Consent, documentation, confidentiality and disclosure in an era of privacy concerns

R. Solomon,
Distinguished University Professor,
Faculty of Law, Western University
London, Ontario
rsolomon@uwo.ca
519-661-3603
## Contents

- **Introduction** ........................................................................................................................................................ 3
- **Consent, capacity and substitute consent** ............................................................................................................. 3
- **Documentation** .................................................................................................................................................... 5
- **Confidentiality, privilege and disclosure** ............................................................................................................... 8
- **Disclosure** .......................................................................................................................................................... 11
- **Mandatory reporting obligations and the duty to warn** ....................................................................................... 13
- **Appendix** ........................................................................................................................................................... 15
Introduction

Preliminary issues

- Changing legal environment
- Canadian courts’ expectations and attitudes
- Source of legal authority in counselling: client consent unless altered by statute
- Requirements of the law versus management policy

Consent, capacity and substitute consent

The issue of consent arises in numerous circumstances

Identify the specific consent issue in question – who is giving consent to whom and for what?

The general principles of consent under the common law

1. Generally, a counsellor must obtain a client's consent to initiate any test, procedure or counselling.
2. The consent should be obtained in advance and cover not only the intervention, but also any related issues regarding the collection, use and disclosure of patient information.
3. The consent must relate to the specific treatment or counselling that is undertaken.
4. If a client is competent to consent, then it is his or her consent alone that is required unless a statute provides otherwise. The consent of next-of-kin is only relevant if a client is incapable of consenting.
5. To be valid, consent must be given voluntarily (i.e. the decision is the product of the client’s conscious mind). The consent must be based on a full and frank disclosure of the nature of the intervention and its risks.
6. Unless a statute provides otherwise, a client may consent implicitly or explicitly. The fact that a client comes for treatment or counselling provides a broad measure of implied consent.
7. Clients may seek treatment, and yet expressly limit the scope of their consent. If the conditions imposed by a client would render the treatment futile or harmful, a counsellor should withdraw from the treatment relationship.

Capacity to consent

- Identify the specific capacity issue – who is capable of giving consent to whom for what?
- Capacity to consent under common law and the *Health Care Consent Act, 1996 (HCCA).*
  - A person is capable if he or she is able to understand the information relevant to making an informed decision, and is able to appreciate the reasonably foreseeable consequences of the decision. (s. 4)
  - A person's capacity concerning the same treatment may change over time. (s. 15(2))
  - If a person regains capacity, it is his or her decision that governs and not that of the substitute decision maker. (s. 16)
  - A person may be capable of consenting to some treatments, but not others. (s. 15(1))
All individuals are presumed to be capable with respect to treatment, admission to a care facility, and personal assistance services. A person is entitled to rely on this presumption, unless he or she has reasonable grounds to believe otherwise. (s. 4(2) and (3))

- Capacity and youth
  - Under the HCCA, the test of capacity is the same for all individuals, regardless of their age, and legal and mental health status.
  - It is up to the person providing the service to decide if the patient is capable of making the decision in issue. The clinician need only be of the opinion that the patient was capable and consented. The clinician need not be right.

Statutory ages of consent
- Child and Family Services Act, R.S.O. 1990, c. C.11 (CFSA), establishes a three-tiered age of consent for stipulated care givers and service providers for specified services.
  - A capable person 16 years of age or older may consent without parental knowledge or approval to any services. (s. 27(1))
  - A person under the age of 16 needs parental consent for residential care services and the administration of psychotropic drugs. (ss. 27(2) and 132(1)(b))
  - A capable child who is 12 or older may consent to counselling services without parental approval or consent. However, if the child is under the age of 16, the counsellor is required to advise the child of the desirability of involving his or her parents. (s. 28)
  - CFSA does not address the issue of whether a capable child under 12 can consent to counselling without parental consent.
- HCCA and Mental Health Act, R.S.O. 1990, c. M.7 (MHA).
  - A parent or guardian has authority to exercise the rights under PHIPA on behalf of a child who is under the age of 16, unless the information relates to treatment under the HCCA or counselling under the CFSA, or unless the child is capable and disagrees with the parent or guardian’s decision.
  - Consequently, parents will rarely have authority under PHIPA to control the records of their child, if the child is capable.

