

Factors that influence decision making by 8-12 year olds in child and adolescent mental health services (CAMHS): a systematic review

Ann Cox¹, Chris Brannigan², Martyn Harling² and Michael Townend²

¹ Derbyshire Healthcare NHS Foundation Trust and University of Derby

² College of Health and Social Care, University of Derby

Abstract

There is significant legal guidance and case law available to support clinicians in assessing whether young people aged over 13 years are able to make informed decisions about their own healthcare; however when working with children aged 8-12 years, the guidance is unclear. In order to assess whether 8-12 year olds are able to make decisions in their own healthcare, we first need to understand the factors that influence this process.

A systematic literature review of five electronic databases (PsycINFO, EBSCO, Science Direct, Science Full Text, Web of Science All Databases) was conducted. The search identified 12 studies and one piece of government guidance. The studies were identified from a variety of health and social research journals. The six factors that were identified were: 1) consent, competence and capacity, 2) best interests, 3) communication, 4) risks and conflicts, 5) legal frameworks, and, 6) parental role.

The review concludes that it is possible for some children 8-12 years of age to make decisions regarding their own healthcare. The necessary conditions are that age specific language is used through a variety of mediums which will include risks, benefits and options for the proposed interventions. Clinicians need to be skilled in the assessment of the child's ability to make decisions and be effective communicators with a commitment to children's involvement. Further research in both these areas is needed.

Key practitioner messages:

- There is a legal requirement that a child's voice is heard
- All children's views should be given due weight
- Clinicians need to be skilled in order to assess competence and capacity
- Children aged 8-12 can make informed decisions about their own healthcare when supported with appropriate age related information

Keywords: children, mental health, decision making, empowerment

Introduction

There is a legal requirement to ensure children's views are taken into consideration within health and social care decision making processes (Children Act, 1989, Section 17.4a; United Nations Convention on the Rights of the Child (UNCRC), 1989, Article 12, p.5). What is less clear is when this involvement should take place; how should it take place and what conditions need to exist for the involvement to be both appropriate and effective. This includes the age of the child and their capacity to make decisions.

International law, UK legislation, British Government policy and case law all influence and offer guidance in this respect (e.g. Human Rights Act (HRA), 1998; Mental Health Act (MHA), 1983; Gillick v Norfolk and Wisbech Health Authority, 1985). Each of these areas will be briefly introduced in order to support the need for a systematic review.

The UNCRC (1989) (Article 12, p.5) states 'parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the

child, the views of the child being given due weight in accordance with the age and maturity of the child'. The Human Rights Act (1998) further supports this in its declaration in that if a person's rights, which include those of a child, are infringed by a public body, then they would have the right to seek legal redress within their legal jurisdiction. This important legal position and imperative to involve children in decision making was subsequently included as one of the essential positions within the Robbins Report (Robbins, 1999).

In the UK, the Children Act (1989) also recognised the imperative to involve children in decisions about their own welfare; in doing so the issues of the capacity of children to participate in decision making is explicit but in the context of their age and ability to understand the implications of their decisions. The National Service Framework for Children (NSF) (DH, 2003), and the CAMHS review (CAMHS, 2008) also strongly emphasised notions of involvement within decision making: 'seeing the world through the child's eyes' (DH, 2003, p.4, para.1.7) and 'patient being the centre of care' (CAMHS, 2008, p.11) as their key policy and practice objectives.

Case law regarding consent has influenced practice within all aspects of health. One such was *Bolam v Friern Hospital Management Committee* (1957) from which a four stage test (*The Bolam Test*) was developed to establish whether harm to a patient was negligent or whether it was what any 'competent' practitioner would do. *The Bolam Test* is still used by courts to establish whether reasonable practice has taken place (*Sidaway v Board of Governors of the Bethlem Royal Hospital*, 1985; *Simms v Simms*, 2003; DH, 2009a). *R v Bournemouth Community and Mental Health NHS Trust* (1997) concluded that the Trust had treated a patient on false premise of consent as the patient did not dissent although this case was in relation to a patient that was severely learning disabled. *Bolitho v City and Hackney Health Authority* (1997) considered 'reasonable practice' with regards to whether a child should have been intubated (the insertion of a tube through the mouth or nose into the larynx to aid ventilation, (Marcovitch, 2010)) or not, to which it concluded that the courts should decide 'reasonable practice' and not professionals. Though case law is helpful in contributing to the development of better practice, there have also been many criticisms of particular case laws when newer, more appropriate cases pass through the legal system, thus creating constantly evolving fields of practice.

From a legal field perspective it is important to consider the age of criminal responsibility, which currently stands at 10 years of age (Children and Young Persons Act, 1963). Children aged 10 years and over are considered capable of intending to commit a crime. One of the most noted cases is that of James Bulger where two children, Jon Venables and Robert Thompson, both 10 years old at the time, abducted, tortured and murdered 2½ year old James. The prosecuting QC argued that Venables and Thompson understood that what they did was wrong and had understanding of the consequences of their actions (*T v United Kingdom*, 1999; *V v United Kingdom*, 1999). If children aged 10 years can understand the consequences and gravity of torture and murder, and be held legally accountable, then it is arguable that competency for the purpose of treatment decisions, which would be of less gravity – for example, decisions made as out-patients in CAMHS – is possible; despite the outcomes of treatment being dependent on variables including the therapeutic relationship, systemic considerations and clinician proficiency (Shirk & Karver, 2003).

