

## **Brief guide: capacity and competence to consent in under 18s**

### **Context**

Assessing the ability of children and young people under 18 years to make decisions about their care is an integral part of the work in child and adolescent mental health services (CAMHS). A number of key policy documents, listed in the appendices, relate to this issue. In this document we have used the term child to refer to anyone under the age of 18. Guidance on definitions of capacity and Gillick competence can be found in [appendix A](#).

### **Evidence required**

Look for evidence that staff have received training in assessing capacity and competency for informed consent and in the Mental Capacity Act (MCA). Specifically look for training in issues relating to consent in under 18s as well as understanding information sharing with respect to safeguarding children and working with other agencies.

Evidence that valid consent to treatment has been obtained should always be recorded. Valid consent to treatment means that the medical professional has given the child and/or those with parental responsibility appropriate information about the purpose and nature of treatment, including any risks and any alternatives. Evidence in the record, or gathered at interview, may include:

- Giving children and parents information about the reason for and nature of the treatment.
- Giving child-friendly information leaflets about different treatments and what they involve.
- Asking children for their views about treatment before starting treatment.
- Getting session-by-session feedback on treatment sessions.
- Discussing with the child and/or parents other options available and the advantages/disadvantages of each option if symptoms are not improving.

Where the child is deemed to be Gillick competent, and they are able to give consent to treatment, it is still good practice to provide parents with information and this should be documented in the clinical record. The extent of information shared should be discussed with the child and their agreement sought (see below under information sharing). Where there are safeguarding concerns, information may need to be shared with parents in the absence of agreement.

Where a child is not Gillick competent and a parent(s) is consenting to treatment on their behalf, parent(s) must be given information about the nature and purpose of treatment and this must be documented in the clinical record.

### **Information sharing**

Parents generally need to be provided with information about their child's problems and treatment in order to adequately support and care for them. Check the clinical records to see whether there is evidence of a discussion with the child, and where appropriate their parent(s), about information sharing and confidentiality and the limits of confidentiality. The extent and nature of the discussion will vary according to the age of the child and the nature of treatment as some treatments, for example family therapy, directly involve the parents, whereas others such as medication or individual counselling involve the child. Where information is shared with parents about the problems or treatment of a competent child, the child's agreement to share the information should be obtained and evidence recorded in the notes. The agreement should be absolutely clear and should cover the specific detail of what will be shared, the reason the information is being shared, as well as any special aspects of the processing that may affect the individual. It should also be freely given, for example without undue influence from the parents.

Where a competent child refuses to allow information to be shared with their parent(s), there should be evidence that the risks of not sharing the information have been considered. Where it is thought to be in the child's best interests to share information, there should be evidence of attempts to seek a compromise. It is sometimes possible to provide parent(s) with general information about the treatment or condition as a compromise, rather than the specific details of the child's case. Where it is the clinician's opinion that it is

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necessary to share information in the best interests of the competent child, against their wishes, the Caldicott Guardian should be consulted.

**Treatment refusal:** where the child/parent refuses treatment, there should be evidence in the records that risks have been considered and explored. This includes whether refusal may result in significant harm to the child and that safeguarding concerns have been considered. The case records should document fully what decisions were made and why, including when the decision relates to hospital admission and whether the use of the Mental Health Act would have been appropriate or not.

**Complex cases:** wherever possible for more complex cases, such as those involving disagreements about treatment, there should be evidence of discussion with colleagues and the offer of a second opinion (this should be proportionate to the circumstances of the case).

## Intelligence

There are sections relating to capacity and consent in CAMHS in the Quality Network for Inpatient CAMHS and Quality Network for Community CAMHS peer review and accreditation schemes. If the trust is participating in these schemes, the reports should be available from intelligence.

## Policy

In UK law, a person's 18th birthday draws the line between childhood and adulthood (Children Act 1989 s105), so in health care matters, an 18 year old enjoys as much autonomy as any other adult.

To a more limited extent, 16 and 17 year-olds can also take medical decisions independently of their parents. The right of younger children to provide independent consent is proportionate to their competence, a child's age alone is clearly an unreliable predictor of his or her competence to make decisions.

Young people aged 16 or 17 are presumed in UK law, like adults, to have the capacity to consent to medical treatment. However, unlike adults, their refusal of treatment can, in some circumstances be overridden by a parent, someone with parental responsibility or a court. This is because we have an overriding duty to act in the best interests of a child. This would include circumstances where refusal would likely lead to death, severe permanent injury or irreversible mental or physical harm.

If there are reasons to believe a child aged 16 or over lacks capacity, an assessment of capacity to consent should be conducted and recorded in their notes.

Children under 16 may be competent to consent to treatment (Gillick competence) and records should show that this has been assessed before starting treatment. The routine assessment of competence in under 16s should be appropriate to the child's age. For example, routine assessments of competence would not be expected in the case of eight and nine-year-olds but would be more usual for children aged 14 and 15. Where treatment is going ahead on the basis of parental consent, records should show that the person(s) holding parental responsibility and legally capable of consenting on behalf of the child has been identified

## Reporting

Issues relating to capacity and consent in under 18s should be reported in the '**Good practice in applying the Mental Capacity Act**' section of the '**Effective**' key question.