- Substitute consent

A substitute decision maker must: (s.21(1))
- give or refuse consent in accordance with any known relevant wishes expressed by the person while capable and 16 years of age or older; or
- base consent on the incapable person’s best interests, if no prior wish is known or it is impossible to follow.

Before giving or refusing consent, a substitute decision maker is entitled to all the information necessary for making an informed decision. (s.22(1))

- Counselling children: Custody, access and substitute consent
Documentation

General principles

1. The term patient record (i.e. health information record) generally includes all recorded information, whether in a written, printed, photographed, electronic, or videotaped format that a practitioner or agency has about a patient’s treatment, counselling or care.
2. Jot notes, and audio or videotapes that are used only as an aid in creating the official record are not likely to be considered to be part of the record.
3. Unless a statute provides otherwise, the nature of the service or function should dictate the contents of, and access to, the record. Does the record relate to a patient’s treatment or to an administrative matter, such as staffing, budgets or incident reports?
4. The content of a patient record and the level of detail should be based on the patient’s needs. The driving force underlying documentation is not the law, but rather the treatment or counselling needs of the patient.
5. The level of detail should also reflect the clinician’s assessment of the patient. The record generated in seeing a stable, long-standing patient need not be as extensive as that in seeing a new, rash or manipulative patient.
6. The more serious the problem and the greater the risks, the more detailed the record. The amount of information recorded will likely be greatest at the outset and will decrease once a treatment plan has been initiated.
7. The record should provide a concise and accurate summary of what the practitioner observed, saw, heard, and thought, what he or she did, and why that approach was adopted.
8. The record should also permit a colleague to recreate the practitioner’s thinking and assume responsibility for the patient’s care or, in other words, provide for continuity of care.
9. Practitioners need to resist the tendency to put off recordkeeping or to make only sparse entries because of time pressures.
10. Similarly, a practitioner must ensure that the record honestly reflects his or her honest assessment of the situation, even when pressured by patients, employers or third parties to support their preferred outcome.

If a clinician has a record that is sufficient to provide for ongoing, quality care, then the record will be adequate for legal purposes.

Guidelines for recordkeeping

1. All statements should be written in an objective, professional tone, particularly those relating to drug and alcohol use, sexual activities, mental competency, or other sensitive matters. The author should refrain from using pejorative or judgmental language, or terms that suggest ill-will, malice or sarcasm.
2. Entries should be made in chronological order. The record should be made in dark ink and be legible.
3. Subsequent, corrections, alterations or additions should be made openly, signed and dated with the original entry left intact and legible.
4. Except in the case of a sole practitioner, the author should print his or her name, sign the record and indicate his or her position.
5. Records should be complete, as any omissions will likely be interpreted negatively.
6. The author should limit the record to information that is relevant to the client’s treatment. The more sensitive the information, the more important it is to ensure that it is relevant to the client’s treatment. Even if sensitive information needs to be recorded, it may be appropriate to record the information in general terms.
7. Items that are relevant should not be omitted simply because they are embarrassing or uncomplimentary. Practitioners who omit such information may be exposing themselves to needless legal challenges.
8. A practitioner’s decision must be consistent with the record upon which it is based. If not, the decision can be challenged, and the practitioner may be accused of being arbitrary or discriminatory.

Information should be recorded when the intervention or event occurs, or as soon as possible thereafter. The longer the delay before recording the information, the more likely it is that the record will be challenged and perhaps even ruled inadmissible.

