

# Consent of Minors in Social Work Practice

ISSUES PAPER

SHERYL PEARSON, MSW, RSW, LLB

KAREN NIELSEN, PHD, RSW

PETER BAYLIS, PHD, RSW

## Minors and Consent and Social Work Practice

Working with minor clients in Alberta, whether you are a physician, psychologist, social worker or other health care professional poses challenges in the areas of client consent and confidentiality due to a dearth of clear policy related to this issue. The intention of this paper is to explore the issue and canvass the current related law and policy with the hopes of establishing some Guidelines for social workers in this area in the near future.

Primary Issues:

1. Can a minor consent to services and, if so, when?
2. What are a minor's rights to confidentiality?
3. If a minor cannot consent to services, from whom must consent be obtained before services can be provided?

### **Issue #1: Can a minor consent to services and, if so, when?**

Under the ACSW Standards of Practice, a social worker will obtain informed consent from a client before providing professional services to a client (Standard B.4(a)). In most cases, when services are provided to minors informed consent must be obtained from the minor's guardian (to be discussed later in this paper). However, there are exceptions to every rule. If the minor is a mature minor, a social worker may provide services to the minor by obtaining consent directly from the minor without obtaining consent from the guardian. The question then becomes, when does a minor become a "mature minor" for the purpose of consent for services?

The ACSW Standards of Practice define a client as

A(a)i. an adult or minor age 14 or over who has the requisite understanding to appreciate the nature and consequences of the professional services being provide.

The definition of client continues:

A(a)v Notwithstanding A(a)i any person shall be the client for issues directly affecting the physical or emotional well-being of the individual, such as sexual or other exploitive relationships, and/or issues specifically reserved to the individual, and agreed to by the guardian prior to rendering service.

This second provision, while relevant for the purposes of determining who can be a client, does not mean that a person deemed a client by virtue of this standard will be able to give informed consent. Thus, while Standard A(a)v suggests that an 8 year old may be a client for issues specifically reserved to the individual, this does not displace the need to obtain informed consent from a guardian, as inferred at the end of the standard where it states "and agreed to by the guardian prior to rendering service."

In Alberta, a minor is a person who is under the age of age of eighteen (*Age of Majority Act*) and the *Child, Youth and Family Enhancement Act*, s.1(d) defines a child as a person

who is under the age of 18. The law also recognizes that there comes a time in the maturation process when teenagers should have more and more say over the decisions affecting their own bodies. When a teenager reaches the point where he or she has sufficient intelligence and understanding to appreciate the nature and consequences of what treatment is proposed, the individual is considered to be a mature minor (Consent for Minor Patients, Discussion Paper prepared on behalf of the College of Physicians and Surgeons, page 1 ). The more serious the proposed treatment, the greater the level of maturity that is required before a child can be considered a mature minor.

Another term commonly referred to when discussing consent of minors is the term “emancipated minor.” There is no law in Alberta that provides for the emancipation of a minor, often understood to as formalizing a minor’s independence from his/her parents. While this term and legal status exists in Quebec, there is no legal recognition of this status in Alberta.

In Canada, the Common Law Mature Minor Doctrine addresses the ability of a minor to consent to medical treatment. This doctrine examines the capacity of the minor in regard to decision-making and their cognitive capacity in regards to their understanding and appreciation of the proposed medical treatment (Ferguson, 2004). The Mature Minor Doctrine is recognized in the case of *C. v. Wren* (1986) which dealt with a 16-year-old-girl who was pregnant and who left home and made arrangements for an abortion. The parents opposed the abortion and sought to prevent the procedure by challenging her capacity to consent. The court concluded that the girl understood the nature of the procedure and the risks. Consequently, she was competent to give consent and her parents’ wishes were not relevant. The court stated that the parental right to make treatment decisions for a child terminates if and when the child achieves a sufficient understanding to fully comprehend the proposed treatment.

