

BC Association of Clinical Counsellors

Legal Commentary*

CONSENT TO CLINICAL COUNSELLING SERVICES

What counsellors need to know about the law of consent before they provide clinical counselling services to their clients.

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* This commentary is intended to help clinical counsellors gain a better understanding of legal issues that are relevant to their practice. It is not meant to be a substitute for legal advice. If a counsellor has a particular concern about an issue that he or she is facing in practice, that counsellor should seek independent legal advice from a lawyer. Neither Mr. Bryce nor the BCACC can provide individual counsellors with legal advice.

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INTRODUCTION

In articles published in *Insights into Clinical Counselling*, I have addressed the issue of consent to counselling therapy services in two specific or narrow contexts:

- obtaining parental consent when counselling children during marital breakdowns;¹
- obtaining consent from children directly, without the need for parental consent.²

In presentations to students attending two British Columbia graduate school counselling programs I have given talks on the broader question of the law of consent to counselling therapy generally.³

With the passage of BC's new *Family Law Act*⁴ (FLA) in March 2013, new rules came into effect that make it clear that parents must consult with each other before they consent to counselling and the provision of other health care services for their children. Rather than write a third article on this narrow aspect of the law of consent, the BCACC asked that now I produce a broader and more complete legal commentary that would update the subjects covered in the previous articles and presentations.

In chapter 1 of this Legal Commentary, I will review the law of informed consent, and, with that foundation, discuss in chapter 2 how counsellors should obtain consent from parents before they provide counselling to children, in particular if the parents are separating or have divorced. This will be followed by a discussion in chapter 3 on the capacity of children to consent to their own counselling therapy services, even if they are under the age of majority and one or both of their parents object.

With the posting of this new Legal Commentary at the BCACC website, the above two *Insights* articles are no longer applicable, so they been removed from the website.

¹ Bryce, G. & M. Sandor "Consent for Counselling Children during Marital Breakdowns," 13:3 *Insights* at 12 to 14, 25 to 26 (Winter 2002).

² Bryce, G.K. "Obtaining Consent from Children (Revised)." 19:4 *Insights* at 14, 15, 30 & 31 (Winter 2008).

³ Presentation to CPSY 609 course Seminar on Ethical Integration, Trinity Western University, Langley, BC (March 2009) and presentations to the COUN 510 course Professional Ethics and Law, City University, Vancouver, BC (May 2011, and May & July, 2012).

⁴ S.B.C. 2011, c.25.

The issue of a client's consent to the use, collection and disclosure of that client's personal information, as regulated under BC's *Personal Information Protection Act*⁵ (PIPA), will *not* be considered in detail in this Legal Commentary. This type of consent has a different focus or purpose than consent to counselling; the two forms of consent should not be confused or merged with each other.

I will, however, address two specific aspects of consent as it applies to personal information in chapters 2 and 3, respectively. But I will not consider the broader question of personal information consent, in particular as regulated under PIPA.

The BCACC has produced the following documents that discuss the issue of consent in relation to the use, collection and disclosure of client personal information:

- *Personal Information Protection Act: A Counsellor's Guide for Developing Client Personal Information Protection Policies and Procedures* (approved by the Board on October 16, 2004);
- *Standard for Informed Consent to Clinical Counselling and the Collection, Use and Disclosure of Personal Information* (approved by the Board on October 16, 2010).

Counsellors wanting to learn more about personal information consent may also want to consult the following:

- Bryce, G.K. "BC's New Personal Information Protection Act: Entrenching Common Practice or Adding New Complexities?" part 1 @15:3 *Insights* at 14, 30 to 32 (Winter 2004), and part 2 @ 16:1 *Insights* at 13, 31 to 33 (Summer 2004), a publication of the BCACC;
- Bryce, G. K. "Personal Information Protection in the Private Sector: B.C.'s New *Personal Information Protection Act*," chapter 15, *Legal Handbook for Helping Professionals* (3rd ed., 2006), Victoria, BC: Sedgewick Society for Consumer and Public Education.

Finally, I would like to thank respected family law lawyer, John-Paul E. Boyd,⁶ for his helpful comments and suggestions on an earlier draft of chapter 2 of this Legal Commentary. Any errors or omissions remain my responsibility.

⁵ S.B.C. 2003, c.63.

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1) INFORMED CONSENT

The law of informed consent is a topic that can create confusion if not anxiety for many counsellors. Such a response to consent is not necessary, at least so long as counsellors understand the basic rules and decision-making framework for this aspect of clinical practice.

In this chapter I will review the essential legal elements of a valid, informed consent. From this foundation, I will discuss the importance of focusing on the process of obtaining consent, rather than on clients signing consent forms. This flows into a discussion on how consent can be communicated by a client. There are, however, certain issues that this chapter will not address.

1.1) Excluded aspects

Because it is highly unlikely the following situations will ever arise in counselling practice, this chapter will not address the following situations:

- consent to unforeseen but necessary medical treatment while the client is unconscious or semi-conscious and thus unable to consent;
- the provision of psychiatric care or treatment to a person involuntarily detained pursuant to the *Mental Health Act*;
- the capacity of a substitute decision-maker to give consent on behalf of a client, and the limits of such consent;
- who may provide consent as a temporary substitute decision-maker for a client, and the limits of such consent;
- appointing a personal guardian to give consent;
- the use and limitations of advanced directives.

If a counsellor is faced with one of these scenarios, he or she should consult with independent legal counsel before proceeding further.

1.2) Why is client consent important?

Aside from the fact that a failure to obtain client consent would be a breach of the BCACC codes and standards, ensuring that a client has given valid and informed consent is important because, without such consent, it is likely that anything the counsellor then does during the subsequent counselling session would be done without proper authority. And that might expose the counsellor to legal liability.

For example, if a counsellor touched the client during the counselling session without consent, that simple touch would likely constitute a battery. And the counsellor would then be liable in civil law for the tort of battery, which, as noted in the landmark Canadian case of Reibl v. Hughes, is defined as an intentional tort, consisting of an unprivileged and unconsented invasion of one's bodily security.⁷ Further, it is not necessary for the client who has been touched without consent to prove causation. Instead, the counsellor would have the burden to prove that the client consented to what was done.

In brief, it is important for a counsellor to obtain client consent before providing counselling therapy services so as to avoid any subsequent legal problems that might arise in the absence of a valid and informed consent. While consent is important to support counselling (as I will explain in more detail later) counsellors should not assume that having a client sign a consent form is the solution. This observation will become clearer as we explore the elements of informed consent.

1.3) Who must obtain the client's consent?

The onus rests on the counsellor to obtain the client's consent.

If the counsellor is part of a team providing a set of closely related procedures, it may be possible for the counsellor to obtain consent for the entire team, rather than requiring each team member to obtain their own separate consent.

In appropriate circumstances, the counsellor may ask a trainee (for example) to obtain consent. But if a counsellor delegates obtaining client consent, the counsellor must ensure the delegate has the knowledge and experience to meet the requirements placed on a counsellor to obtain a valid consent.

Herein, this Legal Commentary will refer to a counsellor because, in most circumstances, the counsellor will retain ultimate authority and responsibility to ensure the client has been given an adequate explanation about the nature of the proposed counselling therapy and its anticipated outcome, as well as information about risks and available alternatives.

⁷ Reibl v. Hughes [1980] 2 S.C.R. 880 at 890, 1980 CanLII 23 (SCC).

1.4) BC's health care consent legislation: A useful framework

British Columbia, like some other Canadian provinces, has established a legislative framework that sets out the rules of consent: the *Health Care (Consent) and Care Facility (Admission) Act*⁸ (the *Health Care Consent Act*).

Section 5(1) of the *Health Care Consent Act* states that: “A health care provider must not provide any health care to an adult without the adult’s consent.” Certain exceptions are then granted to this general rule, but none apply to counselling services.

The directive set out in section 5(1) raises important questions: (a) *Are clinical counsellors “health care providers” as defined under the Health Care Consent Act? and, (b) if they are not, should counsellors nonetheless apply the rules of consent as set out in this Act?*

(a) Are clinical counsellors “health care providers”?

Section 1 of the *Health Care Consent Act* defines a health care provider as (emphasis added): “a person, or a person in a prescribed class of persons, who, under a prescribed Act, is licensed, certified or registered to provide health care.” In turn, the Health Care Consent Regulation⁹ lists the professions that are prescribed for the purposes of being a health care provider. Under section 3 of this Regulation, the prescribed classes of persons are all the health professions regulated under the *Health Professions Act*¹⁰ (HPA) and social workers regulated under the *Social Workers Act*.¹¹ Therefore, since they are not yet registered under the HPA, clinical counsellors are not one of the prescribed types of health care providers who must follow the general rules of consent as set out under the Act. This leads to the second question:

(b) Should counsellors nonetheless follow the Act?

While clinical counsellors are not one of the prescribed health care providers, this does not mean that the rules set out under the *Health Care Consent Act* are ones that counsellors should not follow. In fact, just the opposite is true.

The *Health Care Consent Act* is widely recognized as codifying the common law rules regarding informed consent. For example, in the 2011 case of Glaholt v. Ross, Madam

⁸ R.S.B.C. 1996, c.181.

⁹ BC Reg 20/2000.

¹⁰ R.S.B.C. 1996, c.183.

¹¹ R.S.B.C. 2008, c.31.

Justice Gray of the BC Supreme Court observed:¹² “The common law concerning consent was codified in British Columbia by the *Health Care (Consent) and Care Facility (Admission) Act*.”

