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Seeking consent:

working with children

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Introduction

If your work involves healthcare of any kind for children (in the healthcare context anything from helping a child get dressed to carrying out major surgery, whether in hospital or in the child's own home), you need to make sure you have consent to do what you propose to do. Obtaining such consent before providing care is both a fundamental part of good practice and a legal requirement. The process for obtaining consent will vary from simple situations such as assistance with dressing, when a question 'shall I help you?' would suffice if the child is able to understand, to complex situations where a considerable amount of information would be needed to support decision-making.

If children are not legally competent (do not 'have capacity') to give consent for themselves, you will need consent from some-one who has parental responsibility for them, unless it is an emergency and it would be unreasonable to wait. The word "parents" is used throughout this guidance as shorthand for people with parental responsibility – see page 6 for information on when birth parents do and do not have parental responsibility, and on who else can exercise this responsibility.

The Department of Health guidance, *Reference guide to consent for examination or treatment*, sets out in detail the current English law on consent and gives references to legal cases and good practice guidance from regulatory bodies for those who want to know more. This booklet focuses on the particular issues which may arise when seeking consent from children and their parents.

The first part of this booklet sets out whom you should seek consent from – when children can consent for themselves and when others need to decide on their behalf. The second part gives guidance on how best to seek consent, and what you need to take into consideration. The third section looks at some of the more complex situations which sometimes arise: for example where children and parents cannot agree, or where consent is being sought for an intervention which will not directly benefit the child, such as donating bone marrow for a sister or brother. The final sections cover treatment for mental disorders and for research.

Who can give consent?

If children are competent to give consent for themselves, you should seek consent directly from them. The legal position regarding ‘competence’ is different for children aged over and under 16.

Children aged 16 and 17

Once children reach the age of 16, they are presumed in law to be competent to give consent for themselves for their own surgical, medical or dental treatment, and any associated procedures, such as investigations, anaesthesia or nursing care. This means that in many respects they should be treated as adults – for example if a signature on a consent form is necessary, they can sign for themselves.

However, it is still good practice to encourage competent children to involve their families in decision-making. Where a competent child does ask you to keep their confidence, you must do so, unless you can justify disclosure on the grounds that you have reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm. You should however seek to persuade them to involve their family, unless you believe that it is not in their best interests to do so.

How do you assess competence?

Like adults, children aged 16 and 17 may sometimes *not* be competent to take particular decisions. For example, they may be unconscious, or be unable to take a decision because of the effects of pain, fatigue or medication. For patients to have the capacity (be competent) to take a particular decision, they must be able to

- comprehend and retain information material to the decision, especially as to the consequences of having or not having the intervention in question, and
- use and weigh this information in the decision-making process.

You should never automatically assume that a child with learning disabilities is not competent to take his or her own decisions: many children *will* be competent if information is presented in an appropriate way and they are supported through the decision-making process. If a child of 16 or 17 is not competent to take a particular decision, then a person with parental responsibility can take that decision for them, although the child should still be involved as much as possible (see page 9). However, once children reach the age of 18, **no-one** else can take decisions on their behalf. If an 18 year-old is not competent to take their own decisions, clinicians can provide treatment and care that is in their “best interests”. More information on “best interests” and treating people over 18 who are not competent to consent is given in the Department of Health’s *Reference guide to consent for examination or treatment*.

Younger children

Unlike 16 or 17 year olds, children under 16 are not automatically presumed to be legally competent to make decisions about their healthcare. However, the courts have stated that under 16s *will* be competent to give valid consent to a particular intervention if they have “sufficient understanding and intelligence to enable him or her to understand fully what is proposed” (sometimes known as “Gillick competence”). In other words, there is no specific age when a child becomes competent to consent to treatment: it depends both on the child and on the seriousness and complexity of the treatment being proposed.

‘Competence’ is not a simple attribute that a child either possesses or does not possess: much will depend on the relationship and trust between you and your colleagues, and the child and their family. You can help children to develop competence by involving them from an early age in decisions and encouraging them to take an increasing part in the decisions about their care. This will particularly apply where you are caring for a particular child over a period of time, for example where the child needs a series of operations.

If a child under 16 is competent to consent for himself or herself to a particular intervention, it is still good practice to involve their family in decision-making unless the child specifically asks you not to do so and you cannot persuade them otherwise. As with older children, you must respect any request from a competent under-16 year old to keep their treatment confidential, unless you can justify disclosure on the grounds that you have reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm.