In Alberta, the mature minor doctrine has been supplanted by the *Child, Youth and Family Enhancement Act* when treatment is refused in circumstances covered by the *Child Youth and Family Enhancement Act* (formerly *Child Welfare Act*). Thus, when a child is deemed to be in need of protective services, the jurisdiction of the Director of Child and Family Services may supersede the mature minor doctrine and the Director may apply for a court order authorizing treatment even when the minor is not consenting to treatment (*C.U. v. McGonigle* (2000)). This supplanting of the mature minor doctrine is limited, however, to situations where the child is deemed to be in need of protective services and the minor’s consent or absence of consent is deemed not to be in the best interests of the child.

That said, in the Supreme Court of Canada case *A.C. v. Winnipeg Child and Family Services* (2009) the court found that the “best interests” standard in the *Child and Family Services Act* operates as a sliding scale of scrutiny, with the child’s views becoming increasingly determinative depending on his or her maturity. The more serious the nature of the decision and the more severe its potential impact on life or health, the greater the degree of scrutiny required.

In this case, C was admitted to hospital when she was 14 years, 10 months old, suffering from lower gastrointestinal bleeding caused by Crohn’s disease. She is a devout Jehovah’s Witness and, some months before, had signed an advance medical directive containing her written instructions not to be given blood under any circumstances. Her doctor believed that internal bleeding created an imminent, serious risk to her health and perhaps her life. She refused to consent to the receipt of blood. A brief psychiatric assessment took place at the hospital on the night after her admission. The Director of Child and Family Services apprehended her as a child in need of protection, and sought a treatment order from the court under s. 25(8) of the Manitoba *Child and Family Services Act*, by which the court may authorize treatment that it considers to be in the child’s best interests. Based on the court’s interpretation of s. 25(8) of the Child and Family Services Act young people under 16 will have the right to demonstrate mature medical decisional capacity, although in this specific case the minor was not deemed to have medical decisional capacity. The court agreed that this interpretation protects both the integrity of the statute and of the adolescent. This seminal case suggests that as a minor becomes more mature, what the minor believes to be in his or her best interests will be more determinative of his best interests and that the ability of a minor to make decisions in their best interests may arise before the age of 16.

While the above cases relate to consent for treatment of medical services, the analysis is germane to consent for social work services. In terms of chronological age, the Courts in Alberta have not established a set age for maturity; however, the “threshold for recognition of maturity by the Courts is at least sixteen years and none have recognized individuals younger than fourteen years” (College of Physicians and Surgeons of Alberta, 2006, p. 1). Still, the common law has recognized the rebuttable presumption that “persons of any age are capable of making their own medical treatment decisions...” (i.e., rebuttable by a young person from seven to fourteen years of age, and by the state from fourteen to twenty-one years old)”(Day, 2007). And although “developmental milestones give us a general sense of capacities, there is no bright-line of a particular age that will indicate ability to participate in independent decision making.” (Kenny, Downie, and Harrison, 2008, p. 124)

For instance, Alberta Ministry of *Children’s Services* recognizes the age of twelve as being old enough to discuss and seek a child’s opinion on treatment decisions. This does not mean a child of 12 has decision making capacity, but rather that a child has the right to be consulted on matters regarding his/her person. The legal representation service provided by the Office of the Child and Youth Advocate of Alberta (Legal Representation for Children and Youth – LRCY) is also relevant to this discussion. This service is available for children and youth in Alberta who are the subject of proceedings under the *Child Youth and Family Enhancement Act*.<sup>1</sup> Under this service, when legal counsel are appointed to represent children and youth they must assume an instructional advocacy role if the child/youth “is able to express a wish, opinion, or position, unless there are conditions present that would preclude counsel from doing so” (Guidelines on the Role of Counsel, Office of the Child and Youth Advocate, Guideline #1). This does

---

<sup>1</sup> As well as the *Protection of Sexually Exploited Children Act* RSA 2000, c P-30.3.

not mean that a young person is deemed competent to instruct counsel, or even that they have capacity. It simply means that they have certain abilities.

