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ARTICLE

Implementing legislative changes on young people's consent to treatment: a guide for trainers

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SUMMARY

This article reviews the recent changes in the law in England and Wales relating to consent to treatment for young people, in particular the Mental Capacity Act 2005 and the 2007 amendments to the Mental Health Act 1983. Using a fictitious case study, it offers a structured approach to the application of these new items of legislation that could be useful to trainers and their trainees.

DECLARATION OF INTEREST

None.

As the General Medical Council reminds us, 'Medical students are tomorrow's doctors' (General Medical Council 2009: p. 14). Consequently, consultants have a duty to nurture a way of thinking in the future generations of doctors whom they train (BMA Central Consultants and Specialists Committee 2008). Although certain aspects of clinical practice may change, complex and uncertain situations will always exist and trainees need to acquire means of learning how to manage these. Such situations often arise in child and adolescent psychiatry, especially when medico-legal matters are under consideration.

The law concerning consent and capacity in young people under the age of 18 in England and Wales has never been easy to interpret, deriving as it does from a historical evolution of statute law and common (or case) law. Not even paediatricians or professionals working routinely within child and adolescent mental health services (CAMHS) always correctly apply the complex legislation relating to consent to treatment in this group. Potter (2004), for example, reported an overall correct response rate of 48% among 49 CAMHS staff who completed a quiz on consent. Paediatricians fared little better in a study by Fisher-Jeffes *et al* (2007), who found a lot of uncertainty in their professional group concerning treatment of minors in emergencies. At the time of writing, it appears that many health and social care professionals are not complying with the Mental Capacity Act 2005 (British Medical Association 2010), and there is still very little empirical or translational research on matters of consent in young people or how to teach about them.

Another source of confusion has been the use of the terms competence and capacity. Not only are these often used interchangeably, but in the USA the UK's legal concept of capacity is often referred to as competence, which is unfortunate for a British audience. Tan & Jones (2001) have usefully reviewed the use of these concepts (see below) and suggested that the legal and clinical use of the terms be distinguished.

The Mental Capacity Act 2005 and the amended Mental Health Act 1983

In the decade or so since Shaw (2001) and Paul (2004) reviewed young people's consent and related matters in *Advances*, the journal has published a number of related papers on consent and mental health legislation as it affects young people (in particular: Branton 2010; Curtice 2010; Hawkins 2011), perhaps reflecting the state of rapid change. Essentially an already complex area has been further complicated by two new items of legislation in England and Wales. These are the above-mentioned Mental Capacity Act 2005, most of which came into force in October 2007, and the 2007 amendments to the Mental Health Act 1983. Of the latter, those affecting consent to admission to hospital for treatment of a mental disorder came into operation in January 2008. The most significant practical change concerning the Mental Capacity Act is that no longer can the refusal of a competent young person between the ages of 16 and 18 be overridden by someone with parental responsibility.

A detailed analysis of the amended Mental Health Act and its ethical implications is beyond the scope of this article, but mental health law is essentially concerned with balancing the human rights and autonomy of the individual with the

need to protect the public from harm (Hall 2009). It could be argued, be it from a consideration of human rights or as part of public protection, that there is also a need to protect the individual from self-harm. There is no lower age limit to the use of the Mental Health Act. The 2007 amendments broaden the definition of mental disorder to include any disorder or disability of mind, thus embracing behavioural and emotional disorders, and remove the treatability test. As a result, a greater number of individuals can now be legally detained, including those with sexual deviant behaviour. This is counterbalanced by a code of practice (Department of Health 2008) which specifies the need for clinicians applying the Act to promote the patient's well-being, be minimally restrictive, be respectful, allow patient participation and be equitable.

Teaching and learning about consent: what's the best way?

Consultants are faced with the problem of being clear themselves about these legislative changes and also teaching them to doctors in training. Developing a means of doing so can both enhance their own continuing professional development (CPD) and benefit trainees. Matters concerning consent in undergraduate medical settings are often covered in medical ethics courses. Although there is still debate on which learning and teaching methods are best suited to medical ethics education, there is now some consensus that small-group teaching is widely accepted to be the best approach, at least in UK medical schools (Mattick 2006). It seems clear that using case material can encourage student-centred learning, problem-solving, integration into other disciplines, reflective practice and the development of professionalism.

