School Counsellors' Perspectives and Practices Regarding Informed Consent

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Abstract
Obtaining informed consent can be challenging when counselling youth in a school setting. This study explored how school counsellors (n=123) in Newfoundland and Labrador obtained informed consent when counselling youth. Surveys were distributed to school counsellors via an online survey platform. Findings suggested that many school counsellors obtained informed consent from their student clients regardless of their students' ages. Importantly though, some variation did exist among participants in terms of informed consent practices as well as parental/guardian access to student client information practices. Perceptions regarding the nature and importance of information to provide through the informed consent process varied in some cases. Implications for policy, future research, and practice are highlighted.

Counsellors have a responsibility to be straightforward with potential future clients so that those clients can be *informed* before deciding whether or not to enter into a counselling relationship with a counsellor. Informed consent stresses that "all other things being equal, the right to make decisions about whether or not to receive psychological services, and the nature of those services, belongs to the client" (Truscott & Crook, 2004, p. 55). Remley and Herlihy (2005) note that "providing clients with information about how the counselling process works helps demystify counselling and makes clients active partners in defining the counselling relationship" (pp. 77-78). Informed consent is considered a crucial aspect of the counselling process, but we know relatively little about how informed consent is practiced in professional contexts, especially in schools. Understanding how informed consent is negotiated by counsellors working with minor students in school settings is important to inform training, practice, and future research. The current study investigated how school counsellors working in the province of Newfoundland and Labrador view and approach informed consent when working with students under the age of 19, which is the age of majority in Newfoundland and Labrador.

Research Questions

The following represent the research questions for the current study:

1.) What are the current informed consent practices of counsellors (e.g., obtaining informed consent from the client and/or parents/guardians) and what are the current practices of counsellors around parental/guardian access to client files for counsellors working with children, early adolescents, or late adolescents?
2.) What informed consent dimensions do counsellors view as important when obtaining informed consent from parents/guardians?
3.) What informed consent dimensions do counsellors view as important when obtaining informed consent from clients?

Informed Consent Foundation and Benefits

Counsellors have ethical and legal responsibilities to protect their clients' rights, such as ensuring their clients have sufficient information to make informed decisions about counselling (Paez & Britton, 2004).

Schulz, Sheppard, Lehr, and Shepard (2006) note that legally, consent is a contractual relationship with the consent agreement being based upon a 'fiduciary' relationship. This highlights that "the choice to enter or continue therapy must be made knowingly, intelligently, and voluntarily" (Beeman & Scott, 1991, p. 230). Indeed, informed consent is rooted in the ethical principles of nonmaleficence (i.e., to do no harm) and autonomy (Handelsman, Kemper, Kesson-Craig, McLain, & Johnsrud, 1986).

When counsellors respect their clients' autonomy and respectfully facilitate an informed consent process, the therapeutic alliance can be enhanced (Beahrs & Gutheil, 2001; Fisher & Oransky, 2008). Sullivan, Martin, and Handelsman (1993) empirically showed that "clients may be more favorably disposed to therapists who take the time and effort to provide [informed consent] information" (p. 162). This has the potential to impact counselling outcomes (Martin, Garske, & Davis, 2000). Informed consent is also important because it can contribute to the demystification of the counselling process, which can help clients feel safe and reduce anxiety (Fisher & Oransky, 2008). It also helps clients to feel ownership over the counselling process (Fisher & Oransky, 2008), ultimately leading them to become more active in counselling (Beahrs and Gutheil, 2001).

Informed Consent Information and Details

Authors note three key elements of informed consent: knowledge, voluntariness, and competence/rationality (Beeman & Scott, 1991; Cahana & Hurst, 2008; Lyden & Peters, 2004; Saks & Jeste, 2006). *Knowledge* refers to the type of information that counsellors should provide, *voluntariness* covers consent decisions being made in the absence of coercion or manipulation, and c*ompetence/rationality* suggests that clients must have the capacity to reason about the proposed counselling, including being able to reflect on the pros and cons as well as consider relevant information (Beeman & Scott, 1991; Cahana & Hurst, 2008; Lyden & Peters, 2004; Saks & Jeste, 2006).

Literature on informed consent in counselling contexts highlights that clients should be provided with *knowledge* such as counsellor credentials, nature of the counselling, goals, confidentiality and its limitations, fees, potential techniques, record-keeping, benefits and risks, alternative treatments, and the right to refuse counselling (CPA, 2001; Fisher & Oransky, 2008; Knapp & VandeCreek, 2006; Paez & Britton, 2004; Sperry, 2007).

