

How Private Is Private?

A Review of the Law and Practice of Counsellor-Client Confidentiality in Canada and its Exceptions

By George K. Bryce¹ and Adrienne Mahaffey²

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¹ **George Bryce** (B.A., B.Sc., M.H.A., LL.B.) George is lawyer and mediator with more than fifteen years experience in administrative law, professional governance, legal research, opinion writing and social policy analysis. George has been legal counsel for the BCACC since 1993, and was honoured in 1999 with the President’s Award for Distinguished Contributions to the Profession of Counselling and the Association. He has made a number of presentations on a wide range of legal and policy issues, and authors *The Counsellor’s Counsel*, a regular column in *Insights*, the membership publication of the BCACC.

² **Adrienne Mahaffey** (B.Comm., LL.B., M.A.) Adrienne is the current Chair of Ethics and Standards for the BCACC, and conducts her private counselling practice with the Alpine Anxiety and Stress Relief Clinic in Vancouver. She has also served as a Director at Large for the BC Chapter of the CCA. Adrienne's interest in ethics and confidentiality issues arises out of her background as a lawyer in a litigation practice. She has been an instructor at local colleges and training institutes, and has made presentations before a diverse range of legal and counselling organizations.

INTRODUCTION

This paper contains the full text and additional information in support of our presentation “How Private Is Private?” that was given at the CCA/BCACC Conference 2007, *Connecting with our Clients: Counselling in the 21st Century*, held in Vancouver, BC in May, 2007. This paper is being posted at the conference website and elsewhere so that all counsellors may have access to the information that we presented, including the references and reading materials that are set out in the last chapter.

We start by defining a counsellor’s duty of confidentiality and consider some of its exceptions. We then explain why counsellor-client confidentiality is important to an effective counselling relationship, and provide some examples of when confidentiality can be compromised. This leads us to consider the legal consequences of breaches of the duty of confidentiality. Next, we consider situations when a counsellor may have an overriding duty to breach confidentiality. Then, after discussing a client’s rights to access the clinical record and to request corrections to that personal information, we review what counsellors should do if a third-party requests a copy of the counsellor’s clinical records. This moves us to consider the issues of privilege and then consent. We end our presentation by discussing Canada’s new personal information protection legislation for the private sector. We hope that, by the end, we will have answered the question posed by the title of our presentation: *How private is private?*

A Caution

We have attempted to consider the legal issues raised in this paper from a national perspective, however, time and resources have limited our ability to read every applicable federal, provincial or territorial statute and regulation, or to study the reported court or tribunal decisions that have considered the numerous pieces of legislation or have helped to develop the common law (or the civil law in Quebec) on the topic of our paper. Thus, in the interests of being national in scope, we have had to be general in our commentary. We may have over-looked a specific section in one statute or case from one jurisdiction that would suggest that the law in that jurisdiction is different from what it is elsewhere in Canada. Therefore, we advise counsellors to obtain independent legal advice for any questions or concerns they may have concerning how the legal topics covered in this paper may apply to their particular clinical practice in their specific province or territory.

The law that we have considered in preparing this paper is current to March 1, 2007.

1) DEFINING THE DUTY OF CONFIDENTIALITY

A counsellor's duty of confidentiality is a legal obligation that has its foundation in English common law, finds expression in professional codes of ethics for counsellors, and – more recently – has been encoded in Canadian privacy legislation. (We will set out the framework for Canada's new privacy legislation in more detail in Chapter 10.)

The concept of confidentiality is often confused with the legal claim of privilege. In our presentation we will clarify these two concepts and, in particular, explain their relationship to each other. We will begin by defining the duty of confidentiality.

What is a counsellor's duty of confidentiality?

A counsellor's duty of confidentiality can be summarized: "A counsellor must not disclose confidential client information."

Like many legal and ethical duties, the duty of confidentiality is not absolute; there are exceptions. An obvious exception is when the client consents to a counsellor disclosing confidential information to some third party. There are also a number of mandatory disclosures, where the law requires a counsellor to breach the duty of confidentiality to achieve some greater social policy objective. We will have more to say about the legally required or authorized disclosures later in Chapters 4 and 5. For now, it is useful to consider the nature and scope of the general duty before considering its exceptions.

While we can find no reported cases where a Canadian court has found that a counsellor or counselling therapist owed a client a duty of confidentiality, the common law has established a clear legal precedence for such a duty. Counsellors would be wise to adopt and follow the common law rule, rather than become the source of a new Canadian legal precedence by failing to do so.

In a 1982 case, Solicitor General of Canada v. Royal Commission of Inquiry re: Health Records, the Supreme Court of Canada was considering the issue of police-informer privilege where the informer was a physician who had disclosed confidential information about his patient to the police. In considering a physician's duty of confidentiality, the majority of the Court pointed out that there is a legal duty on doctors *not* to disclose information to the police or others. The Court also observed that a duty of confidentiality is often also encoded in professional codes of ethics.

Six years later, the Supreme Court of Canada again discussed the duty of confidentiality in a criminal law case: R. v. Dyment, 1988.³ In considering the *Charter* arguments raised in this appeal, the majority of the Court observed:

³ In this case, a doctor had treated Mr. Dyment in a hospital after Mr. Dyment had been in a traffic accident. The doctor collected a vial of free-flowing blood for medical purposes without Mr. Dyment's knowledge or consent. Shortly after, Mr. Dyment explained to the doctor that he had consumed a beer and medication. The doctor, after taking the blood sample, spoke to the police officer who had attended at the accident and - at the end of their conversation – the doctor gave the officer the patient's sample. After the sample was analyzed, Mr. Dyment was then charged and later convicted of impaired driving. At the time, s. 237(2) of the *Criminal Code* did not require a person to give a blood sample. At issue before the Supreme

The use of a person's body without his consent to obtain information about him invades an area of privacy essential to the maintenance of his human dignity. The doctor, whose sole justification for taking the blood sample was that it was to be used for medical purposes, had no right to take it for other purposes or to give it to a stranger for non-medical purposes unless otherwise required by law, and any such law would be subject to *Charter* scrutiny. The *Charter* protection extends to prevent a police officer or agent of the state from taking an intimately personal substance, such as blood, from **a doctor who holds it subject to a duty to respect a person's privacy** (*our emphasis*).