Specific methods of teaching ethically related matters using cases include the expert panel and the case conference. Expert panels can expose students or trainees to differing disciplinary viewpoints but need considerable organisation. Alfandre & Rhodes (2009) recommend that case conferences for teaching residents about clinical ethical dilemmas be convened within 48 h of the dilemma presenting on the ward. Although laudable, this approach will be practically challenging for many clinicians and not suitable for their psychiatric settings. However, the 'best interest meetings' or case conferences now held by many National Health Service (NHS) trusts in response to the Mental Capacity Act could well provide good teaching opportunities if structured with trainees or students in mind. In the next section, I describe how this might be done.

Teaching through case material: an example

The fictitious teaching case outlined below could be adapted for various purposes and audiences, including medical students as well as postgraduate doctors in psychiatry, general medicine, emergency medicine and paediatrics. It could be used as a focus for psychiatric teaching in a group using problem-based learning or as a basis for discussing professionalism in other specialist training, for example, in exploring attitudes towards people who harm themselves. It would be suitable for interdisciplinary discussions or for individuals.

In considering this case, I will use the acronym ETHICS (Box 1) as a mnemonic or teaching prompt to ensure that the relevant material is systematically covered.

The case

You are on call on New Year's Eve and are rung by the accident and emergency (A&E) trainee doctor at 2 am about a 17-year-old girl, who has taken a substantial overdose of paracetamol. She is currently on the observation ward, having been admitted through A&E.

On admission, her blood levels of paracetamol were above the BNF's normal treatment line and she was given acetylcysteine. However, half way through treatment she had discontinued the drip, saying she had 'had enough of it'. Although she described feeling desperate at the time she took the tablets, she was claiming that she now regretted taking them.

She lives with her grandmother and does not want her parents to be told anything. They have just arrived and want the trainee doctor to tell them what is going on and whether their daughter has 'opened up' to medical staff.

The trainee doctor is worried about the continued risk of paracetamol toxicity and wants to know whether it is legal to treat the girl against her will, now that she is saying she does not want to continue with the treatment. The doctor also wants to know whether the patient should be detained under the Mental Health Act, especially as she will not explain her change of mind about treatment.

BOX 1 ETHICS: a practical framework for considering consent

- E Ethical principles: the four principles of biomedical ethics (Box 2)
- T Third parties: determine the effect of family context, parental responsibility and confidentiality
- H Have the best interests of the patient been considered?
- I Informed consent: is it present?
- C Capacity and competence considerations
- S Summarise the case, what you are planning to do and what you have learnt

BOX 2 The four principles of biomedical ethics

1 Beneficence: to act in the best interests of the patient
2 Non-maleficence: to do no unnecessary harm to the patient
3 Autonomy: to respect the wishes of the patient
4 Justice: to ensure equality of treatment for all patients

(after Beauchamp & Childress 1979)

ETHICS: E – Ethical principles: the four principles of biomedical ethics

In an approach sometimes known as 'principlism', clinicians weigh four principles when making ethical decisions in medical practice: beneficence, non-maleficence, autonomy and justice (Box 2) (Beauchamp 1979). On their own, these four principles cannot determine decision-making, but they can guide it.

Beneficence, or acting in the best interests of the patient, is often in conflict with autonomy. In the case of mental illness, should beneficence carry more weight than autonomy? Some writers have argued that autonomy has tended to dominate thinking in medical ethics, possibly because consent is so central to the practice of all medicine. Certainly it is emphasised in the Human Rights Act 1998 and the United Nations Convention on the Rights of the Child 1989 (Box 3).

In thinking about the case…

The principles of beneficence and autonomy appear to be in conflict in our teaching case: although we may want to respect the girl's wishes, it is difficult to concur with her apparent desire to kill herself. The girl's actions also indicate a conflict in her own mind about what she wants to happen. Acting in her best interests is discussed further below, in consideration of the Mental Capacity Act.