Further, if not more importantly, because the *Health Care Consent Act* does not go further and state that it applies *only* to prescribed health care professions or has extinguished the common law rules, clinical counsellors and other non-prescribed health professionals can (indeed, should) use the rules of consent set out within the Act as a framework for how they should conduct this aspect of their clinical practices. Because this Act has codified the common law rules, it can serve as a useful guide to understanding consent, whether or not any profession is required to follow this Act.

For these reasons, I will use the framework of the *Health Care Consent Act* to organize the following general discussion on the law of consent, at least as it applied to adults.

1.5) Consent of adults vs. children

The *Health Care Consent Act* sets out the rules of consent that apply to anyone who is 19 years of age and older.¹³ On the other hand, the *Infants Act*¹⁴ speaks to the capacity of someone under the age of 19 (a “mature minor”) to give his or her own consent, even if that consent over-rides the consent (or refusal) of that child’s parents or guardians.

The general rules of consent discussed in this chapter apply to adults. In chapter 3, I will consider a mature minor’s ability to consent to counselling without the need for parental consent and explain where those rules may differ from those that apply to adults.

1.6) Scope of the right to consent

So long as a client is capable of giving consent to counselling therapy services, the client has the following consequential rights:¹⁵

- (a) the right to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal may result in injury or death;
- (b) the right to select a particular form of available health care on any grounds, including moral or religious grounds;
- (c) the right to revoke consent and to do so at any time;

¹² *Glaholt v. Ross*, 2011 BCSC 1133, at para. 187.

¹³ Section 1 of Act, definition of “adult”; see also section 3(1) of the *Health Care Consent Act*.

¹⁴ R.S.B.C. 1996, c. 223.

¹⁵ These consequential rights are based on section 4 of the *Health Care Consent Act*.

- (d) the right to expect that a decision to give, refuse or revoke consent will be respected;
- (e) the right to be involved to the greatest degree possible in all case planning and decision making.

Collectively, the right to consent embraces each of these related rights. As such, these rights should be viewed as essential parts of or extensions to the general right to consent to counselling therapy or services.

1.7) The general rule of consent

The general rule of consent is: A counsellor must not provide counselling therapy to a client without first receiving that client's consent to obtain those services.¹⁶ Consent is the end result of a discussion that leads to a client voluntarily agreeing to be provided with services that a counsellor has proposed.

As noted in the Introduction, the *Health Care Consent Act* provides a series of exceptions to the general rule of consent. None of those exceptions are likely to ever apply to situations when counsellors are providing counselling services to their clients.¹⁷ As such, these statutory exceptions will not be considered in this Legal Commentary.

The essential elements of the general rule of consent and how the client may give or communicate his or her consent will be considered next.

1.8) Six elements of consent

There are six essential elements or components of valid consent. The absence of any one of these elements could then render any apparent consent null and void. Therefore, it is important to understand each element, and also how they relate to each other.

(a) The client must be capable of giving consent

Unless they have evidence to the contrary, counsellors can assume that the adult clients they are seeing have the capability to give, refuse or revoke consent to counselling

¹⁶ See section 5(1) of the *Health Care Consent Act*.

¹⁷ See sections 11 to 15 of the *Health Care Consent Act*.

services.¹⁸ This presumption is itself set out under the *Health Care Consent Act* in these terms (emphasis added):

Presumption of capability

3(1) Until the contrary is demonstrated, every adult is presumed to be capable of
(a) giving, refusing or revoking consent to health care, ..

This presumption can be set aside if the counsellor has a reason to believe that the client is not otherwise capable of giving, refusing or revoking consent. But, as will be explained further in chapter 3, this presumption of capability does not apply to children.

As one of the six elements of consent,¹⁹ before a counsellor can rely on a client's consent to the proposed therapy, the client who is giving consent must be capable of making a decision about whether to give (or refuse or withdraw) consent to the proposed counselling.²⁰

Given the presumption of capability, in most situations, before a counsellor provides clinical services to a client, it will *not* be necessary for the counsellor to undertake a competency assessment to ensure that a client is capable of giving consent. For example, if a client knows who they are, where they are, what sort of counselling is being proposed, and the consequences of the decision they are being asked to make, it is likely safe for a counsellor to then rely on the legal presumption that the particular client is capable. However, this presumption can be set aside if the counsellor has a reason to believe that the client is not otherwise capable of giving, refusing or revoking consent.

Section 3(1) of the *Health Care Consent Act* goes on to state that, simply because the client may not communicate well with the counsellor does not automatically give the counsellor the grounds to decide that client is thus incapable of understanding what is necessary to give valid consent.²¹ Communication difficulties are not the same as capacity to consent. (See the further discussion on this point under Duty to Communicate Appropriately, below.)

¹⁸ See section 3(1) of the *Health Care Consent Act*. The definition of “health care” for which consent may be given is defined in section 1 of the Act to mean “anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health,” and includes “a series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem.”

¹⁹ While the capability to consent is listed here as the first element of consent, it is listed as the fourth element in section 6 of the *Health Care Consent Act*. I have placed it first here because, without capability to consent, none of the other elements of consent would have much relevance.

²⁰ See section 6(d) of the *Health Care Consent Act*.

²¹ See section 3(2) of the *Health Care Consent Act*.

Section 7 of the *Health Care Consent Act* goes on to set out two requirements when making a decision as to whether any particular client is *not* capable of giving, refusing or revoking consent, thus setting aside the presumption. The two requirements that a counsellor should keep in mind can be framed by asking:²²

1. Does this client demonstrate or indicate that he or she *understands the information* I have provided (e.g. about their condition, the nature of the proposed counselling, any risks or benefits, and the alternatives, if any)?
2. Does this client also demonstrate that he or she understands that the information I have given *applies to their particular situation*?

A simple way to ascertain if the client meets this two-part test would be to ask the client to repeat back the information that was given, using his or her own words. The counsellor should then pay attention to the way the client answers the question to ensure the client's answer is clear, consistent and unambiguous. The counsellor should then record the client's answers in the clinical notes, as well as any pertinent questions the client may ask that reflect an understanding of the proposed services.

If the answer to either of the above two screening questions is "No," the counsellor should not proceed further, because the presumption of capacity may now be in question for the subject adult. It may then be necessary to stop further counselling and take another path.

If the counsellor determines there is a need to continue with counselling, the counsellor may then have to seek out someone else who holds the appropriate authority to give substitute consent in place of the client's consent. But because it is unlikely that a clinical counsellor will be providing counselling therapy to an adult client who is incapable or unable to give consent, this Legal Commentary will not address the requirements for obtaining substitute consent.²³ Counsellors who find themselves in such a rare situation should obtain independent advice before proceeding.²⁴

In most situations it is likely that counsellors can rely on the presumption of capacity that gives their adult clients the ability to give, refuse or revoke consent, unless the contrary is demonstrated.

²² See section 7 of the *Health Care Consent Act*.

²³ See section 11 of the *Health Care Consent Act*.

²⁴ The BC Ministry of Health has produced a *Practice Guidelines for Determining Incapability to Consent to Health Care*, which is attached to the more detailed guideline: *A Health Care Provider's Guide to Consent to Health Care*. See the Additional Readings at the end of this Commentary.

(b) Consent must relate to the services to be provided

The consent a client has given must relate to the counselling therapy services the counsellor was proposing.²⁵ Further, a consent given in one context may not be consent that would apply to all subsequent services. Consent is usually specific or applies to the therapies that are to be provided and have been disclosed to the client.²⁶

That said, a counsellor may ask a client to consent to a general plan or course of counselling, including future repeats of certain therapeutic modalities. In such situations, the counsellor must get the client's clear consent for the plan from the start.

If a counsellor proposes one type of therapy but later provides a significantly different and unrelated type of counselling therapy, such a change would likely void the client's original consent to the first proposed therapy. The counsellor might then be liable for any resulting harm suffered by the client that may be linked to the subsequent and non-consented therapy. If the original counselling therapy changes, the client should separately consent to the new approach.

I will discuss the dynamic nature of consent in more detail at the end of this chapter under the heading Consent Is a Process, Not a Form.

(c) Consent must be voluntary

A client must give the counsellor voluntary consent.²⁷ For example, the client would not be giving valid consent if he or she were doing so under some form of threat or intimidation, in particular a threat of physical harm.

A counsellor who is concerned that a client is attending the session and agreeing to counselling under some form of duress or coercion should explore these reasons to ensure they would not effectively nullify that client's consent.

Sometimes a client may not want to attend counselling, but has been "forced" to attend by a spouse, family member or friend. There may even be a court order in place that requires the client to obtain counselling. In such situations, the client's reluctance to attend counselling is not the same as overt coercion, where someone may be forcing attendance under a threat of bodily harm, for example. While initially reluctant, the client may nonetheless agree to counselling after the counsellor has explained the benefits.

²⁵ See section 6(a) of the *Health Care Consent Act*.

²⁶ See section 9(2) of the *Health Care Consent Act*.

²⁷ See section 6(b) of the *Health Care Consent Act*.

Even if directed by a court to participate, such a client would still have to consent to the subsequent counselling.²⁸

(d) Consent cannot be obtained by fraud or misrepresentation

The consent a client gives the counsellor must not be obtained by either fraud or misrepresentation.²⁹ While this aspect of valid consent may be similar to the need for the consent to be related to proposed services, it goes further than that.

