ALBERTA COLLEGE of OCCUPATIONAL THERAPISTS

Practice Guideline

INFORMED CONSENT[1]

Prepared August 2022

GUIDELINE CONTENTS

*Key terms are **bolded** the first time they are used. For explanations of key terms, see Appendix D.*

[1] In preparation of this practice guideline, ACOT has referred to numerous pieces of legislation as well as guidelines and standards of practice from other provincial and national regulators. See Appendix B for the list of relevant legislation and Appendix C for the list of documents referenced.

1. Background

This guideline describes the key elements in the **informed consent** process and identifies the contextual factors that should be considered when seeking and receiving informed consent. Informed consent occurs when a client gives consent to a proposed OT service following a process of discussion and decision-making, leading to an informed choice.

The obligation to obtain and maintain informed consent in a way that is appropriate for the client and the practice context is a core competency of OTs (Competencies 2021, E1.3)[2] and is standard practice across regulated healthcare professionals in Canada. ACOT's Standards of Practice (SoP) require OTs to document the informed consent discussion, including the terms of any agreement as well as the client's consent or lack of consent to the proposed service (SoP 2.5 and 2.8). This obligation is also grounded in our ethical duty to demonstrate respect and uphold the dignity and autonomy of clients. Specifically, ACOT's Code of Ethics (CoE) requires OTs to collaborate in setting goals and priorities for OT services, to provide clients with the information they need to make choices about the options available to them, and to respect client choices (CoE 1.3, 1.4 &1.5).[3]

Additionally, the 2021 Canadian Competencies for OTs calls on OTs to continuously strive to create culturally safer, anti-racist, anti-oppressive and inclusive spaces (Competencies 2021, C2.1) and work to reduce the effects of the unequal distribution of power in the delivery of OT services (Competencies 2021, C1.5). These are foundational concepts to address throughout consent discussions. Building a relationship of trust and addressing power imbalances allows information about a proposed service to be shared in a meaningful way and creates the conditions whereby a client can come to an informed decision about whether to proceed.

This guideline is applicable to all OTs including clinicians, consultants, researchers, educators, and administrators. The OT services for which informed consent must be obtained include consultation, screening, assessment, treatment/intervention, making referrals, administration, education and participation in research. Informed consent may look different for OTs in non-clinical roles. See ACOT's Standards for Documentation guideline for examples of meeting and documenting informed consent requirements when you are in a non-clinical role or setting.

This guideline does not address consent requirements set by research and ethics boards. For research specific requirements, refer to the research ethics board(s) governing your research. Similarly, this guideline does not address consent requirements set by legislation for the collection, use and disclosure of information. For more on this, refer to ACOT's Practice Guideline: Information Privacy and Disclosure Legislation.

2. Components of Informed Consent

In order to be valid, **consent** must be:

- given by a person with **capacity**
- specific to the proposed service and service provider
- given by a **client** or **substitute decision** maker who is informed

[2]ACOTRO, ACOTOP, & CAOT (2021). Competencies for Occupational Therapists in Canada. (versions available in English and French)

[3] See Appendix A for a full list of relevant SoP, CoE and 2021 Competencies. ACOT is currently in the process of refreshing the Standards of Practice and Code of Ethics.

- given voluntarily
- ongoing

3. Responsibility for the Informed Consent Discussion

It is understood that OTs may work on interprofessional teams and that some of the initial informed consent discussion may be performed by another team member. For example, another member of the team might act as a primary point of contact with a client/family and discuss and answer questions about fees and cancellation policies, how information is shared, whether family members can be contacted by other team members, etc. Although some of the informed consent discussion may be performed by another colleague, the OT remains responsible and accountable for obtaining initial informed consent and for ensuring the client's ongoing consent to OT services (SoP 1.4). Before relying on consent obtained by a colleague, it is important to consider whether the consent discussion was specific enough to the proposed OT service to be considered valid consent for that service.