ETHICS: T – Third parties: family context, parental responsibility and confidentiality

Who has parental responsibility for the patient? Usually, but not always, it will be the parents (Box 4). The role of those with parental responsibility has taken on an additional level of complexity with the Mental Capacity Act 2005. If a 16- to 18-year-old does not have capacity to consent to treatment, a decision can now be made by someone with parental responsibility only if the decision falls within the 'zone of parental control'.‡ This remains a somewhat nebulous concept, poorly

‡For a discussion of this concept in *Advances*, see Hawkins T, Player B, Curtice M (2011) The zone of parental control and decision-making in young people: legal derivation and influences, **17**: 220–226. Ed.

BOX 3 Glossary of relevant legislation and legal terms

Best interests

Guidelines about best interests are usefully provided by Joyce (2007). Considerations of best interests have become a key part of the Mental Capacity Act 2005 (see below).

Children Act 1989

Applies to anyone aged under 18. Relevant areas here are parental responsibility, secure accommodation and child protection. The welfare of the child should be the court's paramount consideration and this is often called the child's best interests.

Children Act 2004

Concerns cooperation between agencies in safeguarding and promoting children's welfare.

Family Law Reform Act 1969

Until the arrival of the Mental Capacity Act, this Act has concerned the consent to treatment of young people aged 16 and 17, who have traditionally been considered to have capacity to consent. Essentially, consent obtained from someone in this age group has as much validity as consent from someone aged 18 and over, and no other consent (for example from a parent) is needed.

Gillick competence

A concept brought into legislation through case law: a child 'who has attained sufficient understanding and intelligence to be able to understand fully what is involved in the proposed intervention will be regarded as competent to consent to a particular intervention, such as admission to hospital or proposed treatment'. For a fascinating description of the law lords' decisions and interpretation of the law in this landmark case, see Hope (2003: 122–128), in which three lords of the five voted in favour of allowing a child under the age of 16 to seek contraceptive advice without the need of informing her parent.

Human Rights Act 1998

People representing public bodies must act in accordance with this legislation, which is now enshrined in UK law. Parts of this Act that might affect young people include Article 5 (liberty and security of person) and Article 8 (respect for private and family life).

Mental Capacity Act 2005

Provides the legal framework for making decisions on behalf of adults (over 16) who lack capacity. It posits rules for decision-making in such cases. Acting in the person's best interests is a key feature of the Act. Note that young people under the age of 18 cannot make advance decisions and that deprivation of liberty safeguards do not apply to them.

Mental Health Act 1983

Provides for the care of people with mental disorder and covers, in particular, compulsory admission and treatment in hospital. The 2007 amendments to the Act have changed the definition of mental disorder to 'any disorder or disability of mind', which is a much broader definition. It excludes drug dependence but includes intellectual ('learning') disability. There are also changes to professional roles, alterations to the treatability test and introduction of deprivation of liberty safeguards.

United Nations Convention on the Rights of the Child 1989

Not part of UK domestic law but ratified by government, rights include: the best interests of the child (Article 3) and respect for the views of the child (Article 12). There is also an emphasis on the evolving capacities of the child.

(Unless otherwise stated, definitions are derived from Department of Health 2009a)

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BOX 4 Who can have parental responsibility?

The following individuals may have individual or shared parental responsibility:

Birth mother: will always have parental responsibility unless child has been adopted by someone else

Biological father: if he was married to the mother at the time of the birth or if he subsequently acquired it (by registration, court order or subsequent marriage to the mother)

Both biological parents: if they are registered on the child's birth certificate after various dates (1 December 2003 for England and Wales; 15 April 2002 for Northern Ireland; 4 April 2006 for Scotland)

Step-parents: may acquire it through a parental responsibility agreement or court order

Other individuals: may acquire it through a residence order, through adoption or by being appointed as a guardian

Local authority: has parental responsibility under a care order, interim care order or emergency protection order but not if the child has been taken into care with parental agreement (voluntary accommodation)

(Department of Health 2009a)

defined and deriving from case law of the European Court of Human Rights. As yet there are no comprehensive guidelines on which decisions may fall within this category, but the following should be considered (Department of Health 2009a):

- whether the nature of the decision is one that falls within usual parenting decisions
- whether there are indications that the parent may not be acting in the best interests of the child
- whether the parent has the capacity to make the decision in question.

