



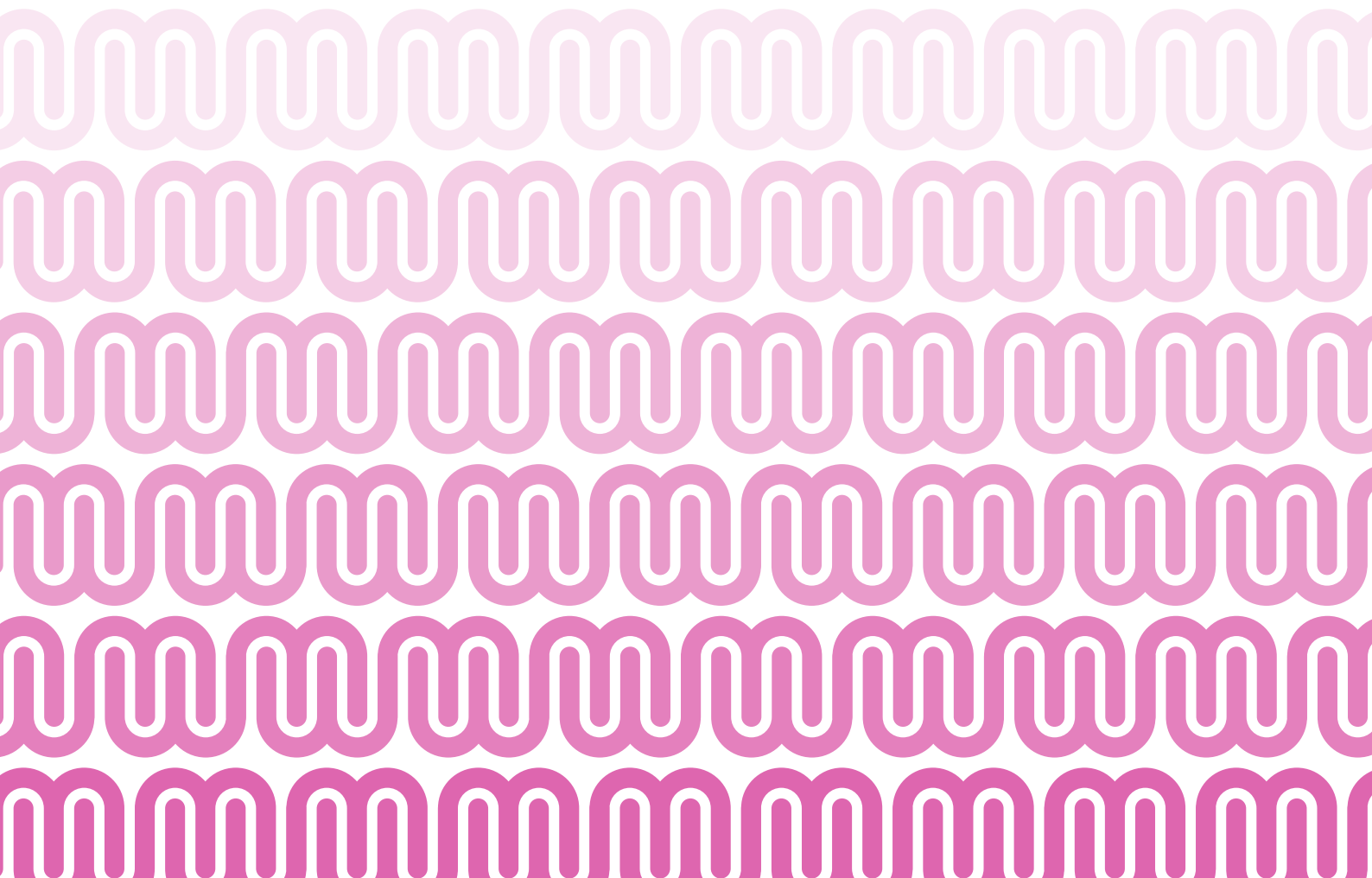
**mental welfare**  
commission for scotland

# **Capacity, consent and compulsion for young people with borderline personality disorder**

Good practice guide

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3 October 2019



# Our mission and purpose

## Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

## Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

## Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

## Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

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## Who is this guidance for?

We have written this guidance primarily for professionals working with young people with borderline personality disorder (BPD) such as medical practitioners (mainly psychiatrists and GPs), nurses and social workers, including mental health officers. The guidance is not written specifically for patients, relatives or carers but might be useful in describing available options and approaches.

## Why we wrote this guidance

This guidance focuses on the crucial issue of decision-making capacity in young people with a diagnosis of borderline personality disorder, and how it affects the ability to treat a young person without their consent. This can be a very challenging area of practice and we discuss the difficulties and dilemmas around the possible use of compulsory treatment. These include:

- The need to balance the importance of promoting a collaborative relationship between the patient and the clinicians and service, together with key stakeholders, whilst managing the risks presented and associated with this diagnosis.
- The fact that at times, compulsory treatment may be necessary for the patient's safety, and yet compulsory measures can also be unhelpful for the longer-term therapeutic goals of promoting autonomy and self-management which are regarded as the cornerstones of successful treatment. Compulsory treatment may also negatively impact on the relationship between the patient and staff, which in turn can be detrimental for the patient in their recovery.
- The obligation to protect life under Article 2 of the European Convention of Human Rights<sup>1</sup>, set against the enormous difficulty in being able to predict suicide in individuals, and the lack of evidence supporting the use of compulsory admission in the prevention of suicide<sup>2</sup>.
- The use of mental health or incapacity law depends on a diagnosis of mental disorder, and diagnosing borderline personality disorder in young people has been problematic, particularly if there has been little prior contact with services.

Notwithstanding the difficulties of intervention, it is important that professionals do not conclude without proper reflection that 'there is nothing we can do' for a young person who is difficult to engage. The Commission's themed visit report 'Living with Borderline Personality Disorder'<sup>3</sup> found that, for many people with BPD, their diagnosis was experienced historically

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<sup>1</sup> In the case of *Rabone v Pennine Care NHS Trust [2012] UKSC 2* the Supreme Court ruled that an NHS Trust had an 'operational duty' under Article 2 to take reasonable steps to protect an informal patient where there was a 'real and immediate risk' of suicide.

<sup>2</sup> Wang, D.W.L. & Colucci, E. (2017). Should compulsory admission to hospital be part of suicide prevention strategies? *BJPsych Bulletin* 41, 169-171

<sup>3</sup> [https://www.mwscot.org.uk/sites/default/files/2019-06/nov2018bpd\\_report\\_final.pdf](https://www.mwscot.org.uk/sites/default/files/2019-06/nov2018bpd_report_final.pdf)

as one of exclusion and a way of saying that services cannot and therefore will not help. That approach is changing now that there is greater evidence to support certain types of therapeutic intervention for BPD. It is important that any legal interventions are considered in the context of a positive response to the needs of children and young people with this diagnosis.

While this guide focus on BPD in young people, much of it may be relevant for services working with young people with other mental health diagnoses or indeed adults with BPD.

## Language and terminology

In the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) a 'child or young person' is defined as a person under the age of 18 years<sup>4</sup>. However, in terms of legal capacity, including the ability to give medical consent, a child is generally defined as a person under the age of 16 years<sup>5</sup>. Similarly, the Adults with Incapacity (Scotland) Act 2000 (AWIA) defines an adult as a person aged 16 or above<sup>6</sup>.

In this guidance we focus particularly on the issue of legal capacity, so we use 'child' for a person aged under 16, and 'adult' for those aged 16 and over. We use 'young person' to mean someone aged under 18.