Research has shown that clients value information given to them during the informed consent process (Braaten & Handelsman, 1997), especially information about therapeutic techniques, confidentiality, and risks of alternative treatments (Braaten & Handelsman, 1997). Beeman and Scott conducted a study in 1991, which involved surveying 255 psychologists about their views toward providing informed consent information to adolescents. Interestingly, only about 54% of the psychologists rated the importance of discussing the limits of confidentiality as high (Beeman & Scott, 1991).

A study by Somberg, Stone, and Claiborn (1993) identified cognitive-behavioural therapists as more likely to inform their clients about the projected length of treatment and discuss alternative treatment options compared with eclectic and psychodynamic therapists. Croarkin, Berg, and Spira (2003) noted in their research that psychodynamic therapists gave lower importance to the overall value of informed consent in therapy, the perceived benefits of informed consent for clients, and the use of written informed consent procedures.

Considering Competency and Minors in Relation to Informed Consent

A key consideration with the informed consent process is the issue of competency, especially when working with vulnerable populations such as youth. Henkelman and Everall (2001) explain competence in a therapeutic context as a client's ability to make a choice about engaging in, or continuing with, treatment, and to make these decisions in an understandable way. From a legal perspective, adults are typically presumed to be competent (i.e., unless shown to be incompetent), whereas those who have not reached the legal age of majority are generally presumed to be incompetent under the law (Croxton, Churchill, & Fellin, 1988; Koocher, 2008; Lyden & Peters, 2004). Thus, when minor clients do not have the legal capacity to give consent, proxy consent must come from competent guardians on the client's behalf (Knapp & VandeCreek, 2006; Koocher, 2008). Isaacs and Stone (1999) suggest that the younger the client the more control parents/guardians have over such decisions. Parents or legal guardians of minors, with some exceptions, have legal rights to control professional services offered to their children (Glosoff & Pate, 2002). Competency laws often focus on specific ages, while counsellors tend to consider maturation levels (Isaacs & Stone, 1999). As well, the age of majority is not always equivalent to the age of consent (Schulz et al., 2006). The *mature minor* rule has also left some room for flexibility whereby courts consider children's capacity to consent on a case-by-case basis (see Hesson, Bakal, & Dobson, 1993 and Lehr, Lehr, & Sumarah, 2007 for further description).

The Canadian Counselling and Psychotherapy Association (CCPA, 2015) also highlights the 'mature minor' rule:

> The parents and guardians of younger children have the legal authority to give consent on their behalf. However, the parental right to give consent diminishes and may even terminate as the child grows older and acquires sufficient understanding and intelligence to fully comprehend the conditions for informed consent. Counsellors should be vigilant to keep themselves informed of their statutory obligations with respect to the rights of children, including their right to privacy and self-determination commensurate with their ability to do so and with regard to their best interests (p. 18).

Although the mature minor rule offers flexibility, it also creates a degree of uncertainty as the onus of determining competency is placed upon the counsellor. Grisso and Vierling (1978) identified the following abilities as important markers of competency: devote attention to the task, delay responses for reflection, consider treatment alternatives and risks simultaneously, hypothesize about future or potential risks and alternatives, and reason inductively and deductively. Weithorn and Campbell (1982) showed that while children at the age of nine had a reduced ability to understand and reason with treatment information as compared with adults, they did tend to make similar treatment choices. No differences were found, however, between 14-year-olds and adults in terms of ability to select a reasonable outcome, rationalize reasons, or understand and identify risks (Weithorn & Campbell, 1982).

Steinberg, Cauffman, Woolard, Graham, and Banich (2009) argue that there are varying aspects of maturity that need to be considered. They note that although many adolescents perform comparably to adults on cognitive measures such as logical reasoning about moral, social, and interpersonal issues, adolescents and adults are not equally mature when it comes to psychosocial capacities such as impulse control or resistance to peer pressure. Steinberg et al. (2009) do note that when reasoned decision making can occur in the context of minimized emotional and social influences and where there are consultants who can provide unbiased information about costs, benefits, and alternative courses of action, the decision-making capabilities of many adolescents are comparable to the decision-making capabilities of adults.

However, even if it is determined that a youth client is not competent to provide informed consent, some suggest that it is still important to involve the young person in the process. Lawrence and Kurpius (2000) explain that "minors over the age of seven years can give informed assent to be involved in counselling or research. Although this is not legally recognized, it demonstrates respect for the minor and signals that the minor has agreed to participate" (p. 134).