A counsellor's duty of confidentiality also finds expression in professional codes of ethics, such as:

- a) Canadian Counselling Association, *Code of Ethics* (January 2007) at topic B2. *Confidentiality* states: "Counselling relationships and information resulting there from are kept confidential."
- b) American Association for Marriage and Family Therapy, *Code of Ethics* (July 1, 2001) at Principle II, *Confidentiality*, states (in part): "Therapists respect and guard the confidences of each individual client. ... 2.2 Marriage and family therapists do not disclose client confidences. ... 2.4 Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards."
- c) British Columbia Association of Clinical Counsellors, *Code of Ethical Conduct* (March 2004) at topic 4, *Confidentiality*, states (in part): "The assurance of privacy is an important factor in facilitating the therapeutic alliance between counsellor and client... . Counsellors respect and uphold client rights to privacy regarding all content and records of counselling sessions... ."

We have quoted from these professional codes the basic duty of confidentiality, but not included any of the exceptions. We will address these in more detail later in Chapter 4.

More recently, the federal and some of the provincial governments have established personal information protection legislation that sets national standards for the use, collection and disclosure of personal information in the private sector. Certain provisions of this new legislation appear to have replaced the common law duty of confidentiality, as least it applies to health care providers who work in the private sector. In brief, this new legislation declares that practitioners are responsible for personal information under their control, including information that is not in their custody but

Court of Canada was whether: (1) the police officer's taking of the blood sample amounted to a seizure contemplated by s. 8 of the *Canadian Charter of Rights and Freedoms*; (2) and that such taking amounted to unreasonable search and seizure; and (3) the evidence of the blood analysis should be excluded under s. 24(2) of the *Charter*.

under their control.⁴ More to the point, such practitioners may only disclose an individual's personal information without consent in a limited number of narrowly defined circumstances. (Again, we will discuss the privacy legislation further in Chapter 10.)

When does the duty arise?

In most situations, the duty of confidentiality will arise during the counselling session, when the client tells the counsellor directly about the problem the client is trying to deal with, in particular when the client discloses sensitive personal information. The duty of confidentiality arises as soon as a client tells or gives the counsellor personal information. Therefore, a counsellor does not have a duty if the counsellor has not received any private or confidential information about the client.

On the other hand, a counsellor does not have a duty of confidentiality if the counsellor obtains information about a client from a public source outside the clinical setting, such as information about the client that is broadcasted in print media, over the radio, on television or through the internet. If the counsellor obtained the same information from the client as was disclosed to the public outside the clinical setting, the counsellor's duty would not extend to keeping that public information about the client confidential. However, the counsellor would have a duty in relation to the other non-public information that the client provided during the counselling session.

To who is this duty owed?

The duty of confidentiality is a duty that is owed by the counsellor to the person whose personal information the counsellor has obtained.

Obviously, the counsellor has a duty to the client who tells or gives the counsellor specific information about his or her personal circumstances. The counsellor would owe the same duty if that client information was collected by an assistant or someone else on behalf of the counsellor for the purposes of providing counselling services to that client.

But a counsellor also appears to owe a duty of confidentiality to third parties who are not clients but whose information the counsellor also may obtain. This particular formulation of the duty does not appear to be well expressed in professional codes, which tend to focus on the client providing confidential information to the counsellor as the triggering event. This expression of the duty may also not be fully developed in the common law, but Canada's new private sector privacy legislation appears to create such a version of the duty.

Canada's new privacy legislation provides that a counsellor may only disclose an individual's private information without consent in one of a series of narrowly prescribed circumstances. This statutory duty of confidentiality appears to apply equally to the

⁴ For example, if a practitioner has collected personal information from or about a client but stores that information at an off-site location, the security of that information remains the responsibility of that practitioner.

information that a counsellor collects from the client that is about that client and to information that is about a third party which is provided to the counsellor by the client during a clinical session, or even about any non-public third party information that may be obtained some other means. (Again, we will discuss the new privacy legislation further in Chapter 10.)

While there have been no reported cases on these new legislative provisions, Canada's new privacy legislation does appear to provide a new way to look at the duty of confidentiality. Rather than focusing the duty on the person who provided the counsellor with the information, *the duty is owed to the person who is the subject of the personal information that has been collected*. Thus, the counsellor owes a duty to the client who provided his or her own personal information *and* to any third party whose information the client may also have provided to the counsellor.

We therefore may want to change our language. From now on we should perhaps *not* refer to "counsellor-client confidentiality", but instead speak of the broader "duty of confidentiality over any person's personal information" that a counsellor may obtain or collect during counselling regardless of its source.

2) THE IMPORTANCE OF PRIVACY (AND CONFIDENTIALITY) IN THE THERAPEUTIC CONTEXT

Privacy is perhaps best defined as the opportunity for individuals to control the access to themselves by others (DuBois, 2004, p. 315). The therapeutic relationship inevitably requires a client to relinquish some privacy “in exchange for the prospect of therapeutic understanding and assistance” (Smith Bell and Winslade, 1994, p. 183). In addition, as discussed above, the therapeutic relationship frequently leads to disclosure of private information about people who are not present: spouses, bosses, parents, children, siblings and many others. These individuals have the same interest in controlling access to their private information, and not infrequently it is an interest that is shared by the client. The client may well not even make a distinction between his or her own private information and that of the third party.

Likewise the research around privacy in the counsellor-client context has a tendency to focus on the client’s personal information, without attempting to distinguish different privacy interests. Nevertheless, even if privacy interests are clearly separable in all the circumstances, a privacy breach involving third party information can damage the client and the therapeutic relationship, either as a result of the disclosure itself, or because such disclosure may lead the client to wonder if his or her own personal information has been safely confided. Certainly, a counsellor can do harm to that third party by such disclosure.

The nature of privacy as the general public understands it (and expects it) can vary widely. One author outlined four types of privacy:

1. *Physical privacy*: spatial seclusion and isolation;
2. *Informational privacy*: confidentiality, secrecy, data protection and control over personal information;
3. *Proprietary privacy*: control over names, likenesses and repositories of personal identity;
4. *Decisional privacy*: who makes or influences important decisions concerning personal items such as friendship, health, sex, religion, politics, or marriage.

(Allen, 1999 as cited in Monshi and Zieglmayer, 2004, p. 309).

Privacy in a clinical setting is a functional aspect of all of these forms of privacy, although we often emphasize just informational privacy.

