A teaching trust of Brighton and Sussex Medical School

Sussex Partnership NHS Foundation Trust

CONSENT TO TREATMENT POLICY – PART 4 MHA 1983

(Replaces Policy No.183.Clinical)

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PROCEDURE SPONSOR	Director of Corporate Affairs
PROCEDURE AUTHOR	Practice Development Manager – Mental Health Law

Key policy issues:

- Policy outlines requirements to meet Part IV of the Mental Health Act 1983 as amended by the Mental Health Act 2007.
- Outlines requirements of consent to treatment provisions of Part 4A of the Mental Health Act 1983 and the Health and Social Care Act 2012 for patients subject to a Community Treatment Order.

If you require this document in another format such as large print, audio or other community language please contact the Corporate Governance Team on 01903 843041 or email: policies@sussexpartnership.nhs.uk

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1 Introduction

The powers to treat patients detained under the Mental Health Act (MHA) 1983 are set out in Part 4 and 4A of the MHA 1983. Treatment for mental disorder may be given with or without the detained patient's consent; therefore compulsory treatment may be a severe infringement of a patient's rights without strict adherence to the legislation.

This policy sets out the requirements of Part 4 and 4A MHA 1983 to ensure all clinicians act in accordance with the MHA 1983 and associated Code of Practice when treating patients detained under the MHA 1983.

1.1 Purpose of policy

This policy promotes good practice when treating patients detained under the MHA 1983. Adherence to this policy will ensure compliance with the MHA 1983 and the associated code of practice.

1.2 Scope of policy

This policy details the roles and responsibilities of all staff concerned with the administration of medical treatment for mental disorder and aims to ensure that staff are aware of the legal requirements for detained patients and that their practice is informed by this.

The policy applies to patients detained under the MHA 1983 only.

There is no minimum age limit for detention under the MHA. It may be used to detain children or young people who need to be admitted to hospital for assessment and/or treatment of their mental disorder when they cannot be admitted and/or treated on an informal basis, and where the criteria for detention under the Act are met.

1.3 Principles

Although the Mental Health Act permits some medical treatment for mental disorder to be given without consent, the patient's consent should still be sought before treatment is given, wherever practicable.

Neither the existence of mental disorder nor the fact of detention under the Mental Health Act should give rise to an assumption of incapacity. The person's capacity must be assessed in relation to the particular decision they are being asked to make.

Consent or refusal to consent should be recorded within in the patient's notes, as should an assessment as to the patient's capacity to consent.

If a patient withdraws consent, the clinician in charge of the treatment should review the treatment and consider whether to provide alternative treatment, give no further treatment or proceed with treatment in the absence of consent under the Mental Health Act (where appropriate). The responsibility for ensuring that a treatment plan is in place lies with the Responsible Clinician (RC). Treatment plans are essential for patients who are being given treatment for mental disorder under the Mental Health Act 1983. Treatment may not

automatically continue to be given to the patient in the fact of a refusal without appropriate review by the RC.

1.4 Children and Young People and Consent

As with adults, treatment for mental disorder for under 18's is regulated by Parts 4 and 4A of the MHA. The valid consent of a child or young person is sufficient authority for their admission to hospital and/or treatment for mental disorder; additional consent by a person with parental responsibility is not required. It is good practice to involve the child or young person's parents and/or others involved in their care and decision-making process, if the competent child or young person with capacity consents to information about their care and treatment being shared.

A young person must have the capacity, or a child must have competence, to make the particular decision in question.

The capacity of a young person (aged 16 or 17 years) to consent is assessed using the MCA test, using the Carenotes Capacity assessment form (16+).

The test for children under 16 is determined by considering whether they are "Gillick" competent, using the Trust Gillick Competency Assessment form (see Appendix 1).

1.4.1 Parental responsibility

When making decisions under the MHA it is important to identify who has parental responsibility. Someone with parental responsibility will usually, although not always be a parent, although others may acquire parental responsibility. Where the parents are not married it will be necessary to identify if the father has gained parental responsibility.

