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In the twilight zone: adolescent capacity in the criminal justice arena†

ARTICLE

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SUMMARY

The rights and duties of an adolescent has been the focus of much controversy, especially in the field of capacity and consent, and to a lesser extent in youth justice. Society is constantly reviewing how to ensure fairness to all, while not denying anyone their rights. Developments in neurobiology have forced us to rethink age-old concepts about adolescent development within competence and culpability. This article focuses on the theoretical foundations of capacity or competence and provides guidance on how to negotiate common clinical pitfalls when assessing capacity in an adolescent.

DECLARATION OF INTEREST

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As a group, adolescents (11- to 19-year-olds) sit rather uncomfortably in terms of legal protection. It is a cliché that a juvenile (or adolescent) is 'no longer a child, not yet an adult'. In many respects adolescents could be, and indeed are, seen in Anglo-American law as miniature adults. However, in some areas the law treats the adolescent as an 'infant'. For example, an adolescent cannot enter into a contract to buy a car or vote in elections; an adolescent under 16 cannot consent to sex. On the one hand, in 2005 the US Supreme Court abolished the death penalty for all minors (under 18 years of age) and controversially ruled (Sarkar 2007) that (on the basis of the reduced capacity of children) there should be a categorical exemption for all minors. On the other hand, in some other aspects the law presumes full capacity for minors in all instances (as in tort law in the USA) or disregards the question of capacity altogether (as in judicial transfer or trying juvenile crimes in adult courts, again in the USA). Although this false dichotomy, or binary understanding of capacity, may sometimes make intuitive sense, it could easily be argued that things do not miraculously change on the day the child reaches 18. Much of what follows from these intuitive assumptions is based more on convention than empirical research. In this article I will examine the theoretical basis of capacity as applied to adolescents as a group and apply it in some commonly encountered clinical contexts.

Capacity as an ethical principle

The law cares for capacity out of respect for autonomy of the individual, which is assumed to be inviolable except under strictly defined circumstances. Bioethicists Beauchamp & Childress (2001) define capacity as 'the ability to perform a task'. Naturally, capacity is relative to the task. It is rarely the case that a person is incompetent in all areas of life; much more common is to find that even an impaired person is competent to make some decisions, but not others. Although as a group adolescents are more variable than adults in their understanding, processing and expression of choice, adults can also be remarkably different in terms of intelligence, cultural competence and overall understanding of life. The general thinking is that variations in the adolescent group are far more pronounced (and widely varying) than the differences one would find in adults as a group. It is therefore argued that adolescents need more protection and perhaps more stringent determination of capacity than adults as a group.

Rights follow from our unique ability as humans to reason and rationalise, but very few rights are unqualified or inalienable. Writing on liberty, albeit in Victorian England, even John Stuart Mill thought that rights are only appropriate for those who can exercise a rational choice ('only to human beings in the maturity of their faculties') and explicitly excluded children (Mill 1859: chapter 1). A century on, following on from the Civil Rights movement in the USA of the 1960s, new personal and civil rights have been carved out and have since been codified in law worldwide.

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†For a commentary on this article see pp. 12–14, this issue.

Issues in capacity and competence: the evolving law

Presence of capacity (and capacity to make even unwise decisions) is presumed in adults of sound mind. Capacity (as a medical discourse) is most often thought of as capacity to consent to or refuse treatment, and the General Medical Council (2007) has published guidance on assessing its presence or absence in children and young people. Capacity could, however, be better viewed as a social construct, used often in medicine (and psychiatry). Presumption of capacity to consent (or refuse) has not been widely debated in areas beyond medical treatment until relatively recently, when Appelbaum and colleagues investigated capacity to participate in medical research (Appelbaum 1999). One particular area in which capacity and the maturational process have been examined (and debated) a great deal is in criminal law, which we will look at later.

