Ethics Toolkit

Treating 16 and 17-year-olds in Scotland

February 2025

BMA Medical ethics and human rights

bma.org.uk

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About this toolkit

When they reach the age of 16, all young people in the UK are assumed in law to have the capacity to make their own decisions about medical treatment and in Scotland, young people are classed as adults from that age. It is not until they reach the age of 18, however, that they are treated in the same way as adults in every area of medical law, and this can make decision making for this group complex. As a result, in the past some of the answers doctors seek were found in our guidance on children and young people, some in our Consent and refusal by adults with decision-making capacity toolkit and some in our guidance on Adults with incapacity in Scotland toolkit.

To make our guidance as helpful and as accessible as possible we have produced this separate guidance on treating 16 and 17-year-olds in Scotland, bringing together in one place the key information doctors need to know when treating that group of patients. There is a separate toolkit on the treatment of 16 and 17-year-olds in in England, Wales, and Northern Ireland.

For healthcare professionals who need guidance on the treatment of children and young people under the age of 16, the BMA has published a children and young people under 16 toolkit.

These are available on the BMA's website. Individual healthcare professionals, trusts, health boards, and medical schools may download and make copies of them.

The BMA would welcome feedback on the usefulness of the toolkit. If you have any comments, please address them to:

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1 Introduction

When they reach the age of 16, all young people in the UK are assumed in law to have the capacity to make their own decisions about medical treatment and in Scotland, young people are classed as adults from that age. It is not until they reach the age of 18, however, that they are treated in the same way as adults in every area of medical law, and this can make decision making for this group complex. As a result, in the past some of the answers doctors seek were found in our guidance on children and young people, some in our Consent and refusal by adults with decision-making capacity toolkit and some in our guidance on Adults with incapacity in Scotland.

To make our guidance as helpful and as accessible as possible we have produced this separate guidance on treating 16 and 17-year-olds in Scotland, bringing together in one place the key information doctors need to know when treating that group of patients.

There are separate toolkits on treating 16 and 17-year-olds in England, Wales, and Northern Ireland, and treating children and young people under 16 which applies across the UK.

Key resources

BMA – Consent and refusal by adults with decision-making capacity
BMA – Adults with incapacity Scotland
BMA – Treatment of 16 and 17-year-olds in England, Wales, and Northern Ireland toolkit
BMA – Children and Young People under 16 toolkit
GMC – 0-18 years

2 Consent and refusal of treatment

Consent to treatment

Are 16 and 17-year-olds able to consent to treatment?

When a young person reaches the age of 16, they are assumed to have legal capacity to give consent, in accordance with section 8 Family Law Reform Act 1969. Where there is doubt about the young person's capacity, this should be assessed in line with the guidance set out in section 5.

Who can consent to or authorise treatment for a 16 or 17-year-old?

The following are legally entitled to give consent to medical treatment for a 16 or 17-year-old in Scotland:

- the 16 or 17-year-old unless they lack capacity – see section 4 on capacity and incapacity and section 5 on assessing capacity; and
- a parent or other person or agency with parental responsibility where they are asked to do so by the young person.

In addition, where a 16 or 17-year-old lacks capacity to make a decision, the Adults with Incapacity (Scotland) Act 2000 (AWIA) allows the healthcare professional in charge of their care to provide treatment without consent, where it would benefit them (see section 6).

Are there any procedures for 16 and 17-year-olds who lack capacity that need additional safeguards?

There are certain safeguarded treatments that cannot be undertaken on the basis of the general authority to treat, or proxy consent provisions of the Act. These treatments are set out in the Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002. The following treatments require approval by the Court of Session:

- sterilisation where there is no serious malformation or disease of the reproductive organs;
- surgical implantation of hormones for the purpose of reducing sex drive; and
- neurosurgery for mental disorder.

What other treatments may require additional safeguards?

In England, case law (including Supreme Court case law) and Court of Protection guidance have made clear that certain categories of cases are ones where legal advice should be sought to determine whether an application to court is required. Given that these are cases where there is doubt or disagreement about the correct course of action, or where it is considered that the proposed treatment would involve serious interference with the person's human rights, the BMA recommends that doctors in Scotland seek legal advice in cases where:

- at the end of the decision-making process:
  - the decision is finely balanced;
  - there is a difference of medical opinion; or
  - there is a doubt or dispute that cannot be resolved locally (see section 12 on dispute resolution) about whether a particular treatment will benefit the patient.

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- there is a conflict of interest on the part of those involved in the decision-making process;
- the procedure is for the purpose of donation of an organ, bone marrow, stem cells, tissue, or bodily fluid to another person;
- the action proposed involves a procedure for the covert insertion of a contraceptive device or other means of contraception;
- it is proposed that an experimental or innovative treatment be carried out; or
- the case involves a significant ethical question in an untested or controversial area of medicine.

Refusal of treatment

Is the refusal of a 16 or 17-year-old binding in Scotland?

In Scotland, it seems likely from current case law and statute that a refusal by a 16 or 17-year-old who has capacity cannot be overridden by a court, even if that treatment is necessary to save or prolong life. This matter is not beyond doubt, however, and so legal advice should be sought if such situations arise. For 16 and 17-year-olds, the only aspect of parental responsibility that still applies is the giving of 'guidance' – they cannot consent to treatment that the young person has refused.

Treatment in emergencies

In an emergency, where consent cannot be obtained, on what basis can a 16 or 17-year-old be treated?

As with adults, in an emergency, where consent cannot be obtained, for example, when a 16 or 17-year-old is unconscious, it is legally and ethically appropriate for healthcare professionals to proceed with the treatment necessary to preserve the life, health, or wellbeing of the young person. An emergency is best described as a situation where the requirement for treatment is so pressing that there is no time to refer the matter to court. If such an emergency involves administering a treatment to which the young person is known or believed to object, for example, the administration of blood to a Jehovah's Witness, viable alternatives should be explored if time allows. In extreme situations, however, healthcare professionals are advised to take all essential steps to stabilise the young person. Legal advice may be needed once emergency action has been taken.

Key resources

GMC – 0-18 years
BMA – Adults with incapacity Scotland toolkit

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Seeking consent from 16 and 17-year-olds

When is it necessary to seek consent?

Doctors must obtain consent from 16 and 17-year-olds who have the capacity to give it any time they wish to initiate an examination, treatment, or any other intervention. Consent is also required for the participation of 16 and 17-year-olds in research (see section 19).

As with adults, the only exceptions to this are in emergencies where it is not possible to obtain consent, or when the law prescribes otherwise, such as when compulsory treatment for a 16 or 17-year-old's psychiatric disorder is authorised by mental health legislation (see section 18). Mental health legislation cannot authorise non-consensual treatment for physical conditions that are not directly related to a psychiatric disorder.

Proceeding with treatment without valid consent leaves the doctor who is carrying out the procedure and, where different, the doctor who sought consent at risk of criticism and, potentially, legal, and/or regulatory sanctions.

What is required for consent to be considered valid?