In this guidance we use the term borderline personality disorder. This is the term used in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). In the WHO International Classification of Diseases (ICD-10), the term emotionally unstable personality disorder is used to mean essentially the same condition. Both terms are used by services.

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<sup>4</sup> Section 2 (1) and section 23 (2)

<sup>5</sup> Age of Legal Capacity (Scotland) Act 1991 and Children (Scotland) Act 1995

<sup>6</sup> Section 1(6)

## What is borderline personality disorder?

Borderline personality disorder (BPD) is characterised by pervasive and persistent patterns of impulsivity and instability. It is thought to affect around 1% of the population<sup>7</sup> although data for young people is scarce.<sup>8</sup> People with BPD are impulsive and have difficulty in regulating their emotions. As a result their mood fluctuates rapidly in response to minor triggers. They often have a poorly developed sense of identity and may often lack a sense of continuity and consistency in themselves in terms of their aims and preferences.

Individuals with BPD have difficulties interpersonally: their relationships with others can often be intense but short lived and characterised by fluctuations between extremes of idealisation and devaluation. Conflict and breakdown of these relationships can evoke strong fears of abandonment in the individual with BPD and result in powerful feelings of dysphoria (a profound sense of unease) and despair. There may be frequent feelings of intense anger and difficulties controlling anger which further impacts on interpersonal relationships, including relationships with services.

As a result of these difficulties with emotional regulation, poor impulse control and difficulties with others, overdoses and other acts of self-harm are common and people with BPD can be frequent users of health services.

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<sup>7</sup> National Institute for Health and Care Excellence, Borderline Personality Disorder: Treatment and management (CG78). NICE 2009.

<sup>8</sup> Cailhol, L., Gicquel, L. & Raynaud, J-P. (2015). Borderline Personality Disorder in Rey JM (ed.) IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions.

## BPD in young people

Historically clinicians have been cautious in making a diagnosis of personality disorder for patients under the age of 18.

[ICD-10 states](#) that since personality disorders ‘tend to appear in late childhood or adolescence and continue to be manifest into adulthood it is therefore unlikely that the diagnosis of personality disorder will be appropriate before the age of 16 or 17 years’. However some patients under the age of 18 do present with personality-related conditions. In such situations terms such as “emergent personality disorder” or “evolving personality disorder” are sometimes used. If the clinician is unclear whether personality disorder is present or not, an individual may be described as having “borderline traits”.

Many studies now suggest that we can reliably diagnose borderline personality disorder (BPD) in adolescents and it is being more frequently demonstrated that the diagnostic criteria for BPD can be as reliable and valid in adolescence as they are in adulthood<sup>9</sup>. The recent Royal College of Psychiatrists in Scotland report<sup>10</sup> on BPD, supports this view, although translation of this view into practise is still not universal.<sup>11 12</sup>

The evolving view is also reflected in the criteria in the forthcoming ICD 11 diagnostic system, which have recently been issued<sup>13</sup>, and are intended to become fully implemented in 2022. ICD 11 includes a sizeable change in the classification of personality disorder across the age range and adopts a dimensional approach. In ICD 11 there will be a single diagnosis of personality disorder which can be described in terms of severity (mild, moderate and severe). Prominent trait qualifiers may be coded which provide information about the specific pattern of traits that the individual experiences and contribute to the diagnosis. One of these qualifiers remains as a Borderline pattern qualifier. Importantly for young people, although ICD 11 still requires that the difficulties an individual experiences must not be developmentally appropriate, it has removed the caution against diagnosis in under 18s, but requires that symptoms must have been in evidence for at least two years. ICD 11 also recognises that stability of symptoms may only be relative from young adulthood.

The reluctance to diagnose personality disorder in young people reflects a number of issues. The characteristics of BPD may appear to be similar to those traditionally thought of as characteristic adolescent struggles-unstable sense of identity, moodiness, impulsivity, intense and fluctuant interpersonal relationships, etc. Therefore, depending on the type of clinical setting, it can sometimes be thought to be difficult to disentangle features suggestive of borderline personality disorder from normal adolescent development.

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<sup>9</sup> Adolescent borderline personality disorder - Larrivé Dialogues in Clinical Neuroscience - Vol 15, No. 2 (2013)

<sup>10</sup> Royal College Psych (2018) [https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr214.pdf?sfvrsn=ed59144\\_2](https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr214.pdf?sfvrsn=ed59144_2)

<sup>11</sup> Laurensen, E.M.R., Hufsebaut, J et al. (2013). Diagnosis of Personality Disorder in Adolescence: a study of psychologists. Child Adolescent Psychiatry and Mental Health. 7:3. [www.ncbi.nlm.nih.gov/pmc/articles/PMC3583803/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3583803/)

<sup>12</sup> Boylan, K. (2018). Diagnosing BPD in Adolescents: More good than harm. J. Can Acad Child Adolesc Psychiatry 27(3), 155-156

<sup>13</sup> WHO ICD 11 criteria June 2019.

<https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2fid%2fentity%2f405565289>

Also, diagnosing the disorder has required symptoms to persist over time, and a young person may be too young to have experienced the enduring patterns of difficulties this aspect of diagnosis requires. Additionally, since personality disorder has been defined as pervasive and enduring, for some clinicians it may seem premature to diagnose teenagers with a condition that can have a high level of stigma attached to it, when their personalities are still forming and developing.

#### **Challenges to the diagnosis of borderline personality disorder in the under 18s**

- Diagnostic criteria have not been generally supportive of diagnosis before young adulthood.
- Personality is still developing and may change thereby generating concerns that diagnosis may be inaccurate and premature.
- Adolescence is described as a time of identity formation, experimentation, risk taking, unstable moods, impulsivity, fluctuant relationships therefore potentially creating differentiation difficulties with BPD.
- Less longitudinal history available to support confident diagnosis due to younger age.
- Overlap with presentations of mental illness e.g. depression, impulsivity, anxiety in adolescence.
- Stigma associated with the diagnosis and concerns about the impact on the young person.
- Awareness of the difficulty in removing a diagnosis when no longer clinically relevant.
- Cultural aspects and the increasing frequency of self-harm in the adolescent population in UK.
- Difficulties disentangling the presentation when there is co-occurring substance misuse.

Despite these caveats, most clinicians will be familiar with more severe cases where distinctions can be made and the distinctive dimensions of BPD can be recognised in adolescence with the benefit of timely diagnosis becoming increasingly emphasised<sup>14</sup>.

We discuss at page 22 how the requirement for a diagnosis of 'mental disorder' to justify legal measures applies in such cases.

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<sup>14</sup> Boylan, K. (2018). Diagnosing BPD in Adolescents: More good than harm. *J. Can Acad Child Adolesc Psychiatry* 27(3), 155-156



## Use of mental health and incapacity legislation in Scotland for individuals with personality disorder

Personality disorder is one of the three types of mental disorder which can be a basis for compulsory measures under the Mental Health Act and AWIA (alongside learning disability and mental illness)<sup>15</sup>. However, it is rarely recorded as the sole basis for compulsory measures.

A review of the Mental Welfare Commission's database from 31<sup>st</sup> May 2015- 1<sup>st</sup> June 2018 found that 13015 Short Term Detention Certificates (STDCs) were granted. Of these, 932 (7%) were in relation to individuals who were thought likely to have personality disorder, either alone or co-morbid with mental illness or a learning disability.