People with parental responsibility

If a child is not competent to give consent for themselves, you should seek consent from a person with 'parental responsibility'. This will often, but not always, be the child's parent. Legally, you only need consent from one person with parental responsibility, although clearly it is good practice to involve all those close to the child in the decision-making process.

The *Children Act 1989* sets out who has parental responsibility and these include:

- the child's parents if married to each other at the time of conception or birth;
- the child's mother, but not father if they were not so married *unless* the father has acquired parental responsibility via a court order or a parental responsibility agreement or the couple subsequently marry;
- the child's legally appointed guardian – appointed either by a court or by a parent with parental responsibility in the event of their own death;
- a person in whose favour a court has made a residence order concerning the child;
- a local authority designated in a care order in respect of the child (but not where the child is being looked after under section 20 of the *Children Act*, also known as being 'accommodated' or in 'voluntary care');
- a local authority or other authorised person who holds an emergency protection order in respect of the child.

Foster parents, step-parents and grandparents do not automatically have parental responsibility.

If the mother is herself under 16, she will only be able to give valid consent for her child's treatment if she herself is "Gillick competent" to take the decision in question (see page 5). Whether or not she is able to give valid consent on behalf of her child may therefore vary, depending on the complexity of the decision to be taken.

If a child is a ward of court, all "important steps" in the child's life must first be approved by the court. If possible it will be helpful to keep copies of the wardship papers with the child's medical record, so that it is clear what, if any, treatment may be provided without reference to the court (for example routine treatment for asthma).

While only a person exercising parental responsibility can give valid consent, persons with parental responsibility can arrange for some or all of that responsibility to be met by others. Parents might, for example, give authority for someone who cares for their child on a regular basis, such as a grandparent or childminder, to give consent under defined circumstances (for example in emergencies or for routine treatments for coughs and colds). Where such explicit authority has been given, the consent of the person with the authority will be valid and you will not need to try to contact those with parental responsibility as well, unless you have reason to believe that the parent's view might differ. The *Children Act* does not specify that such authority should be given in writing, but clearly it is helpful for healthcare workers if it is. Where a child with complex health needs is regularly cared for away from home (for example if they attend a residential school), it will be good practice for a healthcare plan to be clearly agreed between the child, the parents, and the clinicians regularly involved in caring for the child at home and elsewhere. This will enable any significant differences of opinion to be identified and resolved in advance, rather than under pressure in a medical emergency.

The *Children Act* also allows a person who does not have parental responsibility for a child but who ‘has care’ of a child to ‘do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child’s welfare’. This might apply, for example, to childminders or teachers, where explicit authority to consent on behalf of a child has not been given by the person with parental responsibility. However, it would rarely be ‘reasonable’ for those with care of a child to consent to treatment on the child’s behalf if a parent could be contacted instead. In an emergency, it would certainly be reasonable for a teacher or childminder to take a child for appropriate medical care, which could then be lawfully provided on the basis that the care was in the child’s best interests and no-one with parental responsibility could be contacted (see page 17).

Where a person exercising parental responsibility is giving consent for a child’s treatment, it is very important that they have the necessary information both about the proposed procedure and the child, in order to take a proper view as to the child’s best interests. This may be particularly relevant if consent is being given by a person with parental responsibility who does not have day-to-day contact with the child.

Making sure children are involved in decision-making

Even where children are not able to give valid consent for themselves, it is very important to involve them as much as possible in decisions about their own health. Even very young children will have opinions about their healthcare, and you should use methods appropriate to their age and understanding to enable these views to be taken into account. A child who is unable to understand any aspects of the healthcare decision may still be able to express preferences about who goes with them to the clinic or what toys or comforters they would like to have with them while they are there. Similarly, where treatment choices involve multiple decisions, children may be able to give their own consent to some aspects of their care, even where they are not able to make a decision on the treatment as a whole.

Parents will often be unsure about how much information they want their child to have (particularly when a young child is seriously ill), and you will need to discuss this sensitively with them.

Decision-making with older children will often be a matter of negotiation between the child, those with parental responsibility and clinicians: children should never feel that decisions are being made over their heads.

Example 1

Mary is 15 and pregnant after having sex with her 16 year-old boyfriend. She is seeking an abortion, but does not wish her parents to know about it. The health professionals involved in her care have tried without success to persuade her to involve her family.

