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# An ethical framework to understanding Canada's mature minor doctrine

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**AN ETHICAL FRAMEWORK TO UNDERSTANDING CANADA'S MATURE  
MINOR DOCTRINE**

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## Dedication

This final project is dedicated to my supportive family, Anna, Peter, and my boyfriend Greg. I am so thankful for their patience and understanding in helping me reach my academic goals.

## Abstract

The intent of this project is to provide counsellors and psychologists with guidance for applying the mature minor doctrine in Canada. In addition, relevant consent forms located in the appendix of the project will provide further resources on ethical practice.

The literature review focuses on the Canadian Charter of Rights and Freedoms relevant to minors; counselling theories that support minors' rights to self-determination; the informed consent process with minors; and laws and ethics relating to consent and mature minors. The final section of the project discusses the strengths and limitations of the project.

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## Chapter 1: Introduction

A counsellor is in a position of significant privileged responsibility as a result of inviting the client to share intimate details about him or herself. To exercise due respect and trust in the resulting situation, counsellors depend heavily on a code of conduct. This code, often referred to as a code of ethics within the counselling profession, enumerates morals and values that make respectful care of and for the client the top priority in client-therapist working relationships. As has been expressed numerous ways counsellors need to be well read in the theory and application of ethics, as they face many situations in their practice in which demonstrating respect to a client may be contra-indicated due to legal and/or ethical reasons. For example, respect for a client's privacy cannot be honoured if the client threatens to harm another person. Another example, as in the case of this project, are clients under the age of 18 who may be counselled without parent permission and/or their knowledge. While this act may be seen as distrustful to the minors' parents, as will be noted throughout this section, teens have the right to make decisions on their own behalf if they are able to demonstrate sufficient intelligence.

This chapter will focus on three areas. First, I will provide a rationale for the project. Second, I will discuss why this topic is personally meaningful to me. Third, I will provide a brief description of the structure of the remaining chapters. To provide the reader with a point of reference for future discussion, key terms used in this project are briefly defined in Appendix A.

### *Rationale*

The issue being addressed in this project centres on consent and confidentiality. These are significant issues within the field of counselling because it is believed that

good therapy entails meeting these two requirements. However, there are circumstances in which not all parties, such as guardian(s)/parent(s), will give consent for minors to receive counselling. At this point, the counsellor faces an ethical dilemma because the rights of the minor conflict with the rights of the guardian(s)/parent(s). One of the strategies to manage this type of dilemma is to consider the minor a “mature minor.” Other situations in which a counsellor may need to evoke a mature minor clause include: a minor in foster care, a minor who is parentless or separated from their family, and a minor who makes confidentiality a prerequisite for treatment (Sneiderman, Irvine, & Osborne, 2003).

A mature minor, as will be extensively explored in the proceeding chapter, is a person under the age of majority who can demonstrate sufficient intelligence and understanding of the nature of the treatment, including the risks and benefits to give consent to treatment (Alkhatib, Regan, & Jackson, 2008; Sneiderman et al., 2003). The mature minor clause is an extremely important rule for practitioners to know because if parent(s)/guardian(s) are not able or willing to provide consent for their children, it is not up to society or the counsellor to decide what is in the best interests of a minor who classifies as a mature minor. If the minor qualifies as a mature minor he or she should be the one to decide what is in his or her best interest.

Although the mature minor principle promotes a minor’s right to self-determination/autonomy, the rules surrounding this doctrine are confusing, specifically the rules relating to consent (Hesson, Bakal, & Dobson, 1993). Canadian common law has not specified an age at which minors can consent to or refuse treatment; this lack of clarity makes the mature minor rule confusing for health practitioners (Hesson et al.;

Rozovsky, 2003; Sneiderman et al., 2003). Every Canadian province has its own consent legislation. Some of the provinces follow the mature minor principle, though they may place restrictions on its application (i.e., whether the treatment is deemed to be in the best interests of the minor), and some provinces do not adhere to the mature minor doctrine. For the author of this project, identifying each province's consent rules was very time-consuming and to whom they apply was also confusing (i.e., doctors, counsellors *et al.*). Therefore, this project intends to provide some clarity on the mature minor doctrine in Canada for counsellors and psychologists. The following will provide examples of age of consent across selected provinces and territories (see Appendix B for a table that summarizes this information).

### *Provincial Legislation*

#### *Alberta*

In Alberta, according to the *Child Welfare Act* (1984), children over the age of 12 are granted certain rights such as notice, appeal, and decision-making (Hesson et al., 1993). In regards to minors consenting to medical treatment, Alberta law does not identify an age at which parental consent is no longer needed, besides the age of majority (18) (Rosemaire, 1997).

#### *British Columbia*

Under the *Infants Act*, which was amended in 1993, British Columbia has determined that a minor can provide consent to treatment regardless of age if the minor understands the nature and potential risks and benefits of the treatment (Sneiderman et al., 2003). The treatment needs to be supported by a physician to ensure the treatment is in the best interest of the minor (Rozovsky, 2003; Sneiderman et al.).

### *Manitoba*

The mature minor principle is in effect under Manitoba's *Child and Family Services Act*, which allows a physician to accept the consent of a minor if s/he believes the minor has the ability to make the decision and if it is in his or her best interest (Rozovsky, 2003).

### *Maritimes*

Under New Brunswick's *Medical Consent of Minors Act*, minors over the age of 16 may consent to treatment (Hesson et al., 1993). Anyone under the age of 16 can consent to treatment if the minor is capable of understanding the nature of the treatment and the treatment is determined to be in the best interests of the minor by two physicians (Rozovsky, 2003; Sneiderman et al., 2003). This act applies to dental and surgical treatment, all diagnostic and preventative care, and any ancillary treatment (not purely medical) (Hesson et al.; Rozovsky).

### *Northwest Territories*

In the Northwest Territories, a minor in-patient may only be released under the authority of a written order signed by the client, the doctor, the board, or if the client is under the age of 19, by a parent or guardian (Sneiderman et al., 2003). However the parent/guardian also needs to sign a form freeing the hospital of responsibility for the release of the minor (Cohen- Almagor, cited in Sneiderman et al.).

### *Ontario*

Ontario does not identify a specific age of consent under the *Health Care Consent Act*; instead the minor must have an understanding of the treatment information and be able to identify likely consequences, adhering to the mature minor principle (Sneiderman

et al., 2003). Ontario also has further information regarding age of consent found in the *Child and Family Services Act (1984)* such as the definition of competence and the criteria required for consent to be legitimate (Hesson et al., 1993).

#### *Quebec*

Quebec's *Civil Code* has resolved that minors over the age of 14 can give consent to health-care; under that age consent must be given by parent/guardian (Rozovsky, 2003). This codes also indicates that the authorization of the court is required if a minor over the age of 14 refuses treatment (Rozovsky).

#### *Saskatchewan and Prince Edward Island*

Saskatchewan and Prince Edward Island consent legislation is only found in hospital acts and applies only to treatment in hospitals (Hesson et al., 1993). None of the hospital acts recognize the mature minor rule (Hesson et al.). Under the *Hospital Standards Act (1979)*, Saskatchewan identifies the age of consent as 18 (Hesson et al.). Prince Edward Island *Hospitals Act (1981)* also sets the age of consent at 18 (Hesson et al.).

The above demonstrates considerable variance among Canadian provinces and territories with regard to an age of consent. New Brunswick, British Columbia, Ontario and Alberta adhere to the standards of the mature minor doctrine and base consent on cognitive ability, while other provinces such as Saskatchewan and Prince Edward Island have created a statutory age of consent. It is important to note, however, that the minor's autonomy is limited under such legislation as British Columbia's *Infants Act*, because it is up to a physician to determine if the treatment is in the best interests of the minor (Sneiderman et al., 2003).

In the course of my research on the mature minor doctrine in Canada, I discovered that part of the confusion surrounding the mature minor rule is caused by health practitioners' unclear understanding of how to assess a minor client's capacity to consent to treatment. There is no case law in Canada that specifically explains how to assess an individual's capacity to consent, nor is there any legal competency test for minors (Ford & Kessel, 2001; Sneiderman et al., 2003). Despite the lack of clarity related to competence, counsellors still have a responsibility to determine whether their client qualifies as a mature minor (Hesson et al., 1993). Therefore, this project is meant to provide counsellors with some guidelines on how to assess a minor client's capacity to consent to counselling.

#### *Personal Relevance*

My interest in this topic stems from learning about ethics in my graduate counselling ethics course. Before I began the course, I believed that there were black and white solutions to solving ethical dilemmas; however, I learned from the course that there are no prescribed solutions to dealing with ethical issues. Rather, every situation is different and requires careful thought and analysis. This is why I chose to create a project that focuses on ethics as my final project for the Masters of Education Counselling Psychology Program. In my graduate ethics class (Education 5620), a case study helped me to understand and appreciate the complexity of ethics within the counselling profession. This case example will be explained next.

The ethical dilemma in this case study centred on consent and confidentiality. The client was a 15-year-old girl who was bingeing and purging; the counsellor had to decide whether the girl's parents should be informed. At first, I thought of the solution to this

ethical dilemma in black and white terms; however, as I began to further explore this issue, I realized that there were many dimensions to this problem, and like all ethical dilemmas, there was no cut-and-dried answer. I had to consider the rights of the parents and the rights of the girl as well as the rights of the school and my own credibility. I had to assess the severity of the girl's problem, explore the laws and ethics related to minors and consult with trusted colleagues. I engaged in a careful ethical decision-making process wherein I explored the costs and benefits of several courses of action before I made a decision.

Throughout this entire process, I had to keep in mind that the girl was in the most vulnerable position, and as a result, her interests needed to come first. Counsellors and psychologists working with minors who seek treatment without parental consent must work through a similar ethical decision-making process and have a thorough understanding of the mature minor rule.

In sum, I believe that this project will be a useful resource for counsellors and psychologists because it will provide them with clarity on the mature minor issue and also provide guidance with regards to handling ethical dilemmas where consent and confidentiality are an issue. Samples of relevant consent forms are located in this project as appendices C (for adolescents) and D (for parents). Also Appendix E is an information form for parents and minors on the mature minor doctrine. Although ethics can be complex, I see ethics as being very simple because the counsellor/psychologist should always do what is in the best interests of the client. Counsellors and psychologists owe it to their clients to strive for the highest level of ethical practice.