Informed Consent in a School Context

Informed consent can also be challenging for school counsellors. School counsellors must balance their legal and ethical responsibilities while trying to work with a variety of stakeholders, including students, students' parents/guardians, teachers, administrators, regulatory bodies, and the school districts (Glosoff & Pate, 2002). There are different perspectives regarding the level of responsibility for school counsellors to obtain parental/guardian consent to offer counselling to students who are minors. Research on school counsellors in Virginia highlighted that confidentiality and the rights of parents/guardians were among the most challenging and common ethical dilemmas they encountered (Bodenhorn, 2006). One view is that counsellors should fulfill the 'in loco parentis' legal responsibility, which mandates that educators act towards their students as caring parents/guardians would (Jenkins, 2004). Indeed, Remley and Herlihy (2001) argue that school counsellors do not necessarily require parental/guardian permission to offer counselling services to students. Others, however, suggest that counselling goes beyond the regular experiences of a typical school day and therefore should entail parental/guardian involvement to the highest extent possible. As well, involving parents/guardians in the counselling process is typically in the best interest of the client (Glosoff & Pate, 2002). Still others note that the legal rights of parents/guardians cannot be dismissed and that parents/guardians should be involved if a minor does not fall under a mature minor classification. Huss, Bryant, and Mulet (2008) have made the case that to establish an ethical and collaborative process, school counsellors should create agreements between students, parents/guardians, school administration, and themselves so that clearly defined, agreed-upon conditions are present.

Lehr et al. (2007) conducted research with school counsellors in Nova Scotia, Canada regarding confidentiality and informed consent. While most of the participants stated that the age for consent should be set at 16, some said 14. Others thought that all high school students should be able to provide their own consent, whereas some identified the ages of 17, 18, and 19 as being appropriate (Lehr et al., 2007). Participants in this study reported feeling conflicted about issues related to the autonomy of minors and the perceived rights of others who are considered to be responsible for those minors (Lehr et al., 2007).

The Current Study

The aim of the current study was to add to the limited amount of empirical research on the subject of informed consent in school contexts, particularly for practice with different-aged youth. Informed consent is an integral part of the counselling process, but informed consent practices tend to be varied, as are perspectives on the most appropriate ways to obtain informed consent in schools. This study elucidates current practices of school counsellors, which has the potential to open dialogue and encourage a closer consideration of *best practice* in this area.

Methodology

This study utilized a survey method to examine how school counsellors working within the province of

Newfoundland and Labrador obtain informed consent for counselling minors at differing age levels. The survey used in this research was developed by Dr. David Beeman (1991) and subsequently modified, with permission, by the current authors.

Participants

In total, 195 school counsellors in the province of Newfoundland and Labrador were invited to participate in this study. Participation involved reviewing an electronic informed consent form, providing consent, and then following a link at the end of the informed consent form to complete the online survey. One-hundred and twenty-three school counsellors completed the electronic survey, resulting in a response rate of 63.08%.

Sampling

Participants in this study were school counsellors from the English-speaking school districts in Newfoundland and Labrador. These districts were the Eastern, Nova Central, Western, and Labrador school districts.[1]

In the case of the Eastern school district, which required that permission also be obtained from the principal/s of each school, the researchers emailed and telephoned each principal in an effort to obtain written and/or verbal consent before proceeding with sending the electronic invitations to the respective school counsellors. Four out of 117 principals who had school counsellors working at their schools denied permission to have the researchers contact their school's counsellor. Once consent was received from the other school principals, an invitation e-mail was sent to school counsellors inviting them to participate in the study.

Research Design and Data Analysis

The survey utilized in this study was administered electronically via an electronic survey platform system to all school counsellors in the four English-speaking school districts of Newfoundland and Labrador. After the proper permissions were obtained from school district personnel, and in some cases school principals, school counsellors were contacted via e-mail with an invitation to participate. In this email, counsellors were provided with a link, which allowed them to access the informed consent form and the survey.

Two weeks after the initial invitation was sent to potential participants, a reminder e-mail was sent. The survey was selected due to its focus on how counsellors navigate issues of informed consent when working with their minor clients. As noted above, it was modified to also examine how informed consent practices vary depending on the particular ages of the minors with whom counsellors are working. It was also shifted to focus on a school context. Participants were asked to provide demographic information (i.e., sex, age, education, years of experience, nature of counselling position, grades and courses taught, theoretical orientation) and school information (i.e., location of school/s, type of school/s serviced, approximate amount of time spent counselling students). As an extra incentive to participate, counsellors could e-mail their names and addresses to be entered into a draw for a $25 gift card.

[1] As of 2013, these districts have been amalgamated into one English district.

All data was transferred from the online data platform into an SPSS datafile. Following this transfer, data was manually hand checked to ensure an accurate data transfer. Data was analyzed using SPSS to explore the study research questions.