It is good practice, of course, always to consider family context and dynamics and be alert to breaches of confidentiality when discussing a young patient with parents.

In thinking about the case…

It is necessary to establish who has parental responsibility for the girl and the nature of the relationship between her and her grandmother. Is she staying with her grandmother under an informal arrangement? In this case, the parent(s) would retain parental responsibility. Although there is a need to respect the confidentiality of the patient, this is only ever conditional, and could be overridden if disclosure were in the public interest, or if there were a statutory obligation, such as a concern about child protection (Royal College of Psychiatrists 2010). It is good practice to involve the family in discussions if possible, and the views of interested parties should be sought under the best interests considerations of the Mental Capacity Act, if this applies.

ETHICS: H – Have the best interests of the patient been considered?

Best interest decisions should be guided principally by section 4 of the Mental Capacity Act and chapter 5 of the code of practice to the Act (Department for Constitutional Affairs 2007: pp. 64–91). Section 4 of the Act includes a checklist of factors, referred to as the statutory checklist, which includes past and present wishes, feelings, beliefs and values, and recommends that other individuals, such as a person with lasting power of attorney, should also be consulted. A useful publication by Joyce (2007), written with the Mental Capacity Act in mind, considers best interests decisions in a number of hypothetical cases. A discussion of best interests could also be a basis for considering other ethical principles.

In thinking about the case…

It is unclear what the girl's wishes are as presented here, and it is clearly important to make every attempt to ascertain them. Application of the Mental Capacity Act statutory checklist (outlined in section 4 of the Act and referred to with worked examples in Joyce 2007: 8) may be helpful. A point of particular relevance is that her mental state may be influencing her judgement and at some later point her capacity in relation to making treatment decisions might alter (see below).

ETHICS: I – Informed consent: is it present?

In all emergencies, treatment can be given under common law, overriding all other considerations and regardless of the patient's age. The three principle components of consent, i.e. that it is informed, competent and voluntary, are enshrined in English law (Hope 2003). They see two additional elements, understanding and deciding, as related to consent but falling within the definition of competence. This analysis, which has the appearance of being pleasingly straightforward, is not without problems, one of which being how much information is needed for a patient to be appropriately informed. This is further discussed in professional guides to practice (e.g. British Medical Association 2004, 2009; Department of Health 2009b). It is important to note that these guidelines for doctors on gaining consent have yet to take into account case law that might arise in the wake of the new legislation, summarising only what has been the case in the past.

The legal basis of consent for children up to the age of 16 has been decided in case law (*Gillick v. West Norfolk and Wisbech Area Health Authority* 1986). A competent child under 16 years of age (a so-called Gillick competent child: Box 3) can consent to treatment, but the courts have traditionally been generally intolerant of such a child's refusal

of treatment. The maxim has therefore evolved that a competent child can consent to treatment but cannot refuse it, or at least refusal can be overruled by someone with parental responsibility. This apparent inconsistency in the legislation has made many doctors uneasy. The developmental perspectives and their social context are complex and well summarised by Shaw (2001) and Paul (2004) and more recently by Curtis & Hawkins (2010) in the context of Human Rights Act legislation and by Hawkins et al (2011) in the context of the zone of parental control.

Before 2007, consent to treatment among 16- to 18-year-olds was largely influenced by the Family Law Reform Act 1969. However, the Mental Capacity Act now applies and it assumes that young people of this age have capacity unless it can be shown that they do not. As discussed in the next section, if a young person is unable to make a decision or lacks capacity, other considerations will need to be taken into account in their consent to or refusal of treatment.

Section 131 of the Mental Health Act 1983 was amended in 2007 (implemented in 2008) so that young people between 16 and 18 specifically cannot have their consent or refusal to admission to a hospital or registered establishment for the treatment of a mental disorder overridden by someone with parental responsibility.