The next chapter is a literature review on the mature minor doctrine. Specifically, the review will explore the Canadian Charter of Rights and Freedoms, the importance of acknowledging minors' rights to self-determination, the informed consent process with minors, and court cases that lead to the development of the mature minor doctrine in Canada. The chapter following the literature review covers methodology and will identify databases used, the code of ethics that was chosen for the project, how material used in a graduate course was updated and revised, and challenges that were faced while completing the project. The final chapter is a synopsis of the project, which will include the strengths and limitations of the project. Appendix A contains the glossary covering such terms as age of majority, competence, and cognitive ability.

## Chapter 2: Literature Review

In the past, Canadian law has assumed that minors lacked the cognitive abilities to make decisions for themselves (Hesson et al., 1993). As a result, minors have often been denied the right to self-determination (Hesson et al.). In the early 1970s, the children's rights movement caused a shift in emphasis from children needing to be protected to having the right for self-determination, such as the right to act separately from parental control (Hart, 1991). As a result, the mature minor doctrine was developed and applied to Canadian common law (Hesson et al.; Rozovsky, 2003); however, the rules regulating this doctrine can be confusing (Hesson et al.) and can potentially harm minors if not properly understood by health practitioners. Therefore, this project is intended to shed some light on the issue of the mature minor doctrine. In particular, the literature review in this chapter will explore the foundation upon which the mature minor rule is based, how the informed consent process changes for use with minors and the doctrine of the mature minor rule. Further, samples of relevant informed consent forms are included as appendices C and D to this project.

In particular, this chapter examines sections of the Canadian Charter of Rights and Freedoms relevant to both minors and children with regard to the mature minor principle and counselling theories that support individuals' rights to self-determination. Emphasis is placed on the informed consent process (adapted for use with minors); specifically the criteria needed for a valid consent. The mechanics of the mature minor rule are explored, including court cases that led to the development of the mature minor principle. The chapter concludes with a synopsis of the literature review.

### *Canadian Charter of Rights and Freedoms*

The Canadian Charter of Rights and Freedoms is the foundation upon which the mature minor doctrine is based. Thus, counsellors working with minors need to be aware of sections 7 and 15 of the Charter, which are relevant to minors (Hesson et al., 1993). These sections will be addressed next.

#### *Children's Rights*

Section 15 of the Canadian Charter of Rights and Freedoms states that every individual will be provided equal benefit and equal protection and will not be discriminated against based on age or any other personal characteristics (Rozovsky, 2003; Sniderman et al., 2003). Thus, refusing to treat a minor solely because of his or her age could be seen as an infringement of his or her rights under this section of the Charter (Hesson et al., 1993).

Section 7 of the Charter states that, in accordance with the principles of fundamental justice, every individual has the right to life, liberty and security of his or her person (Cram & Dobson, 1993; Hesson et al., 1993). However, these rights are not absolute and can be removed if justified in a democratic society, such as in the case of an immature minor (Hesson et al.; Rozovsky, 2003). In the context of this paper this means that there are situations in which minors may not be granted life, liberty and security of his or her person. For example, on July 1, 2006 Alberta enacted a law called the Protection of Children Abusing Drugs Act (PChAD), which allows parent(s)/guardian(s) to ask a court to force their child into a drug treatment program when their child is abusing drugs (Jablonski, 2005). Such an order allows for a minor to be taken to a safe-house for up to five days for detoxification from drugs and/or alcohol, whether s/he is

willing or not (Jablonski). In this situation the rights of the parent(s)/guardian(s) to take care of their children is paramount because the child is causing harm to him- or herself. Along with being aware of the rights that are afforded to minors under the Charter, counsellors also need to be aware of rights afforded to parents because until the age of majority, parental rights do not diminish (Rozovsky).

### *Parental Rights*

Parent(s)/guardian(s) are given rights with the understanding that they will care for their children and act in their best interests (Rozovsky, 2003). As a result they are given authority to make decisions for their children in regards to physical and mental health, education, discipline, spiritual training and even marriage (Hesson et al., 1993). Parental rights do not terminate until the age of majority; however, parental rights are also not absolute and can be removed by the state if the parent(s)/guardian(s) are not acting in their child's best interest (Rozovsky). When a child becomes a mature minor, the rights of parent(s)/guardian(s) to make treatment decisions for their child also end (Rozovsky). However, in a case such as the above example of a minor's substance abuse, parental rights override the minor's right to self-determination. It is expected that counsellors will encounter situations in which the rights of the parent(s)/guardian(s) conflict with those of the minor(s).

### *Parent-Child Disagreement*

When the rights of the guardian(s)/parent(s) conflict with the rights of the minor, it can be confusing as to who (guardian(s)/parent(s) or minor) has the authority to accept or refuse treatment since, until the age of majority, parents are legally responsible for their child(ren)'s well-being. Health practitioners may be divided between respecting the

autonomy of the minor and respecting the rights of the parent(s)/guardian(s) (Hesson et al., 1993). When a situation like this arises counsellors become embroiled in an ethical and legal dilemma.

There are no cut and dried answers for dealing with ethical/legal dilemmas. Counsellors need to consider rights afforded to all parties under the Canadian Charter of Rights and Freedoms, and also consider ethical guidelines. This is the topic that will be addressed next. See Appendix F for tips on how to work through this type of dilemma.

### *Ethical Considerations*

While knowledge of the Canadian Charter of Rights and Freedoms is essential, it is also important for counsellors to be aware of ethical guidelines that are relevant to minors and consent (Hesson et al., 1993). For psychologists this denotes following the codes and principles in the Canadian Code of Ethics for Psychologists (Cram & Dobson, 1993). Adhering to ethical guidelines means that the counsellor considers what is morally right; this is distinct from adhering to the law, which signifies taking into account what is allowed and what is not allowed (Campbell, 2006).

Hesson et al. (1993) articulated that the following codes need to be included in a mature minor case. Principle I, section 9 of the Canadian Code of Ethics for Psychologists states that refusing to provide treatment to a competent minor on the basis of age could be considered ethically wrong (Canadian Psychological Association, 2001). Further, principle I, section 5 of the code indicates that psychologists should not participate in practices that could compromise the legal, civil, or moral rights of others (Canadian Psychological Association, 2001). This may seem simple when there is no conflict between guardian(s)/parent(s) and minor(s). However, if the guardian(s) or

parent(s) request that a counsellor/psychologist provide treatment to a competent minor who does not consent, this could be considered an ethical and legal violation (Hesson et al.).

Principle 1 sections 5 and 9 of the code discuss the morals behind allowing minors rights of autonomy. However, as stated in Principle II, section 38 psychologists cannot respect the autonomy of a mature minor if the minor was causing harm to him or herself or someone else (Canadian Psychological Association, 2001).

There are no simple solutions to deal with minors consenting to treatment without parental support. Codes of conduct will provide guidelines that can aid counsellors and psychologists, but ultimately it is up to the counsellor/psychologist to determine if they award mature minor status to a client.

The preceding section discussed the Canadian Charter of Rights and Freedoms, including rights afforded to minors and parents, and ethical guidelines relevant to consent with minors. The next section will explore self-determination and why it is important for all individuals, including minors, to be granted these rights. In particular, counselling theories that support all individuals, including minors', rights to self-determination will be looked at.

#### *The Importance of Self-Determination*

The mature minor doctrine is based on the fundamental principle of autonomy (the individual's freedom to choose their own direction) and most counselling theories support this underlying value, including feminist therapy and person-centred-counselling, which both support the client's right to self-determination (Corey, 2001). These two theories will be addressed next.

### *Self-Actualizing Tendency*

Person-centred therapy is based on the principle that all people have an innate potential for understanding themselves and working through their own problems without direct intervention from the counsellor (Corey, 2001). The person centred therapist trusts in the inner resources of the client (Raskin, Rogers & Witty, 2008), and believes that not only is it possible for people to grow, it is inevitable (Zeigler, 2002). Person-centred therapy discourages the notion that the therapist knows what is best for the client because the therapist trusts in the client's ability to direct his or her life in a positive way (Corey). In person-centred therapy it is not the counsellor's responsibility to decide his or her client's fate; rather it is the counsellor's responsibility to create an environment where the client feels safe and accepted (Zeigler). With regard to the mature minor issue, the counsellor who supports a person centred therapy view can trust in the inner resources of the minor and his or her ability to provide valid consent to counselling when a minor is granted mature minor status.

Feminist therapy also believes in the client's ability to make self-directed decisions (Corey, 2001). Feminist therapy holds that the client is the expert in his or her life not the therapist (Rader & Gilbert, 2005). Both person-centred and feminist therapies support individual's rights to self-determination. They conclude that all people, including minors, have the innate potential for self-determination. In relation to the mature minor issue, the counsellor who practices feminist therapy believes that a mature minor client is an expert in his or her life.

*Empowering the Client*

Counsellors empower clients when they allow them to make decisions for themselves (Corey, Corey, & Callanan, 2007). By encouraging them to make decisions for themselves counsellors give their clients the message that they know what is best for them. Feminist theory, as do most therapies, illustrates that by placing the responsibility onto the client (e.g., minor) to make decisions and changes in their life, the client will become aware of their personal power (Corey, 2001). Both person-centred and feminist therapy accentuate that the client is capable of taking responsibility for their life and actively participating in it (Corey). If the mature minor client was not responsible for deciding his or her own fate, then it would be difficult for him or her to believe that she/he could actively make changes in his or her life. If the responsibility for making decisions was completely external to the client, then she/he would be powerless to change, thus rendering therapy ineffective. It is the tone of this project that mature minor clients are no different than adult clients in their ability to make decisions and take responsibility for their life.

The previous section discussed the importance of allowing mature minor's rights of self-determination. Mature minors can be resourceful and capable of making good decisions. They are the ones that often are in the best position to decide their own fate rather than the counsellor or society. The next section will explore the consent process with minors. It is during the informed consent process that minors are granted rights to self-determination. The rationale and purpose of informed consent will be addressed along with the criteria needed for a valid consent. Please also see appendices C and D for sample consent forms and Appendix A for a glossary of terms.