Dilemmas and Discussions

While it is commonly understood that one basis for a healthy relationship is respect for the privacy of the other, we are frequently confronted with certain dilemmas when we seek to define and apply this respect in a therapeutic context. These are not trivial dilemmas.

Clinical research indicates that the strength and quality of the clinical relationship has an important impact on the outcome of the therapy (Lambert and Barley, 2001, p. 359).

Moreover ... privacy violations can harm people in numerous ways, especially when the information shared is sensitive. Sieber (2001) lists six kinds of harm that can arise from privacy violations: inconvenience, psychological, physical, social, economic, and legal. Some violations of privacy can obviously lead to several of these harms at once (DuBois, 2004, p. 315).

The trust conveyed through promising and maintaining confidentiality is so critical that many psychological services may well be worthless without it (Truscott and Crook, 2004, p. 67).

Trust is an important indicator of a strong relationship. Without the client's trust that his or her privacy will be respected, there will likely be no useful therapy. If there is no trust there is no safety; if there is no safety the relationship is not healing. Even more concretely:

[T]he information necessary to make a proper psychotherapeutic diagnosis must almost always come from the patient, since it requires full disclosure of the patient's innermost feelings, fantasies, terrors and shame in a safe environment. A patient who does not expect confidentiality from the therapist may not make the necessary disclosures, making the diagnosis inaccurate; if the diagnosis is inaccurate the patient may be treated incorrectly (Smith Bell and Winslade, 1994, pp. 188-189).

In other words, not only must the counsellor be trustworthy, the client must be made *aware* that the counsellor is trustworthy in order to benefit from (and not be harmed by), the therapy and the therapeutic alliance.

One of the dilemmas confronting counsellors, therefore, is the seemingly simple question of how we can *demonstrate* respect for privacy. From this direction, confidentiality, and rules around confidentiality, can be viewed as attempts to create a framework, in terms of respect for the privacy of the client, which offers the client some control and hence, some sense of safety over disclosure of personal information. Confidentiality as a practice can then be communicated to the client and visibly applied by the counsellor. One author offered the following explanation:

Privacy refers to the freedom of individuals to choose for themselves the time and the circumstances under which and the extent to which their beliefs, behavior, and opinions are to be shared or withheld from others.

Confidentiality involves professional ethics rather than any legalism and indicates an explicit promise or contract to reveal nothing about an individual except under conditions agreed to by the source or subject (Siegel, 1979, p. 251).

Professional ethics for healers around confidentiality date back at least to the Hippocratic Oath: “Whatsoever I shall see or hear in the course of my professional in my intercourse with men, if it be what should not be noised abroad, I will never divulge, holding such things to be holy secrets” (as cited in Siegel, 1979, p. 252). Even the Hippocratic Oath, however, does not attempt to outline “what should not be noised abroad”, and initially these questions were presumably left to the social and ethical judgment of the healer.

The need for ethical judgment makes considerable sense in a multicultural environment and with a global perspective. A study done in Sri Lanka points out that health issues there are generally considered to be issues for the entire family, and as such privacy interest, or the interest in controlling access to self, lies in *sharing* health information with at least some, rather than keeping it secret from all. A violation of the privacy interest in sharing certain information could cause significant discomfort and harm (Monshi and Zieglmayer, 2004; DuBois, 2004). In addition to a purely cultural perspective, individuals, depending on their stage of development (Laufer & Wolfe, 1977, as cited in DuBois, 2004, p. 314), and personal preference, also have varying notions as to what constitutes privacy. In some way, modern ethical decision making processes must account for the reality that:

The private life is not a natural fact; it is a historical reality that is constructed in different ways by various societies. There is no private life that has well-determined boundaries established once and for all. What does exist is the attribution of human action to the private or to the public sphere, which itself is subject to change (Prost, 1993, as cited in Monshi and Zieglmayer, 2004, p. 311).

Codifying what ethics apply around confidentiality as a visible manifestation of privacy is therefore something of a social adventure. The very basis for ethical principles, including the ethics underlying confidentiality, is sometimes a subject of discussion; are ethics purely utilitarian, the greatest good for the greatest number, are they intrinsically “right”, or do they reflect pure moral values? (Kampf and McSherry, 2006, p. 125; Knapp and Vandecreek, 2006, pp. 15-23).

Most modern ethical codes take a values-based approach, and regard confidentiality as an expression of values such as autonomy or respect for the person. Many have specific rules of behaviour around particular situations where the consequences of making even a single misjudgment are deemed to be extraordinarily severe. For whatever remains, codes frequently incorporate a recommended approach to ethical decision-making, applying these underlying values.

From a values-based perspective, then, the need for judgment as exemplified by the Hippocratic Oath is not and should never be outmoded. On occasion this represents an alarming responsibility. The need to make decisions and communications around confidentiality in a culturally, socially, and personally sensitive manner is a second

dilemma confronting counsellors. Decisions around confidentiality are not easy decisions.⁵

Current Expectations of Confidentiality

In a 2002 study, patients in the Western medical system were surveyed on their views of confidentiality. This study suggested that the majority of patients felt that only they themselves could normally consent to the release of their own information, while just over one third agreed that under certain circumstances, permission may not be needed. Over three quarters supported disclosure if other people were at risk (Jones, 2002). While these results were not limited to psychological or psychiatric treatment, they may serve as a starting point for our discussion of clients' attitudes towards confidential information generally.

Clearly, people involved in a Western medical community expect a high degree of confidentiality in the treatment of their personal health care information. "Clients assume or seek assurances that sensitive information will be ... confidential ..., and unless they can trust the counsellor and rely on confidentiality, they are unlikely to cooperate fully in the therapy" (Smith Bell and Winslade, 1994, p. 180). In one study, clients were asked to rate the degree to which they would be comfortable with disclosure to romantic partners, friends, university personnel (the study participants were clients in a university counselling centre), parents, employers and insurance companies. The vast majority of clients preferred that none of these people be recipients of personal information the clients disclosed in therapy (VandeCreek et al, 1987, p. 65). While these studies are somewhat dated, the likelihood is that there has been at least no dramatic change to confidentiality expectations.