4. Tailoring the Informed Consent Process

Informed consent is an ongoing and interactive process. It will vary not only with the nature of the proposed service and the practice context, but also with the unique circumstances of each client. It is important to be sensitive to the many factors that can impact the client's experience of an informed consent discussion. This includes addressing any power imbalance between the OT and the client. Building a relationship of trust allows information about the proposed service to be shared in a meaningful way and creates the conditions whereby a client can come to an informed decision about whether to proceed. OTs working with clients impacted by structures of oppression will need to pay particular attention to their consent processes to ensure that the consent discussion aligns with the client's needs and circumstances. It is foundational to the informed consent process to listen to your client and tailor your consent process to best support their understanding of the information they need.

The following list of reflective questions is intended to prompt OTs to consider and address factors that can impact a client's ability to effectively participate in the informed consent process. This list is not exhaustive nor listed in order of importance; OTs must rely on their professional judgment to choose the best approach for their client, practice context and the nature of the proposed OT service (CoE 2.5).

Reflective Questions

- Have I created an environment that supports clients to participate in the consent process to the best of their abilities?
- Have I acknowledged and addressed any power differences between myself and my client? What steps can I take to minimize the impact of power differences on the consent process?
- Does the client feel safe expressing their concerns or asking questions?
- Are there financial, medical, or other reasons why a client may feel pressured to proceed with the service (e.g., being cut off from benefits? What steps can you take to address the client's concerns?

- Would the client like to have a friend or family member with them for support in making their decision?
- Is my language appropriate to the age and abilities of the client?
- Does the client speak English at home? Would language interpretation services be of benefit?
- Is my informed consent process culturally appropriate?
- Is my informed consent process commensurate with the level of risk to my client?
- Would the client benefit from having information provided to them in an alternate, accessible format?
- Does the client have a hearing impairment that is impeding their ability to understand the information provided?
- Would the client benefit from having augmentative communication technology available?
- Is the client's current physical and emotional state conducive to making an informed decision?
- Does the client require additional time to process the information?
- Although a client might not have capacity to consent, what can I do to allow them to participate in the decision and to recognize and respect their assent or dissent?

5. Ensuring Consent is Informed: providing relevant information

Once you've set the stage, the informed consent discussion involves an exchange of information whereby the client learns about the proposed OT service and the OT learns about the client's needs and expectations. OTs should reflect on the required level of information sharing that is acceptable based on the nature of the proposed service, its degree of risk, and on the client's needs and circumstances. The key question to ask is "what would a reasonable person like to know in the circumstances?"

The list of topics below, should be addressed in an informed consent discussion where relevant:

- nature and purpose of the proposed service (including mode of service delivery[4])
- intended duration of the service and the processes/circumstances for ending services
- probable risks and benefits of accepting or declining the service
- reasonable alternatives to the proposed service
- right to refuse or withdraw consent
- participation of other care providers in the delivery of services if required (e.g., students, support personnel, others)

[4] See also ACOT's practice guidelines on Electronic Communications with Clients and Considerations for Virtual Practice .

- confidentiality and limits of confidentiality including what information will be collected, what it will be used for and when it can be accessed or disclosed
- how and when communication will happen between the OT and client, substitute decision maker or other parties (e.g., third party payers)
- terms of agreement for the services provided including fees, financial arrangements, and cancellation policies

Clients must be given the opportunity to ask questions. After sharing information with the client, verify their understanding and clarify as appropriate (SoP 8.6).

The details of what was covered in an informed consent discussion, who was involved, and the client's consent, refusal or withdrawal, can either be documented in a client record or recorded in a formal consent form. Note that the signing of a consent form alone does not constitute informed consent or ongoing consent. The discussion and confirmation of understanding throughout your involvement with the client is what is most important.

