1. INTRODUCTION

1. Consent has ethical, clinical and legal components. This guidance will concentrate on the clinical component and will propose principles and standards of good practice for clinical psychologists working with children and young people up to 18 years of age.

2. The guidance will particularly focus on principles and procedures relevant to mainstream clinical activity such as routine assessment and clinical interventions. It will not address a number of specialist aspects of consent such as the use of video recording, access to patient records, the use of case material in papers and conference presentations.

3. The legal framework for consent for working with children provides only a minimum clinical standard. Good clinical practice for clinical psychologists involves working in partnership with children and their parents/carers. However, it is not uncommon for psychological interventions to be negotiated in the context of significant differences of view between parent(s) and their children. The intention of this guidance is to propose principles and procedures which will ensure that all interventions are carried out with informed consent (legal minimum) and to provide guidance that is relevant to common clinical situations such as when there is conflict about possible interventions between parents and children.

4. The legal framework for consent in England, Wales and Northern Ireland is different from that of Scotland. The differences between the laws and procedures have been comprehensively described elsewhere and will not be specifically addressed here. The aim of this clinical guidance is that, as much as possible, it should be applicable in the context of both legal frameworks.

5. Child clinical psychologists work with a wide range of childhood difficulties including children with disabilities, children with paediatric disorders and children with mental health problems. In addition, children's understanding of their difficulties and possible interventions will be significantly affected by their cognitive, emotional and social developmental level. The aim is to propose principles and standards that can be flexibly applied to this very wide range of problems.
6. Clinical practice with respect to consent for children and young people presents complex and difficult dilemmas for clinical psychologists and requires the achievement of a systemic balance between (1) respecting the rights and wishes of young people, (2) respecting the rights of parents, (3) fulfilling a professional obligation to protect young people and (4) ensuring their full access to appropriate health care. At a national, service and individual level, the balance between the ethical, clinical and legal components will continuously need to be re-examined through the complexities of specific cases.

2. CONSENT AND COMPETENCE

1. Consent for medical treatment has been well defined in the Mental Health Act Code of Practice 1999 as follows: 'Consent is the voluntary and continuing permission of the patient to receive a particular treatment based on an adequate knowledge of the purpose, nature, likely effects and the risks of that treatment including the likelihood of its success and any alternatives to it. Permission given under any unfair undue pressure is not 'consent'.

2. Adults (18 years and older) and young people aged 16-18 years are presumed competent to give consent unless there are explicit reasons why this is not the case such as use of the Mental Health Act.

3. For children and young people under 16 years, consent can be provided by either a child, a parent, a local authority (for children in care) or a court. For this group there is not a presumption of competence to give consent and the clinical psychologist, similar to other health professionals, is required to assess whether the patient is competent to provide consent.

4. An individual child under 16 years of age may consent to psychological input independent of the wishes of the parent/carer, providing this is supported by an assessment of competence by the psychologist. A competent young person should have 'sufficient understanding and intelligence to enable him/her to fully understand what is being proposed' (Gillick ruling). This requires an understanding of the risks and benefits of the intervention beyond the immediate discomforts and inconveniences that treatment may entail. Competence is therefore specific to the complexity of the intervention being considered and the previous experience of the child. It is not a general attribute of the child. The assessment of competence should not be based on age.
5. There is not a formal standardised assessment procedure for the assessment of competence. Clinical psychologists should consider the following criteria for competence which are consistent with the Good Practice guidelines of the BMA and Law Society (1995).

1. ability to understand that there is a choice and choices have consequences
2. willingness and ability to make a choice
3. understanding of the nature and purpose of the intervention.
4. understanding of the possible negative effects of the intervention.
5. understanding of the alternatives to the intervention and the risks attached to them, and the consequences of no intervention.
6. freedom from pressure.
7. reason for the absence of consent from the parent.

6. Obtaining consent does not require the psychologist to obtain written consent for all interventions. The requirement is that agreement is obtained on the basis of adequate information. For the majority of situations this will be done by verbal agreement in a way which is consistent with existing clinical practice.