Current legal quagmire
- Many clinicians are justifiably confused about their recordkeeping, confidentiality and disclosure obligations, largely because of the patchwork of overlapping common law, equitable and statutory principles.
- Many provincial statutes apply to a single institution, service or category of professional, such as the CFSA, MHA, and Regulated Health Professions Act, S.O. 1991, c. 18 (RHPA).
- Two provincial statutes regulate government and other public sector agencies.
  - The Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. F.31 (FIPPA) contains confidentiality, recordkeeping, access, and disclosure provisions that apply to almost all provincially-created government agencies, such as public and psychiatric hospitals, the Ministry of Health, and universities and colleges. (s. 2(1))
  - The Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. M.56 (MFIPPA) contains parallel provisions governing municipally-created government agencies, such as boards of health, public schools, and municipal police departments.
  - FIPPA and MFIPPA do not apply to healthcare practitioners and others working in the private sector.

PHIPA
- PHIPA generally applies to the collection, use and disclosure of all “personal health information” (PHI) by health information custodians (HICs) and others. (s. 7(1)(a) and (b))
- The term HIC is broadly defined to include, among others: (s. 3(1))
  - regulated health practitioners, members of the College of Social Work or Social Service Work who provide healthcare.
  - community care access centres, long-term care homes, retirement homes, homes for special care, laboratories, pharmacies, and ambulance service; and
  - public and private hospitals, psychiatric and mental health facilities, and community or mental health centres or programs whose primary purpose is to provide healthcare.
• PHI is limited to information that identifies an individual or that can be reasonably foreseen to identify an individual. (s. 4(1) and (2))
• Whether PHIPA directly applies may be of greater theoretical than practical importance.
  o First, agencies and others governed by PHIPA will likely require all employees and consultants to comply with the Act. Thus, clinicians not directly governed by PHIPA may be required to comply by their employer.
  o Second, virtually all of PHIPA applies to non-HICs who receive PHI from a HIC. (s. 7(1)(b)(ii)) For example, a school guidance counsellor who received a report from a student’s psychologist would be subject to almost all of the provisions of the Act.
• Although HICs have expressed concern about PHIPA, the Act significantly narrows the right of patients to access their PHI while broadening the rights of HICs to disclose patient information without the patient’s consent or knowledge.

Ownership of and client access to clinical records at common law


A patient requested that her doctor provide a complete copy of her medical file. The physician provided a copy of material that she had personally prepared. However, the physician refused to release copies of documents that other doctors had prepared when treating the patient. The physician argued that she had an ethical duty to keep such third-party communications confidential. She suggested that the patient contact the other doctors directly to obtain copies of their records.

The Supreme Court unanimously rejected the physician’s position and ordered her to release the entire file. The Court stated that, in the absence of legislation, a patient is entitled to examine and obtain a copy of the whole record, including reports from other physicians and any other information the physician considered in providing advice or treatment. The Court also noted that a physician can apply to have a court deny the patient access if the physician can prove that allowing access would endanger the patient or others. Since the physician in this case could not prove that granting access would pose a risk, the patient’s request had to be allowed.

Ownership and access to administrative records at common law

Patient access and the right to seek correction under PHIPA

• Individuals have a right of access to a record of personal health information about themselves, but it is subject to numerous exceptions, including:
  o a record that was created for quality assurance purposes, or that contains quality of care information or raw data from a standardized psychological test or assessment; (s. 51(1))
  o where granting access could be reasonably expected to create a risk of serious harm to the individual’s treatment or recovery, or a risk of serious bodily harm to the individual or another person; (s. 52(1)(e)) and
  o where granting access could be reasonably expected to lead to the identification of a person who was legally required to provide information to the custodian, or a person who provided information in confidence. (s. 52(1)(e))
• Correction of a record.
If an individual believes that the record is inaccurate or incomplete for its intended purpose, he or she may make a written request that the record be corrected.

In most circumstances, a custodian must correct the record if the individual demonstrates that it is inaccurate or incomplete, and provides the required information to correct the record. (s. 55(8))

However, a HIC is not required to correct a record if it consists of a professional opinion or observation that the custodian made in good faith. (s. 55(9))

Other record keeping issues

- In the absence of a statute to the contrary, the record can be maintained in a written, computer or microfiche format, provided it is dated, secure, permanent, and unalterable without detection.