Case law

The principle issues governing capacity to consent to a medical procedure (intervention) in any person of doubtful capacity is derived from common law and was first enunciated in *Re C (Adult: refusal of treatment)* [1994]. C was a patient in Broadmoor hospital and refused operation on his gangrened leg based on the psychotic belief that he was a doctor and knew best. Although the surgeons warned him that without the operation he would most likely die, the Court gave him permission to refuse, finding that he was sufficiently competent to make that treatment decision. The operation never took place, but fortunately C did not die. Nevertheless, the ruling in *Re C* identified a number of planks on which capacity rests. In determining capacity one has to therefore ask a number of questions (Box 1). From these questions it can be seen that understanding is thought to be the central principle in terms of capacity, be it in adults or the so-called Gillick-competent child. In *Gillick v. West Norfolk and Wisbech Area Health Authority and another* [1986], Lord Scarman said: '[A] minor's capacity to make his or her own decision depends on the minor having sufficient understanding and intelligence to make the decision and is not to be determined by reference to any judicially fixed age limit'.

BOX 1 Questions for determining capacity to consent to or refuse treatment

- Does the patient understand why they need the intervention?
- Does the patient understand what the intervention involves and what it is for?
- Does the patient understand the probable benefits and risks and what the alternatives are?
- Does the patient have the ability to weigh up information based on the above and come to a rational decision, and can he express the decision so reached?

Developments in rights of the adolescents

A change in societal outlook (and considerable pressure from the Council of Europe (2000: Addendum, para. 8.1), who demanded that adolescents need more, not less, protection than adults) has meant that there is now the provision of older adolescents (16- to 18-year-olds) being able to consent to (and refuse) treatment. Children of this age group can be treated (for mental disorders) over their objection with parental consent only up to the first 28 days, after which the case is automatically referred to a tribunal. An adolescent over the age of 16 is also regarded as an adult for 'community treatment' (non-hospital but compulsory) and is afforded for the first time the same safeguard as adult community patients (Section 64E(1)(b) of the Mental Health Act 1983, as amended in 2007).

In the end it would appear that neither parent nor child has an exclusive veto, or for that matter, a right, to consent. The doctor is free to act on either and free to choose between the warring parent and child when there is conflict. Only if both 'key holders' refuse will the door remain locked. Hence the concept of the 'flak jacket' of Lord Donaldson who said so succinctly: 'Anyone who gives him a flak jacket (that is consent) may take it back, but the doctor only needs one and so long as he continues to have one he has the right to proceed' (*Re W (A minor) (Medical treatment)* 1992: para. 635).

Capacity in practice

It is indisputable that there are basic conditions that underlie the search for a concept of variable competence. The competence-limiting conditions set out in Box 2 are applicable to both adolescents and adults. For the reasons stated earlier, the issues are more acute in adolescents. Based on the principles in Box 2, clinicians faced with a dilemma about competence and capacity should assess a juvenile patient's appreciation and understanding of the situation. Procedures therefore should involve a detailed examination of the patient's understanding not only of the procedure, but also of the wider consequence of their decision.

It is therefore essential that this information be provided in a form that the juvenile patient can understand. Understanding is the central plank of the Gillick competence (and in all other models of capacity), so it is imperative that the child's

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BOX 2 Competence-limiting conditions

Limits of consciousness

Consciousness spans a wide spectrum, at one extreme of which we find someone to be unconscious. In that event, the matter is straightforward and capacity is assumed not to be present. What complicates matters is what to do with an unconscious patient in terms of usurping their capacity. Here the 'sliding scale' begins to operate. The question then becomes, 'Is the person going to be unconscious forever, for long, or are they expected to regain consciousness soon?' What is at stake to invoke the procedure? One can think of many a juvenile confronted by the police who, although not technically unconscious or incontinent from fear, is under the influence of one or more psychoactive substance (not excluding alcohol), which ought at least to trigger a doubt in the mind of a person assessing capacity to consent, at least for the time being.

Limits of intelligence

Similarly, if we leave the extremes of intelligence aside, one may experience the quandary about who decides what degree of manifest intelligence is enough to offer the child a choice about treatment or intervention.

Limits of rationality

For the sake of argument, if the severely disabled person is incompetent, so must be the gifted toddler. However clever a toddler is, his (or her) grasp of the problem and his perception of the world and his place in it are too limited. It could also be because he lacks the requisite moral and psychological development that he is deemed to be incompetent. In this example doubts arise not because he is not intelligent, but because there are many more components to reasoning and intelligence than the simple ability to learn.