3. PRINCIPLES OF GOOD PRACTICE

1. All clinical work with children and young people must be supported by informed consent provided either by the child, or by a parent/carer if the child is not considered competent to provide consent.

2. It is preferable but not obligatory that clinical work is undertaken with the consent of both the parent(s) and the child.

Although legally consent can be provided either by a child or a parent, clinical practice preferably involves the explicit agreement of both the child and the parent in carrying out clinical work.

3. In the circumstance in which the child's wishes are different from that of the parent, the primary obligation of the psychologist is that the child's interests take precedence over that of the parent.

Consent cannot be considered in isolation from the general approach of working in partnership with parents, children and their families. However, there will be clinical situations where the choices of the child and the parent will differ and that this cannot be resolved by negotiation. In this circumstance, the primary obligation of the psychologist is to consider the child's best interests and to respect the child's wishes if this position is consistent with their best interests. The competence of the child relative to the problem will also need to be considered.
4. Consent is not a single event, but a process which needs to be reviewed, particularly if the focus of the intervention changes or at agreed time intervals.

Interventions may initially be focused on a particular problem. During the intervention, other concerns may emerge which alter the intervention significantly and consent may need to be explicitly renegotiated.

5. For children and young people under 16 years of age, psychologists should actively seek to enhance the child's ability to participate in decisions about their psychological care.

It should be noted that this includes supporting the wish of the child that the parent provides consent on his/her behalf.

6. For children not considered competent to provide consent, clinical work with a child should be carried out in a way which supports active participation in decision making. This requires children to be provided with clear information tailored to the child's developmental level and to elicit their views about key aspects of the intervention plan.

A child's appropriate participation in the intervention cannot be assumed by attendance at an appointment. For a child who is not considered competent to provide formal consent for an intervention, it remains the obligation of the clinical psychologist to work with the child in a collaborative way. This requires the psychologist to inform the child and to obtain his/her views about specific aspects of the intervention. In this way, a child may agree to do a psychometric test or agree to attend a family meeting without providing informed consent for the overall intervention.

7. A clinical psychologist is not obliged to provide an intervention on the basis of having obtained consent.

A court, or a parent can provide consent for an intervention to take place. The authorisation of the court indicates that such an intervention would be lawful. However, the decision to carry out the intervention must be based on the clinical psychologist's judgement that the intervention is in the best interests of the child. The provision of consent by a court or parent is not an instruction for the intervention to take place.

8. Although consent is an essential component of good clinical practice, the psychologist retains the discretion to override issues of consent if this is judged to be in the best interests of the child's psychological and emotional well being.

The best interests of the child include a wide range of considerations and are not tightly defined in law. As well as the child's physical and
mental health needs, it includes, for example, consideration of the effects of overriding the child's wishes, the risk of non-intervention, the likely benefits of intervention and the views of parents and family members. Examples of when this principle would apply are when there are child protection concerns, when there are risks to self or others and when the impact of non-intervention would be likely to be seriously detrimental to the child's psychological development. All previous principles need to be considered in relation to this principle.

4. STANDARDS OF GOOD PRACTICE

1. Information about psychological assessments and interventions must be provided to children in a way that is appropriate to their developmental level.

The amount of information provided to parents and children should be appropriate to the length and size of impact of the treatment being considered. For example, long term individual therapy or in-patient treatment will require more comprehensive information (including written information) to support consent than more brief consultations. Written information should include the nature of planned work, likely benefits and risks and any possible alternatives to what is planned.

2. Child Participation: For all children (competent or not competent to give consent) all assessments and interventions involving the child should be carried out in such a way that the child is always informed of what he/she will be asked to participate in.

The psychologist is expected to explain to the child at an appropriate developmental level about the purpose of the clinical work and the practical arrangements for the work (i.e. frequency of sessions etc) and to take the child's views into account in making a plan of the work to be carried out. If a child withdraws agreement for a particular part of the work, then the plan should be reconsidered usually with the inclusion of the consenting parent.