In order for consent to be valid, 16 and 17-year-olds must:

- have the capacity to make the decision;
- have been offered sufficient information to make an informed decision;
- be acting voluntarily and free from undue pressure; and
- be aware that they can refuse.

How should consent be obtained?

Consent can be explicit or implied. Explicit or express consent is when a person actively agrees, either orally or in writing. Implied consent is when consent is signalled by the behaviour of a patient, for example by opening their mouth to allow a doctor to examine their throat. This is not a lesser form of consent, provided the patient genuinely knows and understands what is being proposed and is aware that they have the option to refuse.

The General Medical Council (GMC) at paragraph 5 of its guidance *Decision making and consent*, advises that doctors can apply their own professional judgement about the most appropriate way to seek consent which will be dependent on the specific circumstances of each decision, including:

'a. the nature and severity of the patient's condition and how quickly the decision must be made
b. the complexity of the decision, the number of available options and the level of risk or degree of uncertainty associated with any of them
c. the impact of the potential outcome on the patient's individual circumstances
d. what you already know about the patient, and what they already know about their condition and the potential options for treating or managing it
e. the nature of the consultation.'

The GMC also advises, at paragraph 7, that whilst it would be reasonable for a doctor to rely on a patient's non-verbal consent for some routine, quick, minimally, or non-invasive interventions, doctors should still:

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'a. explain what is going to be done and why
b. make clear the patient can say no, and stop immediately if they do
c. be alert for any sign that the patient may be confused or unhappy about what you are doing.'

Does consent always need to be in writing?

No. Written consent is only legally required for a small number of treatments (such as some forms of fertility treatment) although it is often advised in other circumstances, particularly where the procedure is very invasive or entails more than minimal risks. Doctors should familiarise themselves with the latest clinical guidance in their area of practice. Consent forms can be used to document that discussions about the procedure have taken place. However, consent forms are evidence of the consent process, rather than consent itself. A 16 or 17-year-old genuinely understanding what is being proposed is more important than how consent is recorded.

What should be recorded in a patient's medical records?

Details of the discussions that have taken place with a patient, and any other relevant people, should be recorded in the patient's medical records. This should usually include discussions about the treatment options, including potential harms and benefits of any treatment, any specific concerns the patient had, and any other information that was given to them.

How long is consent valid for?

Consent should be a continuing process, rather than a one-off decision. Like adults, 16 or 17-year-olds can change their mind about treatment at any time. Before beginning any treatment, doctors should check that the patient still consents. This is particularly important if:

– a significant length of time has passed since the patient agreed to the treatment;
– there is new information available;
– there have been any significant changes to the patient's condition; or
– the process of seeking consent had been delegated to a colleague.

It is important that patients are given continuing opportunities to ask further questions and to review their decisions and are kept informed about the progress of their treatment or care.

Do I have to provide treatment which I do not think is clinically appropriate for the patient?

If a patient asks for treatment that you do not think would be clinically appropriate for them, you should discuss their reasons for requesting it with them. Any significant factors for the patient should be explored further, including non-clinical factors such as their beliefs or views. Following this, if you still consider that the treatment is not clinically appropriate, you do not have to provide it. However, the reasons for this should be explained clearly to the patient, as well as other options available to them, including seeking a second opinion.

Key resources

BMA – Consent and refusal by adults with decision-making capacity
GMC – Decision making and consent

4 Capacity and incapacity

What is capacity?

Decision-making capacity refers to the everyday ability we possess to make decisions or to take actions that influence our lives, from simple decisions about what to have for breakfast, to complex decisions about serious medical treatment. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for themselves or for other people.

Young people aged 16 and over are presumed in law to have capacity to give their consent to medical treatment in Scotland. This means that it is never for the 16 or 17-year-old to prove their own capacity. Where a person intends to take steps on the basis that the young person lacks capacity to make the relevant decision, that person must be able to explain why they consider that they are allowed to do so, including why the young person can be said to lack capacity.

When does a 16 or 17-year-old lack capacity?

From the age of 16, treatment decisions for patients who lack capacity are covered by the Adults with Incapacity (Scotland) Act 2000 (AWIA). For the purpose of the AWIA, a 16 or 17-year-old lacks capacity if, at the time a decision needs to be made, due either to a mental disorder or to a physical disability or neurological impairment which prevents communication and which cannot be made good by human or mechanical aid, they are incapable of:

- acting;
- making the decision;
- communicating the decision;
- understanding the decision; or
- retaining the memory of the decision.

The AWIA therefore contains a two-stage test:

Stage 1 – Is the individual incapable of acting, making decisions, communicating decisions, understanding decisions, or retaining the memory of decisions?

Stage 2 – If so, is that due to either a mental disorder or to a physical disability or neurological impairment which prevents communication and which cannot be made good by human or mechanical aid?

The assessment of incapacity is 'task specific' – it is not an 'all or nothing' concept. The assessment of incapacity must be made in relation to the particular decision that needs to be made, at the time it needs to be made. A central tenet of the AWIA is that an adult (which includes a 16 or 17-year-old) must not be labelled as incapable simply because of a specific diagnosis or other circumstance.

What are the basic principles of the AWIA?

The AWIA contains a set of guiding principles which doctors are legally required to apply to all their interactions with patients with incapacity. Actions or decisions that clearly conflict with these principles are unlikely to be lawful, although there may be occasions where they are in tension, and some balancing will be required. A list of the principles, with brief descriptions, is given below.

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Benefit

Any action or decision must be necessary and must be likely to be of benefit to the young person. There should be a reasonable expectation that the patient will benefit, and that benefit cannot be achieved without the proposed intervention. If the young person is likely to regain capacity in a reasonable time, and the decision can be delayed without causing them harm, it should be. For more information on benefit see section 6.

Least restrictive intervention

Any action or decision taken should be the least restrictive necessary to achieve the purpose. It should be the option that restricts the young person's freedom as little as possible.

Take account of the young person's wishes and feelings

In deciding if an action or decision is to be made, and what that should be, account must be taken of the present and past wishes and feelings of the young person as far as these may be understood, and to what is known about their beliefs and values as far as they can be ascertained by any means of communication, whether human or by mechanical aid.

Consultation with relevant others

You must take account of the views of others with an interest in the young person's welfare. The AWIA lists those who should be consulted whenever practicable and reasonable. It includes the young person's primary carer, nearest relative, attorney, or guardian, if there is one – see proxy decision makers in section 8. This is not an exhaustive list and the views of others who appear to you to have an interest in the welfare of the young person or the intervention should be considered, so far as reasonable and practicable.

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Assessing capacity

What are the basic principles of assessing capacity?

The AWIA sets out several principles that govern decision making for patients aged 16 and over. Actions or decisions that clearly conflict with these principles are unlikely to be lawful, although there may be occasions where they are in tension, and some balancing will be required. A list of the principles, with brief descriptions, is given below.

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Who should assess capacity?

The law does not specify who should assess capacity where a patient's ability to make a decision has been called into question.