6. Who Can Provide Consent

Usually, consent will be sought directly from your client. However, in the case of children, or adults who lack capacity, you need to seek consent from **a substitute decision maker**. Capacity refers to the ability to understand the information that is relevant to the making of a personal decision and to appreciate the reasonably foreseeable consequences of the decision or lack of a decision.[5]

Substitute decision maker is the umbrella term used in this document to describe someone who is authorized to make healthcare decisions on behalf of a client (or in partnership with a client in the case of co-decision makers) when that client lacks the capacity to make the decision for themselves. A substitute decision maker could be an **agent, co-decision maker, guardian** or **specific decision-maker** depending on the legislation granting the decision-making authority. The term 'alternate decision maker' is sometimes used interchangeably with the term 'substitute decision maker'.

The basis of any concerns regarding capacity, along with decisions related to identifying a substitute decision maker should all be documented in the client record.

For ease of reference, the textbox on the following page includes descriptions of decision makers whose authority is set out in legislation in Alberta. It is beyond the scope of this guideline to explain each step in the process authorizing a substitute decision maker to make decisions on behalf of the client. The official Acts and Regulations referred to in this document should be consulted for all purposes of interpreting and applying the law regarding substitute and co-decision and supported decision making in Alberta.

[5] *Personal Directives Act*, R.S.A. 2000, c. P-6, s. 1(b*); Adult Guardianship and Trustee* Act, R.S.A. 2008, c. A-42, s. 1(d); *Mental Health Ac*t, RSA 2000, c M-13 at s. 26. See also *RMK v NK, 2020 AB*QB 328 at paras 126-130.

Agent: A person designated in a personal directive to make personal decisions on behalf of a client.

Co-decision Maker: A person selected by the client and appointed by the Court to make decisions in partnership with the client when the client has significantly impaired capacity but can still participate in decision-making.

Guardian (adults): An individual appointed by the Court in accordance with the Adult Guardianship and Trusteeship Act to make decisions on behalf of the adult client when the client lacks capacity.

Guardian (minors): Generally speaking, a minor child's parent is also their guardian. In some situations, OTs will need to confirm that a parent is a guardian and where there is no parent, will need to identify who the guardian is. Guardians can include a divorced parent with custody of the child, or a person appointed pursuant to a will, personal directive, court order, agreement or by authorization of legislation. (See section 6.a. Children Under the Age of 18 and 6.b. Mature Minors).

Specific Decision Maker: If there is no substitute decision maker in place and a capacity assessment indicates that an adult has lost the ability to consent to healthcare treatment, a health-care provider can choose one of the adult's relatives from a ranked list to be a specific decision maker. Specific decision makers must be 18 or older, be available and willing to make the decision, have had contact with the client within the past 12 months, have no disputes with the client, and have knowledge of the client's wishes, beliefs, and values.

Supported Decision Making: Supported decision making allows an adult *with capacity* to formally authorize up to three "supporters" to help them make personal decisions (including health related decisions) not related to financial matters. Although, supporters cannot consent on a client's behalf, they can be included in an informed consent discussion and, if the client wishes, supporters can help them make and communicate their decision about a proposed service.

a) Children Under the Age of 18

Unless a child is determined to be a mature minor, clients under the age of 18 years of age will require a guardian to provide informed consent on their behalf. (See section 6.b. Mature Minors; where applicable see also section 6.d. Imminent Risk/Emergency Situations).

In your initial interaction with a minor client, you should confirm that the adult who is consenting is the child's guardian. Individuals such as stepparents, grandparents, significant others, family friends, foster parents or caregivers, cannot provide consent unless they are the child's legal guardian. A foster parent can only gain guardianship through a court order or agreement with a director of the child welfare authority.[6]

In situations of parental separation, divorce, or death, OTs should request a copy of the court order, separation agreement or will/grant of probate declaring guardianship and attach it to the client record. If a copy of the guardianship document is not available, the OT should document the terms of the order/agreement/will as described by the guardian who brought the child for treatment. If both parents retain all rights of guardianship, either parent can consent to the treatment. If one parent consents to the

[6] The foster care handbook : a guide for caregivers [2021] - Open Government (alberta.ca)

proposed services, the other parent does not have the authority to prevent or override the other parent's consent so long as the proposed service is in the best interests of the child. If you are concerned that a child's guardian is not acting in the child's best interest, you have an obligation to report your concerns to a Director of Child Youth and Family Enhancement.[7]

Even though a minor may not be able to provide informed consent, it is good practice to seek their assent in a developmentally appropriate manner and recognize and acknowledge their dissent.