Instructional advocacy is defined to include: 1) consulting with the child to ascertain his/her interests, 2) getting consent from the child before advocating those interests in court, and 3) reporting back to the child on the outcome of the advocacy (LRCY Role of Counsel Guidelines, Guideline #2). Guideline #3 goes on to say, “a child being under a particular age (for example 12 years) does not necessarily justify a departure from the role of instructional advocate unless, for example, the child is an infant and can be assumed to be preverbal. In other words, age is not determinative of a child’s ability to give instructions.”

What this means is that children as young as 3-4 who receive this service may have the ability to instruct counsel. While the ability of a child to instruct counsel is distinct from medical decision making authority or consenting for services (i.e. the child’s voice as represented by the lawyer is but one of several views which the judge will consider in making a determination of the child’s best interests) there is a common theme. Most notable is an underpinning view that minors have a right to be heard and a right to have a say in their future.

The College of Alberta Psychologists has published a Practice Alert for Mature Minors. This practice alert provides guidance for determining whether a minor is a mature minor. It states that:

The common law recognizes that mature minors can provide their own consent, provided that they have sufficient understanding and cognitive skills to enable them to understand fully what is being proposed. Although chronological age is only one of several factors to be considered, court precedent suggests a benchmark: a minor would not likely be considered a mature minor before the age of 15. However, not all minors over the age of 15 will be mature minors. Psychologists must consider a variety of factors before treating a minor as a mature minor including:

- What is the nature, purpose and utility of the recommended treatment?  
What are the risks and benefits?
- Does the minor demonstrate the intellectual capacity and sophistication to understand the information relevant to making the decision, and to appreciate the potential consequences?
- Is there reason to believe that the minor’s views are stable and a true reflection of their core values and beliefs?
- What is the potential impact of the minor’s lifestyle, family relationships and broader social affiliations on their ability to exercise independent judgement?
- Does the minor have any emotional or psychiatric vulnerabilities?
- Does the minor’s condition or illness have an impact on their decision-making ability?

- Is any relevant information available from adults, such as teachers or doctors, who know the minor (p.1)?<sup>2</sup>

### **Summary of Issue #1**

With all that said, what does this mean with regard to the question of when a minor can consent to social work services?

The case law establishes that minors age 16 years of age and older have *defacto* medical decision making authority, even in potentially life threatening situations, unless the minor does not understand the decision or appreciate its consequences. With respect to minors under 16 years of age, they have the right to demonstrate mature medical decisional capacity. Although the application of the mature minor doctrine has generally been limited to the context of medical decision making authority, it can be applied analogously to consent for social work services. While the College of Alberta Psychologists suggest that a minor will not likely be considered a mature minor before the age of 15, the Alberta College of Social Workers Standards of Practice suggest that a minor age 14 or older, can be a client. This age should not be taken as an end point, but rather a starting point for assessing whether a minor has the requisite understanding to appreciate the nature and consequences of the service being provided. The list of factors to consider identified by the College of Psychologists are a useful place to start in making this determination.

### **Issue #2: What are a Minor's Rights to Confidentiality?**

Health care professionals have a legal and ethical obligation to keep their patients'/clients' health related information confidential. This obligation has distinct implications for social workers when the client is a minor. Confidentiality with a minor should be considered separately from consent for services, though the two can overlap. Arguably, if a minor is deemed a mature for the purposes of consenting for services, then the client has a right to disclose information or not. Conversely, if a minor was not deemed a mature minor for the purpose of consenting for services, then the right to confidentiality must be independently determined.

The Standards of Practice state:

D.5(a) Except as noted in section D.6, a social worker will disclose information about a client to others only with documented informed consent from the client.

As noted earlier, a client is defined in the Standards as a minor age 14 or older who has the requisite understanding to appreciate the nature and consequences of the professional services being provided. Thus, where confidentiality of a mature minor is concerned, the duty is owed to the mature minor directly. If a mature minor withholds consent for access

to information he has disclosed to a social worker, that information cannot be disclosed, even if requested by a parent or guardian.

