Legal Frameworks for Capacity and Consent for Young People

This guidance is not intended to replace legal advice. Please consult with your own organisation's legal team as necessary. Information is correct as of December 2019 It is your responsibility to confirm if there has been updated case law in this area.

Introduction

This guidance has been developed to support services working with children and young people in understanding the legislation interfaces around capacity and consent. At the age of sixteen, a young person can be presumed to have the capacity to consent; however, a young person under the age of sixteen may also have the capacity to consent, depending on their maturity and ability to understand what is involved. It is important to note that parental responsibility comes to an end when the child attains the age of 18 years or earlier if a court order is made. Someone who has parental responsibility for a young person may be asked to make decisions about their care or treatment if they lack capacity to make the decision for themselves. The general rule is that the person or people who have parental responsibility for the young person should make the decision.

Gillick competence

Children under the age of 18 can consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment.

This is known as being Gillick competent. Gillick competence is a functional ability to make a decision. Victoria Gillick challenged Department of Health guidance which enabled doctors to provide contraceptive advice and treatment to girls under 16 without their parents knowing. In 1983 the judgement from this case laid out criteria for establishing whether a child under 16 has the capacity to provide consent to treatment; the so-called 'Gillick test'. It was determined that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects, risks, chances of success and the availability of other options.

If a child passes the Gillick test, he or she is considered 'Gillick competent' to consent to that medical treatment or intervention. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Additionally, a child may have the capacity to consent to some treatments but not others. The understanding required for different interventions will vary and can fluctuate. Therefore each individual decision requires assessment of Gillick competence.

If a child does not pass the Gillick test, then the consent of a person with parental responsibility (or sometimes the courts) is needed in order to proceed with the treatment.

The Mental Capacity Act 2005

The Mental Capacity Act 2005 (MCA) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves because of a disturbance or impairment in the functioning of their mind or brain. The Act's starting point is to assume that anyone aged 16 or over has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. This is known as the presumption of capacity. The MCA also states that people must be given all practicable help and support to enable them to make their own decisions or to maximise their participation in any decision-making process.

The MCA is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives. The aim is to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

The five statutory principles are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the decision is made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

For further information the MCA code of practice can be found here.

Deprivation of Liberty

A deprivation of liberty (DoL) within any age relates to Article 5 of the Human Rights Act 1998 (Right to Liberty) and is when a person lacks mental capacity to consent to the restrictions around them (within their care and support plan) that results in a deprivation of their liberty.

To determine if a person is deprived of their liberty we apply the 'acid test' (as set out in Cheshire West and Chester v P (2014).

a) The person lacks mental capacity (because of an impairment relating to their mind or brain) to consent to the restrictions around them within their care and support plans
b) The person is under continuous supervision and control e.g. a member of staff knowing the person's whereabouts for the duration of a 24 hour period
c) The person is not being free to leave where they reside.

Deprivation of Liberty Safeguards

The Mental Capacity Act Deprivation of Liberty safeguards (DoLS) (formerly known as the Bournewood safeguards) were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007 (which received Royal Assent in July 2007).

The MCA DOL safeguards apply to anyone:

- aged 18 and over
- who suffers from a mental disorder or disability of the mind – such as dementia or a profound learning disability
- who lacks the capacity to give informed consent to the arrangements made for their care and / or treatment and
- for whom deprivation of liberty (within the meaning of Article 5 of the ECHR) is considered after an independent assessment, to be necessary and in their best interests to protect them from harm

The safeguards cover patients in hospitals and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements. The safeguards are designed to protect the interests of an extremely vulnerable group of service users and to:

- ensure people can be given the care they need in the least restrictive regimes
- prevent arbitrary decisions that deprive vulnerable people of their liberty
- provide safeguards for vulnerable people
- provide them with rights of challenge against unlawful detention
- avoid unnecessary bureaucracy

Court of Protection Deprivation of Liberty

A Court of Protection Deprivation of Liberty (COPDOL) is an application to the Court of Protection for people who are not safeguarded under the current Deprivation of Liberty Safeguards (2007) legislation.

The DoLS legislation safeguards people who are deprived of their liberty of whom reside in care homes or hospitals; however this legislation does not cover people in domiciliary care settings including supported living and, in a person's own home.