407 of these STDCs (3%) related to young people in the 0-17 age range. Of the 407 STDCs, 28 (7%) related to individuals who were described as likely to have a personality disorder; 20 were also likely to have either mental illness or a learning disability and 8 were described as likely to have personality disorder alone. All of these young people who were described as likely to have solely personality disorder were in the age of 16-17 inclusive.

In the same three year period, 3745 new hospital-based compulsory treatment orders (HCTO) were granted. Of these 206 were for individuals with a diagnosed personality disorder (6%). Six of the 135 HCTOs (4%) granted in the 0-17 years range included personality disorder as a diagnosis. There were 2 community CTOs (CCTO) granted over the three year timeframe for the under-18 population and neither of these related to individuals with a diagnosis of personality disorder. Across the entire age range of 0-85+, only 7 individuals of the 375 CCTOs were identified as having a personality disorder (2%).

Review of the use of AWIA demonstrated that the use of guardianship powers for people with identified personality disorder is uncommon. From 31 May 2015 to 01 June 2018 inclusive, 8818 new guardianships under AWIA were created for individuals across the age range. Of these 19 people (0.2%) were identified as having a personality disorder and 5 of these were identified as borderline personality disorder. All of these 5 individuals had either comorbid mental illness or learning disability and all were over the age of 30.

The AWIA may also be used to authorise medical treatment where an adult is incapable of consenting to the treatment. Section 47 provides that a doctor may certify incapacity and then give treatment that the doctor considers reasonable. These certificates are not centrally recorded and we do not know how often personality disorder is relevant to the finding of incapacity.

In short, the Mental Health Act is used for compulsory treatment of individuals with personality disorder but this tends to be concentrated in the shorter STDC as opposed to the longer duration of a CTO. It is very uncommon for individuals with personality disorder alone to be identified as lacking capacity to the extent that guardianship is sought.

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<sup>15</sup> Section 328, Mental Health Act

## Balancing risk and benefit for young people with BPD

People with borderline personality disorder can be exposed to significant risks to their health, safety and welfare, and may be unwilling to engage in treatment. At times of crisis there can often be a conflict for clinicians between respecting the individual's apparent choices and their duty to protect a vulnerable person.

Two common clinical scenarios that involve individuals with BPD are where an individual:

- 1) is threatening to either seriously harm themselves or attempt suicide, or
- 2) has attempted to harm themselves and requires medical treatment as a consequence of their injuries but is refusing treatment.

Conversely, a young person may be seeking treatment which the clinician does not feel to be appropriate or helpful. Sometimes individuals express heightened suicidal or self-harm ideation when faced with discharge from hospital.

We give examples of these scenarios on pages 27-28.

### Principles to inform decisions

Decisions taken for people with BPD have the potential to impact on their human rights. Most human rights can be limited in certain circumstances providing that this is proportionate, justified and necessary. The underlying principles contained in the Mental Health Act and AWIA broadly reflect the European Convention on Human Rights and should be considered before any action takes place<sup>16</sup>. We have published guidance for professionals in this area<sup>17</sup>.

It is important that any arguments against admission are focused on the needs of the patient, and that these are not conflated with other pressures, such as service capacity. Individuals with BPD are as entitled as any other patient to a mental health service.

It is not acceptable to use the important principle of patients taking personal responsibility for their recovery as a justification for declining hospital admission when patients are not offered ongoing support in another setting to promote that recovery.

### Dilemmas around the admission process

As discussed above a key component of the treatment for patients with BPD involves working collaboratively with the individual. This can be difficult to achieve due to some of the essential features of BPD and the nature and constraints of services.

There can be a significant dilemma for clinicians who may be tempted or pressed to admit individuals to hospital who threaten or display self-destructive behaviour and who raise concerns about risk. Whilst hospital admission may resolve difficulties in the short term, in the longer term this management response may prove unhelpful and even damaging<sup>18</sup> to the young person.

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<sup>16</sup> Section 2 of the Mental Health Act also reflects the requirement in article 3 of the UN Convention on the Rights of the Child that 'In all actions concerning children ... the best interests of the child shall be a primary consideration'

<sup>17</sup> Human rights in mental health services MWCS. Edinburgh 2017.

<sup>18</sup> Paris J. Is hospitalization useful for suicidal patients with BPD? *J Pers Disord* (2004), 18:240-247.

In some cases, an individual's self-destructive behaviour may help to regulate emotional distress and any message given to the patient that he or she is not able to get through this crisis without the hospital may be unhelpful.

There are also concerns that hospitalisation makes psychological therapy (which is the treatment of choice) "almost impossible"<sup>19</sup> since hospital admission may prevent individuals from dealing with the interpersonal conflicts or misunderstandings which were often the trigger of the suicidal action/attempt in the first place. Admission may also unfortunately reinforce pathological behaviours and make the patient worse.

For young people there may be concern about the impact of repeated hospitalizations on the young person's adolescent stage of development and functioning. Adolescence marks a time of rapid social change and being hospitalised away from home for long periods or repeatedly may rapidly degrade the young person's social network, and impact on their education which may in turn increase pressure on the individual and act as a destabilising influence in the future.

### **Potential benefits of admission**

Despite these concerns, young people with BPD have a right to timely, effective treatment. In some cases hospital treatment may be justified to prevent serious harm, and may be life-saving. The suicide rate in individuals with BPD is significantly elevated compared to the general population and the lifetime risk of death by suicide is estimated to be up to 10%<sup>20</sup> (although, even in higher risk populations, predicting an individual completed suicide is extremely difficult)<sup>21</sup>. Brief periods of intense distress and near lethal suicide attempts may require brief admission in order to reduce risk of serious harm and re-evaluate the treatment plan. Admission may also be valuable in order to establish a diagnosis or formulation, explore co-morbidities with other forms of mental illness and develop treatment plans in relation to these.

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<sup>19</sup> Paris J. Is hospitalization useful for suicidal patients with BPD? *J Pers Disord* (2004), 18:240-247.

<sup>20</sup> Soloff, P & Chiappetta M (2012). Prospective Predictor of Suicidal Behaviour in BPD at 6 year follow up. *American Journal of Psychiatry*. 169(5): 484-490

<sup>21</sup> Carter, G et al. (2017) Predicting suicidal behaviours using clinical instruments: systematic review and meta-analysis of positive predictive values for risk scales. *B J Psych* 210, 387-395

## **Dilemmas of compulsory intervention and/or hospital admission**

- Interventions with the best evidence base depend on engagement of patient and compulsory admission complicates this approach.
- May compromise the therapeutic aim of encouraging the patient to take greater responsibility for self-management.
- May harm the therapeutic relationship with the clinical team, and encourage feelings of lack of self-worth in patient.
- Some self-harming behaviour may help to regulate emotional distress and not be helped by an inpatient stay.
- Long periods of hospitalisation may harm family and social relationships and education.

### *But*

- Admission may be necessary to keep the person safe, at least in short term.
- Admission may provide period of respite from crisis and create space to assess more fully and develop care plans.
- Compulsory admission with its inherent safeguards can be an effective way to quickly deal with a highly risky situation if alternatives are not appropriate.

## **Resolving the dilemma**

The short and the long-term potential benefits of admission should always be weighed against the short and long term risks of harm and discussed with the patient<sup>22</sup>.

If the patient has had previous admissions the outcome of these should inform the decision-making process around future admissions at times of crisis.

Crisis care plans can be very helpful for patients known to a service and act as a powerful mechanism to safeguard the individual's rights and give voice to the patient at times in the future when they might lack capacity. A crisis care plan can also be a helpful mechanism for supporting discussions at times of crisis around issues of capacity and the benefits of various treatment options for the patient.

