NAVIGATING INFORMED CONSENT: ETHICAL CHALLENGES IN ADDICTION TREATMENT

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ABSTRACT

This project explores issues related to informed consent processes in the context of addiction treatment. Substance use disorder presents unique ethical challenges for informed consent. While the topic of informed consent in psychotherapy has been addressed in academic literature, this project shows that there is limited information specific to informed consent in addiction settings, as well as a lack of guidance for same in Canadian codes of ethics. To establish the relevance of this issue, a fictional ethical dilemma is presented to illustrate how such concerns can arise in professional practice. This is followed by an in-depth analysis of the history of informed consent, the essential components of informed consent, and factors that influence the process. The project then provides a foundational overview of substance use disorder treatment facilities, the types of professionals who work in addiction treatment contexts, and different ways of conceptualizing addiction. Finally, the initial ethical dilemma is revisited, along with actionable suggestions for navigating informed consent in substance use disorder treatment. The aim of this project is to address gaps in the literature and ethical standards of practice on informed consent in addiction treatment settings and to provide practical guidance for supporting client autonomy through ethical, client-centred care.

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Ethical conduct in the world of psychotherapy can be broken down into a set of legal and moral expectations for professional behaviour, including the foundational aspect of informed consent. Informed consent is broadly understood as the process of seeking active participation from and providing necessary information to a client to help them make an autonomous, informed decision about consenting to treatment (Canadian Psychological Association [CPA], 2017). While obtaining consent may be seen as a simple, procedural process that practitioners and non-licensed mental health clinicians engage in nearly daily, its importance has become lost on many, practitioners and clients alike. More worryingly, the process of obtaining consent from clients often lacks the key component of being adequately *informed.* Clients may not receive the information that a reasonable person would need to make a decision about their medical and mental health care (Beauchamp & Faden, 2024), which can raise significant ethical concerns (Canadian Counselling and Psychotherapy Association [CCPA], 2020).

One of the primary duties of psychotherapists is to respect client dignity as well as respect and encourage client autonomy (CCPA, 2020; CPA, 2017). Psychotherapists also have the responsibility to proactively promote what is in the client's best interest, or, in other words, enact a duty of beneficence (CCPA, 2020). However, in situations where a client's autonomy is compromised, such scenarios can lead to complex ethical dilemmas in which these principles and duties conflict with one another, potentially resulting in negative outcomes. An area in which informed consent practices are often implemented in questionable ethical circumstances is in the realm of substance use disorder treatment, which this project will primarily concern itself with.

Project Problem and Scenario

Treatment for substance use disorder, commonly referred to as addiction, poses unique challenges to the informed consent process because clients may arrive for care while under the influence of substances, in withdrawal from substances, or under external pressure to attend treatment (Walker et al., 2005). Such situations often place therapists in an ethically grey territory, where a practitioner's duty to respect client autonomy is in direct conflict with their duty of beneficence. When a client's capacity to provide informed consent is unclear, the practitioner must navigate how to balance quality of care and the obligation of beneficence with respecting and encouraging client autonomy to the best of their ability.

To illustrate the sort of dilemma that can occur around informed consent in the treatment of addiction, the following hypothetical ethical dilemma is provided:

1. Professional Context: You are a registered clinical counsellor working at an inpatient addiction treatment centre.
2. Dilemma: You are confronted with whether to admit an adult client for treatment services at a treatment centre. The client presents with signs consistent with intoxication from illicit drugs, possibly opioids, and is refusing to be admitted. His sole caregiver (his mother) is seeking services for the client, as he appears to be a danger to himself.
3. Client Context: At intake, the mother reports concerns around the possibility of her son overdosing or using laced drugs and indicates that he has a history of health complications related to drug use. She also indicates concerns about harm to others by describing that her son can exhibit erratic behaviour when using and has reportedly brought drug dealers to his mother's home. Further, on their way to the treatment

centre, accompanied by the client's mother and intervention worker, the client reportedly used fentanyl in the car. Upon arrival at the treatment centre, the client appears intoxicated and is unable to engage in clear conversation. Based on his current state, you determined that he is incapable of providing informed consent to treatment at this time. The mother begs you to admit him to treatment, as she fears for her son's life if he does not get help.

4. Historical Background: According to the mother, she has been trying to get her 32-year-old son to go to treatment for his fentanyl addiction for the past five months. The client is currently living on the street and is actively using to the point that if he stops, he will go into severe withdrawal. After many months of ambivalence about seeking treatment, the client agreed to pursue treatment for his addiction with the support of his mother and a community-based intervention worker. This intervention worker, who has known and worked with the client for the past six months, has developed a strong rapport with the client and has played an important role in helping the client accept support and initiate the process of accessing an addiction treatment centre. You learned this information at intake from both the mother and the intervention worker, but not directly from the client.
5. Additional Information: The client is not court-mandated to receive treatment. The mother has not filed for guardianship, nor does she have power of attorney. No lawyers are involved. According to the mother and intervention worker, the client agreed to treatment previously, but you did not hear this directly from the client. The client survived an overdose scare five days ago. There is no other policy or

background given that may assist with the information needed to make a decision. No supervisor is on duty or reachable when the client arrives at the treatment centre.

Additional factors to consider that could impact the ethical decision-making process:

a. Would your decision change if the client were under the age of majority?
b. Would your decision change if the mother had guardianship of her son?
c. Would your decision change if you, as an admitting therapist, were not certified by a regulatory body, and considered someone who has recovered from addiction?

This scenario illustrates the ethical problem addiction practitioners often need to navigate, which is made more difficult by the absence of clear, practice-based frameworks for addiction practitioners to base their decisions upon. While legal and ethical standards clearly mandate informed consent within the health and mental health fields, it may be surprising to know that informed consent practices in psychotherapy are still not routine (Barnett et al., 2007; Dsubanko-Obermayr & Baumann, 1998; Ladwig et al., 2024; Trachsel et al., 2015). Despite literature being available on informed consent as a concept (Pietrzykowski & Smilowska, 2021), there is a striking gap when it comes to guidance on its practical implementation within mental health settings (Carter et al., 2012; Ladwig et al., 2024). This ambiguity leaves practitioners without a clear framework to determine whether their informed consent procedures genuinely reflect the ethical codes and principles that should ground their work. And for those who work in addiction settings, it can also mean having to navigate consent-related decisions in situations where clients may be deemed incapable of providing consent (such as in the ethical dilemma above), leading practitioners to have to rely on personal and professional judgment given the absence of concrete guidelines.

Motivation and Purpose of the Project

In addition to these broader systemic gaps, there is also a notable lack of comprehensive literature available on the internal operations, ethical practices, and informed consent processes that exist in addiction treatment facilities. In my review of the literature, I found that much of the focus is placed on treatment outcomes rather than on the real-world application of standards of practice and ethical considerations for individuals struggling with substance use disorder. These gaps in the literature underscore the relevance of the present project, which aims to shed light on informed consent practices within addiction treatment centres and propose practical recommendations that will support both practitioners and the clients they serve.

My own experience working in inpatient addiction treatment further informs the relevance of this project. Throughout my time supporting individuals in addiction recovery, I observed firsthand the ethical complexities that can arise when clients are admitted to treatment facilities under less-than-ideal conditions. These experiences have shaped my understanding and awareness of the nuances that exist beyond facility policies, documentation processes, and treatment protocols. They have also motivated me to engage in this project with the goal of generating realistic and ethically grounded recommendations that reflect the realities of real-life practice.

In a field where professional competence is essential to delivering ethical and effective care, routine practices such as informed consent warrant greater consistency, clarity, and attention (Blease et al., 2016). Using the fictional ethical dilemma as a starting point, this project aims to examine the complexities of informed consent within psychotherapy, with a particular focus on addiction treatment. It will explore the broader landscape of addiction care, identify key challenges that compromise informed consent in these settings, and offer practical, ethically

grounded recommendations for navigating such challenges. Ultimately, the goal is to provide clinicians working in the substance use disorder field with actionable strategies to uphold client autonomy and ethical integrity. The hypothetical dilemma introduced earlier will be revisited later in the project to demonstrate how the proposed recommendations can guide real-world ethical decision-making. To ensure the relevance of the work to professional practice, the project draws upon two federal-level codes of ethics that guide licensed mental health practitioners in Canada: the CPA's *Canadian Code of Ethics for Psychologists* (2017) and the CCPA's *Code of Ethics* (2020). As such, the findings and suggestions presented will be grounded in standards expected nationwide and applicable within addiction treatment contexts.

CHAPTER 2: EVOLUTION OF INFORMED CONSENT: FROM HEALTHCARE TO PSYCHOTHERAPY

Informed Consent and the Law in Health Care

To gain a better understanding of the history and evolution of informed consent, this chapter begins with an overview of informed consent in the health care sector of Canada. Historically, consent in health care has emphasized the provider making decisions that they think are beneficial for the patient, which represents the idea of *paternalism*. From a biomedical standpoint, paternalism is understood as an intentional override of a person's choices for the sake of their well-being (Beauchamp & Childress, 2009). Beauchamp and Childress (p. 208) describe a paternalistic act as being "justified… by appeal to the goal of benefitting or of preventing or mitigating harm to the person whose preferences or actions are overridden." In short, paternalism can be understood as a process that prioritizes beneficence (doing what a practitioner sees as benefiting the patient) over respecting an individual's autonomy (Bogatyńska-Kucharska et al., 2023).

An article by Susanne Raab (2020) outlined that the evolution of informed consent in Canadian health care originates in the Supreme Court of Canada's decisions of *Hopp v. Lepp* (1980) and *Reibl v. Hughes* (1980) (Raab, 2020). These cases marked a shift away from a paternalistic approach where healthcare professionals make decisions on behalf of patients based on what they believe is best, often without providing full disclosure of the risks and benefits of certain treatments. Following a disc operation that left a patient permanently disabled, the plaintiff in the *Hopp v. Lepp* trial sued the surgeon for failing to inform him that this was the surgeon's first time performing such an operation and failing to disclose that he could opt for having the operation done at a larger facility. In this case, Chief Justice Laskin challenged the

paternalistic approach the medical system took with respect to informed consent, which essentially followed the idea that medical professionals were the ones to decide what risks should or shouldn't be disclosed to patients. The verdict of *Hopp v. Lepp* set the precedent that medical professionals must inform their patients of the risks that a reasonable person would want to know (Raab, 2020).

Shortly after the *Hopp v. Lepp* trial came *Reibl v. Hughes*. In this case, a patient suffered a stroke during an endarterectomy, leaving him permanently paralyzed on the right side of his body (1980). The plaintiff sued the surgeon for failing to inform him of the risk of stroke during surgery. The surgeon was found guilty of negligence, and Chief Justice Laskin used the case to further shift the healthcare sector into taking a more patient-centred approach towards informed consent. *Reibl v. Hughes* set the precedent that patients must be adequately informed of the risks associated with treatment and that failing to do so is grounds for negligence (Raab, 2020). These cases illustrate a move towards informed consent consistent with a *patient-centred* approach, which prioritizes individual autonomy and supports informed decision-making (Annoni, 2020). Currently, informed consent for health care is understood as the process through which clients are appropriately informed of their rights for treatment(s), including the risks and benefits of said treatment(s), and are afforded conditions to make their decision free of coercion or duress (Carter et al., 2012; Walker et al., 2005). This process has become a cornerstone of ethical practice in the medical field and is centred on respecting clients' autonomy in making informed decisions for themselves and their well-being.