- Statements of opinion, preliminary conclusions and other non-factual material.
  - Identify the statement as an opinion or preliminary conclusion.
  - Explain the factual bases and observations that underlie the opinion.
  - If appropriate, resolve any preliminary conclusions based on subsequent findings.

- For how long should records be kept?
  - Statutory requirements.
  - Civil liability. The statutory limitation periods may be misleading.
    - Repeal of the limitations period for all sexual assaults, other sexual misconduct involving those under 18, and all assaults on those under 18 or in intimate relationships.

- Email communications: specify uses and limits on responses.
- Recording information about a third party.
- Recording information from a third party.
  - *PHIPA* permits the *indirect* collection of information without the patient’s consent in specified situations. For example, indirect collection is permitted if the information is reasonably necessary for providing care and the patient cannot be relied upon to provide the information accurately, completely or in a timely manner. (s. 36(1)(b))
  - *Briante (Litigation guardian of) v. Vancouver Island Health Authority*, 2014 BCSC 1511. A psychiatric nurse’s failure to include all available sources of information in the patient history was held to be negligent. Family members and other potential sources of relevant collateral information should be interviewed and all relevant information should be recorded. The Court stated that the nurse’s confidentiality obligation may have limited the information that she could share with the patient’s family, but it did not negate her duty or limit her ability to gather and record information from them.

Confidentiality, privilege and disclosure

The legal obligation of confidentiality

- The legal obligation of confidentiality may be defined as the obligation not to willingly disclose information obtained in confidence from a person, without that person’s consent.
• In certain limited situations (i.e. search warrants, subpoenas and mandatory reporting obligations), individuals may be required by law to release what would otherwise be confidential information without consent. Such disclosures do not constitute breaches of confidentiality, because the disclosures are not made willingly.

• The courts will recognize a confidentiality obligation in any circumstance in which there is a reasonable expectation of privacy. Generally, no expectation of privacy arises regarding information about conduct occurring in public (e.g. a fight between two patients in a hospital cafeteria) or information that cannot be linked directly or indirectly to an identifiable patient. This common law principle has been incorporated in MFIPPA, FIPPA and PHIPA.

• The obligation of confidentiality applies to any information that patients disclose about themselves or others during treatment. Similarly, practitioners must maintain the confidentiality of patient information that has been sent to them by consultants and other practitioners.

• The fact that a person is a patient is confidential and cannot be disclosed without the person’s consent. Consequently, care must be exercised in communicating with patients, whether it involves sending them information by mail, email, fax, telephone, or pager.

• The obligation of confidentiality is not absolute and may be breached to avert a “serious miscarriage of justice” or a “clear and imminent risk of death or serious injury to a third person.”

The sources of confidentiality obligations

• Health practitioners are typically governed by three or more different sets of confidentiality, recordkeeping, access, and disclosure policies at any one time.
  o statutory obligations
  o professional obligations (e.g. Social Work and Social Service Work Act, 1998, S.O. 1998, c. 30 and RHPA)
  o common law principles (e.g. invasion of privacy or breach of confidence)
  o contractual obligations implied or expressly set out in the terms of a treatment relationship or employment contract
  o equitable principles arising in fiduciary relationships (e.g. physician/patient relationships)

The consequences of breaching confidentiality

The consequences of breaching confidentiality vary with the source of the obligation. A single wrongful disclosure may trigger several adverse consequences.
  o prosecution for breaches of provincial statutes
  o fines, civil damages and remedial orders by the provincial privacy commissioner
  o disciplinary action by a College or licensing body
  o damages for invasion of privacy or breach of confidence
  o damages for breach of contract
  o dismissal for cause (i.e. no notice or severance)
  o damages for breach of a fiduciary duty
Explaining the meaning and limits of confidentiality at the outset of the relationship

- mandatory reporting
- search warrants, statutes and court orders
- limiting the confidentiality undertaking and getting the patient’s explicit consent

