



College of
Registered
Psychotherapists
of Ontario

Quality Assurance Program

Informed Consent Workbook

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Introduction

This workbook provides a detailed review of informed consent, including related laws, principles and concepts. It will help psychotherapists understand what kind of information should be imparted to clients so they are able to provide consent that is informed and may help psychotherapists identify situations where a client is not able to provide informed consent, whether this is due to the client's capacity, challenges in communication or insufficient information.

Scenarios are included to ground the content of this workbook in the practice of psychotherapy and exercises have been incorporated to help you practice your knowledge, skill and judgment.

Important Information

This workbook is intended as an educational resource. It does not constitute legal or clinical advice. Where you have specific concerns about your professional obligations, please consult with a lawyer, supervisor or other qualified professional.

Section 1 – Consent as a Legal Concept

As a member of the College of Registered Psychotherapists of Ontario (CRPO), you engage your client in a collaborative therapeutic process. Taking into consideration the nature of your practice and the circumstances of the client, you may also work collaboratively with the client's family members/loved ones, their health-care team and community agencies and services. While your interactions with the client and others involved in their care are a routine part of your practice, the information that is collected and shared within these inter-relationships requires careful management.

In Ontario, clients (or their substitute decision-makers) have the right to make their own choices about their health and wellbeing, including how their personal information is collected and shared with others. As a founding principle of ethical health care, informed consent is both an ethical and legal concept, requiring health professionals to abide by related laws and professional obligations.

The laws that set out the requirements pertaining to informed consent also set out the consequences for professionals who provide treatment without a client's informed consent. There are repercussions for professionals who collect, use or disclose a client's personal health information without first obtaining their informed consent. The consequences can be serious and could include criminal charges, civil suits and findings or actions issued by the body that regulates the profession.

Seeking a client's informed consent:

- protects the client's right to "security of the person," as enshrined in the Canadian Charter of Rights and Freedoms;
- enhances communication and builds trust between the health professional and the client (this relationship is legally called a 'fiduciary relationship'); and
- is a risk management measure for the health professional. By assuring the client has provided informed consent, the professional is managing risk as this relates to potential complaints or litigation.

Consent Laws

There are three main laws that set out the requirements of consent in Ontario:

Health Care Consent Act, 1996 (HCCA), which addresses consent and capacity as it relates to treatments. Among other things, it defines a person's right to consent to or refuse treatment.

Personal Health Information Protection Act, 2004 (PHIPA), which sets the requirements for the collection, use and disclosure of a client's personal health information by a health information custodian. It also defines a client's right to consent to the collection, use or disclosure of their personal health information.

Substitute Decisions Act, 1992 (SDA), which sets out the role and responsibilities of a substitute decision maker and provides safeguards to protect incapable people from harm.

Below are examples of situations where a member may need to consult with a particular law. The laws that are particularly relevant in the situation appear in **bold**.

HCCA: From the time a client initiates therapy, and in particular, before the client and therapist begin the therapeutic process.

HCCA: Where the therapist is of the opinion that changes to the therapeutic plan are beneficial or necessary.

PHIPA: When a therapist collects information about a client, including name, address, health card number, details about the client's health, and information about the care provided to the client. (This, along with other information, is defined as "personal health information" in the Act.).

PHIPA: When a therapist refers a client to another health care professional.

HCCA and SDA: When a therapist has reason to believe that a client may not be capable of providing consent for one or more aspects of therapy.

PHIPA and SDA: When a therapist collects the personal health information of a client and the client is not capable.

A Closer Look

Health Care Consent Act (HCCA)

- Outlines the principles for obtaining and withdrawing informed consent for treatment, admission to a facility and personal assistance services.
- Defines "capacity" and "capacity evaluation."
- Lists the substitute-decision maker's hierarchy.
- Presents the client's right to withdraw consent.
- Outlines exemptions under emergency situations and for crisis admissions.
- Defines and sets rules for a formal capacity evaluation.

A Closer Look

Substitute Decisions Act (SDA)

- Covers financial or property management decisions and decisions about personal care, which include health care, food, housing and safety.
- Outlines the responsibility of the substitute decision-maker (SDM).
- States that a SDM must be at least 18 years of age for matters related to property, and at least 16 years old related to personal care decisions.
- Allows people to designate someone to make personal care or financial decisions for them if they become incapacitated, through a legal document called a Power of Attorney (POA).

A Closer Look

Personal Health Information and Protection Act (PHIPA)

- Applies to all types of health-care settings, including: publicsector organizations (e.g. hospitals, psychiatric facilities), private businesses (e.g. pharmacies, long-term care homes), health-care professionals.
- Provides rules related to the collection, use, release, storage, security and destruction of personal health information.
- Defines “personal health information.”
- Defines both the “custodian” and the “agent” of health information.
- Gives patients the right to access to their health records and to decide how their health information is used.

Before you continue, assess your current level of knowledge on informed consent using the Informed Consent Self-Check below.

Key Points from Section 1

- *Clients have the right to make choices about their own health care.*
- *Informed consent is a matter of both law and ethics.*
- *There are consequences if a professional provides treatment without a client’s informed consent.*

Informed Consent Self-Check

Use this tool to quickly assess your current level of knowledge on informed consent. You will revisit these questions again at the end of the workbook, which will help you see where your knowledge has been enhanced.

Informed Consent Self-Check Questions	Not at All	Somewhat	Fully
I can explain the process for obtaining informed consent.			
I know when I must obtain informed consent.			
I understand that obtaining a signed consent form is different than engaging the client in the informed consent process.			
I understand consent must be informed, voluntary, and obtained from a client who can understand the information I am sharing.			
I understand my role in determining the client's capacity to provide consent.			
I know there is a hierarchy of people that can be substitute decision-makers.			
I know that my client can withdraw consent at any time.			
I recognize when I need to revisit consent, and I understand that consent is an ongoing process.			
I know that I am required to document the consent process.			

Section 2 – Consent to Treatment

Informed consent involves two-way communication between the member and client, where the member is responsible for providing sufficient information so that a client (and/or their substitute decision-maker) is able to agree to or refuse treatment.

Treatment, according to Section 2 (1) of the HCCA is, “anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose...”

A client who consents is agreeing to engage in (or receive) the treatment proposed by the member. Clients have the right to refuse a proposed treatment and are entitled to withdraw consent at any time.

Duty to Provide Information

According to the HCCA, health-care professionals are required to provide information about:

- the nature and purpose of the proposed treatment and/or assessment;
- benefits;
- material risks, including foreseeable costs and any limitations to the treatment or assessment;
- effects of the treatment or assessment, particularly those that a client might consider uncomfortable or undesirable;
- alternative options available; and
- consequences associated with refusing the treatment or assessment.

In addition to the requirements of the HCCA, CRPO requires that members represent their qualifications and services transparently and accurately in interactions with clients, and more broadly, when working in a professional capacity.

A Closer Look

Dual Registration

If a member is registered with more than one regulatory body (e.g. a member who is registered with the College of Naturopaths of Ontario and CRPO), the member’s clients must be made aware of the member’s dual roles.

If treating a client in both capacities of the dual practice, it must be clear to the client when the member is operating as a psychotherapist and when they are operating in their other professional capacity.

Taking some time to clarify the distinction in roles supports informed consent.

Information provided during the informed consent process can be relayed to the client by spoken or manual communication (e.g. sign language) or in writing. If information is provided in writing, the member must take care to ensure the client understands the written information, and the client must be provided the opportunity to seek and obtain clarification.

Members should be reasonably aware of, and sensitive to, individual client concerns and/or interests, such as strongly held values or beliefs, or even certain personal considerations. For example, a client ascribing to a particular religion would want to know if an aspect of the intervention would violate their beliefs.

Another relevant consideration is the degree of risk that a particular intervention, technique, method or approach presents to the client. A higher level of risk to the client's health and well-being calls for a more detailed discussion with the client about the therapy, the member's qualifications and area of practice, potential benefits and risks, limitations, possible outcomes, and alternatives.