Consent obtained by fraud or misrepresentation would not be informed consent, and any misrepresentation about the nature of the intended service means the victim has not given true and informed consent to the actual service that was provided. For example, if a client is told one thing but experiences something quite different, his or her consent to the first event would be rendered null and void. Consent voided because of fraud or misrepresentation can have serious legal consequences, such as leading to a criminal charge of assault or a civil claim for damages.

(e) Consent must be informed

The consent a client gives the counsellor must also be informed.³⁰ This means that the counsellor must give the client the information that a reasonable person would require to be able to understand the proposed counselling therapy or services and to then make an informed decision.³¹ (Again, false or deceptive information would void any consent.) Health care providers thus have a duty of disclosure that is intended to ensure a client's consent is informed.

There are four aspects to the nature or scope of the information a counsellor must give to a client to thus meet their duty of disclosure:

1. the information must relate to the client's condition or circumstances for which the counselling are proposed;
2. the information must describe the nature of the proposed counselling;

²⁸ If such a client refused to continue, the court order may then direct the counsellor to report that refusal to the court.

²⁹ See section 6(c) of the *Health Care Consent Act*.

³⁰ This aspect of consent is often given prominence when counsellors talk about "informed consent." But, as the discussion in this section should illustrate, informed consent is but one of the six important elements of a valid consent.

³¹ See section 6(e) of the *Health Care Consent Act*.

3. the information must disclose the risks³² and benefits of the proposed counselling that a reasonable person would expect to be told about;
4. the information must include any alternative therapy (counselling or otherwise), if any, including doing nothing.

If one or more of the above four requirements is missing, the client's consent may then be found to be uninformed, and – much like fraud or misrepresentation – would render null and void any consent that was given.

In Glaholt v. Ross, the court explained the importance of this element of consent in the context of a patient who had received an eye injection from an ophthalmologist (emphasis added):³³

A physician must disclose to a patient the nature of a proposed treatment, its gravity, any material risks, and any special or unusual risks attendant upon the treatment. The scope of the duty and whether or not there has been a breach must be decided in relation to the circumstances of each case.

The Court must consider two questions: first, whether Ms. Glaholt had the requisite information to provide informed consent; and second, if not, whether a reasonable person in her circumstances would have consented to the procedure if provided with that information. That is because the failure to give an adequate warning will have caused Ms. Glaholt damage only if a reasonable person in her circumstances would have refused consent.

If someone other than the counsellor is to provide the client with some aspect of the proposed counselling service, the client should know in advance that these services will be delegated to another person, and, in turn, to consent to that delegation.

A client's particular circumstances or previously expressed concerns might require the counsellor to disclose potential although uncommon negative outcomes of the proposed

³² While likely not applicable to most forms of counselling, there is a line of reported Canadian cases which address the question of the disclosure of "material risk." Through these cases, the courts have found that the materiality of a risk is reflected in the frequency of the risk and by its seriousness should that risk occur. In general terms, the more frequent a risk, the greater is the obligation to discuss it with the client. In particular, even uncommon risks of great potential seriousness should be disclosed. For example, even if a risk is "a mere possibility" yet it carries with it serious consequences such as paralysis or death, it should be regarded as material and should be disclosed to a client.

³³ Glaholt v. Ross, 2011 BCSC 1133, 2011 CarswellBC 2226, [2011] B.C.W.L.D. 7188, [2011] B.C.W.L.D. 7186, [2011] B.C.W.L.D. 7150, [2011] B.C.W.L.D. 7149, [2011] B.C.W.L.D. 7144, [2011] B.C.W.L.D. 7143, 86 C.C.L.T. (3d) 295, 206 A.C.W.S. (3d) 423 (BCSC, August 19, 2011) 2011 BCSC 1133, at para. 194 and 195 (citations omitted)

counselling therapy, when ordinarily these types of risks might not be seen as material. The courts have made it clear that the duty of disclosure extends to what a health care provider knows (or should have known) that the particular client deems relevant to their subsequent decision whether or not to undergo treatment. So, a counsellor should try to put him or herself in the shoes of their particular client when providing information about risks and benefits of any proposed counselling.

The inclusion of alternatives to counselling in the information the counsellor communicates to the client does not mean that the counsellor must discuss what is commonly regarded as unconventional therapy or services. However, the client should be advised if there are other, generally accepted alternatives, and why the recommended therapy has been proposed.

As a general rule of thumb a counsellor should ask him or herself: *What information about the counselling therapy services I am proposing would a reasonable person in this client's position want to have before making a decision?*

(f) Client must be able to ask questions

While it can be viewed as part of “informed consent,” the final element of a valid consent is that the client must be given an opportunity to ask the counsellor questions and to receive answers about the proposed counselling therapy services.³⁴ This can be a critical part of the consent process.

As will be discussed in more detail below, under Consent is a Process, Not a Form, if a counsellor fails to have this dialogue with a client (or at least give the client an opportunity to ask questions) before the client signs a consent form, this failure can invalidate the form itself. By engaging in a direct conversation with the client before giving consent, the counsellor can not only ensure the client is capable of giving consent, but can also ensure the client's consent is fully informed, and that the client understands the counsellor's explanation before giving consent. Allowing the client to ask questions gives the counsellor an opportunity to watch the client's reaction to ensure he or she understands the counsellor's answers. Indeed, the nature of the client's questions can be an important part of the counsellor's assessment of the client's capability to consent, being the first element of consent as discussed above.

For these reasons, a counsellor should communicate with a client in a way that is appropriate to that client's particular skills, ability and language. This raises the duty of a counsellor to communicate with the client.

³⁴ See section 6(f) of the *Health Care Consent Act*.

1.9) Duty to communicate appropriately

When seeking a client's consent, in particular when determining if a client is capable of giving consent, the counsellor must communicate with the client in a manner that is appropriate to that particular client's skills and abilities.³⁵

While such situations may not arise often, the counsellor may need to allow a client's spouse, relative or friend who has accompanied the client and offered their assistance to then help that client understand what the counsellor is saying so as to then help the counsellor obtain informed consent. For example, the client may require the communication assistance of an interpreter for a language the counsellor does not speak or a sign language interpreter if the client is deaf or hard of hearing.

This leads to a consideration of the different ways that clients can communicate their consent to a counsellor.

1.10) Communicating consent

It is useful to consider the different ways that clients can communicate their consent to counsellors. The question can be asked: *What are the different forms of client consent?*

In brief, there are two ways that clients can communicate or give their consent: (a) by either expressed consent or (b) by inferred consent.³⁶

(a) Expressed consent

A client's expressed consent to counselling can be communicated to the counsellor either in writing or verbally.

Written expressed consent is probably the form of consent most counsellors try to obtain, but, as I will discuss in more detail below, asking a client to sign a standard consent form in the waiting room is not good practice and is unlikely to result in a valid consent.

As noted in the Introduction, the BCACC has produced a separate *Standard for Informed Consent to Clinical Counselling and the Collection, Use and Disclosure of Personal Information*. This practice standard provides a useful framework for counsellors who want to prepare a template to document the client's consent in a written form. While useful, counsellors should understand that following this standard might not protect them

³⁵ See section 8 of the *Health Care Consent Act*.

³⁶ See section 9(1) of the *Health Care Consent Act*.

in all circumstances. (For a further discussion on this point, see *Consent is a Process, Not a Form*, below.)

Consent that the client gives verbally can be as valid and reliable as a written consent. In fact, given the dynamic nature of counselling practice, receiving a client's verbal consent to the initiation if not the continuation of therapy may be the best way that the client can communicate his or her consent to the counsellor. Therefore, a counsellor should make a notation in the clinical notes of a client's verbal consent to counselling, even if the client has already signed some sort of written consent form. The client's consent can be confirmed or validated by a suitable notation in the counsellor's clinical notes.

(b) Inferred consent

Inferred consent³⁷ is given by any action a client takes, other than expressed (verbal or written) consent. In these cases, consent is inferred by what the client does or does not do, rather than what the client says or does not say. Inferred consent can communicate to the counsellor without words that the client is consenting to what is happening or has been proposed.

Common examples of inferred consent would be a simple nod of the head or other similar gesture. It is also possible to infer valid consent when the client comes into the counsellor's office, tells the counsellor personal information or does not leave, in particular if the session becomes difficult. Not leaving the office is likely inferred consent.

The law has recognized the validity of inferred consent for well over one hundred years. For example, in 1891 an English court found that if a patient holds up an arm for a vaccination, and the doctor then injects the patient, reasonably believing that the patient is consenting to that injection, the patient cannot later complain that he had not given consent.³⁸ Indeed, many of us give inferred consent by submitting to often invasive physical examinations by our medical doctors and we do so without first signing a consent form.

In the recent case of Glaholt v. Ross mentioned above, the court found that Ms. Glaholt had cooperated with Dr. Ross by following his instructions concerning the movement of her body and eyes. She did not express any concern about the treatment he was about to provide her by way of an injection into her eye. In these circumstances, the court found

³⁷ Inferred consent is sometimes also referred to as implied consent. For the purposes of this Commentary, I will adopt the term "inferred consent" as that is the terminology used in the *Health Care Consent Act*.

³⁸ O'Brien v. Cunard SS. Co (1891), 28 N.E. 266.

that Dr. Ross reasonably believed that Ms. Glaholt had consented to the pending injection. As a result, her subsequent claim for battery against Dr. Ross was dismissed.³⁹

Whether it was reasonable for a counsellor to infer that consent was given, or whether the counsellor cannot infer an implied consent, and must therefore respect the wishes of the client and not continue with counselling, will depend on the circumstances.