Results

Demographic Variables

The sample consisted primarily of female participants (n = 84, 72.4%) and half of the participants (n = 59, 50.9%) fell into the 41-50 age range (see Tables 1 and 2). Participants reported a range of theoretical counselling orientations (see Table 3). A majority of the sample (n= 53, 46.1%) reported that they were primarily working with children aged 5-11. A little more than a third (n= 41, 35.7%) of respondents were primarily working with early adolescents (aged 12-15) and 18.3% (n=21) were primarily working with late adolescents (aged 16-18) at the time of their participation in this study. Many of the participants were working with multiple age groups of students and were able to reflect this appropriately in their responses while completing the subsequent survey questions.

Table 1
Sex and Age of Survey Participants

Characteristic	n	% of Sample
Sex		
Male	32	27.6
Female	84	72.4
Age		
Under 30	10	8.6
31-40	24	20.7
41-50	59	50.9
51-60	21	18.1
61+	2	1.7

Table 2
Years of Experience, Percentage of Counselling Allocation, and Location of School/s

Characteristic	n	% of Sample
Years of experience		
0-5	35	30.4
6-10	20	17.4
11-15	18	15.7
16-20	17	14.8
21-25	15	13
26+	10	8.7
Nature of assignment		
Full time counsellor		
Part time counsellor + other	77 37	66.4 31.9

Part time counsellor only	2	1.7
Location of school/s Urban Rural Both	 43 67 3	 38.1 59.3 2.7

Table 3
Counsellor Self-Reported Theoretical Orientations

Theoretical Models	Frequency	Valid Percent
Adlerian Existential Reality Behavioural Gestalt Cognitive Humanistic Psychoanalytic Systems/Family Transactional Analysis Eclectic Do not subscribe to a theoretical model	3 4 12 27 3 39 10 2 6 1 42 28	1.7 2.3 6.8 15.3 1.7 22.0 5.6 1.1 3.4 0.6 23.7 15.8

Current Informed Consent Practices

The first research question focused on the current informed consent practices of counsellors (i.e., obtaining informed consent from the client and/or parents/guardians) and the current practices of counsellors around parental/guardian access to client files for counsellors working with children, early adolescents, or late adolescents.

Children. A majority of counsellors (n=47, 74.6%) working with children aged 5-11 indicated that they obtain consent from the child's parents/guardians, although a sizeable percentage (n=16, 25.4%) did report no such consent practices.

A majority of counsellors surveyed (n=47, 73.4%) indicated that they also obtain informed consent directly from the child, with a smaller percentage (n=17, 26.6%) reporting no such practices.

More than ninety percent (n=47, 90.4%) of survey participants indicated that when they are working with children in the school setting, parents/guardians have access to information regarding the counselling of their children. Five participants (9.6%) reported no such access for parents/guardians.

Early adolescents. The majority of surveyed counsellors (n=42, 68.9%) who work with early adolescents aged 12-15 indicated that they *do not* obtain informed consent from the parents/guardians of the early

adolescents they are working with. Less than a third (n=19, 31.1%) do obtain such consent from parents/guardians.

Eighty-two percent (n=50) of survey participants working with early adolescents obtain informed consent for counselling from the early adolescents they are working with. Eighteen percent (n=11) do not obtain such consent.

A little more than seventy-one percent (n=37, 71.2%) of those working with early adolescents said that parents/guardians have access to information regarding the counselling of their early adolescents. Twenty-eight percent (n=15, 28.8%) reported no such access for parents/guardians.

Late adolescents. The vast majority (n=38, 97.4%) of surveyed counsellors who work with late adolescents aged 16-18 indicated that they *do not* obtain informed consent for counselling from the parents/guardians of their late adolescent clients.

Similarly, the vast majority (n=36, 90%) of surveyed participants who work with late adolescents said that they obtain informed consent for counselling from their late adolescent clients. Only four participants (10%) reported no such informed consent practices.

More than half (n=17, 51.5%) of surveyed counsellors working with late adolescents said that parents/guardians *do not* have access to information involving the counselling of their late adolescents, whereas 48.5% (n=16) of surveyed counsellors indicated that parents/guardians do have access to this counselling information.

Dimensions of Informed Consent for Parents/Guardians

The second research question focused on the informed consent dimensions that counsellors viewed as important when obtaining informed consent from parents/guardians.

When working with children aged 5-11, 40.7% of counsellors viewed going over the limits to confidentiality with parents/guardians as extremely important (see Table 4).

When working with early adolescents aged 12-15, surveyed counsellors viewed limits to confidentiality (54.7% extremely important) as an important aspect of obtaining informed consent from parents/guardians (see Table 5).

When working with late adolescents aged 16-18, counsellors also viewed limits to confidentiality (54.5% extremely important) as an important aspect of obtaining informed consent from parents/guardians (see Table 6).