After several discussions with Mary, the doctor who would be treating her is satisfied that she fully understands the implications of having or not having an abortion and is quite clear in her own mind what she wants. She is therefore competent to consent for herself. He is also convinced that it is not possible, in the short-term at least, to persuade her to talk to her parents, but he strongly encourages her to involve another adult whom she trusts for support. As she has grounds under the *Abortion Act 1967*, the abortion can go ahead. The clinic staff make sure that Mary is aware of ongoing sources of confidential support and advice, in both sexual health and wider health matters, such as that provided by her school nurse, her GP and local contraceptive clinic.

Example 2

Before taking a class of 12 year-olds on a week-long school holiday, their school seeks explicit agreement in advance from the children's parents that the teachers in charge may consent to any treatment which becomes immediately necessary during the week. Part way through the holiday, Jonathan suffers from a bad asthma attack in the middle of the night and is quite unable to communicate. However, the teacher taking him to A&E is able to consent on his behalf to nebuliser treatment. The task of the staff in the A&E is made much easier because the teacher bringing Jonathan has clear evidence that she has his parents' authority to exercise parental responsibility where necessary. This avoids the necessity of trying to track down Jonathan's parents urgently by phone before the treatment is given. However, all reasonable action should be taken to contact his parents the next day so that they can be appropriately involved in any follow-up care.

Example 3

Irene is 13 and goes on her own to see her GP about a vaginal discharge. In response to gentle questioning she reveals that her stepfather has been sexually abusing her for the past four years. Irene is competent to consent for herself to the treatment of the discharge and wishes to keep the consultation confidential as she does not wish to upset her mother. However she clearly wishes the abuse to stop. After listening to Irene talk about her experiences, her GP sympathetically explains to her that in view of the harm that Irene is suffering, she must involve the child protection team in order to help stop the abuse. The GP helps Irene to understand that this is the best and safest thing to do in the circumstances and reassures Irene that she will continue to offer her support during the process.

How do I go about seeking consent?

The first part of this booklet summarised *who* can lawfully give consent for a child's treatment or care. This section looks at some of the issues which arise when seeking consent. Any reference to "parents" should be read as referring to people with parental responsibility for the child.

Is the consent valid?

For consent to be valid, the person (child or parent) giving consent must be:

- capable of taking that particular decision ('competent')
- acting voluntarily (not under pressure or duress from anyone)
- provided with enough information to enable them to make the decision.

Guidance on how to assess if the person giving consent is capable of taking that decision is given on pages 4-5. See page 17 for advice if neither the child nor anyone with parental responsibility is in a position to give valid consent.

What information do children and their parents need?

Children and their parents clearly need enough information before they can decide whether to consent to, or refuse, treatment. In particular, they need information about:

- the benefits and the risks of the proposed treatment
- what the treatment will involve
- what the implications of not having the treatment are
- what alternatives may be available
- what the practical effects on their lives of having, or not having, the treatment will be.

It is essential that this information is provided in a form that the particular patient can understand, and that you check the child's understanding. This will involve explaining what is proposed in language which is suited to the child's age and abilities, using pictures, toys and play activity where appropriate and drawing on the skills of specialist colleagues. Except in an emergency, information should be provided at the child's own pace, allowing time and opportunity to answer questions and to address concerns, fears and expectations.

It may also involve using interpreters, where the child's, or their parents', first language is not English. If an interpreter is necessary, you should avoid asking the child or any family member to interpret for their parents.

Where a child has a disability, you should take particular care to ensure that the information is provided in a suitable form, involving, for example, interpreters for hearing impaired children or appropriate materials for those with learning disabilities. Specialist colleagues may be able to act as facilitators or advocates where children have particular needs.

The process of seeking consent

Sometimes you will have to seek consent urgently, for example if a child has had a road accident and immediate surgery is necessary. However, where treatment is not immediately necessary, seeking consent should usually be seen as a *process*, not a one-off event. For example, if a tonsillectomy is suggested, seeking consent does not simply consist in asking for a signature just before the operation takes place. Rather, the whole process of discussing options and coming to a decision should be seen as part of the consent process. Information about the risks of treatment should be discussed early on in this process, and not presented at the last minute when it is too late for it to be considered properly.