Paternalism and the Evolution of Informed Consent in Psychotherapy

While the cases of *Hopp v. Lepp* and *Reibl v. Hughes* concern themselves more specifically with the medical side of health care, they have also influenced the expectations for

mental health practitioners in Canada, specifically with respect to paternalism and a move towards more client-centred autonomy and care. The conflict between paternalism and patient (or client, as is more appropriate for psychotherapy) autonomy has a long history in psychotherapy. Tensions between respecting client autonomy and practitioners' perception of the need for clinical guidance can complicate how consent is understood and applied in practice. The roots of paternalism in psychotherapy can be traced back to its medical origins. Historically, physicians were regarded as the primary decision-makers, often withholding information or making choices on behalf of patients in the name of beneficence (Braaten & Handelsman, 1997). Psychotherapy, heavily influenced by medical models, adopted this paternalistic approach in its early developments (Braaten & Handelsman, 1997). However, through the development of professional standards and evolving legal precedents, psychotherapy has also gradually shifted toward a more patient- or client-centred framework that emphasizes autonomy and transparency in the consent process. In psychotherapy, paternalism often shows up in decisions made about forced hospitalizations, treatment choices, and general decision-making (Annoni, 2020). Annoni (2020) outlines three essential features that characterize paternalism: it limits autonomy, is driven by beneficence or nonmaleficence, and targets the same person who is expected to benefit from the interference.

Informed consent practices in psychotherapy are still deeply intertwined with the concept of paternalism, and while there is much literature (Bogatyńska-Kucharska et al., 2023) that supports moving away from this approach, it remains a nuanced topic that warrants debate on its appropriate use in psychotherapy. Although both the CPA (2017) and CCPA (2020) codes prioritize client autonomy, the practical application of these principles can be far from straightforward, particularly when working with clients who may lack full decision-making

capacity. In such cases, substitute decision-makers, such as powers of attorney or guardians, may be necessary. Before exploring these forms of substitute decision-making, it is first essential to understand the fundamental components that define valid informed consent.

Informed Consent and the Reasonable Person Standard

In the CCPA's *Code of Ethics* section B4, "Client's Rights and Informed Consent" (2020), it is specified that when counselling is initiated as well as throughout the therapeutic process, counsellors must "inform clients of the purposes, goals, techniques, procedures, limitations, potential risks and benefits of services to be performed, and other such pertinent information that supports the informed decision-making process" (p. 9). In the CPA's *Code of Ethics for Psychologists*, the issue of informed consent and freedom of consent is outlined within section "Principle I: Respect for the Dignity of Persons and Peoples" (CPA, 2017). This means that the issue of consent is considered a primary concern for clinicians, as the code is broken down into four principles that are ordered according to weight of importance, which help guide ethical practice and ethical decision-making (Principle I: Respect for the Dignity of Persons and Peoples; Principle II: Responsible Caring; Principle II: Integrity in Relationships; Principle IV: Responsibility to Society). Code sections I.16 through I.30 further outline the considerations for ethical consent practices.

Although professional codes of ethics establish the importance of informed consent, it is equally important to understand the practical components that make consent truly informed. A term that consistently resurfaces in the literature is the concept of the reasonable person, which provides a legal and ethical benchmark for information disclosure in therapeutic settings. According to the *Standards of Practice, Sixth Edition* (CCPA, 2021), the reasonable person doctrine requires practitioners to provide clients with all the information a reasonable person

would need to make an informed decision, as well as to answer any questions the client or the substitute decision maker might have. Similarly, Section I.23 of the CPA's *Code of Ethics* (2017) encourages practitioners to "provide, in obtaining informed consent, as much information as reasonable or prudent individuals and groups would want to know before making a decision or consenting to the activity or treatment" (p. 14). This includes information about the nature and purpose of the activity, risks and benefits, available alternatives, the right to withdraw at any time, and limits of confidentiality, among other factors.

Although the codes generally endorse the reasonable person standard, there are variations in what needs to happen for the process of informed consent to meet this standard. Despite this variability, the literature generally agrees on three foundational components necessary for informed consent to be considered valid. Based on the works of Carter et al. (2012), Faden and Beauchamp (1986), Roberts (2002), and Walker et al. (2005), the following sections will outline the three foundational components of informed consent.

Cognitive Capacity

The first foundational component of informed consent is cognitive capacity. For consent to be valid, clients must possess the mental ability to understand the nature and purpose of the proposed treatment. This means being able to comprehend the basic facts, consider potential outcomes, and reason through the available options in order to come to an informed decision (Fields & Calvert, 2015). Without this capacity, the process of consent becomes ethically compromised, as the client cannot participate in the decision-making process in a meaningful manner (Carter et al., 2012; Faden & Beauchamp, 1986; Roberts, 2002; Walker et al., 2005). Code I.33 in the CPA's *Code of Ethics* (2017) encompasses this ethical duty as practitioners needing to "seek to use methods that maximize the understanding and ability to consent of

vulnerable groups or members of vulnerable groups, including individuals of diminished capacity to give informed consent" (p. 16).

Free Will

The second component emphasizes the importance of free will in the decision-making process. Informed consent must be given voluntarily, without coercion, manipulation, or undue influence from the therapist or others. This is clearly reflected in code I.27 in the CPA's *Code of Ethics* (2017), as practitioners must "take all reasonable steps to ensure that consent is not given under conditions of coercion, undue pressure, or undue reward" (p. 15). This requirement protects the client's right to self-determination and is particularly significant in therapeutic relationships, where inherent power differentials may subtly pressure clients into compliance (Barstow, 2015). Therapists must be aware of how their authority, tone, or even the structure of the consent conversation might affect a client's sense of freedom (Barstow, 2015). Creating a therapeutic environment in which clients feel able to ask questions, express hesitation, or decline services is essential to upholding this principle. Ethical consent is not merely about agreeing to treatment but about actively participating in the process and making a choice that is authentic to the client (Carter et al., 2012; Faden & Beauchamp, 1986; Roberts, 2002; Walker et al., 2005).

Adequate Information About Treatment

The third component involves adequate information and disclosure, which sits at the core of the reasonable person standard. Clients must be given clear, relevant, and comprehensible information about the proposed treatment. This includes things such as the goals of the proposed treatment, procedures, potential risks, anticipated benefits, and available alternatives. The information provided should be what a reasonable person in the client's position would need to make an informed decision. This also requires adapting one's communication to the client's level

of understanding to ensure full understanding, as reflected in I.7 in the CPA's *Code of Ethics* (2017): "Make every reasonable effort to ensure that psychological knowledge is not misinterpreted or misused, intentionally or unintentionally, to infringe on moral rights" (p. 13). The ethical imperative here is one of *transparency*; clients are entitled to know not only what will happen in therapy but also the reasoning behind therapist recommendations and what other paths are available to them. This empowers clients to weigh their options meaningfully and reinforces the principles of respect for the dignity of persons and peoples, responsible caring, and integrity in relationships (Carter et al., 2012; CPA, 2017; Faden & Beauchamp, 1986; Roberts, 2002; Walker et al., 2005).

Together, these three elements reflect the core values underpinning informed consent practices: respect for client autonomy, commitment to transparency, and supporting client self-determination. These principles function not only as safeguards against coercion but also as active affirmations of the client's right to participate in their care plan with dignity and clarity (CPA, 2017). However, when even one of these conditions cannot be satisfied, as in the case of the dilemma presented in Chapter 1, the ethical terrain becomes more complex. The validity of consent provided by a client can become questionable in situations involving diminished capacity or unclear voluntariness, such as when clients are intoxicated, prompting considerations for further interventions for client care. These grey areas highlight the limitations of viewing consent as a single event or a checklist to be completed.

Consent as More Than a Signature

While the above elements define what constitutes valid informed consent, in practice, informed consent is often reduced to a routine process aimed at gaining one crucial thing: a signature (Walker et al., 2005). This section addresses the limitations of a purely documentation-

based approach and takes a closer look at a more relational, ongoing, and client-centred process. Having a signed document may provide some sense of security to the practitioner, but it does not necessarily provide the same level of relief to a client. Practitioners may feel as though their duty to inform has been fulfilled once a client has signed a consent document, though this mentality prioritizes the practitioner's need for procedural completeness and legal protection rather than putting the client and their autonomy first. As Barstow discussed in her book *Right Use of Power: The Heart of Ethics* (2015), ethical conduct involves ensuring that the client is the most important person in the room, and this cannot be fulfilled by reducing informed consent to a signature on a paper. This intention not only helps practitioners engage in consent in a way that prioritizes the client's best interest, but it also honours the first principle of the *Canadian Code of Ethics for Psychologists*: Respect for the dignity of persons and peoples (CPA, 2017). More specifically, the CPA codes I.1, I.7, I.16, I.17, I.21, I.25, and I.27 (2017) emphasize the ethical responsibility psychologists have in upholding client respect, protecting rights, and ensuring clear and meaningful informed consent. Collectively, they highlight the importance of treating informed consent as an ongoing, collaborative process that requires time and effort, rather than treating it as a one-time formality. These codes also address the need for practitioners to protect clients from coercion, ensure transparency, and work to actively involve clients in the decision-making process (CPA, 2017).

While there is value in maintaining the use of formal documentation in a therapy setting, practitioners should not limit themselves to viewing informed consent as a singular, isolated event. Walker et al. (2005) suggests shifting our understanding of informed consent from a consent event to a consent process, which aligns with CPA code I.17. A process-based approach can help combine the more legally practical aspects of informed consent, such as documentation,

with the more client-centred aspects of therapy, such as ensuring the active participation of the client in the therapeutic process. Given the inherent power differential that exists in the therapist-client relationship, it is imperative to approach informed consent as an ongoing dialogue in order to minimize the risk of coercion, misunderstanding, or inauthentic compliance (Barstow, 2015). Ensuring that clients actively engage in the consent process helps to reaffirm their autonomy and reinforces the idea that they are collaborators in, rather than recipients of, their care (Barstow, 2015). Basing the process on the CPA's first principle, one can presume that respecting the dignity of persons and peoples involves going beyond simply seeking client compliance via a quick read and signature and that clinicians should instead strive for active client engagement in the process to enhance autonomy and dignity (2017).

Sharing Power in Consent

In line with Barstow's (2015) work on the division of power in the counselling setting, practitioners and mental health workers alike need to acknowledge that there are multiple points of power imbalance in the therapeutic setting, one of which relates to knowledge. In this context, knowledge refers to the practitioner's access to specialized information about mental health, treatment options, therapeutic processes, and potential outcomes, all of which is information that the client may not yet possess or understand entirely. Client empowerment through the use of psychoeducation and knowledge sharing during the informed consent process offers a pathway to correct this power imbalance. As Beahrs and Gutheil state in their 2001 article "Informed Consent in Psychotherapy," having an "open discussion of treatment options empowers patients through increasing their useful knowledge and becomes therapeutic in and of itself" (p. 5). Enhancing a client's sense of knowledge contributes to their ability to take ownership of the therapeutic process, allowing them to make informed decisions that best reflect their interests

(Barstow, 2015; Beahrs & Gutheil, 2001). This, in turn, helps foster the sentiment of the client being the most important person in the room and moves practitioners away from the traditional paternalistic approach of therapy and towards more client-centred empowerment (Barstow, 2015; Beahrs & Gutheil, 2001).

Evening out the power dynamic in the therapeutic context is also beneficial to the practitioner. Beahrs (1990) argues that informed consent allows clients to accept more personal responsibility for their decisions in therapy. As a result, the liability for the choices made throughout the therapeutic process is appropriately divided between the practitioner and client, which contributes to the development of a well-balanced working alliance (Beahrs & Gutheil, 2001). In other words, when a client is appropriately informed, the responsibility for treatment and associated outcomes no longer lies uniquely with the service provider but is instead shared as part of a mutual process.

Repercussions of Not Securing Consent

Conversely, when informed consent practices are neglected, the repercussions can be profound. Such consequences can range from professional and ethical violations to damaging therapeutic relationships to even legal repercussions that can impact a therapist's career. From an interpersonal point of view, failure to secure appropriate consent from a client may jeopardize the quality of the therapeutic relationship. A study by Braaten and Handelsman (1997) showed that clients value the information that is shared during the informed consent process. Based on their results, findings conclude that participants found the informed consent process helpful for setting the boundaries for counselling and for understanding the benefits of therapy. Participants also found that the vast majority of the topics addressed during the consent process were of interest to them (Braaten & Handelsman, 1997).