CCG's and Local Authorities are responsible to apply to the Court of Protection (for a COPDOL) to seek authorisation to continue to support and care for the person, in their best interests, that results in a deprivation of their liberty.

The Inherent Jurisdiction of the High Court

This refers to the authority of the High Court to make rulings where there is no other court or legislation available. The inherent jurisdiction may be called upon to provide a legal framework for both adults and children who fall between legislative gaps, such as follows:

- The Court of Protection (COP), with one or two specific exceptions, cannot make decisions and declarations on behalf of a person under the age of 16 years who lacks capacity. For example the COP cannot authorise the deprivation of liberty for a 15 - year old, but under certain circumstances the High Court can
- The COP cannot make decision or declarations on behalf of anyone aged 16 years or over if their lack of capacity is not linked to an impairment or disturbance in the functioning of the mind or brain. If a vulnerable person's capacity is impaired by undue pressure from other(s), then this is outside the jurisdiction of the COP. For example, the COP cannot place restrictions on a vulnerable person's contact with an exploitative third party, but the High Court can, provided there is sufficient evidence that the vulnerable person is unable exercise free choice

The Mental Health Act 1983

The Mental Health Act (MHA) provides for the assessment and treatment of people with a mental disorder and sets out the rights that they have. In 2007 the Act was amended to ensure that service users are receiving the treatment they need and to provide professionals with a clear framework to work to. The MHA defines a mental disorder as any disorder or disability of the mind and is wide ranging including a number of disorders such as schizophrenia, depression, anxiety disorders and eating disorders. Suffering from one of these disorders by itself does not mean that a person is subject to the provisions of the Act. The MHA sets out the legal rights that apply to people with a mental disorder. Under this law a person can be admitted, detained and treated in hospital for a mental disorder without their consent.

Can a person under age 18 be subject to the Mental Health Act?

A person under 18 who has a mental disorder and is assessed as needing the protection of the Act can be detained and treated under it. There is no lower age limit on the powers of the Act and there are no specific provisions that specifically deal with young people. However from April 2010, if a person under 18 is detained in hospital under the Act they have the right to be placed on a ward that is suitable for their age and needs.

For further information the MHA can be found here.

Looked after Children

A looked after child who is being looked after by their local authority is known as a child in care. They might be living:

- with foster parents
- at home with their parents under the supervision of social services
- in residential children's homes
- other residential settings like schools or secure units

They might have been placed in care voluntarily by parents struggling to cope. Or, children's services may have intervened because a child was at significant risk of harm.

Interim Care order

The time limits that used to apply to interim care orders were removed under the Children and Family Act (2014). A court can make an interim care order or interim supervision order for any time period specified in the order. This will allow time for matters to be investigated further and plans to be made. The interim care order will detail:

- where the child will live
- arrangements for attending school
- arrangements for seeing parents

The judge will decide how long the interim care order will last and how often it will be reviewed. In some cases the child may continue living at home with the parents under specified conditions

Children who are looked after under section 20 of the Children Act (1989)

Section 20 is about local authority (social services/children's services) providing accommodation for children who do not have somewhere suitable to live. It is sometimes called 'voluntary care' or 'voluntary accommodation' because usually parents must agree to the child being accommodated. Section 20 is not just housing. It is taking a child into the care system by agreement rather than by court order. The local authority is responsible for taking care of the child while they are in section 20 accommodation.

Children who are looked after under section 31 of the Children Act (1989) Care Order/Supervision Order

If social services think a care order is necessary they will ask the court for a full care order/supervision order to be made. The court will only make a full care order/supervision order if they are convinced that the following threshold criteria is met:

- the child is suffering, or is likely to suffer, significant harm
- making an order would be better for the child than making no order at all (presumption of "no order")
- and that harm is due to either
- the care the child is receiving or likely to receive if the care order isn't made
- or, the child is beyond parental control, e.g. the child is absconding from home and partaking in risky behaviours and parents are unable to safeguard them

No care order or supervision order may be made with respect to a child who has reached the age of seventeen (or sixteen, in the case of a child who is married).