These expectations occur against a backdrop in which increasingly a balance must somehow obtain between the rights of the individual and the rights of a group or society. For example, what are and should be the confidentiality expectations of a client in group or family therapy, or where there is another third party involved or paying for the therapy such as a government agency, employer, insurer, or court of law? While there seems to be reasonably broad acceptance that if harm to another is involved, disclosure may be paramount, there is still a need to be able to make such decisions in consideration of the individual circumstances. The client or others may disagree with the counsellor's assessment of harm. Additionally, some authors have pointed out that court proceedings can substantially transform a counsellor's role or perceived role from one of therapist to either supporter or adversary (Smith-Bell and Winslade, 1994, p. 189).⁶ Out of these types of necessities come many limits on confidentiality with which clients may or may not be familiar, and which may occur with or without the consent of the client. "[T]he balance (or imbalance) between the right of the individual to privacy and the need of the public to know is clearly in question" (Siegel, 1979, p. 251).

⁵ For an excellent book providing examples and detailed discussion of these types of decisions, see Levin, C., Furlong, A. and O'Neil, M.K. (Eds). (2003). *Confidentiality: Ethical Perspectives and Clinical Dilemmas*. London: The Analytic Press.

⁶ Unfortunately, the original source for this point is incorrectly cited in the Smith-Bell and Winslade, 1994, text and consequently is not known to us.

The degree of actual confidentiality that is available may depend considerably on the counsellor's role, the purpose of the psychological activity and the legal status of the client, along with other legal and policy-based requirements (Fisher and Fried, 2003, p.107).

Breaching Confidentiality from a Practice Perspective in Order to Warn or Report

Most counsellors are probably aware that there are times (fortunately occurring rarely) when they must breach confidentiality and give a warning or report their client's conduct to the authorities. It is useful to consider these two situations separately.

The Duty to Warn

The principle of breaching confidentiality if someone is actively in danger is well absorbed among patients and counsellors alike. However, the ethical circumstances of a decision to breach confidentiality are worthy of discussion.

With respect to a duty to warn, the leading American case on the subject, Tarasoff, is a situation in which the therapist had reported the threat against Ms. Tarasoff to the campus police, who had detained his client and then released him. Subsequently the therapist's supervisor directed that no further action should be taken. No one warned Ms. Tarasoff of her danger. The court went one step further and determined that Ms. Tarasoff should have been told of her danger. The duty to warn is accepted in all Canadian jurisdictions. It only "kicks in" when the risk of harm is both imminent and significant or severe, so the therapist is still obliged to exercise professional judgment.

The Duty to Report

In addition to the duty to warn, statutory and ethical provisions requiring reporting of certain harms to authorities are commonplace. The duty that everyone has to inform child welfare officials of suspected child abuse or neglect is the most obvious example of the duty to report.

Two different thresholds

The threshold that must be met before a counsellor would have a duty to report suspected child abuse is much lower than the threshold that applies in the duty to warn about a dangerous client. For example, a counsellor would have to report the client's statements to the authorities if that counsellor has a *reason to believe* that a child under 19 years of age has been or is likely to be physically harmed, sexually abused or sexually exploited, or needs protection.

In contrast, a counsellor would have a duty to warn a third party or notify the police if the counsellor *concluded* that a client constituted *imminent* risk of serious physical or psychological harm, or death to an identifiable person or group. (It is

important to note here however that if the threat was to a child, then the lower threshold would apply.)

Discussion

The law attempts to provide guidance and consistency. In so doing the law must of necessity make a difficult social choice. For example, one author observes that even the act of reporting a client to the police, as was done in Tarasoff, would make it impossible to continue with therapy (Siegel, 1979, p. 253). Another article notes that, since the introduction of mandatory reporting of child abuse, there have been no self referrals for treatment to the Johns Hopkins Sexual Disorders Clinic, and that, because there are no disclosures of relapse, no children at risk have been identified (Smith Bell and Winslade, 1994, p. 188).

In spite of these dilemmas, there is some evidence that both reporting and warning laws in themselves were accepted quite early on. Smith Bell and Winslade note that those who support reporting laws argue that they are therapeutic even for the reported client, because they establish social expectation and consequences. A 1987 study suggested that of surveyed psychologists, 78.5% were in a practice where confidentiality was broken in regard to suicidal clients at least once. 62.2% were in practices where confidentiality was breached in case of child abuse, and 58.1% where the client was homicidal. Slightly less than 10% of those surveyed viewed such action as unethical (Pope et al, 1987, p. 1002-3).

What controversy there may be at this point, then, is apparently not, aside from theoretical discussion, on the subject of whether reporting and warning are in themselves bad ideas. However, it is possible that on occasion counselors choose to ignore even a clear legal duty. There is little research as to the process that may factor into decisions to report (or warn) in similar circumstances to those that obtained in Tarasoff. However, indications are that in at least one area, counsellors in practice *may* exercise more discretion than might be expected on a strict interpretation of the law.

Specifically, several studies have suggested that admissions of child abuse by a parent are not always reported (Slovenko and Grossman, 1991, as cited in Smith Bell and Winslade, 1994, p. 187; numerous studies cited in Finkelhor and Zellman, 1991), and that the majority of counsellors who are confronted with this issue are so-called “discretionary” reporters who sometimes knowingly violate the law, considering the decision around reporting to be a decision of conscience. Although at the time much of this work was done there had been approximately 20 years of mandatory reporting in the jurisdictions surveyed, there is a need to repeat and update this research in light of a now even longer history of mandatory reporting, and to provide a more international perspective.

Sometimes reporting of admitted child abuse did not occur because it was viewed as a breach of the confidential relationship between the counsellor and the parent, but usually the calculations were more complicated than that. A decision not to report typically was based upon a private determination that reporting would cause more harm than good. According to Finkelhor and Zellman (1991), considerations included whether the family was already in treatment, and whether reporting would disrupt treatment.

Several counsellors cited the poor quality of available services for the child, and a significant number believed that they could help the child better than the available services. There is some indication (Slovenko and Grossman, 1991, as cited in Smith Bell and Winslade, 1994, p. 187) that “reporting child abuse is more likely where there are significant penalties for failing to do so.” Some research has shown that the frequency of reporting in this area is influenced by a number of external factors, including - probably disturbingly - social status and other characteristics of the client (various studies cited in Nicolai and Scott, 1994, p. 154).