Sometimes the decision to admit the young person to hospital has to be taken as an emergency and may involve clinicians not familiar with or directly involved in their care- such as Accident and Emergency department when an individual has self-harmed in a way that requires immediate medical treatment. Liaison psychiatry teams and out of hours mental health services may be called upon. Having access to a clear crisis plan can help to inform the assessment.

A decision in relation to hospitalisation should occur as part of a continuum of care alternatives, so that deciding not to admit someone does not mean that clinicians ignore the patient's presenting behaviour; suicidal ideation is a sign of significant distress. The clinician can acknowledge the patient's suffering and need for relief of dysphoria by working with him or her to develop alternative strategies to self-harm.

The views of family members, friends or carers on the patient's care can also provide important information to support the care of the patient at times of crisis, and the value of

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<sup>22</sup> Warrender, D. (2017) Borderline personality disorder and the ethics of risk management: The action/consequence model. *Nursing Ethics* 1–10.

their contribution and involvement in care planning in the longer term may also be substantial<sup>23</sup>.

## **Reviewing and ending admission**

Where admission or treatment is undertaken on a compulsory basis case management on a voluntary basis should be resumed as soon as possible although this is not always without difficulty. Compulsory treatment has the danger of removing personal responsibility for self-management from the patient and a fundamental principle in the treatment of personality disorder is the assumption of responsibility by the patient for their own recovery – although this may sometimes need to be done in a graded way.

When someone has been detained, a care planning meeting after detention should be promptly organised to determine what was and was not helpful and to integrate these findings into the future community care plan for the patient. Given the challenges around the usefulness of hospital admission and detention, it is important to inform future planning when an individual has been detained so that hospital admission and compulsory measures do not become the primary way to resolve challenging situations.

The care planning process following detention should take account of the wishes and feelings of the patient and the views of any named person or primary carers. It is also an opportunity to develop future crisis plans, and to discuss with the patient if an advance statement would be helpful to them.

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<sup>23</sup> Seeking the views of named persons and primary carer is also a statutory duty should formal measures under the Mental Health Act prove necessary.

## Assessing capacity for patients with BPD

### Why capacity is important

The concept of decision-making capacity is crucial in determining whether treatment refusals should be upheld by professionals. This can be particularly important when an individual has presented to services with injury but is refusing treatment.

An individual with capacity in relation to a treatment decision (whether an adult or, it would seem, a capacitous child<sup>24</sup>) has the right to refuse that treatment, unless the treatment is authorised by compulsory measures under the Mental Health Act.

Although a patient with capacity may be given treatment they do not consent to under the Mental Health Act, the grounds for intervention under the Act include that the patient has 'SIDMA', i.e. because of mental disorder, their ability to make decisions about the provision of medical treatment is significantly impaired. This will involve consideration of many of the same issues as are relevant to assessing capacity.

### What is decision making capacity?

Two key definitions relating to incapacity and medical treatment in Scotland are important.

Although the wording is not identical, for most practical purposes, they operate in a very similar manner.

1. The Adults with Incapacity (Scotland) Act 2000 (AWIA) generally defines<sup>25</sup> incapacity as being incapable of acting, or making decisions, or communicating decisions, or understanding decisions, or retaining the memory of decisions; by reason of mental disorder or inability to communicate due to physical disability.
2. Guidance<sup>26</sup> derived from case law sets out that, in order to be able to consent to medical treatment, the individual must be able to:
  - Understand broadly what the treatment is, its purpose and nature and why it is being proposed;
  - Understand its principal benefits, risks and alternatives and be able to make a choice;
  - Understand in broad terms what the consequences will be of not receiving the proposed treatment;
  - Retain the information long enough to use it and weigh it in the balance in order to arrive at a decision; and
  - Communicate that decision.

We give further guidance on capacity and medical treatment in relation to adults in [Consent to Treatment](#) and [Right to Treat](#). We focus below on issues that are particularly relevant to young people with BPD. It is impossible to provide an exhaustive checklist and every young person will be different, but we intend that this can assist in reflection and decision making.

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<sup>24</sup> See page 24

<sup>25</sup> AWIA s1(6)

<sup>26</sup> Consent to Treatment MWC (updated 2018). A similar definition is in the AWIA Code of Practice for Medical Practitioners: <https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-third-edition-practitioners-authorized-carry-out-medical-treatment-research-under-part-5-act/> This guidance concerns adults, but similar issues are relevant in assessing treatment capacity in children

## **Problems in assessing (in)capacity in BPD**

The assessment of capacity to consent to treatment in individuals with BPD can be complex and cause anxiety to clinicians, especially when high stakes decisions have to be made. This applies also to assessments in young people who are presenting with behaviour that presents risk but where a diagnosis of BPD has not yet been established. In the following paragraphs the focus is on individuals with established BPD but the principles of the approach may be relevant to young people without a formal BPD diagnosis. In either case it is important that clinicians document their findings clearly including supporting examples which may be helpful to illustrate observed difficulties.

At times of significant distress individuals with BPD may describe transient dissociative symptoms, pronounced paranoid ideation or unusual perceptual experiences and at such times, individuals with BPD's interpretation of the world can be characterised by extreme shifts in thinking. Such disturbances in mental state, if pronounced, may impact on an individual's capacity to make decisions about their treatment. However, it is not uncommon for there to be no clear-cut evidence of other significant psychopathology (including no evidence of cognitive impairment) in the patient's mental state at the time of examination.

There are other features of the presentation of BPD which may be relevant in assessing capacity, but it can be difficult to distinguish these from factors which are not in themselves part of a capacity assessment – such as disagreeing with the doctor, or taking an unwise decision.

The question for clinicians, particularly where high stakes decisions must be made, may be - how do the essential features of BPD impair the individual's ability to understand and reflect on the risks and benefits of treatment?

### **Emotional arousal**

The element of the capacity assessment concerning the ability 'to use or weigh' relevant information about options in the process of making a decision is the element that causes most interpretative difficulty in BPD<sup>27</sup>.

One of the challenges of assessing capacity can be the changeable nature of an individual with BPD's presentation which is often closely linked to the individual's emotional arousal in the context of intense interpersonal relationships. At times of dysregulation the individual may experience extreme emotional states with pronounced depression, hopelessness and anger. These, together with an already underlying instability in self-image or sense of self, may give rise to rapidly varying wishes and intentions. There may be disordered thinking with extreme polarised black and white views that appear inflexible and may be held with unquestioning conviction for a period of time, only to alter when the individual's emotions shift<sup>28</sup>.

High levels of emotional arousal may interfere with the individual's ability to take in and process information, and are therefore relevant in assessing decision-making capacity. Also, at times, due to high levels of emotional arousal individuals can misinterpret the intentions and actions of others which in turn impacts on their ability to understand the information provided and make use of it.

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<sup>27</sup> Ayre, K., Owen, G. & Moran, P. (2017). Mental Capacity and Borderline Personality Disorder. *BJPsych Bulletin*. 41(1):33-36.

<sup>28</sup> Some individuals with BPD also demonstrate highly changeable views when not experiencing significant emotional dysregulation.

Assessment of how the individual uses information may be difficult if the individual is unwilling to engage in the assessment process (due to their difficulties in interpersonal relationships and vulnerability to respond with anger).

It has been argued that <sup>29</sup> at the extremes of emotional dysregulation, BPD patients may become enveloped in that mental state to the extent that they are unable to view things objectively. Research findings have shown that individuals with BPD may have differences in neuro-psychological tests, although the importance of these findings on an individual's decision making capacity remains unclear <sup>30 31 32</sup>.