### *Informed Consent*

Informed consent, in its most basic form, entails a client giving permission to engage in treatment with the health practitioner (Kuther, 2003). The moral foundation on which informed consent is based is the individual's fundamental right to autonomy (the client's right to choose); (Crowhurst & Dobson, 1993; Tymchuk, 1997) and beneficence (doing good for the client); (Schachter, Kleinman, & Harvey, 2005).

#### *Rationale*

Informed consent is critical because it protects the client's right to make autonomous decisions (Corey et al., 2007; Crowhurst & Dobson, 1993). Also, through the informed consent process the counsellor demonstrates respect for the client's insight because the client is seen as the expert in his or her life. This helps to create a positive relationship as it increases the probability the client will feel respected and validated, making therapy more likely to be effective (Gilbert, 1980). This is important because the strongest predictor of success in therapy is the relationship that the client has with the counsellor (Kirschenbaum & Jourdan, 2005).

#### *Purpose*

The purpose of informed consent is to encourage anyone, including the minor, to become an active participant in his or her therapy and to help the client make informed treatment decisions (Corey et al., 2007). When the client is informed of all aspects of his or her therapy it is more likely that counselling will become a collaborative effort between client and counsellor (Corey et al.). In summary, the client needs to be involved in all decisions that affect him or her. The next section will explore criteria needed for a valid consent.

### *Criteria for Informed Consent*

In order for an individual to make an informed treatment decision and exercise his or her right to autonomy, the counsellor needs to ensure that certain criteria are met. The counsellor needs to make certain that he or she shares any relevant information regarding treatment, allows the client to process the information and make a voluntary decision, and ensures that the client has the ability to make informed decisions (Campbell, 2006; Marques-Lopez, 2006).

In order for individuals to engage in such a process they need to have the legal capacity for this (Marques-Lopez, 2006; Sneiderman et al., 2003). Legal capacity refers to the intellectual ability to make a decision regarding treatment (Rozovsky, 2003).

Minors are not automatically assumed to possess this legal capacity. Parent(s)/guardian(s) are legally expected to care for their child(ren)'s best interest(s), and consequently are given rights to direct medical treatment (Sneiderman et al., 2003). However, Canadian common law has given rise to the mature minor doctrine, which affords minors the opportunity to make autonomous treatment decisions (Rozovsky, 2003). Counsellors and other health-care professionals can use the mature minor rule to promote minors' rights to self-determination and allow them to consent to counselling without parental/guardian consent. Before reviewing this doctrine counsellors need to have a clear understanding of what consent refers to.

As previously mentioned in this section, in order for consent to be valid the counsellor needs to ensure that the following criteria are met: capacity to consent, disclosure of relevant treatment information, and that the consent is provided voluntarily (Rozovsky, 2003; Crowhurst & Dobson, 1993). These three criteria apply to everyone,

whether minor or adult; however, this project focuses on these criteria with regard to minors and the mature minor doctrine in Canada. Unless otherwise specified, all references to counsellors, law and minors will be addressed in a Canadian context.

The following section will elaborate on the capacity criterion. Four subsections will provide context and examples related to the criterion variable of capacity.

### *Capacity*

The first criterion for a valid informed consent is capacity. In order for anyone to engage in the informed consent process, an individual needs to possess the capacity to do so (Sneiderman et al., 2003). Capacity refers to “[t]he assessment of an individual’s decision-making abilities in context” (Campbell, 2006, p. 38). Decision-making abilities include the client’s understanding of his or her medical condition, the clients’ understanding of the nature of the proposed treatment and its potential risks, and the client’s ability to apply his or her own values and preferences to the treatment decision (Sneiderman et al.).

Capacity needs to be determined by the health practitioner in relation to the specific treatment being proposed (Schachter et al., 2005). For example, if a minor wants to receive an abortion she needs to understand information that is relevant to receiving an abortion, which may include physical, psychological, and social consequences of both receiving and not receiving an abortion. A minor may also be able to understand and comprehend the nature of one treatment, but not another (Rozovsky, 2003). For example, a minor may be able to understand the treatment information relating to an abortion, but the same minor may not be able to understand treatment information related to physician-assisted suicide.

### *Capacity Can Change*

An individual's capacity is something that can change over time (Campbell, 2006; Rozovsky, 2003). For example, a minor who is intoxicated may not have the capacity to comprehend the treatment information, but this may change when he or she is abstinent. Further, a depressed youth may not have the capacity to make a treatment decision because of the severity of his or her symptoms. However, once the depression is addressed, the individual may regain the capacity to make informed treatment decisions. Hence, counsellors and psychologists must continually assess capacity to give consent (Campbell).

When assessing capacity there are various factors that counsellors need to be aware of, some of which are specific to minors, because they can impact an individual's ability to consent to treatment (Campbell, 2006). These factors can impact a minor's judgement, consequently impacting their ability to provide consent to counselling. These factors, outlined in the next section, can also be used to argue against giving a minor the right to consent.

### *Psychosocial Factors*

Steinberg and Scott (2003) have identified various psychosocial factors that impact a minor client's capacity to make decisions. Psychosocial factors include a teens' level of social and emotional maturity such as: their ease at being influenced by peers; they place greater emphasis on rewards than risks; they hold a stronger focus on short-term than long-term consequences; and they have a difficult time managing their moods and impulses (Steinberg & Cauffman, 1996). Steinberg and Scott articulated that although adolescents may have similar cognitive capabilities as adults, their decision-

making capabilities are different because of their immature psychosocial development. Steinberg and Scott have also indicated that part of the reason for this lack of psychosocial maturity is biological in nature. The pre-frontal cortex of an adolescent's brain, which is responsible for long-term planning, judgement and decision-making, may not be fully developed even in late adolescence (Sowell, Thompson, Holmes, Jernigan, & Toga, cited in Steinberg & Scott).

These psychosocial and biological factors imply that, not only must minors possess the cognitive ability to make treatment decisions; they also must possess the emotional, physical and social maturity. Although emotional and social maturity are broad concepts that can include various dimensions, Steinberg and Cauffman (1996) have defined emotional and social maturity in relation to decision-making capacity. According to their conclusions, the following dimensions are relevant to emotional and social maturity: temperance (ability to control impulsivity, avoid black and white thinking in decision making, and the ability to assess a decision carefully and ask others for help when needed); responsibility (self-reliance, awareness of one's identity, healthy independence); and perspective (awareness of the intricacy of a situation and the ability to understand the broader picture when attempting to make a rational decision). An example of a minor who may possess the cognitive ability to make decisions, but lacks emotional maturity is a minor who is able to weigh the cost and benefits of receiving treatment for depression, but struggles to stay employed and is very impulsive. A counsellor who is considering granting mature minor status to a youth needs to consider cognitive, social and emotional maturity.

### *Minor's Stage of Life*

The minor's life-stage can also impact capacity to consent to treatment (Sneiderman et al., 2003). Adolescence is seen as a period in one's life when preferences, beliefs and values are still under development (Roberts, 2002; Steinberg & Scott, 2003). Thus, there is some uncertainty whether a minor's treatment decisions are based on values and beliefs that are truly their own (Sneiderman et al.). In a court case involving a 13-year-old boy who opted out of receiving treatment for cancer, the Saskatchewan Court of Queen's Bench found that he lacked the capacity to consent to withholding treatment because he had essentially been convinced to adopt his father's value system (Rozovsky, 2003). Since the mature minor principle is based on capacity, and part of capacity involves making decisions based on one's own value system (Sneiderman et al.) it is important for the counsellor to ensure that the minor is making decisions based on his or her own values. Thus, in this situation, the court found the minor was not making decisions based on his own values and beliefs and consequently was denied his right to self-determination.

Roberts (2002) stated that individuals working with minors should have open discussions with minors about their values and beliefs. This will help minors make decisions with clarity (Roberts). In summary, when considering granting mature minor status a counsellor needs to assess if a minor is making decisions based on his or her own value system.

### *Impact of Illness*

Roberts (2002) found that illness can impact an individual, including minors, decision-making ability both positively and negatively. While the experience of having

an illness can bring greater clarity to one's values, some mental illnesses may diminish decision-making ability. For example, youth with depression may experience trouble making decisions, low energy and pessimistic thinking, all of which will impact their ability to make a decision (Roberts).

A counsellor needs to let a depressed client know that because of the depression, the way the client interprets information may be biased (Beck & Weishaar, 2008). A counsellor can implement a clinical intervention such as cognitive therapy, which has been proven effective with depression (Beck & Weishaar), to help lessen the symptoms of depression so that the client can make sound decisions. It may be a good idea to postpone major decision-making until the symptoms of depression have been alleviated. This relates to capacity to give consent to counselling because if a minor's judgment is clouded by symptoms of mental illness his or her capacity to give consent to counselling is decreased. Counsellors need to consider the client's diagnosis and how it will impact his or her ability to make sound decisions.

As demonstrated thus far, there are various factors that can impact a minor's ability to make decisions and consequently affect their ability to consent to counselling, such as the minor's stage in life, psychosocial factors (social and emotional maturity), biological factors, and mental illness. To this end, counsellors need to complete a thorough assessment, determining the minor client's ability to make decisions and which factors will or could impact that ability. The topic of assessment is addressed next.

#### *Assessing Capacity*

As mentioned in Chapter 1, it is the counsellor's responsibility to assess capacity. The following are, in the writer's opinion, key guidelines, as identified in the literature, to

aid counsellors and psychologists when assessing a minor client's ability to provide a valid consent to counselling. Some of the literature used in this project discussed capacity in relation to medical treatment; however, the same principles could be used in the context of counselling.

### *Risks and Benefits*

According to Campbell (2006), health practitioners should, when wanting to determine if a minor is capable of consenting to her or his mental health care, focus on the following: the risks and benefits of treatment and the risks and benefits of no treatment; the risks and benefits of alternative forms of treatment; the consequences of a decision; and their ability to articulate a decision.