Limits of knowledge and perception

Take the analogy of knowing and seeing to a real-life situation. It is easy to see that if a blind man walks into traffic and gets hit by a car, it is not because he does not know that roads are dangerous places. Roads can be dangerous places even for those with the gift of vision. It is essentially because he does not see the danger coming. It is a rather crude analogy but it demonstrates that knowledge alone (without perception and context) is not enough of a determinant of competence.

(Adapted from Gaylin 1982)

understanding be checked. This may involve explaining what is proposed in language that is suited to the child's age and abilities, or by using pictures, toys and play activity. Often it would be essential to draw 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 their concerns, fears and expectations, however unreasonable they might seem to the examiner. In cases where the child's language is different from that of the examiner, an interpreter may be needed.

Capacity in another dimension: criminal justice

It is common knowledge that to assist their lawyer and make adequate decisions as to a criminal justice proceeding, a youth (like an adult) would need to have a basic capacity to express their ideas logically and coherently, manage anxiety and frustration, concentrate on what others were communicating, use available information to assess various possible trial strategies and make informed decisions with an understanding of the long-term implications.

The concept of legal protection of the juvenile offenders first emerged in the USA in the landmark case of *Re Gault* (1967). The court noted:

> Neither the Fourteenth Amendment nor the Bill of Rights is for adults alone… A juvenile charged with delinquency is entitled to have the court apply those common law jurisprudential principles which experience and reason have shown are necessary to give the accused the essence of a fair trial.

To be deemed to have adjudicative competence (no equivalent phrase exists in the UK), defendants must understand the charges against them, have some rudimentary understanding of the court proceedings, be able to understand and answer questions posed to them by their attorney and be able to make basic decisions about their trial, such as weighing the consequences of accepting or turning down a plea agreement. In equivalent terms, this roughly corresponds to an unsophisticated (and unsatisfactory) mixture of the Pritchard criteria for fitness to plead and fitness to stand trial (Box 3). However, one must remember that both the Pritchard criteria and the criteria for fitness to stand trial are age-neutral, i.e. applicable to all ages.

BOX 3 Tests of fitness to plead

In England and Wales, the legal test of fitness to plead is based on *R v. Pritchard* (1836). The accused will be unfit to plead if they are unable to either:

- comprehend the course of proceedings during the trial so as to make a proper defence;
- know that they might challenge any jurors to whom they may object;
- comprehend the evidence; or
- give proper instructions to their legal representatives.

In Scotland the test is based on *HMA v. Wilson* [1942], and has two elements:

- to be able to instruct counsel; and
- to understand and follow proceedings.

Fitness to plead *v.* effective participation in trial

Fitness to plead for an adult and 'effective participation' in trial are not the same thing. In *Kunnath v. The State* [1993] the Privy Council stated that:

> It is an essential principle of the criminal law that a trial for an indictable offence should be conducted in the presence of the defendant. The basis of this principle is not simply that there should be corporeal presence but that the defendant, by reason of his presence, should be able to understand the proceedings and decide what witnesses he wishes to call, whether or not to give evidence and if so, upon what matters relevant to the case against him.

However unsatisfactory the current arrangements might be in the UK, adolescents are required, in essence, to have full capacity to participate in legal proceedings (and to be compliant with Article 6 of the Human Rights Act 1983). One must have some rudimentary understanding of the court proceedings, be able to understand and answer questions posed by their defending lawyer and be able to make basic decisions about the trial, such as weighing the consequences of accepting or turning down a plea agreement. In *T v. United Kingdom* [2000], the European Court stated clearly: 'In conclusion, the Court considers that the applicant was unable to participate effectively in the criminal proceedings against him and was, in consequence, denied a fair hearing in breach of Article 6 §1'.