Counsellors should be cautious, however, because a client who simply remains silent is not necessarily consenting. In such circumstances, a positive gesture from the client suggesting consent may be sufficient to convey inferred consent. But it would be preferable to get the client's verbal consent at the least.

For inferred consent, the onus rests on the provider of the service or treatment to demonstrate that this form of consent was given and that it addressed the essential elements of a valid consent, as discussed above. Again, a notation of the inferred consent in the clinical notes should be sufficient documentation of the client's consent without the need to stop the sessions and ask the client to sign a new written consent form.

(c) Withdrawal of consent

A client can withdraw consent at any time, even withdrawing or cancelling an earlier written consent in a consent form. A client's withdrawal of consent effectively ends the counselling session.

The withdrawal of consent does not have to be in writing. It can be expressed overtly, such as if the client says he or she wants to end the session or even walks out the door. Withdrawing consent can also be implied by how the client is responding without saying anything.

Counsellors should be sensitive to the possibility that a client may have expressed an implied withdrawal of consent and should then check with the client if they think this may be occurring. In so doing, counsellors should remain aware of the effects of the client's culture, to educate themselves as to these effects, and to seek information from the client about the client's understanding of their decision-making role.

(d) Documenting consent

It is important for the counsellor to document accurately and completely in the clinical notes the decisions the client has made in relation to the proposed counselling services.

³⁹ Glaholt v. Ross, 2011 BCSC 1133, at para. 191 to 193.

While obtaining a client's signature on a consent form is one way to document consent, it should be obvious from the above that relying only on a signed consent form can lead to difficulties. This is especially the case if the client gave consent orally or consent was inferred from his or her conduct.

While written consent may be helpful for personally invasive or potentially traumatic counselling therapy or services, at the least a counsellor should document client consent in the clinical notes, accompanied by a summary of the conversation that took place between the counsellor and the client leading up to that consent. Presenting clinical notes later as evidence that the client consented can be as legally persuasive as presenting a consent form signed by the client.

1.11) Consent is a process, not a form

The observation "consent is a process, not a form" should be a mantra for all health professionals. Counsellors who insist that their clients must sign consent to treatment forms, should heed the advice of this simple phrase. A client's signature on a consent form is not a guarantee that valid consent has been given.

While most counsellors are trained to use consent forms, and the BCACC has produced standards about how such forms should be worded, it is unlikely that simply asking the client to read and sign a consent form will contribute to the counselling session or, more importantly, give the counsellor a reliable document to defend his or her actions should the client later sue the counsellor in negligence.

Placing too great an emphasis on having a client sign a long or detailed legal form may not a good way to start a clinical relationship. An overly legalistic consent form may give the client reason to believe that the counsellor is more concerned about protecting him or herself than wanting to help the client.⁴⁰

When seeking consent from a client, a counsellor should understand that consent is a dynamic process and one that does not end when the client gives initial consent. Consent is an on-going communication process between the counsellor and client. It is not a one-

⁴⁰ Fundamentally, a consent form is designed to protect the counsellor, not the client. Consider situations where other professions do not use such forms. Many medical practitioners do not ask their patients to sign a consent form in situations that can be more invasive than counselling. For example, women consent to a pelvic examination or PAP smear by simply putting their feet into the stirrups of their doctor's examination table. Men consent to a prostate examination by pulling their pants down and rolling onto their sides. If medical doctors do not feel there is a need for patients to sign written consent forms and they can rely on implied consent in these situations, one wonders why counsellors feel they must have clients sign written consent forms for clinical services that have much less risk.

way street, and does not end if the client signs a form. True consent directly engages the client in the counselling process and respects his or her role in the decisions that will need to be made, and respects the fact that consent can ebb and flow throughout a counselling session.

Simply giving a client sitting in the waiting room a standard consent form and asking the client to read, fill in the blanks and sign the form is *not* appropriate practice. As should be obvious by the six essential elements of valid consent discussed above, in order to obtain valid consent, the counsellor needs to engage in a meaningful and direct conversation with the client about the nature of what counselling entails and any proposed specific treatment plans. The counsellor needs to disclose whether there might be serious, negative outcomes, any material risks, and any special or unusual negative outcomes that the client might experience during or after the clinical session. Simply setting these matters out in general terms on a consent form without giving the client an opportunity to ask the counsellor questions and receive answers about the counselling session before signing the form could render the client's apparent consent of no more value than the paper it was written on. Indeed, subsequent conversations between a counsellor and a client could substantially change the nature and purpose of the client's consent, in particular if more information about the services and their risks were disclosed after the client signed the counsellor's standard consent form.

A client should be asked to sign a consent form only after the essential steps to obtain valid consent have been completed, in particular after the client has had an opportunity to ask questions and receive clear answers from the counsellor about the proposed counselling services.

Relying on a client's signature on a consent form can be particularly problematic in counselling sessions where the counsellor is trying to assist a client with what may be difficult emotional and psychological problems. While a distressed client is not likely to be inherently or automatically incapable of giving valid consent, to ensure an emotionally distraught client gives proper and informed consent, it is particularly important that the counsellor have a full and open discussion with the client that covers all the aspects of informed consent as outlined above.

It is also possible that, during a session, a client may express extreme discomfort and effectively revoke a previously given consent. A client can revoke consent verbally, even if the client had previously signed a consent form. A client does not have to revoke a written consent by signing another form.

Once the original consent has been revoked, the counsellor should stop the session and, before continuing, obtain the client's renewed consent and agreement to proceed. It is most likely this consent to continue will be given verbally or implied by the client's physical actions. (Details on forms of consent will be discussed below.) Ultimately, the counsellor must respect the client's decision not to proceed further, effectively revoking any previously given consent, even if the counsellor thinks that decision was unwise.

During a clinical session the nature of the counselling services may change significantly compared to what the client may have originally agreed to. In such a situation, the counsellor should seek further consent for the new services that are then being proposed or provided. It is highly unlikely that a blanket consent form will allow consent to be specific to the counselling therapies that are actually provided, or that it will accommodate significant changes to services during the counselling sessions.

Sometimes a client may not truly understand what the counsellor is telling them about a proposed counselling therapy because the client is just not emotionally able to properly focus on and process the information the counsellor is providing. Therefore, it can be important for the counsellor to be constantly reviewing if not renewing the client's consent throughout the clinical sessions. Documenting on-going consent in the clinical notes would be preferable to stopping the session to have the client sign a revised or updated written consent form.

Some counsellors require someone to witness the client's signing a consent form. But witnessing any form is not the same as attesting that the client was fully informed and was giving valid consent. All witnessing a form provides is that the client who signed the form is the same person who is named on that form.

Further, caution should be taken to include in a consent to treatment form a separate consent to the collection, use and disclosure of personal information. Depending on the circumstances, there may not be a need for the client to sign a written consent form in relation to personal information, because the rules of this form of consent are already set out in the *Personal Information Protection Act (PIPA)* that is binding on counsellors in private practice. Instead, a counsellor may want to simply provide a client with information that explains the counsellor's privacy policy, and how the counsellor will use the information the client will provide during the counselling sessions as required by PIPA. Further, there is no need for the counsellor to obtain the clients "consent" to situations when the counsellor may be required by law to disclose otherwise confidential information to the police or other authorities, as is also permitted under PIPA. The law directs that such disclosures are mandatory in such circumstances: the client's consent to such a disclosure is irrelevant. What is more important is that the client be made aware of

the limits of counsellor confidentiality.⁴¹

1.12) Summary

The six essential elements of adult consent to counselling services can be summarized as follows:

1. while the adult client is presumed capable, it may nonetheless be necessary for a counsellor to determine if he or she is incapable of making a decision about whether to give or refuse consent to the proposed counselling;
2. the adult's consent must relate to the proposed counselling;
3. the adult's consent must be given voluntarily;
4. the adult's consent can not be obtained by fraud or misrepresentation;
5. the counsellor must provide the adult with information that a reasonable person would require to understand the proposed counselling and to make a decision;
6. the adult should have an opportunity to ask the counsellor questions and receive answers about the proposed counselling.

(Refinements to these elements as they apply to children consenting to counselling will be considered in chapter 3.)

In terms of documenting consent, a client's signature on a consent to treatment form is not "consent." It is simply evidence in the form of a written document that the counsellor gave appropriate explanations, the client understood that information and then agreed to the proposed counselling therapy services. Fundamentally, consent is the result of communications between the counsellor and the client leading to a decision. Consent is not a form.

⁴¹ For a discussion of the various duties to report as exceptions to a counsellor's duty of confidentiality, see Bryce, G, [*Legal Commentary: How Private is Private?*](#), a publication of the BCACC (June 20, 2012).

2) PARENTAL CONSENT

As noted in the companion *Legal Commentary on the New Family Law Act*,⁴² significant changes in terminology have resulted from the new *Family Law Act*⁴³ (FLA). Because of those changes, the article that Martha Sandor and I prepared in 2002⁴⁴ on parental consent needs to be updated. While the common law rules regarding parental consent have not changed, the new FLA requires our earlier summary to be updated to reflect the new family law terminology. This chapter therefore replaces that earlier article.

2.1) Counselling for marital breakdowns

When a marriage breaks down, and there are children involved, it can be useful for the parents and children to obtain counselling to help them through this often-traumatic event and prepare for life after divorce. While many parents try not to use their children as pawns in the separation/divorce process, it can be difficult to prevent the emotional spillover of that process from negatively impacting the children. Regardless of the problems the parents see in their relationship, for the children that relationship is usually the only experience of family they have had, and so children often experience some form of loss as a result of their parents' separation or divorce.