Clinicians should always check whether any child arrangement orders, parental responsibility agreement or orders or special guardianship orders have been obtained.

See also the MCA Code of Practice Chapter 19 for more detail.

2 Duties

Director of Corporate Affairs
To ensure an appropriate policy is in place which adheres to the requirements of the MHA 1983 and associate Code of Practice

Senior Managers
To ensure this policy is properly implemented within their designated areas of responsibility and all staff properly adhere to the principles herein.

Consultants / Approved Clinicians/Responsible Clinicians
To ensure this policy is implemented in daily practice.

All Staff
To adhere to the requirements of this policy to ensure that detained patients are treated in accordance with this policy.

3 Definitions

Term	Definition
Appropriate medical treatment	Sections 3, 36, 37, 37/41, 47, 47/49, 48, 48/49 and community treatment orders require that appropriate medical treatment is available. This is treatment relevant to the person's case, taking into account the nature and degree of their mental disorder and all other circumstances of their case. Treatment must be available to the patient and it is not sufficient that appropriate treatment could be theoretically provided. The MHA code of Practice 2015 states at 1.15: "Treatment should address an individual patient's needs, taking account of their circumstances and preferences where appropriate." The Code goes on to state at 1.16: "Patients should be offered treatment and care in environments that are safe for them, staff and any visitors and are supportive and, therapeutic."
Consent	The voluntary and continuing permission of the patient to receive a particular treatment, based on sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.
Mental Disorder	Any disorder or disability of the mind
Treatment	Medical treatment for Mental Disorder which is for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations. Includes medication, nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care. The MHA Code of Practice 2015 also states at 2.13 that "medical treatment of mental disorder can include measures to address alcohol or drug dependence if that is an appropriate part of treatment the mental disorder which is the primary focus of the treatment".

4 Procedure

This policy refers to detained patients and SCT patients who have been recalled as detained patients.

4.1 The Three Month Rule (Section 63)

Sections 63 of the Act provides the authority to give appropriate treatment to detained patients with or without their consent in the first 3 calendar months starting with the first time they are given such treatment.

This authority does not apply to patients subject to Sections 4, 5(4), 5(2), 35, 135(1), 136, Guardianship and conditional discharge (41 only). If a patient is detained under these Sections, treatment can only be given if they have the capacity to consent to it or, if they

lack capacity, under the powers of the Mental Capacity Act 2005. The three month rule does not apply to SCT patients unless they are recalled to hospital.

Where practicable, consent should be sought before any treatment is commenced, even treatment given under the authority of s63. A record of the patient's capacity to consent and any consequent consent or refusal should be recorded by the Responsible Clinician/Approved Clinician on a Carenotes "Mental Capacity Assessment over 16" form selecting the "Detained Patient – Section 63". This should be reviewed regularly.

Assessments of competency for children aged 16 years and under must be recorded on the Gillick Competency Assessment form (Appendix 1).

4.2 Treatment Post Three Months (Section 58)

4.2.1 Detained Patients with capacity who consent to treatment

After medication has been given for the first three month under Section 63, Section 58 then comes into force. The purpose of this section is to provide further safeguards and protection for patients who require further treatment.

If the person has the capacity to consent to the proposed treatment, the AC/Responsible Clinician must complete form T2. This form is used to demonstrate that the patient has understood the nature, purpose and likely effect of the proposed treatment and that they have consented to it.

The AC must personally seek consent from the patient to continue medication beyond the 3 month period. A record of the discussion with the patient, the treatment plan and an assessment of their capacity to consent to the treatment should be made on the Carenotes "Mental Capacity Assessment over 16" form selecting the "Detained Patient – Section 58" option. This should be reviewed/renewed on a regular basis.

Assessments of competency for children aged 16 years and under must be recorded on the Gillick Competency Assessment form (Appendix 1).