Confidentiality under PHIPA

- The Act generally prohibits HICs from collecting, using or disclosing PHI, unless the individual consents or they are permitted to do so by the Act. However, the Act permits disclosure without consent in numerous circumstances, including to:
  - contact the individual’s relatives or friends, if the individual is injured, incapacitated or ill, and unable to consent;
  - another HIC who also provides or assists in providing (provided or assisted in providing) healthcare to the individual, and the disclosure is for the purpose of improving or maintaining the quality of care that the recipient custodian is providing to that individual (s. 39(1)(d)). This is the legal basis of the “circle of care” rhetoric;
  - a medical officer of health for purposes of the Health Promotion and Protection Act, and to similar individuals in other jurisdictions carrying out similar functions; (s 39(2))
  - the head of a penal, custodial or psychiatric facility to facilitate the provision of care to, or the placement, detention or release of a detained individual; (s. 40(2))
  - the Public Guardian and Trustee and the Children’s Lawyer or a Children’s Aid Society; (s. 43(1)(e))
  - a person carrying out an inspection or investigation under a warrant, or provincial or federal law; (s. 43(1)(g)) and
  - eliminate or reduce a significant risk of serious bodily harm to a person or a group of persons. (s. 40(1))
- The so-called “lock-box” provisions.
- While PHIPA gives HICs broad discretion to disclose patient information without consent, they may be subject to other confidentiality obligations that prohibit disclosure.

Privilege

- Meaning of privilege.
- Confidential communication may be privileged in three situations: common law privilege granted on a category-by-category basis; common law privilege granted on a case-by-case basis; and privilege created by provincial and federal statutes.
- Common law category-by-category privilege.
  - There is no category privilege for health, counselling and care professionals.
  - Solicitor/client privilege.
- Category privilege is recognized in other situations, including: negotiations, settlements and mediation; spousal privilege; and informant privilege. Common law case-by-case privilege.
- Privilege created by provincial and federal statute.
- Counselling records, the Canadian Charter of Rights and Freedoms and victims of sexual and physical abuse.
Disclosure

Disclosure of Confidential Information Required by Search Warrant, Subpoena or Other Court Orders, the Evidence Acts, and Federal and Provincial Statutes.

Disclosure with a client's implied consent

- Implicit common law right to share confidential information with other clinicians both inside and outside the agency for advice on the best course of action.
- A similar right to share confidential information for compassionate reasons, to undertake an internal audit or other routine administrative tasks, and to ensure the quality of the services.
- An individual who applies for a benefit, exemption, accreditation, placement, referral, or reference letter will likely be viewed as implicitly consenting to the release of confidential information that is necessary to process that application.
- A patient’s express refusal of consent to disclose information will negate these implied rights to disclose his or her confidential information.

Express consent and minimizing privacy problems

- The common law, equitable, regulatory, and statutory provisions all permit the collection, use and disclosure of confidential patient information with the patient’s express consent. Consequently, practitioners can avoid confusion and potential legal problems by obtaining their patients’ express consent to their recordkeeping, confidentiality, disclosure, and access policies.
- Fortunately, the key recordkeeping, confidentiality and disclosure requirements of the common law, equity, regulatory statutes, and the other statutes are very similar, which means that agencies can develop a single set of policies that simultaneously meet their overlapping obligations.
- While agencies may have to designate a contact person, provide patients with a statement of their information policies or meet other similar technical requirements in some of the statutes, the legislation has not fundamentally changed the nature of good recordkeeping, confidentiality and disclosure practices.
- The issues covered in the express consent should include, if relevant:
  - the team approach to providing care;
  - the role of students;
  - observing, audiotaping and videotaping sessions;
  - the use of patient information for research or teaching purposes;
  - integrated care with other agencies;
  - external audits of files;
  - communications with referring agencies or funders;
  - the means of communicating with the patient;
  - communications with family; and
  - disclosure of patient information without consent in situations of imminent peril.
- Patients should be given a copy of the policies, and asked if they have any questions and if they agree to be bound by them. The patient’s response should be documented in the record.
Information sharing and integrated care