From an ethical standpoint, licensed professionals who fail to implement client-centred informed consent practices are in violation of their legal and ethical duties. Informed consent is a clear requirement in professional practice codes of ethics. Failing at this not only violates the requirement for informed consent but also indicates a failure to uphold professional standards of practice, responsible caring, professional competence, and respect for autonomy (CCPA, 2020; CPA, 2017). If a client decides to legally pursue a licensed professional for failing to obtain informed consent, this may lead to allegations of professional misconduct and may result in disciplinary measures from the practitioner's governing body. The practitioner could face legal consequences and risks, such as monetary loss, potential license suspension, and a tarnished professional reputation (Faber et al., 2023). Legal consequences could also result in the practitioner's employment status being jeopardized (Kirkcaldy et al., 2022).

Ultimately, practitioners who do not implement adequate informed consent practices are neglecting their clients' autonomy to make decisions for themselves. This can contribute to the power imbalance that exists in the therapeutic space and establishes the practitioner as overpowering the client (Barstow, 2015).

The Role of Power of Attorney and Guardianship in Informed Consent

Ethical tensions become even more pronounced when working with a client who may lack the legal or cognitive capacity to undergo the informed consent process. In such circumstances, the role of substitute decision-makers, such as those holding power of attorney or guardianship, becomes an important factor to consider in the informed consent process (Pavey Law, n.d.). Knowing what legal mechanisms can influence a person's ability to provide consent can help us better understand the nuances in informed consent practices.

Power of Attorney

Power of attorney is granted by an individual when they are of sound mind to give power to an appointed individual to make decisions on their behalf (Pooran Law, 2025). Power of attorney is appropriate to use when a person believes they will be unable to make decisions on their own at a later time. For example, a parent may want to grant their child power of attorney over their financial and/or medical decisions if they lose their ability to make decisions due to declining dementia. Power of attorney must be given before the person loses their ability to make decisions (Pooran Law, 2025). Power of attorney can also only be used if the individual in question is incapable of making rational decisions either temporarily or permanently (i.e., they are in a coma or they have a lasting mental disability) (Pooran Law, 2025).

Guardianship

Guardianship is a legal arrangement in which an individual is appointed to make decisions on behalf of another person who is unable to do so themselves (Azad, 2025). In the case of minors, guardianship typically refers to the legal authority granted to parents or court-appointed individuals to manage a child's well-being, including medical, personal, and financial decisions (Azad, 2025). These rights are usually granted to biological or adoptive parents by default. However, if a court determines that a parent is unfit or unable to fulfill this role, an alternate guardian may be appointed to act in the child's best interest (Azad, 2025).

In the case of adults, guardianship can only be established if someone is appointed by the provincial court to have authority over a person's decision-making (Azad, 2025). This can occur when an adult is deemed incapable of making decisions for themselves. Their appointed guardian then takes responsibility for the incapacitated individual's legal, moral, and financial decisions

(Azad, 2025). Obtaining guardianship over an adult involves a formal application process that is reviewed and approved by the court (Azad, 2025).

Upholding Ethical Standards When Consent Is Delegated

When substitute decision-makers such as power of attorney or guardianship are involved, the core elements of informed consent of cognitive capacity, free will, and adequate information continue to guide ethical practice, but in an adapted manner. Assessing a client's cognitive capacity becomes crucial to determine whether a substitute decision-maker is necessary (Fields & Calvert, 2015). Regardless of whether a power of attorney or guardianship is in place or not, the principle of free will must still be respected (CPA, 2017). Even in situations where a substitute decision-maker is needed, the individual's own preferences and expressed wishes need to be considered in order to preserve as much of the client's autonomy as possible, a process known as *assent* (Flowers & Dawes, 2023).

Adequate information and disclosure remain essential to ethical practice, as practitioners must ensure that the substitute decision-maker is fully informed and understands treatment options, risks, and alternatives (CPA, 2017). This also requires adapting communication to convey as much information as possible to the client themselves, in line with assent (CPA, 2017). Maintaining open communication with both the decision-maker and the client is essential to ensure that decisions are made in the client's best interest. These adaptations aim to uphold the ethical standards and obligations of the informed consent process, even in situations where it cannot be fully carried out with the client alone. To better understand how client autonomy can still be respected in such circumstances, it is important to distinguish between consent and assent.

Consent vs. Assent

Consent is the most widely used term in both ethical and legal contexts to refer to someone formally agreeing to do something (Lord, 2024). Adults who do not have a power of attorney or guardianship in place are able to provide consent on their own accord for their participation in various activities. In instances involving a power of attorney or guardianship, the appointed individual has the power to consent on the other person's behalf. Assent still plays a meaningful role for those who may not possess the ability to formally consent to things. Assent essentially refers to a person actively expressing a willingness to participate in a decision, even if they are not legally able to provide full consent (Lord, 2024). For example, a therapist might receive formal consent from a parent for their teenager to attend therapy, but the therapist would still need to seek out the teenager's assent by ensuring that they express willingness to attend sessions and engage in the therapeutic process by their own volition.

The aforementioned core elements underpinning informed consent (i.e. cognitive capacity, free will, and adequate information) remain foundational to the assent process, though they must be appropriately adapted to meet an individual's specific needs. The person holding decision-making power, whether through power of attorney or guardianship, has a duty to take into consideration the individual's wishes when making a decision on their behalf (Lord, 2024). While assent may not have the same legal weight as consent, it still plays a vital role in the decision-making process and aims to help preserve as much autonomy as is reasonably possible given an individual's unique circumstances (Flowers & Dawes, 2023).

CHAPTER 3: ADDICTION TREATMENT

To provide a clearer understanding of consent practices in addiction treatment, this chapter outlines the general functioning of treatment centres. For the purposes of this project, I will use terms such as *recovered addicts*, *people in recovery*, and *ex-addicts*. This language reflects the terminology commonly used by my colleagues and clients in addiction treatment, both in how they refer to themselves personally and within the professional context of rehabilitation settings.

There are multiple care options for those struggling with substance use disorder. Commonly known resources include treatment or detox centres and programs such as Alcoholics Anonymous, Narcotics Anonymous, and Self-Management and Recovery and Training (SMART), to name a few. Individuals can also address their substance use disorder in individual counselling settings to tailor their goals, whether that be reducing their usage or pursuing complete sobriety. A distinction worth noting is that residential treatment centres require clients to live on-site for a determined amount of time, where they are under continuous supervision and follow a structured therapeutic program that can involve, but is not limited to, therapeutic groups, individual counselling, and peer support (Government of Canada, 2024). This is a far more involved and intensive process compared to outpatient addiction services, where individuals can live independently while attending therapy sessions and accessing support resources. In my experience, some addiction cases can be so severe and persistent that clients and their immediate support system (e.g., family, caseworkers) start to consider the option of residential treatment more seriously.

General Overview of Addiction Treatment Centres

Addiction treatment centres vary in stay durations and treatment approaches, though overall, they can be understood as facilities that provide room, board, supervision, treatment, and access to support services with the goal of addiction treatment (Government of Canada, 2024). Residential treatment is usually considered when an individual has not seen lasting results from traditional outpatient treatment approaches or is struggling to maintain their wellness without significant assistance and would benefit from being in a structured, supportive environment (Lindner Center of Hope, 2023). Due to substance abuse having a high comorbidity with other mental health difficulties, treatment centres usually aim to treat both the addiction and co-occurring mental health difficulties of clients (Government of Canada, 2024; National Institutes on Drug Abuse, 2020).

While the issue of informed consent is worth exploring in all categories of addiction treatment, this project primarily concerns itself with inpatient addiction treatment facilities. The reason for this focus is that, in my experience, residential treatment centres often involve higher-stakes decisions, as they provide not only treatment but also aim for a safe environment for clients to live in while completing therapy, unlike traditional outpatient services. Based on my observations in clinical settings, practitioners working in outpatient settings often lack both the necessary infrastructure and the scope of practice required to provide more intensive care. In contrast, inpatient treatment centres are explicitly designed to support longer-term care, making informed consent a much more involved and layered process. The fictional ethical dilemma provided at the beginning of the project aims to provide a realistic scenario that those working in addiction inpatient settings are likely to face.

Addiction Treatment in an Albertan Context

Given that this project is being completed through an Albertan university, it is worth briefly examining a recent provincial development in addiction treatment and its implications for informed consent practices. In 2024, the Government of Alberta proposed the Compassionate Intervention Act*,* a policy aimed at addressing the issue of substance use disorder by allowing adult family members, guardians, health care providers, police, or peace officers to request court-ordered treatment for adults struggling with addiction. If a request is approved, the individual in question may be involuntarily taken into immediate care, such as a detoxification facility, and then transferred to longer-term care, where treatment can last anywhere from three to six months. When reading this policy, I considered that while it may be well-intentioned and presented as a "recovery-oriented, life-saving intervention," it ultimately frames those struggling with addiction as being incapable of making decisions for themselves and removes their autonomy to make decisions about their care, making the Compassionate Intervention Act a paternalistic piece of legislation that brings the province farther away from client-centred care (Government of Alberta, 2024). This is a clear example of how even government bodies can create opportunities to override client autonomy and justify their actions through the guise of beneficence, but by doing so, they ignore the importance of informed consent in the treatment of addiction and the ethical practice of psychotherapy. While it is beyond the scope of this project to focus heavily on Alberta's Compassionate Intervention Act, it is still of interest to be informed of real-life legislation that can threaten client autonomy and undermine the value of informed consent in addiction treatment.

Treatment Centre Admission Standards and Criteria

Addiction treatment centres in Canada exist in both the public and private healthcare sectors (Addiction Rehab Centres Canada, 2022). Due to the high demand for services, publicly funded care options often have lengthy waitlists and are more likely to require a referral from a licensed care provider, such as a doctor, psychologist, counsellor, or social worker (Addiction Rehab Centres Canada, 2022). Private options are more likely to accept self-referrals and are faster to access, though this route is not accessible to many clients due to the cost of treatment (Addiction Rehab Centres Canada, 2022). No matter the treatment route selected, the aforementioned professionals and/or treatment centre workers must deem a client to have significant substance use difficulties that would warrant inpatient treatment (Canada Drug Rehab Directory, 2018).

Many addiction treatment centres require that clients arrive at treatment sober and not in active withdrawal (Canada Drug Rehab Directory, 2018). This can be due to centres not having access to appropriate resources or not having the infrastructure in place to facilitate detoxification needs. There is also the possibility that it is a policy choice made to help mitigate the complications that can arise from admitting or not admitting intoxicated clients. In other words, facilities may be motivated to minimize the potential ethical dilemmas and associated consequences of such situations. The majority of treatment centres instill a zero substance use policy while clients are in treatment (Canada Drug Rehab Directory, 2018). This is mainly done to help clients focus on recovery, participate actively in treatment, and create a safe environment for everyone at the facility (Canada Drug Rehab Directory, 2018).

Although many residential treatment centres strive to address both substance use and mental health concerns, there are important differences in the services each facility can provide.

Some centres specialize exclusively in addiction treatment and may have limited resources to manage co-occurring mental health disorders beyond basic support. Others are designed to offer integrated care, targeting specific client populations such as individuals with co-occurring substance use and psychotic disorders (Government of Canada, 2024; National Institutes on Drug Abuse, 2020). Understanding these distinctions is useful, as the complexity of a client's needs can impact their admission process, the informed consent discussions that take place, and the types of ethical dilemmas that may arise during treatment (Truscott & Crook, 2021; Walker et al., 2005).

