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Consent quiz: how well would you do?

A survey of the knowledge of CAMHS workers of the law relating to consent to treatment in children

The law relating to consent to treatment in children can be confusing. It is made up of a patchwork of statutory and case law that reflects an ambivalence between respecting the rights and autonomy of the child and the pervading paternalism within the courts and society more generally. This has lead to an ebb and flow of these competing pressures over the years.

The emphasis in teaching within mental health tends to be on the treatment of children without consent and, therefore, on the application of the Mental Health Act 1983. However, the Act is seldom used with children. The Code of Practice (Department of Health and the Welsh Office, 1999), as well academic commentators (Bridge, 1997; Fennell, 1992, 1996), argue that children with mental disorder should be detained under the Act when appropriate, but also acknowledge that to do so may be 'swimming against the overwhelming tide of professional opinion' (Fennell, 1996). The Mental Health Bill (Department of Health, 2002) does, however, set out to clarify the rights of 16–18-year-olds caught in this situation.

This survey did not set out to be comprehensive, nor particularly scientific. Our primary aim was to test the water to see whether this subject needed to be covered within the in-service teaching programme. However, it uncovered major misconceptions regarding the law and what is meant by 'legally valid consent'.

Method

The quiz (Box 1) was given to all professionally qualified staff who attended team meetings in five community-based teams and the Adolescent Substance Misuse Team in the South Wales Child and Adolescent Mental Health Network during a one-week period in April 2003, and to all those attending a compulsory teaching event for the staff of the regional in-patient unit. The staff included a mix of different professionals, and all forms were completed anonymously.

Results

The quiz was completed by 49 people (approximately 94% return rate). They included 25 nurses (14 from the in-patient unit); 14 psychiatrists (5 consultants, 3 specialist registrars, 2 senior house officers, and 4 other non-training grade child and adolescent psychiatrists) and 10 professionals from other disciplines such as social work and psychology. The average duration of time that they had been in their current posts was 3.7 years, and they had been professionally qualified for an average of 12.5 years.

The nurses gave correct responses to an average of 45% of the questions, the psychiatrists 61% and the others 36%. There was no difference between the in-patient and community nurses. The overall correct response rate was 48% (Table 1).

Discussion: the law relating to consent to treatment in children

When can a child consent to treatment?

The Family Law Reform Act 1969, Section 8, stated that the consent of a minor over the age of 16 years 'shall be as effective as it would be if he were of full age'. Under 16 years old, Lord Scarman in Gillick (1986) stated that the child could consent, '. . . when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision'. The level of understanding required, however, did not only include what the treatment involved, the alternatives, and the risks and outcomes of each course. He also stated that the child needed to have considered '. . . Moral and family questions, especially the relationship with the parents; long-term problems associated with . . .; the risks to health . . .'. Therefore, in order for a child under the age of 16 years to consent to treatment, there must be a much more thorough consideration of the issues than if the child is over 16 years or in the case of an adult. Over 16 years, the competence of a child is assumed; but under 16 years it has to be demonstrated.

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Box 1. The questionnaire

Is there legally valid consent in the following circumstances?

Case 1
A 15-year-old girl, understanding the implications of the treatment and of refusing to accept the treatment, refuses to consent to the treatment but her mother gives consent — **yes no d/k**

Case 2
A 13-year-old girl who understands the implications of treatment consents but her mother refuses — **yes no d/k**

Case 3
A 14-year-old boy, who understands the treatment and its implications refuses to give consent himself. His mother also refuses but her ex-husband who is his father, gives consent for the treatment to go ahead. The boy had lived with his father until he was 10 years old, but no longer does so, but sees him fortnightly — **yes no d/k**

Case 4
A 13-year-old boy with mild learning difficulties who does not fully understand the treatment consents, his mother refuses but his step-father signs the consent form — **yes no d/k**

Case 5
A 16-year-old boy who understands the implications of the treatment refuses, but his mother gives consent for the treatment — **yes no d/k**

Case 6
A 15-year-old girl (who is subject to a Supervision Order) refuses her consent, but the social worker who accompanies her signs the consent form — **yes no d/k**

Case 7
A 13-year-old (who is the subject of a Care Order) is brought to the clinic by her social worker. Can the social worker consent to the treatment? — **yes no d/k**

Case 8
A 16-year-old consents to treatment which her mother refuses to allow — **yes no d/k**

Case 9
A 17-year-old refuses treatment which her father is consenting to and saying it should go ahead — **yes no d/k**

Case 10
An 18-year-old with severe learning difficulties is unable to understand the treatment. The mother gives consent for the treatment — **yes no d/k**

Table 1. Correct responses and percentage of respondents answering correctly

Case number	Correct response	Percentage correct
1	Yes	65%
2	Yes	43%
3	Yes or D/K*	51%
4	No	84%
5	Yes	20%
6	No	61%
7	Yes	39%
8	Yes	86%
9	Yes	14%
10	No	18%

*In question 3 either Yes or Don't Know were accepted as correct as it was not clear whether the father had been married to the mother at the time of the child's birth, which would have given him parental responsibility.