A care order gives the local authority parental responsibility for a child. Parental responsibility is shared with the parents, but the local authority has the power to decide how much involvement a parent should have with their child and how far the parents can use their parental responsibility.

Deprivation of Liberty in relation to Young people aged 16 -17 Years

Most of the Mental Capacity Act 2005 applies to young people aged 16-17 years, who may lack capacity to make specific decisions but the statutory framework of the Deprivation of Liberty Safeguards (DoLS) does not apply to those under 18 years of age Mental Capacity Act 2005, s4A(5), to be read alongside Schedule A1 s13.

Since the MCA 2005 specifically restricts the DoLS to adults a legal framework must be placed around the arrangement in order to ensure that the deprivation of liberty is lawful. A deprivation of liberty will be lawful if warranted under statute; for example, under:

- Section 25 of the Children Act 1989 (placement in secure accommodation)
- Mental Health Act 1983
- Youth remand provisions of the Legal Aid, Sentencing and Punishment of Offenders Act 2012
- Custodial sentencing provisions of the Power of Criminal Courts (Sentencing) Act 2000

Where the deprivation of liberty is not authorised by statute, then the appropriate consent must be obtained.

Where parents cannot consent to deprivation of liberty, the local authority will have to seek court approval from the Court of Protection.

In the matter of D (A Child) [2019] UKSC 42

The Supreme Court has held:

- Where a 16 or 17 year old lacks capacity to give their own consent to circumstances satisfying the ‘acid test’ in Cheshire West

And

- If the state either knows or ought to know of the circumstances

Then the child is to be seen as deprived of their liberty for purposes of Article 5 European Convention of Human Rights and requires the protections afforded by that Article. This is so

whether or not their parent(s) are either seeking to consent to those arrangements if imposed by others or directly implementing them themselves.

Therefore the law, as it currently stands:

- For 16 and 17 year olds who lack capacity/Gillick competence to consent to their confinement; Parents **CANNOT give** valid consent
- Under 18's who have capacity/Gillick competence to consent, but who object to their confinement. Parental consent cannot be relied upon

Deprivation of Liberty in relation to Children under 16 Years

The Mental Capacity Act 2005 does not apply to those under 16 years, therefore an application must be made for authorisation under the inherent jurisdiction of the High Court.

Case Example

Sam is a 15 year old living in a children's home. He is subject to a Care Order under the local authority.

Under the arrangements, staff know the whereabouts of Sam at all times; he is never left alone in the home; he is never left alone with other residents; he is subject to 1:1 staffing including during breaks at school; he is subject to constant observations by staff and has no free time when he is not observed; the external doors of the home are locked at night; the bedroom doors are alarmed at night to ensure privacy and to ensure that the whereabouts of all residents are known; the internal doors are locked if Sam's behaviour necessitates it. Sam cannot leave the home unsupervised and cannot leave unaccompanied without permission; he is monitored at all activities outside of the home and is accompanied on all recreational and social events; he is not permitted any internet access and the use of his mobile telephone is restricted to four telephone numbers and cannot travel alone on public transport.

Points to consider

- Consider whether Sam can consent to the arrangements?
- Consider whether Sam is deprived of liberty?
- Consider If Sam lacks capacity to consent to the arrangements; can anyone else consent on his behalf?
- Consider whether there needs to be a legal framework in place? If so why?
- If yes, which Court would need to be approached?

Parental Responsibility

Basic principles

Parental responsibility refers to the rights, duties, powers and responsibilities that most parents have in respect of their children. Parental responsibility includes the right of parents to consent to treatment on behalf of their children, provided the treatment is in the best 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. Gillick competent children can decide many aspects of their care for themselves. 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

Who possesses parental responsibility?

The law for a child whose birth was registered from15 April 2002 in Northern Ireland, 1st December 2003 in England and Wales and 4th May 2006 in Scotland, identifies that both of the child's parents have parental responsibility if they are registered on the child's birth certificate.

Throughout the United Kingdom, a mother automatically acquires parental responsibility at birth. However, the acquisition of parental responsibility by a father varies according to where and when the child's birth was registered.

