

Feeling the way: childhood mental illness and consent to admission and treatment

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With the enactment of the Human Rights Act 1998 and with the prospect of new mental health legislation, formal admission and compulsory treatment are topical issues (Department of Health, 1999). Discussions rarely centre on children, probably as admissions for severe mental illness are uncommon in this age group, and are scattered among specialist adolescent units, secure social service facilities and adult psychiatric wards. The question of whether a competent child's human rights are infringed by overriding their autonomy requires careful thought by mental health professionals, regardless of how often they encounter young people. Ultimately the ethical and legal framework developed from extreme cases influences daily clinical practice. To stimulate debate, we summarise the history and legal framework of consent, and discuss the developmental issues affecting capacity, and the ethical and clinical implications in relation to children with psychiatric disorder.

HISTORY OF CONSENT

Although conceived by clinicians as a medico-legal requirement (Kessel, 1994), consent has a moral foundation expressed in the ethical principle of respect for autonomy, which is enshrined by Article 5 (the right to liberty) and Article 8 (the right to privacy) of the Human Rights Act 1998. Although the right to information was acknowledged by Percival as early as the 19th century, it was also seen as potentially harmful, and he recommended benevolent deception (Faden & Beauchamp, 1986). Such beneficence dominated physicians' attitudes to information-sharing for centuries, and given the recent events at Alder Hey Hospital, some would argue still does.

The concept of informed consent in relation to patient autonomy developed from legal cases concerning battery and negligence brought against doctors in the

mid-20th century (Faden & Beauchamp, 1986). The Nuremberg Code 1947, together with the World Medical Association Declaration of Helsinki 1964, also increased the focus on patient autonomy, especially pertaining to medical research (Faden & Beauchamp, 1986). Legal opinion predicts that the Human Rights Act 1998 will lead to an increase in the amount of information that doctors are expected to provide for their patients and a correspondingly stronger emphasis on patient self-determinism (Hewson, 2000). Adolescents will be able to demand greater autonomy, but whether this will reverse the trend of recent case law towards greater paternalism is difficult to predict.

LEGAL FRAMEWORK

The United Nations Convention on the Rights of the Child, ratified by Britain in 1991, states that children have the same inherent dignity and equal rights as adults do, but also recognises that children are born dependent and have a right to protection and guidance.

English statute, although not as unequivocal as the United Nations Convention, endorses a limited degree of autonomy for children. The Family Law Reform Act 1969 empowered 16- and 17-year-olds to consent to medical interventions in the same manner as adults (Kennedy & Grubb, 1994). The Children Act 1989 weighed the principle that children's wishes should be sought and respected whenever possible against professional's perceptions of the child's best interests, and granted limited rights to refuse medical examination and treatment to children looked after by the local authority (Kennedy & Grubb, 1994).

The application of the Mental Health Act 1983 is the same regardless of age and there is no lower age threshold. Sadly, it seems that the Government of England and Wales is unlikely to accept the

recommendation of the expert Mental Health Act Review Committee that the age for capacity to make treatment decisions be lowered to 16, with a presumption of competence from the age of 10 to 12 years (Department of Health, 1999).

According to the Mental Health Act 1983 *Code of Practice*, parental authority is sufficient for the detention and treatment of any minor regardless of competence (Department of Health & Welsh Office, 1999). Few child psychiatrists would be willing to use parental authority alone to override the wishes of a competent 16-year-old, suggesting that this advice conflicts with current clinical practice as well as human rights theory (Shaw, 1999).

Case law distinguishes between consent and refusal of treatment (Dickenson, 1994). Lord Scarman's ruling that:

"the parental right to determine whether their child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable them to understand fully what is proposed"

gave rise to the term 'Gillick competent' (Gillick *v.* West Norfolk and Wisbech Area Health Authority, 1986).

However, in the case of R, a 15-year-old ward of court admitted for assessment of a suspected psychotic illness, who refused medication, the Appeal Court judged that a child with a fluctuating mental capacity could never be considered competent, even when lucid (Re: R (A minor) (Wardship: Medical Treatment) 1991). In a subsequent case involving W, a 16-year-old girl with anorexia nervosa, the Appeal Court held that the Family Law Reform Act 1969 had not removed a parent's right to consent on their child's behalf (Re: W (A minor) (Wardship: Medical Treatment), 1992).