In its guidance on decision making and consent at paragraph 82 the GMC states: 'Assessing capacity is a core clinical skill and doesn't necessarily require specialist input (for example, by a psychiatrist). You should be able to draw reasonable conclusions about your patient's capacity during your dialogue with them. You should be alert to signs that patients may lack capacity and must give them all reasonable help and support to make a decision.'

Healthcare professionals who assess capacity need to be skilled and experienced in discussions with young people and eliciting their views. The treating doctor may be the most appropriate person, but other members of the healthcare team, or someone close to the young person may also have valuable contributions to make. The healthcare professional providing the treatment must be satisfied that the young person has capacity before providing the treatment if they are relying on their consent.

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Although assessing capacity is a core clinical skill, in complex cases, where there is doubt about whether the 16 or 17-year-old has the requisite capacity, you should seek specialist input from colleagues such as psychiatrists or psychologists. You should also seek specialist input if the young person or someone close to them disagrees with your assessment.

How do you assess capacity?

The law of Scotland generally presumes that those aged 16 or over are legally capable of making decisions, including treatment decisions, for themselves but that presumption can be overturned where there is evidence of impaired capacity.

If doctors receive requests from other healthcare professionals or those in social care to assess capacity, and insufficient information as to the reason for the request is provided, doctors should ask that the relevant information about the person and the decision(s) in question is provided before carrying out the assessment.

When assessing whether an individual lacks capacity to make a particular decision, doctors should ensure, as far as possible, that any factors likely to affect the patient's ability to decide for themselves are addressed beforehand. These may include medication, medical condition, pain, time of day, fatigue, or mood. Any information must be given as clearly and plainly as possible, with communication aids used where appropriate. Those assessing a patient's incapacity are also under an obligation to enhance their ability to make decisions as far as reasonably possible. This will involve seeking to ensure that patients are engaged in decision making when they are best able to participate and are encouraged to participate in decision making to the greatest extent, they are able.

The AWIA uses a 'functional' test of incapacity. First it must be established that the person is unable to make the decision that needs to be made. Secondly, it needs to be established that this inability to make a decision is the result of a mental disorder (which includes mental illness, learning disability, dementia and acquired brain injury), or severe communication difficulty because of a physical disability or neurological impairment (such as stroke or severe sensory impairment).

Under the AWIA, a person is regarded as being unable to make a decision if, at the time the decision needs to be made, they are incapable, even with all practicable support, of:

- acting;
- making decisions;
- communicating decisions;
- understanding decisions; or
- retaining the memory of decisions.

When doctors are involved in assessing a patient's capacity to make a decision about treatment, the Code of Practice (see key resources) states that they need to identify whether the patient:

- `is capable of making and communicating their choice
- understand the nature of what is being asked and why
- has memory abilities that allow the retention of information
- is aware of any alternatives – has knowledge of the risks and benefits involved
- is aware that such information is of personal relevance to them
- is aware of their right to, and how to, refuse, as well as the consequences of refusal
- has ever expressed their wishes relevant to the issue when greater capacity existed

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– is expressing views consistent with previously preferred moral, cultural, family, and experiential background; and
– is not under undue influence from a relative, carer or other third party declaring an interest in the care and treatment of the adult.'

In assessing capacity, family members and close friends may be able to provide valuable background information, although their views about what they might want for the individual must not be allowed to influence the assessment of capacity.

Any decision that a person lacks capacity must be based on a reasonable belief backed by objective reasons. However, difficult judgements will still need to be made, particularly where there is fluctuating capacity where some capacity is demonstrable, but its extent is uncertain, or where impairment may interact with coercion or duress from those close to the individual. More detailed advice on assessing capacity in these circumstances is available from other sources (see key resources).

Where there are disputes about whether a person lacks capacity that cannot be resolved using more informal methods, the Sheriff Court can be asked for a ruling.

What do you do if a 16 or 17-year-old refuses to be assessed?

Occasionally, a young person whose capacity is in doubt may refuse to be assessed. In most cases, a sensitive explanation of the potential consequences of such a refusal, such as the possibility that any decision they may make will be challenged later, will be sufficient for them to agree. However, if the young person flatly refuses, in most cases no one can be required to undergo an assessment. In these circumstances, doctors should document the refusal in the medical record, make a decision about capacity based on the information they have available, and document the decision reached and the reasons for it. Where the question of capacity cannot be resolved on the basis of existing information, legal advice should be sought.

If there are reasonable grounds to believe that the refusal of assessment results from coercion or undue influence by a third party, for example if there is a history of abuse, advice should be sought from the local authority under adult support and protection arrangements.

Key resources

GMC – Decision making and consent
GMC – 0-18 years
Scottish Government – Adults with incapacity (Scotland) Act 2000 Code of Practice
Scottish Government – Adults with incapacity: guide to assessing capacity

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Benefit

What is meant by benefit?

Doctors have a general duty to provide treatment that benefits their patients who lack capacity. There should be a reasonable expectation that the patient will benefit from any proposed intervention and that benefit cannot be achieved without the intervention. Benefit in this context has its ordinary meaning of an advantage or net gain for the patient. It is broader than whether the treatment simply achieves a physiological goal. It includes other less tangible advantages such as respecting the patient's known wishes and values. It also encompasses avoiding harming the individual by infringing their rights. The Supreme Court has said that decision makers must put themselves in the place of the individual patient and ask what their attitude to the treatment is or would be likely to be.

The healthcare team, proxy decision makers, and people close to the patient should discuss what might benefit the patient, taking into account the patient's past and present wishes. Depending on the powers they have been given, proxies may have the authority to decline treatment if they believe that would benefit the patient, although this decision can be challenged (see section 8). In complex cases where the assessment of benefit is difficult or agreement cannot be reached, it may be necessary to take legal advice.

What should you consider when assessing benefit?

Lacking capacity should not exclude a 16 or 17-year-old from participating in the decision-making process as far as possible. The decision maker must also consider whether the person will regain capacity. A decision should be delayed if it can reasonably be left until the individual regains the capacity to make it, without unduly disadvantaging the patient.

When determining whether an intervention would benefit a 16 or 17-year-old with incapacity, assumptions must not be made merely on the basis of their age or appearance, their medical condition or any disability, or an aspect of their behaviour – this is the principle of equal consideration and non-discrimination.

In most circumstances, it will be clear what would benefit the young person, and a decision as to care or treatment will not be challenging or time consuming – but this is not always the case. Whether to provide analgesics for a 16 or 17-year-old in pain is likely to be a straightforward question but a decision about whether to continue providing life-sustaining treatment is less so. Where a decision is likely to have grave consequences for a 16 or 17-year-old it will require greater consideration, wider consultation with those close to the young person, and more detailed documented evidence about the decision reached and the reasons for it. Relevant factors to consider are likely to include (as far as they are reasonably ascertainable):

- the young person's past and present wishes and feelings, including any relevant written statement made when they had capacity;
- the young person's wishes, beliefs, or values where they would have an impact on the decision; and
- other factors the 16 or 17-year-old would have considered if able to do so.