If someone other than a parent/guardian will be accompanying a child to appointments, this should be discussed with the guardian in advance and documented in the chart. Prior to proceeding with the service, ensure you have obtained informed consent from the guardian. For ongoing consent in such cases OTs can rely on the guardian's prior consent and the child's assent but should confirm ongoing consent with the guardian whenever appropriate (see section 8. Importance of Ongoing Consent). If the child's guardian wishes to appoint someone else to act on their behalf in emergency situations or due to their temporary absence, this should be confirmed in writing.[8]

b) Mature Minors

While the age of capacity to consent to healthcare treatment in Alberta is 18, the law recognizes that that some children are sufficiently mature to make their own health care decisions and provide their own informed consent.[9] This is referred to as the 'mature minor' doctrine. A minor can be considered a mature minor when they have reached a point of having sufficient intelligence and understanding to appreciate the nature and consequences (risks, benefits) of the OT services proposed. Some case law suggests that minors aged 16 and up have *defacto* medical decision-making authority unless the minor does not appear to understand the relevant information or to appreciate the reasonably foreseeable consequences of a decision. The OT proposing the OT service is responsible for assessing and determining whether a client under 18 is a mature minor, and therefore, able to provide consent. The OT should consult with other members of the healthcare team as appropriate. The decision and the reasoning for making this determination should be clearly documented.

Factors to consider in assessing whether a client is a mature minor include:

- their age, intelligence & maturity
- the complexity and seriousness of the health care treatment
- their understanding of the risks, alternatives, and consequences of proceeding with, or refusing the service
- indications of independence that may support a minor's increased level of maturity (e.g., self-supporting, married, has children)

Where a child is a mature minor, they may provide informed consent to accept or refuse the proposed service. A mature minor's guardian may not override that decision, though a court order may override the minor's decision-making capacity. Be sure to inquire whether any such order exists and obtain a copy for attachment to the client record where possible.

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[7] *Child, Youth, and Family Enhancement Act*, RSA 2000, c C-12 at s. 4.
[8] *Family Law Act,* SA 2003 c F-4.5, at s. 21(6)(k).
[9] The "mature minor" doctrine was initially adopted by the Alberta Court of Appeal in *JSC v Wren*, 1986 ABCA 249, and is applied as part of the common law. Subsequent case law from the Supreme Court (*AC v Manitoba (Director of Child and Family Services)*, 2009 SCC 30) further affirmed that a minor's thoughts of what is in their best interest becomes increasingly determinative as they mature.

c) Adults With Impaired Capacity or Lack of Capacity

Adults 18 years of age and up are presumed to have the capacity to consent to healthcare services. This means that you should obtain consent from adults directly, unless you have a reason to believe that they may lack capacity.

When you have a cause for concern regarding a client's capacity, you should not provide services to the client until questions of capacity and consent can be addressed. (See also section 6.d. Imminent Risk/Emergency Situations).

Some reasons to question capacity include:

- notable behavioural changes such as having significant difficulty remembering how to engage in activities that were formerly familiar to the client
- a client struggling to understand information relevant to making a decision or to appreciate the reasonably foreseeable consequences of a decision
- significant changes in the client's choices regarding services or tolerance for risk
- inconsistencies in what the client tells you
- the client appears to be unduly influenced by another individual

A decision that is unanticipated or in disagreement with an OT's recommendation is not a reason to doubt a client's capacity. In such situations you should clarify the client's response and where appropriate, engage in further discussion to better understand the client's rationale.