Table 4

Counsellors' Views on the Level of Importance of Information to Parents/Guardians of Child Clients Aged 5-11 During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and	11	19	19	3	3	55

setting of sessions	20.0%	34.5%	34.5%	5.5%	5.5%	
The nature of the sessions and what will take place	1 1.8%	9 16.4%	25 45.5%	11 20.0%	9 16.4%	55
Limits to confidentiality	1 1.9%	0 0.0%	14 25.9%	17 31.5%	22 40.7%	54
Intended outcome of counselling	0 0.0%	1 1.9%	24 44.4%	15 27.8	14 25.9%	54
Probability of intended outcome	2 3.7%	8 14.8%	26 48.1%	12 22.2%	6 11.1%	54
Description of counsellor's orientation to counselling	28 51.9%	13 24.1%	9 16.7%	3 5.6	1 1.9%	54
Training and qualifications of counsellor	9 16.7%	15 27.8%	16 29.6%	7 13.0%	7 13.0%	54
Possible advantages of counselling	1 1.9%	2 3.7%	23 42.6%	17 31.5%	11 20.4%	54
Possible negative side effects of counselling	4 7.4%	11 20.4%	23 42.6%	11 20.4%	5 9.3%	54
Description of alternatives	5 9.4%	11 20.8%	20 37.7%	13 24.5%	4 7.5%	53
Option to refuse/withdraw counselling	2 3.8%	4 7.5%	22 41.5%	15 28.3%	10 18.9%	53

Number reflects frequency of response and percent reflects valid percentage of respondents

Table 5

Counsellors' Views on the Level of Importance of Information to Parents/Guardians of Early Adolescent Clients Aged 12-15 During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and setting of sessions	15 28.3%	17 32.1%	16 30.2%	3 5.7%	2 3.8%	53
The nature of the sessions and what	4 7.5%	9 17.0%	28 52.8%	7 13.2%	5 9.4%	53

will take place						
Limits to confidentiality	1 1.9%	2 3.8%	9 17.0%	12 22.6%	29 54.7%	53
Intended outcome of counselling	3 5.7%	2 3.8%	27 50.9%	14 26.4%	7 13.2%	53
Probability of intended outcome	5 9.4%	10 18.9%	25 47.2%	9 17.0%	4 7.5%	53
Description of counsellor's orientation to counselling	25 47.2%	16 30.2%	9 17.0%	3 5.7%	0 0.0%	53
Training and qualifications of counsellor	9 17.0%	15 28.3%	19 35.8%	8 15.1%	2 3.8%	53
Possible advantages of counselling	2 3.8%	7 13.2%	18 34.0%	18 34.0%	8 15.1%	53
Possible negative side effects of counselling	2 3.8%	11 21.2%	26 50%	9 17.3%	4 7.7%	52
Description of alternatives	3 5.8%	13 25.0%	18 34.6%	12 23.1%	6 11.5%	52
Option to refuse/withdraw counselling	5 9.4%	3 5.7%	19 35.8%	16 30.2%	10 18.9%	53

Number reflects frequency of response and percent reflects valid percentage of respondents

Table 6

Counsellors' Views on the Level of Importance of Information to Parents/Guardians of Late Adolescent Clients Aged 16-18 During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and setting of sessions	15 45.5%	11 33.3%	3 9.1%	4 12.1%	0 0.0%	33
The nature of the sessions and what will take place	9 27.3%	11 33.3%	9 27.3%	3 9.1%	1 3.0%	33
Limits to confidentiality	1 3.0%	0 0.0%	4 12.1%	10 30.3%	18 54.5%	33
Intended outcome of counselling	4 12.5%	6 18.8%	14 43.8%	5 15.6%	3 9.4%	32
Probability of	8	8	11	4	1	32

intended outcome	25.0%	25.0%	34.4%	12.5%	3.1%	
Description of counsellor's orientation to counselling	15 46.9%	9 28.1%	8 25.0%	0 0.0%	0 0.0%	32
Training and qualifications of counsellor	5 16.1%	7 22.6%	13 41.9%	4 12.9%	2 6.5%	31
Possible advantages of counselling	3 9.4%	3 9.4%	8 25.0%	11 34.4%	7 21.9%	32
Possible negative side effects of counselling	4 12.5%	7 21.9%	13 40.6%	6 18.8%	2 6.3%	32
Description of alternatives	4 12.1%	4 12.1%	14 42.4%	6 18.2%	5 15.2%	33
Option to refuse/withdraw counselling	6 18.2%	2 6.1%	10 30.3%	7 21.2%	8 24.2%	33

Number reflects frequency of response and percent reflects valid percentage of respondents

Dimensions of Informed Consent for Clients

The final research question in this study focused on the dimensions of informed consent counsellors viewed as important when obtaining informed consent from their clients. When working with *children* aged 5-11, counsellors viewed limits to confidentiality (44.4%, extremely important) as being a critical component of obtaining informed consent from the client (see Table 7). When working with *early adolescents* aged 12-15, counsellors viewed limits to confidentiality (69.2%, extremely important) as a critical dimension of obtaining informed consent from the client (see Table 8). When working with *late adolescents* aged 16-18, counsellors viewed limits to confidentiality (79.4%, extremely important) and option to refuse or withdraw counselling (46.9%, extremely important) as needed dimensions when obtaining informed consent from clients (see Table 9).