For significant decisions, a crucial part of assessing benefit involves discussion with those close to the young person, including family, friends, or carers, where it is practical or appropriate to do so, bearing in mind the duty of confidentiality (for more on information sharing, see section 13). It should also include anyone previously nominated by the person as someone to be consulted. The BMA has a toolkit about how to make decisions for those who

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lack capacity, including taking account of the individual's wishes, beliefs, and values to reach a decision. Although this is based on the legislation in England and Wales, it contains a lot of practical information and guidance that may be helpful for those practising in Scotland (see key resources). Where there is a proxy with the authority to make treatment decisions on behalf of the individual (see section 8), they should be provided with as much information as is necessary for them to make the decision in question.

What if there is disagreement over what will benefit a 16 or 17-year-old?

Where there is disagreement over what will benefit a 16 or 17-year-old who lacks capacity, further discussion should take place, and a second opinion should be offered. If agreement cannot be reached through discussion, it may be necessary to seek independent mediation, the views of a Clinical Ethics Committee (CEC), and/or legal advice. In the interim, in terms of any treatment on which there is dispute only that which is essential to preserve life or prevent serious deterioration should be provided (see section 12 on dispute resolution).

Can it ever benefit a 16 or 17-year-old to be given medication covertly?

The Code of Practice for Part 5 of the Act (see key resources) states that the use of covert medication is permissible in certain, limited circumstances, that is to safeguard the health of a patient who is unable to consent to the treatment in question and where other alternatives have been explored and none are practicable. Healthcare staff should not give medication except in accordance with the law, and even where the law allows, it should not be given in a disguised form unless the patient has refused, and their health is at risk because of this. Where covert medication is given, healthcare staff are required to record this in the patient's records. Detailed advice and guidance on the use of covert medication has been published by the Mental Welfare Commission (see key resources).

Are there any exceptions to the benefit principle?

There are two circumstances to which the benefit principle may not apply. The first is where the young person has previously made a valid and applicable advance statement to refuse treatment while they had capacity, which the Code of Practice says at paragraph 2.30 is 'potentially binding'. In such circumstances, the advance statement should normally be respected, even if you or others think that the decision does not benefit the patient. For more information on advance statements (see section 11). The second exception relates to the enrolment of adults with incapacity in certain forms of research (see section 19).

Key resources

Mental Welfare Commission for Scotland – Covert Medication - a legal and practical guide

Scottish Government – Adults with incapacity. Code of Practice for Medical Practitioners

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Certificate of incapacity and general authority to treat

When should a certificate of incapacity be completed?

Other than in an emergency (see section 2), in order to provide medical treatment or care to a patient who lacks capacity the healthcare professional primarily responsible for the patient's care, normally a GP or consultant, must complete a section 47 certificate of incapacity (Certificate). The Certificate is to state that the young person lacks capacity in relation to a decision about the proposed medical treatment, and authorising treatment that other healthcare professionals will provide (under the instructions of the doctor, or with their agreement). A Certificate is needed to allow healthcare professionals to rely on a proxy's consent to treatment (see section 8), or in the absence of a proxy decision maker, to act under the general authority to treat – see below.

What information should the Certificate include?

The Certificate must state:

- that the doctor has examined the young person and is of the opinion that they lack capacity for this particular matter;
- the nature of the medical treatment in question;
- the likely duration of the young person's incapacity; and
- the period for which the specified treatment is authorised.

For routine healthcare needs, multiple treatments can be covered on one Certificate. However, a separate Certificate is required for any intervention that would normally require the signed consent of the young person, such as surgery. A treatment plan may be completed and attached to the Certificate – see below. There is a standard format for the Certificate which must be used. Detailed advice about completing Certificates, with examples, is published by the Scottish Government (see key resources).

How long does a Certificate last?

A Certificate can be issued with a duration of up to one year, but can authorise treatment for up to three years if, in the view of the doctor, no curative treatment is available, and the young person's capacity is unlikely to improve, and the young person has at least one of the conditions listed in the Adults with Incapacity Act (AWIA):

- severe or profound learning disability;
- severe dementia; or
- severe neurological disorder.

The doctor should keep the young person's capacity to consent to treatment under review at appropriate intervals during the duration of the Certificate. Where a new Certificate is issued, doctors must consult any proxy decision maker. The guidance from the Scottish Government on section 47 Certificates states that it is also good practice where reasonable and practicable to discuss it with the young person's nearest relative or carer (see key resources).

When should a new Certificate be completed?

A new Certificate is needed if a new treatment is required that is not covered by the initial Certificate. A new Certificate may also be needed if the young person's condition or diagnosis changes.

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When should a treatment plan be completed?

Where there are multiple or complex ongoing healthcare needs, the use of a treatment plan is recommended. Certain basic healthcare procedures can be authorised under a single entry on the treatment plan for 'fundamental healthcare procedures' (if the young person is incapable of consenting to any of those procedures). These include nutrition, hydration, hygiene, skin care and integrity, elimination or relief of pain and discomfort, mobility, communication, eyesight, hearing, and oral hygiene. Interventions that fall outside of these fundamental healthcare procedures should be listed separately, with a note made of whether or not the young person is capable or incapable of deciding on each intervention. As with the Certificate, the treatment plan should be completed by the clinician with overall responsibility for the young person and should be reviewed regularly. Detailed advice on the use of treatment plans is published by the Scottish Government (see key resources)

When can a doctor act under a general authority to treat?

Where there is no proxy decision maker, doctors may issue a Certificate and act under the general authority to treat. This applies to the doctor who has signed the Certificate and members of the healthcare team acting on their behalf. This general authority may not be used where there is a proxy decision maker and it is reasonable for that person's consent to be sought, but this has not been done. Nor can it be used where a pending application has been made to the sheriff for an intervention or guardianship order with powers that cover the medical treatment in question (see section 10), or if there is an appeal to the Court of Session regarding treatment. In these cases, only emergency treatment (see section 2) may be provided until the court has ruled.

Can doctors charge a fee for completion of a Certificate of incapacity?

In both primary and secondary care, it is part of doctors' terms and conditions to assess their patients' capacity for medical treatment they are providing. Provision of Certificates in other circumstances and for parts of the AWIA unrelated to medical treatment may attract a fee.

Key resources

Scottish Government – Section 47 Certificate of Incapacity
Scottish Government – Adults with incapacity: code of practice for medical practitioners, Annex 5 Treatment plan for patients

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Proxy decision makers

Who are proxy decision makers?

A proxy decision maker can be a:

– welfare guardian or welfare intervener (appointed by the Sheriff Court – see section 10); or
– welfare attorney (appointed by the patient under a power of attorney – see section 9).