The risks that need to be disclosed in the therapeutic context include those that will impact the client's consent (Rozovsky, 2003). The more serious the risk(s), the greater the responsibility of the health practitioner to inform the client of the risk(s) (Rozovsky). This process can take one or more sessions and should be clearly documented in the client's file.

For example, if a minor was seeking grief and loss counselling, the counsellor must address the following with the minor before determining if a minor can provide consent to counselling:

1. Outline the risks of grief and loss treatment. This includes, but not limited: therapy may not work (e.g., a counsellor may use cognitive therapy with a client and this type of therapy may not be effective for the client) therefore, no promises can be made about the outcome of treatment (Corey et al., 2007); there may be disruptions in the client's life, for example, as part of working

through grief the client may experience unpleasant emotions such as anger and denial.

2. Discuss the benefits of receiving treatment for grief and loss. This may include: resolve the grief more quickly than without treatment; the client may learn different skills and techniques such as journaling or cognitive restructuring to help him or her process the grief.
3. Highlight the risks of not receiving treatment for grief and loss. This may include: prolonged grieving process because of not receiving adequate support through the grief process. As a result the client may adopt coping mechanisms which may be problematic (e.g., addictions to numb the pain of the loss).
4. Provide alternative forms of treatment, including the risks and benefits. Alternative treatment will vary depending on the type of treatment, but may include: self-help groups such as 12-step programs, chat room online support, indigenous healing practices, and stress management programs (Corey et al., 2007). The benefits of alternative forms of treatment may include: may be a better fit for the individual needs of the client; may require less work; and may be less expensive than the original treatment. The risks could include: may be costly, may require more time and effort to work through the problem, may not be a good fit for the client.

In addition to the risks and benefits outlined above, Rozovsky (2003) has suggested that health practitioners should also focus on the following information when discussing risks and benefits: the impact of treatment on the client's lifestyle, economic considerations, who is to perform the treatment and their expertise. For example, a minor

who is an active soccer player on a team in the midst of playoffs is considering taking anti-depressant medication. Since the medication may have an adverse effect on the minor's ability to play soccer (e.g., drowsiness), that risk needs to be discussed.

### *Contextual Factors*

Health practitioners should consider the client's capacity to consent to treatment/counselling in the context of the following: the client's cultural background, the diagnosis and the counsellor's potential for bias (Campbell, 2006). Each of these factors will be reviewed next.

*Cultural background.* The first contextual factor to consider when assessing capacity to consent to counselling is the client's cultural background (Campbell, 2006). The client's culture, including the community s/he belongs to, and family involvement all influence the minor client's capacity to consent to treatment (Campbell). For instance, a minor client raised in an abusive home may believe that abuse is a normal part of life and therefore not see a need for counselling. Consequently, the client's judgment is clouded. If this is the case, the chances of this minor being granted mature minor status decrease.

Also, clients from non-Western cultures may have different views regarding the importance of family involvement in treatment or different beliefs regarding the authority of the clinician (Corey et al., 2007). For example, in comparison to American clients, Hispanic clients may be more reluctant to assert their rights to a helping professional (Leon & Dziegielewski, 1999). Thus, a Hispanic minor may be hesitant to assert his or her rights to a counsellor and therefore his or her ability to provide a valid consent to counselling is diminished.

Furthermore, in many non-Western cultures psychological help is not the norm; instead informal groups such as friends and relatives provide support (Corey et al., 2007). For example, among Hispanics, seeking support and guidance within the family is the norm; family members are not encouraged to look externally (Paulino & Burgos-Servido, 1997, cited in Leon & Dziegielewski, 1999). Thus, a minor who is Hispanic may be reluctant to seek help from a counsellor.

*Client's diagnosis.* The second contextual factor to consider is the client's diagnosis and how this may affect their ability to make decisions pertaining to their mental health care (Campbell, 2006). For example, according to cognitive therapy, a client with depression would process information in a biased manner that may not be in his or her best interest (Beck & Weishaar, 2008). For instance, if a depressive client were asked by a counsellor if s/he believed therapy would be effective, the client may answer in the negative because of the hopelessness and pessimistic thinking that is present in depressed individuals (Leahy & Holland, 2000). Therefore, a counsellor may need to develop a treatment plan that addresses the depression before the client is able to be involved in meaningful decision-making. Meaningful decision-making is often based on one's own value and belief system (Sneiderman et al., 2003). When considering whether a minor should be granted mature minor status a counsellor needs to determine the extent to which the diagnosis (symptoms) impacts the client's ability to make treatment decisions. There are various assessment instruments that counsellors can use to assess symptom severity. For example, the Beck Depression Inventory is an assessment instrument that could be used by counsellors to assess the severity of depressive symptoms (Dozois, Dobson, & Ahnberg, 1998).

*Counsellor bias.* The last contextual factor to consider is the counsellor's judgement and bias (Campbell, 2006) because biases may impact the counsellor's assessment of an individual's decision making abilities. For example, a counsellor may have a bias that all teens are immature and are not responsible enough to make their own decisions. This bias could impact the counsellor's decisions of whether or not to grant mature minor status. Counsellors can determine what their biases are by spending time reflecting on the following: generalizations they hold about individuals who are part of a specific group, how their cultural upbringing has impacted their values and beliefs, and how they perceive others who are different from themselves (Corey et al., 2007). Also journaling and receiving their own counselling is helpful in exploring one's own biases.

#### *Consider Capacity in Relation to the Decision*

Health practitioners should assess capacity for making treatment decisions relative to the specific decision to be made by the client: the higher the risk(s), the higher the capacity required (Campbell, 2006; Rozovsky, 2003). For example, deciding whether or not to end one's life obviously entails more risk than deciding if one should take antidepressant medication for symptoms of grief. Thus, the decision of whether or not to end one's life requires a higher level of understanding. Accordingly, when counsellors are deciding whether to grant a minor mature status they need to ensure that the client's level of understanding matches the level required for a specific treatment decision.

#### *Reassessing Capacity*

Even if a health practitioner had determined that the minor has sufficient capacity to consent to his/her mental health care, he or she must continually reassess the minor's capacity as capacity may change (Campbell, 2006). For example, a minor may have the

capacity at the time to decide if s/he would like his or her parents involved in counselling, however, if the counsellor notices that the minor begins to develop symptoms of depression, the minor's capacity to consent to treatment must be re-assessed and documented.

### *Absent Capacity*

If the minor client does not possess the capacity to make treatment decisions, health practitioners should consider whether the passage of time would affect their capacity to consent to treatment (Campbell, 2006). If capacity would likely remain unchanged, health practitioners should involve the guardian(s)/parent(s) in decision-making, because their consent is legally required if the minor does not possess the capacity to consent (Rozovsky, 2003; Sneiderman et al., 2007). However, even if the minor client does not possess the capacity to consent, the minor should still be involved to the extent possible in decisions that impact him or her. In addition to these guidelines, there are some additional issues that are worth mentioning so that counsellors can offer a comprehensive assessment of capacity to consent to counselling, the first pertaining to emotional maturity.

The first element pertains to minors' emotional maturity. As previously mentioned, it is important for counsellors to consider a minor's emotional maturity when assessing a minor's competence (Fundudis, 2003). Fundudis referred to emotional maturity as a minor's ability to adapt to emotion, changes in mood state, control impulsivity and tolerate frustration. Steinberg and Scott (2003) found that it can be a greater challenge for minors to regulate their moods, impulses and behaviours than it is for adults. The implication of this pertaining to consent is that a counsellor needs to

determine the extent to which these variables impact with minor's ability to consent to counselling. For example, if a minor has extreme mood swings and is impulsive; a counsellor needs to take this element into account when considering whether to grant mature minor status.

The second element worth mentioning since it pertains to capacity is minor's cognitive developmental abilities. It is important for counsellors to be aware of minor's cognitive developmental abilities because this will help counsellors develop an appreciation for what the minor is truly capable of in regards to cognitive functioning.

#### *Minors' Developmental Abilities*

When assessing a minor's capacity to consent to treatment/counselling, it is important for counsellors to have an understanding of the minor's cognitive developmental abilities; individuals such as Piaget and Vygotsky, as summarized next, have played key roles in the growing understanding of this development (as cited in Rushforth, 1999).

Piaget, as cited in Rushforth (1999) posited a theory of cognitive development, which indicated that children would progress through a series of stages with regard to their cognitive development. He suggested that children's developmental capacity between the ages of six and twelve is similar to adults in terms of reasoning and logical skills and children around the age of eleven or twelve reach the formal operation stage in which they would develop more sophisticated ways of thinking (Fundudis, 2003). Thus, it can be assumed by counsellors that minors do have the ability to make executive decisions. It can also be assumed that minors who have reached the formal operation stage have the cognitive capacity to consent to counselling, much like adults do.

Weithorn and Campbell (1982) conducted a study that supports Piaget's theory of cognitive development. This is an important study to review because a child with a high degree of cognitive development (that is, reached formal operational thought) might be in a better position to consent to counselling than a youth who is in an earlier stage of cognitive development. Specifically, these authors concluded that minors aged 14 and older have the same level of cognitive development as adults in terms of: (a) indicating a choice; (b) understanding the information; and (c) following a rational decision-making process as adults.

It is likely then to conclude, based on the above findings, that when an individual under the age of 18 has reached the formal operational thought stage, he or she is able to truly appreciate the nature of the decision making process, such as consenting to counselling without obtaining parental consent. Therefore youth possessing this level of maturity would classify as a mature minor.

Weithorn and Campbell (1982) also discovered that although children age nine and under seemed less competent with regard to understanding treatment information (medical and psychological treatment) and having a rational reasoning process; these children were able to understand basic treatment information. They identified that children could be part of the decision-making process even when not able to make autonomous decisions. For example, the children were presented with treatment dilemmas and were able to indicate their treatment preferences, which were reasonable. Of course, children over the age of 14 were able to engage in a more rational decision making process.

Vygotsky's work can also be used in assisting counsellors in determining if a minor is able to give consent to counselling. Vygotsky, was a contemporary of Piaget, acknowledged that a child's comprehension is limited; however, he concluded that a child's comprehension significantly improves with proper one to one instruction (Rushforth, 1999). This means that when assessing a minor client's competence to understand treatment information, counsellors should help the minor understand the information by carefully reviewing the information with the minor, asking them questions about the process, etc.