Examples of higher risk situations include those where:

- a client presents a risk of harm to self or others;
- a client is at risk of being abused or neglected;
- it is known or likely that a client will experience significant distress during therapy or as an effect of therapy;
- complex or specialized methods, techniques or interventions are used (e.g. exposure therapy, eye movement desensitization and reprocessing, concurrent disorders);
- there is a specific consequence associated with providing or refusing consent (e.g. a client will lose her job for failing to participate in therapy due to an agreement between the client and her employer, therapy is a term of a custody order and custody will be impacted if the client refuses to participate);
- a mandatory report to a children's aid society may be necessary; or
- the member is providing therapy to a health professional who discloses sexual abuse of a patient or client.

If such considerations are ignored by the member, the consent given by the client may not be informed.

What Makes Consent "Informed"?

Consent is considered informed if the person making the decision received all information that a reasonable person in the same circumstances would require in order to make such a decision, before voluntarily agreeing to the intervention. This information must also include responses to questions and requests for additional information. Case law (*Reibl v Hughes, 1980*) indicates that health professionals should consider the sufficiency of the information provided to a client during the informed consent process from the client's perspective; it is not about what a reasonable health-care professional would disclose, but what a reasonable person in the client's position would want to know.

Practice Snapshot

Isabella, an RP, proposes that her client Liam—who has indicated that he is overwhelmed in groups—go on a full-day rural retreat. After Liam arrives at the site, he learns that there will be strictly enforced rules of total silence. Isabella was afraid Liam would not go if he knew about the strict silence. There is no way for Liam to leave and he finds the silence emotionally excruciating.

Liam complains to CRPO. Isabella defends her actions by explaining that she felt that Liam had provided implied consent. He did not refuse what she had proposed; he simply said he felt overwhelmed in groups.

The Inquiries, Complaints and Reports Committee (ICRC) issues a decision critical of Isabella for not obtaining informed consent because:

- she did not explain the nature of the retreat and how the retreat would help Liam;
- she did not set out alternatives;
- she misrepresented the benefits of the retreat, as there was little evidence to support her view that a strict regime of total silence would help Liam; and
- she did not explain the risks, including the potential for emotional or psychological distress, of attending a retreat where silence was required.

The HCCA identifies four elements of consent:

The consent must relate to the treatment. The member must seek consent for a specific purpose, and the consent applies only when used for the intended purpose.

The consent must be informed. The client must have sufficient information to make a decision and must have the opportunity for their questions to be answered.

The consent must be given voluntarily. It must be clear that it is the client's choice to refuse or consent to services. A client cannot be coerced to provide consent.

The consent must not be obtained through misrepresentation or fraud. The client must be provided with information that is accurate and factual. Opinions expressed by the member should be based in truth and fact.

According to the HCCA, one health professional is allowed to obtain client consent for a plan of care on behalf of all members of the health team involved in providing care to the client. Members of CRPO must be assured that the person who obtained the client's consent did so in accordance with requirements and that the client's consent was informed. Otherwise, members must acquire the client's informed consent independently. See section 3 of this workbook, "Consent to Collect, Use and Disclose Personal Health Information," for more information about sharing (or disclosing) client health information in a health team context.

Some common situations where consent may apply to a team of professionals involved in the client's treatment include upon admission to a residential treatment centre or long term care facility, or when a client is engaged in community-based mental health care.

A Closer Look

Characteristics of Consent

- The member has provided truthful and accurate information that relates to the proposed treatment.
- The client received all the information that a reasonable person in the same circumstances would require in order to make such a decision, including responses to questions.
- There is reason to believe the client understood the provided information.
- The client voluntarily agreed.
- The client consented before treatment was provided.

Initial Informed Consent Process in Three Steps

1. The first step in the informed consent process is to determine if the client is capable of providing consent. This can be as simple as developing an awareness of the signs of incapacity and observing the client for these signs from the earliest interaction. If there is no reason to believe the client would be incapable of providing informed consent, move on to the next stage in the process. (More information on consent and capacity appears later in this workbook.)
2. The next stage involves gathering general information about the client's concerns, providing detailed information about the proposed treatment, responding to the client's questions and taking reasonable measures to assure the client understands the information. See the previous section, "Duty to Provide Information," for a description of the information that is shared with clients during this stage.
3. Finally, the member must ascertain whether the client consents to the treatment proposed. The HCCA says that a client's consent can be explicit or implied. These forms of consent will be discussed later in this section.

It is common for health professionals to provide service agreements, consent forms or other types of prepared materials to explain the services and describe the rights and responsibilities of the client and health professional. Prepared materials are useful in setting some structure to the informed consent process, for example, by listing the matters that members and clients must address. However, in and of themselves, these materials are not an adequate substitution for a thorough discussion between the client and the therapist. Unless there is a reason to rely on written communications to obtain a client's informed consent, members should expect to engage the client in a discussion where the member provides information and takes steps to ensure the client understands the information.

A Closer Look

The client's signature – does it mean consent was given?

Some professionals mistakenly believe that a client's signature on a consent form demonstrates that the client has provided informed consent. Members must be aware that a client's signature on a document does not constitute informed consent.

Members must document the informed consent process, including whether consent was provided, in the client's clinical record.

Ongoing Consent

Informed consent begins in the member's initial interactions with a client, where the member seeks consent to engage the client in therapeutic assessment and treatment. It does not end there, however. Members are required to seek and obtain informed consent at various points in the therapeutic process. For example:

- where it is reasonable or necessary to modify the therapeutic plan;
- where the member thinks it is reasonable or necessary to refer the client to another health care or service provider; or
- in cases of information or reports provided to third parties (e.g. family members or insurance providers), unless consent is not required by law.

To summarize, consent should be thought of as an ongoing dialogue between the member and client, where the member recognizes those situations where it is prudent or necessary to obtain informed consent, and acts to acquire it.

Client's Communication of Consent

A client can communicate their consent explicitly or implicitly. Consent that is provided in writing or using spoken or manual language is considered explicit. Consent is considered implied when a therapist infers the client's consent based on the client's communication cues, such as gestures, facial expression and posture.

There are advantages and disadvantages associated with each form of consent, and depending on the member's practice context, the situation, client factors, and degree of risk, some types will be preferable to others. For example, where there is a higher degree of risk to the client and/or higher risk of liability for the member, it may be prudent for the member to obtain written consent. Where risk is lower, verbal and implied consent are acceptable. There are exceptions. For example, in an emergency situation where a client cannot explicitly communicate their consent due to injury, a member can rely on implied consent.

Regardless of the manner in which a client's consent is communicated, members must ensure that the client has been provided sufficient information so that consent is informed.

Practice Snapshot

Margot, a client with a cocaine addiction, was referred to an addiction clinic by her probation officer. During an initial discussion with the clinic's psychotherapist, Margot learned about the different program options, including residential versus day treatment, female versus co-ed and the length of the programs. The psychotherapist explained that the terms of Margot's probation required that she participate in some form of treatment, and that he was required to report certain information to the probation office. He further explained that Margot could refuse treatment, but doing so might be considered a breach of the terms of her probation. Eventually, Margot decided on attending a short-term residential program.

On the day of admission to the clinic, Margot declined to be admitted. The psychotherapist explained that he was required to report to the probation office if Margot refused treatment.

Margot clarified that she didn't want to be in residential treatment because she wanted to be available for her kids when they came home from school. The psychotherapist modified Margot's treatment plan so that Margot could attend intensive day treatment, supported by community meetings.

In this scenario, Margot initially provided informed consent. However, after further consideration, she withdrew her consent. After considering the reasons for her withdrawal of consent and exploring other options, Margot and her therapist were able to work together to find a plan that met Margot's needs. With Margot's consent, the therapist could proceed with the revised plan.

Written: Written consent provides some physical evidence that a client gave his or her consent, which can be an advantage in cases where a member has provided sufficient information to assure the client's consent is informed. Members who rely on written consent forms or service agreements as evidence of consent, must either:

- engage the client in an informed consent discussion before asking for the client's signature; or
- provide a form in advance, ensuring that it contains enough information for the client to fully understand the information presented. In this case, a client must have the opportunity to ask questions and receive responses before providing a signature.