Given that capacity can fluctuate (and that incapacity may be transient), consideration should be given to revisiting the informed consent discussion at a later time, to see whether the client is more capable of providing consent under better conditions. If concerns persist, consult a physician who can determine if the client's decision-making ability is being affected by a medical condition that may be temporary or reversible.[10]

If a capacity assessment has not yet been completed, and there are legitimate reasons to believe an adult is unable to make their own decisions, a capacity assessment should be initiated. In Alberta, a formal capacity assessment can only be performed by a physician, psychologist or designated capacity assessor.[10] The capacity assessment will help determine whether a substitute decision maker should be appointed, or whether the client's personal directive should be enacted which would give their agent authority to make personal decisions.

If a capacity assessment has already been completed, review the assessment to determine how it applies to your proposed OT service. For example, the capacity assessment may indicate that a client has only lost capacity to make financial decisions (which would not necessarily signify loss of capacity for health or lifestyle decisions). If you determine that the capacity assessment does not apply to the proposed OT service and you have no other reason to doubt the client's capacity to consent to the service, you can proceed to have an informed consent discussion directly with the client. You would document that you have reviewed the capacity assessment and determined that it does not apply to the proposed OT service. You would also document that there were no other reasons to doubt the client's capacity.

If the capacity assessment does apply to the proposed OT service (e.g., the capacity assessment states that the client does not have capacity to make health care or personal decisions), informed consent must be

[10] For more on capacity assessment, who can be a designated capacity assessor and enacting a personal directive see: https://www.alberta.ca/capacity-assessment.aspx and https://www.alberta.ca/personal-directive.aspx

sought from the relevant substitute decision maker. If the adult has regained capacity, they should have another capacity assessment.

To identify the appropriate substitute decision maker (and to determine the substitute decision maker's authority), consult the court order or personal directive.

If an adult who has been determined to lack capacity does not have a substitute decision maker in place, a health-care provider can choose one of the adult's relatives from a ranked list to be a specific decision maker.[11] Specific decision makers must be 18 years of age or older, be available and willing to make the decision, have had contact with the client within the past 12 months, have no disputes with the client, and have knowledge of the client's wishes, beliefs, and values. If no one meets these criteria, the Office of the Public Guardian and Trustee can be asked to be the decision maker. Note that specific decision makers have no authority to make decisions with respect to healthcare that would likely result in the imminent death of the client.

Even though a client may not have the capacity to consent, it is good practice to seek their assent and recognize and acknowledge their dissent.

The Adult Guardianship and Trustee Act, s. 4(1) also makes provision for clients with capacity to formally identify supported decision makers to assist them in making personal decision. Supported decision making allows an adult with capacity to formally authorize up to three "supporters" to help them make personal decisions (including health related decisions) not related to financial matters. Although supporters cannot consent on a client's behalf, they can be included in an informed consent discussion and, if the client wishes, supporters can help them make and communicate their decision about a proposed service.[12] Although, these "supporters" cannot consent on a client's behalf, they can be included in an informed consent discussion.[13]

d) Imminent Risk/Emergency Situations

Where a delay in obtaining consent would prolong suffering or place the client at risk of serious mental or physical harm, a health care practitioner can provide services even if the client lacks capacity or if the substitute decision maker cannot be reached. In such situations, services should only be provided to the extent necessary to alleviate the risk of serious mental or physical harm. Details of the mental or physical risk should be documented clearly. As soon as practical after the services have been provided, the OT should make reasonable efforts to inform the client or substitute decision maker as to what has occurred. If the OT service can wait until the client regains capacity or substitute decision maker can be reached, the service should be delayed so that consent can be sought.

e) Concerns Regarding Substitute Decision Makers

Where a substitute decision maker is in place, the OT should verify their authority to assist/consent by reviewing the document appointing them (i.e., court order, personal directive, separation agreement, etc.).