- There is no legal impediment to practitioners and agencies developing a model of integrated service delivery. Once the various agencies are committed to providing integrated care, developing the necessary information policies is largely a matter of mutual agreement.
- Care must be taken to ensure that the information policies meet all the common law, equitable, professional, and statutory obligations of the participating practitioners. As indicated, these obligations are very similar.
- A blanket statement that patient information will be shared among a long list of agencies and practitioners may be challenged. The patients must understand who will be disclosing what information to whom for what purpose? Will the patients understand that they can ask questions, refuse consent, limit their consent, or consent to the policies in their entirety?
- The patient’s consent to the information policies should be obtained at the outset of the relationship, when the patient’s consent is first sought for treatment.

A framework for analyzing disclosure of patient information

Is the information that is to be disclosed confidential?

- Information about activities occurring in public is generally not confidential.
- Information that does not identify a specific individual or that cannot be reasonably foreseen to identify an individual is not confidential.
- If the specific information is not confidential, it may be used and disclosed without the patient’s consent.

If the information is confidential, has the patient expressly consented to its use and disclosure?

- If so, the information may be used and disclosed.

If the information is confidential, has the patient implicitly consented to its use and disclosure?

- In several situations, practitioners may assume that they have implied consent to use and disclose patient information in the absence of an express refusal (e.g. consulting with another professional).
- If the practitioner has implied consent, the information may be used and disclosed.

If the information is confidential and the patient has not consented, is the disclosure of the information required by law, pursuant to:

- A search warrant, subpoena or other court order;
- Search consequent on a lawful arrest;
- The federal or provincial evidence acts; or
- A mandatory reporting obligation (e.g. communicable diseases, gunshot wounds or child abuse)?

- If disclosure of the information is required by law, it must be disclosed regardless of the patient’s consent.
If the information is confidential and the patient has not consented, is the disclosure of the information without consent authorized by statute?

- *PHA, MHA, CFFSA, RHPA, MFIPPA, FIPPA, PHIPA*, and other statutes contain numerous provisions that authorize disclosure of confidential patient information criminal code without consent, including:
  - In compassionate or exigent circumstances;
  - For management, administrative, monitoring, funding, auditing, and accreditation purposes;
  - To facilitate quality assurance, risk minimization and similar programs; and
  - For teaching and research purposes.

- If the disclosure is authorized by statute, the information may be disclosed.

If the information is confidential and the patient has not consented, is this a situation in which breaching confidentiality is legally justified?

- To prevent serious miscarriage of justice; or
- To avert a clear risk of imminent serious bodily harm or death to an identifiable person or group.

- If the breach of confidentiality is legally justifiable, the information may be disclosed.

- If the information is confidential and the preceding provisions do not authorize or permit disclosure, the information should not be disclosed.

**Mandatory reporting obligations and the duty to warn**

**Reporting obligations under the Criminal Code**

**Reporting obligations under Provincial Law**

- Health Protection and Promotion Act, R.S.O. 1990, c. H.7, s. 28 – communicable, reportable and virulent diseases.
- Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008 – alleged, suspected or witnessed abuse that constitutes a crime.
- Education Act – student misbehaviour that may constitute grounds for suspension or expulsion.
- CFSA, s. 72 – suspected child abuse. (See the Appendix)
The duty to warn

**Tarasoff v. Regents of the University of California**, 17 Cal. Rptr. 3rd (U.S. Cal., 1976)

A patient told his psychologist at the University Hospital that he intended to kill his former girlfriend when she returned from vacation. The psychologist concluded the patient was dangerous and contacted the campus police. The patient was picked up, briefly detained and then released. Neither the woman nor her family was warned of the potential danger. When the woman returned, the patient killed her. The family sued the psychologist for failing to warn. The psychologist brought a motion to dismiss, alleging that no legal duty of care arose in the circumstances.