The Standards of Practice presume confidentiality of mature minors:

D.3 A social worker working with a person under the age of majority who has *not* been designated as a mature minor or as an adult and who has a guardian will discuss with the relevant parties where appropriate, who will have access to all or parts of the record. The discussion and any agreement reached with regard to access shall be recorded on the client file.

Similarly, standard D.6 states:

A social worker working with a person under the age of majority who has *not* been designated a mature minor or who has a guardian will discuss with the relevant parties, where appropriate, the limit the law imposes on the right to confidentiality with respect to communications with the social worker.

Given that both standard D.3 and D.6 refer to persons who have *not* been designated mature minors, it can be presumed that minors who *are* designated mature minors have the same rights to confidentiality as adults. This is echoed by the Professional Guidelines for Psychologists adopted by CAP November 2001, revised May 2002 and further revised March, 2010 which state:

If the minor's capacity and his or her understanding of the treatment and/or services are sufficient to warrant his or her being treated as a mature minor, the role of the parent or guardian changes to one of advisor and supporter. The parent or guardian no longer has the automatic right of access to the mature minor's confidential information unless the mature minor provides written consent... Where the mature minor refuses to release information to his or her parent or guardian, the prudent psychologist should err on the side of caution and uphold the duty of confidentiality owed to the mature minor, even where the parent or guardian is the one seeking the information until the courts determine whether the parent or guardian can access the information (p.?).

The *Health Information Act* provides that:

- S. 104(1) Any right or power conferred on an individual by this Act may be exercised
- (a) if the individual is 18 years of age or older, by the individual,
  - (b) if the individual is under 18 years of age **and** understands the nature of the right or power and the consequences of exercising the right or power, by the individual.

This section of the *HIA* was relied on by the office of the Information and Privacy Commissioner, Calgary Health Region, to deny a parent access to her teenage daughter's psychological questionnaire results.

The Privacy Commissioner examined the records for evidence indicating whether or not the daughter was capable of understanding the nature of her rights or powers and the consequences of exercising her rights or powers under the Act. In this case, the daughter was 15 ½ at the time of the access request and had been living independently from her mother for over two years. Her records from two years previous to the access request indicated that she had reasonable comprehension for her age, was a good student and an independent thinker.

The custodian, a regional health authority, had provided a letter to the mother of the individual describing the daughter as a "mature minor" who could consent to and control release of her patient record, and that the daughter would need to be involved in any decisions about her hospital records. Based on the evidence of the daughter's understanding and the applicant's failure to discharge the burden of proof to show that her daughter lacked understanding of the nature and consequences of exercising her own rights or powers under the *Health Information Act*, the Privacy Commissioner found that the mother did not have authority to exercise the rights or powers of her minor daughter.

The Privacy Commissioner stated that factors that must be regarded to determine whether a person under 18 is a mature minor are the individual's age, maturity, independence, level of understanding, and the nature and complexity of the *HIA* rights or powers. The opinions and views of the minor are just one of the factors that must be taken into account. The context of each request should be considered to determine whether the right of access may be exercised by the minor or by a guardian

The *HIA* does not explicitly provide any specific ages of a child or youth for the health care provider to use a guide for decision-making. It would appear that each case should be examined on an individual basis and decisions surrounding that case be considered carefully and professionally by those involved. That said, if a person is deemed a "mature minor" for an event of care; the caregiver has a duty to keep the health information associated with that care event confidential.