Substitute makers must make decisions that are in the client's best interest. If you are concerned that an adult client's substitute or co-decision maker is not acting in the client's best interest or is acting outside their authority, seek further guidance from the Office of the Public Guardian.[14]

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[11] See Specific decision-making | Alberta.ca
[12] See Supported decision-making : Adult Guardianship and Trusteeship Act - Open Government (alberta.ca)
[13] See Supported decision-making | Alberta.ca
[14] https://www.alberta.ca/contact-office-public-guardian-trustee.aspx

If you are concerned that a child's guardian is not acting in the child's best interest, you have an obligation to report your concerns to a Director of Child Youth and Family Enhancement.

Where there is more than one substitute decision maker in place for an adult client and they disagree, they should be encouraged to come to a consensus. Where agreement cannot be reached, the proposed service cannot proceed without direction from the Court. Seek guidance from the Office of the Public Guardian and Trustee in this situation.

Substitute decision makers who do not appear to understand the information provided, or who do not appear to appreciate the reasonably foreseeable consequences of the decision, may be unable to provide consent due to lack of capacity. In such cases, consent must be sought from a different substitute decision maker.

7. Determining Voluntariness

Consent must be freely given. If the client's consent was coerced, provided out of duress, undue influence, compulsion, or intentional misrepresentation, you have not obtained informed consent. In circumstances where the client is under the influence of another person, or if you feel that the client is fearful of expressing their concerns or questions to you, care must be taken to ensure the client fully agrees with the decision.

8. Importance of Ongoing Consent

Although your client may have previously provided informed consent to services, they have the right to withdraw consent at any time. You have an obligation to ensure ongoing informed consent and should explicitly confirm and document that you have your client's consent to proceed in situations where:

- you are unsure if your client still consents to the service,
- the plan for service changes,
- there is a change in diagnosis, symptoms or circumstances,
- the service poses a new material or special risk,
- the service involves touch, disrobing, or involves physical discomfort or emotional sensitivity,
- the client or substitute decision maker is no longer capable of giving consent.

If your client has already provided informed consent to begin services, you may be able to rely on **implied consent** for subsequent appointments (e.g., client continues to show up for appointments) if there are no changes in the agreed nature of the service or client's health condition/status. However, caution should always be used when relying on implied consent. It is best practice to reaffirm the client's ongoing consent by asking for their **explicit consent.** This can be accomplished without repeating the initial consent discussion. For example, the OT might describe the session plan, confirm that the client wishes to proceed, and ensure that the client feels comfortable asking questions.

Contact ACOT if you have any concerns with the content in this practice guideline or if you would like to discuss requirements for your specific role and/or practice setting.

Appendix A – Standards of Practice, Code of Ethics and Core Competencies Relating to Informed Consent

Standards of Practice

SoP 1.2 - Be knowledgeable of and adhere to all relevant public protection legislation, regulatory and professional legislation, bylaws, standards of practice, and code of ethics applicable to their occupational therapy practice.

SoP 1.4 - Be responsible for the occupational therapy services provided by oneself and demonstrate accountability for services provided by other personnel who are under the therapist's supervision.

SoP 2.5 - Discuss and document the terms of agreement for the services to be provided.

SoP 2.8 - Document the screening results and recommendations along with the client's consent to and agreement with the services offered or lack of consent or agreement.

Code of Ethics Indicators

CoE 1.3 - Collaborate with the client(s) in setting goals and priorities of services as much as reasonably possible.

CoE 1.4 - Provide clients with the information they need to make decisions about the options available to them.

CoE 1.5 - Accept clients' choices.

CoE 2.5 - Exercising independent judgment

Competencies for Occupational Therapists in Canada (2021)

A1- Establish trusted professional relationships with clients

A1.1 - Co-create with clients a shared understanding of scope of services, expectations, and priorities.

A1.4 – Support clients to make informed decisions, discussing risks, benefits, and consequences.

A3.2 - Develop a shared understanding of the client's occupational challenges and goals.

A3.4 - Evaluate risks with the client and others.

A4.1 - Agree on the assessment approach.

A5.1 - Agree on the service delivery approach.