Focus of Treatment at Residential Centres

Addiction treatment has a unique place within the mental health sphere. Unlike most other mental health difficulties, addiction treatment is heavily focused on peer support and group treatment approaches. This is not to say that group therapy or peer support is not used or helpful for the treatment of other disorders, but addiction recovery places a particular emphasis on the importance of community (Reif et al., 2014). An example of this can be seen in the use of sponsors in Alcoholics/Narcotics Anonymous. Sponsors are designated individuals who have or are in the process of recovering from addiction themselves and are meant to provide support and guidance to fellow addicts in recovery (McGovern et al., 2021). The reasoning behind this is that addiction can be highly isolating, and people struggling with substance abuse are likely to have a limited support network available to them, especially in moments of relapse (American Addiction Centers, 2024; Whelan et al., 2009). In addition to attending support meetings, those in Alcoholics or Narcotics Anonymous groups learn to rely on each other for support, including connecting with sponsors.

In addition to the large emphasis on peer support and group therapy, there are also many people with addiction who go on to work in addiction treatment centres after achieving sustained sobriety (Kessler, 2020). It has been suggested that many recovered addicts choose to work within the field of addiction out of a sense of motivation to help others and remain consistent in their own recovery (Doukas & Cullen, 2010). In line with one of the core principles of Alcoholics Anonymous, some recovered addicts deem it necessary to act in service to others by giving back to the addiction community and helping others in their recovery journey (Liberty Addiction Recovery, 2025). Many of these individuals go on to obtain professional accreditations to work in treatment facilities, such as becoming a licensed counsellor or social worker. There are also many who find work in treatment facilities as unlicensed staff members with a wide range of responsibilities (Walker et al., 2005). An advantage recovered addicts have when working in rehabilitation centres is that they have similar lived experiences to clients, which helps in their ability to empathize and support those in active treatment (Kessler, 2020). A qualitative study aimed at examining factors that contribute to early withdrawal from treatment programs found that participants often preferred to have counsellors who were also recovering addicts (Prangley et al., 2018). Clients viewed these counsellors as positive role models and were more successful in helping them integrate into the therapeutic community (Prangley et al., 2018).

A controversial aspect of having ex-addicts work in treatment facilities is the role of self-disclosure regarding their addiction journey (Ham et al., 2013). Debates on the appropriateness of staff self-disclosure in addiction treatment are common and warranted. While it is important to be aware of this reality, delving into details on this subject goes beyond the scope of this project.

CHAPTER 4: INFORMED CONSENT IN ADDICTION TREATMENT

In order to implement better informed consent practices in the treatment of addiction, and with a view to revisiting the ethical dilemma from Chapter 1, the current state and challenges of informed consent practices in these settings must be understood. As discussed in the previous chapter, addiction treatment in general tends to rely heavily on individuals who are in recovery or have recovered from addiction taking on roles as treatment providers (Kessler, 2020). Historically, there has also been a tendency for addiction treatment centres to be less strict about requiring formal education to work at such facilities (Scott, 2000). In many places, the minimum level of education required to hold counsellor-like positions does not reach a bachelor's degree (Scott, 2000). Addiction treatment seems to find itself in a unique in-between area of counselling, where personal experience is often given the same level of credibility as formal education or licensing (Kessler, 2020; Scott, 2000). While there is no denying that having personal experience in the realm of addiction as a counsellor may have its advantages (Cleary & Armour, 2022; Prangley et al., 2018), it also comes with challenges of working within an ethical and legal grey area that can lead to complications in client care.

Mental Health Workers with Lived Experience

Studies have pointed to many advantages of recovered addicts working in addiction recovery. It has been found that many recovered addicts show improvement in their mental well-being and have an enhanced sense of meaning, purposefulness, empowerment, and satisfaction as a result of working in addiction treatment, which contributes to a stronger commitment to their own recovery process (Elisha & Shachaf-Friedman, 2024). Recovered addicts also possess a lived understanding of the recovery process that non-addict workers lack, allowing them to form deeper, more personal connections with clients in treatment centres (Elisha & Shachaf-Friedman,

2024; Kessler, 2020). As mentioned previously in Chapter 3, this personal experience has led to many clients preferring counsellors who are recovered addicts, as they are seen as positive role models in the recovery process (Prangley et al., 2018). Many addiction treatment programs opt for incorporating peer support roles into their treatment model as positions designated for recovered addicts. Research has also shown that peer-based support and interventions can help contribute to improvements in client engagement, reducing feelings of stigma and increasing treatment retention (Bassuk et al., 2016; Reif et al., 2014).

While counsellors with lived experience in addiction can offer valuable insight and skills in treatment settings, relying solely on personal experience without formal training can present important challenges. The limited literature on this topic makes it difficult to assess how extensively addiction treatment providers are trained in informed consent practices. However, given that there are individuals working in the field who do not hold formal education in counselling or related disciplines (U.S. Department of Health and Human Services 2017), it is reasonable to assume that a significant portion may lack the ethical and legal training typically associated with completing a graduate-level education (Walker et al., 2005). Because of this, non-licensed mental health workers, such as those in addiction treatment settings, may not have as many tools at their disposal to help them navigate complex clinical situations, such as those surrounding informed consent (Walker et al., 2005).

Not having professional accreditation also poses issues in terms of professional expectations, or lack thereof. While having professional credentials does not ensure perfect practice free from ethical dilemmas, it does require practitioners to adhere to established codes of ethics, practice standards, and ongoing training requirements. Further, members of the public have recourse with respect to oversight of practitioner behaviour. Non-licensed mental health

workers, in contrast, operate without such formal frameworks. It is fair to assume that non-licensed mental health workers also want to perform their jobs to the best of their abilities, though it is also unreasonable to expect them to uphold the same level of ethical and legal responsibility as those who have undergone more formal training and who are bound morally and legally to codes of conduct. The educational and accreditation gaps among practitioners working in addiction treatment not only increase the risk of inconsistent practice and compromise the quality of client care but also create ethically ambiguous situations for both workers and clients.

Professionals and Informed Consent

Unfortunately, the literature suggests that there are still gaps in informed consent practices of both regulated and unregulated professionals (Trachsel et al., 2015). For example, a study by Braddock et al. (1999) examined 1,057 encounters between patients and medical practitioners to assess whether the decisions made during these interactions met the criteria for informed decision-making. Out of a total of 3,552 clinical decisions that arose during these exchanges, only 9% of decisions were deemed to be fully informed. Interestingly, basic decisions were found to be most often completely informed, representing 17.2% of decisions, and more complex decisions were only completely informed 0.5% of the time (Braddock et al., 1999). These findings may suggest that practitioners are more likely to take an inappropriately paternalistic approach when decisions are seen as being more complex, resulting in unjustified infringement on client autonomy (Walker et al., 2005). Another study done by Dsubanko-Obermayr and Baumann (1998) aimed to examine the real-life practice of informed consent in psychotherapy, as well as clinicians' attitudes towards the informed consent process. It found that while psychotherapists generally viewed the informed consent process as being highly important, their clinical practice did not reflect adequate application of informed consent. Within

the first five sessions of therapy, clients in the study were found to be inadequately informed of the psychotherapy process, leading them to engage in therapy with insufficient knowledge to make an informed decision (Dsubanko-Obermayr & Baumann, 1998).

A more recent study done in Germany surveyed 530 psychotherapists and postgraduate psychotherapy students on their attitudes towards and practice of informed consent. Similar to the results from Dsubanko-Obermayr and Baumann (1998), Gerke et al. (2023) found that practitioners valued informed consent as either important or very important for the practice of psychotherapy. Despite the positive attitude towards informed consent, 52% of participants reported concerns about creating anxiety for clients by engaging in certain components of the informed consent process, such as going over the risks and side effects of therapy. One in five of these participants reported that because of this concern, they chose not to inform clients of the risks and side effects of therapy. Furthermore, over half of the participants reported uncertainty about whether their approach to obtaining informed consent in psychotherapy aligned with the legal and ethical standards of the profession (Gerke et al., 2023).

Addiction Professionals and Informed Consent

Tying this back more specifically to addiction, a qualitative study conducted by Leung et al. (2025) aimed at getting treatment providers' perspectives on how to support client decision-making for sharing treatment information in substance use and mental health settings. The study included licensed and certified counsellors and social workers in the United States who have worked in mental health and substance use treatment. One of the study's findings was that in many facilities, a client's first moment to decide what information to share, if any, about their mental health or substance use is during their initial intake, which is usually conducted by a front desk worker or intake staff and is mainly concerned with getting papers signed. Some

participants explained that this approach is ineffective for some treatment settings because clients often want the opportunity to discuss the treatment process before signing documents. Participants reported that the staff, who were usually responsible for following these procedures, were not thoroughly trained on how to answer consent-based questions and often did not have enough time to allow for in-depth conversations about consent. Participants also brought up how the laws and policies around consent to share mental health and substance use information are often confusing for even staff to understand and are rarely client-centred. An example provided by one of the participants was their agency's 12-page consent form, written in overly complex language that is not designed to facilitate client understanding. This demonstrates how even policymakers are not always well-equipped or attentive to prioritizing client care and autonomy in the consent process (Leung et al., 2025).

While the above studies and the aforementioned codes of ethics highlight the gaps that exist in informed consent in the context of addiction and more general practice, it is perhaps even more striking that clearer guidance is also lacking in a code of ethics designated specifically for addiction professionals. The National Association of Alcoholism and Drug Abuse Counselors (NAADAC) represents the professional interests of addiction counsellors, educators, and other addiction-focused health care professionals in the United States (NAADAC, 2025). The 2025 *NAADAC/NCC AP Ethical Standards*, developed by the NAADAC and the National Certification Commission for Addiction Professionals (NCC AP), reflects American standards but is also referenced in Canada and other countries as a guideline for ethical practice among addiction professionals. While the code does address the need for informed consent in its section on the counselling relationship, it does not provide any insight on how to tailor this process to addiction counselling/treatment, nor on how to navigate informed consent with clients whose

ability to consent may be compromised as a result of their substance use (e.g., intoxicated or in withdrawal).

Moving Beyond Titles and Certifications

Holding a professional license, certification, or membership can offer advantages, such as greater education, training, and legal and ethical responsibility; however, it is not a guaranteed safeguard against poorly informed consent practices. A key issue remains: informed consent procedures are often not clearly defined in codes of ethics, leaving room for varied interpretation and inconsistent application. Although professional credentials increase accountability, the onus ultimately falls on practitioners to actively educate themselves and stay current with best practices. Notably, many ethical codes emphasize the importance of ongoing professional development, reinforcing the expectation that informed consent practices should evolve alongside clinical competence (CCPA, 2020; CPA, 2017; NAADAC & NCC AP, 2025).

Regardless of whether practitioners ground themselves in formal education or lived experience (or a blend of both), improving informed consent practices in addiction treatment is essential for improving client care, respecting client autonomy, and developing a greater sense of professional competency. As has been established, addiction treatment regularly involves working with individuals whose decision-making ability may be impaired by intoxication, withdrawal, coercion, or desperation, all of which contribute to complications in the consent process. In such cases, vague or generic procedural approaches to informed consent are simply insufficient if we are trying to take a truly client-centred approach to treatment. If the aim is to keep the client as the most important person in the room, treatment providers ought to do everything in their power to foster transparency, promote client autonomy, and ensure that clients are fully informed, active participants in their own care (Barstow, 2015). This is

particularly vital in addiction treatment, where client agency is so often questioned or overlooked. In light of this, the next chapter will explore how different conceptualizations of addiction shape treatment approaches and influence the degree to which clients are seen as capable decision-makers within the informed consent process.

CHAPTER 5: RETHINKING AUTONOMY IN ADDICTION TREATMENT

Client autonomy is central to the ethical practice of psychotherapy, yet in the treatment of substance use disorders, it is often the first principle to be questioned or compromised (Wild et al., 2012). As the project has established thus far, informed consent is a standard expectation that is a requirement across mental health services, yet those struggling with addiction are often considered incapable of making decisions that require sound judgment, such as those associated with informed consent (Walker et al., 2005). Concerns about a client's ability to fully exercise autonomy become especially pronounced when they are under the influence of a substance or experiencing withdrawal (Scott, 2000; Walker et al., 2005). Establishing whether a client is capable of making an informed decision is crucial for determining whether taking a paternalistic approach to the informed consent process is needed and justified. This chapter takes a closer look at the issue of client autonomy in addiction treatment, discusses substance users' ability to consent, examines the social biases we have towards drugs, and explores ways to increase client autonomy in the informed consent process.