Table 7
Counsellors' Views on the Level of Importance of Information to Child Clients Aged 5-11 During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and setting of sessions	4 7.4%	9 16.7%	21 38.9%	16 29.6%	4 7.4%	54
The nature of the sessions and what will take place	1 1.9%	2 3.7%	24 44.4%	18 33.3%	9 16.7%	54
Limits to	1	1	14	14	24	54

confidentiality	1.9%	1.9%	25.9%	25.9%	44.4%	
Intended outcome of counselling	1 1.9%	6 11.1%	23 42.6%	15 27.8%	9 16.7%	54
Probability of intended outcome	8 15.1%	9 17.0%	20 37.7%	12 22.6%	9 17.0%	53
Description of counsellor's orientation to counselling	36 69.2%	8 15.4%	8 15.4%	0 0.0%	0 0.0%	52
Training and qualifications of counsellor	27 50.9%	9 17.0%	10 18.9%	4 7.5%	3 5.7%	53
Possible advantages of counselling	1 1.9%	6 11.3%	20 37.7%	18 34.0%	8 15.1%	53
Possible negative side effects of counselling	11 20.8%	14 26.4%	17 32.1%	6 11.3%	5 9.4%	53
Description of alternatives	13 25.0%	12 23.1%	18 34.6%	8 15.4%	1 1.9%	52
Option to refuse/withdraw counselling	5 9.6%	4 7.7%	19 36.5%	13 25.0%	11 21.2%	52

Number reflects frequency of response and percent reflects valid percentage of respondents

Table 8

Counsellors' Views on the Level of Importance of Information to Early Adolescent Clients Aged 12-15 During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and setting of sessions	3 5.7%	8 15.1%	23 43.4%	9 17.0%	10 18.9%	53
The nature of the sessions and what will take place	0 0.0%	3 5.7%	20 37.7%	17 32.1%	13 24.5%	53
Limits to confidentiality	0 0.0%	0 0.0%	8 15.4%	8 15.4%	36 69.2%	52
Intended outcome	0	2	21	22	8	53

of counselling	0.0%	3.8%	39.6%	41.5%	15.1%	
Probability of intended outcome	0 0.0%	12 22.6%	24 45.3%	10 18.9%	7 13.2%	53
Description of counsellor's orientation to counselling	31 58.5%	11 20.8%	7 13.2%	3 5.7%	1 1.9%	53
Training and qualifications of counsellor	22 41.5%	11 20.8%	12 22.6%	5 9.4%	3 5.7%	53
Possible advantages of counselling	1 1.9%	7 13.2%	21 39.6%	17 32.1%	7 13.2%	53
Possible negative side effects of counselling	4 7.5%	16 30.2%	21 39.6%	6 11.3%	6 11.3%	53
Description of alternatives	2 3.8%	13 25.0%	21 40.4%	12 23.1%	4 7.7%	52
Option to refuse/withdraw counselling	1 1.9%	4 7.5%	15 28.3%	16 30.2%	17 32.1%	53

Number reflects frequency of response and percent reflects valid percentage of respondents

Table 9

Counsellors' Views on the Level of Importance of Information to Late Adolescent Clients Aged 16-18 During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and setting of sessions	1 2.9%	4 11.8%	15 44.1%	8 23.5%	6 17.6%	34
The nature of the sessions and what will take place	1 2.9%	2 5.9%	13 38.2%	10 29.4%	8 23.5%	34
Limits to confidentiality	0 0.0%	0 0.0%	4 11.8%	3 8.8%	27 79.4%	34
Intended outcome of counselling	0 0.0%	1 3.0%	10 30.3%	11 33.3%	11 33.3%	33
Probability of intended outcome	0	7 21.2%	15 45.5%	6 18.2%	5 15.2%	33

	0.0%					
Description of counsellor's orientation to counselling	9 26.5%	12 35.3%	10 29.4%	1 2.9%	2 5.9%	34
Training and qualifications of counsellor	8 23.5%	9 26.5%	10 29.4%	5 14.7%	2 5.9%	34
Possible advantages of counselling	1 2.9%	3 8.8%	14 41.2%	8 23.5%	8 23.5%	34
Possible negative side effects of counselling	4 12.5%	8 25.0%	12 37.5%	5 15.6%	3 9.4%	32
Description of alternatives	1 2.9%	6 17.6%	14 41.2%	7 20.6%	6 17.6%	34
Option to refuse/withdraw counselling	2 6.3%	2 6.3%	9 28.1%	4 12.5%	15 46.9%	32