The case law which has largely influenced CAMHS practice with regard to consent is that of *Gillick v Norwich and Wisbech Health Authority* (1985). Lord Fraser further reviewed the *Gillick* case, and deemed that a young person had the ability and right to consent to contraceptive treatment. The child had to show understanding for that specific decision at that specific time, with an understanding of the risks, benefits and options. The term 'Fraser competent' was established from this ruling but only referred to the ruling regarding the advice and treatment of contraceptives. Fraser competence is classified as a guideline and is not statute law. 'Gillick competence', however, has been generalised in healthcare to refer to any young person who is deemed as having capacity to understand the options, including the risks and benefits of a particular treatment. This terminology is now used within best practice guidance and legal

frameworks (e.g. Department of Health & National Institute for Mental Health in England, 2009b; Mental Capacity Act (MCA), 2005).

Although the Gillick Framework is helpful when working with young people, it does not make clear how or when this can be applied to younger children. Plans to improve access of children and young people to psychological therapies (CYP-IAPT) is planned for full implementation within CAMH services in the UK by 2018-2019 (Her Majesty's Treasury, 2015, p.59). CYP-IAPT is a service transformation of existing children's mental health services into collaborative partnerships within the community that will include all services from the National Health Service (NHS) to 3rd sector agencies and local authorities. Embedded in this transformation is outcome monitoring, access to evidence based therapies and participation. There are 9 participation priorities which embed the involvement of children and young people in all aspects of their care and CAMH service development (DH, 2012). With these developments in mind, it is important for all clinicians to understand the factors that influence decision making by children aged 8-12 years in order to fully empower and legally address their rights, whilst they receive care from CAMH services.

Methodology

A systematic search of five electronic databases was undertaken in order to gain an insight into the factors that are necessary for children aged 8-12 years to make decisions. PsycINFO, EBSCO, Science Direct, Science Full Text and Web of Science All Databases were accessed for the search. The rationale for using these databases was to ensure the search remained within the health and social science field. The search was conducted on the 12 July 2014. The keywords used were 'child* + legal* + decision making', 'child* + legal* + consent*' and 'child* + legal* + capacity'. The parameters were set so the search extracted information from 2004 onwards in line with the NSF (DH, 2004). Although legal frameworks developed before 2004 have relevance, these would still be apparent in the studies identified. The search was restricted to journals published in the English language and the review included only papers which were focused on English and Welsh law, due to the differences in the law in other parts of the UK and other countries. The search excluded literature in other languages.

The primary search results generated 523 pieces of literature; all were assessed by title, abstract and conclusion to determine relevance to the review using a data extraction form (Jones, 2007, p.44) (see **Appendix 1**, p.209). Literature was excluded if it did not discuss children aged 8-12 years or it was outside of the health and social care field. This excluded almost all of the studies identified in the initial electronic search and left 12 articles and one piece of government guidance. The full text of each of these was read and all were included in the review. The exclusion of the 510 pieces of literature through this process suggests a lack of published research focused specifically on this age group.

The data extraction form (Jones, 2007, p.44) was used to elicit data from the 13 pieces of literature. Keywords, definitions, conceptual frameworks and findings from the data extraction form were depicted in diagrammatic form, in order to define categories. The categories were then drawn together under themes. This method is somewhat similar in structure to the constant comparative method as defined by Glaser & Strauss (1967).

Results

The articles identified were deemed to have content relevant information to 8-12 year olds or discussions that focused on children aged under 13 and aspects of decision making. Through the process of extracting the information from the literature, 6 main themes were identified through the use of the extraction tool. These were: 1) consent, capacity and competence, 2) best interests, 3) communication, 4) risks and conflicts, 5) legal frameworks, and, 6) parental role. A summary of the content of these studies can be found in **Table 1** (p.198). The following discussion will consider each of the 6 main themes in turn.

Table 1. Summary of studies, themes and conclusions.