Autonomy and the Brain Disease Model of Addiction

One of the fundamental principles upon which the CCPA and CPA codes are based is the need to respect client autonomy, which the CCPA describes as "respecting the rights of clients to agency and self-determination" (2020, p. 2). As outlined in Chapter 2, three foundational components must be present for informed consent to be considered valid: 1) the client must have the cognitive capacity to understand the information provided, 2) they must be able to make a voluntary and autonomous decision free from coercion, and 3) they must receive complete and comprehensible information about the proposed treatment (Carter et al., 2012; Faden & Beauchamp, 1986; Roberts, 2002; Walker et al., 2005). While practitioners may struggle with

implementing best practice for those struggling with addiction due to unique considerations with respect to client autonomy. The reality is that addiction can come with complications that may impede one's ability to engage in the informed consent process in a meaningful way.

An example of this can be seen in cases where individuals are struggling with drug-induced psychoses. For multiple years, I worked in addiction treatment centres with a focus on mental health and psychotic disorders, where I saw firsthand how each component of informed consent can become significantly more challenging to achieve when a client is in a drug-induced psychosis. First off, the client's cognitive capacity may be compromised as they are struggling with possible hallucinations, delusions, or disorganized thoughts that hinder their ability to understand information about the proposed treatment. Second, their ability to make fully autonomous and voluntary decisions may be inhibited. This can be the result of not only the client's psychotic state but also external pressures, such as family or service providers imploring the client to receive treatment in their moment of crisis. Third, the client may not be in a mental state that allows them to fully comprehend and consider the information required to make an informed decision, regardless of how practitioners adapt their language and delivery. This is just one example of how certain clinical presentations can complicate the informed consent process.

A widespread yet controversial way to view addiction is through the brain disease model of addiction. Originally proposed by Alan Leshner in 1997, the brain disease model presents the issue of addiction as a chronic, relapsing biomedical problem in the brain. In essence, the brain disease model argues that extensive and prolonged drug use leads to lasting structural and functional alterations in the brain that inhibit voluntary control in individuals (Leshner, 1997). The brain disease model has led some to argue that individuals with opioid addiction lack the capacity to consent to certain treatments, with some even claiming that heroin users are

incapable of making rational decisions about participating in heroin-assisted treatment, whether in clinical practice or research settings (Charland, 2002; Cohen, 2002). In other words, the brain disease model presents those struggling with substance use disorder as incapable of exercising voluntary choice and that they are at the mercy of their addiction. If it is assumed that individuals struggling with substance use disorder are fundamentally incapable of giving consent due to their addiction, this will undoubtedly influence the way the informed consent process is approached. The brain disease model of addiction has been widely referred to in both public and scientific discourse for the past 30 years, shaping how addiction is understood and treated (Blithikioti et al., 2025). While this model originally aimed to help reduce stigma by framing addiction as a medical condition rather than a moral failing, it has been rightfully criticized for overstating and justifying a loss of agency and autonomy among substance users (Blithikioti et al., 2025; Trujols, 2015).

Criticisms of the Brain Disease Model

Ample studies have challenged the deterministic assumptions of the brain disease model, offering evidence that people with substance use disorders can and do make rational, informed decisions about their care and substance use (Blithikioti et al., 2025; Charland, 2020; Morán-Sánchez et al., 2016; Perneger et al., 1998; Scherbaum & Rist, 2010). For instance, a study conducted by Perneger et al. (1998) evaluated the effectiveness of an experimental heroin maintenance program designed for individuals who had previously failed at least two addiction treatment attempts. 51 participants were randomly assigned to either immediate enrollment in the heroin maintenance program or a delayed-entry group that received conventional treatments, such as methadone maintenance. At the end of the six-month trial, participants in the delayed group were offered the opportunity to join the heroin maintenance program. Notably, only nine

of the 24 individuals in this group opted to enter the program. The authors note that the main reason others declined the treatment was that they were successfully treated with the alternative treatment program. These findings suggest that even among severely dependent and treatment-resistant heroin users, participants were capable of assessing their options and making reasoned decisions about whether to continue heroin use or pursue other forms of care. This level of discernment directly contradicts the brain disease model's assertion that heroin users are incapable of exercising self-control or autonomy (Perneger et al., 1998).

Further support for this perspective comes from a study done by Scherbaum and Rist (2010), which explored the attitudes of opioid-dependent individuals toward participating in heroin prescription trials. The researchers analyzed 277 anonymous questionnaires completed by opioid users and found that 44% of respondents indicated they would not participate in a heroin-assisted treatment program, even if given the opportunity. Most notably, the decision to decline participation was not correlated with the severity of the individual's addiction. This suggests that participants were not simply acting out of a compulsion or lack of control but were instead thoughtfully weighing their options. Moreover, those who expressed interest in the heroin prescription trial were able to state clear reasons for their decision, demonstrating an ability to consider both the risks and benefits of treatment participation. Taken together, these findings reinforce the idea that individuals with opioid dependence retain significant decision-making capacity, contrary to what the brain disease model would imply. Rather than being driven solely by uncontrollable drug cravings, these individuals engaged in a reflective and rational decision-making process about their treatment options, very much aligning with the established prerequisites for informed consent (Scherbaum & Rist, 2010).

A more recent study done by Morán-Sánchez et al. (2016) compared individuals diagnosed with substance use disorder to non-psychiatric controls to assess their capacity to make informed decisions about participating in research. The study compared the scores of each group on the MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR), a widely used standardized instrument for assessing decisional capacity regarding consent to participate in research. The study found that while participants with substance use disorder performed lower on the MacCAT-CR dimension related to understanding and appreciation, there was no statistically significant difference between the substance use disorder group and the non-psychiatric controls in terms of their capacity to consent to research. They also found that these lower scores on the MacCAT-CR were dependent on individual factors, such as the type of substance used, the severity of use, cognitive functioning, and time since last usage. Based on their findings, the authors argue that presuming incapacity solely based on a substance use diagnosis is inappropriate, ethically problematic, and can lead to reinforcement of stigma, increased violation of autonomy, and wrongful exclusion of individuals from participating in research (Morán-Sánchez et al., 2016).

While substance users certainly experience moments where they are impaired in their ability to provide consent, it has not been proven that addiction causes a complete lack of capacity in individuals (Carter et al., 2012). Recognizing that such impairments are usually temporary rather than fixed traits of addiction is essential for guiding how practitioners should go about their informed consent practices. The onus remains on practitioners to adapt their approach in ways that promote meaningful client participation while upholding each person's right to autonomy. The following section will explore key factors practitioners must consider when navigating informed consent in addiction treatment settings.

Meeting Clients Where They Are At

It has been suggested that many substance users often overestimate their ability for abstinence, underestimate the challenges of remaining abstinent, and may not fully appreciate the risks associated with treatment (e.g., having a higher risk of overdose in the event of relapse post-treatment) (Mattick & Hall, 1996). In addition, acute intoxication with many commonly treated substances can impair an individual's ability to comprehend information or diminish their interest in the potential consequences of their treatment options (Carter et al., 2012). The same can be said when clients are in a state of withdrawal, which happens when they cease the use of the substance they have become dependent on (Carter et al., 2012). To reiterate, both intoxication and withdrawal are temporary states of being that hinder an individual's autonomy and are not indicative of an inherent inability to exercise free will. Individuals who are dependent on drugs but not abstinent can often experience substantial periods between episodes of intoxication and withdrawal during which their cognitive functioning remains relatively intact (Carter et al., 2012). With this in mind, it is reasonable for a practitioner to take advantage of this window of clarity between intoxication and withdrawal to proceed with the informed consent process.

An uncomfortable but important reality of working in addiction treatment is that it usually involves supporting individuals who are actively using substances. This means encounters with clients in states of intoxication are sometimes unavoidable. In an ideal world, clients would present to treatment in a clear state of mind that allows for a smooth informed consent process to take place, but this is merely wishful thinking. Practitioners need to be able to adapt to the client's needs in the moment and not fall into the trap of black and white answers, such as assuming that if there is a hint of drugs present in the client's system, the informed consent process cannot take place. As Carter et al. (2012) eloquently put it, "the aim of treatment

should be to increase patient decision-making capacity and autonomy, rather than preventing addicted individuals from participating in research and treatment that may be of benefit to them" (p. 114). Actionable suggestions to help in this direction will be provided in the following chapter, when the fictional ethical dilemma is revisited.

A Suggestion for Reframing Substance Dependence

When thinking about how substance use affects informed consent, it can help to compare it to prescription medication. For instance, if a person with bipolar disorder is stabilized with lithium, their ability to give informed consent is not questioned simply because they rely on a medication to maintain cognitive and emotional stability. In fact, the medication is more likely viewed as enabling, not compromising, their decision-making ability. While I recognize that there is a fundamental difference between prescribed medications and non-prescribed substance use and abuse, this comparison aims to highlight the reality that many individuals who use substances are not seeking intoxication but rather attempting to return to a functional baseline, allowing them to feel physically and mentally stable (Khantzian, 1997).

For those experiencing withdrawal, this baseline may only be accessible once they have consumed enough of their drug of choice to alleviate the most impairing symptoms. In such cases, asking clients to engage in the informed consent process while they are either in acute withdrawal or actively intoxicated is counterproductive. Instead, creating space for clients to reach that window of relative clarity, free from severe impairment or distress, may not only increase their capacity to provide meaningful consent, but also reflect a more compassionate, realistic, and client-centred approach. I suggest that reframing substance use in this light could help reduce some of the stigma or discomfort practitioners may feel about clients using in limited, strategic ways to facilitate participation in their own care.

Guidelines for Admitting Clients to Addiction Treatment

Carter et al.(2012) suggest a three-part guideline for admitting individuals into addiction treatment. The first point to consider is to avoid engaging in detailed informed consent until the client is stabilized. Clients often arrive in a state of despair when entering treatment, making them more likely to make rash decisions motivated by their heightened state. At this stage of care, clients should only be asked whether they agree to immediate intake and allow for stabilization to take place, whether that means calming down emotionally, coming down from intoxication, or completing withdrawal. This process aligns with the mentality of viewing consent as an ongoing process instead of an isolated event. This initial stage also gives clients the opportunity to regain the cognitive clarity needed to meaningfully participate in the informed consent process (Carter et al., 2012).

Once the client is deemed stable, practitioners may begin to provide more detailed information to the client about care options (Carter et al., 2012). The goal at this stage is to provide clear and transparent information about the risks, benefits, effectiveness, and requirements for the treatment options. This also involves making the client aware of alternative treatment options that are not provided by the facility they are currently at. The option the client chooses, whether it be engaging in treatment or not, should reflect their own individual goals and needs. In other words, the client must be adequately informed and encouraged to make a decision that respects their right to autonomy (Carter et al., 2012). When the client has been adequately informed of their options and has made a decision for treatment, practitioners can embark on a more detailed informed consent process that involves a formal explanation of treatment expectations, rules, responsibilities, and boundaries. This is done to ensure that the client fully understands what they are agreeing to and is aware of the expectations of treatment moving

forward (Carter et al., 2012). Throughout the therapeutic process, treatment goals can be revised and consent can be revisited as needed to ensure full participation from the client.

These guidelines offer a practical framework that aligns with the key components of informed consent discussed throughout this project. With this foundation in place, the next chapter will revisit the fictional ethical dilemma introduced in Chapter 1. A detailed analysis of how such complex situations can be ethically navigated in the context of addiction treatment is provided.