Counselling provided to the children of divorcing parents by knowledgeable, experienced and compassionate counsellors before, during and after separation or divorce can help the children adjust to the new reality for their family. Counselling can help the children deal with their feelings of guilt, shame or frustration, which may result from their parents' separation, even if not intended. Counselling can help the children develop new perspectives and coping skills for the future.

This chapter will consider the specific questions that may arise when a parent brings a child to a counsellor for clinical services, even if so directed to do so by the courts.

2.2) Parental consent

The law recognizes that a parent ("guardian" under the FLA) can have different relationships with a child that are relevant to giving consent to counselling therapy services. A separation of these legal relationships sometimes becomes necessary when the courts are adjudicating the breakdown of a marriage where children are involved, and, as discussed in more detail in the *Legal Commentary on the New Family Law Act*, the

⁴² Published concurrently with this Commentary, and posted at the membership side of the BCACC website.

⁴³ S.B.C. 2011, c.25.

⁴⁴ *Supra* at footnote #3.

new FLA redefines these different relationships.

(a) Focus on the guardian not the parent

In the rest of this chapter, I will use the term “guardian” instead of “parent.” In most instances a guardian will be one (if not both) of the parents who are guardians under the new FLA, but non-parents can also become guardians. From time-to-time I may refer to a “guardian parent” or a “non-guardian parent” where such a distinction is necessary.

For the purposes of a counsellor obtaining consent to provide counselling to a child, the guardian who holds the appropriate parental responsibilities (what used to be known as guardianship under the old FRA) for that child has the legal authority to give consent.

(b) Parental responsibility re: giving consent

As discussed in the *Legal Commentary on the New Family Law Act*, the new FLA makes it clear that parental responsibilities can be shared between guardians or allocated to one guardian only, so that only one guardian parent may make decisions on issues covered by the responsibility. Under the new FLA, a child’s guardians are presumed to share all parental responsibilities in consultation with each other *unless or until an agreement or court order says otherwise*.

If through an agreement or a court order, only one guardian has been granted parental responsibilities, in particular those responsibilities concerning consent to health care and related treatments, then only that guardian has the legal authority to give consent for the counsellor to then provide counselling services to the child.

If the separating parents remain guardians and both retain joint parental responsibilities, which is presumed, but can also be set out in an agreement or by court order, then – as a matter of law – either or both of the guardian parents can give consent for the counsellor to then provide counselling services to the child.

If one guardian parent brings a child to the counsellor for counselling, the counsellor should ascertain where the family is in the separation and divorce process, and whether that parent has the legal authority (as a guardian, holds the appropriate parental responsibilities) to consent to the counsellor providing services to that child.

In most situations, it would be reasonable for a counsellor to assume that a parent of a minor child is the lawful guardian of that child and, in turn, has the authority to give consent to any proposed counselling therapy or services for that child. But if a counsellor is concerned or becomes aware of circumstances that suggest that the adult

accompanying the child may *not* be a guardian of that child, the counsellor should make further inquiries to confirm the adult is a guardian before providing therapy for that child.

Section 40(2) of the FLA states that, unless a separation agreement or court order allocates parental responsibilities differently, “each child’s guardian may exercise all parental responsibilities with respect to the child.” Thus either or both guardian parent may consent. While the law allows a counsellor to rely on the consent of only one guardian parent in a situation where the guardians share joint parental responsibilities, as a matter of practice a counsellor should make reasonable efforts to obtain consent from both parents.

There is one important issue that can complicate matters where there are two (if not more) guardians who can give or refuse consent for a child to obtain counselling therapy or services. This is the guardian parents’ duty to consult.

(c) Guardians’ duty to consult

Section 40(2) of FLA effectively requires the guardian parents who hold joint parental responsibilities to consult with each other before either makes health care decisions for a child. There are several points that flow from a guardian’s duty to consult as it relates to section 41(f) of the FLA that speaks to “giving, refusing or withdrawing consent to medical, dental and other health-related treatments for the child.”

First, if both of the guardian parents hold the same parental responsibilities under section 41(f) of the FLA, a counsellor should try to obtain the consent of both guardians, including any guardians who are not parents, before providing counselling services to the affected child. While trying to obtain the consent of both guardians is recommended practice, as a matter of law, a counsellor can still rely on the consent of just one guardian. In these situations, section 40(2) of the FLA requires guardians with parental responsibility for giving, refusing or withdrawing consent to first consult with each other before so acting.

However, section 40(2) of the FLA does not go further and require the counsellor to actively seek out and obtain the approval of both guardian parents. As discussed above, a counsellor is entitled to rely on the parent who advises the counsellor that he or she is a guardian and has either been awarded sole parental responsibilities to consent to health care services for the child, or has consulted with the other guardian parent as required by the FLA.

Second, if parental responsibility for decisions falling under section 41(f) of the FLA regarding consenting to health care has been allocated to only one guardian or parent,⁴⁵ then – as a matter of law – the counsellor only needs to obtain the consent of that guardian. Further, in this situation, the guardian with sole authority under section 41(f) is *not* required by section 40(2) of the Act to consult with the non-guardian parent or the child’s other guardians.

The duty of parents to consult that is implied by section 40(2) of the FLA is one that the guardian parent, not the counsellor, holds under the Act. As such, it is not the counsellor’s legal responsibility to confirm (such as by talking directly with the other parent) that the guardians have in fact consulted with each other. The counsellor is entitled to rely on the guardian parent who advises the counsellor that he or she has either been awarded sole parental responsibilities to consent to health care services for the child, or has consulted with the other parent as required by the Act. In most situations, it would be reasonable for the counsellor to rely on the information that the consenting parent provided at the start of counselling.

A guardian’s failure to consult as required by section 40(2) of the FLA is an issue that the affected guardian or parent can take to court for adjudication. Counsellors should avoid putting themselves into positions where they are passing judgment on the adequacy of these consultations.

Further, the duty to consult does not mean that both guardian parents must therefore both agree. Section 40(2) of the FLA does not create a requirement that there must be mutual agreement; it is simply a duty one guardian parent has to consult with the other.

(d) Exceptions to the guardians’ duty to consult

A guardian’s duty to consult with the other guardian is also subject to an exception that is also set out in section 40(2) of the FLA: “unless consultation would be unreasonable or inappropriate in the circumstances.” This means that, if it was not reasonable or appropriate for one guardian parent to consult with the other, the duty to consult is thus not activated.

⁴⁵ For example, this is likely to be the parent who remains as the child’s guardian in situations where the other parent is no longer a guardian because of a history of conflict or violence.

It is not the counsellor's responsibility to decide if it was reasonable or appropriate for one guardian not to consult with the other in any specific situation. A guardian or parent who does not believe it was reasonable or appropriate for the other guardian not to have consulted can take that issue to the court for adjudication.⁴⁶

If a counsellor has not obtained the consent of a child's other guardians, the counsellor should make a note in the clinical records as to what the consenting guardian parent has said about either consulting or not consulting other guardians. Again, the counsellor is not required to confirm that these consultations took place. But the counsellor should be aware of the guardian parent's duty to consult with the other guardian parent. It may be good practice to remind the guardian parent who is consenting of this duty.

As was the case with a parent's status as a guardian, unless circumstances suggest otherwise, a counsellor can rely on the information one guardian provides as to what steps he or she took to consult with other guardians. If the counsellor is concerned that one guardian has not consulted or may not have a good reason for refusing to consult with the other guardian, the counsellor should simply remind the consenting guardian of his or her duty to consult and make a note of that conversation in the clinical record. So long as the counsellor has at least raised the issue, there is no requirement for the counsellor to go further and actively seek out the other guardians and make a separate determination whether it was reasonable or appropriate for the consenting guardian not to consult with the other guardians in the circumstances.

(e) Parents in conflict

Sometimes it is not possible or practicable for the counsellor to obtain consent from both guardian parents. For example, one guardian parent may be adamantly opposed to the child receiving counselling, while the other feels counselling is essential for the child's wellbeing. While as a matter of law the counsellor can rely on the consent of one guardian parent in these situations, as a matter of practice the counsellor should encourage the consenting parent to help the counsellor obtain consent directly from the other guardian parent. Dual consent means there should be less collateral undermining of the benefits of counselling for the child. (A parent who is no longer a guardian of the child under the FLA has no legal authority to give or refuse consent, and in turn the guardian parent has no duty to consult with that non-guardian parent.)

But if only one guardian parent with joint parental responsibilities under the FLA

⁴⁶ The sort of circumstances when one guardian parent might be able to unilaterally consent without consulting the other guardian parent would include emergency situations or where the other parent simply cannot be reached. No doubt, future court cases will provide examples of where this duty does not apply.

consents, then for the purposes of the counsellor providing therapy or other services to the child, the consent of that guardian parent is sufficient, at law, for the counsellor to then provide counselling to that child.

If the consenting parent failed to consult with the other guardian parent before giving consent, as required under section 40(2) of the FLA, that is an issue the non-consenting parent can take to the court against the consenting parent as a possible breach of this FLA provision. The consenting parent’s failure to consult with the other guardian parent is not something that can be held against the counsellor who provided the services. To require otherwise places the counsellor in the role of a judge in a court of law.