A6.2 - Confirm shared understandings and progress of the plan

B1 - Communicate in a respectful and effective manner

B.1.2 - Foster the exchange of information to develop mutual understanding.

B1.4 - Adjust to power imbalances that affect relationships and communication

C1 - Promote equity in practice

C2 - Promote anti-oppressive behaviour and culturally safer, inclusive relationships

E1.1 - Respect the laws, codes of ethics, rules and regulations that govern occupational therapy.

E1.3 - Obtain and maintain informed consent in a way that is appropriate for the practice context.

E2.1 - Follow organizational policies and procedures and take action if they are in conflict with professional standards, client values, protocols, or evidence.

Appendix B – Relevant Legislation

It is beyond the scope of this guideline to address all the legislation relevant to the informed consent process. Below is a list of legislation that may be relevant to the informed consent process in your practice setting. As a regulated OT, you are required to be knowledgeable of and adhere to all relevant public protection legislation (SoP 1.2).

- *Adult Guardian and Trustee Act,* SA 2008, c A-4.2
- *Children's First Act,* SA 2013, c C-12.5
- *Child Youth and Family Enhancement Act,* RSA 2000, c C-12
- *Divorce Act,* RSC 1985, c 3
- *Family Law Act,* SA 2003, c F-4.5
- *Freedom of Information and Protection of Privacy Act*, RSA 2000 c F-25
- *Health Information Act*, RSA 2000, c H-5
- *Health Professions Act,* RSA 2000, c H-7
- *Mental Health Act,* RSA 2000, c M-13
- *Personal Information Protection Act,* SA 2003, c P-6.5
- *Personal Directives Act,* RSA 2000, c. P-6
- *Public Health Act,* RSA 2000, c P-37

Appendix C – References and Resources

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Appendix D – Key Terms

Agent: A person designated in a personal directive to make personal decisions on behalf of a client.[15]

Assent: Agreement to participate in a health intervention by someone who does not have the capacity to consent (e.g., a child or an individual with a cognitive impairment).

Capacity: The ability to understand the information that is relevant to the making of a personal decision and to appreciate the reasonably foreseeable consequences of the decision or lack of a decision.[16]

Capacity Assessment: If there are legitimate reasons to believe an adult is unable to make their own decisions, a formal capacity assessment can be initiated. Capacity is assessed to provide the Court with information to help determine whether or not a substitute decision maker (or co-decision maker) should be appointed for an adult.[17] In Alberta, a formal capacity assessment can only be performed by a physician, psychologist or designated capacity assessor.

Client: Clients are the individuals, families, groups, organizations, communities, populations, system or combination of these who take part in occupational therapy services. A client may also be referred to as a patient in some clinical settings as well as under the sexual abuse and sexual misconduct provisions in the Health Professions Act (HPA). In some circumstances, clients/patients may be represented by their substitute decision-makers.

Co-decision Maker: A person selected by the client and appointed by the Court to make decisions in partnership with the client when the client has *significantly impaired capacity* but can still participate in decision-making.[18]

Consent: The agreement or permission of the client to proceed with a service. Consent may be provided verbally (e.g., spoken, conveyed via an interpreter or other reliable form of non-verbal communication), written or implied from the circumstances.

Explicit Consent: Direct, expressed agreement for a specific service, given either verbally (e.g., spoken, conveyed via an interpreter or other reliable form of non-verbal communication) or in writing. The term 'explicit consent' is often used interchangeably with 'express' consent.