Although historically people who have been found impaired or incompetent to stand trial have had mental illness or intellectual disability ('mental retardation'), developments in neurobiology (e.g. see Sowell 2001; Steinberg 2009) have suggested that this group should include juveniles. The current thinking in the USA is that juveniles lack adjudicative capacity not because they have a mental illness or intellectual disability, but because they lack sufficient intellectual and emotional maturity. I propose that these attributes can be extrapolated into the current vexing issue of consent to give a voluntary DNA sample to assist the police in their investigation. On 31 March 2009, the UK was holding the DNA profile of 568 612 children between 10 and 15 years of age (National Policing Improvement Agency 2009), and is the only Western democracy to do so.

BOX 4 Assessing competence using the MacArthur Competence Assessment Tool

Understanding	Assessment consists of questions regarding factual knowledge of trial information and the roles of those involved. This is the minimum requirement for the fitness to plead or Pritchard criteria.
Reasoning	This section asks the defendant to choose the more relevant between two pieces of information related to a hypothetical court case and to make a plea decision for the main character. The examinee's response is scored based on the choice and on the reasoning supplied for it. This score provides information relevant to the examinee's ability to consult their lawyer.
Appreciation	These questions assess the examinee's ability to recognise how aspects of the legal system apply to their case and attempt to assess the defendant's implausible or delusional thinking related to the case.

Available options for competence testing in adolescents

The MacArthur Competence Assessment Tool – Criminal Adjudication (MacCAT–CA; Hoge 1999) and its lesser known and less validated UK version, the MacArthur Competence Assessment Tool – Fitness to Plead (MacCAT–FP; Akinkunmi 2002), are structured interviews that assess abilities related to an individual's competence to stand trial or fitness to plead. The measurements are rooted in theory, with standardised administration and scoring and strong psychometric properties, and involve the assessment of abilities beyond just legal knowledge. Although relatively new (it originated in 1998, after 3 years of field trials), the MacCAT–CA is backed by robust research and validation. Administration involves the presentation of a hypothetical crime situation followed by subsequent structured questions tapping three areas (understanding, reasoning and appreciation; Box 4), which yield three separate scores. In many ways, this is more satisfactory than the perfunctory Pritchard test, which may serve adults well, but does not do justice to juveniles. Although the MacCAT–CA was not developed for use with adolescent populations, it has been used as a research measure with adolescents in a number of research studies involving large sample sizes (e.g. Grisso 2003). Some normative data should be available soon. Although years have passed since the European Court judgment in *T v. United Kingdom* [2000], noticeable changes are still awaited. For those who venture into the complex legal arena of youth justice, some sort of structural and replicable test can only be welcome.

Politics, science and law: capacity in another dimension

The more stunning changes, such as abolishing the rebuttable presumption that children aged 10–14 cannot be held responsible for their actions, were not based on empirical research. The age of criminal responsibility (as a conclusive or irrebuttable presumption) has seen progressive upward revision, from age 7 in common law, to age 10 in the Children and Young Persons Act 1963. Although it was commonly thought that the Crime

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and Disorder Act 1988 abolished the concept of presumption of *doli incapax* (literally meaning incapable of evil) in children above the age of criminal responsibility, the effects were thought to be minimal in practical terms. Strictly speaking, only the rebuttable presumption (*praesumptio iuris tantum*) has been abolished through this Act and the age of criminal responsibility still stands at 10 in England and Wales. However, the abolition of the presumption of *doli incapax* is symbolic because it appears to lower the threshold of protection and is seen as an attempt to undermine the distinction between childhood and adult criminal responsibility. Society's tolerance of the young offender varies with time. Both reason and experience (by which I do not mean empirical evidence, which is still emerging) are used as justice for what is little more than political rhetoric.

Physical development and capacity

What every parent knows is well documented in psychological research, i.e. that the period between the ages of 12 and 18 is a time of significant physical, cognitive and emotional development. Physically, the brain grows and maturation or myelination take place at a rapid pace in the adolescent years. Advances in functional imaging confirm that a young child's brain is very different from that of an older child. Temporal lobes and the prefrontal cortex, the areas associated with mature reasoning and self-control, do not develop fully until late adolescence. Several research studies, most notably by Grisso and his team (Grisso 2003, 2006), have shown that although adolescents may engage in adult-like reasoning, they seldom reach the 'right results'. For example, an adolescent's outcome may differ from an adult's because of peer influence and perception of risk. Adolescents engage in more risky behaviour than adults not because they do not see the risk of their conduct, but because they believe that other factors outweigh the risk.