The following table summarizes a parent’s authority to give consent for counselling services to a child in relation to the four different legal statuses that parents may now hold under the FLA.⁴⁷

Table One: A parent’s legal status and authority to give consent

Parent’s legal status	Parent’s authority to consent
<i>Both are guardians, no agreement or order re: parental responsibilities:</i> Parents live together or have lived together and are now separated, and do <i>not</i> have an agreement or court order that allocates their parental responsibilities.	Either parent may give consent to allow a counsellor to provide counselling services to a child, but the consenting parent must consult with the other guardian parent. ⁴⁸
<i>Both are guardians, shared parental responsibilities:</i> Parents have lived together and are now separated, and have an agreement or court order that both parents either share all parental responsibilities or that both parents have responsibility under section 41(f) of the FLA re: “giving, refusing or withdrawing consent to medical, dental and other health-related treatments for the child.”	Either parent may give consent to allow a counsellor to provide counselling services to a child, but the consenting parent must consult with the other guardian parent.

⁴⁷ The use of a “child” in this table should be understood as not including a “mature minor.” Under the *Infants Act*, mature minors are capable of giving their own, separate consent to counselling, even if their parents refuse. See chapter 3, Consent of a Child, for details.

⁴⁸ As noted above, section 40(2) FLA states that, unless a separate agreement or court order allocates parental responsibilities differently, “each child’s guardian may exercise all parental responsibilities with respect to the child in consultation with the child’s other guardians, unless consultation would be unreasonable or inappropriate in the circumstances.” As discussed, counsellors have a duty to obtain the consent of at least one guardian. They should inquire if the other guardian either also consented or was consulted, even if he or she did not consent. Counsellors do not have to confirm that both parents in fact consulted with each other.

<p><i>Both are guardians, but different allocation of parental responsibilities:</i> Parents have lived together and are now separated, and have an agreement or court order that gives only one parent authority under section 41(f) of the FLA re: “giving, refusing or withdrawing consent to medical, dental and other health-related treatments for the child.”</p>	<p>The parent with authority under section 41(f) may give consent, and that parent does not have to consult with the other guardian parent.</p>
<p><i>Only one parent is guardian:</i> Only one parent is a guardian, either because of the presumptions set out in section 39 of the FLA or because the parents have an agreement or court order that states that that parent is not a guardian.</p>	<p>The guardian parent may give consent to allow a counsellor to provide counselling services to a child, and that parent does not have to consult with the other non-guardian parent, because that parent does not hold any parental responsibilities.</p>

2.3) Questions to consider

If a parent or other guardian comes to a counsellor seeking counselling for a child, whether or not that parent or others will be involved in the counselling sessions, there are some basic questions the counsellor should try to answer before proceeding. Answers to these questions should give the counsellor sufficient information to then allow that counsellor to know what his or her legal duties are in relation to obtaining proper consent from parents.

The first set of questions focus on understanding the legal status of the parents:

- Is the counselling being sought in relation to a marriage breakdown?
- What is the current stage in the separation or divorce process?
- Is there a final agreement or court order in place that defines their legal status? If not, at what date in the future is it anticipated there will be a final agreement or court order?
- Does an agreement or court order specify in writing that one parent is no longer a guardian of the child, but may have been granted access to the child?
- Does an agreement or court order specify in writing which guardian parent (if not both) has parental responsibilities? And do the parents hold the same or different parental responsibilities? In particular, have joint parental responsibilities been defined in some specific fashion, such as in relation to section 41(f) of the FLA regarding consenting to health care?
- Has a section 211 of the FLA assessment report been ordered or prepared? Is the parent prepared to make a copy of that report available? Is there an order directing

that a service provider should review such a report?

It would be helpful if the counsellor saw (and made a copy of) any agreement or court order that exists. A counsellor is not expected to understand these legal documents. Depending on the circumstances, the counsellor may have to rely on the information of just one guardian parent as to the current legal situation and a description of content of any agreement or order. There is no legal duty on a counsellor to obtain additional information from other sources to confirm the information one parent may be providing.

If a guardian parent cannot provide a copy of an agreement or order for the counsellor to review, that fact and the information the parent then provided to the counsellor on these issues should be recorded in the clinical notes.

The next set of questions will further assist the counsellor to understand the nature of the relationship between the parents, and in particular whether or not there has been consultation between the guardian parents:

- Does the other guardian parent have knowledge of the proposed counselling? If the other parent does not know about the counselling, why did the requesting parent refuse to consult the other parent?
- Does the other guardian parent agree to the proposed counselling? If the other parent does not agree, why has that parent taken that position?
- Can information the child may provide during counselling be disclosed to one or both guardian parents? And to whom may that disclosed information be provided? And when?

Depending on where the parent(s) are in any legal proceedings and any resulting separation (parenting) agreement or court orders, some of the above questions may need to be revisited during subsequent counselling sessions.

While it is not critical that answers be obtained to every one of the above questions, keeping these questions in mind should help the counsellor obtain sufficient information so that the counsellor can meet his or her legal responsibilities in relation to obtaining proper consent from one or both parents. The answers should also help the counsellor to better understand how well the parents have met their duty to consult with each other.⁴⁹

⁴⁹ To be clear, the duty to consult is one that parents, not counsellors, hold. A counsellor does not have to confirm the parents in fact consulted or that such consultation or a refusal to consult was reasonable in the circumstances.

If the counsellor is seeing an older child, that child (as a “mature minor”) may be able to give his or her own consent to the counselling therapy services without the need for the consent of either parent. In such cases, the legal status of the parents’ relationship to that child would not be a determining factor. The counsellor should follow the guidance for obtaining the consent of a mature child as outlined in chapter 3, Consent of a Child.

2.4) Closing comments

Although efforts are being made to make the legal system more sensitive to issues that can have a negative impact on a family breakdown, such as the changes that have been introduced by the new FLA, at its heart, the system can be very adversarial. Once legal proceedings have been commenced, parents can become entrenched in their positions.

The old language of family law can also further complicate matters. For example, it is not helpful that, in the past, custody disputes were referred to as “custody fights” or “wars.” Again, it is hoped that the new approach and the use of different terminology as reflected in the new FLA will go some distance in addressing these problems.

Regardless, when considering consent for counselling during marital breakdown, it is important for the counsellor to exercise caution and to be mindful of the powerful dynamics that can be at play.

3) CONSENT OF A CHILD

The new *Family Law Act* does not change the common law as it relates to the capacity of a child to give, refuse or withdraw consent to counselling services. In fact, under either the *Infants Act*⁵⁰ or the common law, a child with sufficient capabilities (i.e. a “mature minor”) is able to give legally binding consent to a clinical counsellor and to do so without the need for the counsellor to seek the consent of that child’s parent(s) or guardian(s).⁵¹ This rule reflects the importance of focusing on the maturity of a child rather than on a predetermined chronological age.⁵² The law recognizes that intellectual and emotional capabilities rather than chronological age is the critical factor in allowing children under the age of 19 to give valid consent. This rule is set out in BC legislation.

3.1) Does the *Infants Act* apply to counsellors?

Section 17 of BC’s *Infants Act* states that a child⁵³ under the age of 19 may consent to health care whether or not that health care would, in the absence of consent, constitute a trespass to the child’s person. Further, if the child provides that consent, the child’s consent is effective and it is not necessary for the health care provider to then obtain consent to the health care from the child’s parent or guardian.

These provision of the *Infants Act* apply to “health care providers,” so the first question is whether clinical counsellors fall within that definition. If they do, then section 17 of this Act would apply to their practices.

Section 17(1) defines a health care provider as: “includes a person licensed, certified or registered in British Columbia to provide health care.” In turn, health care is defined as: “anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of health care.”

While the counselling services counsellors provide fall within the scope of the definition of health care, because counselling has not yet been designated as a health profession under the *Health Professions Act*, it could be argued that clinical counsellors are thus not

⁵⁰ R.S.B.C. 1996, c.223.

⁵¹ The *Health Care (Consent) and Care Facilities (Admission) Act*, R.S.B.C. 1996, c.181 has codified the common law in relation to consent, but this new legislation does not apply to persons under 19 years of age.

⁵² While most Canadian provinces have adopted legislation like BC’s *Infants Act*, only the Quebec legislation has established a fixed age of 14 years, below which the parent or guardian or the court *must* consent for the purposes of proposed treatment or services.

⁵³ The *Infants Act* uses the term “infant” which is defined to mean someone who is under the age of nineteen. I prefer to use the term “child,” as an infant is commonly understood by most of us to be a very young child, usually a child under the age of two. Therefore, while the legislation uses the term “infant,” I will use “child” in this chapter.

health care providers and therefore are not covered under section 17 of the *Infants Act*.

On the other hand, because the definition of a health care provider starts with the word “includes,” it could be argued that clinical counsellors are thus *not* excluded from this definition, even if they have yet to be designated under the *Health Professions Act*.

Whether or not counsellors are amongst the health care providers who can rely upon section 17 of the *Infants Act* is not a significant barrier. Even if clinical counsellors do not fall within the scope of this provision, they should be able to rely upon the common law rules that apply to obtaining consent from children as articulated in this section.

3.2) Can counsellors rely on the common law?

The *Infants Act* has “encoded” the common law rules that apply to obtaining consent from children under the age of 19. However, the Act does not go further and expressly state that it replaces or extinguishes the common law. Indeed, as Huddart J. noted in Ney v. Canada (Attorney General)⁵⁴ at paragraph 14 (emphasis added):

A minor is capable of consenting to medical treatment to the extent that he or she can appreciate fully the nature and consequences of the medical procedure to be performed for her or his benefit. That common law rule has been little affected by [the *Infants Act*, which primarily fixes] an age at which a child is deemed capable of consenting.