A client who signs a form without actually understanding the information provided has not provided informed consent. Documentation of consent must be retained in the clinical record.

Spoken or Manual: A client may give consent verbally or manually after the therapist has provided sufficient information so that the client’s consent is informed. As with written consent, the member must be reasonably assured that the client understands the provided information.

Where a client has communicated consent verbally or manually, the member must note relevant aspects of the informed consent discussion in the clinical record. Such notations, which are required by CRPO’s record-keeping standards, can benefit the therapist as they provide useful information about the consent process for any assessments, treatments, changes to the therapeutic plan and sharing of information, etc. that were proposed to the client.

Implied: In some situations it is acceptable for a member to infer that a client has consented based on their communication cues. For example, in the Practice Snapshot immediately below, the client simply nods her head (a gesture) to communicate that she consents to the therapist beginning an assessment.

The main disadvantage of relying on implied consent is the potential for miscommunication. Implied consent relies on a mutual understanding of the meaning of a communication cue. Since factors such as culture and client comfort can influence the meaning of communication cues, members should exercise caution. The most common issue that occurs when a health professional relies on implied consent is that the professional believes that the client understands the information provided, when the client does not.

Practice Snapshot

Ava, an RP, meets a new client, Emma. Emma complains about feeling stressed and tired. After some discussion, Ava says, “I would like to better understand your personal and family background and your health history. There could be a lot of things making you feel tired and stressed, and this information will help me understand what you’re going through. If you are uncomfortable with any of my questions, please let me know. Are you okay if we get started?” Emma nods her head.

Nodding is a common gesture that indicates “yes.” Based on this communication cue, Ava assumes that she obtained implied consent to proceed. Ava must take care to recognize any changes to Emma’s communication cues and reaffirm consent at appropriate intervals during the session.

Practice Snapshot

Dante, RP (Qualifying) has been working with a client for a few months. He explains to the client that, based on some information that has come out of their latest session, it may be helpful to make adjustments to the therapeutic plan. Dante proposes adding additional goals to the plan, and suggests that the client engages in group therapy in addition to the individual therapy already taking place. As Dante is talking, the client frequently nods.

Knowing that nodding is a communication cue that can have more than one meaning, for example, "I'm listening and interested in what you're saying" vs. "I agree with what you are saying," consider what the client might be communicating to Dante in this situation. In this situation, relying on implied consent is likely not sufficient. Dante can identify whether he has the client's consent simply by asking "What do you think about this" or "Are you ok with these suggestions?"

Practice Snapshot

An RP working at a long-term care facility met with a new resident to share information about the weekly group therapy sessions offered at the facility. The RP provided information about the purpose of the group therapy, how the group may benefit the resident and the option to see the RP in one-on-one sessions. At the end of the discussion the resident said he was not interested in attending the group therapy.

The next week, the resident showed-up at the group session, but watched and didn't engage in any discussion. After attending a number of sessions in this manner, he finally shared a story about a past experience during a session. Over the following weeks, the resident became increasingly engaged and therapeutic goals were identified.

In this scenario, the RP recognized that the resident was providing implied consent through his communication cues of attendance and increasing engagement. As the resident began to participate in the therapy with increasing engagement over a number of sessions, the RP saw this as a cue that the resident was consenting to treatment.

Because the RP had provided information about the group therapy sessions in advance, and the resident had many opportunities to ask questions during the initial discussion and during sessions, the RP concluded that informed consent was obtained.

Key Points from Section 2

- *Informed consent involves two-way communication between a member and the client.*
- *Consent is an ongoing process; clients have the right to withdraw consent for any aspect of treatment at any time.*
- *Health professionals have a duty to provide information to clients and to ensure this information is understood by the client.*
- *Members must be attuned to circumstances that warrant a more detailed informed consent discussion.*
- *Consent is considered informed if the person making the decision received all information that a reasonable person in the same circumstances would require in order to make such a decision, before voluntarily agreeing to the intervention.*
- *In some situations, one health-care professional may obtain consent on behalf of the team of health-care professionals who are involved in the care of the client.*
- *There are different ways to communicate consent; each has its own advantages and disadvantages.*

Section 3 – Consent to Collect, Use and Disclose Personal Health Information

As described earlier in this workbook, PHIPA sets the requirements for the collection, use and disclosure of a client's personal health information by a health information custodian. "Health information custodian" is a term defined by PHIPA, and it is important to understand what it means.

In short, a health information custodian is a person or organization that has custody or control over personal health information. The Act includes an extensive list of those considered to be health information custodians. Below are some examples of members who would be considered health information custodians themselves, or agents of a custodian:

- Members of CRPO who currently provide therapy to clients;
- Members of CRPO who no longer provide therapy but who continue to maintain records relating to the care of former clients, as required by the [Professional Practice Standards](#); and
- anyone who operates or works in a group practice who has access to client files due to the responsibilities of their job.

Collecting, Using and Disclosing Client Health Information

Before collecting or using a client's personal health information, a health information custodian must receive the client's consent. According to PHIPA, consent can be communicated explicitly or implicitly, though there are some situations where explicit consent is mandatory.

Consent must also be obtained before a client's personal health information can be disclosed, unless disclosure is permitted or required by law. See section 5, "Consent in Exceptional Circumstances," for more information on required and permissible disclosures.

PHIPA describes the elements of consent. In order for the consent to be valid it must:

Be a consent of the individual: The person whose information is being collected, used or disclosed (or their substitute decision-maker) must be providing the consent

Be knowledgeable: The client must understand why you are collecting the information (Purpose), how you will use the information (Use), who will have access to the information (Disclosure); and any potential outcomes, whether benefits or risks, associated with collecting, using and disclosing the information.

Relate to the information: The consent is acquired for a specific purpose and cannot be applied for another purpose.

Not be obtained through deception or coercion: A client must consent voluntarily.

A Closer Look

CRPO's Professional Practice Standards

Consent and confidentiality are addressed in detail in [CRPO's Professional Practice Standards](#). See the following sections of the Standards to learn more:

- 3.1 Confidentiality**, where consent in the context of team-based care is addressed.
- 3.2 Consent**, which includes information about acceptable forms of consent, capacity, refusal or withdrawal of consent and documentation of consent in the clinical record.
- 3.4 Electronic Practice**, which addresses the unique considerations that apply when a member provides psychotherapy or other services using electronic communications technologies.

Key Points from Section 3

- *The Personal Health Information Protection Act protects a client's right to privacy and confidentiality.*
- *"Health information custodians" have a duty to safeguard a client's personal health information.*
- *Client consent must be obtained before collecting, using or disclosing the client's personal health information.*
- *In limited circumstances, it is permissible to disclose a client's personal health information without their consent.*

Section 4 – Consent and Capacity

There are situations where individuals who need health care are not capable of providing consent. In these situations, specific laws will apply, as will the principles of ethical practice. Taking into consideration the client's health care needs and other relevant factors, members have a duty to abide by these laws and principles while supporting the dignity and autonomy of the client.

A client is not capable of giving consent when they do not understand the information provided, or when they cannot appreciate the reasonably foreseeable consequences of the decision.

Members may assume that a client is capable and needn't conduct an incapacity assessment unless there is reason to believe that a client may be incapable. The simplest form of capacity assessment is engaging the client in the informed consent process and determining whether the client understands the information and can appreciate the consequences of their decisions.

Maturity of Minors

In Ontario, there is no "age of consent" with respect to personal health care decisions. In general, clients of any age are considered capable of refusing or providing consent to their own treatment as long as they possess the maturity to reasonably understand the information provided and can appreciate the consequences of their decisions.

Where a client is a minor (e.g. under the age of 16 for health care decisions, or under the age of 18 for decisions involving contracts), their capacity to provide consent must be determined on a case-by-case basis.

Recognizing Where Informed Consent is Possible

A client may be capable of giving consent for one intervention but not for another. For example, an elderly client with cognitive impairment might not be capable of consenting to a treatment plan proposed by a long-term care facility, but may be capable of providing ongoing consent to engage in a music therapy program.