GPs who are aware that a 16 or 17- year-old has a proxy decision maker should note this in the medical record, together with their contact details. Hospitals and other establishments treating 16 or 17 -year-olds on an in-patient basis need to make reasonable enquiries to ascertain whether there is a proxy decision maker when they are admitted. A register of valid proxies is held by the Office of the Public Guardian and may be checked, including by telephone during office hours. This information might also be available from the young person, their relatives, carers, or others close to the young person. Otherwise, the local authority social work department may be able to help.

What are the responsibilities of a proxy decision maker?

The roles and responsibilities of proxies in relation to medical treatment are set out in the Code of Practice (see key resources). They have a duty of care to the young person on whose behalf they act, and a duty to abide by the general principles set out in the AWIA (see section 4). If it is apparent that a proxy is not fulfilling their duties or is acting contrary to the interests of the young person, this matter should be drawn to the attention of the authorities. Local authorities have a statutory duty to investigate complaints about welfare proxies. Advice is also available from the Public Guardian and Mental Welfare Commission.

What is the role of a proxy decision maker?

When a 16 or 17-year-old lacks the capacity to make a decision, and a certificate of incapacity has been issued, a proxy who has been granted the relevant power may give consent to medical treatment on behalf of the young person. Where a doctor is aware that a proxy decision maker has been appointed, and it is reasonable and practicable to obtain the proxy's consent for treatment, this must be sought. Wherever possible, doctors should postpone treatment until a proxy has been consulted. In all cases, however, it is important to ensure that discussion with a proxy does not introduce delays that jeopardise the patient's care. Proxies may also refuse medical treatment, if they are fulfilling their duty of care to the young person and are abiding by the general principles in the AWIA (see section 4).

The role of a proxy or other person close to the young person is not to decide what they would want in their position. Proxies are under a duty to make decisions that benefit the young person, that are needed, that are in keeping with the young person's past and present wishes, and that the young person cannot make for themself. This means healthcare professionals need, independently, to have their own view as to what would benefit the young person, so that they can engage with the proxy on an informed basis. If any doubt or disagreement about what would benefit the young person cannot be resolved locally, legal advice should be sought. If there is disagreement about how to proceed, there are procedures set out in the Act that must be followed (see dispute resolution in section 12).

Key resources

Mental Welfare Commission for Scotland
Office of the Public Guardian, Scotland
Scottish Government – Adults with incapacity. Code of Practice for Medical Practitioners

9

Powers of Attorney

What is a power of attorney?

A power of attorney is a document appointing someone to act and to make decisions on the young person's behalf. The person who grants the power is known as the 'granter' and the person appointed is the 'attorney'. A power of attorney can be useful both for someone anticipating permanent incapacity or to deal with periods of temporary or fluctuating incapacity.

GPs who are aware that a 16 or 17- year -old has a welfare power of attorney should note this in the medical record, together with their contact details. Hospitals and other establishments treating a 16 or 17-year- old on an in-patient basis need to make reasonable enquiries to ascertain whether there is a valid welfare power of attorney when they are admitted.

Is there more than one type of power of attorney?

Yes. Powers of attorney can deal with continuing (financial) and/or welfare matters. A welfare power of attorney covers personal, welfare, and healthcare decisions, including decisions relating to medical treatment. A power of attorney dealing with health and welfare can only come into effect at the onset of incapacity.

What are the requirements for a 16 or 17-year-old making a valid power of attorney?

The following statutory requirements apply to the creation of a power of attorney:

- it must be in a written document;
- the document must be signed by the granter, and state clearly that the powers are continuing (financial), or welfare, or a combination of both;
- it must contain a statement to the effect that the granter has considered how their incapacity should be determined where the authority of the attorney commences on incapacity; and
- it must incorporate a certificate in the prescribed form by a practising solicitor, a practising member of the Faculty of Advocates, or a registered and licensed medical practitioner which certifies that they:
  - have interviewed the granter immediately before the granter signed the document;
  - are satisfied, either because of knowledge of the granter or because of consultation with another person who has knowledge of the granter, that at the time of granting the power, the granter understands its nature and extent; and
  - have no reason to believe that the granter is acting under undue influence.

A power of attorney must be registered with the Office of the Public Guardian before it can be used. It does not give the attorney any legal power to make decisions before it is registered or before the individual loses capacity. Whether or not the powers can be exercised will depend on the terms of the power of attorney, and whether the granter has included a clause specifying an event that must happen before the attorney can act, for example an assessment of incapacity by a medical practitioner.

Key resources

Office of the Public Guardian Scotland – What is a power of attorney?
Scottish Government – Continuing and welfare attorneys: Code of Practice

10 Guardianship and intervention orders

What are guardianship and intervention orders?

Guardianship and intervention orders provide legal authority for someone to make decisions and act on behalf of a person who lacks capacity in order to safeguard and promote their interests. The powers granted under an order may relate to the person's money, property, personal welfare, and health.

A guardianship order gives authority for the guardian(s) to act and make certain decisions over the long term. An intervention order is appropriate where there is a need for a 'one-off' decision or action. An application can be made for a financial and/or welfare order depending on the needs of the individual.

An application for a guardianship or intervention order is made to the Sheriff Court. The Sheriff decides if the individual needs a guardian and if the person who wishes to be the guardian is suitable. Once granted, the order is registered with the Office of the Public Guardian and is operational. Doctors who are aware that a patient has a guardianship or intervention order should note this in the medical record, together with their contact details.

What are the limits on the powers of a welfare guardian or intervener?

A guardian or intervener does not have powers to:

- consent to specific treatments regulated under the Adults with Incapacity Act (see section 2);
- consent on behalf of the 16 or 17 – year - old to certain medical treatments covered under the Mental Health (Care and Treatment) Act 2003; or
- place the 16 or 17-year-old in a hospital for the treatment of mental disorder against their will. If the 16 or 17-year-old resists treatment for a mental disorder, then an application will need to be made by a mental health officer for an order under the Mental Health (Care and Treatment) (Scotland) Act 2003 (see section 18 on compulsory treatment for a mental health condition).

Key resources

Office of the Public Guardian Scotland – What is a guardianship order?
Office of the Public Guardian Scotland – What is an intervention order?

11 Advance statements refusing treatment

Are advance statements refusing treatment by a 16- or 17-year-old legally binding?

Advance statements are not covered by the Adults with Incapacity (Scotland) Act (AWIA), or case law in Scotland. There is, however, provision in sections 275 and 276 of the Mental Health (Care and Treatment) (Scotland) Act 2003 which enables an individual aged 16 or over who has capacity to make an advance statement setting out how they would wish to be treated, or not to be treated, should their ability to make decisions about treatment for their mental disorder become significantly impaired as a result of their mental disorder (see section 18 on compulsory treatment for a mental health condition).

Where advance statements are not covered by the provisions of the Mental Health (Care and Treatment (Scotland) Act 2003, paragraph 2.30 of the Code of Practice states:

> 'A competently made advance statement made orally or in writing to a practitioner, solicitor or other professional person would be a strong indication of a patient's past wishes about medical treatment but should not be viewed in isolation from the surrounding circumstances. The status of an advance statement should be judged in the light of the age of the statement, its relevance to the patient's current healthcare needs, medical progress since the time it was made which might affect the patient's attitude, and the patient's current wishes and feelings. An advance statement cannot bind a practitioner to do anything illegal or unethical. An advance statement which specifically refuses particular treatments or categories of treatment is called an 'advance directive'. Such documents are potentially binding. When the practitioner contemplates overriding such a directive, appropriate legal and ethical guidance should be sought.'