Therefore, even if they are not covered under section 17 of the *Infants Act*, clinical counsellors can rely on the common law rules when they are seeking the consent of children. So, the question is: *What are the common law rules regarding consent by children?*

There have been few reported cases from BC that have considered the application of the *Infants Act*, in particular in relation to the common law. The leading case occurred in 1993. In Ney v. Canada (Attorney General), members of a religious advocacy group, the Citizens’ Research Institute (CRI), sought a declaration that what is now section 17 of the *Infants Act* be deemed unconstitutional and an infringement on the rights of children and parents, as protected under the *Canadian Charter of Rights and Freedoms*.

In rejecting the CRI’s application to strike-down the child consent provisions of the *Infants Act*, Huddart J. reviewed the common law rules that govern the right of children

⁵⁴ Ney v. Canada (Attorney General), 79 B.C.L.R. (2d) 47, [1993] 6 W.W.R. 135, 102 D.L.R. (4th) 136, 1993 CarswellBC 113, (BCSC, in chambers, May 3, 1993).

under the age of 19 to consent (or to refuse consent or to withdraw consent) to health care. As noted above, she found the Act did not replace those rules.

It is useful to review the common law rules and then consider reported cases that have applied those rules.

3.3) The mature minor rule of consent

As stated at the end of chapter 1, the six essential elements of adult consent to counselling can be summarized as follows:

1. while the adult client is presumed capable, it may be necessary for a counsellor to determine if he or she is incapable of making a decision about whether to give or refuse consent to the proposed counselling;
2. the adult's consent must relate to the proposed counselling;
3. the adult's consent must be given voluntarily;
4. the adult's consent can not be obtained by fraud or misrepresentation;
5. the counsellor must provide the adult with information that a reasonable person would require to understand the proposed counselling and to make a decision;
6. the adult should have an opportunity to ask the counsellor questions and receive answers about the proposed counselling.

But to what extent are these six elements modified if we are considering children and their capacity to consent to counselling services?

In Ney, Hubbart J. summarized the common law rule of child consent to health care in these terms:⁵⁵

In summary, at common law a child is capable of consenting to medical treatment if he or she has sufficient intelligence and maturity to fully appreciate the nature and consequences of a medical procedure to be performed for his or her benefit. It appears that the medical practitioner is to make this determination. If the child is incapable of meeting this test then the parents' consent will be required for treatment. It is not clear whether parental control yields to the child's independence or whether there are concurrent powers of consent. But it is clear that the parents may not veto treatment to which a capable child consents, and that neither child nor parents can require a medical practitioner to treat.

⁵⁵ Ney; *ibid*, at paras 33 and 34

Although the authorities to which I have referred discuss only medical practitioners, the common law has never applied one standard for obtaining consent to medical practitioners and another to nurses or dentists. No argument was presented as to why the same principles should not govern all health care providers whose professions are regulated by statute.

In brief, the common law does not require the consent of a child's parents or guardians, at least so long as the child is capable of giving his or her own consent. This is commonly referred to as the mature minor rule. This rule has two specific elements that are variations on the six essential elements of valid adult consent as summarized above.

(a) Counsellor must assess the child's capacity to consent

As discussed in chapter 1, the general law of consent (as also encoded in the *Health Care Consent Act*) presumes that all adults are capable of giving consent. In turn, if a health care provider is concerned that a particular adult client in a specific situation may not be capable, thus possibly setting aside that presumption, the provider must then ascertain if that adult is not capable. This is done on an assessment as to whether or not the adult demonstrates that he or she understands the information given by the health care provider that applies to that adult's situation. This is the essence of the first element of adult consent as outlined above.

The mature minor rule does not rest on the same presumption of capacity that applies to adults. Instead, the law starts with the presumption that children are not capable of giving consent. The mature minor rule then recognizes that a child, even a young child, may have sufficient capacity to give consent without the need for parental consent.

The mature minor rule (as reflected in the *Infants Act*) requires the provider to consider the extent to which a particular child's physical, mental and emotional development will allow that child to have a full appreciation of the nature and consequences of the proposed counselling services, including the consequences of refusing such services. If the provider determines that the child has the required capacity to make that decision, then that child is a "mature minor." Such a determination sets aside the presumption of child incapacity, and the law then recognizes that the child is then able to consent (or refuse or withdraw consent) regardless of what that child's parents or guardians may have decided.

Even if the *Infants Act* does not apply to counsellors, section 17(3)(a) of the Act simply describes the mature minor rule as requiring a health care provider to explain to the child the nature and consequences and reasonably foreseeable benefits and risks of the

proposed care, and, most importantly, to be satisfied that the child understands these benefits and risks. This necessarily involves the provider having to ascertain that the child has sufficient intelligence and maturity to have such an understanding, as a precondition for then giving consent. This rule applies equally to clinical counsellors.

Whether at common law or through the *Infants Act*, in particular as interpreted in the Ney case, it is clear that there is no longer a set age at which a child is deemed to be capable. Of course the *Health Care Consent Act* effectively declares that when someone turns 19, they are then deemed to be capable of consent, and that presumption can be overturned only in the face of evidence that a particular adult is not capable. But the law clearly takes a flexible approach to determining when any particular child might be capable of giving his or her own consent.

In the Ney case, Huddart J. noted that a child's capacity to consent is not a switch that suddenly turns on or will remain on in all circumstances:⁵⁶

[The] parental right to consent to a child's medical treatment exists only when the child is not capable of granting or refusing consent. This is not a sudden passing of the power but rather a gradual relinquishment of the decision-making power from the parent to the child as the latter's maturity and intelligence increases.

Thus, the further a child matures, the more likely he or she would be able to consent to more complicated or risky services. As was noted by one legal commentator referred to in the Ney decision:⁵⁷

The common law does not fix any age, below which minors are automatically incapable of consenting to medical procedures. It all depends on whether the minor can understand what is involved in the procedure in question. ... [M]any children under the age of ten would probably be capable of consenting to relatively minor and straightforward medical procedures.

For example, if the nature of the therapy were minor or straightforward with little risk to the child, then less understanding may be required than if the treatment was more complex or posed a greater risk to the child's health. The clinical counsellor must provide the child with information that a reasonable person would require to understand the

⁵⁶ Huddart J. in Ney, *ibid*, at paras. 31.

⁵⁷ Professor Skegg quoted by Gosse, R. in "Consent to Medical Treatment: A Minor Digression" (1974), 9 U.B.C.L.R. 56, at pp. 61-62.

services being offered and then make a decision. This would include disclosing information about the nature and purpose of the service or therapy, and any risks and benefits a reasonable person would want to know about. Alternatives to what is being proposed should also be discussed, if applicable. The child should be given an opportunity to have any questions about the services or therapy answered by the counsellor.

The assessment of the child's capabilities is one the counsellor should make, rather than leaving it to the parents or guardians to decide.⁵⁸ The Canadian Bar Association, BC Branch, described this issue in these terms:⁵⁹

Children who are capable can normally get medical treatment without their parents' or guardians' knowledge or consent for things like birth control, abortion, mental health problems, sexually transmitted diseases, and alcohol and drug addiction problems. There are some exceptions to this general rule, and in some cases, parents may be able to get this information. For example, if there is good reason to believe that a child might harm themselves or others, or that there is reportable abuse (physical, sexual or emotional) then the information may not stay private. In such a case, the child should be told why their information won't be kept private and who it will be shared with.

While this scenario may not arise in a counselling practice, if a child cannot communicate consent for some reason (even if the child appears to have sufficient intelligence to understand, etc.), the counsellor should obtain consent from some other source, such as the child's guardian parent.⁶⁰

A counsellor should carefully record in the clinical notes what process the counsellor followed to ascertain whether or not the child understood and appreciated the services being proposed and the risks. This would include any conclusions the counsellor may have reached about the child's intelligence and capacity to understand. A counsellor who is not skilled in performing such assessments should consult with another health care provider who is trained and experienced in these matters.

⁵⁸ Huddart J. in *Ney, supra*, footnote 54, at paras. 31 explained that, in relation to medical treatment, the treating physician alone should make these determinations: "[The] authorities [indicate] that it is the medical practitioner rather than the parents who is to determine whether the minor is capable of consenting." And later at para 33: "It appears that the medical practitioner is to make this determination." The same rule should apply to a counsellor's assessment of a child's capacity in relation to proposed counselling services.

⁵⁹ Canadian Bar Association, BC Branch [Children and Consent to Medical Care](#); posted at the CBABC website (undated).

⁶⁰ For a discussion on parental consent, see the previous chapter in this Commentary.

While the need to assess the capabilities of a child, as part of the mature minor rule, can be seen as a variation of the first element of an adult's valid consent, the second aspect of this rule appears to be unique to children.

(a) Best interests of the child

The common law's mature minor rule places an additional condition on a child's consent that does not appear to be an expressed part of the general law of consent that applies to adults. This additional requirement, as set out in what is now section 17(3)(b) of the *Infants Act*, states that the provider must "made reasonable efforts to determine and has concluded that the health care is in the infant's best interests." A similar requirement is part of the common law mature minor rule.

The condition that a proposed counselling service should be in the child's best interests has its origins more in child protection law than the law of consent. To satisfy this condition, a counsellor should take appropriate steps to ensure that the proposed counselling therapy or service is in fact in the child's best interests.

The best interests of the child should be assessed from the standpoint of the child, not from the standpoint or views of the parents or guardians. A counsellor is thus required to consider the child's circumstances and particular needs.