## Link to regulations

Failure to comply with guidance and legislation in this area would fall under **Regulation 11**– Need for Consent.

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## **Appendix A: Relevant guidance and legislation**

### **The Mental Capacity Act 2005**

This applies to children who are 16 years and over. Mental capacity is present if a person can understand information given to them, retain the information given to them long enough to make a decision, can weigh up the advantages and disadvantages of the proposed course of treatment in order to make a decision, and can communicate their decision. The deprivation of liberty safeguards within the Mental Capacity Act 2005 (MCA) do not apply to under 18s.

### ***Capacity and consent in 16 and 17 year olds***

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 treatment, and refuse, including admission to hospital. Parents cannot override consent or refusal from a competent 16/17-year-old. Neither can they consent on behalf of their competent 16/17-year-old.

However, the Department of Health recommends that it is good practice to encourage children of this age to involve their families in decisions about their care, unless it would not be in the child's interests to do so.

### ***16 and 17-year-olds who do not have capacity***

If a child lacks the capacity to consent, they may be treated without their consent under the MCA as long as the treatment does not involve a deprivation of liberty. Treatment can also proceed with the consent of someone with parental responsibility as long as the treatment falls within the scope of parental responsibility. While only one person with parental responsibility needs to be approached, it is good practice to involve all those close to the child if possible. The definition of 'parental responsibility' is set out in the Children Act 1989.

### **Children under the age of 16 years who are competent**

For children under 16 years the MCA does not apply. Instead a child needs to be assessed whether they have enough understanding to make up their own mind about the benefits and risks of treatment – this is termed 'Gillick competence'. The term 'Fraser guidelines' are also sometimes used. Although often used interchangeably, they are two different concepts: Fraser guidelines refer to specific guidance that must be followed by the healthcare professional to provide contraceptive advice to a child; and Gillick competence refers to the ability of the child to give consent and is used more broadly.

Parents cannot override a competent child's refusal to accept treatment. Where a competent child under 16 refuses a specific treatment which is in their best interests, but the parents support the recommendation for treatment, there should be evidence of that providers have attempted to understand both the child's and parents' position. There should also be evidence that alternative treatments have been considered or a compromise is not possible. However, ultimately the decision rests with the competent child.

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## **Changes to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) - Liberty Protection Safeguards**

The Mental Capacity Amendment Act (2019) has now replaced the DoLS with the Liberty Protection Safeguards (LPS). The intention is for the new LPS system to come into force on 1st October 2020. When it does, the safeguards will apply to those aged 16 or over, instead of 18 and over.

### **Children under 16 who are not Gillick competent**

Children under 16 who are not Gillick competent cannot either give or withhold consent to treatment. People with parental responsibility need to make the decision on their behalf.

### **In an emergency situation, when a person with parental responsibility is not available to consent**

In these circumstances, the child's best interests must be considered and treatment limited to what is reasonably required to deal with the particular emergency.

### **Access to medical records**

In general, parents do not have an automatic right to full access to their competent child's records and the clinician is not allowed to disclose information without the child's consent. However, a best interests' disclosure could be possible where appropriate. Trusts should have procedures in place for accessing medical records and there should be evidence that these are being followed.

Providers should consider whether the child's consent is required for formal requests for records under the Data Protection Act 1998, which made on behalf of a child by a parent or other third party.

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## Appendix B: Parental responsibility

A person who has parental responsibility for a child has the right to make decisions about their care and upbringing. Important decisions in a child's life must be agreed with anyone else who has parental responsibility.

The following people automatically have parental responsibility:

- All birth mothers
- Fathers married to the mother at the time the child was born
- Fathers who are not married to the mother, but are registered on the child's birth certificate. The registration or re-registration must have taken place after December 2003.
- Civil partners and partners of mothers registered as the child's legal parent on the birth certificate.

Others may acquire parental responsibility, for example through a court residency or parental responsibility order.

Parental responsibility may be shared with the local authority if the child is the subject of a care order.

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## Appendix C: Key policy documents and further reading

### Key policy documents

- [Reference guide to consent for examination or treatment Second edition 2009](#)
- [The Mental Health Act 1983](#)
- [Family Law Reform Act 1969](#)
- [Human Rights Act 1998](#)
- [United Nations Convention on the Rights of the Child](#)
- Relevant case law, common law principles and relevant codes of practice.

### Further reading

- [Department for Constitutional Affairs. \*Mental Capacity Act 2005 Code of Practice\*. London: The Stationery Office, 2007](#)
- Department of Health. Children and young people under the age of 18. In: Department of Health. [The Code of Practice to the Mental Health Act 1983](#). London: The Stationery Office, 2008: 326-354
- General Medical Council. [0-18 Guidance for all doctors](#). GMC, 2007.
- [Department of Health, Consent – What You Have a Right to Expect: A Guide for Children and Young People<sup>1</sup>](#)
- [Department of Health, Consent – What You Have a Right to Expect: A Guide for Parents](#)
- [Department of Health, Seeking Consent: Working with Children](#)
- National Society for the Prevention of Cruelty to Children. [Gillick competency and Fraser guidelines](#).
- The Children Acts [1989](#) [6] and [2004](#)
- [Mental Capacity Act 2005](#)

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