Based on the above discussion, once a minor is designated mature for the purposes of consent for services, a duty of confidentiality is presumed. However, if a guardian has consented to the service, and a minor is requesting confidentiality, the question of mature minor must still be determined. For the younger person, confidentiality may still be negotiated. Under the *HIA* it is recognized that if a young person requests that certain information not be disclosed to their guardian, consideration should be given to the request. Specifically it states:

**35(1)** A custodian may disclose individually identifying diagnostic, treatment and care information without the consent of the individual who is the subject of the information (c) to family members of the individual or to another person with

whom the individual is believed to have a close personal relationship, if the information is given in general terms and concerns the presence, location, condition, diagnosis, progress and prognosis of the individual on the day on which the information is disclosed *and the disclosure is not contrary to the express request of the individual* (emphasis added).

The importance of respecting children's wishes, regardless of their age, around confidentiality is also reflected in the *Children First Act*. The *Children's First Act (CFA)* is designed to facilitate the sharing of information between individuals and organizations planning or providing programs and services for children in schools and hospitals. The *CFA* states:

3(a) a service provider may disclose personal information and a custodian may disclose health information about a child to a guardian of the child *if the disclosure is not contrary to the express request of the child* (emphasis added).

It is clear then that the *HIA* and the *Children's First Act* respect the confidentiality of children, regardless of their age. Jackson, Burns, & Richter (2014) have developed a useful guidelines for determining the limits of confidentiality with minors.

Step 1: Gather all relevant information and assess physical and psychological state. Explain limits of confidentiality

Step 2: Assess whether the information shared:

- a) Requires intervention under the *Child, Youth and Family Enhancement Act*?
- b) Identifies a communicable disease requiring disclosure based on the *Mandatory Testing and Disclosure Act*?
- c) Poses imminent danger or harm to the health or safety of the individual or another person?
- d) Is subject to a Court Order?

If yes, the information must be reported to appropriate authorities. If no, encourage the minor to disclose to parent/guardian. If the minor agrees, then disclose only the minimum required. If the minor disagrees this is now an express request under the *HIA* section 35(c). The social worker should then proceed to Step 3.

Step 3: Determine capacity. This includes assessment of the following factors:

- a) Level of intelligence (cognitive abilities)
- b) Decision making capability (presence of cognitive delays, mental illness, or drug usage)
- c) Ability to understand informed consent
- d) Nature and/or seriousness of condition or illness
- e) Living independently, little or no contact with parents or guardian, or are a parent themselves

## **Summary of Issue #2**

If the minor is deemed a mature minor all information is kept confidential. If the minor is not deemed a mature minor, then there is a process to determine which information must be disclosed and which information can be kept confidential. Jackson, Burns, & Richter provide useful guideline for assessing this. Ultimately, minors who are not mature minors do not have an unfettered right to confidentiality, and confidentiality must nonetheless be respected. As provided in Standards D.3 and D.6 it behooves a social worker to negotiate and discuss matters of confidentiality at the outset of their involvement as part of their informed consent to care when working with minors.

## **Issue #3: When a minor cannot consent for services, from whom must consent be obtained?**

When a minor is deemed a mature minor, which for our purposes may be as young as 14 years of age but not younger, then the minor is capable of consenting for services. However, when a minor is under 14 years of age, or a minor over 14 years of age is not deemed mature, consent for services must be sought from a guardian. In other words, if the individual cannot understand and appreciate the nature and consequences of providing or not providing their consent, the consent of a parent, guardian or other authorized representative of the individual must be obtained (section 104(1)(c) to (i) of the *Health Information Act*).

### **Exercise of rights by other persons**

**104(1)** Any right or power conferred on an individual by this Act may be exercised

- (a) if the individual is 18 years of age or older, by the individual,
- (b) if the individual is under 18 years of age and understands the nature of the right or power and the consequences of exercising the right or power, by the individual,
- (c) if the individual is under 18 years of age but does not meet the criterion in clause (b), by the guardian of the individual.