Reference	Age related discussion	Themes elicited	Conclusions
Alderson (2007)	12 years and under considered in several different areas	Consent to healthcare treatment and research, decision making, legal influences, competence, assessment, risk, capacity, ethical influences, parental role, research with minors, communication, cognitive development, social and emotional influences	Basic principles for consent to healthcare and research need to be more clearly agreed. Assessment and communication around competency with children needs to be improved
Al-Samsam (2008)	Under 16s in general	Consent in physical healthcare, capacity, legal influences, ethical influences, parental role, conflict	Both statute and case law provide a framework for healthcare workers; doctors are receding in enjoying treating children due to the presence of unresolved conflicts between parties decision making
Birchley (2010)	School age children in relation to genetic disorders	Parental role, best interests, conflict, legal influences, decision making, consent	We need a best interest standard that proportions value to each individual viewpoint; it needs to be more transparent and transformed into an accountable measure
Bowers & Dubicka (2009)	12 years (inpatient)	Capacity, cognitive development, parental role, legal influences, consent, risks, communication, best interests, ethical influences	We need a single comprehensive guide to the legal framework for the protection of rights of children. Clinicians must increase their knowledge of this area
Boylan & Braye (2006)	Research of children's participation on 8 years and over	Participation and decision making for looked after children in statutory reviews, competency, legal influences, role of advocacy, confidentiality, best interests, professional practices and attitudes	A need to broaden the legal and policy framework scope to include peer, self and citizen advocacy models
Didcock (2007)	Research including 8 & 9 year olds. Under 13 (contraception) 12 years (inpatient)	Consent, competency, decision making, best interests, conflict, cognitive and social development, family influences, legal influences, parental responsibility, confidentiality	Doctors need to keep up to date and seek guidance from experts and clearly document decision making
Donnelly (2010)	6 year old children. Under 16 generally	Participation by children in public law proceedings, decision making communication, legal influences, competence, capacity	There is a need for professionals to develop various engagement strategies to help children to participate. A comprehensive legal framework is needed
Larcher & Hutchinson (2009)	Case studies referring to 5 & 10 year olds. Research relating to 9 years	Consent, decision making, competence, cognitive development, theoretical basis for development of competence, assessment, legal and ethical influences, communication, risks, exploration of systemic influences	There is no single test for competence, need to be clear about what competence is and is not

National institute for Mental Health in England (2009b)	Case study 12 years old. Under 16 generally	Considers admission to hospital or treatment of children, decision making, consent, capacity, competence, cognitive development, parental role, confidentiality	Consider views of patient; is there a way of doing things differently (rather than admission to hospital or something less restrictive)?
Parekh (2006)	5 years; under 12 years	Consent, competency, decision making, cognitive development, legal influences, best interests, parental role, ethical, moral and social influences	Calls for a holistic approach to assessing competence. Consideration to include sociologists, clergymen and a multi-disciplinary team. Current state of the law needs to change
Tan & Fegert (2004)	9 years old and competence	Capacity, competence, decision making, cognitive development, legal influences, capacity, parental role, best interests, family influences, communication, emotional and social influences	We should consider children's competence differently in mental health rather than using an adult adapted model. Children find making decisions difficult due to the failings of their families
Tan, Passerini & Stewart (2007)	Case studies of a 7 & 9 year old; 9 year old capacity in research studies	Consent, confidentiality, decision making, legal and ethical influences, best interests, conflict, competence, capacity, parental role, cognitive development, communication, considers an algorithm, family influences	Ethical, legal, developmental influences and the evidence base, clinical context and evidence base all need to be taken into consideration when discussing formulating an idiosyncratic treatment plan
Wellesley & Jenkins (2009)	Under 16 in general	Consent in research and organ donation, decision making; assessment, competency and capacity, legal influences; parental responsibility, best interests, conflict	Defines the law in these areas. Does not offer any advice for academic or clinical practice

Discussion and findings

For all human beings, it is a fundamental right for each of us to determine what happens to our own bodies (Didcock, 2007) and therefore consent to have any form of treatment is a generally accepted principle. Consent, competence and capacity are examined together as these three facets are reliant on each other in order for an informed decision to be made (DH & National Institute for Mental Health in England (NIMHE), 2009b; Wellesley & Jenkins, 2009). Whilst consent and capacity are static in definition, although capacity is fixed for a particular decision at a particular time, competency is posited to be more fluid (Tan *et al.*, 2007).

Consent

Informed consent requires three main components: information on benefits and risks of all treatment options, the absence of coercion; and for capacity to be present (Tan *et al.*, 2007; Wellesley & Jenkins, 2009). The two latter components depend on the skills, communication and competence of the person facilitating the discussion (Alderson, 2007; Boyden, 2005; Boylan & Braye, 2006; Donnelly, 2010; Tan & Fegert, 2004; Tan *et al.*, 2007). Donnelly (2010); Larcher & Hutchinson (2009) and Tan & Fegert (2004) each state that specific skills are necessary to support children when having discussions that involve the child in making a decision. Since the literature and guidance about children making decisions is unclear (Alderson, 2007), clinicians can 'default' to parental consent (Bowers & Dubicka, 2009). Tan *et*

al. (2007) additionally suggest that the emphasis on autonomy and consent for legal minors can lead to anxiety amongst professionals when frameworks and guidance are absent. Clinicians need to be aware of their own assumptions and understand their competencies in relation to gaining consent and how these are socially constructed (Alderson, 2007; James & Prout, 1997) in order to avoid the possibility of demoralising children participating in decisions that affect them (Donnelly, 2010).

A contentious area of consent for children under the age of 16 is that they can consent to treatment but cannot refuse treatment (Parekh, 2006); this has been debated and has caused considerable confusion amongst practitioners. For example, Al-Samsam (2008) has argued that if children can only agree to treatment and not refuse it they do not really have full consent. Tan *et al.* (2007) also raised concerns that clinicians may use consent to protect themselves rather than purposefully using consent to improve clinical practice and enhance the therapeutic relationship and alliance.