A copy of the T2 and completed s58/Gillick Competency form should be attached to the patient's drug chart where relevant. The T2 box on the patient's drug chart must be ticked and the renewal date recorded above it. The original completed T2 form must be sent to the MHA office for filing in the patient's legal file.

Should the patient later withdraw their consent to treatment then Form T2 becomes invalid. Also should the patient later lose capacity the T2 would also become invalid and treatment may only be given under Section 62 (see below) or under the authorisation of a Second Opinion Approved Doctor (SOAD).

4.2.2 Detained Patients lacking capacity or refusing to give consent to treatment

Where the patient later withdraw their consent to treatment or later loses capacity a SOAD must be requested from the Care Quality Commission. The SOAD Request Form must be completed on-line (https://webdataforms.cqc.org.uk/Checkbox/SOAD.aspx) by the

Responsible Clinician as soon as possible and the receipt forwarded to the MHA Office who will monitor attendance.

It is poor practice to wait until the end of the 3 month period to request a SOAD if it is known that the patient lacks capacity and/or will refuse continued treatment.

The SOAD will consult with the patient, Responsible Clinician and two statutory consultees:

- a nurse involved in the patients care and
- another professional (not a doctor or nurse).

The statutory consultees must have knowledge of the patient and their treatment to help the SOAD decide whether the proposed treatment is appropriate. It is important that the statutory consultees are identified at the point of making the request and that they are available for consultation with the SOAD. The ward where the patient is detained is responsible for ensuring that the identified statutory consultees are available to discuss the patient's treatment with the SOAD at the appropriate time.

Following such consultations the SOAD can authorise the proposed treatment if they consider it to be appropriate. Authorisation will be recorded on Form T3 a copy of which must be kept with the patient's drug chart and in the patient's notes. The T3 box on the patient's drug chart must be ticked and the renewal date recorded above it. The original must be sent to the MHA Office for filing in the patient's legal file.

Only treatment authorised on the T3 can be given and no additions or amendments are permissible without authorisation of the SOAD. If the SOAD does not authorise the RC's treatment plan, the treatment will not be authorised and cannot be given to the patient. **It is the nurse administering the medication who is responsible for ensuring it is compliant with the authorisation.**

It is the responsibility of the RC to discuss the outcome of the SOAD's visit with the patient and ensure the discussion is documented on the trust form provided for this purpose. A copy should be filed in the patient's notes and the original sent to the MHA Office.

Certificates which no longer authorise treatment (or particular treatments) should be clearly marked as such, as well as all copies of those certificates kept with the patient's notes and medication chart.

4.3 Special treatment (Section 57)

This Section applies to detained or informal patients and defines special treatments as:

- Surgery to destroy brain tissue or the functioning of the brain
- Other treatment as specified by the Secretary of State for Health including the surgical implantation of hormones to reduce male sex drive.

In these cases the patient must consent, a SOAD and a multidisciplinary panel appointed by the CQC must confirm that the consent is valid, and the SOAD must consult two statutory consultees before providing authorisation on Form T1.

4.4 ECT (Section 58A)

Please refer to the Trust's ECT Policy for full guidance.

Section 58A applies to ECT and to medication administered as part of ECT.

The three month period does not apply to ECT. Except in an emergency, ECT cannot be given without either the capable consent of the patient or authorisation of the treatment by a SOAD. ECT may only be given if the patient meets one of the three following criteria:

- They are over 18 and have consented to the treatment and that an Approved Clinician or SOAD has certified that consent on Form T4

- They are under 18 and have consented to the treatment and a SOAD has certificated such treatment on Form T5

- They lack capacity to consent and a SOAD has authorised the treatment on Form T6 (there must not be an advance decision or Power of Attorney in place refusing ECT or a deputy appointed by the Court of Protection refusing ECT)

For children and young people who are not capable/competent of consenting to ECT, the SOAD must certify that the child/young person is not capable of understanding the nature, purposes and likely effects of ECT, but it is appropriate for ECT to be given. In addition, in relation to a young person who lacks capacity to consent to ECT, the SOAD must certify that giving the treatment would not conflict with a decision made by a deputy appointed by the Court of Protection, or the Court of Protection.