Time may also be a factor in capacity, where a client is not able to consent to a treatment at one point in time, but is able to consent to the treatment at another time. For example, a client who is under the influence of an intoxicant may not be able to provide consent when treatment is initially proposed, but may be able to do so once the effects of the intoxicant have worn off.

Determining Capacity

Where a member has reason to believe that a client may be incapacitated, careful consideration is necessary. The following questions may be helpful:

- Is the client oriented to time and place? Can they identify people around them? Are they aware of their situation?
- Can the client remember information and keep track of the conversation?
- Is the client able to weigh the options associated with the proposed treatment?

- Are the client's communications and behaviours congruent and proportionate, considering the circumstances?
- Can the client communicate their decision?
- Have factors such as culture and language fluency been considered?
- Have other factors been considered, for example impaired cognition, substance-use, illness (mental and/or physical), disability, or undue influence or abuse?

Practice Snapshot

Marit, an RP, has a first appointment with a family of three, where she learns that the parents are recently separated and their 12 year old daughter, Tia, is struggling in school and has been withdrawing from her friends. The information provided by each of the family members leads Marit to believe that the family would benefit from therapy. However, Marit is concerned that Tia is showing serious signs of anxiety.

Marit suggests one-on-one therapy with Tia, in addition to family sessions that include all three members. She explains the rationale for the proposed approach and the methods she typically uses. When they talk about the goals of the therapy, the parents ask many questions. After explaining costs and terms of service, she asks if anyone has questions. Marit notices that Tia's expression has changed, so she asks if Tia is comfortable with what they've discussed.

Tia says that she does not want to join family sessions and that she only wants to meet with the psychotherapist. Marit asks if she would be willing to consider attending a family session at some point in the future. Tia says she'll think about it, and warns that she won't say anything in front of her parents. Marit asks Tia's parents if they are comfortable with modifying the plan so that Tia attends private sessions only, while the parents attend family sessions. The parents consent. Marit confirms that Tia is comfortable with this arrangement.

In this scenario, the parents consented to a therapeutic plan proposed for the family, the therapist's terms of service and costs, and the therapeutic goals. Because there was no reason for Marit to consider Tia incapable, despite her younger age, Marit had a duty to obtain Tia's consent to the treatment plan. If Tia had not consented to a modified plan to attend private sessions, Marit would only have been able continue therapy with the parents. Going forward, Marit will need to take care to assure that she maintains confidentiality appropriately, considering she is providing therapy to the parents and Tia separately.

Where a Client is Not Capable of Providing Consent

If member has reason to believe that a client is incapable of making decisions regarding their own treatment, consent must be sought from a valid substitute decision-maker before

commencing therapy. A valid substitute decision-maker is a person who may, by law, make treatment-related decisions on behalf of an incapable person. Substitutes are required to refuse or provide consent based on the last known wishes of the incapable client. If these wishes are not known, then decisions must be made in the best interests of the incapable client.

A Closer Look

Common warning signs of incapacity:

- Confusion or disorientation with respect to time, place and persons.
- Lack of concentration, memory loss, inability to make a decision.
- Impairment due to severe pain, anxiety, depression or mania.
- Impairment by alcohol, drugs or other intoxicants.
- Uncharacteristic behavioural changes such as disinhibition, lack of awareness of risks to self or others.
- Delusional thinking or reality distortions.
- Any other observation that causes you concern about the client's capacity to understand the information you provide.

Hierarchy for the Substitute Decision-Maker

The HCCA sets out the hierarchy of substitute decision-makers, which members must adhere to in order to identify the valid substitute decision-maker. The ranking is as follows:

1. A court appointed guardian of the person.
2. A person who has been appointed attorney for personal care. The client would have signed a document appointing the substitute to act on the client's behalf in health care matters if the client ever became incapable.
3. A person appointed by the Consent and Capacity Board to make a health decision in a specific matter.
4. The spouse or partner of the client, which may also include a non-sexual partner (i.e. two people who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives).
5. A child of the client or a parent of the client or the Children's Aid Society who has been given wardship of the client.
6. A parent of the client who does not have custody of the client.
7. A brother or sister of the client.
8. Any other relative.
9. [The Public Guardian or Trustee](#) if there is no one else.

If there are two equally ranked substitute decision-makers (e.g. two sisters of the client), and they cannot agree, the Public Guardian and Trustee may then make the decision.

According to the HCCA, the substitute decision-maker must:

- Be at least 16 years of age. However, there is an exception if the substitute is the parent of the client. For example a 15-year-old mother can be the substitute decision-maker for the care of her child.
- Be capable. In other words, the substitute must understand the information and appreciate the consequences of the decision.
- Be the highest ranked substitute who is available and willing to assume the responsibility of giving or refusing consent.
- Not be prohibited by court order or separation agreement from acting as the client's substitute decision-maker.

Communicating With Clients about Consent and Incapacity

Where a member has a concern about a client's capacity, the member should discuss this with the client. The member should also discuss the selection of the substitute decision-maker, and include the client in discussions about the therapy (e.g. options, plans, goals, and progress) as much as possible. Of course, there are circumstances where involving an incapable client in discussions will not be possible (e.g. if such discussions would be upsetting to the client, or if the client is unconscious).

Capacity of the Substitute Decision-Maker

If there is reason to believe that a client's substitute decision-maker is not able or willing to respect the last known wishes of the client or is not able or willing to work in the best interests of the client, and is making decisions that, in the opinion of the psychotherapist, will harm the client; the psychotherapist should call the office of the [Public Guardian and Trustee](#).

Key Points from Section 4

- *Some clients will not be capable of providing consent and it will be necessary to conduct a capacity assessment.*
- *A client is not capable of giving consent when they do not understand the information provided, or when they cannot appreciate the reasonably foreseeable consequences of the decision.*
- *Examples of factors relevant to capacity: Age and maturity (in the case of minors), cognitive functioning, severe distress, being under the influence.*
- *Simplest form of capacity assessment: Engage client in the informed consent process and determine if client understands the information and can appreciate the consequences.*
- *Where client is not capable, identify the substitute decision maker (SDM) and engage the SDM in the informed consent process.*
- *Respect the dignity and autonomy of the client; they may be capable of giving consent for one aspect of treatment but not for another or they may be capable of providing consent at one point in time, but not another.*

Section 5 – Consent in Exceptional Circumstances

Emergencies

According to the HCCA, an emergency is a situation where a client is experiencing severe suffering or is at risk of sustaining serious harm if a treatment is not administered promptly.

Incapable clients: In emergencies, a treatment can be provided without the consent of an incapable client or their substitute decision-maker only if a delay in treatment would prolong the client's suffering or put them at risk of sustaining harm.

Capable clients: Where a client is capable, emergency treatment can be provided only when these conditions are met:

- a communication barrier exists, and the client is unable to refuse or provide consent despite reasonable efforts to overcome the barrier; and
- a delay in treatment would prolong the client's suffering or serious bodily harm to the client.

In either case, members must attempt to obtain consent as soon as possible, even if it is after the fact. In the case of incapable clients, this can be done by finding the substitute decision-maker and engaging in the informed consent process. In the case of capable clients, this can be accomplished by finding a means to communicate with the client.

Practice Snapshot

Anna, an RP, is seeing her client Paula at the office. Paula suddenly collapses from an apparent heart attack. There is a defibrillator in the room across the hall from Anna's office. Without trying to get consent from a substitute decision-maker, Anna uses the defibrillator. It was appropriate for Anna to act without consent in these circumstances.

Practice Snapshot

Sherif, an RP, is seeing his client Emily at the office. Emily has terminal cancer and has filled out a wallet card saying that she does not want any measures taken to resuscitate her should she have a cardiovascular episode. Emily has mentioned this to Sherif. Emily suddenly collapses from an apparent heart attack. Sherif also has access to a defibrillator. Sherif is not able to act without consent in these circumstances, because Emily has already provided him with a refusal of treatment that applies to this circumstance.