CHAPTER 6: METHOD AND REVIEW OF ETHICAL DILEMMA

Research Method

The purpose of this project is to provide actionable and ethically grounded suggestions and viewpoints on how to handle informed consent in addiction treatment in alignment with the CPA's 2017 *Code of Ethics*. To achieve this goal, I began by compiling and analyzing content found in databases and websites using relevant search terms related to this topic. As I was gathering the literature, I reflected and wrote about how various aspects were relevant to the CPA code and its sections. Much of the motivation for this project came from personal work experience and interest. The parts of this project that are informed by these experiences are clearly indicated to facilitate easy differentiation between academic resources and personal commentary. The ethical dilemma proposed in the project is inspired by personal experiences I have had when working in addiction treatment. This hypothetical scenario served as the starting point for this project, leading to further research being done on the topic of informed consent in addiction treatment.

A broader search on informed consent in the medical field led to a deeper understanding of how informed consent practices trickled down into the practice of psychotherapy. This led to further research on informed consent in psychotherapy, which helped establish the shortcomings that exist within the world of psychotherapy, specifically in relation to issues of paternalistic versus client-centred approaches, inadequate obtaining of informed consent from clients, and the fundamental components of informed consent. These topics were also present when searching for content related to informed consent practices in addiction treatment. Furthermore, when expanding on literature related to addiction, more information on different attitudes towards substance use disorder, such as the brain disease model, came to light. In addition, professionally

regulated and non-regulated staff working in addiction treatment come with varied skill sets and expectations, which brings in an additional layer to consider when determining how informed consent practices are to be implemented.

The research design utilized a systematic literature review method that allowed for a comprehensive search of all relevant literature on informed consent in addiction treatment. Academic literature was accessed primarily through databases available via the University of Lethbridge Library and Google Scholar. Additional sources, such as government websites, addiction treatment centre websites, and legal resources, were accessed through internet web searches. A combination of search terms was used, which included psychotherapy, counselling, psychology, therapy, informed consent, addiction, substance use disorder, recovery, treatment, and ethics. The resources and literature available on the topic of informed consent in addiction treatment were relatively limited, which led to the decision to include comments from personal experience to add more substance to the relevance of this project. Preference was given to recent articles (i.e., published within the previous five years) when possible; however, searches were not strictly constrained to fit this preference. The project was developed, adapted, and completed over a 12-month period.

Statement of Ethical Conduct

A submission for ethical approval was not required, as no human subjects were involved in this project. While completing this project, I adhered to the CPA's *Code of Ethics for Psychologists* (2017). I also drew from the CCPA's *Code of Ethics* (2020).

Review of Ethical Dilemma

When faced with an ethical dilemma, practitioners who follow the *Code of Ethics for Psychologists* (CPA, 2017) must consider and appropriately balance the four principles in their

ethical decision-making process. As a reminder, before revisiting the ethical dilemma, the four principles in ranked order are Principle I: Respect for the Dignity of Persons and People, Principle II: Responsible Caring, Principle III: Integrity in Relationships, and Principle IV: Responsibility to Society (CPA, 2017). The CPA also outlines a ten-step protocol to assist practitioners in navigating their ethical decision-making process. The following review of the ethical dilemma first outlined on the second page of Chapter 1 will cover all ten protocol steps from the *Code of Ethics for Psychologists* and consider both the CPA principles and the findings outlined in the previous five chapters.

Step 1

Step 1: Identification of the individuals and groups potentially affected by the decision (CPA, 2017). The primary individuals who will likely be affected by the decision taken are the client themselves and the practitioner present at intake. The secondary people affected are the client's mother and caseworker, as well as the other staff working at the treatment centre. Tertiary parties affected include the reputation and standing of the treatment centre, as well as current clients attending the treatment centre. Clients in the future may also be affected by how the dilemma is resolved.

Step 2

Step 2: Identification of ethically relevant issues and practices, including the moral rights, values, well-being, best interests, and any other relevant characteristics of the individuals and groups involved, as well as the cultural, social, historical, economic, institutional, legal, or political context or other circumstances in which the ethical problem arose (CPA, 2017).

Principle I: Respect for the Dignity of Persons and Peoples

Within the first principle, the main ethical standards to consider relate to the values of general respect, general rights, informed consent, freedom of consent, and protection for vulnerable individuals and groups (CPA, 2017). As a whole, the relevant codes in these sections emphasize the importance of seeking client participation, respecting client rights, providing clear and necessary information to the client, ensuring that consent is obtained free of pressure or coercion, and adapting one's approach in the event that a client is deemed to have diminished capacity to give consent. It is also within principle I that informed consent is recognized as a process that requires time (code I.17) and can be re-established at multiple stages (code I.29) (CPA, 2017).

Upholding the client's dignity requires careful consideration of whether he is capable of engaging in a decision-making process in a meaningful way (CPA, 2017). In the context of the ethical dilemma, due to the client's state of intoxication, he is temporarily unable to satisfy the requirement for cognitive capacity to engage in the informed consent process in a truly informed manner. Since the client has not clearly expressed whether he wishes to undergo treatment, you must rely on the reports of his mother and the caseworker. At this time, it appears that there is no direct confirmation from the client himself. Seeing that you are unable to obtain active participation from the client at the moment of his arrival, leaning more on sections of the code related to the second principle may be more helpful in making an immediate decision on how to approach client care.

Principle II: Responsible Caring

A main point of relevance in Principle II for this ethical dilemma is the practitioner's duty of beneficence, which means choosing a course of action that maximizes benefits and

minimizes harm (CPA, 2017). This also means paying close attention to your own biases and belief systems that may influence your perception of what beneficence would look like in this context. If we assume you subscribe to the belief that those who struggle with substance use still have the ability to make informed decisions about their health, it is reasonable to assume that the present client would eventually return to a state of being that would allow him to engage in an informed consent process. Beneficence includes promoting the long-term well-being of the client, not just focusing on immediate safety or compliance. Waiting for the client to regain capacity to engage in informed consent respects both his autonomy and supports what is in his best interest. Cognitive capacity and clarity may be achieved as he recovers from his current state of intoxication, has enough of the substance in his system to allow him to be at his functional baseline before entering withdrawal, or after he recovers from a detoxification period where he is no longer in a state of acute withdrawal.

Based on the information that the client recently survived an overdose and is actively using fentanyl, you can conclude that the client's safety is at risk. It may seem reasonable to keep the client at the treatment centre temporarily until he stabilizes and is out of immediate risk. While such an action would entail making a decision on the client's behalf without their immediate meaningful participation in consent, it would provide the client with a temporary safe place to stay until he is able to provide informed consent. As the client does not have a legal guardian or power of attorney, you are unable to obtain legal consent for this decision from any other party.

While the CPA *Code of Ethics* outlines the duty of beneficence, provincial standards may offer more direct guidance in such cases. For example, standard 3.8 in the 2023 College of Alberta Psychologists (CAP) *Standards of Practice* allows a psychologist to provide services to a

client without the need for informed consent in emergency situations, "but only to the extent necessary to reduce or alleviate the emergency; further professional services shall be provided by the psychologist only with informed consent from the client" (p. 12). In an Albertan context, this section of the CAP *Standards of Practice* could provide ethical justification for taking a paternalistic action when immediate safety is at risk.

Principle III: Integrity in Relationships

Principle III's relevance to this dilemma is primarily related to the need for honesty, accuracy, objectivity, and straightforwardness (CPA, 2017). Despite the client being unable to consent at this given time, the client's mother and case worker have placed trust in you to make a decision on how to proceed with the client. It is possible that their current state of urgency may make it more challenging for you to remain objective and unbiased; however, you can still maintain open and honest communication with them as you navigate the decision-making process. This can involve engaging in transparent dialogue about the implications of certain decisions (such as delaying client admission or referring to another resource) and explaining your capacities and limitations given the present circumstances (e.g., that since there is no active participation from the client, you are not able to fully admit them to treatment at this very moment). You can also explain the professional obligations you have to respect, such as the need to gain fully informed consent from the client in order to admit them to treatment in an ethically sound manner.

Principle IV: Responsibility to Society

Principle IV emphasizes a clinician's responsibility to society by upholding public trust in the profession of psychology, contributing to ethical systems of care, and protecting the welfare of society (CPA, 2017). While the dilemma primarily affects the client and his support

network, the decision you make also has broader implications. Admitting the client into treatment when the facility may not be equipped to handle his detox needs could put the safety of other staff and current clients at risk. Admitting the client without a reasonable consent process could also raise questions about professional boundaries and clinical judgment, potentially undermining public confidence. In contrast, refusing care to a vulnerable individual could be interpreted as a systemic failure, which can have implications for you, the treatment centre, or the profession of psychology's reputation.

Step 3

Step 3: Consideration of how one's own biases, external pressures, personal needs, self-interest, or cultural, social, historical, economic, institutional, legal, or political context and background might influence the development of or choice between courses of action (CPA, 2017). On a personal level, you may be emotionally affected by witnessing the mother's desperation, which may lead to a decision that prioritizes the mother's wishes over the client's interests. While the mother's input is still an important factor to consider in your decision-making process, you will need to be mindful of the fact that the client is the primary person who will be impacted by your choice. You may feel externally pressured to make a quick decision due to the urgency expressed by the mother. Not having a supervisor present could also contribute to making you feel pressured to act and likely increase your stress about making the right decision.

Your own personal views on addiction will also influence your decision-making. We have already assumed that you take the stance that those struggling with substance use still have some capacity to make decisions. If you subscribe to the brain disease model of addiction, your decision would likely reflect the belief that the client lacks the ability to make rational decisions

(Charland, 2002; Cohen, 2002), which could make a paternalistic approach seem more reasonable. Your own internal beliefs about harm reduction versus taking an abstinence-only approach to addiction could also contribute to your decision-making. On a professional level, you may be fearful of your risk for liability if the client is turned away and overdoses. As a helping professional, you are aware of the fact that many addiction resources are lacking in staff and number of beds (Whitter & Silva, 2025), as well as there being an increase in drug tampering, which puts substance users at risk (Payer et al., 2020). You would likely have a sense of moral obligation to help the client and would likely feel a sense of guilt or remorse were you to refuse any form of care at this time.

Step 4

Step 4: Development of alternative courses of action (CPA, 2017):

Alternative 1: Decline Admission and Refer to External Supports

Due to the client's current inability to provide consent and that there is no court order, guardianship, or power of attorney in place that would provide someone else with the legal ability to decide on behalf of the client, you choose not to admit the client at this time. You explain to the mother and caseworker that, without clear and informed consent from the client, admitting him to treatment now would be unethical and legally unadvisable. You provide the mother and caseworker with information on alternative resources available in the community (e.g., hospitals, detox centres, crisis resources). You also advise the mother and caseworker that the client is welcome to return once he is fully sober and capable of consenting to treatment.

Alternative 2: Admit the Client Without Consent Based on Imminent Risk

Based on the knowledge that the client recently overdosed, is actively using fentanyl, and has reportedly agreed to treatment before arriving, you deem that the client is at high risk of

harm to himself. You decide to admit the client to treatment without his formal consent in order to prioritize his immediate safety. You place the client in an available room and redistribute staff to ensure the client is monitored. Despite not having legal authority over her son, you ask the mother to complete a consent form on behalf of the client as a precaution for both you and the treatment centre. You document the circumstances that led to you making this decision and include this in the consent form as justification for the action taken.

Alternative 3: Temporarily Hold the Client at the Centre with an Ongoing Consent Process

Seeing that the client is vulnerable and has reportedly agreed to treatment previously, you decide to temporarily allow him to remain at the treatment centre without formal admission. You explain to the mother and caseworker that the client will be monitored until he has regained enough clarity to accept or decline treatment. If, once the client is more autonomous, he agrees to stay at the centre, you plan to obtain consent at multiple time points to ensure engagement in an ongoing consent process. Depending on the severity of his withdrawal symptoms, you may be able to monitor him at the centre, or you may refer him to an external detox facility. You make sure that the mother and the caseworker understand the conditions of the client's stay. You request that a nursing staff member be present to assist in monitoring the client, and the remaining staff are redistributed as needed to maintain regular programming. You document your decision-making process, the factors that led to your decision, and the conditions of the client's temporary stay.