We might conclude that laws may be necessary largely in order to make the choice prescriptively, on behalf of the entire community, when otherwise the waters would be considerably murkier. Counsellors must fully inform themselves as to their legal duties and the extent of these duties. Where the law has made a clear social choice, such as in the area of reporting of child abuse or neglect, the only element lawfully open to evaluation by a counsellor is whether the circumstances exist to require the report. Where additional judgment *is* required, for example, as to the level of risk in a potential duty to warn situation, the factors considered in making that judgment should be both manifest and reviewable.

Confidentiality Breaches in Clinical Practice

Confidentiality breaches occur in myriad ways and are often surprisingly unintentional. The degree of censure with which they are viewed also varies in sometimes surprising ways. For example, one study found, among other findings, that breaches of confidentiality were viewed as less egregious when the disclosure was made to an insurance company as opposed to a private individual and when an excuse (“I don’t remember disclosing the information and it could have been someone else”) was used as opposed to a justification (“The disclosure was made “in an effort to help treatment... and there were good therapeutic reasons for what I did”). What may create difficulty in terms of understanding how best to deal with such breaches is that, in comparing excuses vs. justifications, the perception was that although the justification was less acceptable, it was also more professionally attractive than the excuse (Goesling et al, 2000). In other words, an excuse for breaching confidentiality was more acceptable, but also made the clinician appear less professional. This is an interesting contradiction and may deserve some examination within the profession. The public was also not surveyed in this study and it may be interesting to examine public perceptions of unauthorized disclosure in more detail.

Boundary Issues – Accepting Referrals

One area where the potential for confidentiality breaches – or the perception of a possible breach – arises is with regard to the acceptance of referrals. For example, in accepting a referral from a past or existing client, there is the potential for harm should issues around the past or existing client come up in session. (Not to mention the potential for the existing client to raise issues about the newly referred individual, invoking that person’s right to privacy as well as the client’s own.) Particularly in smaller communities,

accepting a referral may include some level of contact with the client in the counsellor's personal capacity.

When an ethical boundary is in question here it can war with the counsellor's need to make a living. In many ways this need is the proverbial elephant in the room when we engage in discussions of ethical issues that will impact our business; it may be pleasant to think that business never factors into our calculations, and we may believe and hope that it never does – but – it may. As one author put it, "...I would like to remark that if a Martian read the volumes reporting the first two psychotherapy conferences and if he read all the papers of this conference it would never occur to him that psychotherapy is something done for money" (Colby, 1968, as cited in Pope et al, 1987, p. 1001).

These are classic situations for ethical decision making processes or frameworks, in the application of which we are invited to consider both harms and benefits and what the other options for treatment may be. "Although it is necessary to examine the meaning of accepting a referral, we must aspire to a standard that protects our patients and yet does not descend to a neurotic over-scrupulousness or self-righteousness" (Shapiro and Ginzberg, 2003, p. 258). Sometimes the decision is obvious; other times it is more obscure. Other factors, such as the size of the community and the degree of the various connections, the availability of other expertise, or the ability of either individual to set and respect their own boundaries, may all come into play.

At its heart, a large portion of the decision to accept or not accept a referral comes from the need and ability, in all the circumstances, to protect client confidentiality.

Boundary Issues – Third Parties

One statistic that is not available is the frequency to which counsellors may disclose information to a third party where consent is required, but has not been obtained.

There are certainly therapeutic techniques wherein a counsellor may disclose information to a third party; therapeutic letters, invitations to participate in a therapeutic process or to clarify information with which the client may be unfamiliar. All of these require explicit consent.

Conferrals with the client's other treatment providers also require consent and the practitioners should share information to the most limited extent necessary to achieve the best therapeutic benefit for the client.

Further, thank-you letters for referrals should only be sent with the consent of the new client; otherwise the counsellor is revealing to a third party that the client is in therapy.

The general rule is that when in doubt, consent should be obtained.

Boundary Issues – Family and Group Therapy

Similarly, in family therapy situations, counsellors have taken different approaches to confidentiality as between members participating in therapy that run the entire gamut of disclosing or not disclosing information. Counsellors may treat each

family member as an individual, each with his or her own confidentiality and privacy rights even as between other members in therapy, or may do the opposite, stating at the outset that secrets are not kept as between family members (Margolin, 1982). These decisions have historically been based in part on the therapeutic technique or theory involved and the counsellor's understanding of the client as a person, along with the client's level of capacity.

Furthermore, information disclosed in a group setting should be kept confidential, but the counsellor cannot guarantee that confidentiality (Truscott and Crook, 2004, p. 74).

Any of these discussions or approaches requires the counsellor to assume significant responsibility to clarify and, to the extent possible, maintain confidentiality boundaries; failure to do so can lead to injury for one or all of the clients.

Inappropriate Sharing of Confidential Information

It is interesting to compare and contrast two studies from the 1980's, both of which looked at the actual occurrence of confidentiality breaches in health care. One study looked at medical doctors and students, and contrasted the occurrence with patients' expectations (Weiss, 1982); the other compared and contrasted the occurrence of confidentiality breach among psychologists with psychologists' evaluations of how ethical the behaviour would be (Pope et al, 1987).

Behaviour	Patient expectation that disclosure would occur	Actual reported occurrence by physicians and medical students
Discussing patients with spouse	17%	51%
Discussing patients at a party	9%	36%
Discussing patients (with names)	23%	60%

(Weiss, 1982).

Behaviour	Belief that the behaviour is unethical	Actual reported occurrence by psychologists ("sometimes" to "very often")
Discussing clients (without names) with friends	71.5%	76.4%
Discussing clients (with names) with friends	98.0%	8.1%
Unintentionally disclosing confidential data	89.5%	61.9%

(Pope et al, 1987).

The Pope et al (1987) survey revealed that, for the most part, psychologists' activities were on most ethical issues consistent with their ethical judgment. However, there were four behaviours (of a list of 83) where the respondents indicated that they engaged in the behaviour more frequently than they believed was ethical. Of interest for the purposes of this discussion is that three of those four areas concerned confidentiality, as outlined in the chart above. The study of medical doctors has the potential to suggest that clients may have higher expectations of confidentiality than were being delivered by psychologists in some instances (with the caveat that this requires us to hypothesize that

patients of medical doctors have at least similar or the same expectations of confidentiality as clients of counsellors and psychologists).