When assessing the validity of an advance statement it is important to remember the general presumption of capacity in Scottish law. Doctors should always start from the presumption that a 16 or 17-year-old who has made an advance statement had the capacity to make it, unless there are reasonable grounds to doubt the person had the capacity to make the statement at the time they made it. In cases of genuine doubt about the existence or validity of an advance statement, doctors can provide treatment that is immediately necessary to stabilise or to prevent a deterioration in the patient's condition until the existence, and the validity and applicability, of the advance statement can be established. If doubts cannot be resolved locally, and time permits, legal advice should be sought about approaching the court for a decision.

Advance requests for future treatment, or statements about matters other than medical treatment, are not legally binding, although they can be a useful indication of a patient's wishes and feelings when making decisions that benefit them.

11

Are there limits to advance statements refusing treatment?

Although any written or oral statements of patients' future wishes are clearly a vital part of decision making, there are limits to patients' ability to influence their future care. Nobody can authorise or refuse in advance procedures they could not authorise or refuse contemporaneously. They cannot, for example, insist upon treatment that is not clinically indicated. In the BMA's view, it would also be inappropriate for patients to refuse in advance the provision of all forms of 'basic care' such as hygiene and interventions designed solely for the alleviation of pain or distress. This also includes the offer of oral food and water (but not clinically assisted nutrition and hydration).

Is there a specific format for advance statements refusing treatment?

There is no specific format in which an advance statement refusing treatment needs to be made. Oral advance statements can potentially be binding, particularly when supported by appropriate evidence, although a note should be made of any such oral decision in the medical record. It is worth bearing in mind that advance statements can also be recorded, for example on smart phones, although patients have to take appropriate steps to ensure relevant people are made aware of their existence. Patients wishing to make an advance statement that is likely to have serious consequences for them, including any decision relating to life-sustaining treatment, should ideally put their wishes in writing. In the BMA's view, patients making a written advance statement refusing treatment should include the following:

- full details of the person making the advance statement including their name and address;
- a statement that the document should be used if the person ever lacks capacity to make treatment decisions;
- a clear statement of the decision, the treatment to be refused, and the circumstances in which the decision will apply;
- the signature of the person making it and any person witnessing the signature; and
- the date the document was written or subsequently reviewed.

It is advisable for patients to review their advance statements regularly, particularly where there are any material changes in their condition or treatment options, and at least every five years.

How should advance statements be stored?

The storage of advance statements, and the obligation to ensure that relevant healthcare professionals are aware of them, are the responsibility of those who make them. A copy of any written advance statement should be given to the patient's GP for storage in the medical record. A copy of the document should be provided to another healthcare professional involved in the patient's care on request. It is good practice for anyone who makes an advance statement to draw it to the attention of anyone who may be called upon to assist in making decisions on their behalf, such as friends, family, or any proxy decision maker. The patient or family members should draw it to the attention of hospital staff before an episode of care.

Key resources

Law Society Scotland – Advance choices, and medical decision making in intensive care situations

Scottish Government – Adults with incapacity. Code of Practice for Medical Practitioners

12 Dispute resolution

When do disputes occur?

Disputes can arise where a 16 or 17-year-old has capacity and refuses treatment that healthcare providers believe is both necessary and to their benefit, or where the 16 or 17-year-old lacks capacity and there is a disagreement with the proxy decision maker, or others close to the patient.

These may relate to:

- whether the young person retains the capacity to make a decision;
- whether a proposed decision or intervention will benefit the young person with incapacity; or
- whether the decision or the intervention is the most suitable of the available options.

How should a dispute be approached?

Many disputes arise because of poor communication and all efforts should be made to avoid this. An independent second opinion, the view of a clinical ethics committee (CEC), and/or independent mediation may help to resolve some disagreements. Healthcare professionals must always focus on the overall benefit to the young person.

What happens if the 16 or 17-year-old lacks capacity, and the dispute cannot be resolved?

Where the doctor who signed the Certificate of incapacity (see section 7) and a proxy disagree about a treatment (or non-treatment) decision, the doctor can obtain a second opinion from a medical practitioner nominated by the Mental Welfare Commission. The nominated medical practitioner must consult the proxy. They must also consult anybody else nominated by the proxy (as far as is reasonable and practicable). If the nominated medical practitioner agrees with the treating doctor, the treatment may be given notwithstanding the proxy's refusal, unless the proxy makes an application to the Court. If the nominated medical practitioner disagrees with the treating doctor, legal advice should be sought.

What role does the court have where the 16 or 17-year-old lacks capacity?

Appeal to the court should be very rare. In all cases of disagreement that cannot be resolved, doctors should seek legal advice. All decisions about medical treatment, under the general authority to treat, or where there is a proxy, are open to appeal to the courts. Any person with an interest in the personal welfare of a 16 or 17-year-old with incapacity may challenge a decision by appealing to the Sheriff and then, by leave of the Sheriff, to the Court of Session. This person may be the treating doctor, another member of the clinical team caring for the young person, a proxy decision maker, or a close relation or person who has lived with, and cared for, the young person over a significant period. It does not include 'onlookers' such as interested pressure groups, uninvolved neighbours or those seeking to achieve objectives which are of wider significance than the welfare of the young person. While an appeal is pending, doctors may provide only emergency treatment (see section 2). The courts can instruct that the patient should receive the treatment in question but cannot instruct a particular doctor to provide treatment contrary to their professional judgement or conscience. Going to court can be distressing for those concerned. However, the benefits are that a court can give rulings very quickly when necessary, and it can provide a protective role for both patients and the healthcare team in cases where there is a disagreement that cannot be resolved.

12

Can the courts insist on treatment if a 16 or 17-year-old has capacity?

In Scotland, it seems likely from current case law and statute that a refusal by a 16 or 17-year-old who has capacity cannot be overridden by a court, even if that treatment is necessary to save or prolong life. This matter is not beyond doubt, however, and so legal advice should be sought if such situations arise.

Key resources

GMC – 0-18 years

13

Confidentiality and information sharing

When is a duty of confidentiality owed to a 16 or 17-year-old who has capacity?

The duty of confidentiality owed to 16 or 17-year-olds is the same as that owed to those aged 18 and over. The duty of confidentiality is not absolute and confidential information can be disclosed when one of the following circumstances applies:

- consent;
- a legal requirement to disclose or the disclosure has statutory authorisation which has set aside the common law duty of confidentiality; or
- where there is an overriding public interest.

The BMA's *Confidentiality and health records toolkit* provides more detail on the latter two points (see key resources).