Duty to Prevent Harm

As we saw in Section 1, “Consent as a Legal Concept,” members who are health information custodians are required to seek the consent of clients regarding the collection, use and disclosure of their personal health information. However, there are some situations in which a client’s consent to disclose certain personal health information is not necessarily required, particularly in instances where there is reason to believe that:

- another regulated professional or another person involved in the care of the client is practising or behaving in a manner that presents a risk to a client;
- the safety or wellbeing of a child is at risk;
- a client is at risk of harming self or others; or
- a third-party (e.g. someone known to a client) is at risk of harming self or others.

In these situations, members have a duty to act to prevent harm. Failure to do so can call into question a member’s judgment and professional ethics. It can result in serious consequences. There are many examples of health professionals who failed to take steps to prevent harm, which resulted in complaints, litigation and loss of employment.

There are two legal mechanisms that can help a member fulfill their duty to act to prevent harm: mandatory reports and the duty to warn.

Mandatory Reports

A number of mandatory reporting obligations exist, and these are set out in specific pieces of provincial legislation. For example, the [Child and Family Services Act, 1990](#), addresses the duty to report to the Children’s Aid Society if a child is in need of protection. Some of these reporting obligations are described in CRPO’s [Professional Practice and Jurisprudence](#) study guide, including the:

- Sexual Abuse Mandatory Report
- Incompetence, Incapacity and Professional Misconduct Mandatory Report
- Offences Mandatory Self-Report
- Professional Negligence Self-Report

Additional reporting obligations are listed below; however, this section should not be considered an exhaustive description of these obligations. CRPO members are responsible for understanding the mandatory reporting obligations that are relevant to their practice and work setting.

Reporting harm, neglect, abuse or abandonment of a child and criminal acts: Members are required to report to the Children’s Aid Society where there is a concern or reason to believe that a child is in need of protection due to physical or emotional harm, neglect or abandonment, or sexual abuse or exploitation. In addition, a report must be made if a child

requires services or treatment that the person having charge of the child (e.g. a parent or guardian) is unable or unwilling to provide or consent to.

Members also have a duty to report situations where a child under 12 years of age:

- has, on more than one occasion, injured another person or caused loss or damage to property because of inadequate supervision or encouragement by the person having charge of the child; or
- may require treatment or services to prevent a recurrence of serious injury to another person or serious damage to another person's property where the person having charge of the child is unable or unwilling to provide or consent to those services or treatment.

See [Child and Family Services Act](#), provision 72(1) for more information.

Reporting improper or incompetent care, abuse, or neglect of clients in long-term care homes or retirement homes: Members who work in long-term care homes as staff or as service providers are required to report certain matters to the director of the long-term care facility and/or to the Registrar of the [Retirement Homes Regulatory Authority](#), including:

- improper or incompetent treatment or care of a resident;
- abuse, neglect or unlawful conduct resulting in harm or risk of harm to a resident;
- misuse or misappropriation of a resident's money; and
- misappropriation of facility funds.

For more information, see [Long-Term Care Homes Act, 2007](#), provision 24.(1) and [Retirement Homes Act, 2010](#), 75.(1).

A Closer Look

Other Reporting Obligations

See [CRPO's list of Mandatory Reporting Obligations for Registered Psychotherapists](#) for more information about this subject.

Permissible Disclosures

There are instances outside of a member's mandatory reporting obligations where it is considered permissible to disclose a client's personal health information. For example, members may disclose a client's personal health information, in accordance with PHIPA, if there is reason to believe that the disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to the client or another person. However, such disclosures must meet certain criteria:

- there is a clear risk to an identifiable person or a group of persons;

- there is a risk of serious bodily harm or death; and
- there is no other reasonable way to prevent the risk of harm.

This form of disclosure is often referred to as the *duty to warn*.

Other Situations

There are still other circumstances where it may be necessary or permissible for a member to disclose a client's personal health information, such as during a proceeding before the courts, when communicating with a substitute-decision maker regarding the care of a client, or for the purposes of administration or enforcement of the RHPA (e.g. where a member is required to engage in a practice assessment or where a member becomes involved in a proceeding before a CRPO committee).

Exercising Judgment

As each situation is different, members must rely on their professional judgment to determine whether and how to disclose information appropriately, considering the circumstances. Consultation with a clinical supervisor or a legal expert may be helpful or necessary prior to making such disclosures.

CRPO is in the process of developing a guideline on this topic. The guideline will expand on relevant considerations and provide detailed examples.

Key Points from Section 5

- *Members have a duty to prevent harm.*
- *In these situations, the laws permit – and in some cases require – a member to act without first obtaining the client's consent, for example, in an emergency, or if the client or another person is at risk of serious bodily harm.*
- *Mandatory reporting obligations exist, where a member must report information to the appropriate authorities.*
- *Members must rely on their professional judgment to determine whether and how to disclose information appropriately, considering the circumstances.*

Section 6 – Reflective Practice Exercises

Exercise 1: Exploring Dialogue between Client and Therapist

The HCCA sets out the information that must be conveyed to a client during the informed consent process.

Immediately below you will find an example scenario and a hypothetical discussion between a therapist and client. Read the scenario and sample dialogue, and then complete the exercises that follow.

Mike has had frequent outbursts where he has been verbally abusive and aggressive toward other employees. On one occasion, Mike briefly locked a shift supervisor in a cooled storage room because he believed the shift supervisor had changed the schedule in a way that caused Mike to miss a shift. On another occasion, Mike and a co-worker had a disagreement in the staff break room. Mike berated the co-worker using vulgar language and punched the wall that the co-worker was leaning against, causing a hole that had to be repaired.

After the second incident, the HR manager gave Mike an ultimatum: engage in therapy to manage his outbursts at work, or lose his job. Mike agreed to a performance improvement plan that included engaging in therapy. Mike also filled out the Employee Assistance Provider's (EAP) consent forms, which the HR manager had provided and faxed to the EAP at Mike's request.

Vadim, RP, received the referral from the EAP, and noticed, in addition to the client's name, and the scheduled appointment time, that the client's concerns were summarized as "Anger management classes required by employer."

Information that Vadim must provide to Mike, according to HCCA	Dialogue between Mike and Vadim
<p>Nature and purpose of the proposed treatment and/or assessment:</p> <ul style="list-style-type: none"> • Explain what assessments or treatments are being proposed, and why. Explain the general approach to therapy, common methods, specific interventions or exercises, and between-session assignments. • Discuss possible goals, and 	<p><i>Vadim: I see that your employer expects you to come to these sessions. Can you tell me about that?</i></p> <p><i>Mike: I'm supposed to attend these sessions or I'm going to be fired. I really don't want to do this.</i></p> <p><i>Vadim: I can understand your feelings about being here today. As I understand the situation, your employer expects you to come to these sessions in the hopes it will help you communicate better with the other staff.</i></p> <p><i>Mike: Yeah – I blew up at a couple of the guys at work. I shouldn't have done that.</i></p>

clarify how the above fits in with the goals.

- Communicate who will be doing the intervention – is it the RP? If the RP works in a shared-care setting, explain the roles of the other professionals who may be involved in the client's care.

Vadim: I can see you've been reflecting on this. Let's talk more about that in a minute.

I want to tell you about what I do, and what you can expect during the sessions. I also want to tell you a little bit about what I expect from clients too. We need to have this conversation before we can dig into the things that brought you here today because I need to know that you understand what this is about, and what our work is together. Are you okay with that?

Mike: Sure.

Vadim: The kind of therapy I do is eclectic - this means that I take parts of many therapy approaches to find the things that work best for you. Together we'll be working on managing strong feelings and building your communication skills. We may try one thing for a while to see how that's working for you, and if you're not finding that useful, we could try another. The particular approach or suggestions that I offer you will depend on what you tell me and the things that I've found to be particularly helpful with other clients who have had similar experiences. Our meetings together will last about 50 minutes. Today what I'm hoping we can do is just talk about what has been happening at work, and you can let me know about anything else that is on your mind.

How does that sound to you?

Mike: Fine, I guess. I mean, you're probably going to tell me to breathe and count to ten when I start to get mad.