That said, it would seem then that psychologists, and perhaps other mental health professionals, may in the 1980's have been more aware of the need for and expectations around confidentiality than medical doctors. Nevertheless, maintaining confidentiality was an issue. One would hope that 20 to 25 years later, and among a population including all counsellors, these statistics would not be at such variance, but the Pope study has not been repeated.

Sharing Clinical Information with the Client

Further, in one other area of confidentiality, although behaviour and ethical judgment were consistent, there may yet be a need for further discussion of the ownership of information in a client's file. Almost one in four of the psychologists who responded to the Pope et al (1987) survey indicated that they would refuse to allow clients to read their chart notes, and the majority did not consider this unethical in at least some circumstances. According to another older study, clients were also uncertain as to the availability to them of their own records, wanting to "know more ... than they believed would be made available to them" (VandeCreek et al, 1987, p. 66). It is possible that there is still some residual misunderstanding of the client's right to the information in his or her own file, and it would be useful to more methodically explore the current understanding on this issue.

Canada's new privacy legislation now provides clearer rules regarding the client's right to access the information in the clinical record. We will consider this in more detail in Chapter 6.

Objections to Information Contained in Clinical Records

Although little research has been done in the area, some complaints about counsellors feature information contained in clinical notes being viewed and to which the client subsequently objects. Sometimes this objection is understandable; personal comments or venting of personal issues or frustration in notes is clearly not appropriate. Sometimes the notes are lacking in information: something more than name, date and fee is, from an ethical perspective, necessary and this seems to have been generally accepted some time ago (Pope et al, 1987, p. 995). One would expect that limits on what information goes into clinical notes are generally those of whether the notes are therapeutically helpful and necessary; however, what in fact is going into clinical notes does not appear to have been investigated recently or broadly enough to draw any conclusions as to general practices in this area.

Again, Canada's new privacy legislation now addresses the client's right to request changes to the information in the clinical record. We will have more to say about this controversial topic in Chapter 6.

Some clients seem to perceive supervision or consultation, even without identifying information, as a breach of confidentiality, and this suggests that, as with

other limitations on information privacy, an explanation of the need and ethical intent of supervision can be helpful to build the therapeutic relationship and the client's awareness of the significance the therapist attaches to the client's privacy. (We will have more to say on this topic in Chapter 5.)

Breaches of Confidentiality Due to Inappropriate Use of the Internet

The use of the internet presents challenges of technology to the modern practice. Many counsellors, for example, will organize their offices to protect client privacy e.g. through the use of separate entrances and exits, maintaining confidential answering machines or services of some kind (Smith Bell and Winslade, 1994, p. 183), and as legally required via the use of locked and secure storage facilities and the like. However although the same types of concerns exist when therapeutic communication occurs over the internet, the vulnerability of electronic entrances and exits and of secure storage is much less visible.

For example, a breach of confidentiality could occur simply because the person to whom the confidentiality is owed may not be the person on the other end of the connection. With internet technology, impersonation of another is much simpler than in the past, when therapy had to be conducted in person. Even telephone therapy allowed the counsellor to recognize a voice, something that is not available in text-based internet therapy. There are numerous suggestions for dealing with this problem, but absolute certainty may, at least at the current time, be beyond the reach of technology.

Confidentiality breaches can occur also because the counsellor is not sufficiently familiar with the technology. According to one very comprehensive article (Fisher and Fried, 2003), counsellors who perform internet counselling and/or use computers to communicate or keep client records risk breaching confidentiality if they fail to:

- a) Ensure privacy of data with both physical security and appropriate encryption and backup procedures;
- b) Password protection, with passwords that are not shared and changed often;
- c) Firewall techniques;
- d) Consider the use of videoconferencing where possible;
- e) Ensure that all employees and contractors in your practice on your confidentiality procedures;
- f) Mask faces in visual images and voice recordings, where those images or recordings could be intercepted by another;
- g) Destroy recordings or images when they are no longer needed, as long as this destruction is consistent with other ethical and legal obligations;
- h) Be mindful of ways to protect security of wireless devices;
- i) Avoid emailing confidential information without appropriate encryption;
- j) Use privacy screens to protect monitors from viewing by others;

- k) Use up to date virus protection software and other security measures;
- l) Remove all data when disposing of or recycling old computers;
- m) Obtain technical assistance and expertise whenever in doubt;
- n) Become familiar with disclosure and privacy laws in any jurisdiction in which the therapeutic relationship resides;
- o) Advise clients of the risks to confidentiality inherent in an electronically based therapeutic relationship;
- p) Where email addresses are not confidential, inform clients that emails sent to you may be read by others.

Counsellors engaging in any type of telephone or internet practice would be well advised to review the Fisher and Fried (2003) article in its entirety, as well as other resources on the subject. They would also be wise to study the privacy legislation that applies in their jurisdiction, in particular as that legislation may require them to establish and disclose their information collection, use and disposal practices.

3) CONSEQUENCES OF BREACHING CONFIDENTIALITY

A counsellor who breaches the duty of confidentiality without consent or lawful authority, will face both practice and legal consequences. We will briefly consider both in this chapter.

Practice Consequences of Breaching Confidentiality

With respect to the impact on a counsellor's practice, one author has postulated six kinds of harm that can arise from privacy violations: inconvenience, psychological, physical, social, economic, and legal (Sieber, 2001, as cited in DuBois, 2004, p. 315). These harms can cover a broad spectrum of degree, from minimal irritation to legal proceedings initiated on the strength of the information disclosed, loss of important relationships including but not limited the therapeutic relationship, and economic loss, perhaps due to a lawsuit, the loss of employment, or other factors directly linked to the breach of confidentiality.

In minor instances, if the client is reasonably healthy and the relationship is in good repair, discussion with the counsellor may be possible and a repair effected. More commonly, clients may say nothing, but will begin to limit what they do disclose, potentially affecting the efficacy of their treatment, or terminate the therapeutic relationship.

Legal consequences, which are over and above the practice consequences, may arise when a client feels seriously harmed or betrayed. We now consider these legal consequences for breaching the duty of confidentiality.

Legal Consequences of Breaching Confidentiality

A counsellor who breaches the duty of confidentiality by disclosing to a third party confidential client information,⁷ without either the client's consent or a lawful excuse or authority, faces a number of separate and distinct legal consequences. Whether or not any of these will result in any form of a legal penalty will very much depend on the circumstances of the alleged breach and the legal mechanism that is employed in response to that breach.