In all cases, SOADs should indicate on the certificate the maximum number of administrations of ECT which it approves (Para 25.23 Code of Practice 2015)

The authority to treat forms (T4/5/6) must be copied and placed on the patient's health record, the original should be sent to the MHA Office to place on the patient's legal file.

The RC must personally seek consent from the patient to administer ECT. A record of the discussion with the patient and an assessment of their capacity to consent to the treatment will be made by the RC on the Carenotes "Mental Capacity Assessment over 16" form selecting the "Detained Patient – Section 58A ECT" option.

Assessments of competency for children aged 16 years and under must be recorded on the Gillick Competency Assessment form (Appendix 1).

ECT may be given in emergency situation subject to the constraints and restricts of Section 62 (see below), even in cases where an Advanced Decision to refuse treatment is in place.

4.5 Urgent Treatment (Section 62)

Section 62 authorises the administration of urgent treatment in emergency circumstances where other parts of the Act cannot be used.

Urgent treatment is:

- Treatment which is necessary to save a persons life and,
- Treatment which (not being irreversible) is immediately necessary to prevent a serious deterioration of a patients condition or,
- Treatment which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering to the patient or,
- Treatment which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others

Only the first two points of the definition can be used for the administration of ECT.

Section 62 may be used while an Approved Clinician (AC) /Responsible Clinician (RC) waits for authorisation from a SOAD provided a SOAD has been requested. Section 62(2) states that if a patient who had previously consented to the treatment withdraws that consent and the AC/RC considers that ceasing the treatment would cause serious suffering then the treatment may continue. In this case the AC/RC should make an immediate request for a SOAD.

All uses of Section 62 should be recorded on the Carenotes Section 62 form by the Approved Clinician/Responsible Clinician.

Key points to remember:

- Section 62 Urgent treatment can only be authorised and the section 62 form only completed by the AC (usually the RC) in charge of the patient's treatment.

- The authorised acting AC/RC (on-call consultant) is able to authorise urgent treatment out of hours. The advice can be given over the telephone - the on-call consultant must then access Carenotes and complete a s.62 Urgent Treatment form to document the authorisation given.

- "Date of Treatment", can either be expressed as a specific date, a date range, or numbers of treatment (for example 2 x ECT treatments).

- Following external legal advice and the view of the CQC, a s.62 form must only authorise treatment for a maximum of one week, after which time a new capacity assessment must be completed.

- If further urgent treatment is required under s.62 then a new s.62 form must be completed by the AC/RC (or authorised acting RC).

- Where a detained patient is being treated under the authority of a s.62 form, the daily monitoring of the s.62 form for that patient is the responsibility of the ward clinical team to ensure treatment being given for mental disorder is included on the current s.62 form.

4.6 Patients subject to a Community Treatment Order

All patients subject to a Community treatment Order ("CTO") are covered by Part 4A MHA 1983 unless they are subject to recall to hospital in which case the provisions under Part 4 MHA 1983 (Sections 58 and 58A) apply as above.

All CTO patients require a certificate of treatment to authorise the administration of medication in the community:

- CTO11 – The patient lacks capacity and treatment.

- CTO12 – the patient has capacity and consents to the treatment proposed

For the first month of a CTO, treatment can be given to a CTO patient (provided that patient is not refusing consent to it) without SOAD authorisation. After the first month SOAD certification is needed (irrespective of whether the patient is consenting or incapable but compliant), unless the three-month period that was applicable to treatment with medication as an inpatient is still to expire at this time, in which case that three-month period must run its course before certification is needed. Assuming they support the treatment, SOADs are required to certify the appropriateness of medication for mental disorder (i.e. irrespective of whether the patient is consenting to it or lacks capacity to consent) given after the first month of a patient being in the community on CTO.