Vadim: That's one of the things we might do. After we get a chance to talk a bit more, I'll probably suggest some exercises, and you can let me know what you think about the suggestions.

You and your employer agreed that your sessions would be weekly. You'll only be meeting with me, so our sessions are one-on-one. Because this is mandatory therapy through your employer, I'm required to provide your employer with a written progress report. I'm also required to inform your employer if you miss a scheduled appointment, or if you don't engage with the therapy. I will consider you "not engaged" if you choose not to speak during sessions, or if you routinely refuse to

	<p><i>participate. When I provide a progress report to your employer, I only share highlights of your progress on the matters that brought you here today.</i></p> <p><i>Do you have any questions about the information I'm required to provide in the reports or anything else?</i></p> <p><i>Mike: I get it. I have to attend the sessions and you'll share some information about how things are going with my employer. Who sees those reports? Will my supervisor or shift manager see it, or does it go to HR?</i></p> <p><i>Vadim: I'm not sure. I can check on that and get back to you with that information.</i></p>
<p>Benefits</p> <ul style="list-style-type: none"> • Explain how the therapy might be helpful to the client. 	<p><i>Vadim: Your employer won't see details of what you've shared in sessions, so I hope you'll feel comfortable talking about the things that are bothering you at work, because this may help us identify what is causing conflict in the workplace.</i></p> <p><i>Mike: Oh man, I can tell you a lot about that kind of stuff.</i></p> <p><i>Vadim: That's great. If we can find the points of conflict, then maybe we can find ways to deal with that conflict that work better for you and others in your workplace.</i></p> <p><i>We can also talk about other things in your life that are worrying you or causing you stress. And we can even work on some personal goals.</i></p> <p><i>What do you think about that?</i></p> <p><i>Mike: Well, I'm not usually a therapy guy, but I have to be here! I have been arguing a lot with my daughter lately, maybe we can talk about that too. Since she turned 16, I've been having such a hard time getting through to her.</i></p>
<p>Risks and limitations</p> <ul style="list-style-type: none"> • Explain any risks or limitations. Risks might include effects that are considered uncomfortable or undesirable by the client. Limitations might include a limit on the number of sessions that are covered by the client's insurance provider, constraints on the 	<p><i>Vadim: I will provide a copy of the report to you before I send it to your employer. You are welcome ask about anything in that report, or request changes if I've provided incorrect information. I can't change my professional opinion, even if you don't agree. How is this information settling with you?</i></p> <p><i>Mike: I'm just glad I'll see it before you send it to my employer.</i></p> <p><i>Vadim: We'll spend a little more time with the first one before it goes out. Maybe after the first time, this process</i></p>

<p>RP's availability due to planned leave or full client load, or the boundaries of the RP's area of practice.</p> <ul style="list-style-type: none"> • Discuss any costs associated with the therapy. 	<p><i>will feel a little more comfortable.</i></p> <p><i>From what I understand, your employer has made it clear that your ability to continue in your role depends on improving your communication skills. Attending these sessions shows your willingness to work on your communication skills, but it's your commitment to this work that will help you develop the skills you need. Even if you've completed your sessions with me, I cannot guarantee that you will keep your job, ultimately that's up to your employer. I'm wondering if you have any thoughts to share about that.</i></p> <p><i>Mike: I know I have to make changes. I need my job too. So, I'll do what I have to do.</i></p> <p><i>Vadim: Is there any other part of this agreement with your employer that you think I should know about?</i></p> <p><i>Mike: Well, they told me I have to schedule appointments with you during my time off. They said I could trade a shift here or there if I need to make the scheduling work.</i></p> <p><i>Vadim: Thanks for letting me know that. I work from 10–5, Monday through Friday, so we can schedule your appointments anywhere in that time frame. Your insurance provider will pay for up to 8 sessions. As we get closer to that number, we can talk about whether you would like to continue on and we can look at what resources are available to you.</i></p> <p><i>Mike: Eight sessions will probably be enough for me.</i></p> <p><i>Vadim: This is a copy of my service policies. I want to point out the policy on missed sessions. In the event you're unable to attend a session, you must provide at least 24 hours' notice. Just call the number here to let us know that you won't be able to make it. If you don't provide 24 hours' notice, I'm required to charge you for the session. Your insurer will not reimburse you for this, so you'll be stuck paying out of pocket if you miss an appointment. If you're sick the day of a scheduled session, just call and let us know because we can waive the charge for a missed session in this case.</i></p> <p><i>There are no additional costs associated with your attendance at sessions, but I may recommend some</i></p>
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	<p><i>workbooks and apps that might be helpful to practice your skills between sessions. Just to give you a sense of costs, one of the apps I often recommend is \$9.00. One of the workbooks, which you can order online, is \$35.00. If you prefer, I can provide photocopies of some worksheets that I've made up – there is no charge for the photocopied worksheets.</i></p> <p><i>Mike: That's good that you have lot of options. Do you have those written down anywhere?</i></p> <p><i>Vadim: I do. I'll give you a list before you go today.</i></p>
<p>Uncomfortable or undesirable effects</p> <ul style="list-style-type: none"> • Provide information about material effects, that is to say, those effects that a reasonable person would want to know about it. Warn the client about uncomfortable or undesirable effects that are commonly experienced in addition to those that are rare but serious. 	<p><i>Vadim: Once we begin our work together, you might start to notice some changes in how you think or feel about things and even how you react to things. You might find that this impacts how you relate to others. I want to do my best to help you work through these thoughts and feelings. If you notice these kinds of things coming up at home, in your work or anywhere, really, maybe make a mental note, or write it down, and we can talk about this. If you're feeling overwhelmed by any of these changes, you don't have to hold it in until our next session – you can call me and we can check in. I might not be able to answer the phone, but leave a message and I'll call you back as soon as I can.</i></p> <p><i>If during any of this, you have sudden thoughts about harming yourself or another person, please call this crisis line. They have people waiting by the phones 24/7, and they can help you.</i></p> <p><i>Mike: Ok.</i></p>
<p>Alternative options and consequences associated with refusing</p> <ul style="list-style-type: none"> • If there are reasonable alternatives to the intervention, the RP must share this information with the client, even if the RP does not recommend the alternative option. • The RP must describe the option and share a reasonable amount of information about how the client can access the 	<p><i>Vadim: There are other services out there that can help you manage feelings and improve your communication skills. For example, group therapy is another common approach. My colleague who works in the office down the hall does that kind of work. I can connect you with her if group therapy is something you think you will prefer. That being said, I don't recommend group therapy for you, because one-on-one sessions may be a more appropriate starting place. What do you think about exploring these kinds of alternate options?</i></p> <p><i>Mike: Oh, I don't want to be in front of a bunch of people talking about my personal stuff.</i></p> <p><i>Vadim: I can understand that. One of the benefits of group</i></p>

<p>alternate option. For example, if the RP does not provide these alternate services themselves, they must share information about a professional (or the type of professional) who may provide such services.</p> <ul style="list-style-type: none"> • If the RP cannot recommend the alternate option, the therapist should explain why. For example, the RP may feel the alternate option is too aggressive a course of action based on the needs of the client. 	<p><i>therapy is that you can practice your communication skills with a variety of people, and you can practice managing your feelings in the presence of others while you're in the safety of the therapeutic space.</i></p> <p><i>My main interest in this is that you have solutions that work for you. If you feel as though our sessions aren't working for you, let me know. We can explore options, for example, we can try to work it out together, I can provide the names of other therapists who are experienced in this area, or we can revisit the idea of group therapy. You can expect me to ask about how this is working for you, and I want you to feel free to share your thoughts on that with me at any time.</i></p> <p><i>Mike: Ok. Things are good so far.</i></p> <p><i>Vadim: It is your right to refuse any part of the therapy at any time. You can even refuse to engage in therapy entirely. That being said, I want to talk about the consequences of refusing: Because you made an agreement with your employer to engage in therapy as part of an improvement plan, if you decide to end therapy or refuse to participate fully, you could lose your job.</i></p> <p><i>Mike: I understand that. But if I don't like something and want to try something else, that doesn't mean I'm refusing, right?</i></p> <p><i>Vadim: If something isn't working for you, and you want to try something new, I usually wouldn't see that as refusing.</i></p>
<p>Confirming consent</p>	<p><i>Vadim: I want to close up this part of our discussion by letting you know that as a therapist, I'm a regulated health professional. This means I have to follow standards and laws and that I'm accountable to the body that regulates therapists in Ontario. If you ever have questions or concerns about my practice, and you're not comfortable bringing them to me or to the EAP, you can contact the College of Registered Psychotherapists of Ontario. If you have a complaint, they are the organization to contact. Their information is on that sheet I handed you earlier.</i></p> <p><i>Mike: I'm the kind of guy who says what's on his mind, so I'll let you know when I don't like something. But this is good to know.</i></p> <p><i>Vadim: That was a lot of information. Any questions?</i></p> <p><i>Mike: No. I'm good.</i></p>