Who can act as proxy to consent on behalf of a child?

Anyone with parental responsibility can consent on behalf of a child up to the age of 18 years. The Children Act 1989 sets out who has parental responsibility. Parental responsibility for a child is held by the mother; the father if married to the mother at the time of the birth; and if the child is subject to a Care Order, the local authority shares parental responsibility. In other circumstances, fathers and sometimes step-parents can apply to the Court for a Parental Responsibility Order. Birth parents cannot lose parental responsibility other than by the child being adopted. No-one can consent on behalf of another adult (Kennedy & Grubb, 2000).

Consent and refusal of treatment are different

The Courts consider consent to treatment differently to refusal. This did not appear to be the intention of Lord Scarman in Gillick, as he made it explicit that he was referring to '. . . the right to determine whether or not a minor child below the age of 16 years will have treatment'. However, subsequent cases have determined that a child under 16 years (*Re R*, 1992) and between 16–18 years (*Re W*, 1993) can consent to treatment, but cannot refuse in the face of proxy consent by someone with parental responsibility. It has been argued that refusal to consent involves a higher order of decision making (McCall-Smith, 1992), with often more serious implications than does consenting to treatment (Pearce, 1994). However, it does appear illogical that the decision will then be made by someone who is not obliged to consider the issues or the implications of the decision so deeply. Parents must, however, act in the child's best interests (*Re J*, 1990).

The nature of consent

Consent is the legal expression of the ethical principle that each person has a right to self-determination and to

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have their autonomy respected (Kennedy & Grubb, 2000).

As Lord Donaldson Master of the Rolls (MR) stated in *Re R* (1992) '. . . consent by itself creates no obligation to treat'. Even if there is valid consent, if the child or parent is against this course of action this will have to be weighed in the balance. Whether, when and how to treat are matters of clinical judgement. The two cases *Re R* (1992) and *Re W* (1993) shed some light on the legal perception of consent. In the first of these cases, Lord Donaldson MR likened consent to a 'key' that unlocked the door to allow the doctor to treat; in the second he used the analogy of consent being a 'flak jacket' protecting the doctor from possible litigation or prosecution.

Conclusion

This small-scale survey suggests that there are basic misperceptions among child and adolescent mental health professionals regarding the legal nature of consent and how the law in this area applies to minors. It is necessary to have a sound knowledge of the law relating to consent in children in general, before considering the treatment of mental disorder without consent. In the quiz, how well did you perform?

Declaration of interest

None.

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Caring for Sikh patients wearing a *kirpan* (traditional small sword): cultural sensitivity and safety issues

Devout Sikh men wear the *kirpan* (a traditional small sword) as part of their religious faith. The *kirpan* is one of five symbols of Sikhism (the five *K*s described below). Many traditional Sikhs undergo the *amrit* ceremony, akin to baptism, following which they are meant to wear the five *K*s at all times. Several legal controversies have emerged in the West, especially in the USA (Lal, 1999) and Canada (Wayland, 1997), over safety issues related to the *kirpan*, such as students wearing it to school or passengers wearing it during flights (for an overview of the recent cases, see www.sikhs.ca/kirpan).

Some educational institutions in the UK have been provided guidelines to ensure that Sikh students are allowed to wear the *kirpan* without compromising health and safety standards (http://www.dfes.gov.uk/schoolsecurity/dwtannexf.shtml). In-patient psychiatric services looking after Sikh patients may face similar dilemmas between respecting the Sikh religious traditions and ensuring safety of the patient and others. This paper briefly outlines the history of Sikhism, summarises the importance of the *kirpan* in the Sikh tradition and recommends policies that health authorities and mental health trusts can adopt to ensure that when caring for Sikh patients, neither cultural sensitivity nor individual safety are compromised.

Overview of Sikhism

This is a brief outline and interested readers can find more details in Singh (2001), McLeod (1989) or at several websites (www.sikhnet.com; www.allaboutsikhs.com; www.sikhs.org; www.srigurugranthsahib.org; www.sikhnation.com). There are 22 million Sikhs worldwide, 20 million of whom live in India. The religion emerged in the state of Punjab, North India, in the 16th century. The founder of the faith, Guru Nanak, was born in 1469 AD into a Hindu family during a turbulent period of serious conflict between the ruling *Mughals* (Muslim invaders from Persia) and the majority Hindu population,

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