A person may be a guardian by virtue of meeting one or more of the requirements under The Alberta *Family Law Act*, by virtue of an agreement, by appointment under or a court order. The scenarios of persons who could potentially be a guardian by virtue of one of the legal mechanisms above are:

#### **1. Natural parent**

- Yes (if meets the co-habitation or marriage criteria under *FLA*)

#### **2. Adoptive parent**

- Yes (provided the court order is current and consent has not been revoked by natural parents)

### 3. Step-parent

- No (unless there is a court order appointing them)

### 4. Divorced parents

- yes if joint custody
- access parent is still a guardian but only has the “right to know”, not a “right to be consulted.”

### 5. Common law relationships (including same sex partners)

- yes, if both partners are natural parents then both are guardians, if not, then the non-natural parent is not a guardian unless appointed by court order

### 6. Guardians appointed under court order

- includes guardians appointed for children after apprehension by a child welfare authority.

### 7. Guardians appointed under a will

### 8. Guardians appointed by agreement or temporary appointment

- foster parents
- guardians by agreement under the FLA even though the child begins to usually reside with only one of the parents
- an agent can be appointed to act on behalf of guardian in an emergency situation due to illness or other reason (s. 21(6)(k) *FLA*)

### 9. Foster parent

- through a court order or agreement with the Director of CFS

In establishing whether someone is a guardian, it is prudent to consult the *Family Law Act*, the will, or the court order. There are a range of people, including step-parents and common law partners, who will not necessarily be a guardian. Only a guardian of a child can give or refuse to give consent for treatment. Said another way, all people who have guardianship have the rights of guardian, including giving or refusing to give consent for treatment, with the exception of divorced parents where sole custody has been granted to one parent.

The College of Physicians and Surgeons provides a useful overview of the law as it relates to divorced parents:

“When a father and mother end their marriage by divorce, the Court can order, among other things, that the father and mother have joint custody or one of the parents have sole custody with reasonable access granted to the other parent.

The legal concept of guardianship is not identical to the legal concept of custody. The definition of “custody” under the *Divorce Act* has been described as “almost the equivalent of guardianship”. However, an Order of sole custody does not

mean that the non-custodial parent's guardianship rights are fully extinguished. There are several continuing rights of guardianship with survive an Order of sole custody. Under the *Divorce Act*, unless the Court orders otherwise, the parent with access rights has the right to make inquiries and to be given information about the health and education and welfare of the child. This is a "right to know" but not a "right to be consulted"

[...]

Accordingly, if the custodial parent is consenting to treatment for the minor child, which would appear to be in the best interests of the child, the non-custodial parent cannot stop the treatment by advising the physician health care provider that the non-custodial parent does not consent to that treatment. [Conversely], where parents have been granted joint custody after divorce, each parent continues to have the full complement of guardianship rights as existed during the marriage. Each parent has the right to consent to treatment (Consent for Minor Patients, Discussion Paper prepared on behalf of the College of Physicians and Surgeons, pages 4-5)

While the above discussion address the question of who can give consent, the question remains, then, from whom *must* consent be obtained when providing services to a minor? Is consent required from all guardians or only one guardian? Is there a difference when the guardians reside together, as in the case of an intact family, versus when the guardians no longer reside together? What about when foster parents have been appointed as guardians by the director of child and family services by virtue of an agreement—must consent still be sought from the parent guardians? Or what about when grandparents obtain guardian status over a child to be able to provide a child with necessities of life. Must consent still be sought from all parties with guardian status?

Guardianship refers to the largest list of rights and responsibilities towards children. Not all parents are guardians, and not all guardians are parents. Whenever there is more than one legal guardian, those rights and responsibilities are shared between the guardians or divided between them by a specific court order.

The College of Alberta Psychologists best practices for working with a child of divorce is to have one of the following three conditions met:

1. Have written consent of the other parent.
2. The parent bringing the child shows proof of sole guardianship or—if there is more than one guardian—sole responsibility for decisions or sole custody.
3. A court order is in place allowing the parent to bring the child for counselling or directing the child into counselling (The CAP Monitor, page 6).