Competence

Wellesley & Jenkins (2009) state that competence is a defined set of abilities needed for a specific task and Tan *et al.* (2007) propose that competence is developed and defined through shared usage within a healthcare setting; however, the level of the shared usage would be dependent on each individual's service and how much the service in question valued and considered the child's participation. If a service defaults to parental consent without consideration of the child, then the shared usage may be very underdeveloped.

The law does not specify any age for which a child can be considered competent (Parekh, 2006). Parekh (2006) recommended that there should be a wide range of professionals involved in assessing competence including clergymen, psychologists and sociologists, and that medical staff should have competence assessment specifically included within their training. However, it seems unlikely that organisations would be able to facilitate an assessment of competence inclusive of all of the suggested professionals on a regular and recurrent basis. The impact of such an assessment on the child would also need to be considered. Being assessed by different professionals could hinder the decision making process for the child. The child might feel intimidated by so many assessments and ongoing questioning. The process could cause significant delay in decision making and a delay in treatment in some contexts which could be expected to have a negative impact on the child.

Competence will also rely on some extent in the child being assured in their own ability and understanding (Donnelly, 2010). Maturity and appropriate levels of cognitive development will be necessary for children to understand the risks, benefits, options and ethical and moral aspects of their decisions (Parekh, 2006). Such understanding is structured through many aspects of a young person's life. These include age, cognitive and social development, emotional factors, health status and family relationships (Didcock, 2007). Alderson (2007) and Larcher & Hutchinson (2009) suggested that the framing of competency has moved towards considering an individual's experience, learning and understanding and away from exclusively being defined according to age. Tan & Fegert (2004) explained that children who are raised in a warm and trusting environment are more likely to be able to make a decision from an early age. By contrast Tan *et al.* (2007) found that if there are attachment difficulties for the child or difficulties within the home then this will directly impact on the child's ability to form independent views and make autonomous decisions. Acknowledging the relationship between family difficulties and child mental health (Green *et al.*, 2005), further consideration is needed on the impact of mental health on declining cognitive abilities (Billick *et al.*, 1998; DH & NIMHE, 2009b) and subsequent decision making.

Several discussions have taken place about the level of cognitive ability of the child and the impact that this has on decision making (Alderson, 2007; Didcock, 2007; Donnelly, 2010; Larcher & Hutchinson, 2009; Parekh, 2006; Tan & Fegert, 2004 and Tan *et al.*, 2007). In 1956

Piaget & Inhelder undertook an experiment to ascertain whether children could consider reasoning from another person's perspective. When considering a platform that projected three mountains with different colours and markings, the child was asked to consider relational viewpoints. Piaget & Inhelder found that only children aged 7 years or over could do this (Piaget & Inhelder, 1956/1971). Donaldson (1978) refuted this finding when she conducted an experiment and suggested that children as young as 3 could complete harder geometric puzzles. Weithorne & Campbell (1982) experimented with giving hypothetical questions to different age groups and found that 9 year olds answered similarly to 14 year olds; however, Brazier (1992) suggested that only children aged 13 years or over possessed capacity. Such disagreements simply strengthen the need for competency to be assessed on an individual basis.

Capacity

Mental capacity is where an assessment is made to determine whether someone with a mental illness has the ability to make specific decisions (Letts, 2010; Tan *et al.*, 2007) and refers to the legal power given to a person by law (Wellesley & Jenkins, 2009). The MCA (2005) only includes guidance for young people aged 16 years and above. The concept of mental capacity can be considered for younger children. Children under the age of 16 are presumed to lack capacity until proven otherwise (Alderson, 2007; Larcher & Hutchinson, 2009; Wellesley & Jenkins, 2009). This was considered by Alderson (2007) as a double disadvantage because children would always be starting from a negative position. Alderson & Montgomery (1996) suggested that by the age of 5 years, children have a good solid understanding of the world and its concepts and children at this age should be presumed to have capacity. Tan & Fegert (2004) suggested that the notion of capacity, based predominantly on intellectual acumen, is open to challenge, and that capacity should not be determined by any judicial fixed age limit (Al-Samsam, 2008).

Best interests

If a child is assessed as unable to make an informed decision, parents and professionals make the decision, which is limited to the child's best interests. The statutory and professional guidance examines best interests to support professionals in this process (Children Act, 1989; MHA, 1983; DH, 2001a; General Medical Council (GMC), 2013; Nursing and Midwifery Council (NMC), 2013). Birchley (2010) suggested that best interests should be an amalgamation of the views of law professionals, doctors, parents and children themselves. Boylan & Braye (2006) further advocated that best interests should be seen as a process of promoting the child's voice and providing a co-extensive culture in which this voice can be heard. By contrast Birchley (2010) argued that defining best interests is almost impossible and is open to subjective interpretation, it is therefore unreliable and could be solely defined on the basis of one medical opinion. Birchley (*op cit.*) also recognised that it is a demanding standard: it is not in a child's best interests to eat fatty foods or be around smokers and yet children regularly are. Bowers & Dubicka (2009) acknowledged that all parents may not act in the child's best interests and parents' understanding of the child's best interests may vary.