Child patients and their parents who have given consent to a particular intervention are entitled to change their minds and withdraw their consent at any point. However, if you have started a procedure, such as an operation under local anaesthetic, and it would be dangerous to stop at that point, it would be lawful to continue until any risk to the child is over. Withdrawal of consent in such circumstances may reflect fear or pain, rather than genuine refusal, and you should do all you can to reassure the patient.

Sometimes, during an operation, it may become clear that the child would benefit from an additional procedure, for which consent has not been obtained. You **must** obtain further consent for this procedure before going ahead, unless the delay involved in doing so would genuinely put the child's life or health at risk.

Consent forms

Legally, it makes no difference whether patients sign a form to indicate their consent, or whether they give consent orally or even non-verbally (for example by holding out an arm for blood pressure to be taken). A consent form is only a record, not proof that genuine consent has been given. It is good practice to seek written consent if treatment is complex, or involves significant risks or side-effects. Where children are competent to give consent for themselves (see pages 3-5), their own signature on a consent form is sufficient without the need for their parents also to sign. If parents have been involved in the decision, however, it may be appropriate for both the child and their parent to sign.

More complex situations

Where no-one is able to give a valid consent

Sometimes there may be no-one able to give valid consent to treatment. This might be because a child is unconscious after an accident, needs treatment urgently, and no-one with parental responsibility can be contacted. It may also be because the child is homeless or is an unaccompanied refugee, and does not have capacity to give consent for himself or herself. In such circumstances, it is lawful to provide immediately necessary treatment on the basis that it is in the child's best interests.

Sometimes, the person with parental responsibility may be available, but is not competent to give or withhold consent: for example if the person with parental responsibility is under the influence of drugs, or the mother of a child is herself under 16 and is not competent to make that particular decision (see page 7). In such cases, if there is no-one else with parental responsibility available and the treatment cannot wait, it will be lawful to provide it on the basis that it is in the child's best interests.

Another scenario might be where the parents of a seriously ill child are not competent to give valid consent because of extreme distress. If it is genuinely not possible to delay treatment until the parents are in a position to make a decision, treatment may lawfully be started if clinicians believe it to be in the child's best interests. However, all attempts must be made to ensure that as soon as the parents are able to make a decision, their consent to further treatment is sought.

Where clinicians and those with parental responsibility do not agree

Clinicians and parents will not always agree on what is best for a child. Usually, if parents refuse treatment for their child, then treatment will not go ahead. However, if you and your colleagues believe that it is crucial for the child to have the treatment in question (for example if the child would die, or suffer serious permanent injury without it), then the courts can be asked to decide what is in the child's best interests. Applications to court can be made at short notice if necessary.¹ If the emergency is such that there is no time to apply to court, any doubts should be resolved in favour of the preservation of life.

Sometimes, the opposite situation will arise: where clinicians believe that treatment which the parents want is not appropriate. One example would be where a child is very seriously ill, and clinicians believe that the suffering involved in further treatment would outweigh the possible benefits. Parents cannot require you to provide a particular treatment if you do not believe that it is clinically appropriate, but again the courts can be asked to rule if agreement cannot be reached. While a court would not require you to provide treatment against your clinical judgement, it could require you to transfer responsibility for the child's care to another clinician who does believe that the proposed treatment is appropriate. Further guidance on withholding and withdrawing life-sustaining treatment is given in the Department of Health's *Reference guide to consent for examination or treatment* (2001), the BMA guidance *Withholding and withdrawing life prolonging medical treatment* (2001) and the Royal College of Paediatrics and Child Health guidance *Withholding or withdrawing life saving treatment in children: a framework for practice* (1997).

¹ This should generally be done via your organisation's legal service.

Where parents do not agree with each other

The consent of any one person with parental responsibility is sufficient for treatment lawfully to be given, even if another person with parental responsibility does not agree. For example, treatment could lawfully be given with the consent of the local authority where a child is on a care order, even if the child's mother did not agree. Clearly consensus between those with parental responsibility should be achieved if at all possible.

In addition, the courts have said that a small number of “important decisions” should not be taken by one person with parental responsibility against the wishes of another, citing in particular non-therapeutic male circumcision. It is possible that major experimental treatment, where clinical opinion is divided, might also come into this category, although such a case has not yet come to court.

Where children and those with parental responsibility do not agree

Inevitably there will be times when children and those with parental responsibility for them do not agree on whether the child should have a particular investigation or treatment.