Guardian (adults): An individual appointed by the Court in accordance with the *Adult Guardianship and Trusteeship Act* to make decisions on behalf of the adult client when the client lacks capacity.[19]

Guardian (minors): Generally speaking, a minor child's parent is also their guardian. In some situations, OTs will need to confirm that a parent is a guardian and where there is no parent, will need to identify who the guardian is. Guardians can include a divorced parent with custody of the child, or a person appointed pursuant to a will, personal directive, court order, agreement or by authorization of legislation (See section 6.a. Children Under the Age of 18).[20]

Implied consent: Implied consent is inferred from the words or behaviour of the client, or surrounding

[15] *Personal Directives Act*, R.S.A. 2000, c. P-6, s. 1(a).
[16] *Personal Directives Act*, R.S.A. 2000, c. P-6, s. 1(b); *Adult Guardianship and Trustee* Act, R.S.A. 2008, c. A-42, s. 1(d); *Mental Health Act*, RSA 2000, c M-13 at s. 26. See also *RMK v NK, 2020 ABQB* 328 at paras 126-130.
[17] *Adult Guardianship and Trustee Act, R.S.A.* 2008, c. A-42, s. 1(e).
[18] *Adult Guardianship and Trustee Act*, R.S.A. 2008, c. A-42, s. 1(h & i).
[19] *Adult Guardianship and Trustee Act*, R.S.A. 2008, c. A-42, s. 1(p).
[20] *Family Law Act;* SA 2003, c F-4.5, s. 20, *Youth and Family Enhancement Act* RSA 2000, c C-12 .

circumstances, which show the client's willingness to receive treatment.[21] Caution should always be used when relying on implied consent. It is best practice to seek a client's explicit consent prior to providing services. Detailed records should be kept when relying on implied consent. (See section 8. Ongoing Consent).

Informed Consent: Informed consent occurs when a client or substitute decision maker gives consent to a proposed service following a process of discussion and decision-making, leading to an informed choice. In order to be valid, the client/substitute decision-maker must have capacity to give consent and be informed; the consent must also be given voluntarily and be specific to the proposed service and service provider.

Mature Minor: While the age of capacity to consent to healthcare treatment in Alberta is 18, the law recognizes that some children are sufficiently mature to make their own health care decisions and provide their own informed consent. This is referred to as the 'mature minor' doctrine. A minor can be considered a mature minor when they have reached a point of having sufficient intelligence and understanding to appreciate the nature and consequences of the services proposed. (See section 6.b. Mature Minors).

OT Services: OT services include consultation, screening, assessment, treatment/intervention, making referrals, administration, education, and participation in research.

Risks: Risks include material risks and special risks. Material risks are risks that are known to occur with the associated service or those that commonly occur. Special risks are risks that are unlikely but may have serious consequences. A client's unique or exceptional circumstances might require the discussion of these potential, but normally uncommon, special risks.

Specific Decision Maker: If there is no substitute decision maker in place and a capacity assessment indicates that an adult has lost the ability to consent to healthcare treatment, a health-care provider can choose one of the adult's relatives from a ranked list to be a specific decision maker.[22] Specific decision makers must be 18 or older, be available and willing to make the decision, have had contact with the client within the past 12 months, have no disputes with the client, and have knowledge of the client's wishes, beliefs, and values.

Substitute Decision Maker: The umbrella term used in this document to describe someone who is authorized to make healthcare decisions on behalf of a client (or in partnership with a client in the case of co-decision makers) when that client lacks the capacity to make the decision for themselves. A substitute decision maker could be an agent, co-decision maker, guardian or specific decision-maker depending on the legislation granting the decision-making authority (See Appendix B for a listing of relevant legislation). The term 'alternate decision maker' is sometimes used interchangeably with the term 'substitute decision maker'.

Supported Decision Making: Supported decision making allows an adult *with capacity* to formally authorize up to three "supporters" to help them make personal decisions (including health related decisions) not related to financial matters. Although, supporters cannot consent on a client's behalf, they can be included in an informed consent discussion and, if the client wishes, supporters can help them make and communicate their decision about a proposed service.[23]

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[21] The case *V.A.H. v. Lynch*, 2008 ABQB 448 at para 283, provides a summary of how **implied consent** is interpreted in Alberta and held that "[i]mplied consent is found where there are indicia of the patient's willingness to receive medical treatment: i.e., presenting an arm for injection."

[22] See Specific decision-making | Alberta.ca

[23] See Supported decision-making : Adult Guardianship and Trusteeship Act - Open Government (alberta.ca)