Force may not be used to treat CTO patients whilst they are in the community if they object to treatment. Force may be used where a patient is incapacitated, provided that the person giving the treatment decides that the patient does not object to the treatment

A patient who is capable of giving consent and refuses to do so therefore cannot be compelled to accept treatment. Neither can treatment be imposed upon an incapable patient if it conflicts with a valid advance refusal of treatment or a Court of Protection ruling, or with a refusal of consent by a deputy or attorney as defined in the Mental Capacity Act: in such cases the patient must be considered to have equivalent status as if they were contemporaneously refusing consent.

4.6.1 CTO patient recalled to hospital

In general, CTO patients recalled to hospital are subject to s58 and s58A in the same way as other detained patients. However, there are 3 exceptions:

- Certificate of Treatment (T2/T3) under s58 is not needed for medication if less than one month has passed since the patient was discharged from hospital and became an SCT patient.

- A certificate of treatment is not needed under either s58 or s58A if the treatment is already explicitly authorised for administration on recall on the patient's CTO11.

- Treatment that was already being given on the basis of a CTO11 may be continued, even though it is not authorised for administration on recall, if the RC

considers that discontinuing it would cause the patient serious suffering. However it may only be continued pending compliance with s58 or s58A (as applicable) – in other words while steps are taken to obtain a new T2 or T3 certificate.

4.6.2 CTO Patients not recalled to hospital (Part 4A MHA 1983)

CTO patients who have not been recalled to hospital who have the capacity to consent to treatment may not be given that treatment unless they consent. There are no exceptions to this rule, even in emergencies. The effect is that treatment can be given without their consent only if they are recalled to hospital.

CTO patients who lack the capacity to consent to treatment may be given it if their attorney or deputy, or the Court of Protection, consents to the treatment on their behalf and treatment does not conflict with an advance decision.

4.6.3 CTO Patients and Emergency Treatment

Emergency treatment for patients who lack capacity and are subject to CTO may be given under Section 64(g) MHA 1983. The categories under which emergency treatment can be given are the same as those for Section 62 above. However, treatment may be given even if it contradicts a refusal by an attorney, deputy or Court Oder and force may be used in exceptional circumstances provided it is proportional to the risk and likelihood of serious harm.

4.7 Review of Treatment

All treatments should be reviewed regularly and a new capacity assessment and statutory form completed when:

- There is a change in the treatment plan from that recorded;
- If consent is re-established after being withdrawn;
- When there is a break in the patient's detention/SCT;
- When there is a permanent change of RC;
- When the patient's detention/CTO is renewed;
- If there is a change in the hospital where the patient is detained

It is good practice to renew capacity and consent at any such reviews.

For patients whose treatment has been authorised by a SOAD under s58 or 58A the following circumstances will cease to authorise treatment:

- The SOAD specified a time limit on the approval of a course of treatment and the time limit expires;
- The patient lacked capacity but now has capacity;
- For ECT only – the certificate was given on the understanding that the treatment would not conflict with an advance decision, decision of an attorney, a deputy or the Court of Protection to refuse treatment, but the person giving the treatment becomes aware that there is such a conflict.

All out of date forms must be crossed through and removed from the drug chart and replaced with the valid form authorising the treatment.

In all the circumstances listed above treatment cannot be continued while a new certificate is obtained unless the treatment is immediately necessary under s62 MHA.

It is not good practice to use a certificate that was issued to a patient when detained and who has since been discharged onto SCT to authorise treatment if the patient is then recalled to hospital, even if the certificate remains technically valid. A new certificate should be obtained as necessary.