The current legal situation regarding valid consent for young people is summarised in Box 5. It will be noted that this summary does not mention the particularly difficult situation for families and clinicians in which a 16- to 18-year-old withholds consent. In such a case, treatment under common law, under the Mental Health Act or under the zone of parental control could be considered. In the past, courts in England and Wales have decided in favour of the preservation of life, but as the Department of Health (2009b: p. 34) reminds us, there is no post-Human Rights Act 1998 authority for someone with parental responsibility consenting to treatment where a young person with capacity is refusing it. This is therefore new territory that has yet to be charted. In the meantime, readers are referred to the detailed guidance on pp. 34–35 of this Department of Health document.

BOX 5 Young people and consent to treatment in England and Wales: summary notes

Under 16 years of age

- No changes introduced by the new legislation (Mental Capacity Act 2005 and the 2007 amendments to the Mental Health Act 1983)
- Capacity is not presumed
- A child deemed to be Gillick competent can give valid consent
- A child deemed not to be Gillick competent cannot give valid consent: someone with parental responsibility would need to give consent

16–18 years of age

- Previously governed by Family Law Reform Act 1969
- Now subject to the Mental Capacity Act 2005
- Capacity is not presumed
- The young person can give valid consent *unless* he or she lacks capacity or is unable to make a decision
- If the young person lacks capacity or is unable to make a decision, the clinician should consider whether treatment can be given under common law, under the Mental Health Act, or under the provisions of the zone of parental control

In thinking about the case…

It was perfectly legal for the girl to give autonomous consent for the treatment. However, the complication arises that she subsequently withdrew consent during treatment. The primary consideration now is whether treatment can continue under common law without her consent.

ETHICS: C – Capacity and competence considerations

Within the practice of child psychiatry, Tan & Jones (2001) have suggested that capacity (the legal ability to consent to treatment) should be separated from competence (the clinical ability to consent to treatment). Capacity, as a legal concept, is function specific, the standard of proof is the balance of probabilities, it is presumed to be present unless proven absent, presumed to continue, and just because a decision may be imprudent is not sufficient grounds for the patient to be deemed incapacitous (Hope 2003). When might capacity not be present? Johnston & Liddle (2007) point out that the statutory definition of those who lack capacity (Box 6) does not necessarily help the clinician very much. In the opinion of Church & Watts (2007), clinicians should assess and diagnose any impairment or disturbance in mental functioning before assessing capacity, but this may be difficult practically in many on-call situations.

The Mental Capacity Act requires clinicians assessing capacity to place young people between the ages of 16 and 18 into one of two categories: those who lack capacity within the meaning of the Mental Capacity Act, that is according to the

BOX 6 Statutory definition of lack of capacity

'For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

(Mental Capacity Act 2005: part 1, section 2)

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criteria specified in Box 6; and those who are unable to decide for reasons of immaturity, for example because they feel overwhelmed by the implications of the decision, in which case the Act does not apply (Department of Health 2009a). The impairment of or disturbance in the functioning of the mind or brain referred to in Box 6 includes situations in which the impairment is temporary, for example because of severe pain, distress, or the effects of medication or alcohol (Department of Health 2009a). Thus, many young people presenting to A&E following an overdose of tablets, for example, may fall within this group.

Unlike capacity, competence is a clinical judgement explicitly defined in case law. The three key cognitive abilities determining that a patient is competent to consent to treatment are that they understand the relevant information, believe it and can use or weigh it as part of the process of decision-making and communicating their decision (Box 7).

BOX 7 Steps for clinicians in the assessment of competence

Step 1: Identify information relevant to the decision

- Can the patient understand the treatment?
- Can they understand the benefits and risks (and the consequences of refusing treatment)?

Step 2: Assess cognitive ability

- Can they understand the information?
- Can they believe the information?
- Can they weigh up the information and come to a decision?