In contrast, competent adults can refuse any medical intervention for reasons that are "rational or irrational or for no reason" (Sidaway *v.* Governors of Bethlem Royal Hospital, 1985). Equally, adults detained under the Mental Health Act 1983 are not necessarily incompetent with regard to all treatment decisions. The case of C, a patient at Broadmoor with schizophrenia who refused the amputation of his gangrenous foot, led to a legal test of competence in adults; namely the comprehension and retention of relevant information, believing it and weighing it up in order to reach a decision (Re: C (Adult: Refusal of treatment), 1994).

In summary, English law affords minors the right to consent to, but not to refuse, medical treatment, which suggests a right to agree with your doctors (Dickenson, 1994). However, the decision to refuse medical treatment can have grave consequences, and our society is driven towards the preservation of life. In the past the need for a higher level of understanding if treatment was refused was justified as refusal questions expert opinion and doctors were expected to act in their patients' best interest (Batten, 1996).

This assumption is debatable in the light of recent medical scandals, as is the similar assumption that parents inevitably act with their child's welfare in mind, particularly for those working in child protection scenarios (Batten, 1996). Paradoxically, the legal system is unwilling to accept the right of a 17-year-old to determine what happens to his or her body, when the age of criminal responsibility now stands at 10 years (Dickenson, 1994). If parents and the courts can overrule competent minors, children are not being granted the "equal and inalienable" rights afforded them by the United Nations Convention on the Rights of the Child.

CAPACITY AND DEVELOPMENT

There is no legal test of competence for children, but good practice guidelines published by the British Medical Association & the Law Society (1995) recommend assessing the young person's understanding that there is a choice, that choices have consequences, and that an ability to make choices exists. After assessing the child's comprehension of the nature and purpose of the proposed intervention, together with its risks, benefits and any alternatives, one should consider the young person's freedom from pressure to act in any given way.

Vygotsky's work suggests that although their level of maturity limits children's cognitive abilities, like adults, they have the capacity to learn from instruction and experience (Rushforth, 1999). A study of healthy children's understanding of a research project concluded that while those under the age of 9 had little idea of what they had agreed to, many adult participants also had patchy comprehension of the procedures and their implications (Ondrusek *et al.*, 1998).

When hypothetical situations were explained to healthy volunteers, 9- and 14-year-olds made decisions comparable to those of adults, although the younger group showed less understanding and used concrete rather than abstract reasoning (Weithorn & Campbell, 1982). As children make similar choices to those of adults and, by the age of 14, base them on similar reasoning to that of adults, it seems illogical to treat them differently.

The legal definition of capacity emphasises rationality, but this is not the only determinant of our ability to make decisions. Other attributes, such as emotion, experience, preference and social context, contribute to decision-making (Dickenson, 1994; Rushforth, 1999). From her study of 120 children undergoing orthopaedic surgery, Alderson contrasts child factors (such as temperament, understanding, intelligence and independence) with parental influence and the approach of the medical team, who are in turn constrained by the legal and ethical framework in which they work (Alderson, 1993).

Parental expectations can mould the level of maturity in their offspring, and competence could be construed as a way of relating to others (Alderson, 1993). The legal philosopher John Eekelaar argues that learning to take responsibility for decisions is an important part of a child's development (Eekelaar, 1994). His concept of dynamic self-determinism proposed that, as far as possible, decisions should be devolved to the child, within a supportive framework that prevents adverse consequences, in order to enhance the child's ability to make mature, informed choices.

Of particular relevance to child mental health professionals is the dynamic nature of maturity, psychopathology and capacity, all of which may fluctuate (Batten, 1996). Psychopathology may impede information-processing and retention, as well as combining with family difficulties or abnormal attachments to influence the interpretation of information. The experience of serious illness may enable understanding, but may also impede self-determinism by disrupting normal developmental processes, while the family may respond to a sick child with overprotection.

ETHICAL CONSIDERATIONS

Dyer & Bloch (1987) assert that the basis of informed consent is the balance between

respect for autonomy, beneficence and the fiduciary principle. Whereas the balance has been firmly tipped towards autonomy for adults with psychiatric illness, for children the major influence remains their welfare as perceived by clinicians and those with parental responsibility.