For births registered in England, Wales or Northern Ireland:

- A father acquires parental responsibility if he is married to the mother at the time of the child's birth or subsequently
- An unmarried father will acquire parental responsibility if he is recorded on the child's birth certificate (at registration or upon re-registration) from 1st December 2003 in England or Wales and from 15th April 2002 in Northern Ireland
- For births registered in Scotland:
- A father acquires parental responsibility if he is married to the mother at the time of the child's conception or subsequently. An unmarried father will acquire parental responsibility if he is recorded on the child's birth certificate (at registration or upon re-registration) from 4th May 2006
- An unmarried father, whose child's birth was registered before the dates mentioned above, or afterwards if he is not recorded on the child's birth certificate, does not have parental responsibility even if he has lived with the mother for a long time. However, the father can acquire parental responsibility by way of a court registered parental responsibility agreement with the mother or by obtaining a parental responsibility order or a residence order from the courts
- Married step-parents and registered civil partners can acquire parental responsibility in the same ways

Parental responsibility awarded by a court can only be removed by a court.

Parents do not lose parental responsibility if they divorce; neither can a separated or divorced parent relinquish parental responsibility. This is true even if the parent without custody does not have contact. Other people can also acquire parental responsibility for a child. A guardian appointed by a court will also acquire parental responsibility. When a child is adopted, the adoptive parents are the child's legal parents and automatically acquire parental responsibility.

A local authority acquires parental responsibility (shared with anyone else with parental responsibility) while the child is subject to a care order. A supervision order imposes a duty on the Local Authority to ‘advise, assist and befriend’ the child. A care order gives the Local Authority parental responsibility for the child meaning it can take decisions for the child and override the wishes of the parents. Foster parents do not have parental responsibility, they have day to day responsibilities for day to day care but parental responsibility remains with the Local Authority.

For a child born under a surrogacy arrangement, parental responsibility will lie with the surrogate mother (and husband if married) until the intended parents either (a) obtain a parental order from a court under the Human Fertilisation and Embryology Act 1990 or (b) adopt the child.

When Parental responsibility ends

In England, Wales and Northern Ireland, parental responsibilities may be exercised until a young person reaches 18 years.

MCA Example Case

Child B is a 16 and half years old who is under the Care of the Local Authority subject to section 20 of the Children Act due to an adoption breakdown. Child B has regular contact with her adoptive parents whom continue to hold parental responsibility in partnership with the Local Authority. Child B is placed out of her originating area in a residential placement in view of her high risk of child sexual exploitation and challenging behaviours.

Child B has learning disabilities and has complex emotional health issues related to attachment. Child B has the contraceptive implant fitted which she previously consented to given the concerns around her vulnerabilities and assessed as being sexually exploited. Child B has now advised her parents and residential carers that she wants the contraceptive implant removing as she wants to have a baby.

All professionals and her parents are very concerned that this would have an adverse impact on Child B and that if she were to have a child that the child would need to be removed from her care for safeguarding reasons. In addition they are concerned that she is being influenced by her boyfriend who is 35 years. The social worker has contacted the sexual health clinic to advise that they should not remove the implant due to her vulnerabilities and requested staff at the residential home to not support her to make an appointment for removal of an implant. Parents are also in full support and agree with the social workers recommendations. Child B is very angry about this and states she can make her own decisions as she is now 16 years.

Points to Consider

- Does Child B have Gillick competence
- Have the principles of the MCA been considered for each specific decision
- How do the roles of parental responsibility apply
- Have the least restrictive options been considered and documented
- What evidence of enabling decision making has been provided and documented
- Consider the impact of abuse and exploitation on her capacity to make decisions
- Consider safeguarding processes and the principles of making safeguarding personal

Useful resources

- Case Law http://www.familylawweek.co.uk/site.aspx?i=ed182592
- MCA code of Practice
- MHA Code of Practice 1983
- 39 Essex Chambers Mental Capacity Law
- British and Irish Legal Information Institute
- Mental Capacity Act 2005
- Children Act 1989 2004
- Lancashire Safeguarding Adult Board MCA and DoLS Guidance for Professionals
- Lancashire Safeguarding Adult Board 7 Minute Briefing Series

For further advice please contact your organisation's MCA Lead or seek legal advice on individual cases.