Step 3: Assess other factors that may interfere with decision-making

- Mental illness
- Lack of maturity

(adapted from Hope 2003)

In thinking about the case…

As this patient is 17 years old the Mental Capacity Act applies. She is presumed to have capacity, which is a legal concept. It could be argued, however, that she currently lacks capacity (according to Box 6) owing to the effects of the overdose. A clinical test of her competence would need to be undertaken (Box 7). It could be argued from this that she lacks competence owing either to mental illness, if there are grounds for suspecting this, or to the possible effects of the overdose.

ETHICS: S – Summarise the case, what you are planning to do and what you have learnt

This is an opportunity to assess students' or trainees' clinical reasoning, ability to consider differing points of view, thoughtfulness in making a treatment plan, reflection on aspects of professionalism and ability to extract learning points. It can also highlight gaps in knowledge and allow teachers to provide feedback.

In thinking about the case…

There are three possible courses of action here. The first, of course, is treatment under common law in what is, after all, an emergency. The second, which may follow the first, is use of the Mental Health Act. This may well be more appropriate on the grounds that the girl meets the (now broader) criteria for a mental disorder. The aim of treatment would be to prevent suicide and this could include treatment of her related medical condition, that is, drug toxicity. A third course of action would be to decide that the girl lacks capacity under the Mental Capacity Act and treat her under parental consent if this is considered to fall appropriately within the zone of parental control. Would a decision of this kind fall within the category of usual parenting decisions? That remains to be clarified in case law. Furthermore, the Mental Capacity Act does not address deprivation of liberty and it lacks the safeguards offered by use of the Mental Health Act. If, however, it is decided that the girl does have capacity and is competent, treating her merely under parental consent is no longer possible and, by implication, she could not be prevented from taking her life should she wish to do so. Wishing to die is not in itself symptomatic of mental disorder.[§]

Conclusions

It is the view of many that the landscape of child and adolescent mental healthcare is changing in the direction of allowing young people more autonomy (see, for example, Parker & Dickinson 2001). It is as yet unclear whether this will be shown to be true, as many clinicians may respond by greater use of the Mental Health Act, or by deciding that a young person is not mature enough to make a decision or does not have capacity. Many child psychiatrists may be bemused at being asked to make the distinction between whether a patient is 'unable to decide' because of lack of maturity or because of lack of capacity, in the terms of the Mental Capacity Act.

What is clear is that there is now much more complexity in the decision-making process, that many documents on the subject have rapidly become out of date, and some newer concepts have yet to be tested for usefulness (for example, the zone of parental control).

Making decisions about people's lives in situations of uncertainty is an important part of professionalism, and it affects doctors in all branches of medicine. Psychiatrists, owing to the particular nature of their work, are expected to have a sophisticated understanding of the legal

MCQ answers
1 a 2 a 3 d 4 e 5 d

[§]For articles of related interest in *Advances*, see Brindle N, Branton T (2010) Interface between the Mental Health Act and Mental Capacity Act: deprivation of liberty safeguards, **16**: 430–437. Kelly C, Dale E (2011) Ethical perspectives on suicide and suicide prevention. **17**: 214–219. Ed.

aspects of consent to treatment and are likely to be approached by other doctors and health professionals for advice on these matters. One way trainers can help trainees and themselves to become fully familiar with the changing legislation is to introduce a medico-legal slot into trainees' meetings as part of a rolling educational programme to initiate discussions of emergencies arising on-call. The ETHICS tool (Box 1), which is at least a systematic way of considering the material, might be useful here.

References

Alfandre D, Rhodes R (2009) Improving ethics education during residency training. *Medical Teacher* **31**: 513–7.

Beauchamp TL, Childress J (1979) *Principles of Biomedical Ethics*. Oxford University Press.

Branton T, Brookes G (2010) Definitions and criteria: the 2007 amendments to the Mental Health Act 1983. *Advances in Psychiatric Treatment* **16**: 161–7.

British Medical Association (2004) *Medical Ethics Today (2nd edn)*. BMA.

British Medical Association (2009) *Consent Tool Kit (5th edn)*. BMA.

British Medical Association (2010) Medics urged to brush up on consent. *BMA News* July **3**: 11.

BMA Central Consultants and Specialists Committee (2008) *The Role of the Consultant*. BMA.