### **Lack of care for own interests**

It has been argued that in depression, even though the patient may understand the risks, ultimately their mental disorder may affect whether they care about that risk or not, which reduces the authenticity of the individual's subsequent decision <sup>33</sup>. It may be argued that if depression can lead to a pathological lack of care about one's own interests and so negatively impact on the reliability of the individual's decision-making, parallels can be made with patients with BPD when in heightened emotional states.

In some people, the disorder may manifest not simply in a lack of care for one's own wellbeing, but an active desire for self-punishment.

In the case of B V Croydon Health Authority<sup>34</sup> a young woman with BPD was starving herself to the point where enforced nasogastric feeding was considered. In his judgement Lord Justice Hoffman wrote that he found it difficult to conclude that the patient had capacity despite her seeming to have a good understanding of the risks and benefits and options available. He questioned her capacity due to the fact that, despite being seemingly able to put forward cogent and articulate statements about her wishes, she was locked into a cycle of routinely punishing herself, of which the current refusal of treatment was a part, which therefore called her decision making ability into question.

### **Contradictory or ambivalent decisions**

Individuals may at times of stress make mixed, contradictory and ambivalent statements and communications or display incongruent behaviours so that obtaining a clear understanding of intentions or meaning may prove impossible. A distinction may be drawn between the right of any patient to change their mind, sometimes more than once, and a mental state where no true decision at all can be discerned – the latter may be evidence of incapacity.

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<sup>29</sup> Fuchs, T. (2007). Fragmented Selves: temporality and identity in borderline personality disorder. *Psychopathology*.40:379-387

<sup>30</sup> Bazanis et al. (2002). Neurocognitive deficits in decision making and planning in patients with DSM IIR borderline personality disorder. *Psychological Medicine*. 32: 1395-1405.

<sup>31</sup> Schuermann et al. (2011). Impaired decision making ability and feedback evaluation in borderline personality disorder. *Psychological Medicine*. 41: 1917-1927.

<sup>32</sup> Franzen et al. (2011). Superior "theory of mind" in borderline personality disorder: an analysis of interaction in a virtual trust game. *Psychiatry Research*. 187(1-2): 224-233.

<sup>33</sup> Elliot, C. (1997). Are severely depressed patients competent to consent to research? *Archives of General Psychiatry*.54: 113-116.

<sup>34</sup> B vs Croydon Health Authority (1995). *Fam* 133



### **The patient/doctor dynamic**

It has been argued<sup>35</sup> that for patients with BPD a capacity assessment cannot be easily separated out from the interpersonal dynamic that exists between doctor and patient. A capacity assessment occurs within an interpersonal interaction and, because in BPD a person's enduring pattern of inner experience and way of relating with others deviates markedly from the norm, the doctor-patient relationship in which consent occurs may often be disrupted. This may then impact on the experience and meaning of the capacity assessment to the patient and its subsequent findings.

In one case reported in the literature, an individual with personality disorder was treated for a physical health issue without consent on the grounds that she was incompetent to refuse treatment as a result of her personality disturbance<sup>36</sup>. This partly reflected the fact that the patient was disposed to disbelieve what she had been told as a consequence of her disturbed relationship with the clinical team. The patient's refusal to consent was judged as a manifestation of her tendency to adopt a contrary and self-destructive stance in response to clinical advice. The repeated pattern of similar interaction with mental health services for the patient demonstrated that she was unable to choose to behave otherwise which again was thought to provide evidence of her incapacity.

### **The nature of the decision**

Capacity should be assessed by reference to the decision to be taken. Lord Donaldson pointed out in the case of *Re T (Adult: Refusal of Treatment)*<sup>37</sup> that doctors should consider whether the capacity that is present is commensurate with the seriousness of the decision.<sup>38 39</sup> In other words, it is legitimate to look for a higher level of decision-making ability for a choice which is likely to lead to the death of or serious harm to the patient.

### **Making the best assessment**

One of the key challenges for clinicians is not simply to obtain an accurate assessment of capacity but to try and ensure that the overall decision on treatment reflects the rights and interests of the patient.

Importantly, a conclusion that the patient lacks capacity does not mean that the clinician should simply impose their view of what is the optimal treatment. Even patients who lack capacity are entitled to have their views and perspectives given due weight.<sup>40</sup>

The UN Convention on the Rights of Persons with Disabilities states that the 'rights, will and preference' of a disabled person should be respected, and this approach is increasingly influential. It also expects that a person whose decision making may be impaired should be given the necessary support to make an authentic decision.

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<sup>35</sup> Szmuckler, G. (2009). "Personality Disorder" and capacity to make treatment decisions. *Journal of Medical Ethics*;35: 647-650

<sup>36</sup> Winburn, E. & Mullen, R. (2008). Personality Disorder and Competence to refuse treatment. *Journal of Medical Ethics*. 34; 715-716.

<sup>37</sup> *Re T (Adult: Refusal of Treatment)* (1992) 4 All ER 649 at 669.

<sup>38</sup> Ayre, K, Owen, G & Moran, P (2017) Mental Capacity and Borderline Personality Disorder. *BJPsych* 41(1) 33-36

<sup>39</sup> Buchanan, A. (2004). Mental Capacity, legal competence and consent to treatment. *J R Soc Med* 97, 415-420

<sup>40</sup> This is reflected in the principles of the Mental Health Act and AWIA, as well as Article 8 of ECHR, and the UNCRPD.

The decision on treatment should not be based on risk averse practice<sup>41</sup>, but in circumstances where there is a risk of death or significant injury it would be prudent for the clinician to have discussed the reasons for their decision with the wider team and where possible with people who are important to the service user. Senior clinicians in the team or the on-call senior clinicians ought to be involved in such decisions.

Factors which will improve the quality of assessments of capacity include:

- **Ensuring the assessor has the right expertise, or access to it.** In this complex area, an assessment of capacity should ideally be performed by a CAMHS specialist when available.
- **Understanding the full history.** Particularly if the patient is uncooperative, it can be difficult to know on the basis of a single encounter what is behind an unwillingness to accept treatment. Information from family or carers may be essential here to provide a comprehensive understanding of the young person's difficulties.
- **Taking time.** This can help establish if the patient's stance is a consistent one, or is a transient response to a particular situation.
- **Involving others.** This reflects the requirement in the Mental Health Act to have regard particularly to the views of named persons and carers, and may be particularly helpful if it is suspected that the relationship between the patient and the doctor or treatment team is contributing to the patient's refusal of treatment. Information from families can be extremely helpful in identifying presentations which are uncharacteristic. It is also important to involve advocacy wherever possible, to provide an independent and non-judgmental support to the patient.
- **Considering each aspect of the capacity test in turn.** It is only necessary for one of the incapacity criteria to be met for incapacity to be established, and each should be considered in its own right.
- **Considering the environmental factors.** Wherever possible assessments of capacity for treatment decisions ought to be made in a calm environment.

Whilst this reflects best practise, in some situations some of these suggestions may be unrealistic, and immediate decisions may have to be taken in a crisis. In that event it may be reasonable to make a decision which can buy time to consider whether and how treatment should continue<sup>42</sup>.

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<sup>41</sup> Goodman, M. et al. (2012). Suicidal risk and management in borderline personality disorder. *Curr Psychiatry Rep* 14,79-85

<sup>42</sup> Hubbeling, D. (2014). Decision-making should not be decisive in emergencies. *Med.Health Care and Philos* 17,229-238

**Suggested questions to consider when assessing capacity or SIDMA in young people with BPD:**

What limitations are there on assessment? (Time pressures/ limited patient co-operation)  
Can these be ameliorated?