Having reviewed the law and the position of other regulatory bodies, the answer to the question of who consent must be obtained from is that it depends on the circumstances. In other words, who consent *must* be obtained from, versus who consent *may* be obtained from, is a matter of professional judgment on the part of the social worker. It is

acknowledged that families dealing with separation and divorce sometimes have acrimonious dynamics. Allowing one guardian the authority to exclusively bring a minor for services, potentially against the express wishes of the other guardian, could very well put a minor in an untenable position and would arguably not be in the best interests of the child. And at the same time, refusing treatment of a minor because one guardian will not consent may be equally untenable for the minor, the guardian and the social worker and may not be in the best interests of the child. Given that there is not one rule that will likely fit all situations, a social worker will need to assess each situation, including the point of view of all guardians, the nature of the services being sought, the age of the child, the status of the family, and any court orders in place.

### **Summary of Issue #3**

There is no simple answer to this question of who must consent be obtained from when a minor cannot consent for him/herself. Section 104 of the HIA provides that consent of a guardian must be sought when a minor is not deemed a mature minor, however beyond this the law does not provide certainty as to which guardian or how many guardians consent must be obtained from. What is clear is that the answer will be dictated by the best interests of the child and must be considered in light of the circumstances and based on professional judgement.

A best practice would be to obtain consent from all guardians where reasonably practicable. Where this is not reasonably practicable, the social worker should determine who the most appropriate guardian is to give consent, and then obtain consent from that guardian. Of course, all decisions regarding consent for services on behalf of minors must be made in the best interests of the child, regardless of who is giving consent.

## References

### Articles

Kenny, N. Downie, J. Harrison, C., (2008). 'Respectful involvement of children in medical decision making'. In: Peter A. Singer; A. M. Viens (ed), *The Cambridge Textbook of Bioethics*. 1st ed. Cambridge: Cambridge University Press. pp.121-126.

Ferguson, L. The End of an Age: Beyond Age Restrictions for Minors' Medical Treatment Decisions. *SSRN Journal*. doi:10.2139/ssrn.998227

Jackson, M., Burns, K., & Richter, M. (2014). Confidentiality and treatment decisions of minor clients: a health professional's dilemma & policy makers challenge. *Springerplus*, 3(1), 320. doi:10.1186/2193-1801-3-320

Day, D. (2007) The capable minor's health care: Who decides. *The Canadian Bar Review* 86 (3).

### Policy/Working Papers

Alberta College of Social Workers, Standards of Practice, 2013

College of Alberta Psychologists Practice Alert for Mature Minors:  
<http://www.cap.ab.ca/pdfs/MatureMinorsSept2014.pdf>

Consent for Minor Patients, Discussion Paper prepared on behalf of the College of Physicians and Surgeons

Guidelines on the Role of Counsel, Office of the Child and Youth Advocate;  
[http://www.ocya.alberta.ca/wp-content/uploads/2014/08/PolMan\\_2015Feb\\_LRCY.pdf](http://www.ocya.alberta.ca/wp-content/uploads/2014/08/PolMan_2015Feb_LRCY.pdf)

Health Information Act Practice Guidelines

Professional Guidelines for Psychologists: *Limits to Confidentiality and Consent for Services: Special Issues in Working with Minors*, Rev. March 2010.

The CAP Monitor, Issue 41, Winter 2012.

### Legislation

*Age of Majority Act*, RSA 2000, c.A-6

*Child and Family Services Act*, The, CCSM c.C80

*Child, Youth and Family Enhancement Act*, RSA 2000, c.C-12

*Children First Act*, SA 2013, c.C-12.5

*Family Law Act*, SA 2003, c F-4.5  
*Health Information Act*, RSA 2000, c.H-5

### **Cases**

*AC v. Winnipeg and Child and Family Services* [2009] 2 SCR 181.

*C. v. Wren* (1986) 35 DLR (4<sup>th</sup>) 419 (Alta CA).

*C.U. v. McGonigle* (2000), 2000 ABQB 626 (CanLII), 273 A.R. 106 (Q.B.).