When disclosing confidential information healthcare professionals must:

- disclose only the minimum relevant information necessary;
- ensure the disclosure is to the appropriate authority;
- document the disclosure in the medical record;
- be prepared to justify their decisions to disclose (or not to disclose); and
- seek advice from the Caldicott Guardian, Data Protection Officer, or other appropriate senior person if there is uncertainty.

Can a 16 or 17-year-old with capacity consent to, or refuse, the disclosure of their personal information?

Yes. 16 or 17-year-olds can give or withhold their consent to the release of information, and healthcare professionals should comply with such requests, unless there are convincing reasons to the contrary, for example where disclosure is justified in the public interest (for information about public interest disclosures see the BMA's *Confidentiality and health records toolkit* and see section 17 on safeguarding). If the information is about particularly important or life-changing decisions, however, healthcare professionals should try to encourage the 16 or 17-year-old to share information with a parent or carer.

Can a parent or carer give, or withhold consent to the disclosure of personal information of a 16 or 17-year-old who has capacity?

No. Where a 16 or 17-year-old has capacity no other person can consent to or refuse the disclosure of their personal health information.

Is a duty of confidentiality owed to 16 or 17-year-olds who lack capacity?

Yes. Healthcare professionals owe the same duty of confidentiality to all their patients whether or not they have capacity. Healthcare professionals may therefore usually only disclose information about a young person who lacks capacity where it benefits the patient, or when one of the following circumstances applies:

- a legal requirement to disclose or the disclosure has statutory authorisation which has set aside the common law duty of confidentiality; or
- where there is an overriding public interest.

The BMA's *Confidentiality and health records toolkit* provides more detail on the latter two points (see key resources).

13

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- ensure the disclosure is to the appropriate authority;
- document the disclosure in the medical record;
- be prepared to justify their decisions to disclose (or not to disclose); and
- seek advice from the Caldicott Guardian, Data Protection Officer, or other appropriate senior person if there is uncertainty.

Can a welfare attorney, or proxy decision maker give or withhold consent to the disclosure of personal information of a 16 or 17-year-old who lacks capacity?

A proxy decision maker can give or withhold consent to the release of information where the young person lacks capacity. Where a proxy decision maker refuses to share relevant information with other healthcare professionals or agencies, and the healthcare professional considers that it will not benefit the young person, for example, if it puts the young person at risk of significant harm, disclosure may take place in the public interest without consent.

What if there are concerns that a 16 or 17-year-old is at risk of abuse or neglect?

Where healthcare professionals have concerns about a 16 or 17-year-old who may be at serious risk of abuse or neglect, whether or not they lack capacity, these concerns must be acted upon, and information given promptly to an appropriate person or statutory body to prevent further harm (see section 17 on safeguarding). Young people may try to elicit a promise of confidentiality from adults to whom they disclose abuse. Doctors must avoid making promises of confidentiality that they cannot keep. Where doctors believe it is important that action is taken, they need to discuss disclosure with the young person, and if possible, they should be given sufficient time to come to a considered decision. If the young person cannot be persuaded to agree to voluntary disclosure, and there is an immediate need to disclose information to an outside agency, they should be told what action is to be taken unless doing so would expose the young person or others to increased risk of serious harm.

Key resources

BMA – Confidentiality and health records toolkit.

14 Restraint and other restrictive practices

What is restraint, and when can it be used?

There may be occasions when healthcare professionals need to consider the use of restraint in treating a 16 or 17-year-old who lacks capacity. Restraint is the use or threat of force, to make someone do something they are resisting, or restricting a person's freedom of movement, whether they are resisting or not.

In Scotland, section 47(7)(a) of the Adults with Incapacity (Scotland) Act 2000 (AWIA) states that the use of force or detention is not authorised, 'unless it is immediately necessary and only for so long as is necessary in the circumstances'. Healthcare professionals therefore have the right to use proportionate restraint to prevent the immediate risk of harm to the patient or others. Where relevant, any use of restrictive practices, including the use of restraint, should comply with the Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002 (the Regulations), and the Mental Welfare Commission's guidance on rights, risks, and limits to freedom. Further information about the use of restraint in Scotland can also be found in the BMA Adults with Incapacity Scotland toolkit (see key resources).

Key resources

BMA – Adults with Incapacity Scotland toolkit
Mental Welfare Commission for Scotland – Rights, Risks, and limits to freedom

15 Sexual activity

Can a young person aged 16 or 17-years-old consent to treatment associated with sexual activity?

As with other medical interventions, a 16 or 17-year-old with capacity may give valid consent to abortion, contraception, and treatment for a sexually transmitted infection. A parent's refusal to give consent for an abortion cannot override the consent of a young person aged 16 or 17 with capacity.

If a 16 or 17-year-old lacks capacity, and it would benefit them, a proxy decision maker can legally give consent for the provision of contraception and abortion (provided the legal requirements of abortion legislation are met). If a young person lacks capacity to consent to the provision of contraception and the termination of pregnancy, this raises a question about the ability of the young person to consent to sexual intercourse. In cases of doubt, or where the provision of contraception will involve restraint or an invasive procedure, for example, insertion of an Intra Uterine Device (IUD), doctors should seek legal advice.

Where healthcare professionals believe that the 16 or 17-year-old may be subject to coercion or exploitation, existing safeguarding guidelines must be followed. Healthcare professionals with concerns should seek advice and help, anonymously, if necessary, from colleagues with expertise in safeguarding, such as named and designated professionals (see section 17 on safeguarding).

Does a healthcare professional need to inform the parents of a young person about their sexual activity?

No. All young people are entitled to have their confidentiality respected, unless there are very convincing reasons to the contrary, for example, if serious abuse is suspected (see section 13 confidentiality and information sharing and section 17 on safeguarding).

What if a healthcare professional disapproves of young people being sexually active?

Healthcare professionals must not allow any personal views held about a patient to prejudice their assessment of the patient's clinical needs or delay or restrict the patient's access to care. Doctors should not impose their beliefs on patients. The GMC states in its guidance on 0-18 years:

'If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see another doctor. You should make sure that information about alternative services is readily available to all patients. Children and young people, in particular, may have difficulty in making alternative arrangements themselves, so you must make sure that arrangements are made for another suitably qualified colleague to take over your role as quickly as possible' (paragraph 65).

Key resources

GMC – 0-18 years
RCPCH – Safeguarding guidance for children and young people under 18 accessing early medical abortion services

16

Female genital mutilation

What is female genital mutilation (FGM)?

FGM is a collective term used for a range of practices involving the removal or alteration of parts of healthy female genitalia for non-therapeutic reasons. Different degrees of mutilation are practised by a variety of cultural groups in the UK. FGM has immediate risks, including severe pain, haemorrhage, tetanus and other infections, septicaemia, or even death. In the longer term, girls and women may experience problems with their sexual, reproductive, and general physical and psychological health. The risk of FGM may also give rise to legitimate grounds for an application for refugee or asylum status.

Are there any considerations additional to the usual safeguarding measures?