Professionals also need to be mindful that parents may not always have capacity (Al-Samsam, 2008; MCA, 2005). If this is the case then these decisions would fall out of the Zone of Parental Control (ZPC) and professionals would need to make the decision on behalf of the child (DH, 2008, paragraphs 36.9-36.15).

Communication

The quality of the information elicited from a child is highly dependent on professional practice, attitudes and communication skills (Boylan & Braye, 2006) alongside the level of cognitive development of the child (Taylor, Tapp & Henaghan, 2007). Clinicians need to be skilled in delivering the correct information in the most appropriate way to the child and understand the

child in a medical and social context (Larcher & Hutchinson, 2009); and this should not be undertaken by unskilled staff (Wellesley & Jenkins, 2009). Children should be given information that is complementary to their learning and understanding; which could include toys, videos, leaflets, worksheets, both verbal and written communication, over a period of time and hold discussions with one or more clinicians (Alderson, 2007; Al-Samsam, 2008; Bowers & Dubicka, 2009; DH, 2001a; GMC, 2013; Taylor *et al.*, 2007). The child should understand general and specific information about their disorder and treatment options (Tan & Fegert, 2004). Larcher & Hutchinson (2009) state that clinicians should improve the child's skills for competence and consider increasing the child's level of experience, which is a contributory factor in competence and capacity (Tan & Fegert, 2004), however, there is a lack of guidance about how this should be implemented. Furthermore, Rushford (1999) suggests that this is an ethical responsibility.

Risks and conflicts

The law does not recognise that giving too much information may be more harmful than useful (Wellesley & Jenkins, 2009). However, the provision of information alone is inadequate. Other considerations are that decisions which carry significant weight may be burdensome and can result in 'significant harm' to children (Alderson & Montgomery, 1996). Cantwell & Scott (1995) suggested that 'children are harmed' by the burden of saying what they want within an environment where family members might be present, thus making competence an area of debate (Alderson & Montgomery, 1996; Billick *et al.*, 1998). A child should only make a decision if the weight of that decision will not burden the child (Alderson & Montgomery, 1996). The decisions made in CAMHS for this age group will not, arguably, be of a life threatening severity and therefore will carry less weight.

The literature has shown that children who do participate more in their decisions and care have significantly more motivation throughout their treatment; this may not always be a fully informed decision by the child but a child who has had their views heard and treated as important (Tan *et al.*, 2007). There is a clear message from children of the importance that their rights regarding decision making are supported within a therapeutic relationship (Boylan & Braye, 2006).

Consideration needs to be given to whether parents have capacity to make decisions too. Safeguarding of the child is always of paramount importance - a child may be put at risk by making an informed decision if the parents do not agree with the decision. This could increase the risk to the child at home through parental retribution.

The legal framework

The legal framework (Children Act, 1989; Gillick v Norfolk & Wisbech Health Authority, 1985; HRA, 1998; MHA, 1983; UNCRC, 1989) and government guidance (CAMHS review, 2008; DH, 2003; DH, 2004; DH & NIMHE, 2009b; Robbins, 1999) that directly impact on decision making in 8-12 year olds, has been previously explored in this review. The legal framework can be contradictory at times, for example, children can be prescribed contraceptives, whilst it is illegal for a child under the age of 16 to have sexual intercourse (Didcock, 2007; Parekh, 2006). Other contradictions arise from guidance and case reviews. For example, whilst there is increased pressure to ensure patient autonomy, choice and confidentiality (DH, 2001a, 2001b), there has been an emphasis in ensuring information is shared between all parties to ensure that children remain safe. In the *Bichard Inquiry Report*, Lord Laming felt that the lack of communication and sharing of information led to the failure to protect children, which left professionals working in this area feeling confused about when information should be shared (Bichard Inquiry Report, 2004). Such conflicts highlight the difficulties that clinicians struggle with in practice. Likewise these contradictory notions can be consistent with the themes of risk and conflict within clinical practice. One of the major challenges in this area is to provide a consistent and united approach (Donnelly, 2010) throughout children's services.

Parental role

Parents do have to be involved (Tan *et al.*, 2007) and have continued responsibility for their children in concordance with the Children Act (1989). Boylan & Braye (2006) suggested that children's participation can be hindered by clinicians having a more dominant commitment to parental consent. In this regard Paul, Foreman & Kent (2000) found that a high proportion of children and young people attending outpatients appointments had not consented to attend. Clinicians play an important role in balancing the views of children and parents.

Conclusion

This paper has considered factors that were identified through the use of a data extraction form (Jones, 2007, p.44) from selected literature of a systematic review. These are 'consent, competence and capacity', best interests, communication, risks and conflicts, legal frameworks and parental role, each of which influence decision making by 8-12 year olds.

The limitations for this review are that information may be relevant for this age group outside of the health and social care field. Further results may be generated by widening the lower age range in the inclusion criteria. Finally, consideration needs to be given in identifying government and public health policy through literature searching; as it is likely that some documentation has not been captured through the defined search process.