Church M, Watts S (2007) Assessment of mental capacity: a flow chart guide. *Psychiatric Bulletin* **31**: 304–7.

Curtice M, Hawkins T (2010) The Human Rights Act 1998: implications for the medical treatment of children and young people. *Advances in Psychiatric Treatment* **16**: 413–20.

Department for Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice*. TSO (The Stationery Office).

Department of Health (2008) *Mental Health Act 1983 Code of Practice*. TSO (The Stationery Office).

Department of Health, National Institute for Mental Health in England (2009a) *The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder: A Guide for Professionals*. Department of Health/NIMHE.

Department of Health (2009b) *Reference Guide to Consent for Examination or Treatment (2nd edn)*. Department of Health.

Fisher-Jeffes L, Barton C, Finlay F (2007) Clinicians' knowledge of informed consent. *Journal of Medical Ethics* **33**: 181–4.

General Medical Council (2009) *Tomorrow's Doctors: Outcomes and Standards for Undergraduate Medical Education*. GMC.

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

Hall I, Ali A (2009) Changes to the Mental Health and Mental Capacity Acts: implications for patients and professionals. *Psychiatric Bulletin* **33**: 226–30.

Hawkins T, Player B, Curtice M (2011) The zone of parental control and decision-making in young people: legal derivation and influences. *Advances in Psychiatric Treatment* **17**: 220–6.

Hope T, Savulescu J, Hendrick J (2003) *Medical Ethics and Law: The Core Curriculum*. Churchill Livingstone.

Johnston C, Liddle J (2007) The Mental Capacity Act 2005: a new framework for healthcare decision making. *Journal of Medical Ethics* **33**: 94–7.

Joyce T (2007) *Best Interests: Guidance on Determining the Best Interests of Adults Who Lack the Capacity to Make a Decision (or Decisions) for Themselves (England and Wales)*. British Psychological Society.

Mattick K, Bligh J (2006) Teaching and assessing medical ethics: where are we now? *Journal of Medical Ethics* **32**: 181–5.

Parker M, Dickinson D (2001) *The Cambridge Medical Ethics Workbook: Case Studies, Commentaries and Activities*. Cambridge University Press.

Paul M (2004) Decision-making about children's mental health care: ethical challenges. *Advances in Psychiatric Treatment* **10**: 301–11.

Potter R (2004) 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. *Psychiatric Bulletin* **28**: 91–3.

Royal College of Psychiatrists (2010) *Good Psychiatric Practice: Confidentiality and Information Sharing (2nd edition) (College Report CR160)*. Royal College of Psychiatrists.

Shaw M (2001) Competence and consent to treatment in children and adolescents. *Advances in Psychiatric Treatment* **7**: 150–9.

Tan JOA, Jones DPH (2001) Children's consent. *Current Opinion in Psychiatry* **14**: 303–7.

MCQs

Select the single best option for each question stem

1 Before the implementation of the Mental Capacity Act 2005, consent by 16- to 18-year-olds was largely governed by the:

a Family Law Reform Act 1969
b Family Reformation Bill 1786
c Family Restoration Proceedings 1961
d Mental Health Act 1983
e Mental Health Act amendments of 2007.

2 In considerations of capacity:

a the standard of proof is the balance of probabilities
b the standard of proof is that it be beyond reasonable doubt
c the standard of proof is that there are sufficient grounds for incapacity
d capacity is always taken to be absent unless proved present
e an imprudent decision can be taken as an indication of incapacity.

3 The four principles approach to ethical decision-making in medical practice includes the concept of:

a harmony
b relativity
c the Platonic ideal
d autonomy
e injustice.

4 In the latest Mental Health Act code of practice, clinicians are encouraged to:

a use the most restrictive alternative
b obtain consent from parents when a young person lacks capacity
c place the public good before individual autonomy
d be mindful of the cost of detention
e be equitable.

5 The following individual will normally have parental responsibility:

a a step-mother
b the biological father who pays child support
c the mother's partner
d the biological father if he was married to the mother at the time of the birth
e the local authority in cases of voluntary accommodation.