Number reflects frequency of response and percent reflects valid percentage of respondents

Discussion

Informed consent is an important aspect of a client-counsellor relationship. Research has shown the importance of consent throughout counselling to facilitate trust and respect, which can enhance therapeutic gains (Beahrs & Gutheil, 2001; Fisher & Oransky, 2008). Informed consent practices can vary and such variations seem to be apparent when it comes to school counsellors' work with minors. Many counselling organizations and school boards have not established policies related to informed consent for counselling which can result in inconsistencies in practice.

Informed Consent and Information Sharing Practices

Researchers have documented the value of informed consent for the counselling relationship. Obtaining consent can demonstrate respect for clients, by acknowledging a person's right to make decisions (Crowhurst & Dobson, 1993; Glosoff & Pate, 2002; Goddard, Murray, & Simpson, 2008; Henkelman & Everall, 2001; Martindale, Chambers, & Thompson, 2009). Such respect can serve to build the therapeutic alliance (Fisher & Oransky, 2008; Lyden & Peters, 2004).

Inherent in professional judgment is a certain degree of subjectivity, and so there tends to be some variability in practice. Some of these variances were noted in the results of the current study. Yet, there were also many similarities and patterns. The majority of survey participants who worked with children aged 5-11 indicated that they generally obtain consent from their child clients as well as the parents/guardians of their child clients. A general trend was noted in the survey results such that as the age of the students increased, there was an increased tendency to obtain consent from student clients and a lower likelihood of seeking consent from parents/guardians.

A similar trend was noted for access to counselling information. As the ages of the students increased, the percentage of counsellors who permitted parents/guardians to have access to counselling information regarding their children decreased. These findings corroborate Wagner's (1981) study, which showed that counselling practices in an elementary school may look very different from practices in a high school – elementary school counsellors often tend to adopt a more liberal practice around providing confidential information to parents/guardians than do those who work with an older student population.

As the subject of competency of minors to provide consent for their own treatment has long been the source of considerable debate, the responses of counsellors to the questions raised in the current study are likely unsurprising. As was suggested by Isaacs and Stone (1999), the younger the age of the client, the more control that is extended to parents/guardians to make decisions concerning their children. Research conducted by Weithorn and Campbell (1982) supports the idea that younger children have more limited abilities in terms of reasoning and understanding treatment information as compared with their adolescent and adult counterparts. Many counsellors therefore feel that their children clients require someone with the capacity and competence to make decisions in their best interest by providing proxy consent or, at least, in addition to the consent or assent that the child has given.

While the majority of survey respondents reported that they obtain informed consent from both parents/guardians and children aged 5-11, approximately a quarter noted that they do not obtain consent from the parents/guardians of the children they work with, and a similar percentage do not obtain consent from the children themselves. In relation to early adolescents aged 12-15, eighty-two percent (82%) of survey respondents reported that they obtain consent from the students, and close to sixty-nine percent (68.9%) responded that they do not obtain consent from the early adolescents' parents/guardians. For those working with late adolescents aged 16-18, the vast majority (97.4%) of counsellors said that they do not obtain consent from the students' parents/guardians, while ninety percent (90%) do obtain informed consent from the students themselves. A minority of survey respondents who work with late adolescents (10%) are not obtaining informed consent from the late adolescents with whom they work.

While there were certainly some patterns noted in terms of informed consent practices of school counsellors who work with minors in Newfoundland and Labrador, there remains a degree of inconsistency as well. This is unsurprising and some discrepancy is to be expected given the lack of clear guidelines and established policies around informed consent within many school districts and organizations. When considering the specialization of counselling in many settings and particularly in schools, the lack of policies related to informed consent make more sense. Counsellors who work within schools often operate as 'islands' - meaning that they are typically one of the only professionals in the school setting who truly understand the job scope and what the role entails. Few other educational professionals who work within schools have received the training and background that would lend itself to a true understanding of a school counsellor's role.

Of course, in the formation of any informed consent guidelines, counsellors themselves should undoubtedly take some sort of lead position so that the relevant ethical principles can be applied and the counsellors can draw upon their experiences and expertise to provide input. Any such framework should be put into place to protect clients and counsellors alike, as opposed to promoting a culture of distrust or fear amongst counsellors. Basic guidelines could help mitigate ambiguity while at the same time instilling a sense of security in times of uncertainty or when making difficult decisions. A policy

framework should, however, be guiding in principle and still allow for some flexibility and the implementation of sound clinical judgment on the part of the professional school counsellor.