Neurologically, higher cognitive functioning (often called executive functioning) is thought to be developing through adolescence and is rarely achieved until mid- to late adolescence. These higher functions involve planning and organisational skills, emotional impulse control and the ability to consider alternative solutions to problems. Support for this comes from another case in the US Supreme Court debating the death penalty for juveniles. In *Eddings v. Oklahoma* (1982) the Court cancelled the death sentence, not on that occasion because it considered the death penalty to be fundamentally unconstitutional, but because the trial court had failed to consider age as a mitigating factor. Justice Powell, writing for the Court said:

> [Y]outh is more than a chronological fact. It is a time of life when a person may be the most susceptible to influence and psychological damage. Our history is replete with laws and judicial recognition that minors, especially in their earlier years, generally are less mature and responsible than adults.

Development in mid-adolescence

By mid-adolescence, most young people generally reach a level of intellectual ability to use abstract thinking and deductive reasoning. They have developed expressive and receptive language to interact with others in a 'verbally competent' manner and have greatly increased ability in their attention (and concentration) span on tasks that are presented to them. Their short- and long-term memory functioning has solidified. However, decisions become increasingly focused on longer-term consequences (rather than the short-term fixes employed by the younger child) only as the individual gets older. Ironically, as adolescents develop an increasing sense of independence, autonomy and identity formation, they often are more influenced by their peers.

Despite the scientific evidence, the matter is far from settled, as can be seen from the following dissenting judgment from one of America's most influential jurists, Justice Antonin Scalia. In a scathing dissent in *Roper v. Simmons* (2004), he wrote:

> We need not look far to find studies contradicting the Court's conclusions. As petitioner points out, the American Psychological Association (APA), which claims in this case that scientific evidence shows persons under 18 lack the ability to take moral responsibility for their decisions, has previously taken precisely the opposite position before this very Court. In its brief in Hodgson v. Minnesota, 497 U.S. 417 (1990), the APA found a 'rich body of research' showing that juveniles are mature enough to decide whether to obtain an abortion without parental involvement. Brief for APA as Amicus Curiae, O. T. 1989, No. 88—805 etc., p. 18. The APA brief, citing psychology treatises and studies too numerous to list here, asserted: '[B]y middle adolescence (age 14–15) young people develop abilities similar to adults in reasoning about moral dilemmas, understanding social rules and laws, [and] reasoning about interpersonal relationships and interpersonal problems.' Id., at 19–20 (citations omitted). Given the nuances of scientific methodology and conflicting views, courts – which can only consider the limited evidence on the record before them – are ill equipped to determine which view of science is the right one.

Adolescent's capacity in criminal justice scenarios: what the science says

There seems to be some consensus developing among practitioners in youth justice that an adolescent's capacity is something to be explored and not taken for granted. To address these

questions, the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice conducted the first large-scale (1400 individuals aged 11–24 across four centres in the USA) study of age differences in competence to stand trial (Grisso 2003).

The findings of the MacArthur study clearly showed that adolescents aged 11–13 were more than three times as likely as young adults (individuals aged 18–24) to be 'seriously impaired' on legal (adjudicative capacity) abilities and that adolescents aged 14–15 were twice as likely as young adults to be seriously impaired. The study found that adolescents aged 15 and younger also differed from young adults in their legal decision-making. A particular example is often quoted in the literature where younger individuals were less likely to recognise the risks inherent in different choices and less likely to think about the long-term consequences of their choices (Cauffman 2000). This choice could be, for example, in choosing between confessing *v.* remaining silent when being questioned by the police.

The results of the MacArthur study indicate that, taken at its lowest, when compared with adults, a significantly greater proportion of adolescents (aged 15 or younger) in the community, and an even larger proportion of youth offenders of this age group, is probably not competent to stand trial in criminal proceedings. This is in addition to the fact that adolescents of below-average IQ are especially at risk of being incompetent to stand trial.