3. The assessment of competence. In circumstances in which a child wishes to provide independent consent to an intervention, the clinical psychologist must carry out an informal assessment of the child's competence.

As described above (see section on Consent and competence) the clinical psychologist should explore with the child his/her reasons for wishing to provide independent consent and, where appropriate, encourage the child to discuss with his/her parent. In addition, the clinical psychologist needs to reach a judgement concerning the child competence based on the criteria described above.
At a minimum, the psychologist should:

1. Record in the clinical notes, the assessment of the child's competency, the reason's for the parent not providing consent and the agreement with the child concerning confidentiality, the arrangements for future contact with the family and with other health professionals, particularly the GP.

2. For a child or young person considered competent, it is suggested that he/she be provided with written confirmation of the arrangements in (1).

3. It is recommended that all such cases are either discussed in supervision or involve consultation with senior colleagues and that this should also be recorded in case notes.

4. The negotiation of consent. All assessments or interventions require the provision of informed consent by a competent child or by one parent/carer.

This consent is based on information (see 1 above), support for the child to participate in clinical decision making (see 2 and 3 above) and, very often, negotiation of different views both within the family and between the family and the clinician.

The negotiation of consent is a very common and familiar component of clinical work with young people and their families. This should be distinguished from the more rare circumstance of refusal described in 5 below. The clinical task is often to establish a way of working in which negotiation about the young person's participation in therapy is a central and often very demanding task. For example, many disaffected young people with significant relationship and conduct problems relate to psychological services in a way which is consistent with the problem for which they have been referred. In this circumstance, consent may often need to be obtained in a series of smaller steps. For example, the young person may refuse 'counselling' but may agree to meet with the psychologist for a single appointment to consider ways of staying out of trouble at school. This work is very familiar to clinical psychologists and needs to be differentiated from the more extreme global refusal situations described in (5) below. In these circumstances, clinical notes should include a record of what has been agreed at each stage.

In general, clinical notes should specify who has provided formal consent and the limits of what has been agreed. In many cases, these notes do not need to be unnecessarily complex. For example, a parent may consent to six sessions of family therapy to address family difficulties in response to a young person's recent overdose.
5. Refusal by a competent child who consistently expresses a wish not to participate in an intervention which is considered to be in his/her best interests will require consultation either with senior colleagues or with the clinical supervisor.

For the majority of clinical psychologists, this circumstance is comparatively rare and needs to be distinguished from the more common situation of working with hard to engage young people and their families (see 4 above). The circumstances addressed in this section will usually only arise in a multi-disciplinary setting and consultation with senior colleagues will be central to appropriate decision making. It is likely that the approval of the court will usually be required for the intervention to proceed. In general the harm caused by overriding the child's wishes must be balanced against the harm caused by not carrying out the intervention. In practice, overriding a competent child's wishes in this circumstance is likely only to be justifiable in circumstances where there is a significant threat to life or long term significant harm and where the benefits of an intervention are relatively clear.

6. Confidentiality. Sharing or obtaining information about a child from other agencies or professionals should be carried out with the competent child's consent or the parent's consent for the child who is not competent.

In the situation in which a psychologist decides that the best interests of the child need to take precedence over consent, the reasons for this judgement should be recorded in case notes including efforts to obtain consent from the child or parent. The most common situation for this is when consent has not been obtained to share information with other agencies about concerns of possible or actual abuse of the child.

7. Supervision and review. Good clinical practice will not be achieved simply by the application of fixed procedural formulae but requires organisational and professional structures that enable clinical psychologists periodically to examine their clinical practice, particularly through supervision and consultation with peer child professionals.

This principle applies to many areas of clinical practice but is restated to emphasise that the achievement of good clinical practice requires a combination both individual and organisational components.

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This position paper on consent has been developed by a SIG working group. The group consisted of Peter Fuggle (chair), Jo Douglas, Diane Melvin, Brenda Renz, Jean Lyon and Rhiannon Powell. Helpful comments were also received from Lorna Todd.