The review has evidenced that it is legally possible for children to make decisions should they have capacity to do so; however, the differences between adult capacity and children's capacity is significant with children's rights remaining limited. Children are always presumed to lack competence and children are not allowed to refuse treatment, only accept it.

One of CAMHS' underpinning philosophies is the family orientated approach (CAMHS Review, 2008) which can mean that information is shared with the family during the course of the child's assessment and treatment process. Only offering the option of a discussion in a family setting of the child's mental health can potentially disempower the child and can decrease the opportunity for them to make their own decision without the expectations of others in the process (Tan *et al.*, 2007). Plans and guidance need to be in place in order to support clinicians and children as to how these situations can be best managed and all views can be heard.

Through the review of the literature there are areas that need clarity around the involvement of children in their own healthcare. Consideration needs to be given when involvement should take place; in line with legal obligations, in that clinicians have a duty to ensure that the involvement of children in their own healthcare should be facilitated in all situations. The level of involvement may vary dependent on whether the child should be supported to make a fully informed decision, therefore giving informed consent, or whether they should be part of the decision making process in a different way – perhaps ensuring their voice is carefully heard and fully taken into account. The review determines that decision making will be dependent on factors, including competency, cognitive ability, severity of mental health difficulty, environmental factors, such as the home situation and whether the child will be put at risk through making a specific decision. It was identified that the terms and conditions that need to exist for involvement to be appropriate and effective will include all of those factors identified above. It will also include factors around the clinician's skills and abilities to have the discussion using the variety of media with the child, a developed therapeutic relationship and an organisational philosophy that supports and values child empowerment and participation.

Though clinicians need to identify how we improve skills for clinical competence, the review was unclear about how they should do this. It was, though, evident within the literature that experience of a situation is important for understanding, so including children in decision making will improve their competency and confidence.

Implications for both academic and clinical practice

A framework needs to be developed as to how the child can lead in their treatment choices; with attention given to the families' involvement and rights. The family orientated approach in CAMHS needs to consider how services can best deliver holistic and family orientated care whilst empowering the child to have autonomy to make decisions and cautiously assessing any possible risks to the child making decisions within the family setting.

A key component of facilitating the child's involvement is understanding what the training requirements are that are needed to develop the skills of clinicians in this area. Communication, skills and training of professionals have been highlighted as important factors when giving information to children; however, there were no suggestions as to what this training might involve or how someone might be trained. There is a need to help clarify the legal position for clinicians and the child, as the absence of legal and competency frameworks leaves this area of practice open to interpretation and subjectivism. This is further compounded by the absence of NICE (National Institute of Health and Care Excellence) guidance in this area. The development of guidance and a legal framework would support clinicians and children in this area. It is important that CAMH services have a well developed understanding of their legal position when working with children aged 8-12 and imperative to ensure children's decision making is empowered and is at the heart of organisational philosophy and policy. The factors considered in this paper are clearly discussed in the identified literature, however, there is a significant absence of the necessary conditions needed for decision making from the child's perspective and the child's voice has yet to be heard; this needs to be addressed in further research.

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References

- Alderson, P. (2007) 'Competent children? Minors' consent to health care treatment and research', *Social Science and Medicine*, **65**, pp. 2272-2283, doi: 10.1016/j.socscimed.2007.08.005
- Alderson, P. & Montgomery, J. (1996) *Health Care Choices: Making Decisions with Children*, London: Institute for Public Policy Research.
- Al-Samsam, R.H. (2008) 'Legal aspects of consent to treatment in children', *Paediatrics and Child Health*, **18**(10), pp. 469-473, doi: 10.1016/j.paed.2008.07.007
- Bichard Inquiry Report* (2004) London: The Home Office.
- Billick, S.B., Edwards, J.L., Burgert, W., Serlen, J.R. & Bruni, S.M. (1998) 'A clinical study of competency in child psychiatric inpatients', *Journal of the American Academy of Psychiatry and Law*, **26**(4), pp. 587-594, doi: 10.1177/1359104507075921
- Birchley, G. (2010) 'What limits, if any, should be placed on a parent's rights to consent and/or refuse to consent to medical treatment for their child?', *Nursing Philosophy*, **11**(4), pp. 280-285, doi: 10.1111/j.1466-769X.2010.00456.x
- Bolam v Friern Hospital Management Committee* (1957) 1 W.L.R. 582.
- Bolitho v City and Hackney Health Authority* (1997) 3 W.L.R. 1151.

Bowers, M. & Dubicka, B. (2009) 'Legal dilemmas for clinicians involved in the care and treatment of children and young people with mental disorder', *Child: Care, Health and Development*, **36**(4), pp. 592-596, doi: 10.1111/j.1365-2214.2009.01040.x

Boyden, J. (2005) 'Childhood and the policy makers: a comparative perspective on the globalisation of childhood', in James, A. & Prout, A. (eds.), (2005), *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*, London: Falmer Press, pp. 218-221.