The Court acknowledged the psychologist’s arguments about the difficulty of predicting dangerousness, but indicated that this was not the issue. The psychologist was not being sued because he had negligently assessed his patient. Rather, he was being sued because he had concluded that the patient was dangerous and failed to warn the intended victim. The psychologist also argued that there should be no duty to warn because it would necessitate breaching his ethical obligation to maintain confidentiality. In rejecting this argument, the Court emphasized that the confidentiality obligation to the patient ends when the public peril begins.

Consequently, the judge rejected the psychologist’s request to dismiss the family’s claim and sent the case to trial. The psychologist and the University settled out of court for close to two million dollars before the trial.


A psychiatrist interviewed the accused at the request of his criminal lawyer. The accused, who was charged with the aggravated sexual assault of a prostitute, confessed to the psychiatrist that he had committed the crime and described his plan to kidnap, rape and kill prostitutes upon his release. His plan involved: deliberately choosing small prostitutes who could be easily overwhelmed; sexually assaulting them; and strangling, disfiguring and burying them. The accused also described the modifications that he had made to his basement apartment to avoid detection. The psychiatrist told the lawyer that the accused was dangerous and would likely commit future crimes. The accused pled guilty to the assault charge, but the psychiatrist’s concerns were not addressed at the sentencing hearing.

The psychiatrist sought a declaration allowing him to disclose the privileged information in the interest of public safety. The Supreme Court of Canada stated that danger to public safety may in appropriate circumstances justify setting aside solicitor/client privilege. The Court stated that as a general principle there must be a clear risk of imminent serious bodily harm or death to an identifiable person or group. The Supreme Court upheld the psychiatrist’s request for a declaration authorizing disclosure of the privileged information.

**Conclusion**

- The key common law, equitable and statutory requirements for collecting, using and disclosing client information largely overlap. While some statutes require service providers to designate a contact person, provide a statement of their information policies or meet similar requirements, they do not alter the basic common law and equitable principles for collecting, using and disclosing confidential information.
- Consequently, service providers can develop a single set of policies that simultaneously meet all of their legal obligations.
- Consistent with the law’s focus on autonomy, service providers can collect, use and disclose confidential information with the client’s express consent. Agencies should provide clients with a statement of their information policies at the outset of the relationship, and obtain the client’s express consent to those policies.
Appendix

Reporting obligations under the Child and Family Services Act

1. Despite the provisions of any other Act, any person who has reasonable grounds to suspect, among other things, any of the following circumstances must forthwith report the suspicion and the grounds upon which it is based to a Children’s Aid Society. (s. 72(1))
   - A child has suffered or is at risk of suffering physical harm that: is inflicted by the parent or person in charge of the child; resulted from that person’s failure to adequately care or provide for, supervise, or protect the child; or resulted from that person’s pattern of neglect.
   - A child has suffered or is at risk of suffering emotional harm, as demonstrated by serious anxiety, depression, withdrawal, self-destructive or aggressive behaviour, or delayed development, which is caused or contributed to, as described above, by the parent or person in charge of the child.
   - A child has suffered or is at risk of suffering sexual molestation or exploitation inflicted by the parent or person in charge of the child, or caused by that person’s failure to protect the child when that person knows or ought to know of the possibility. Pending legislation would expand the definition of sexual exploitation to include child pornography.
   - A child requires medical treatment and the parent or person in charge of the child fails or refuses to provide the treatment, or is unavailable or unable to consent.
   - A child requires treatment for a mental, emotional or developmental condition that could seriously impair the child’s development and the parent or person in charge of the child fails or refuses to provide the treatment, or is unavailable or unable to consent.

2. It is an offence for those performing professional or official duties regarding children (e.g. clergy, teachers, counsellors, healthcare professionals, youth workers, service providers, coroners, and solicitors) to fail to report as required. The offence carries a fine of up to $1,000. (s. 72(4) and (6.2))

3. The duty to report suspected abuse applies to parents, foster parents and guardians, even if the abuser is their spouse or partner. Moreover, parents and foster parents have been held civilly liable for failing to protect their children from abuse in these circumstances.

4. The duty to report applies to the police, despite their general oath of secrecy regarding information obtained in the course of their duties and even if they do not have grounds to lay a criminal charge.