Alternative 4: Refer to Medical Detox for Stabilization

While you recognize the immediate risk the client poses to himself, you are also mindful of the fact that he is unable to consent to treatment at this time. Furthermore, it is unclear whether the centre can adequately support the client's detox needs, as it is not designated or

advertised as a detox facility. You decide to contact a nearby detox facility or emergency resource to help coordinate a direct transfer of the client. The client, his mother, and his caseworker are permitted to remain at the centre until the transfer plan is made and secure transportation is arranged. You make sure to include the mother and caseworker in this process and provide them with your contact information to ensure continuity of care. You explain that this is not a refusal of treatment but a step towards a longer-term care plan tailored to the client's needs. All actions are documented, along with the rationale, and you plan to follow up with the client's support system to facilitate his return to the treatment centre once he is stabilized and capable of consenting to treatment.

Step 5

Step 5: Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individuals and groups involved or likely to be affected, considering relevant individual and cultural, social, historical, economic, institutional, legal, and political contextual factors (CPA, 2017). Tables 1, 2, 3, and 4 present the risks and benefits of the proposed four alternative actions.

Table 1

Possible Positive and Negative Consequences of Alternative 1

Action	Possible Positive Consequences	Possible Negative Consequences
Decline admission and refer to additional supports.	The need to respect client autonomy – which cannot be fully engaged at this time due to circumstances - is upheld as well as the ethical standards of informed consent outlined in Principle I.	The clinician may feel distressed about having no follow up plan with the client or his support system.

	Professional boundaries are maintained, which could help protect the clinician and the treatment centre from liability.	May be viewed as the clinician prioritizing themselves and the centre from liability, as opposed to client care.
	The client's support system would be able to access more appropriate resource for immediate care.	The working alliance with the mother and caseworker may be damaged.
	The clinician is working within their scope of practice (Principle II).	The mother may feel abandoned or dismissed in a time of need
	Staff and current clients are unaffected.	This may be a missed opportunity for the client to access treatment.
		When the client regains awareness, he may feel embarrassed, abandoned, or dismissed by the course of action chosen.

Table 2

Possible Positive and Negative Consequences of Alternative 2

Action	Possible Positive Consequences	Possible Negative Consequences
Admit the client without consent based on imminent risk.	This approach would prioritize immediate risk mitigation, which aligns with the values of beneficence and offsetting harm outlined in Principle II.	The client's right to autonomy is overridden without any legal authority, violating values outlined in Principle I.
	The clinician may feel at ease knowing that the client is in a secure place.	The clinician is choosing a somewhat paternalistic approach to care as opposed to a client-centred approach.

	The mother and caseworker will be happy with this decision.	The consent form signed by the mother is not legally valid and may increase risk of liability.
	The client will be able to transition more smoothly into the regular treatment program since he will already be at the facility	Admitting the client under such conditions could place staff, other clients, or the facility at risk if the client is severely unstable or has other health complications that cannot be supported.

Table 3

Possible Positive and Negative Consequences of Alternative 3

Action	Possible Positive Consequences	Possible Negative Consequences
Temporarily hold the client at the centre with an ongoing consent process.	Temporary override of obtaining consent can be justifiable under these circumstances as he is deemed high risk and will be given the opportunity to consent as soon as he is capable. This approach balances the values of respecting client autonomy (Principle I) with duty of beneficence (Principle II).	This course of action involves overriding the client's autonomy, even if in the short-term, meaning there is still a certain level of paternalism.
	The client will be in a safe location until he is able to start recovering from his intoxication, which will bring peace of mind to the mother, caseworker, and clinician.	Redistribution of staff may impact quality of care for the other clients at the centre.
	The client's support system is actively involved in the process, facilitating the development of a strong working alliance.	If the client's detox symptoms deteriorate, the treatment centre may not be equipped to respond appropriately, increasing

		safety risk for both the client and the facility as a whole.
	Consent is approached as an ongoing process and is obtained at multiple stages, which aligns with a client-centred approach to care and honours the ethical implementation of informed consent, as highlighted throughout Principle I.	

Table 4

Possible Positive and Negative Consequences of Alternative 4

Action	Possible Positive Consequences	Possible Negative Consequences
Refer to medical detox for stabilization.	Client autonomy, ethical standards of consent, and Principle I and II are upheld while actively ensuring client safety through other resources.	Not keeping the client at the treatment centre may lead to delays or disruptions in continuity of care.
	The clinician will have greater peace of mind knowing that the client has safely accessed another resource.	Despite clarifying the intention behind the decision, the mother may feel disappointed that her son was not admitted to treatment.
	The clinician has maintained open, honest, and straightforward communication with the client's support system (Principle III). The mother and caseworker are supported through the process of transitioning the client to an alternative resource. This can help maintain a good working	The client may refuse to return for treatment.

	alliance while also maintaining professional boundaries.	
	Due to the planned continuity of care, the client will have a smoother transition back to the treatment centre (if he so chooses) once stabilized. Preserves ethical and clinical integrity while also reducing the risk for legal liability.	
	Regular programing at the treatment centre is undisrupted.	

Step 6

Step 6: Choice of course of action after conscientious application of existing principles, values, and standards (which includes but would not be limited to relevant laws and regulations) (CPA, 2017). Although both the third and fourth alternatives have strong justifications that align with the CPA *Code of Ethics* (see Table 3 and Table 4), Alternative 4 offers the most balanced and ethically grounded course of action. At the heart of this ethical dilemma lies the tension between respecting client autonomy (Principle I) and fulfilling the duty of responsible caring (Principle II) (CPA, 2017). While alternative three does a good job of trying to find a balance between ensuring the client's supporting informed consent once the client regains capacity, it still presents risks to the client's safety as well as the treatment centre's scope of practice.

A key component of Principle II in the CPA codes relates to practitioner competence and self-knowledge (2017). As stated previously, the clinician in this scenario is uncertain whether the treatment facility is adequately equipped to support the client's detox needs. Considering this, the decision to admit the client temporarily would be mostly motivated by the clinician's

and mother's emotional urge to act quickly, rather than thinking through the most appropriate care for the client. It would also require temporarily overriding the client's autonomy, though on a much smaller scale than in Alternative 2.

Alternative 4 provides a more balanced approach that aligns with the principles of the CPA code. It acknowledges that the client is unable to provide consent independently and aims to preserve as much of his decision-making capacity as possible, while also acknowledging the client's immediate risk of harm. Instead of the more hands-off approach presented in alternative one, alternative four strikes a balance by respecting the client's autonomy while actively facilitating access to appropriate care. Another strength of alternative four is that it is mindful of the possible limitations the treatment centre has in terms of client care and detox needs.

Furthermore, Alternative 4 reflects a commitment to transparent communication, as outlined in Principle III (CPA, 2017). The clinician in this scenario is clear in their communication with the mother and the caseworker, and actively includes them in transitioning the client to a more appropriate care setting. The decision to transition the client to a different resource also works to maximize benefit and minimize harm, further honouring values outlined in Principle II (CPA, 2017). This alternative also keeps the other staff members and active clients as unimpacted as possible while still working towards finding appropriate care for the client. Lastly, by upholding these standards of ethical practice, Alternative 4 can support public trust in the profession of psychology as per Principle IV by demonstrating competent, coordinated, and ethical care (CPA, 2017). While Alternative 4 still has its shortcomings (e.g., emotional distress, potential loss of follow-up with the client), it is the best option for alignment with CPA codes and prioritizes safety, dignity, and continuity of care.

Step 7

Step 7: Action, with a commitment to assume responsibility for the consequences of the action (CPA, 2017). After you have talked to the client's support system and assessed the situation, you explain to the mother and the caseworker that you are unable to admit the client into treatment at this time, as the treatment centre may not be able to provide necessary care to the client in his current state, nor are you able to obtain consent from the client himself. Despite this, you communicate to them that you acknowledge the severity of the situation and want to ensure that the client receives appropriate care so that he can gain enough stability to consent to treatment later on. With the mother's agreement, you call a local detox facility or emergency medical service and explain the current situation. Once an appropriate plan is established, you coordinate the safe transfer of the client to the appropriate care option. Depending on the severity of the situation, this may entail calling emergency services and waiting for transportation, or the mother or caseworker safely transporting the client to the planned location.

You offer to follow up with the mother and the caseworker to check on the client's progress and reassess for the client's admission to treatment once he is medically stable and capable of providing consent. You ask the mother to share your contact information and details about the treatment centre with her son once he is more stabilized in an effort to provide him with easy access to support and treatment when he is ready. Even though getting the client back in for treatment once he is stabilized is desirable, there is a real possibility that the client may not be willing to engage in further treatment at the centre. You discuss this possibility with the mother and explain that you will remain available to support him in accessing treatment if and when he expresses interest. You document all steps, communications, and rationales that

informed your decision-making process, and you plan to review your decision with your supervisor as soon as possible.

Step 8

Step 8: Evaluation of the results of the course of action (CPA, 2017). You follow up with the client's support system to assess whether the client has accessed the planned resource and whether he is interested in initiating an intake process for treatment. You also take the time to communicate with the mother to determine if she felt heard, supported, and respected throughout the process. If the client's support system or the client has any questions or feedback, you do your best to engage in clear and open communication with them. If follow-up is achieved, you take time to consider whether the approach taken has helped to minimize risk, maximize benefit, and preserve client autonomy. Furthermore, you evaluate what aspects of your approach could have been improved once you are aware of its results.

Step 9

Step 9: Assumption of responsibility for consequences of action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issue is not resolved (CPA, 2017). You take responsibility for the decision you made and write out your ethical reasoning at the time of the event while acknowledging any shortcomings that have arisen afterwards. You document your follow-up discussion with your supervisor and include any feedback they give on how you could have improved your approach. If any of the suggested changes can be implemented immediately, you take prompt and appropriate action to do so as soon as possible. If any consequences arise for the client or his support system that are related to the decision you made, you provide them with appropriate support. In the event that the client decides not to pursue treatment, you document the attempts you made to aid him in making an

informed decision (e.g., providing information about treatment options, outlining the risks and benefits of treatment) and respect his choice.

Step 10

Step 10: Appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma (e.g., communication and problem solving with colleagues and team members or other collaborators; changes in procedures and practices) (CPA, 2017). If the results of this decision prove to be unfavourable (e.g., the client refuses to pursue treatment after stabilization, the support system expresses dissatisfaction, or follow-up is not achieved), reassess the ethical dilemma using the decision-making model again to help refine your ethical judgment skills. Keep a record of all your documentation for future reference. Following this event, you raise awareness at the treatment facility that further guidance is necessary to support staff if faced with such a dilemma. You propose to help develop a protocol to assist staff in navigating such events in the future and advocate for the field of addiction counselling to have more codes to guide ethical practice.

Additional Factors to Consider in Decision Making

Now that the ethical dilemma has been revisited, it is helpful to reflect on additional factors that could influence the decision-making process. In light of the factors discussed throughout this project, such as guardianship, assent, and professional registration, consider how your approach might change if these conditions (see below) were present in the proposed ethical dilemma:

The Client Is Under the Age of Majority

If the client in the proposed dilemma were under the age of majority, and the treatment facility was meant for youth, the legal capacity to consent would typically shift to the client's

parent (Azad, 2025). In such a scenario, you would be able to rely more on the mother providing consent for her son's admission and decisions for care until you are able to obtain assent from the client. Given their minor status, your decision may shift towards prioritizing the client's safety and care (Principle II) over respecting their autonomy (Principle I) for the time being (CPA, 2017).