Are there any concerns about the young person's development or cognitive ability?

What support could you offer to enhance the person's decision making ability?

Understanding:

- How is the individual able to take in, make sense of and process information?
- How does the individual's relationship with services/clinicians influence their understanding of the information? What is their interpretation of the information being provided to them?
- Is the individual vulnerable to misinterpreting the intentions and actions of others? If so is this misinterpretation impacting on their ability to make sense of the information provided and their ability to understand and use the information and then make and communicate a decision?
- How flexible is the individual's cognition and responsiveness to new information?
- Does the individual understand the risks of their condition? Note that this is more than a general understanding: the individual must be able to understand the specific risks to their health or welfare. What does the individual think will happen to them if the dangers become realised?
- What is the meaning of the individual's difficulties to them?
- How in-depth is the individual's understanding of their condition?
- How does the individual's interpretation of the world and what is happening to them influence their ability to understand the information provided?

Retain:

- Is the individual able to retain information long enough to make decisions?
- How does the individual's interpretation of information influence what is retained?

**Suggested questions to consider when assessing capacity in young people with BPD (continued):**

Decision-making ability:

- Is there evidence of distortion of thinking/ inflexibility of thinking/ extreme and polarised thinking? Is there evidence of dissociation or paranoid ideation? How does this impact on decision-making ability?
- Is there evidence of unusual perceptual experiences or psychotic symptoms?
- How does the individual's motivation to relieve suffering and distress influence their decision-making?
- Does the individual have the capacity to weigh risks? Does the individual care about the risks to themselves? Is the individual motivated by self-care?
- How is any depressed mood affecting the ability to weigh up and decide and act on those decisions?
- Is there any impaired cognitive function and the ability to think clearly?
- Are levels of emotional arousal interfering with the individual's ability to process information? If so, how?
- How does the individual's interpretation of the world and what is happening to them influence their decision-making ability?
- How durable are the individual's preferences? Have they recently changed? What influenced those changes?
- Is there evidence of such fragmentation of the individual's aims and intentions that strongly held views may be expressed at one moment only to alter with markedly differing views be expressed in another? What evidence supports your view from the individual or from others?
- Is there evidence of ambivalence, contradiction or inconsistency in decision-making? Is the individual's behaviour consistent with their expressed views? -the individual may appear at interview to understand their condition and the risks involved but their behaviour suggests a different meaning.
- What do people who know the individual make of this presentation? Is it different from similar crises in the past and if so how? What was then outcome? What has helped in the past? What has been unhelpful?
- When exploring the suggested questions above think about what evidence is there to support your answers to the questions above and document clearly.

## Legal options to secure treatment

### Emergency treatment at common law

The [AWIA Code of Practice for medical practitioners](#) makes clear<sup>43</sup> that the AWIA does not replace other provisions in the common law that may provide authority to treat a person without consent. In particular, there remains a power to treat a person in an emergency. The Code suggests that the AWIA should be used wherever practicable (for patients aged 16 or over), but common law powers can be used to provide immediate treatment, for example where a patient is unconscious and seriously injured, rather than delay treatment to complete the necessary certification.

This could be appropriate for a young person who has attempted suicide and is unconscious. In most situations it would be reasonable to do this in an emergency even if there was evidence of the young person having expressed a wish that they not be treated<sup>44</sup>.

The same common law power could appropriately be used to treat a child in an emergency, where there is no time to seek parental consent or consider the use of the Mental Health Act.

### Emergency detention under the Mental Health Act

A single doctor can authorise emergency detention if they consider it likely that the patient has a mental disorder and their decision making is significantly impaired, and is satisfied that it is necessary to detain the patient to determine what medical treatment may be required, and that there is significant risk (see below for discussion of these terms). The doctor must also certify that it would take too long to grant a short-term detention certificate.

Unlike an STDC, an emergency detention certificate does not provide a general authority for medical treatment without the patient's consent. However, urgent medical treatment can be given against the patient's will in a limited set of circumstances set out in s243 of the Act, including saving the patient's life. This may therefore be appropriate in responding to an attempted suicide or serious self-harm.

### Compulsory treatment under the Mental Health Act

The Mental Health Act authorises the compulsory treatment of people with mental disorder. It can be applied (if appropriate) whatever the age of the individual. Use of the Mental Health Act must be informed by its principles which include "the importance of providing the maximum benefit to the patient"<sup>45</sup>. For children and young people under the age of 18 the Act has an additional principle that the welfare of the child should be the directing principle under which choices are made by the clinical team<sup>46</sup>. This can at times mean a service having to work more flexibly and prioritise the child's needs over service constraints and design.

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<sup>43</sup> Paragraphs 2.40 to 2.42

<sup>44</sup> The law in Scotland is unclear about the extent to which a person can refuse treatment in advance. There is no statutory equivalent to the Advance Decision to Refuse Treatment in the English Mental Capacity Act, although it may be that a similar principle applies at common law.

<sup>45</sup> Code of Practise volume 1 chapter 1 paragraph 3

<sup>46</sup> Section 2(5)

In order to detain an individual the Mental Health Act requires:

- The presence or likely presence<sup>47</sup> of **mental disorder**: Borderline Personality Disorder falls within the definition of mental disorder (the specific term used within the 2003 Act). A diagnosis is important, because the Act makes clear that reckless behaviour on its own cannot constitute a mental disorder.<sup>48</sup> For young people who have not yet had a conclusive diagnosis the status of emerging or developing BPD may, in the view of the Mental Welfare Commission, be sufficient to count as a mental disorder for the purposes of the Mental Health Act. As described above, most young people in such situations are recorded as having co-morbidity, with mental illness being the most common. However, where there is sufficient evidence of the existence of a personality disorder, this alone will meet the legal test.
- The **availability of medical treatment for the mental disorder** which will prevent deterioration or alleviate symptoms: Importantly the power to detain in hospital and provide treatment under the Mental Health Act only extends to treatment for the mental disorder, not unrelated physical conditions. However, physical conditions which are a cause or consequence of the mental disorder may be treated under the Mental Health Act. The Code of Practice specifically cites deliberate self-harm as an example of this<sup>49</sup> and the Act may be an important means of providing authority to treat when individuals are refusing consent for the injuries caused by deliberate self-harm.
- The range of treatment which can be authorised under the 2003 Act is very broad<sup>50</sup>. As described above many psychological treatments indicated for BPD cannot be delivered without the co-operation of the patient. But there may be occasions when the structure and boundaries of a short term detention or compulsory treatment order may act as a moderating force that allows the phased transfer of autonomy back to the person after a period of treatment, and for the development of a therapeutic relationship.
- **Risk** (to the individual's health, safety or welfare or the safety of another person): All compulsory detentions require that the medical practitioner is satisfied that there is significant risk to the individual or another person if compulsory measures are not employed.