5. The duty to report applies even if the information is confidential or privileged. However, this provision does not abrogate solicitor/client privilege. (s. 72 (7) and (8))

6. The reporting obligation is ongoing. Any person who has acquires additional grounds to suspect abuse must promptly report these grounds to a Children’s Aid Society, even if he or she has made previous reports regarding the child. (s. 72(2))

7. Reports must be made directly to a Children’s Aid Society. A person must not rely on a third person to report on his or her behalf. (s. 72(3))

8. The term “child” is defined, for the purposes of reporting, as a person who is under 16 years of age. There are proposals to define a “child” for reporting purposes as a person who is under the age of 18.

9. The legislation only requires reporting abuse that is attributable to the person “in charge” of the child. Thus, the failure to report abuse by third parties, such as a boyfriend, a visiting relative or casual contact, does not constitute an offence.
10. No action can be brought against a person for complying with these reporting obligations unless he or she acted maliciously or without reasonable grounds. (s. 72(7))

**Disclosure and access under the Child and Family Services Act**

The status of the CFSA’s repealed recordkeeping, confidentiality, disclosure, and access provisions requires explanation. These provisions were enacted in 1984, but were never proclaimed in force and thus were never of any legal force or effect. These provisions were repealed in 2011, but may have been adopted by the Ministry of Children and Youth Services as guidelines that agencies must follow.

1. Disclosure without Consent. (ss. 182-83 – Repealed)
   a. Disclosure without consent is permitted:
      i. to staff of service providers providing approved services or requiring access for the performance of their duties; (s. 182(1)(a) and (c))
      ii. to a child’s foster parent; (s. 182(1)(b))
      iii. to a Children’s Aid Society, if the child is in the Society’s care under a child protection order; or a temporary care or special needs agreement, unless the agreement provides otherwise; (s. 182(1)(d))
      iv. to a peace officer, if the service provider reasonably believes that failure to disclose is likely to cause the person or another person physical or emotional harm, and the need for disclosure is urgent; (s.182(1)(e))
      v. to a person providing medical treatment to the person, if the service provider reasonably believes that failure to disclose is likely to cause the person physical or emotional harm, and the need for disclosure is urgent; (s. 182(1)(f))
      vi. to a review team conducting a child abuse review; (s. 182(1)(g)) or
      vii. to a program supervisor or Director who requests it. (s. 182(3))
   b. Records of mental disorders are subject to further safeguards. Service providers must disclose records pursuant to a court order, unless a physician states in writing that disclosure is likely to harm the person’s treatment, to injure another person’s mental condition or to cause bodily harm to another person. If disclosure is initially denied on this basis, a court must review the matter and decide whether to order disclosure. If the court agrees that such harm is likely to result, it will not order disclosure unless doing so is essential in the interests of justice. (s. 183)

2. Access. (ss. 184-86 – Repealed)
   a. Those over 12 have a right to access their own record, and the records of their child or a child in their lawful care if the child is under 16 years of age. (s. 184(1))
   b. These provisions do not apply to counselling records, which may only be disclosed to a child’s parent with the child’s written consent. (s. 184(2))
   c. The parent of a child under the age of 16 may restrict the child’s access to information in the child’s record that relates to the parent. (s. 184(3))
   d. However, a service provider may refuse or limit access:
      i. of a child to his or her own record, if the child is under 16 years of age and the service provider is of the opinion that disclosure would cause the child physical or mental harm;
ii. of parents or guardians to their child’s record, if the service provider is of the opinion that disclosure is likely to result in physical or emotional harm to the child or another person;

iii. to the name of a person who has provided information, but who is not providing services; and

iv. to a medical, emotional, developmental, social, or similar assessment prepared by a person who is not employed by the service provider. (s. 185)

e. Within 30 days of receiving a request for access, the service provider must: give the person access; notify the person that access is refused and explain the reason for the refusal; notify the person that the record does not exist; or notify the person that Part VIII does not apply to the record. (s. 186(1))