The decision of a competent child to **accept** treatment cannot be over-ridden by a person with parental responsibility. However the courts have said that, exceptionally, if the child **refuses** treatment, those with parental responsibility may consent on their behalf, and treatment can lawfully be given. This power to over-rule a competent child's refusal should be used very rarely, bearing in mind both the consequences of forcing treatment on a child who has refused it and the consequences of non-treatment in this particular case. At all times you should be guided by the best interests of the child.

Where a child is refusing treatment which his or her parents want to accept, and the consequences of refusal are potentially very serious (for example the foreseeable death of the child), you should consider seeking a court ruling on what would be in the best interests of the child. Courts have the power to over-rule the decisions of both children and those with parental responsibility. Where the consequences are less serious, you should do all you can to help the child and their parents reach agreement.

Similarly, there may be differences of opinion between parents and non-competent children. While, legally, the consent of the person with parental responsibility is sufficient for clinicians to proceed, it is clearly good practice to do everything possible to reach agreement. In many cases, it may be possible to delay treatment until the child is content for it to go ahead. Again, you should always be guided by the child's best interests.

Interventions which do not physically benefit the child

Occasionally, a procedure may be suggested that will not physically benefit the particular child: for example using a child as a bone marrow donor for a sibling. If the child is competent, then clearly they should make up their own mind as to whether or not they wish to donate. (It should be noted that the presumption that 16 and 17 year olds are competent only applies to therapeutic treatment, and hence would not cover blood or bone marrow donation. The “test” for competence in such cases is the same as for under 16s: whether the child has “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”).)

Where children are not competent to decide for themselves, then those with parental responsibility can consent on their behalf, *but only if the intervention is in the best interests of the child who will be undergoing the non-therapeutic intervention*. It is not lawful to balance the interests of the child in need of the transplant with the interests of the potential child donor. It will clearly be

very difficult for the parents of a seriously ill child to take a dispassionate view of the best interests of the child's healthy sibling. It is therefore good practice to provide independent scrutiny of the parents' decision, for example through an independent assessor or consideration of the case in a hospital clinical ethics committee. If there is any doubt as to the best interests of the healthy child, a court ruling should be sought.

If there is any question of a child donating a *solid* organ (as opposed to regenerative tissue like bone marrow), then the courts have stated that it is good practice for the courts to be asked to rule in advance – even where the child is competent to make the decision and has expressed his or her willingness to donate.

Example 4

Sara, aged 15, wants to accept immunisation as part of the school immunisation programme, but her mother has contacted her school to refuse consent. The school nurse discusses the benefits and risks of immunisation with Sara and forms the view that Sara is mature enough to understand the implications of having the immunisation. The nurse phones Sara's mother to try to explain that Sara is legally able to consent for herself and that having discussed the risks and benefits she wishes to go ahead. Sara's mother finally accepts that her daughter is able to make up her own mind. Even without the final agreement of Sara's mother, the immunisation could lawfully have been given, but the nurse was anxious to achieve consensus wherever possible.

Example 5

David, aged 14, refuses chemotherapy which his parents wish him to accept. In many ways he seems to be competent to make up his own mind on this decision: he appears to understand the implications of refusing chemotherapy and explains very coherently his concerns about the associated risks of severe nausea and his hair falling out. However, it is clear that he believes that he will 'pull through somehow anyway' without treatment. The clinicians treating him feel it would be very unwise to treat him on the basis of his parents' consent alone, both because it would betray the trusting relationship which has developed between him and those treating him, and because it would be very hard for him psychologically to accept enforced treatment. They are, however, very concerned at the implications for his health if they were to accept his refusal. It is agreed that a court should be asked to decide what is in his 'best interests' so that there is opportunity for all arguments to be discussed openly. The court decides that David should have the treatment. David is able to accept this decision as he no longer feels that those directly involved with him (his parents and the clinicians caring for him) have personally enforced their views on him.

Consent to treatment for mental disorder

The same principles which are used when seeking consent for the treatment of children's physical disorders apply when children are suffering from a mental disorder. However, in addition to the legal and good practice principles outlined earlier in this guidance, additional legal provisions for the treatment of mental disorder exist in the form of the *Mental Health Act 1983*.