FGM is illegal in Scotland under the Prohibition of Female Genital Mutilation Act 2005. If a 16 or 17-year-old is identified as being at risk of FGM, urgent safeguarding action must be taken (see section 17 on safeguarding).

Key resources

GMC – Protecting children and young people
Health Education England – FGM e-learning programme
RCGP – Female Genital Mutilation
RCOG – Female Genital Mutilation and its Management (Green-top Guideline No. 53)
RCPCH – Female Genital Mutilation Resources
Scottish Government – Violence against women and girls

17 Safeguarding

In Scotland, the Children and Young People (Scotland) Act 2014, includes young people aged 16 and 17 years old for the purposes of child protection.

For all young people aged 16 or 17 years old in the UK, the levels of risk reduce due to their increasing maturity. However, where healthcare professionals have concerns about a 16 or 17-year-old who may be at risk of serious abuse or neglect, these concerns must be acted upon following local and national guidelines (see key resources). The benefit to the 16 or 17-year-old involved must always guide decision making.

Paragraph 1 of the GMC's guidance on protecting children and young people outlines the following key principles for protecting children and young people:

a. 'All children and young people have a right to be protected from abuse and neglect – all doctors have a duty to act on any concerns they have about the safety or welfare of a child or young person.
b. All doctors must consider the needs and wellbeing of children and young people – this includes doctors who treat adult patients.
c. Children and young people are individuals with rights – doctors must not unfairly discriminate against a child or young person for any reason.
d. Children and young people have a right to be involved in their own care – this includes the right to receive information that is appropriate to their maturity and understanding, the right to be heard and the right to be involved in major decisions about them in line with their developing capacity (see the advice on assessing capacity in appendix 1 to this guidance).
e. Decisions made about children and young people must be made in their best interests – the factors to be considered when assessing best interests are set out in appendix 2.
f. Children, young people, and their families have a right to receive confidential medical care and advice – but this must not prevent doctors from sharing information if this is necessary to protect children and young people from abuse or neglect.
g. Decisions about child protection are best made with others – consulting with colleagues and other agencies that have appropriate expertise will protect and promote the best interests of children and young people.
h. Doctors must be competent and work within their competence to deal with child protection issues – doctors must keep up to date with best practice through training that is appropriate to their role. Doctors must get advice from a named or designated professional or a lead clinician or, if they are not available, an experienced colleague if they are not sure how to meet their responsibilities to children and young people'.

Key resources

GMC – Protecting children and young people
GMC – 0-18 years
RCPCH intercollegiate document – Safeguarding Children and Young People: Roles and Competences for Health Care Staff
Scottish Government – National Guidance for Child Protection in Scotland

18 Compulsory treatment for a mental health condition

When should mental health legislation be used?

In most cases, treatment and support for a 16 or 17-year-old's mental health condition is provided with consent. In some circumstances, however, mental health legislation can provide a legal structure for compulsory psychiatric care and treatment for a young person's mental health condition, irrespective of whether or not they retain formal decision-making capacity.

Compulsory treatment cannot be used to provide treatment for a physical illness unrelated to the mental health condition. Although for some 16 or 17-year-olds a severe mental illness is associated with a corollary lack of capacity, a mental health condition does not automatically diminish their legal capacity. Doctors who believe that the legislation may apply to one of their 16 or 17-year-old patients, but who are unfamiliar with the legislation, should seek expert advice.

What legislation is applicable in Scotland?

The Mental Health (Care and Treatment) (Scotland) Act 2003 (as amended by the Mental Health (Scotland) Act 2015) applies to all 16 and 17-year-olds. The Act contains specific safeguards namely any functions under the Act in relation to a young person under 18 with mental disorder should be discharged in the way that best secures the welfare of the young person. In particular, it is necessary to take into account:

- the wishes and feelings of the young person and the views of any carers;
- the carer's needs and circumstances which are relevant to the discharge of any function;
- the importance of providing any carer with information as might assist them to care for the patient;
- where the young person is or has been subject to compulsory powers, the importance of providing appropriate services to that young person; and
- the importance of the function being discharged in the manner that appears to involve the minimum restriction on the freedom of the young person as is necessary in the circumstances.

In addition, the legislation provides that a patient aged 16 or over may choose an individual to be their 'named person,' or choose who they would not wish to be their 'named person'. The provisions in sections 275 and 276 of the Mental Health (Care and Treatment) (Scotland) Act 2003 also enable a young person aged 16 or over to make an advance statement setting out how they would wish to be treated, or not to be treated, should their ability to make decisions about treatment for their mental disorder become significantly impaired as a result of their mental disorder. Whilst it is not legally binding, a healthcare professional giving medical treatment must have regard to the wishes specified in it, and record if a decision is made that conflicts with those wishes.

When a young person aged 16 or 17 needs to be admitted, it is best practice to admit them to a unit specialising in child and adolescent psychiatry, and for the Responsible Medical Officer (RMO) responsible for their care to be a child and young person specialist.

Key resources

Department of Health – Mental Health (care and treatment) (Scotland) Act 2003: Code of Practice Volume 1 (2005)

19

Research

Can 16 and 17-year-olds who have capacity participate in research?

Yes, a 16 or 17-year-old with capacity can give their consent to research including research into a clinical trial of an investigational medicinal product (CTIMP). The involvement of those with parental responsibility is however, usually encouraged, unless the 16 or 17-year-old objects.

What information should be provided to obtain valid consent to participate in research?

Information should preferably be provided in writing and should be approved in advance by a research ethics committee. It should include:

- the purpose of the research and what it involves;
- information about research-related procedures
- particularly invasive procedures;
- the probability of random allocation to treatment, if appropriate;
- the fact that the young person can withdraw from the research at any time, without penalty or any adverse effect on the care they receive (but that once data or samples have been anonymised, it will no longer be possible to withdraw consent for their use);
- any financial arrangements in place, such as for covering the young person's expenses and compensation in the event of trial-related injury;
- information about confidentiality and the possibility of access to confidential notes by third parties (such as regulatory authorities, auditors, or ethics committees); and
- what, if any, information they can expect to receive about the research findings and conclusions.

Is consent required for the use of human tissue for research?

The Human Tissue (Scotland) Act 2006 does not cover the use of tissue from living individuals. Research ethics committees may, however, require consent to be obtained where the tissue is used in identifiable form. Where the intention is to perform DNA analysis, however, the requirement for consent in the Human Tissue Act 2004 (England, Wales, and Northern Ireland) extends to Scotland.

Can young people aged 16 and 17-years- old who lack capacity participate in research?

In Scotland, under the Adults with Incapacity (Scotland) Act 2000 Act (AWIA), young people aged 16 or over who lack the capacity to consent can be enrolled in research provided specific conditions are met. Further information involving research on patients who lack capacity in Scotland can be found in the Adults with incapacity Scotland toolkit (see key resources).

Key resources

BMA – Consent and refusal by adults with decision-making capacity
BMA – Adults with Incapacity Scotland toolkit
Health Research Authority – Research involving children

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