What are the legal consequences if a counsellor breaches the duty of confidentiality?

In brief, four distinct legal consequences can arise for a counsellor who breaches the duty of confidentiality without legal authority or justification:

- a) *Civil*: The client could sue the counsellor in court for breach of the duty of confidentiality, and – because of the nature of such a tort – the client would not

⁷ While the counsellor's duty of confidentiality applies to either the client who provided his or her personal information or the person whose personal information the counsellor has obtained during counselling, for the purposes of the rest of this paper we will continue to refer to client personal or confidential information.

- have to also prove damages as part of that claim. All the client would have to do is prove that the counsellor gave the client's confidential information to a third party without consent or authority.
- b) *Criminal*: The client could complain to the police, who could in turn investigate the complaint. The police could then recommend the Crown prosecute the counsellor for the alleged criminal breach of trust.
 - c) *Regulatory*: The client could file a complaint against the counsellor with the office of the applicable privacy commissioner, depending on factors such as where the alleged breach took place. Such a complaint could initiate an investigation by the privacy commissioner (either federal or provincial), and that – in turn – could result in a mediation of the complaint, a formal inquiry, issuing enforceable orders (e.g. access to information) or prosecution in the courts for defined offences. It is also possible for the complainant to claim civil damages against a practitioner or organization that is the subject of the Commissioner's final order.
 - d) *Professional*: The client could file a complaint against the counsellor with that counsellor's professional body (e.g. a college established under provincial legislation or a professional association with bylaw authorities to investigate complaints). Such a complaint could initiate an investigation by the professional body's inquiry committee and, if sustained, it could lead to a citation and formal disciplinary hearing, with resulting remedial orders or a suspension of membership.

Each of these legal responses could be pursued separately from the others, and at different times. So, for example, the offended client could both sue the counsellor in civil court and file a complaint against the counsellor with the regulatory body, if not also the Privacy Commissioner's office. Both the regulatory body and the Privacy Commissioner could then investigate the same facts, albeit under different legal authorities.

What are the main differences between civil, criminal, regulatory and professional legal actions that can flow from a breach?

The following table illustrates the main differences of the four legal consequences if a counsellor breaches the duty of confidentiality. We do not propose to discuss these consequences further in this paper. Indeed, such a discussion would constitute a separate paper in its own right. Instead, we simply want to illustrate the similarities and differences that exist between these four different types of legal consequences.

	Civil	Criminal	Regulatory	Professional
<i>Role of the client</i>	Plaintiff must initiate the action and will usually give evidence	Files a complaint with the police, may become a Crown witness	Files a complaint with the Privacy Commissioner, may become a witness	Files a complaint with the professional body, may become a witness
<i>Who makes the decision to “prosecute” the counsellor?</i>	The client as plaintiff must initiate the civil action	The police investigate and decide whether or not to lay a charge, the Crown decides whether or not to prosecute the charge	Priv. Com. decides whether or not to investigate the complaint and, if sustained, how best to then proceed	Professional body decides whether or not to investigate the complaint and, if sustained, how best to then proceed
<i>Burden of proof</i>	On the plaintiff	On the Crown	On the Privacy Commissioner ⁸	On the professional body
<i>Standard of proof</i>	Balance of probabilities	Beyond a reasonable doubt	Balance of probabilities	Balance of probabilities
<i>Types of legal remedies</i>	Injunctions, court orders, damage awards, etc.	Conviction, with possibility of jail time	Court-like orders, damage awards, ⁹ publication of decision	Remedial measures (e.g. terms on a license) through to expulsion from profession, usually also publication of decision
<i>Remedies not available under this route</i>	Jail time; Terms on a license; Expulsion from profession	Damage awards; Terms on a license; Expulsion from profession	Jail time; Terms on a license; Expulsion from profession	Jail time; Damage awards

⁸ Privacy legislation puts the burden of proving certain things on the shoulders of certain parties attending an inquiry into certain matters. Some acts states that at an inquiry into a decision of a practitioner or organization to refuse an individual access to all or part of the individual’s personal information, or to refuse to give information respecting the collection, use, or disclosure of the individual’s personal information, that practitioner or organization and not the Commissioner has the burden to prove to the satisfaction of the Commissioner that the complaining individual has no right of access to his or her personal information or no right to the information requested respecting the collection, use, or disclosure of the individual’s personal information.

⁹ Canadian privacy legislation goes further than many other regulatory statutes and specifies that an individual may claim civil damages against a practitioner or organization that is subject to the Commissioner’s final order.

4) WHEN *MUST* A COUNSELLOR BREACH CONFIDENTIALITY?

Legislation across Canada and the common law allows a counsellor to disclose confidential client information to a third party if the client consents to that disclosure. In making a disclosure by consent, however, the counsellor should only disclose the information and in the form or method that the client consented to. Disclosing more information or in a method that was not agreed to by the client could constitute a breach of the duty of confidentiality.

Canadian legislation and the common law have also established specific circumstances when a counsellor *must* disclose confidential client information to a third party and do so without the client's consent. In these cases, social policy decisions have been made to the effect that, in defined and limited circumstances, the counsellor has a duty to disclose which supercedes or over-rides the duty of confidentiality owed to the client.

When does the law require a counsellor to breach the duty of confidentiality, and why? (In other words, what are the exceptions to confidentiality that will not result in a counsellor being found liable for a breach?)

The legal exceptions to the counsellors' duty of confidentiality can be framed as over-riding legal duties, and can be summarized as follows. Depending on the circumstances, a counsellor may have a duty to:

- a) Report to the authorities suspected abuse or neglect of a child (Bryce, 1999);
- b) Warn a foreseeable victim (or the police) about a client who may constitute a risk of serious physical harm to an identified or identifiable person (Rivtow Marine, 1974¹⁰; and Smith v. Jones, 1999¹¹; Bryce, 2000; Bryce, 2006);

¹⁰ In this commercial law case that may be applicable by analogy in the health care context, as the Supreme Court of Canada found that there is a duty to warn third parties if one is aware of a danger that is directed toward them.