Section 61 MHA 1983 places a duty on the RC to regularly review the treatment of patients for whom a SOAD has authorised treatment. The review requires the RC to complete Section 61 Review of Treatment form on renewal of a patient's detention, when requested by the CQC, for restricted patients six month after the section began then annually thereafter. Again, it is good practice to renew capacity and consent at any such reviews.

Patient's should be involved in treatment reviews as far as practicable and be enabled to participate in decision-making as far as they are capable of doing. This includes being given sufficient information about their care and treatment in a format that is easily understandable to them. Paragraph 1.10 Code of Practice 2015.

4.8 Information about Consent to Treatment for Patients

Under paragraph 4.20 of the Code of Practice 2015, patients must be told what the MHA 1983 says about treatment for their mental disorder. In particular they must be told:

- The circumstances (if any) in which they can be treated without their consent – and the circumstances in which they have the right to refuse treatment
- The role of second opinion appointed doctors (SOADs) and the circumstances in which they may be involved, and
- (where relevant) the rules on ECT and medication administered as part of ECT.

4.9 MHA Office

Please ensure the original completed statutory treatment forms are sent to the MHA Office to file in the patient's legal file.

Copies of statutory forms referred to in this policy can be accessed on the Trust website (http://staff.sussexpartnership.nhs.uk/i-need-help-with/mental-health-act/mental-health-act-forms).

4.10 Patient signatures

It is no longer necessary to obtain the signature of a consenting patient on a capacity/consent form,

The provision of a patient signature does not demonstrate patient involvement. The priority is for the clinician to demonstrate patient involvement, engagement and empowerment in the process.

It is essential that patients are supported to be engaged in the process of reaching decisions which affect their care and treatment. Consultation with patients involves helping them to understand the information relevant to decisions, their own role and the roles of others who are involved in taking decisions. Where a decision is made that is contrary to the patient's wishes, that decision and the authority for it should be explained to the patient using a form of communication that the patient understands. Carers and advocates should be involved where the patient wishes or if the patient lacks the capacity to understand.

The discussion with the patient must be fully recorded on the Carenotes Capacity/consent form and include:

- Detail of the treatment plan/proposed intervention.
- Reasons for the capacity decision.
- Information and supports provided to the patient as part of the discussion/decision-making process.
- Views of the patient and family/carers (where appropriate)
- Detail of the decision made.

ECT treatment – due to the nature of ECT treatment it has been agreed that the existing practice for obtaining the signature of a consenting patient will remain unchanged.

5 Development, Consultation and Ratification

This policy is reflects Part 4 and 4A MHA 1983 and the associated Code of practice 2015. This policy also reflects amendments introduced by the Health and Social Care Act 2012.

Policy and Procedure to be reviewed and amended by the Mental Health Act Services Team. To be ratified by the Professional Practice Forum.

6 Equality and Human Rights Impact Assessment (EHRIA)

The policy has been equality impact assessed in accordance with the Procedural Documents Policy.

7 Monitoring Compliance

The MHA Office will report to the Mental Health Act Committee any areas of concern regarding compliance of this policy. The MHAC will agree any audits applicable to this policy.

8 Dissemination and Implementation of Policy

8.1 Dissemination

This policy will be uploaded onto the Trust website by the Governance Support Team. Publication will be announced via the Communications e-bulletin to all staff.

8.2 Training

Consent to treatment procedure is part of the essential MHA training; all staff will be made aware of the requirements of this policy. The Trust has also released Capacity and Consent flowcharts which reflects the requirements of this policy.

9 Document Control Including Archive Arrangements

This policy will be stored and archived in accordance with the Trust Procedural Documents Policy.