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<sup>47</sup> In short term and emergency detention, the requirement is that the presence of mental disorder is 'likely', not that it is definitely established

<sup>48</sup> Section 328 lists several factors which cannot on their own constitute mental disorder, including use of alcohol or drugs, behaviour causing alarm or distress to others, and acting as no prudent person would act

<sup>49</sup> Mental Health Act Code of Practice volume 1, chapter 1, para 22

<sup>50</sup> Section 329(1) - Treatment can include nursing, care, psychological intervention, habilitation (including education training in work, social and independent living skills) and rehabilitation. In *Reid v Secretary of State for Scotland* 1999 SC (HL) 17, the court ruled that mere containment was not treatment, but the term could include, for example, anger management in a structured setting

- A significant impairment of decision-making ability (**SIDMA**) in relation to the provision of the relevant medical treatment<sup>51</sup>. The Code of Practice for the Act explains that the factors that might establish that a person has SIDMA are very similar to those which are relevant to incapacity (which we discuss at page 14)<sup>52</sup>. However the intention is that the test is less binary in nature and can be applied more flexibly<sup>53</sup>.
- Crucially, it is not necessary in order to establish SIDMA to show that the patient is *unable* to make a decision – only that their ability to do so in relation to decisions about medical treatment is *significantly impaired* as a consequence of mental disorder. This is a different test, which was deliberately included in the 2003 Act to allow interventions in situations where some degree of capacity was arguably present, but the patient’s decision making was nonetheless adversely affected, and the other tests were met.
- An individual may have SIDMA in relation to the totality of medical treatment needed, even if they have capacity in relation to individual treatments. Once the patient is subject to a STDC or a CTO with a treatment power, medication and other treatment (but not ECT) may be given *even in the face of a refusal by a patient with capacity in relation to that treatment*.
- The **necessity** of an order. All compulsory interventions under the 2003 Act must be judged to be necessary. For an EDC the necessity is to act urgently, whereas for an STDC or CTO the ground is simply necessity. The evidence to support this test includes more than a view that compulsory treatment is more beneficial to the patient than not. It should include evidence to explain why compulsory treatment under the 2003 Act as opposed to other less restrictive legal frameworks is necessary. This is particularly pertinent to children, when parental consent may have a role in providing authority for treatment. We discuss this further at page 25.

## The Adults with Incapacity Act

The AWIA can provide authority for treatment when an adult lacks capacity to consent. It is occasionally used in circumstances when an individual has self-harmed. If the adult is assessed to lack the capacity to provide informed consent to medical treatment, they may be treated under AWIA with the authority of a section 47 certificate. This can cover treatment for physical conditions or treatment to address mental health issues.

There are important differences between compulsory treatment under the AWIA and under the Mental Health Act. Treatment under AWIA allows for restraint only if it is immediately necessary and only for as long as necessary<sup>54</sup>. It does not provide authority to detain an individual in hospital to receive treatment for mental disorder. If an individual is expressing a wish to leave hospital or attempting to do so, s47 of the AWIA cannot be used to keep them in hospital to receive treatment.

Treatment under s47 should comply with the statutory principles underpinning the AWIA. However, there are fewer specific treatment safeguards than the Mental Health Act. There is no process for review of treatment by an independent doctor, and no appeal to the Mental

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<sup>51</sup> For emergency and short-term detention the medical practitioner has to be confident of the likelihood of there being SIDMA. For a compulsory treatment order the presence of SIDMA is required.

<sup>52</sup> Code of Practise VOL 2 paragraphs 22-27

<sup>53</sup> Mental Welfare Commission for Scotland. (2017) SIDMA in Individuals with Eating Disorders.

<sup>54</sup> Adults with Incapacity Act 2000 s47 (7).

Health Tribunal. It is possible to apply to the sheriff<sup>55</sup> to challenge treatment under s47, but this is uncommon.

It is the view of the MWCS that the Mental Health Act is generally to be preferred to the AWIA where a person is being given treatment which they do not want over a significant period of time to address a mental disorder or its causes and consequences. The 'necessity' test in the Mental Health Act may be satisfied if the alternative use of AWIA is inappropriate, for example because of the degree of restraint that is necessary, the need for treatment to be administered in hospital, or because the Mental Health Act provides more appropriate safeguards in the individual case.

However, the AWIA may be appropriately used, particularly to treat physical symptoms related to self-harm, where a young person aged 16 or over lacks capacity to consent.

## **Options for treating children**

As discussed above, the test of necessity in the Mental Health Act should reflect the reasons why the Act should be used in preference to other legislation.

Consent to treatment for children can be complex. In summary, legal authority to treat a child may come: from the child themselves if they have capacity to do so, from individuals with parental authority over the child, or from legislation. In the case of treatment of mental disorder, the Mental Health Act can provide authority to treat when the criteria are met.

## **Consent by a capable child**

The child can themselves provide valid consent for their treatment if it is the opinion of the qualified medical practitioner in attendance that the child is capable of understanding the nature and possible consequences of the procedure or treatment<sup>56</sup>. Although this has not yet been tested in court and is not absolutely settled law, the ability to validly consent to medical treatment also appears to extend to that individual being able to validly refuse consent to treatment, in the same way that an adult with capacity can.

An individual with parental responsibilities in relation to that child cannot provide alternative authority to treat where that child has capacity to make that decision. As a result if a child under the age of 16 has a mental disorder but is capably refusing treatment then they cannot be overruled by their parent – although the parent should be allowed to support the child to make the decision. They may, however, be treated compulsorily if they meet the statutory criteria under the Mental Health Act.

The Code of Practice to the Mental Health Act states, "in practical terms, medical practitioners should look for signs that the child can consent on this basis [i.e. they have capacity] from when the child is about 12 years old"<sup>57</sup>. This is not a fixed rule. Children under the age of 12 may have capacity to consent to their own treatment.

The complexity and implications of the treatment will have a bearing on a child's capacity to consent. A child may be able to consent to more simple aspects of treatment but not more

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<sup>55</sup> Adults with Incapacity Act 2000 s52

<sup>56</sup> Age of Legal Capacity Act 1991. S 2 (4): "A person under the age of 16 years shall have capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is **capable of understanding the nature and possible consequences of the procedure or treatment.**"

<sup>57</sup> Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice Vol. 1, chapter 1, para 32



serious and involved treatments. The child's increasing developmental maturity is a key component in their decision making ability and the understanding required to make decisions about different interventions may vary considerably between children of the same age. Capacity to consent should be assessed carefully in relation to each decision that needs to be made.

A child may lack the competence to make the decision in question either because they have not as yet developed the necessary cognitive skills and understanding to make that particular decision or for another reason, for example, because their mental disorder significantly impairs their ability to make the decision. In practice these two aspects may be difficult to tease apart.

When considering whether a child has the competence to decide about the proposed intervention, practitioners should use the criteria for capacity outlined in the second definition on page 14. When assessing capacity, it is important that the child is given as much support as necessary to help them to make the decision.

As with any patient, the clinician should be prepared to consider alternative treatments which they may feel to be clinically sub-optimal, if they would be more acceptable to the child.

## **Parental consent**

The Children (Scotland) Act 1995 gives parents rights and responsibilities in relation to their children. An individual with parental rights and responsibilities may provide legal authority for treatment if the child does not have capacity to consent. In doing so the individual with parental rights and responsibilities must act in the best interests of the child and take the child's views into account<sup>58</sup>.

Where there is more than one person with parental rights and responsibilities, either may consent on behalf of a child who cannot consent. One may provide lawful consent even if the other refuses – a serious dispute between parents as to medical treatment may need to be resolved through an application to the sheriff.

## **Children who cannot consent – using the Mental Health Act**

It may be difficult to decide whether to treat a child who lacks capacity for mental disorder using the authority of parental consent or the Mental Health Act. There are usually several competing factors to take into account, and generally no single factor is sufficient to determine the course of action.

When considering this, it is important to note that the Mental Health Act provides more statutory safeguards for the child. These include that care and treatment should comply with the statutory principles of the Mental Health Act; the individual has the ability to apply to the Mental Health Tribunal for the order to be revoked or varied; there are safeguards and greater scrutiny of the treatment provided to the individual (notably medication for longer than two months) and there is greater oversight, including by the MWCS. It also provides clear authority both for treatment and detention.