Boylan, J. & Braye, S. (2006) 'Paid, professionalised and proceduralised: can legal and policy frameworks for child advocacy give voice to children and young people?', *The Journal of Social Welfare and Family Law*, **28**(3-4), pp. 233-249, doi: 10.1080/09649060601119417

Brazier, M. (1992) *Medicine, Patients and the Law*, 2nd Edition, London: Penguin.

Cantwell, B. & Scott, S. (1995) 'Children's wishes, children's burdens', *Journal of Social Welfare and Family Law*, **17**(3), pp. 337-354, doi: 10.1080/09649069508413664

Child and Adolescent Mental Health Services (2008) *Children and Young People in Mind: The Final Report of the National CAMHS Review (The Final Report)*, accessed at: <http://webarchive.nationalarchives.gov.uk/20081230004520/publications.dcsf.gov.uk/eorderingdownload/camhs-review.pdf>

Children Act (1989) London: HMSO.

Children and Young Persons Act (1963) accessed at: <http://www.legislation.gov.uk/ukpga/1963/37/section/16>

Department of Health (2001a) *Seeking consent: working with children*, accessed at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4067204.pdf

Department of Health (2001b) *Consent: What You Have the Right to Expect. A Guide for Children and Young People*, London: HMSO.

Department of Health (2003) *Getting the right start: NSF for children. Standard for hospital services*:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199953/Getting_the_right_start_-_National_Service_Framework_for_Children_Standard_for_Hospital_Services.pdf

Department of Health & Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services (Executive Summary)*:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199952/National_Service_Framework_for_Children_Young_People_and_Maternity_Services_-_Core_Standards.pdf

Department of Health (2008) *Code of Practice Mental Health Act 1983. Published Pursuant to Section 118 of the Act*, London: HMSO.

Department of Health (2009a) *Reference Guide to Consent for Examination or Treatment*, 2nd Edition, London: Department of Health.

Department of Health & National Institute for Mental Health in England (2009b) *The Legal Aspects of the Care and Treatment of Children and Young People with a Mental Disorder: A Guide for Professionals*, London: Department of Health.

Department of Health (2012) *My access to psychological therapies*, accessed at: <http://www.myapt.org.uk/9-priorities/>

Didcock, E.A. (2007) 'Issues of consent and competency in children and young people', *Paediatrics and Child Health*, **17**(11), pp. 425-428, doi: [org/10.1016/j.paed.2007.08.001](https://doi.org/10.1016/j.paed.2007.08.001)

Donaldson, M. (1978) *Children's Minds*, London: Harper Collins.

Donnelly, C. (2010) Reflections of a Guardian Ad Litem on the participation of looked after children on public law proceedings, *Child Care in Practice*, **16**(2), pp. 181-193, doi: [10.1080/13575270903493390](https://doi.org/10.1080/13575270903493390)

General Medical Council (2013) *0-18 years guidance: assessing best interests*, accessed at: http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_12_13_assessing_best_interest.asp

Gillick v Norfolk and Wisbech Health Authority (1985) 2 W.L.R. 413.

Glaser, B.G., & Strauss, A.L. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*, Chicago: Aldine.

Green, H., McGinnity, A., Meltzer, H., Ford, T. & Goodman, R. (2005) *Mental Health of Children and Young People in Great Britain, 2004*, Hampshire: Palgrave MacMillan.

Her Majesty's Treasury (2015) *Budget 2015*, HMSO: London.

Human Rights Act (1998), accessed at: <http://www.legislation.gov.uk/ukpga/1998/42/crossheading/public-authorities>

James, A. & Prout, A. (eds.) (1997) *Constructing and Reconstructing Childhood: New Directions in the Sociological Study of Childhood*, London: Falmer.

Jones, K. (2007) 'Doing a literature review in health', in Saks, M. & Allsop, J. (eds.) (2007), *Researching Health: Qualitative, Quantitative and Mixed Methods*, London: Sage, pp.44.

Larcher, V. & Hutchinson, A. (2009) 'How should paediatricians assess Gillick competence?', *Archives of Disease in Childhood*, **95**, pp. 307-311, doi: [10.1136/adc.2008.148676](https://doi.org/10.1136/adc.2008.148676)

Letts, P. (ed.) (2010) *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers*, London: The British Medical Association and the Law Society.

Marcovitch, H. (ed) (2010) *Black's Medical Dictionary, 42nd Edition*, London: A&C Black, accessed at: <http://search.credoreference.com/content/entry/blackmed/intubation/0>

Mental Capacity Act (2005) accessed at: <http://www.legislation.gov.uk/ukpga/2005/9/section/4>

Mental Health Act (1983) accessed at: http://www.legislation.gov.uk/ukpga/1983/20/pdfs/ukpga_19830020_en.pdf

Nursing and Midwifery Council (2013) *Consent*, accessed at: <http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/consent/>

Parekh, S.A. (2006) 'Child consent and the law: an insight and discussion into the law relating to consent and competence', *Child: Care, Health and Development*, **33**(1), pp. 78-82, doi: [10.1111/j.1365-2214.2006.00641.x](https://doi.org/10.1111/j.1365-2214.2006.00641.x)

Paul, M., Foreman, D.M. & Kent, L. (2000) 'Outpatient clinic attendance and consent from children and young people: ethical perspectives and practical considerations', *Clinical Child Psychology and Psychiatry*, **5**(2), pp. 203-211, doi: 10.1177/1359104500005002005

Piaget, J. & Inhelder, B. (1971) *The Child's Conception of Space*, London: Routledge and Keegan Paul (Original work published 1956).