3.4) When parental consent is not required

As noted above, a counsellor should not assess a child's capability to consent by taking into consideration the views of that child's parents as to whether or not their child is capable. The counsellor's assessment should be done independently of the child's parents or guardians. The counsellor could seek out the views of the parents on whether or not the child has the capacity to consent to the particular counselling, but should do so only if the child so agrees.

Further, the counsellor's assessment as to whether or not the counselling is in the best interests of a particular child should also not be influenced by the views or opinions of that child's parents or guardians. The counsellor's assessment must be done objectively and at arms-length from the parents. The counsellor can consult with the parents on the question of best interests, but, again, should do so only if the child so agrees.

Once a counsellor has determined that a child is a mature minor and is thus capable of giving his or her own consent, this finding has a further outcome: The counsellor should not then breach that child's confidentiality by discussing the child's circumstances or the counselling that was provided *unless the child expressly consents to such disclosures* to

the parents or guardians.

The same rule that allows a mature minor to give, withhold or revoke his or her own consent without parental interference applies equally to that mature minor's ability to decide whether or not their personal information can be shared with his or her parents or others. While there are some limits to this rule, such as if the child is in need of protection,⁶¹ in most situations it would be a breach of the mature minor's confidence for a counsellor to speak to that child's parents or guardians about confidential clinical information provided by that child during counselling.

A counsellor should make it clear to any mature minor he or she is counselling that the counsellor will not discuss that child's personal information with parents or guardians without that child's expressed consent to such disclosure. If the counsellor feels there is a need for such disclosure, the counsellor should ask the mature minor if the information in question can be shared with that child's parents or guardians, as may be indicated. In turn, the counsellor should record in the clinical notes whether or not the mature minor gave consent to that disclosure. In these circumstances, a signed consent to disclosure form may be good practice.

3.5) When parental consent may be required

On the other hand, if a counsellor determines that a child lacks the necessary capacity to give independent consent in relation to proposed counselling services, the counsellor must then seek the consent of that child's parents or guardians, applying the rules discussed in the chapter 2. In giving their consent to the proposed counselling services, the parents or guardians themselves are to be guided by what is in the best interests of their child.

In the (hopefully rare) situation when a counsellor feels a parent or guardian is refusing to give consent so that a child may obtain appropriate counselling services, the counsellor may then have a basis to so report that situation to the child protection authorities. This would be, for example, where a parent's refusal might result in some harm to the particular child.⁶²

It is possible for a child to consent independently to counselling services, even during a marriage breakdown. It will likely be a rare situation when a child, even a "mature

⁶¹ For a more detailed consideration of a counsellor's legal duty to report a child in need of protection, see chapter 3 in Bryce, G, [Legal Commentary: How Private is Private?](#), a publication of the BCACC (June 20, 2012).

⁶² *Ibid.*

minor” will come to a counsellor alone and ask for counselling services without a parent also being involved and aware, such as paying for those services. Therefore, as a practical matter, a counsellor should understand the scope and limits of a parent’s role in consenting to counselling services being provided to children, in particular if the counsellor is to see the child alone.

On the other hand, a counsellor should be prepared that from time to time a mature minor may ask the counsellor for counselling, and to do so without having first obtained the consent or approval of that child’s parents or guardians. Such situations are mostly likely to arise in situations of marriage breakdown or divorce.

3.6) Examples from reported cases

It is useful to present a few examples from reported cases where the courts have found that mature minors are capable of giving (or even withholding) consent without having to also involve their parents. These examples will serve to illustrate how the common law mature minor rule has been applied in the past.

I have found no reported Canadian cases that have considered the issue of a mature minor’s right to consent to or refuse in relation to the provision of counselling services. This is not surprising, given that such consent or refusal is unlikely to result in serious harm or death of the affected child, and therefore would not result in a court case. Instead, the reported cases have considered consent or refusal in relation to medical treatments; for example (in chronological order):

- In C. (J.S.) v. Wren,⁶³ the Alberta Court of Appeal found that a 16-year-old girl was of sufficient intelligence and maturity to give valid consent to an abortion that her parents opposed.
- In R. v. W. (D.D.),⁶⁴ the BC Court of Appeal ruled that a 16 year old girl was capable of refusing to provide a sample of her blood for DNA testing that was sought by her mother’s brother for the purposes of proving that he was her father.
- In Van Mol v. Ashmore,⁶⁵ a doctor was found negligent in performing surgery that resulted in a permanent, disabling injury to a 16 year old girl because only she (and not her parents) should have given informed consent. Because the doctor failed to

⁶³ [1987] 2 W.W.R. 669 at 671 (Alta. C.A.)

⁶⁴ (1997) 114 C.C.C. (3d) 506, 90 B.C.A.C. 191, 147 W.A.C. 191, [1997] B.C.J. No. 744 (BCCA)

⁶⁵ (1999) 168 D.L.R. (4th) 637, 116 B.C.A.C. 161, 190 W.A.C. 161, 58 B.C.L.R. (3d) 305, 44 C.C.L.T. (2d) 228, [1999] 6 W.W.R. 501, [1999] B.C.J. No. 31, 6 W.W.R. 501, 1999 BCCA 6 (BCCA)

disclose to her a significant risk of the surgery that then occurred, the BC Court of Appeal determined that the failure to disclose negated her consent.⁶⁶

In another and more recent BC case, the issue was whether child protection authorities have the legislative authority to act, notwithstanding a mature minor's refusal of medical treatment. This possibility was identified by Hubbart J in the Ney case: "[T]his rule is modified only to the extent that the decision of a child or parents may be overridden under the provisions of the *Family and Child Services Act* or by the court acting under its *parens patriae* jurisdiction."

In B. (S.J.) (Litigation Guardian of) v. British Columbia (Director of Child, Family & Community Service),⁶⁷ a 14-year old girl and a member of Fellowship of Jehovah's was diagnosed with cancer, which required surgery followed by chemotherapy. She consented to surgery and chemotherapy, but refused consent to blood transfusions if necessary, based on her religious beliefs. When complications arose with child's condition, the Ministry for Children and Families applied to court seeking authorization for blood transfusion. At trial, the judge determined that chemotherapy and drugs to treat blood clotting were mandatory treatments and granted an order under section 29 of *Child, Family and Community Service Act* (CFCSA). On appeal, the court found that the trial judge did not err in holding that section 29 of CFCSA authorized necessary medical treatment of a mature minor who refused to consent to such health care, even if such refusal was made pursuant to section 17 of the *Infants Act*. In effect, the court ruled that neither the common law right to consent (or refuse) nor the *Infants Act* interferes with the *parens patriae* jurisdiction of the court. Where it is in the minor's best interests, the court may override a minor's refusal to consent to treatment pursuant to the CFCSA.

It is unlikely that a similar case would arise if a child were to refuse to participate in clinical counselling. Unlike the situation in B. (S.J.), court intervention to order a child to have counselling is not likely to take place or be justified because it would probably not be possible to prove that counselling is or will be *essential* to preserve the child's life or prevent serious or permanent impairment to health.

⁶⁶ Speaking for the majority, Lambert J.A. in Van Mol v. Ashmore stated (at para. 89): "If the child did not have sufficient intelligence and understanding to consent, then only the parents could consent and their consent would be sufficient. But once the child had sufficient intelligence and understanding to consent, then the consent of the child alone would be sufficient. The capacity of the parents to consent on behalf of the child did not coexist with the child's own capacity to consent or refuse consent."

⁶⁷ 2005 BCSC 573, 2005 CarswellBC 865, [2005] B.C.W.L.D. 3857, [2005] B.C.W.L.D. 3939, [2005] B.C.W.L.D. 3895, [2005] B.C.W.L.D. 3893, [2005] B.C.W.L.D. 3894, [2005] B.C.W.L.D. 3892, [2005] W.D.F.L. 2679, 42 B.C.L.R. (4th) 321 (BCSC, chambers, April 11, 2005)

3.7) Summary

In deciding whether a child has the capacity to give his or her own consent, the focus of a counsellor's assessment will be on the extent to which the child's physical, mental and emotional development will allow for that child to fully appreciate the nature and consequences of the proposed counselling therapy services, including the refusal of such services. Generally speaking, where the counsellor determines that the child lacks the necessary capacity, the counsellor should then seek out the consent of the parents or guardians who are thus authorized to consent to treatment on the child's behalf. In turn, the parents or guardians must be guided by what is in the best interests of that child.

Given the refinements the mature minor rule makes to the general law of consent that applies to adults, the following are the seven essential elements for valid child consent as they would apply to counselling therapy:

1. the child must be capable of making a decision about whether to give or refuse consent to the proposed counselling;
2. the child's consent must relate to the proposed counselling;
3. the child's consent must be given voluntarily;
4. the child's consent can not be obtained by fraud or misrepresentation;
5. the counsellor must provide the child with information that a reasonable person would require to understand the proposed counselling and to make a decision;
6. the child should have an opportunity to ask questions and receive answers about the proposed counselling;
7. the proposed counselling must be in the child's best interests.

In summary, if a counsellor is satisfied that the above conditions have been met, the counsellor should then be able to provide the intended counselling therapy service to the mature minor with that child's consent and without fear of parental retribution.

ADDITIONAL READINGS

Counsellors may find the following to be useful sources of additional information on the law of consent:

- [*Health Care \(Consent\) and Care Facility \(Admission\) Act*](#), R.S.B.C. 1996, c. 181;
- BC Ministry of Health, [*A Primer to British Columbia's New Health Care Consent Legislation*](#), March 2000;
- BC Ministry of Health, [*A Health Care Provider's Guide to Consent for Health Care*](#).