Although there is a real risk of burdening immature children while relieving parents (and professionals) from their duty to guide and protect, children are maturing earlier and, as most psychiatric disorders are chronic, children and families are facing choices about the quality of life rather than life or death (Dickenson, 1994). As the nature of the choices and the developmental level of those faced with them changes, we should increasingly trust the autonomy of the youngsters who will have to live with their impact.

An additional tension exists between respect for emerging autonomy and the avoidance of harm; psychological or physical impairment may result if the child does not receive treatment (Batten, 1996). Overruling a youngster may seem wrong in terms of denying his or her values, but opinions are divided as to whether it will actually harm them.

CLINICAL ISSUES

How, then, should we deal with children suffering from mental illness? Although it conflicts with the United Nations Convention on the Rights of the Child, the law is clear that in life-threatening situations competent minors will be overruled (Shaw, 1999). In less extreme situations children should be as involved as possible in all decisions that affect them, regardless of competence (Shaw, 1999). There is a sliding scale of involvement from having information, to sharing and ultimately taking responsibility for decisions (Rushforth, 1999). Even formal admission or compulsory treatment do not preclude autonomy over other decisions.

Derived from the Latin words *com* and *sentere*, consent means literally 'to feel with' (Dyer & Bloch, 1987). Rather than coercing, as far as possible the child and adolescent mental health teams should be 'feeling the way with' their patients to seek interventions that are acceptable to all concerned. Many would now construe overruling a child's refusal in non-urgent circumstances as child abuse. Responsibility in extreme cases is being thrown back to

the legal profession but while it remains important that these issues are debated independently of the system that generated them, clinicians should not lose their opportunity to participate.

REFERENCES

Alderson, P. (1993) *Children's Consent to Surgery*. Buckingham: Open University Press.

Batten, D. A. (1996) Informed consent by children and adolescents to psychiatric treatment. *Australian and New Zealand Journal of Psychiatry*, **30**, 623–632.

British Medical Association & the Law Society (1995) *Assessment of Mental Capacity*. London: BMA.

Department of Health (1999) *Reform of the Mental Health Act 1983: Proposals for Consultation*. London: Stationery Office.

— & **Welsh Office (1999)** *Mental Health Act 1983 Code of Practice*. London: Stationery Office.

Dickenson, D. (1994) Children's informed consent to treatment: is the law an ass? *Journal of Medical Ethics*, **20**, 205–206.

Dyer, A. R. & Bloch, S. (1987) Informed consent and the psychiatric patient. *Journal of Medical Ethics*, **13**, 12–16.

Eekelaar, J. (1994) The interests of the child and the child's wishes: the role of dynamic self-determinism. *International Journal of Law and the Family*, **8**, 42–61.

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Faden, R. R. & Beauchamp, T. L. (1986) *A History and Theory of Informed Consent*. Oxford: Oxford University Press.

Hewson, B. (2000) Why the human rights act matters to doctors. *BMJ*, **30**, 780–781.

Kennedy, I. & Grubb, A. (1994) *Medical Law: Texts with Materials*. London: Butterworths.

Kessel, A. S. (1994) On failing to understand informed consent. *British Journal of Hospital Medicine*, **52**, 235–239.

Ondrusek, N., Abramovitch, R., Pencharz, P., et al (1998) Empirical examination of the ability of children to consent to clinical research. *Journal of Medical Ethics*, **24**, 158–165.

Rushforth, H. (1999) Communicating with hospitalised children: review and application of research pertaining to children's understanding of health and illness. *Journal of Child Psychology and Psychiatry*, **40**, 683–691.

Shaw, M. (1999) *Treatment Decisions in Young People: The Legal Framework*. London: FOCUS, The Royal College of Psychiatrists' Research Unit.

Weithorn, L. A. & Campbell, S. B. (1982) The competence of children and adolescents to make informed treatment decisions. *Child Development*, **53**, 1589–1599.

Gillick v. West Norfolk and Wisbech Area Health Authority (1986) AC, 112.

Sidaway v. Governors of Bethlem Royal Hospital (1985) AC, 871.

Re: *C (Adult: Refusal of treatment)* (1994) 1, WLR, 290.

Re: *R (A minor) (Wardship: Medical Treatment)* (1991) 4, All ER 177, CA.

Re: *W (A minor) (Wardship: Medical Treatment)* (1992) 4, All ER 627, CA.