R v Bournewood Community & Mental Health NHS Trust (1997) 3 W.L.R. 107.

Robbins, D. (1999) *Mapping Quality in Children's Services: An Evaluation of Local Responses to the Quality Protects Programme*, London: Department of Health.

Rushford, M. (1999) 'Practitioner review: communicating with hospitalised children: review and application of research pertaining to children's understanding of health and illness', *Journal of Child Psychology and Psychiatry*, **5**, pp. 683-691, doi: 10.1111/1469-7610.00485

Sidaway v Board of Governors of the Bethlem Royal Hospital (1985) A.C. 871.

Simms v Simms (2003) 2 W.L.R. 1465.

Shirk, S.R. & Karver, M. (2003) 'Prediction of treatment outcome from relationship variables in child and adolescent therapy: a meta-analytic review', *Journal of Consulting and Clinical Psychology*, **71**(3), pp. 452-464, doi: 10.1037/0022-006X.71.3.452

T v United Kingdom (1999) (24724/94)

Tan, J.O.A. & Fegert, J.M. (2004) 'Capacity and competence in child and adolescent psychiatry', *Health Care Analysis*, **12**(4), pp. 285-294, doi: 10.1007/s10728-004-6636-9

Tan, J.O.A., Passerini, G.E. & Stewart, A. (2007) 'Consent and confidentiality in clinical work with young people', *Clinical Child Psychology and Psychiatry*, **12**(2), pp. 191-210, doi: 10.1177/1359104507075921

Taylor, N., Tapp, P. & Henaghan, M. (2007) 'Respecting children's participation in family law proceedings', *International Journal of Children's Rights*, **15**(1), pp. 61-82, doi: 10.1163/092755607X185555

United Nations Convention on the Rights of the Child (1989) *United Nations Convention on the Rights of the Child (Article 12)*, London: Unicef UK.

V v United Kingdom (1999) (24888/94)

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

Wellesley, H. & Jenkins, I. (2009) 'Consent in children', *Anaesthesia and Intensive Care Medicine*, **10**(4), pp. 196-199, doi:10.1016/j.mpaic.2009.01.006

Notes on Contributors

Ann Cox is a Registered Mental Health Nurse, Accredited Cognitive Behavioural Psychotherapist and an independent prescriber. Ann is a CAMHS manager and clinical lead, working for Derbyshire Healthcare NHS Foundation Trust. Ann offers a range of lectures on child and adolescent mental health at the University of Derby on a part-time basis. Ann is currently in her 3rd year of a Doctorate in Health and Social Care Practice at the University of Derby, where she is researching children's decision making in CAMHS. Ann has been working in child and adolescent mental health for the past 15 years and has expertise in working with younger children.

Professor Chris Brannigan has been involved in child and adolescent psychology since the 1960s; having taught, researched and held posts in the UK universities as well as honorary posts in Africa, Asia, Australia, North America and various European countries. He has acted as an organisational consultant within the European Union and worked with several UK Government agencies and commercial organisations. He is currently Emeritus Professor in Psychotherapy at the University of Derby and has an Honorary Fellowship of British Association for Behavioural and Cognitive Psychotherapy.

Dr Martyn Harling currently works as a Senior Lecturer in the College of Health and Social Care at the University of Derby, teaching undergraduate students undertaking a range of professional courses in health and social care and postgraduate students on the Doctorate of Health and Social Care Practice programme. He is a Registered Nurse and has worked in a wide range of health and social care services and in several different NHS Trusts.

Dr Michael Townend is a Reader in Cognitive Behavioural Psychotherapy at the University of Derby, where he teaches and researches cognitive behavioural psychotherapy. He is a Consultant in Cognitive Behavioural Psychotherapy at the SPIRE Parkway Hospital, Solihull. Michael was the founding editor of the BABCP Journal – *The Cognitive Behavioural Therapist*. He is currently Programme Leader for the Doctorate in Health and Social Care Practice.

Correspondence

Ann Cox
Derbyshire Healthcare NHS Foundation Trust
Southern County CAMHS
Dale Bank View
Swadlincote
Derbyshire
DE11 0AD

E: ann.cox@derbyshcft.nhs.uk

Appendix 1: Data extraction form

Article no:		Review date:		
Title:				
Author(s):		Publication date:		
Publisher:		Place of publication:		
Journal:		Volume:	Number:	Page no:
Keywords/ definitions:				
Conceptual framework:				
Findings/ argument:				
Author conclusions:				
Own notes:				
Rating: quality of research		Rating: relevance to study		
A	High quality	1	Extremely relevant	
B	Medium quality	2	Quite relevant	
C	Low quality	3	Marginal relevance	

Taken from: Jones, 2007, p.44