Wherever possible, a child should receive treatment for their mental disorder on a consensual basis: either with the child's own consent (where the child is competent to give it) or with consent from a person with parental responsibility and the co-operation of the child (where the child lacks capacity in relation to the decision in question). This is most likely to be achieved where you have been able to develop a trusting relationship with the child, and where the child knows that their views are being taken into account, even if you are not always able to agree with them.

Where consensus cannot be reached, and you have no doubt that the proposed treatment is in the child's best interests, careful thought must be given as to the most appropriate legal framework to use. While treatment may lawfully be provided with the consent of a person with parental responsibility until the child reaches the age of 18, the implications of ignoring a child's refusal on the authority of their parents must be considered. The alternative legal frameworks each have their own advantages and disadvantages: the *Children Act 1989* allows for court involvement in individual treatment decisions and tends to be perceived as less stigmatising than the *Mental Health Act 1983* but does not specifically address mental disorder; the *Mental Health Act 1983* has in the past been perceived as stigmatising but provides significant safeguards for the child.

As a general principle, care and treatment should be provided in the least restrictive setting which is possible in the circumstances and should involve the least possible disruption in the child's ordinary home and school life.

This guidance can only touch briefly on the particular issues raised by consent to treatment for mental disorders. Further guidance, such as that provided by the Department of Health and Welsh Office's *Code of Practice: Mental Health Act 1983* (1999) and the BMA's *Consent, rights and choices in health care for children and young people* (2001), should be consulted as necessary.

Research

The lawfulness of research on children who lack capacity has never explicitly been considered by the English courts. However, parents may often be invited to consent to their child being involved in “therapeutic research”, on the basis that a new treatment may be as effective, or more effective, than the standard treatment. Parents **must** be given sufficient information to ensure that they understand what is involved in the proposed research. In particular, information must be clearly provided covering the following points:

- there is no pressure to take part, and they can withdraw consent at any time, without the rest of the child’s care being affected;
- if the research is a clinical trial, the nature of the trial, and the information available so far on the therapy’s effectiveness and side-effects;
- if the research is a randomised controlled trial, the fact that their child will be randomly assigned to the standard treatment, the new treatment or (if applicable) the placebo.

The possibility of “non-therapeutic” research may also arise, where the child will not directly benefit from the proposed intervention. An example would be taking extra blood samples from a child, in order to carry out research related to the condition from which he or she is suffering. Nursing research, involving activities such as interviews with children or asking them to draw pictures, might also come under the category of ‘non-therapeutic research’. The courts have held that people with parental responsibility can consent to a non-therapeutic intervention on a child as long as that intervention is *not against* the interests of the child and imposes only a minimal burden. (This

contrasts with interventions that would impose more than ‘minimal burden’ on a child, such as bone marrow donation as described on page 20, where to be lawful the intervention must be in the child’s best interests.) You should assess “minimum burden” individually for each child, bearing in mind that children’s reactions to injections, for example, vary considerably.

Appropriately designed information should similarly be available for the children involved in research, and they should be encouraged to be as involved as they are able in any decisions. In particular, children can be encouraged from an early age to sign the research consent form, to show that they agree with what is being proposed. Where parents have consented to non-therapeutic research, but the child (however young) does not agree, the research should not go ahead. It is always good practice to offer feedback on the results of research to children and parents, to show that you value their consent to participate.

Tissue removed from patients during an operation may also potentially be useful for research. The Government has promised a review of the law on the use of such tissue, and further guidance will be issued as soon as possible.

Further sources of guidance and information

Details of the law on which this guidance is based are given in the Department of Health's *Reference guide to consent for examination or treatment*, available from PO Box 777, London SE1 6XH and also on the internet at www.doh.gov.uk/consent.

Other useful texts include:

Alderson P and Montgomery J, *Health care choices: making decisions with children* (1996) IPPR: London.

British Medical Association, *Consent, rights and choices in health care for children and young people* (2001) BMJ Books: London.
(www.bmjpg.com/consent)

Royal College of General Practitioners and Brook, *Confidentiality and young people: improving teenagers' uptake of sexual and other health advice* (2000)
Royal College of General Practitioners and Brook: London.

This booklet has been produced with advice from the Department of Health's "Good practice in consent" Advisory Group. The text of this leaflet and other publications on consent can be found on the internet at www.doh.gov.uk/consent or ordered from the NHS Response Line on 08701 555 455.