Relevant Informed Consent Information to Parents/Guardians and Clients

In the examination of informed consent practices, it is important to consider what exactly informed consent means. What information should be given to whom, and to what extent? Unsurprisingly, counsellors' practices related to the provision of information often differ.

The existing literature on informed consent is fairly consistent in suggesting that there are at least three elements that should be present in order for truly informed consent to be obtained: competency, knowledge, and voluntariness (Batten, 1996; Beeman & Scott, 1991; Cahana & Hurst, 2008; Croxton et al., 1988; Henkelman & Everall, 2001; Lyden & Peters, 2004; Saks & Jeste, 2006).

To satisfy the 'knowledge' component, the appropriate type of counselling information has to be provided in an appropriate manner to certain stakeholders. The companion manual to the *Canadian Code of Ethics for Psychologists* suggests that as much information should be provided as any 'reasonable' person would want to know before agreeing to participate in the counselling (CPA, 2001). A study by Jensen, McNamara, and Gustafson (1991) illustrated that clinicians and clients alike felt that confidentiality (and its limits), fee structuring, therapeutic benefits, and iatrogenic risks were among the most important pieces of information that should be shared during the informed consent process. These results were similar to that of Braaten and Handelsman's 1997 study, which found that the most highly rated pieces of informed consent information included confidentiality, therapeutic techniques, and the risk of alternative treatments. Comparably, a 1991 study by Beeman and Scott also found that the most highly rated pieces of informed consent information were the limits to confidentiality; the intended outcome of therapy; the nature of the sessions; and the time, place, duration, and setting of the sessions. Across all three studies, confidentiality and its limits, in particular, were consistently rated important. Importantly, counselling in a school setting typically comes with its own set of unique challenges related to confidentiality and the limits of confidentiality. Schools often encourage open and clear communication with all members on a student's team, and so school counsellors often find themselves trying to strike a very difficult balance between protecting the privacy of their students but still keeping relevant staff 'in the loop' as much as possible when it is deemed to be in the best interest of the student.

The current study focused a great deal on what information counsellors deem important to be provided to minors of different age groups as well as to the parents/guardians of those minors. This has not been an area of focus in the research literature, and additional study would therefore be warranted to more closely examine how counsellor practices vary depending on the age of clients. There were variations noted in the current study with regard to the type of information counsellors consider to be important to provide to the children, early adolescents, and late adolescents with whom they work – as well as to these clients' respective parents/guardians.

The survey results show that the top three most highly rated pieces of informed consent information that counsellors felt should be shared with parents/guardians of *children* were the limits to confidentiality, the intended outcome of counselling, and the advantages of counselling. The top three most highly rated pieces of information changed slightly for counsellors working with *early adolescents*: limits to confidentiality, option to refuse/withdraw from counselling, and possible advantages of counselling. These findings were very similar to the reports of those working with *late adolescents,*

where the three most important pieces of informed consent information to be shared with parents/guardians were identified as limits to confidentiality, option to refuse/withdraw from counselling, and possible advantages of counselling.

With regard to the provision of information to the clients themselves (in the various age level groups), there were some differences noted, but also some important similarities. Limits to confidentiality and the option to refuse/withdraw were consistently rated as critical dimensions of informed consent.

Although the limits of confidentiality were consistently ranked as being 'extremely important' by survey respondents, a steady increase in percentage was noted as the age of the students increased. Therefore, in the creation of policies related to informed consent, policy-makers would likely need to carefully consider at what age it is appropriate to address confidentiality and its limits with students in a school counselling context.

Further studies would be warranted to more closely examine trends in how the types of information shared during the informed consent process vary based on client ages. Additional research would also aid in the promotion of a bigger-picture dialogue regarding the rights of, minor clients and parents/guardians of minors - as well as the types of information various stakeholders should be privy to prior to the commencement of counselling and throughout the ongoing counselling relationship in a school context.

Concluding Comments

Obtaining informed consent demonstrates respect for the client. Such respect helps to facilitate and strengthen a therapeutic relationship between counsellor and client. Informed consent can also serve to protect counsellors against potential ethical and legal liability.

Some degree of ambiguity is inherent in the process of obtaining informed consent and, thus, there will always be a need for professional judgment. Having said that, the development of further policies and guidelines could help support counsellors in a school context in making informed consent decisions. In the creation of such policies and guidelines, a more in-depth examination of informed consent practices of those who work with minors of different ages would be beneficial. Results of the current study, which highlight common practices and the core pieces of informed consent information that are shared during the informed consent process in school-based counselling, offer important lessons for policy development.

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