	<p><i>Vadim: What do you think about getting started then?</i></p> <p><i>Mike: I'm ready if you're ready.</i></p>
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Based on the scenario and hypothetical dialogue, complete the checklist below to assess whether the informed consent provided by Mike could be considered valid:

Included? (Yes/No)	Characteristics of informed consent
	The RP has provided truthful and accurate information that relates to the proposed assessment or treatment.
	The client received all the information that a reasonable person in the same circumstances would require in order to make such a decision, including responses to questions.
	There is reason to believe the client understood the provided information.
	The client voluntarily agreed.
	The client consented before an assessment or treatment was provided.

Based on the scenario and hypothetical dialogue, assess the level of risk. Is it low, moderate or high?

Considering the level of risk, what form of consent is appropriate – written, verbal (or manual), or implied?

Exercise 2: Assessing Your Own Informed Consent Process

Complete the three steps below to help you assess your own informed consent process. If you would like to see an example of an informed consent discussion, refer to Exercise 1.

STEP 1

Think back to a time when you began to work with a new client. Describe the client and relevant practice details by answering the questions below.

<p>What was your practice context? (E.g. group or independent private practice, employee of an agency, hospital or education institution, etc.)</p>
<p>What can you remember about the client and the matters that brought the client to therapy? (E.g. client's general age and health/wellbeing, gender and relationship status if relevant, client's concerns and, if applicable, reason for referral.)</p>
<p>Was there anything special or exceptional about this case?</p>

STEP 2

Reflect on your communications with this client as they relate to informed consent. Then, following the prompts in the first column, use the second column to briefly summarize the information conveyed in those communications using (point form summary acceptable). If there was any information you did not include in your communications with the client, make note of that in the third column.

Information that must be relayed to client by RPs	Information conveyed to your client	Additional information that you should have conveyed
Nature and purpose of the proposed treatment and/or		

<p>assessment:</p> <ul style="list-style-type: none"> • Explain what assessments or treatments are being proposed, and why. Explain the general approach to therapy, common methods, specific interventions or exercises, and between-session assignments. • Discuss possible goals, and clarify how the above fits in with the goals. • Communicate who will be doing the intervention – is it the RP? If the RP works in a shared-care setting, explain the roles of the other professionals who may be involved in the client's care. 		
<p>Benefits</p> <ul style="list-style-type: none"> • Explain how the therapy might be helpful to the client. 		
<p>Risks and limitations</p> <ul style="list-style-type: none"> • Explain any risks or limitations. Risks might include effects that are considered uncomfortable or undesirable by the client. Limitations might include a limit on the number of sessions that are covered by the client's insurance provider, constraints on the RP's availability due to planned leave or full client load, or the boundaries of the RPs area of practice. • Discuss any costs associated with the therapy. 		
<p>Uncomfortable or undesirable</p>		

<p>effects</p> <ul style="list-style-type: none"> • Provide information about material effects, that is to say, those effects that a reasonable person would want to know about it. Warn the client about uncomfortable or undesirable effects that are commonly experienced in addition to those that are rare but serious. 		
<p>Alternative options and consequences associated with refusing</p> <ul style="list-style-type: none"> • If there are reasonable alternatives to the intervention, the RP must share this information with the client, even if the RP does not recommend the alternative option. • The RP must describe the option and share a reasonable amount of information about how the client can access the alternate option. For example, if the RP does not provide these alternate services themselves, they must share information about a professional (or the type of professional) who may provide such services. • If the RP cannot recommend the alternate option, the therapist should explain why. For example, the RP may feel the alternate option is too aggressive a course of action based on the needs of the client. 		
<p>Confirming consent</p>		

<ul style="list-style-type: none"> Clarify that the client consents. 		
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STEP 3

Assess whether your communications with your client, as you described them in column 2, reflect the characteristics of informed consent by completing this table:

Included? (Yes/No)	Characteristics of informed consent
	The RP has provided truthful and accurate information that relates to the proposed assessment or treatment.
	The client received all the information that a reasonable person in the same circumstances would require in order to make such a decision, including responses to questions.
	There is reason to believe the client understood the provided information.
	The client voluntarily agreed.
	The client consented before an assessment or treatment was provided.

Next, combine the information you included in your discussion with the client (column 2) with the information you would include in future discussion (column 3) and complete the table below. Make note of any differences in your scoring, and consider how you applying similar changes can enhance your practice.

Included? (Yes/No)	Characteristics of informed consent
	The RP has provided truthful and accurate information that relates to the proposed assessment or treatment.
	The client received all the information that a reasonable person in the same circumstances would require in order to make such a decision, including responses to questions.
	There is reason to believe the client understood the provided information.
	The client voluntarily agreed.
	The client consented before an assessment or treatment was provided.

Based on the scenario and dialogue, assess the level of risk. Is it low, moderate or high?

Considering the level of risk, what form of consent is appropriate – written, verbal (or manual), or implied?

Does your answer change if you look at the information you provided in column 3, and the additional information you added in column 3?

Exercise 3: Conscious Decision-Making

Consider a recent situation when you engaged a client in the informed consent process.

Describe the situation. Use the following questions as a guide:

1. Who is the client?
2. Why was the client seeking or referred for psychotherapy?
3. What details are relevant to the situation?
4. Who else is involved in the situation (family members, team members)?

Identify the relevant resources to assist with the decision-making. Use the following questions as a guide:

1. Are there any relevant laws, regulations, standards and/or guidelines?
2. Who are you aware of that has expertise in the area of consent?

Consider the capacity of the client. Use the following questions as a guide:

1. How did you know the client was capable or incapable of making a decision? (Describe client characteristics or other factors that shaped your impression of the client's capacity to provide consent.)
2. What other information did you rely on to help you determine the client's capacity or incapacity to give consent?

Identify the substitute decision-maker. If the client is (or was) incapable of making a decision about the services proposed, how would you determine who has the legal authority to provide informed consent? Use the following questions as a guide:

1. Was there a person involved in the informed consent process who was granted the power of attorney; or was there a spouse, parent or sibling who acted as the substitute decision-maker?
2. Of the people involved in the situation described, who is placed higher in the list of substitute decision-makers described in the *Health Care Consent Act* hierarchy?
3. Who would you consider the substitute decision-maker in this situation?
4. Did you consider or would you consider contacting another appropriate person before proceeding with services?
5. If a third party obtained consent for the initial referral, how did you confirm that consent was obtained from the appropriate person?

Describe informed consent process. What information would you provide the client or substitute decision-maker to ensure that the client and/or the substitute decision-maker understood and could appreciate the consequences of giving or not giving consent? Use the following questions as a guide:

1. What were the purposes of the services, benefits, limitations, risks and alternative options to the proposed treatment?
2. What was the level of risk to the client if he was not fully informed of the proposed services?
3. What was the fee structure, if applicable?
4. When would you provide an opportunity for the client/substitute decision-maker to ask questions?

Consider third-party consent. If a third party obtained informed consent, explain how you ensured that the third party adhered to the requirements relating to informed consent.

Document that informed consent was obtained. In the space below, provide an example of how you would document the informed consent process in the client record.