10 Reference Documents

Mental Health Act 1983 as amended by the Mental Health Act 2007
Mental Health Act Code of Practice 2015
Mental Capacity Act Code of Practice 2007
NICE Guidelines on Decision Making (https://www.nice.org.uk/guidance/ng108

11 Cross Reference

- ECT Policy
- Mental Capacity Act Policy
- Community Treatment Order Policy

Sussex Partnership NHS
NHS Foundation Trust

GILLICK COMPETENCE (UNDER 16s) ASSESSMENT AND CONSENT FORM
ADMISSION TO HOSPITAL AND TREATMENT

This form is to be completed by the admitting doctor or treatments prescriber whenever consent to admission to hospital, initial treatment or ongoing treatment is required. This competency assessment form is also to be used if the child or young person is detained under the Mental Health Act 1983 and the treatment prescriber (Responsible Clinician) is assessing competency/consent under Section 63 (for every new treatment during the first 3 months of detention) and Section 58 after the expiry of the first 3 months of detention(for treatment decision making and the appropriate treatment form (T2, SOAD request, T3, Section 62 urgent treatment form).

Admitting doctor/treatment prescriber: _____
Ward/unit: Chalkhill
Child / Young persons name: _____

DOB: _____ **Age on date of assessment:** _____**NHS number:** _____
Proposed intervention:

CHILDREN (UNDER 16)
COMPETENCE ASSESSMENT (GILLICK/FRASER COMPETENCE)

Competence is assessed relative to a child`s maturity, intelligence and understanding rather than their numerical age.

Decision to be made:

To be assessed as competent, the child needs to comprehend the nature and implications of the treatment. When considering a child`s competence, consider the following:

Is the child able to understand the information related to the decision?	Yes/No
Is the child able to retain the information for long enough to reach a decision?	Yes/No
Is the child able to use or weigh the information in order to reach a decision?	Yes/No
Is the child able to communicate their decision by any means?	Yes/No
The child is assessed to be Gillick competent	Yes/No

Reasons for concluding that the child is or is not Gillick competent:

Were all reasonable steps taken to maximize the child`s competence to make the decision?
(Using parents to explain, using sign language, using pictures etc.)
Give evidence

Can the decision be delayed because the child is likely to regain competence in the near future?
Yes/No

Was a carer or staff member consulted as part of the assessment of competence? Yes/No
Please state who was consulted:

I have informed and explained the young person's competency status to them
Yes/No
If no please confirm that you have flagged this up with the nurse in charge so it can be followed up ASAP ☐

CHILDREN (UNDER 16)
CONSENT TO ADMISSION TO HOSPITAL / FOR TREATMENT

CHILDREN WITH GILLICK COMPETENCE

The child has consented to the proposed intervention Yes/No

(If a Gillick competent child does not consent, it is dangerous to rely on consent by a person with parental responsibility due to post-Human Rights Act 1998 case law which reflects the increased autonomy of children as they develop and gives greater weight to their views.)

CHILDREN ASSESSED AS NOT GILLICK COMPETENT

Consent by a person with parental responsibility and the proposed intervention is within the scope of parental responsibility

Yes/No

(If a child is not Gilick competent, proposed treatment can be given with parental consent if proposed intervention is within the scope of parental responsibility. If proposed treatment is outside the scope of parental responsibility, child cannot be given the proposed treatment unless they meet the admission criteria for the Mental Health Act 1983 or the court has authorized the treatment)

CONSENT MUST BE:

Based on an adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success, the consequences of the treatment not occurring, any alternatives to it and the right to withdraw consent

Free from undue pressure

Given following an opportunity to ask questions

With the knowledge that the proposed treatment is prescribed within its license/outside its licensed indication/is an unlicensed medication (*Delete as appropriate)*

Medication leaflet given to young person / person with parental responsibility Yes/No

If no, give reasons:

SIGNED (TREATMENT PRESCRIBER): _____DATE: _____

If the child is assessed to have Gillick competence and has consented to the proposed intervention, please ask to sign below:

SIGNED (CHILD): _____ _____DATE: _____

If the child is assessed not to be Gillick competent and a person with parental responsibility has consented to the proposed intervention, please ask to sign below:

SIGNED (PERSON WITH PARENTAL RESPONSIBILITY):

_____DATE: _____