An important warning: Despite mounting evidence that minors can be cognitively and emotionally mature enough to make informed treatment decisions, it has been suggested that studies of adolescent decision-making capabilities are biased because they focus on hypothetical dilemmas where the participants experience minimal emotional stimulation (Steinberg & Scott, 2003). It is argued that in real-life decision-making minors usually experience more intense emotional stimulation. As a result, minors might become too emotional to make a rational decision. This argues against youth getting mature minor status and also supports the need for individualized comprehensive assessment to be conducted by trained practitioners (Steinberg & Scott) before declaring or denying mature minor status.

Overall, counsellors need to consider the following when assessing a minor's capacity to consent to counselling: (a) the minors understanding of the treatment information including the risks and benefits of both receiving and not receiving treatment; (b) consider the minor's diagnosis; (c) assess capacity in relation to the specific decision to be made; (d) re-assess capacity; (e) assess emotional and social

maturity; and (f) if capacity is not present, parent(s)/guardian(s) need to be involved in the consent process.

In summary, assessing capacity when determining whether to grant mature minor status is a complex process that requires the counsellor to move beyond ensuring the minor has the cognitive ability to understand various treatment issues. All areas of a minor's development need to be considered when assessing capacity. The next section of the chapter will discuss the voluntary element of a valid informed consent.

### *Voluntary*

So far this chapter has explored the first and second elements of a valid informed consent which include: capacity to consent and disclosure of any relevant treatment information. The final element of a valid informed consent is that it is given freely, without any manipulation or coercion (Canadian Psychological Association, 2001). The following section will expand on the notion of "given freely".

Roberts (2002) has identified voluntarism, which is like given freely, as "[i]deally encompassing the individual's ability to act in accordance with one's authentic sense of what is good, right, and the best in light of one's situation, values, and prior history" (p. 707). Adolescence is often regarded as a time when beliefs and values are forming, a time when minors are trying to determine their authentic selves. Therefore it is important to assess a "young person's freedom from pressure to act in a certain way" (Ford & Kessel, 2001, p. 385). For example, the teen may want to act in a certain way (e.g., engage in self-harm) because his or her friends are also acting in this way, thus they may not be in a position to make a decision without peer pressure. If this is the case the counsellor is likely rather restricted in being able to grant mature minor status.

Roberts (2002) has also identified the possible impact of cultural and religious values on voluntary decision-making ability. He identified that cultural and spiritual values can impact the beliefs an individual holds about who is good and what choices are tolerable. He further identified that culture and religion shapes the beliefs an individual holds about, how symptoms are interpreted, how illness is perceived, and how accepting one is in regards to various treatment options. For example, some Jehovah Witness clients may hold strict beliefs about the acceptability of blood transfusions (Sneiderman et al., 2003). Accordingly, the question arises as to whether the minor feely adopted this belief system or was the minor convinced to adopt it.

As adolescents age, they have a greater ability to recognize their values and beliefs, and their capacity to make voluntary decisions also increases (Roberts, 2002). So in the context of this paper, when a counsellor is considering giving a minor mature minor status, the counsellor needs to take into account the minors understanding of themselves. A minor who has awareness of his or her values and beliefs is more likely to be eligible for mature minor status.

In summary, counsellors need to ensure that the minor client's consent to counselling is voluntary, without undue influence or coercion. To help ensure that the consent is voluntary, the minor's decisions need to be based on beliefs and values that are truly theirs.

Although some of the factors identified in this section could be used against minors being given mature minor status, they do need to be considered by counsellors in their assessment of minors' decision-making abilities. The decision to grant mature minor status requires a comprehensive, documented assessment.

The last section of the chapter will highlight court cases that have led to the development of the mature minor doctrine. This information may be useful to counsellors because it serves as a review of some of the material discussed in this chapter such as the importance of assessing for cognitive and emotional maturity.

#### *Court Cases in Canada*

Mature minor issues evolved in Canada because of cases brought before the court in which consent was an issue. For example, the 1910 case of *Booth v. Toronto General Hospital* established that a 19-year-old boy could consent to the removal of part of his thyroid without parental consent or consultation because he was found to be highly intelligent and had achieved a healthy level of independence (Rozovsky, 2003). This finding supports the research/comments made earlier, in particular when cognitive and emotional maturity is present the minor can be granted mature minor status.

In the 1970 Canadian case of *Johnston v. Wellesley Hospital*, the client was 20 years of age but had not yet reached the age of majority (21) and was considered by Ontario law to be an infant. He was treated in the Wellesley hospital to remove marks and scars caused by acne. The question was whether he had the capacity to consent to this treatment or if his parents should have provided it. After a review of common law, the court found that there was nothing to prohibit an individual under the age of 21 from consenting to his or her own treatment (Rozovsky, 2003). This case is important for counsellors to know because although this individual was under the age of majority he was able to demonstrate sufficient intelligence, and therefore was granted mature minor status.

The Canadian case of *C. (J. S.) v. Wren* involved a 16-year-old girl who wanted an abortion despite her parents' wishes to the contrary (Sneiderman et al., 2003). The court weighed several factors to determine whether she had the ability to consent, including age, maturity level, the extent of her dependence on her parents, and the complexity of the treatment (Rozovsky, 2003) before ruling that she was a mature minor. Thus, counsellors need to be aware that mature minor status is recognized by the courts if proper assessment has been done by a health professional.

#### *Summary*

The mature minor doctrine in Canada has evolved through common law to consider a mature minor to be able to give consent to treatment without parental input if s/he can understand the information relating to his or her condition and the potential risks and benefits of the proposed treatment (Rozovsky, 2003). In such a case, s/he is considered competent to make that specific treatment decision (Sneiderman et al., 2003). When an individual is identified as a mature minor, s/he is afforded some rights of self-determination and is to be treated as an adult with regard to care and treatment by health practitioners; however, s/he is not granted the full legal rights of majority, such as the right to vote (Rozovsky).

The decision to grant a minor the opportunity to consent to his or her own treatment is not determined by age, rather it is determined by cognitive capability: this is the law in Canada (Sneiderman et al., 2003). Cognitive capability includes but is not limited to the client's intellectual ability to make a reasoned choice about treatment (Rozovsky, 2003).

Although it is imperative that minors possess the cognitive ability to make treatment decisions, they also need to possess emotional and social maturity to be granted mature minor status. Emotional and social maturity refers to susceptibility to peer pressure, the ability to control impulses, the ability to make a decision within a larger context, awareness of one's identity, a healthy level of independence and making decisions after carefully assessing the situation (Steinberg & Cauffman, 1996). A thorough assessment needs to be completed by a trained health practitioner before determining mature minor status.

If a minor has these capabilities (cognitive, emotional and social maturity), guardian/parental consent is not required, and guardian(s)/parent(s) cannot overrule the minor's own decision (Rozovsky, 2003). However, like any ethical dilemma, this situation cannot be looked at in terms of black and white because there are several dimensions that need to be explored. These include the minor's capacity to consent, the minor's rights, the rights of parent(s)/guardian(s), ethics and law. Whether a minor can consent to his or her own treatment can become complicated because, although the minor has rights of self-determination, guardian(s)/parent(s) are also granted rights to enable them to care for their children. There are no prescribed steps in the event that consent becomes an issue.

It is interesting that a significant portion of the mature minor legislation applies to work by physicians and/or in hospitals, while little is specifically relevant for psychologists and other health-care providers. The reasons for this discrepancy are manifold, including the fact that physicians and dentists generally work with problems that are more tangible in nature. By contrast, psychologists generally work with less

tangible mental health issues such as depression and anxiety. In the case of physical issues, the physician or dentist is able to see, feel and diagnose the problem with a high degree of confidence. However mental health issues cannot be seen, felt or diagnosed with a very high degree of certainty.

Furthermore, the very nature of mental health issues requires almost complete reliance on information provided by the client, which can easily vary depending on cognitive ability. Regardless of the reason for the lack of legislation, counsellors and psychologists have an ethical and legal responsibility to ensure that they understand the mature minor rule because they work with minors, of which some have the capacity to consent to treatment.

### Chapter 3: Methodology

This section describes the methodology of the preceding literature review and subsequent consent forms. The method of data collection for this project consisted of searching academic and professional literature (journal articles and books) relevant to the mature minor doctrine.

#### *Data Sources*

There were no interviews conducted or human subject data collected and the Canadian Psychological Association Code of Ethics was followed for the duration of this project. The literature review focused on English-language literature published between the years 1982 and 2009 and were started by cross-referencing relevant journal articles that were provided in the author's counselling ethics course. PsycINFO was the primary database used to find academic journal articles using broad search terms such as 'mature minor', 'informed consent', 'informed consent and adolescence', 'competency and adolescent', 'capacity and minors' and 'minor and counsel and consent'. The Canadian Studies database was also used to find journal articles that focused on the mature minor doctrine in Canada. Broad search terms included 'mature minor' and 'mature minor and psychologists'. Through cross-referencing, further relevant journal articles were found in the following databases: PsycINFO, MEDLINE, Academic Search Complete, Academic One File, Canadian Studies, and PubMed Central.

The internet was also used to define key phrases such as 'mature minor' and 'minor consent to treatment'. To provide an overview of the mature minor doctrine, studies that were included focused on the mature minor rule, children's rights, legal and ethical issues related to consent, informed consent, minors' capacity to consent to

treatment, minors' developmental abilities, minors' comprehension of treatment information, factors that can impact capacity, and how to assess capacity.

### *Procedure*

The first step in gathering information was to focus on studies relating to the mature minor doctrine in Canada. However, studies that explored the mature minor rule in other countries such as the United States make clear the general confusion within the health-care community with regard to assessing a minor's capacity, leading the researcher to refocus the search on capacity and how to assess it. The goal was to find common themes in the literature and to include them in the literature review.