The Mother Has Guardianship of Her Son

If the mother had legal guardianship of her adult son, she would have legal authority to consent on his behalf (Azad, 2025). In this scenario, the ethical conundrum of balancing client autonomy with the duty of beneficence is less prominent, as the mother's substituted consent would be legally valid. This, however, does not remove the necessity of obtaining assent from the client when possible (Flowers & Dawes, 2023). In this case, you may be more inclined to consider admitting the client on a temporary basis until you are able to obtain his assent. This decision could be better justified as long as it aligns with the client's best interests.

The Admitting Therapist Is Not Regulated by a Governing Body

If you, as an admitting staff member, were not a regulated practitioner, you would still be able to use the ethical decision-making model to assist you in your deliberation, though there would be a lack of legal and professional body accountability associated with your decision. If you were not a licensed practitioner, you may feel less equipped to be able to justify the decision you took. This could potentially lead to increased liability risk for the treatment facility. Consulting with a senior staff member as soon as possible is strongly recommended, and proceeding with a full admission, such as in alternative two, is strongly discouraged.

CHAPTER 7: IMPLICATIONS, PRACTICAL APPLICATIONS AND FUTURE DIRECTIONS

Implications

To fully grasp the implications of this project, it is helpful to revisit the core findings of the literature review, the ethical tensions presented, as well as the analysis of the ethical dilemma. This project has highlighted the existence of a significant gap between the ethical ideals outlined in professional codes and the realities of informed consent practices in psychotherapy and substance use disorder treatment, specifically. Informed consent is often overlooked in the practice of psychotherapy (Trachsel et al., 2015), and the ethical complications that can arise in the context of addiction treatment further challenge practitioners' ability to uphold client autonomy. While having a professional license does, in theory, offer more training and legal accountability, this project shows that it is not the sole solution to navigating ethical dilemmas encountered in addiction and treatment centre work. Furthermore, the reality of addiction treatment centres is that there are many staff members who do not hold professional licenses. If practitioners aim to uphold the values of prioritizing the client as the most important person in the room (Barstow, 2015) and encouraging client autonomy, then ethical practices and decision-making are essential for all those working in addiction treatment to strive for.

This disconnect between ethical ideals and real-life practice is not only reflected in the literature but also in legislation, such as Alberta's Compassionate Intervention Act. While Canadian codes of ethics, such as the CPA (2017) and CCPA (2020), both advocate for client autonomy and respect for client decisions, this piece of legislation appears to be a regression towards a paternalistic approach to client care, a concept overviewed in Chapter 2. Despite this, the foundational components of informed consent of cognitive capacity, free will, and adequate

information remain central to the ethical practice of informed consent procedures, even in addiction contexts (Carter et al., 2012; Faden & Beauchamp, 1986; Roberts, 2002; Walker et al., 2005).

Practitioners may hold assumptions about substance users' decision-making capacity, and these can also lead to unjustified paternalism and low regard for client choice and autonomy. While there is evidence to suggest that the decision-making capacity of substance users is impacted to a certain degree while using (Blithikioti et al., 2025; Trujols, 2015), it is inappropriate to work from the assumption that they are inherently incapable of making informed decisions for themselves due to their addiction (Morán-Sánchez et al., 2016). Adopting a truly client-centred approach that prioritizes client autonomy means accepting that clients may make health decisions about substance use that you personally disagree with but are nonetheless worthy of respect. This might take the form of a client choosing not to pursue treatment for their addiction despite practitioners suggesting otherwise. Respecting such decisions means respecting people's free will to the fullest extent. This is not to say that paternalistic actions are always wrong; however, practitioners must remain mindful of their use of paternalistic actions and ensure that when employed, they can provide clear justification for doing so. When faced with ethical dilemmas, such as the one presented in this project, it is essential for practitioners and non-licensed workers alike to consider what is in the client's best interest, considering all relevant factors.

Applications

Based on the findings of this project, several key practical applications and considerations are recommended to help enhance informed consent practices in addiction treatment settings. A key point to consider is to approach informed consent as an ongoing

process, rather than a one-time event (Walker et al., 2005). Scott (2000) suggests moving away from a one-size-fits-all approach to substance use disorder treatment, a view I share. I believe this shift should include creating more opportunities to engage clients in informed consent discussions throughout the course of treatment, rather than limiting this process to the initial admission stage in treatment centres. This also entails adapting the consent process along the way. For example, if a client is too intoxicated to receive and process the information required to make an informed decision but remains conscious and aware of their surroundings, a practitioner may seek verbal agreement from the client to wait until the effects of intoxication subside, allowing them to engage more meaningfully in the informed consent process. The point here is to aim to meet the client where they are in terms of their capacities and provide appropriate care in response. To facilitate this process, treatment centres should consider integrating consent check-ins throughout treatment, not just during the initial intake. Furthermore, establishing protocols for situations in which clients are temporarily unable to provide informed consent can help provide needed guidance to staff and help fill in the practical gaps missing from professional codes of ethics.

Practitioners should also remain mindful of their own conceptions and biases towards substance use disorder. Consider what beliefs ground the approach used to obtain informed consent and reflect on whether they help keep the client at the centre of the process. I recommend that practitioners seek opportunities to expand their knowledge of addiction and ethical practice, as well as revisit their ethical obligations not just when faced with ethical dilemmas, but also as part of continuing reflective practice as clinicians (Luft & Roughley, 2016). A way to assist this practice can be through peer consultations, clinical supervisions, and team discussions. All staff working in addiction treatment centres, licensed or not, should be

provided with tools on how to navigate ethical dilemmas that arise. This could potentially be achieved during staff onboarding, through training opportunities during their employment, or by developing guidelines on how to make informed decisions based on ethical codes, service values, capacities, and legal considerations. It can also include training staff on how to assess and navigate client capacity in situations such as withdrawal, intoxication, or coercion.

While improving informed consent practices on an individual level is recommended and helpful, these efforts ought to be further supported through broader systemic changes. At a policy level, regulatory bodies should consider including more explicit guidelines on how to support informed consent as an ongoing process in contexts where client capacity can shift, such as in substance use disorder treatment. This can also include guidance on how to obtain, revisit, and revise informed consent in response to the client's needs and capacities in a manner that still prioritizes respecting client autonomy. At a facility level, treatment centres should clearly outline their capacities for support to guide staff members in making better-informed decisions. If a treatment centre is unable to provide support for, say, detox needs, they should be prepared to offer alternative resources to clients based on their needs, as well as assist them in accessing such resources to the best of their ability. Respecting a client's wishes or choosing not to temporarily override their autonomy does not then mean that practitioners should take a hands-off approach to client care. Practitioners should aim to provide support in whatever capacity is possible to help clients access appropriate care or have the opportunity to decline assistance if they so choose.

Strengths

A primary strength of this project is its grounding in the realities of clinical practice in addiction treatment while integrating ethical codes that guide professional conduct. As demonstrated throughout this project, informed consent in addiction treatment is not as

straightforward as one may presume. By exploring the history of informed consent in health care and therapy and incorporating relevant ethical codes and literature, this project helps connect the ideals of professional ethics with the realities of everyday practice, making this project more relevant to those working in the field. This project also addresses differing perspectives on addiction, the differences among addiction treatment services, factors that influence a client's ability to consent, as well as the strengths and challenges that come with licensed and non-licensed professionals. Together, these elements contribute to developing a deeper understanding of how to approach informed consent in a unique context with care and integrity.

As previously stated in this project, the topic of informed consent in addiction treatment is one that has received limited attention. This project has helped shed light on this gap in the literature and contributed to the discussion through the use of professional lived experience, critical analysis of current standards of practice, and consideration of additional factors in informed consent practice for addiction treatment. It also highlights the fact that ethical ideals are not always reflected in practice, protocols, or even legal legislation, making it all the more important to contribute to the discussion on how to improve ethical practice in addiction treatment.

Finally, a key strength of this project lies in the application of the CPA ethical decision-making model. While more needs to be done in terms of providing professional guidance to practitioners working in addiction treatment, the project utilizes existing tools to illustrate how these can help guide ethical decision-making. Although not everyone working in the field of addiction adheres to the CPA codes, the ethical decision-making model does provide helpful guidance for both licensed and non-licensed professionals on how to navigate such ethical dilemmas. In addition, using the CPA model further grounds the project in a Canadian context

and ensures that its recommendations are aligned with the nation's professional standards of psychological practice.

Limitations

One of the main limitations of this project was the limited availability of literature specifically addressing informed consent in addiction treatment. As a result, some older sources were used in conjunction with personal/professional insights to support and expand the discussion. The project also relied on the use of secondary sources rather than primary data collection, which may have limited the depth of the presented analysis. Despite my best efforts to present a balanced perspective on the topic, these factors may have introduced some inherent and unconscious biases.

While this project does briefly touch on provincially specific issues, such as the Government of Alberta's Compassionate Intervention Act (2024), it primarily adopts a broader, national lens on informed consent in addiction treatment. Although the CPA and CCPA codes offer federal-level ethical frameworks, individual provinces may have distinct guidelines, standards, and regulatory approaches to ethical practice that are not addressed in depth within this project. By not exploring these provincial-level differences, the findings and recommendations of this project may be limited in applicability for practitioners working within their own province's frameworks and legal requirements.

Finally, while this project acknowledges that there are many types of professionals working within the field of substance use disorder, its reliance on the CPA ethical decision-making model may limit the generalizability of the findings and recommendations made. Although the CPA model can be utilized by non-CPA licensed professionals, it is primarily tailored to the practice of psychology and therefore may not fully capture the ethical decision-

making processes or considerations employed by other professionals, such as social workers, nurses, or peer support workers. As a result, some of the guidance offered in this project may not be directly applicable to all practitioners working in addiction treatment settings.

Recommendations for Future Research

Considering the limited literature currently available, it is recommended that further research be undertaken on informed consent practices with a focus on substance use disorder. More specifically, gaining a better understanding of current informed consent practices in addiction treatment facilities from practitioners' perspectives could assist in identifying areas that need improvement. This could be accomplished through qualitative studies that aim to interview practicing professionals on their experiences working in addiction treatment and the challenges they have experienced or observed in relation to informed consent processes. Additional data could be gathered through practitioner-completed questionnaires on the topic. Analyzing such data could offer deeper insight into the realities of informed consent practices in addiction treatment settings and help identify ways to better support professionals in navigating the ethical dilemmas they encounter.

Similar studies would also be valuable in exploring clients' experiences with informed consent procedures in addiction treatment settings. Research using interviews and questionnaires to assess client perspectives, experiences, and insights could help bring a more client-centred perspective to the study of informed consent. In order to improve consent practices, it is important for practitioners to understand how these procedures are experienced by those receiving addiction treatment services.

Project Summary

The purpose of this project was to raise awareness about the complex ethical issues that can arise in informed consent practices within addiction treatment settings and to provide insight into how such dilemmas might be navigated while upholding client autonomy and ethical integrity. The fictional ethical dilemma presented in Chapter 1 served as an anchor for exploring how real-life scenarios can give rise to nuanced ethical challenges. The project examined the history of informed consent and the shift away from paternalism, reviewed key factors involved in informed consent, explained the general structure and function of addiction treatment facilities, outlined the various types of professionals working in these settings, and explored differing views on the decision-making capacity of individuals struggling with substance use. Throughout, ethical codes and professional practice standards were integrated to ground the discussion in Canadian regulatory frameworks and client-centred values.

Based on the findings and recommendations of this project, readers are encouraged to remember that informed consent in addiction treatment does not follow a one-size-fits-all model. Instead, it should be approached as a continuous, adaptive process that respects client autonomy and is responsive to the client's capacity at various stages of care. Regardless of professional credentials, all those working in addiction treatment are encouraged to strive for ethical practice, and organizations are urged to implement changes to support clear, consistent, and compassionate consent practices.

This project aims to contribute to the ongoing dialogue around ethical conduct in addiction care. In an effort to advance these conversations further and promote meaningful change, I intend to present the findings and recommendations of this project at the annual CCPA

conference, with the hope of encouraging reflection and improvement in the ethical practice of informed consent in addiction treatment.

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