It is also worth considering the potential impact on the parent/child relationship of the use of the Mental Health Act. In some circumstances it may be better that the parent is not the one who is authorising the treatment to which the child is objecting. Alternatively there may also

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<sup>58</sup> Children (Scotland) Act 1995 sections 1, 2 and 15(5)

be other instances where it is more beneficial for the child for the authority for their treatment to come from their parent.

At the same time, it is important to keep in mind the necessity criterion for the use of the Mental Health Act. It may be appropriate for the child to be treated informally when the child is incapable of consenting but not actively resisting treatment and consent by a parent is unlikely to be harmful to the ongoing relationship.

In short, it is the balance of all relevant factors set in the context of the clinical presentation and history and integrated by the desire to maximise the child's welfare that should guide clinical staff towards or away from sources of authority to treat.

## Scenarios

This guidance cannot give a definitive answer to the many difficult situations which may arise. The following scenarios give some typical examples, to illustrate the decision-making process which may be appropriate. In difficult cases, where there is time, legal advice may be necessary.

### Emergency treatment of a child

*David, aged 15, has taken an overdose, and has been taken by ambulance to A&E. He states that he wishes to die and does not want treatment. He has a history of self-harming behaviours, is estranged from his parents, and has been excluded from school.*

#### Commentary

In this situation there was insufficient time to establish David's capacity or to seek consent from the parents before beginning treatment. Immediate treatment of the overdose as an emergency was given under common law. Once the immediate crisis was over, further assessment of David's mental state and situation was undertaken, including whether there were grounds to detain him on a short term detention certificate. It was concluded that David was sufficiently stable to return home, with the involvement of social work to develop a plan to offer support to help him.

### Refusing to leave hospital

*Jane, aged 17, was admitted to a psychiatric ward following a suicide attempt. She has been there for two weeks, and the clinical team have concluded that she does not have a mental illness, although she does have significant personality issues. They intend to discharge her, but she is refusing to leave and it's now the start of the weekend. When the team suggest discharge will take place the next working day, i.e. Monday, she appears to become emotionally dysregulated and threatens self-harm on discharge or on Sunday night unless she is placed on constant observations. She is assessed by the weekend doctor on-call who is not familiar with her care and discusses with the consultant on-call who also isn't aware of her.*

#### Commentary

A patient can't insist on staying in hospital when this is not clinically justified, but there is a right to support from the local authority in sections 25 and 26 of the Mental Health Act, reinforced by the added duties in respect of children, so they should not leave without a proper assessment and plan.

Despite her threats of self-harm the team feel that this would not be a helpful step to prolong her hospital stay. When the team agree that she will have a meeting to discuss the plans for discharge on Monday, she is able to accept that is the meeting to discuss her concerns. This provides a clear focus and mechanism for her to ensure relevant members of staff have understood her concerns. The discharge is delayed until Tuesday, which allows for a meeting to be held at the start of the week with relevant people important to Jane, and with the crisis team and community team. The nursing team and medical team describe the assessment and the concerns she may be developing a personality disorder but that in itself is not a reason

for a continued detention. The important aspect here is that decision making is shared and based on evidence both generalised and specific to the individual concerned.<sup>59</sup>

### **Complex presentation**

*Chloe, 17, is transitioning from CAMHS to adult mental health services. She has a diagnosis of borderline personality disorder. She frequently presents at A&E following episodes of self-harm through overdoses and also has a history of cutting. She has an advance statement saying she doesn't want to be admitted. She has been brought to an A&E by her mother after another overdose of paracetamol. Her mum reports that she has been low in mood for the last few months. She has disengaged with the community team. She is unable to answer questions at the moment and needs urgent treatment to counteract the paracetamol. There are questions around the treatment for her paracetamol overdose and setting of further treatment.*

### **Commentary**

Although there is an advance statement in place saying she does not wish to be admitted to hospital there is nothing in her advance statement about treatment. Regardless, the situation is an emergency and a blanket refusal of treatment without consideration of the circumstances and the situation where she might die without treatment are not issues that are considered within the advance statement. The A&E consultant and team decide to go ahead and treat under common law emergency powers.

She is declared medically stable the next day and the liaison psychiatrist meets her. She doesn't want to come into hospital but there are concerns that this is different in that she is lower in her mood according to the family and she is not engaging in any treatment. An MHO is called. An assessment shows that there is a change in presentation and she is depressed as well as having features of personality disorder and is refusing treatment with a plan to die. She is detained under a STDC and admitted to hospital.

After admission a meeting with the community team and family and Chloe agrees that she will work in the DBT programme that the CMHT are running. Chloe reports that she likes some aspects of the ward. A crisis care plan is developed for future episodes of self-harm and also a plan of three respite admissions is agreed per year. She is discharged from the STDC with a plan for a further offer of an admission for three days in four months' time that she may or may not choose to take up.

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<sup>59</sup> Interestingly, but perhaps unsurprisingly, in the development of this vignette, there were differences of opinion as to how to approach Jane's care with different views on how to proceed. The important principle that all agree on here is that of involving the patient and relevant others, and trying to find ways to ensure that the plan, even one where there is disagreement, is discussed and the steps taken both prior to discharge from hospital and availability of support in the community is clearly described and considered in a thoughtful way.

## Further reading

### Suicide Prevention

Mulder, R., Newton-Howes, G & Coid, J. (2016). The futility of risk prediction in psychiatry. *B J Psych* 209(4) 271-272

Wang, D.W.L & Colucci, E. (2017). Should compulsory admission to hospital be part of suicide prevention strategies? *BJPsych Bulletin* 41, 169-171

Hawton, K & Pirkis, J. (2017). Suicide is a complex problem that requires a range of preventative initiatives and methods of evaluation. *BJPsych* 210,381-383

Carter, G. et al. (2017). Predicting suicidal behaviours using clinical instruments: systemic review and meta- analysis of positive predictive values for risk scales. *BJPsych* 210, 387-395

Large, M. et al. (2017). Known unknowns and unknown unknowns in suicide risk assessment: evidence from meta-analyses of aleatory and epistemic uncertainty. *BJPsych Bulletin* 41, 160-163

Riblet, N et al. (2017). Strategies to prevent death by suicide: meta-analysis of randomised controlled trials. *BJPsych* 210, 396-402

### Consent to Treatment

Mental Welfare Commission for Scotland (2018), Consent to Treatment:

[https://www.mwscot.org.uk/sites/default/files/2019-06/consent\\_to\\_treatment\\_2018.pdf](https://www.mwscot.org.uk/sites/default/files/2019-06/consent_to_treatment_2018.pdf)

Cave, E (2019). Informed Consent in Healthcare Settings. SPICe Briefing. The Scottish Parliament.

### Capacity and Borderline Personality Disorder

Ayre, K., Owen, G. & Moran, P. (2017). Mental Capacity and Borderline Personality Disorder. *BJPsych Bulletin* 41(1), 33-36

Szawarski, P. (2013). Classic Cases revisited: The Suicide of Kerrie Woolterton. *Journal of the Intensive Care Society* 14 (3), 211-214

David, A.S et al. (2010). Mentally Disordered or lacking capacity? Lessons for management of serious deliberate self harm. *BMJ* 341, 6025

Winburn, E. & Mullen, R. (2008). Personality Disorder and Competence to Refuse Treatment. *Journal of Medical Ethics* 34, 715-716

Szmuckler, G. (2009). "Personality Disorder" and capacity to make treatment decisions. *Journal of Medical Ethics* 35, 647-650

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