find a clinician who is prepared to give the treatment.[3]

Children do not agree with those with parental responsibility

• If the child is competent and wishes to receive treatment, those with parental responsibility cannot override them.

• If a competent child is refusing treatment, those with parental responsibility can consent if the treatment is deemed to be in the child’s interests.

• Occasions may arise where children disagree with those with parental responsibility and either course of action may be deemed reasonable. Such matters often come to court. Courts have the authority to override the decisions of both the child and those with parental responsibility.

Consent to non-therapeutic procedures

• Examples would be bone marrow or organ donation.

• The automatic competence of 16- and 17-year-olds does not apply here and the competency tests should be applied to all children.

• If the child is not competent and those with parental responsibility give consent, they must do so if the intervention is in the interests of the donor.

• In cases where the parents of the donor and recipient are the same (ie siblings), advice should be sought from an independent assessor, a hospital ethics committee or a court.

Research

• The law differentiates between therapeutic research (eg, an untested treatment which might be better than existing treatment) and non-therapeutic research (eg, the taking of additional blood samples with no therapeutic benefit to the child).

• For therapeutic research, a competent individual, be it the child or a person with parental responsibility, can give consent.

• For non-therapeutic research, the procedure cannot go ahead if the child withholds consent, irrespective of their age and of the views of those with parental responsibility.[10]

Further reading & references

• Consent guidance: patients and doctors making decisions together; General Medical Council

• Under-16s: consent and confidentiality in sexual health services factsheet; Family Planning Association (FPA), 2009

• Reference guide to consent for examination or treatment (second edition); Dept of Health

• Parental responsibility; British Medical Association (BMA), February 2009

• Children Act 1989

• Gillick; Respondent v. West Norfolk and Wisbech Area Health Authority, 1986

• Wheeler R; Gillick or Fraser? A plea for consistency over competence in children. BMJ. 2006 Apr 8;332(7545):807

• 0-18 years guidance: Principles of confidentiality 0-18; General Medical Council

• Immunisation against infectious disease - the Green Book (latest edition); Public Health England

• Lynch J; Consent to Treatment, Radcliffe Publishing, 2010

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