Exercise 4: Comparative Self-Assessment

Now that you have completed this workbook, refer to the self-assessment that you completed before you began the work book. Use the below to re-assess your knowledge of informed consent. Compare your responses.

Self-Assessment Questions	Not at All	Somewhat	Fully
I can explain the process for obtaining informed consent.			
I know when I must obtain informed consent.			
I understand that obtaining a signed consent form is different than engaging the client in the informed consent process.			
I understand consent must be informed, voluntary, and obtained from a client who can understand the information I am sharing.			
I understand my role in determining the client's capacity to provide consent.			
I know there is a hierarchy of people that can be substitute decision-makers.			
I know that my client can withdraw consent at any time.			
I recognize when I need to revisit consent, and I understand that consent is an ongoing process.			
I know that I am required to document the consent process.			

In which areas has your knowledge been enhanced? Describe new learnings.

What resources and/or supports will you rely on in the future when matters relating to informed consent arise?

Exercise 5: Implementing New Learnings

Now that you've completed the Informed Consent Workbook, what changes you will make to your practice in the following areas:

1. Engaging clients in an informed consent discussion.
2. Determining whether written, verbal (or manual) or implied consent is appropriate.
3. Determining the client's capacity to give consent.
4. Determining who the appropriate substitute decision-maker should be when a client is deemed incapable in providing consent.
5. Disclosing a client's personal health information with another health provider.
6. Disclosing a client's personal health information to a third-party who is not a part of the client's care team.

Top 5 Takeaways

What are your five (5) top takeaways from this Workbook?

- 1.
- 2.
- 3.
- 4.
- 5.

Here are CRPO's 5 key messages:

1. Informed consent is a process that involves an ongoing discussion with the client.
2. A client can refuse to consent to any aspect of the therapy and consent can be withdrawn by the client at any time.
3. Members should assume the client is capable of providing consent, unless there is information that would lead them to think otherwise.

4. Considering the risk to the client can help members determine how much detail should be communicated to the client during the informed consent process.
5. Obtaining a signed consent form from a client does not relieve a member of their duty to ensure the client is fully informed.

Appendix I

Member Resource: Informed Consent Checklist

In Ontario, clients and/or, as applicable, their substitute decision-makers (SDMs) have the right to make their own choices about their health and wellbeing, including how their personal information is collected and shared with others. As a founding principle of ethical health care, informed consent is both an ethical and legal concept, requiring that health professionals abide by related laws, professional obligations, and standards of practice.

This checklist summarizes key components of the informed consent process that are described in the *Informed Consent Workbook*. The information provided in this checklist is not intended to replace education and training, nor is it a substitute for the competencies that enable a Member to engage a client in an appropriate informed consent process. Despite any information provided here, members must rely on their professional judgment and assume responsibility for their decisions and actions.

Guiding Principles

1. Members must seek clients' informed consent before engaging in assessment or treatment.

- Consent is considered informed if the person making the decision received all the information that a reasonable person in the same circumstances would require in order to make such a decision, before voluntarily agreeing to the intervention.
- While some clients may not be capable of providing consent for all aspects of treatment, including consent to the terms of service and the financial arrangements, they must be provided the opportunity to consent to any aspects of their care for which their consent can be provided.

2. Consent is an ongoing process.

- There will be instances in the therapeutic process where it may be necessary or advisable to seek or reaffirm a client's consent, e.g. where changes to the therapeutic plan are proposed, where therapeutic goals have shifted.

3. Clients have the right to withdraw consent for some or all aspects of treatment at any time.

4. Clients can communicate consent in a number of ways.

- Standards of practice and the particular circumstances will inform which type of consent is most appropriate, whether is written, spoken or manual (e.g. American Sign Language), or implied.

5. The consent process is documented.

- Relevant observations about the client's capacity to provide consent.
- Information shared with the client.
- Client questions or concerns.
- Which aspects of the therapy the client consented to or refused.

- Instances throughout the course of therapy where the member sought the client's consent, and whether the client provided consent or refused.

More Information

- [Professional Practice Standard 3.2: Consent](#)
- [Informed Consent Workbook](#)

Checklist for the Initial Informed Consent Process

1. Consider the client’s capacity to provide informed consent including:

	<p>Relevant aspects of the client’s profile, mainly age and capacity.</p>	<p>For clients 16 and older, you may presume that the client is capable of providing consent, unless you have reason to believe otherwise.</p> <p>For clients under 16 years of age, you should assess the client’s capacity to provide consent.</p> <p>If the client is not capable of providing informed consent to one or more aspects of the treatment, engage the SDM appropriately.</p>
	<p>Financial and contractual aspects of your practice, as applicable (e.g. terms of service and financial arrangements).</p>	<p>A client may be capable of consenting to treatment, while being incapable of consenting to payment arrangements and/or some aspects of the terms of service (e.g. a minor who is financially dependent on their parent or guardian).</p> <p>If the client is not capable of providing informed consent to the contractual and/or financial aspects of the therapy, engage the SDM appropriately.</p>

2. Engage in the initial informed consent process with the client and/or the SDM by seeking consent for any services you intend to provide to the client. Also seek the client’s consent for the collection, use and/or disclosure of the client’s personal health information.

	<p>Represent yourself and your services accurately.</p>	<p>CRPO requires that Members represent their qualifications and services transparently and accurately in interactions with clients, and more broadly, when working in a professional capacity.</p> <p>Describe to the client:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The terms of service. <input type="checkbox"/> Relevant practice policies. <input type="checkbox"/> Any limitations on the services. <input type="checkbox"/> Any other details that would be relevant. <input type="checkbox"/> Provide CRPO’s contact information upon request.
	<p>Discuss the collection, use and</p>	<p>Describe to the client:</p>

	<p>disclosure of the client's personal health information.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> The information ordinarily collected as part of the clinical record throughout the course of the therapeutic process. <input type="checkbox"/> How you will use that information. <input type="checkbox"/> Your duty to maintain a clinical record. <input type="checkbox"/> Your duty to maintain confidentiality. <input type="checkbox"/> Any limits to confidentiality. <p>You may wish to provide the following information as part of your informed consent discussion. Note that circumstances may render it necessary provide some or all of this information:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The client's right to consent to the disclosure of their personal health information, and your ordinary practice for seeking the client's consent in such cases. <input type="checkbox"/> The client's right to place personal health information in a "lock-box." <input type="checkbox"/> The client's right access the clinical record, to request amendments, etc. <input type="checkbox"/> The client's right to contact the Information Privacy Commissioner of Ontario or CRPO with any concerns.
	<p>Provide information to the client before engaging in assessment or treatment.</p> <p>Note: this is not intended to preclude a member from gathering general impressions about a client, responding sensitively and therapeutically to a client's immediate distress or acting in emergency situations.</p>	<p>At a minimum, provide the following information to the client:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nature and purpose of the proposed treatment and/or assessment. <input type="checkbox"/> Benefits. <input type="checkbox"/> Material risks, including foreseeable costs, any limitations to the treatment or assessment, and any other relevant info. <input type="checkbox"/> Effects of the treatment or assessment, particularly those that a client might consider uncomfortable or undesirable. <input type="checkbox"/> Alternative options. <input type="checkbox"/> Consequences associated with refusing the treatment or assessment.

3. Include any other information that may be relevant to the informed consent process. For example, if using communications technologies for any aspect of the therapy, the client's explicit consent is required.

	<p>If providing psychotherapy services using communications technologies, it is necessary to engage the client in</p>	<p>Seek and obtain the client's explicit consent before using the technology. Discuss:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The intended use of the technology.
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	<p>an informed consent process, obtaining the client's consent before using any proposed technology.</p>	<ul style="list-style-type: none"><input type="checkbox"/> The information ordinarily relayed and any limitations to the type of information that should be relayed using the technology.<input type="checkbox"/> Measures taken to ensure the confidentiality of the client's personal health information.<input type="checkbox"/> The risks and benefits of using the technology.<input type="checkbox"/> Measures the client can employ to protect their own confidentiality.
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