The consent forms found in appendices C and D were initially created as part of a policy and procedure manual for a hypothetical counselling agency. The forms were significantly updated and revised for this project and also include information relevant to mature minors. Further, a form explaining the mature minor rule was created for parents and minors. The literature applicable to consent forms was reviewed and relevant ethical issues identified for inclusion in the forms, such as confidentiality and the nature of treatment, including risks and benefits. The intent was to create several user-friendly informed consent forms that could be used by counsellors and psychologists in their practice. The focus of this project, however, was chapter two; clearly outlining what is mature minor in Canada and how to assess for it.

## Chapter 4: Synthesis

This intent of this project was to provide counsellors and psychologists with in-depth information on the mature minor rule in Canada. The strengths and limitations of the project, as well as recommendations for future research are explored.

### *Strengths*

As previously expressed a confusing aspect of the mature minor rule is identifying when a minor has the capacity to consent to treatment. The project review identified several factors that need to be considered when assessing capacity such as cognitive and emotional maturity, the client's diagnosis, cultural upbringing, and counsellor bias. The project included specific examples of how these factors may impact minor's capacity to consent to counselling.

The literature review also thoroughly explored how the informed consent process differs with minors (e.g., it is made more difficult by the minor's developing character and greater susceptibility to peer influence) and the essential elements of a valid consent, including capacity, disclosure of relevant information, and voluntary consent. It is essential that when counsellors and psychologists are conducting an assessment of a minor's capacity to consent to counselling they consider all of these factors.

As previously noted, counsellors and psychologists will encounter situations where conflicts arise between minors and parents regarding who can provide consent to counselling. For this reason Appendix F was created to provide counsellors and psychologists with tips for addressing conflicts between minors and parent(s)/guardian(s).

The rules relating to consent, particularly whom those rules apply to (i.e., doctors, counsellors, et al.) and what conditions are required for youth to achieve early consent are

somewhat unclear. Thus, in Chapter 1 consent rules for several Canadian provinces were identified. Also, a table was created in Appendix B to provide further clarification of consent rules in selected Canadian provinces and territories. Chapter 2 was designed to bring significant clarity for counsellors as to the conditions required for youth to be granted mature minor status.

For this project, a series of consent forms and handouts pertaining to mature minor were created for use for graduate level counsellors. The consent forms are user-friendly and easy to follow, as well as being relevant to various situations including youth one to one counselling, and informed consent for parents.

Key terms and definitions used in the literature relating to mature minors are rather confusing. For example, capacity, competency, decision-making abilities, rational decision-making process were all used in the literature and have very similar definitions. Thus, Appendix A was created to define key terms used in the project.

### *Limitations*

The project did not identify any standardized instruments that counsellors could use to assess cognitive ability or emotional maturity. It is essential that health practitioners have an understanding of how to assess both of these issues, because in order to qualify as a mature minor, cognitive and emotional maturity needs to be present.

The literature review did not provide an exhaustive exploration of consent rules across all Canadian provinces and territories, such as who may determine age of consent in Saskatchewan and Quebec. The author's interpretation of the legislation could also be inaccurate given their lack of legal training. However, the writer indirectly consulted with

a legal librarian who recommended databases for finding information on consent rules that had already been explored as part of the project research.

The consent forms were meant to be used by practitioners with graduate training in ethics; using them without this training would be unethical. Further, the consent forms were created for a hypothetical private counselling agency, so some of the information used may not be applicable in different settings (i.e., counsellors working in a school setting may have different confidentiality and privacy procedures than others).

### *Future Research*

As stated in the literature review, there is no case law in Canada that specifically addresses how to assess capacity to determine if an individual, including a minor has the ability to consent to treatment (Sneiderman et al., 2003), pointing to an obvious area for future research. Further, the literature review revealed that the rules relating to child consent are so complicated even lawyers struggle to understand them, while many of the rules are relevant only to doctors and physicians, with little relevant existing consent legislation for other health practitioners (Hesson et al., 1993). Thus, future work could focus on developing more comprehensive consent legislation relevant to counsellors and psychologists and other health-care providers working with minors. Current research has also determined that emotional maturity needs to be considered when assessing capacity (Sneiderman, et al.). Thus, future work could focus on developing procedures for such assessment.

### *Summary*

This project explained the mature minor doctrine in Canada for counsellors and psychologists. It is essential that health practitioners working with minors understand the

mature minor doctrine, because some of their minor clients will have the capacity to make autonomous decisions and should consequently be granted the right to limited self-determination.

Mature minors do have the ability to look inside themselves for answers. They are resourceful and in the best position to be the authors of their own lives. The author of this project chose to create a project on the mature minor rule in the hopes that more counsellors and psychologists would gain awareness of the value of this doctrine, using it to grant mature minors the right to autonomy, which many deserve.

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## Appendices

### Appendix A

#### Key Terms and Definitions

***Age of majority:*** The age at which individuals are granted full legal rights in a jurisdiction.

***Autonomy:*** The promotion of self-determination, or the freedom of the client to choose his or her own direction (Corey et al., 2007).

***Beneficence:*** Doing well for others (Corey et al., 2007).

***Canadian Charter of Rights and Freedoms:*** A bill of rights entrenched in the Canadian constitution. The Charter guarantees certain political and civil rights for people in Canada (Wikipedia, n.d.).

***Capacity:*** The ability to understand facts and consequences and make a decision based on a rational decision-making process (Campbell, 2006).

***Child:*** All minors under the age of majority (Rozovsky, 2003).

***Cognitive capability:*** Knowledge and understanding; does the client understand their medical condition; does s/he understand the nature of the proposed treatment (Sneiderman et al., 2003).

***Cognitive Functioning:*** The capacity for thinking, reasoning, and understanding (Steinberg & Cauffman, 1996).

***Common law:*** Law created and refined by judges, developed through judicial decisions based on legal precedent (Hesson et al., 1993).

***Establishment:*** local community service centres, hospitals, functional rehabilitation centres and social service centres (Hesson et al., 1993).

**Ethical:** Correct clinical practice, based on morals and values (Campbell, 2006).

**Guardian:** Someone appointed by the court to represent and make decisions for someone (a minor) legally incapable of doing so (College of Alberta Psychologists, 2006).

**Health practitioners:** A practitioner in one of the health professions regulated by a responsible board such as a registered psychologist.

**Immature minor:** Children older than six who have some understanding of treatment, but do not qualify as mature minors (Sneiderman et al., 2003).

**Incompetency:** The inability to provide a legally valid consent (Crowhurst & Dobson, 1993).

**Infant:** Minors up to the age of 6 (Sneiderman et al., 2003).

**Informed consent:** A process by which both the professional and client participate in a shared decision-making process (Crowhurst & Dobson, 1993).

**Justice:** Fairness or providing equal treatment to all people (Corey et al., 2007).

**Legal:** What a practitioner may or may not do based on local, provincial/state and/or federal laws and regulations (Campbell, 2006).

**Legal or civil rights:** Those rights protected under laws and statutes recognised by the province or territory where the health professional has his or her practice (Canadian Psychological Association, 2001).

**Mature minor:** An individual who has the capacity to understand and appreciate the nature of treatment, including the costs and benefits (Kuther, 2003).

**Minor:** Person under the age of majority (Sneiderman et al., 2003).

**Moral rights:** Fundamental and inalienable rights that may or may not be fully protected by existing laws and statutes (Canadian Psychological Association, 2001).

***Mental capacity:*** Intellectual ability to make a reasoned choice about treatment (Rozovsky, 2003).

***Rational decision-making process:*** A rational decision demonstrates an understanding and appreciation of the relevant treatment information such as consequences, risks, benefits and alternatives, as well as the ability to use the information to weigh the risks and potential benefits of different options while making a choice (Kuther, 2003).

***Self-determination:*** To choose one's own direction (D.L. McBride, personal communication, May 6, 2008).

***Treatment:*** Refers to counselling, assessment, medical assistance.

***Unjust discrimination:*** Activities that are prejudicial or promote prejudice against persons because of their culture, nationality, ethnicity, colour, race, religion, sex, gender, marital status, sexual orientation, physical or mental abilities, age, socio-economic status, or any other personal characteristic (Canadian Psychological Association, 2001).

## Appendix B

## Consent Law in the Provinces

Province	Act(s)	Earliest age of consent	Conditions for youth to achieve early consent	Capacity of minor determined by	Type(s) of applicable treatment	Reference
Alberta	Child Welfare Act (1984)	No statutory age of consent. Children 12 and over have certain rights.				Hesson et al., 1993; Rosemaire, 1997
British Columbia	Infants Act	No statutory age of consent.	a. If the minor understands the nature, likely risks and benefits of treatment. b. If the treatment is in the best interests of the minor.	Health Care Provider		Rozovsky, 2002
Manitoba	Child and Family Services Act	No statutory age of consent.	a. If the minor qualifies as a mature minor. b. If the decisions are in the minor's best interest.	Physician		Rozovsky, 2003
New Brunswick	Medical Consent of Minors Act	16	a. If the minor understands the nature of the treatment. b. If the treatment is determined to be in the best interests of the youth by 2 physicians.	Physician (for minors under the age of 16)	Applies to dental and surgical treatment, all diagnostic and preventative care, and any ancillary treatment (not strictly medical)	Sneiderman et al., 2003; Rozovsky, 2003
Ontario	Health-care Consent Act	No specific age of consent	The minor understands treatment information and possible consequences.			Sneiderman et al., 2003

Province	Act(s)	Earliest age of consent	Conditions for youth to achieve early consent	Capacity of minor determined by	Type(s) of applicable treatment	Reference
Prince Edward Island	Hospitals Act (1981)	18	Reached the age of 18.		Applies only to treatment in hospitals.	Hesson et al., 1993
Quebec	Civil Code	Minors over the age of 14 can give consent to health-care.	a. Over the age of 14. b. If the minor is under the age of 14, parent/guardian consent is required.		Applies to health-care.	Rozovsky, 2003
Saskatchewan	Hospital Standards Act (1979)	18	Reached the age of 18.		Applies only to treatment in hospitals.	Hesson et al., 1993

## Appendix C

### Sample Informed Consent Form for Adolescents

#### Informed Consent for Adolescent Individual Counselling<sup>1</sup>

##### *What is counselling?*

When you come for counselling, you have the opportunity to talk about what is happening in your life, good and bad. Your counsellor will listen to you and offer support and assistance. Common issues that young people may bring up during a counselling session may include:

- Relationships with Friends
- Relationships with Parents
- Drug use
- Self-esteem
- Not feeling they “fit in”
- Having a hard time with school work
- Not knowing what to do when they graduate from school
- Trying to figure out who they are as a person

##### *What are some good things that might happen in counselling?*

There are many good things that can happen during counselling. You might begin to feel better about yourself and more confident in your abilities, you might discover new things about yourself (such as your strengths), and your relationships with your friends and family might improve.