Conclusions

Whatever the context of a capacity assessment, be it for consent to treatment (or refusal), adjudicative competence or other social contexts (such as contraception, abortion or agreeing to give a voluntary DNA sample to assist the police), the essential thing is a contract. This is akin to a kind of social contract from which even convicted criminals are not immune. The first essential of a contract is that there must be *consensus ad idem*, that is, the parties must be of the same mind. This means, for instance, that when A is contracting to buy a car from B, both A and B have in mind the same car. Similarly, a party may deny a contract on the grounds that it is in effect not his deed (*non est factum*) – for instance because he could not read and had been misinformed about what he was signing. If a child (or someone acting for him) found that he had signed a contract fundamentally different from that which he believed it to be, he could disclaim it by pleading *non est factum* or that there was no *consensus ad idem*. It is then imperative that this fundamental ability be established beyond doubt before entering into a contract, whether it is treatment or other forms of social contract.

MCQ answers
1 a 2 d 3 c 4 d 5 c

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Advances in psychiatric treatment (2011), vol. 17, 5–11 doi: 10.1192/apt.bp.108.006254

MCQs

Select the single best option for each question stem

1 The current thinking on adolescent capacity to consent is:
a to be found in the General Medical Council guidance *From 0–18 Years: Guidance for All Doctors*
b that capacity does not exist when the choice expressed is plainly foolish
c that consent need not be knowing, intelligent and voluntary
d that capacity is always needed, even in an emergency
e not found in any Department of Health document.

2 In determining capacity the following factors are important:
a educational achievement
b social class
c the age of the person
d the ability to express a choice
e that a person can have partial capacity.

3 The MacArthur study on juvenile capacity has shown that:
a capacity in adolescents can be taken for granted, as in adults
b younger adolescents (11–13 years old) are as 'impaired' in their legal abilities (adjudicative capacity) as the older youth (18–24)
c adolescents' impairment in legal abilities is related to intelligence
d younger individuals are as likely as adults to think about long-term consequences
e in community samples, adolescents are no more impaired in fitness to stand trial than are adults.

4 Gillick competence:
a is inviolable in all matters regarding children
b was named after Lord Gillick
c was a death knell for parental rights
d Gillick competence depends on a minor having sufficient understanding and intelligence to make the particular decision
e only applies to girls below the age of consent (16 years) seeking contraception.

5 Adjudicative competence:
a is the same as 'fitness to plead' (Pritchard) criteria
b is immaterial in adolescents involved in serious crimes
c can be compromised in mental illness
d is presumed to be absent in mental impairment
e is not compromised by age-related immaturity.

IN OTHER WORDS

Excerpt from *Letters to Felice*, by Franz Kafka

Selected by Femi Oyebode

Now consider, Felice, the change that marriage would bring about for us, what each would lose and each would gain. I should lose my (for the most part) terrible loneliness, and you, whom I love above all others, would be my gain. Whereas you would lose the life you have lived hitherto, with which you were almost completely satisfied. You would lose Berlin, the office you enjoy, your girl friends, the small pleasures of life, the prospect of marrying a decent, cheerful, healthy man, of having beautiful, healthy children for whom, if you think about it, you clearly long. In the place of these incalculable losses, you would gain a sick, weak, unsociable, taciturn, gloomy, stiff, almost hopeless man who possibly has but one virtue, which is that he loves you. Instead of sacrificing yourself for real children, which would be in accordance with your nature as a healthy girl, you would have to sacrifice yourself for this man who is childish, but childish in the worst sense, and who at best might learn from you, letter by letter, the ways of human speech. Any you would lose in all the small things, all of them.

Franz Kafka (1883–1924) studied literature and medicine before turning to law. He graduated from Charles-Ferdinand University of Prague with a doctorate in law in 1906. He is probably best known for his novel *The Metamorphosis* (1915).This excerpt is from a letter to Felice Bauer, with whom Kafka was associated and engaged in 1912–1917. Reprinted (1978) by Penguin Books in *Letters to Felice* (eds E. Heller, J. Born; trans J. Stern, E. Duckworth).

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