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<sup>1</sup> Many of the ideas in the consent form were taken from Kraft, S. (n.d.). *Sample adolescent informed consent form*. Center for Ethical Practice. Retrieved June 21, 2008, from <http://www.centerforethicalpractice.org/Form-AdolescentConsent.htm>.

*What are some bad things that might happen in counselling?*

Counselling can also produce some disruptions in your life. You may begin to experience emotions that are uncomfortable, such as anger and grief. Although experiencing these emotions is not fun, being able to work through them will actually help you. Your counsellor will be available during work hours to help you deal with the positive and negative effects that might happen in counselling.

*Mature Minor*

If your counsellor has assessed that you qualify as a mature minor you have the right to make your own treatment decisions and you are able to choose if your guardian(s)/parent(s) are to be involved in your treatment. Your guardian(s)/parent(s) consent for treatment is not required if you qualify as a mature minor.

*Confidentiality*

Information that I cannot keep confidential

What you share with your counsellor will remain confidential; however, there are instances when your counsellor is legally not allowed to keep information confidential.

- If you tell your counsellor that you will harm yourself, then your counsellor has a duty to protect you.
- If you tell your counsellor that you will harm another person, then your counsellor has a duty to inform the potential victim and notify the proper legal authorities.
- If you tell your counsellor that you are being abused physically, sexually, or emotionally. In this case, your counsellor would be required by law to report this abuse.

- If you are involved in a court case and there is a request for information about what has been going on in therapy. In this case, your counsellor will ask you for your written consent to release any information. However, if you do not consent and the court requires your counsellor to do so, then your counsellor will be legally obligated to release your information. Even in this circumstance, your counsellor will attempt to protect your confidentiality as much as possible and only release as much information as he or she has to.

*Why is it important to involve your parents in your counselling experience?*

Your counsellor believes that if your parent(s) and/or guardian(s) are involved in some aspect of your therapy, this will benefit you. Although your counsellor will not share what is going on with your parent(s) and/or guardian(s), he or she will encourage you to start sharing some aspects of your therapy with your parent(s) and/or guardian(s), because your parent(s) and/or guardian(s) can be your number one source of support. If you do not know how to involve your parent(s) and/or guardian(s), your counsellor will work with you on this issue and support you.

*Communicating with your school*

Your counsellor will not share information about you with your school unless your counsellor has your written consent to do so. Sometimes it may be helpful for your counsellor to talk to someone at your school to see how things are going for you.

I have had the chance to discuss any questions that I have about this information.

Client's signature \_\_\_\_\_ Date \_\_\_\_\_

I have discussed this information with the client.

Staff signature \_\_\_\_\_ Date \_\_\_\_\_

## Appendix D

### Sample Informed Consent Form for Parents

#### Parental Consent for their Adolescent to Receive Counselling<sup>2</sup>

Name \_\_\_\_\_ Date \_\_\_\_\_

One of the top priorities of our agency is to ensure that our clients are provided with all the essential information to make an informed decision whether or not to engage in counselling. We view our clients as partners in the sense that they are completely involved in each aspect of their therapy. The information provided in this handout will assist you in your decision to give consent for your teen to receive counselling at this agency. We ask that you carefully read each section. If you have any questions or concerns, please talk with your counsellor.

#### *Counsellors*

All therapeutic services will be provided to your teen by either a master's level counselling psychologist professional or a psychologist. Our staff are diverse and each specializes in different areas. All counsellors receive supervision by the supervisor/coordinator of this agency.

#### *The Counselling Process*

Each individual who receives counselling will have a unique experience; however, there are some general ideas of what happens in counselling. It is a collaborative process between your teen and their counsellor, meaning that both of them will make decisions about what will happen in therapy. Your teen's counsellor will use

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<sup>2</sup> Many of the ideas for this consent form were taken from Kraft, S. (n.d.). *Sample adolescent informed consent form*. Center for Ethical Practice. Retrieved June 21, 2008 from <http://www.centerforethicalpractice.org/Form-AdolescentConsent.htm>. Ideas were also taken from Corey, G., Corey, M.G., & Callanan, P. (2007). *Issues and Ethics in the Helping Professions* (7<sup>th</sup> ed.). Pacific Grove, CA: Thompson Brooks/Cole.

techniques and strategies that best suit the unique needs of your teen. Your teen's counsellor will not guarantee your teen's problems improve because recovery/healing are dependent on many external factors, which are outside the counsellor's control.

### *Risks and Benefits of Counselling*

There are benefits and risks associated with counselling. Some of the benefits for your teen may include increased self-esteem, improved interpersonal relationships, development of skills (e.g., organizational skills). Some of the risks may include an exacerbation of problems, and experiencing unpleasant emotions (e.g., if your child is receiving counselling for grief and loss, part of working through this issue is experiencing negative emotions such as anger, despair and hopelessness). Your teen's counsellor will be available to you to help you deal with the positive and negative effects of working through your teen's problem.

### *Confidentiality*

We view confidentiality as one of the most important aspects in counselling. Therefore your teen's counsellor will ensure that information that your teen discusses with them during sessions will remain confidential. You will have to waive your right to access your teen's file. Your teen's counsellor will share information with you about your teen when it is relevant to do so, and will serve the teen's best interest. There are some instances in which your teen's counsellor will be unable to keep your teen's information confidential. These include:

- If your teen is causing harm to him or her self or is going to cause harm to him or her self or to a third party.

- If your teen is being physically, sexually, or emotionally abused. In this case, we would need to inform the proper authorities.
- If your teen is involved in a court case, and there is a request for information about what has been going on in counselling, we would need to comply.
- If your teen is participating in counselling as a result of a court order, we are required to release information to the relevant court, social service, or probation departments.

### *The Importance of Confidential Counselling for Adolescents*

One of the most important aspects in a counselling relationship is trust, which only develops if a counsellor can ensure that most of what a client says in a counselling session will remain confidential. If your teen believes that everything they say to their counsellor will be passed on to you, they probably will not share important information and counselling will not be ineffective. There are several issues common to adolescents, such as use of cigarettes, alcohol, and/or drugs; sexual concerns or behaviour; cutting classes; unauthorized time with peers; and criminal activity. It is important that your teen feel comfortable and safe in discussing these issues, so your teen's counsellor will only share information with you regarding these issues if their seriousness increases and there is imminent danger to your teen or others. In such a case, both you and the proper authorities will be notified.

For example, if your teen informs their counsellor that they have experimented with alcohol a couple of times, your teen's counsellor may not inform you of this. However, if your teen informs their counsellor that they are abusing alcohol every weekend and it is causing harm in different areas of their life, then your teen's counsellor

will seriously weigh the pros and cons of disclosing this information to you. Your teen's counsellor will do his or her best to have the discloser come from your teen whenever possible.

Our agency strongly believes that parents and/or guardians are often the best support for their children. Thus we will attempt to incorporate you into your teen's counselling when deemed it is safe, relevant, and important to do so.

#### *Confidentiality from Third Parties*

If you seek reimbursement for counselling services from an insurance company or other third party, certain information about your teen's case may be required. Prior to rendering counselling services, your teen's counsellor will ensure that all parties (you, your teen, your teen's counsellor, and the third party) are aware of the nature of the relationship (i.e., who the client is, and who has access to and control of the information). Your teen's counsellor will also make sure that you and your teen sign a consent form for any disclosure made to a third party.

If a third party requests information after services have been provided and without your and/or your teen's consent, your teen's counsellor will inform you and your teen of this request and will release the information only if you and your teen (when possible) give your consent, or if the third party has a legal right to your teen's information.

#### *Consultation with Colleagues*

Our agency offers practicum placements to students at a masters' level. With your and your teen's permission and a signed consent form, students may observe or co-facilitate counselling sessions. Also, counsellors generally meet with their supervisors to discuss their progress and to receive supervision on their cases. Your family name will

not be mentioned during these discussions. Counsellors who learn about your case are ethically obligated to respect your family's confidentiality.

The counsellor's primary responsibility is to your teen, but if they believe it will assist you in helping your teen, your teen's counsellor will provide you with a referral. You will be consulted as to the progress of therapy when you request this information.

#### *Communicating With Your Teen's School*

Some times it may be helpful for your teen's counsellor to talk with someone at your teen's school to see how your teen is functioning at school. However, your teen's counsellor will not share information with your teen's school unless you and your teen provide a written consent to do so.

#### *Treating Adolescents of Separated or Divorced parents*

We encourage both parents to work together in the best interests of the teen and we are legally required to obtain consent from both parents in order for your teen to receive counselling. Your counsellor will ask for a copy of the court order declaring parental rights upon separation and divorce when treating a teen of parents who are not living together in a common law or married relationship.

#### *Professional Records*

Both legal and ethical guidelines require your teen's counsellor to keep records of your teen's therapy to document progress and interventions used. Although you and your teen have the right to receive a copy of your teen's records we discourage this practice because of the confidential nature of the material. If upon request to review the file, agency protocols will be followed. For example, your teen's counsellor will review your

teen's record with your teen first. Your teen's records are kept in a locked file cabinet and only accessible by your teen's counsellor.

### *Multiple Relationships*

Multiple relationships occur when your teen's counsellor functions in more than one significant role with your teen (e.g., your teen's counsellor is both their therapist and their teacher). Multiple relationships should be avoided because they interfere with the counselling process and there is always the potential that your teen will not benefit from such a relationship. Your teen's counsellor will avoid forming multiple relationships with your teen. When this is not possible, the boundaries of the two relationships will be discussed and documented with your teen.

### *Bartering*

Bartering is a type of multiple relationship and potentially creates harm to your teen and can interfere with the counselling process. An example of a bartering relationship would be an exchange of services between the teen and his or her counsellor (e.g., your teen receives counselling in exchange for fixing the counsellor's car).

Bartering is not allowed at the agency.

### *Medical Concerns*

Counsellors are not medical doctors; hence, they are not able to diagnosis medical conditions or prescribe medication. You are strongly advised to obtain medical consultation to determine if your teen's psychological condition has a medical origin such as infectious disease, side effects of medication, gastrointestinal disorders, etc.

### *Psychological Test Information*

You and your teen have the right to know about what tests will be administered to your teen and to access your teen's psychological test information. Test results are best interpreted by a qualified professional; your counsellor will interpret and explain the results of your test(s) to you and your teen.

There are some circumstances in which your counsellor would not provide you or your teen with your teen's psychological test information or case notes. These include:

- Where disclosure of the information would create a substantially adverse effect on you or your teen's physical, emotional, or mental health.
- Where disclosure of the information would cause harm to a third party.

### *Alternative Treatments*

There are many different ways of approaching your teen's issue(s) and your teen's counsellor will provide your teen with alternatives. Some of these may include family therapy, group therapy, psych-educational groups, support groups, yoga, Eye Movement Desensitization and Reprocessing (EMDR), hypnosis, guided imagery, narrative therapy, gestalt therapy, exercise, and medication.

### *Costs Involved in Counselling*

Our agency works on a sliding fee scale. This means that our fees are adjusted according to your family size and income. You can share with us any other important information that may affect your ability to pay for counselling. Your counsellor will discuss payment with you in the first session.

Payments are due at the end of each session unless other arrangements have been made. You can pay with cash or cheque and your counsellor will provide you with a

receipt. Your counsellor reserves the right to release your financial information to a collection agency if you fail to make payment.

#### *Missed Appointments*

Your teen's counsellor will not charge for missed appointments provided 24-hour cancellation notice was given.

#### *Telephone Calls*

Your teen's counsellor may be available to speak with you in between appointments; however conversations of more than 10 minutes per week will cost \$4.00 per hour.

#### *Referral*

Our counsellors will only provide services in areas that they are competent to provide. If issues arise that are beyond the competence of your teen's counsellor, they will support you and your teen with a referral to another professional with expertise in that area.

#### *Length of Treatment*

It is not easy to predict the length of your teen's therapy, as some youth may only require a few sessions of counselling, while others require months, or even years, of counselling. The length of your teen's therapy can also depend on the counsellor's theoretical orientation (the type of counselling they do). Some counsellors do more short-term counselling, while other counsellors do more long-term counselling. Your counsellor will inform you and your teen of the basic assumptions underlying his or her orientation.

### *Termination of Services*

You, your teen and your teen's counsellor can terminate services when it is apparent that your teen is no longer benefiting from the service and/or when you teen has obtained the goals of counselling established in the first few sessions. Your counsellor will prepare you and your teen for terminating services.

### *Emergencies*

If you or your teen need immediate assistance during business hours (Mon-Fri, 8:00-4:30, Sat 8:00-12:00), you or your teen can call your teen's counsellor. In the event that your teen's counsellor is not available and outside business hours, you can call the 24-hour crisis line at (403) 327-7905. In case of a life-threatening emergency, please contact emergency services (911). If your teen's counsellor is out of town, the agency will provide you and your teen with contact information for alternative sources of assistance.

### *Grievances*

If you are unable to resolve your concern(s) with your counsellor you can contact the College of Alberta Psychologists directly at 1-800-659-0857. Employees will assist and help you determine a way to resolve your concern(s). You may also file a formal complaint. If you would like more information about the professional standards for psychologists, visit their website at [www.cap.ab.ca](http://www.cap.ab.ca). Please be advised that your teen's file may not remain confidential if your counsellor needs to defend his or her case to a board of ethics or in a court of law.

*Please read the following statements and sign at the bottom if you agree*

- I have been given the opportunity to have this information read out loud to me
- I have been given a copy of this informed consent form to take home
- I have been asked if I have any questions about this information
- I realize that by consenting to services at this agency, I waive my parental right to access my teen’s file.

1. Parent or Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

2. Parent or Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Teen signature \_\_\_\_\_ Date \_\_\_\_\_

This consent form is in effect 90 days from the date of this document.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day

Of \_\_\_\_\_, A.D., 20\_\_\_\_.

\_\_\_\_\_

Witness

\_\_\_\_\_

Staff Member

\_\_\_\_\_

Signature

\_\_\_\_\_

Work Address

## Appendix E

### Mature Minor Information Form

#### Mature Minor Information for Parents and Minors

##### *What is the mature minor doctrine?*

The mature minor rule was established by the Canadian government to allow minors (anyone under the age of 18) to provide consent for their own treatment.<sup>3</sup>

##### *How does a minor qualify as a mature minor?*

A mature minor is one who possesses maturity in many different areas:<sup>4</sup>

- The minor is able to understand the treatment information that the counsellor provides him or her.
- The minor is able to understand the risks and benefits of the treatment, and the consequences of not being treated.
- The minor is able to apply his or her values and preferences to the situation and make a decision.

##### *Is parental consent required for a mature minor?*

Parental consent is not required for a minor who qualifies as a mature minor because the Canadian government acknowledges that when minors reach a certain level of maturity (emotional and intellectual) they should be allowed to make certain decisions for themselves.<sup>5</sup> Parents cannot overrule a mature minor's treatment decision(s).<sup>6</sup>

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<sup>3</sup> Rozovsky, L. E. (2003). *The Canadian law of consent to treatment* (3rd ed.). Markham, ON: Lexis Nexis Canada.

<sup>4</sup> Sneiderman, B., Irvine, J. C., & Osborne, P. H. (2003). *Canadian medical law* (3<sup>rd</sup> ed.). Scarborough, ON: Thomson Carswell.

<sup>5</sup> Rozovsky, L. E. (2003). *The Canadian law of consent to treatment* (3rd ed.). Markham, ON: Lexis Nexis Canada.

<sup>6</sup> Rozovsky, L. E. (2003). *The Canadian law of consent to treatment* (3rd ed.). Markham, ON: Lexis Nexis Canada.

However, the Canadian government also acknowledges that parents have a responsibility to care for their children; therefore parent(s)/guardian(s) are given rights under the Canadian Charter of Rights and Freedoms.<sup>7</sup> Your counsellor will always acknowledge and respect rights afforded to both minors and parent(s) under the Canadian Charter of Rights and Freedoms.

*Benefits of involving parents in counselling*

Whether or not a minor qualifies as a mature minor, your counsellor generally would like your parents involved in treatment. The reasons for this include:

- Parent(s)/guardian(s) can be a significant source of support for their child especially when their child is experiencing difficulties in his or her life.
- Since most minor's live with their parent(s)/guardian(s), involving the parent(s)/guardian(s) in treatment could be an opportunity to aid family dynamics and help the minor find a voice in the family.<sup>8</sup>

*What are the benefits of the mature minor doctrine?*

The benefits to the mature minor doctrine include:

- The rule empowers a minor because it gives the minor the message that he or she is capable of making independent decisions.
- Some minors will only seek treatment and receive the necessary support if the treatment is confidential; the mature minor rule allows for that.<sup>9</sup>

*What are the limitations of the mature minor doctrine?*

Limitations to the mature minor doctrine include:

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<sup>7</sup> Hesson, K., Bakel, D., & Dobson, K. S. (1993). Legal and ethical issues concerning children's rights of consent. *Canadian Psychology*, 34(3), 317-328.

<sup>8</sup> Campbell, A. T. (2006). Consent, competence, and confidentiality related to psychiatric conditions in adolescent medicine practice. *Adolescent Medicine Clinic*, 17(1), 25-47.

<sup>9</sup> Sneiderman, B., Irvine, J. C., & Osborne, P. H. (2003). *Canadian medical law* (3rd ed.). Scarborough, ON: Thomson Carswell.

- In order to classify as a mature minor, your child's counsellor needs to complete a thorough, and potentially time-consuming, assessment to determine the minor's cognitive ability (ability to weigh the risks and benefits of a decision) and emotional maturity (ability to regulate emotions, etc).
- The Canadian government has not identified universal criteria that can be used to declare an individual competent to consent to treatment.<sup>10</sup> Consequently this has led to confusion within the health community of how best to assess competency.
- If a minor does not qualify under the mature minor clause, s/he cannot provide consent to his or her own treatment.

*What happens if my child is awarded mature minor status and I do not agree?*

If you disagree with your minor having mature minor status, please file your concerns to your counsellor or the supervisor of the agency. If no resolution, then you can contact the Collage of Alberta Psychologists directly. You may also file a formal complaint.

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<sup>10</sup> Sneiderman, B., Irvine, J. C., & Osborne, P. H. (2003). *Canadian medical law* (3<sup>rd</sup> ed.). Scarborough, ON: Thomson Carswell.

## Appendix F

### Tips for Counsellors When Consent Becomes Problematic

1. Both the rights afforded to minors and guardian(s)/parent(s) under the Canadian Charter of Rights and Freedoms should be considered.
2. Minor's who possess capacity to make treatment decisions (See chapter 2) are encouraged to communicate with their parents, however the minor's treatment decision is binding (Kuther, 2003).
3. There might be good reasons why it would be beneficial to have the parents involved in a minors treatment (Rozovsky, 2003). Since most adolescents live with their families, involving the family in treatment could be an opportunity to aid family dynamics and to help the minor find a voice in the family (Campbell, 2006). There is a difference between having the parents agree with the treatment and having their authorization (Rozovsky, 2003).
4. In more complex situations of disagreements between minor and parents, for example parents wanting a minor hospitalized because the minor has an eating disorder and is experiencing a significant amount of weight loss but refuses to consent to hospitalizations, is it may be useful to consult with ethical and legal experts prior to making a decision about who has the authority to provide consent (Campbell, 2006).
5. Find balance between encouraging the minor's autonomy, ensuring that the parents do not have too much influence over decision making, acknowledging the parent(s) values and life goals for their youth, and always maintaining the minor's best interest (Kuther, 2003).