¹¹ In this case, an accused was charged with aggravated sexual assault on a prostitute. His counsel referred him to a psychiatrist hoping that it would be of assistance in the preparation of the defence or with submissions on sentencing. Counsel informed the accused that the consultation was privileged. During his interview with the psychiatrist, the accused described in considerable detail his plan to kidnap, rape and kill prostitutes. The psychiatrist informed defence counsel that in his opinion the accused was a dangerous individual who would, more likely than not, commit future offences unless he received sufficient treatment. The accused later pled guilty to the included offence of aggravated assault. The psychiatrist phoned defence counsel to inquire about the status of the proceedings and learned that his concerns about the accused would not be addressed in the sentencing hearing. The psychiatrist commenced this action for a declaration that he was entitled to disclose the information he had in his possession in the interests of public safety. He filed an affidavit describing his interview with the accused and his opinion based upon the interview. The trial judge ruled that the public safety exception to the solicitor-client privilege and doctor-patient confidentiality released the psychiatrist from his duties of confidentiality and concluded that he was under a duty to disclose to the police and the Crown both the statements made by the accused and his opinion based upon them. The BC Court of Appeal (BCCA) allowed the accused's appeal but only to the extent that the mandatory order was changed to one *permitting* the psychiatrist to disclose the information to the Crown and police. The Supreme Court of Canada upheld the BCCA decision.

- c) Disclose confidential client information if so ordered by the courts or under the statutory powers of a tribunal or authority (Bryce, 2004).

This is not an exhaustive list and there may be other circumstances when a counsellor may either have an over-riding duty to disclose otherwise confidential client information or when the law would otherwise allow a counsellor to make such a disclosure. The above three are probably the most common examples of “mandatory” disclosures. We will consider the “allowable” disclosures separately in Chapter 5.

What do these over-riding duties arise?

The requirements for these over-riding duties that must be met before the counsellor is authorized or required to breach the duty of confidentiality and disclose confidential information can be summarized as follows:

- a) *Duty to report child abuse/neglect*: Every Canadian province has enacted legislation that established a legal duty which requires anyone, including a counsellor, who has a reason to believe that a child under 19 years of age has been or is likely to be physically harmed, sexually abused or sexually exploited, or needs protection, to then report that belief to the authorities.¹²
- b) *Duty to warn of risk of harm to others*: While there have been no reported Canadian cases where our courts have expressly applied the 1976 Tarasoff case to a counsellor who gave a warning, in general terms, if a counsellor reasonably believes that a client’s behaviour or statements indicate that the client constitutes an imminent risk of serious physical or psychological harm, or death to an identifiable person or group, that counsellor should then breach a client’s confidence and either warn the third party or advise the police of that potential risk.¹³
- c) *Court-ordered disclosures*: The courts have the authority to order that a counsellor disclose otherwise confidential client information. These situations arise usually in the context of a legal proceeding where the counsellor had provided services to one of the parties in the dispute and the other party is trying to gain access to the client’s information. However, there are also situations when government agencies or authorities have court-like powers to order a counsellor to disclose client information. One such example is a disclosure order that a coroner

¹² A variety of actions can be taken if the investigation indicates the child is in need of protection, ranging from providing counselling and support services to the family, to temporarily or permanently removing the child from the home. (In some cases, the abuser or abusers can be removed from the home.) In the most serious cases, abusers could also face criminal charges. Many intervention and education programs are aimed at preventing child abuse and neglect, which range from intensive help for families exhibiting a high risk of abuse, to general education programs for school students and the public.

¹³ Because report suspected child abuse has a lower reporting threshold than the duty to warn others re: a client’s threat to others, the duty to report suspected child abuse supercedes the duty to warn if the client’s threat is directed at children.

may issue to obtain information that is necessary to undertake an inquiry into the death of the client or some other person.

Given these duties, what legal protections exist for counsellors who disclose otherwise confidential information?

What protections exist to support a counsellor who is required to disclose confidential information?

So long as the counsellor acts within the parameters of the applicable legislative, common law, court order, statutory authority or contractual disclosure requirement, the counsellor should be protected from any resulting civil, criminal, regulatory or professional actions that a disgruntled client may try to initiate after such a disclosure has been made.

Specific protections exist that a counsellor may be able to rely upon. For example:

- a) *Duty to report child abuse/neglect*: Canadian child protection legislation contains provisions that provide that no action for damages may be brought against a person who reports his or her concerns under the legislation, unless that person knowingly reported false information or does so maliciously. A report may also be made anonymously.
- b) *Duty to warn of risk of harm to others*: While the Canadian courts have not expressly recognized the duty to warn in the mental health context (commonly referred to as a Tarasoff warning), Canadian privacy legislation provides a basis for a counsellor who is being sued by a client to claim that the warning was justified in the circumstances. Specifically, the legislation allows a counsellor to disclose otherwise confidential client information if there were reasonable grounds for the counsellor to believe that compelling circumstances exist that affect the health or safety of any individual.¹⁴ Therefore, if a counsellor is challenged by a client for warning others instead of keeping information confidential, the counsellor can turn to this statutory provision to defend his or her actions in compliance with what is still a common law duty to warn.¹⁵
- c) *Court-ordered disclosures*: Canadian privacy legislation allows a counsellor to disclose otherwise confidential client information if the disclosure is for the purpose of complying with a subpoena, warrant, or order issued or made by a court, person, or body with jurisdiction to compel the production of personal information. Therefore, if a counsellor is challenged by a client for complying with such an order or demand, the counsellor can turn to these statutory protections to defend his or her actions in compliance with that order or demand.

¹⁴ The nature of this duty to warn is worded differently in each of the five applicable private sector privacy statutes, but the basic purpose is the same within each statute.

¹⁵ The legislation may also further and require the disclosing counsellor to advise the client that the disclosure/warning was made by sending a notice to the last known address of the client. However, no specific deadline is mandated for sending that notice to the client.

On the other hand, a counsellor who discloses more information than is required by or in a method that is not permitted by the law or order that mandates these forms of mandatory disclosures could be found to have breached confidentiality beyond the scope of what was otherwise allowed.

5) WHEN MAY A COUNSELLOR BREACH CONFIDENTIALITY?

Canada's new privacy legislation and the common law also allow a counsellor to disclose confidential client information to a third party without the client's consent, albeit in narrowly prescribed circumstances and then to disclose only as much information as is necessary in those circumstances. We will consider five such situations in this chapter.

Disclosing a client's personal information to an insurance company

A client who is seeing a counsellor who is being paid by an employee assistance plan, or a client who is covered under some sort of private health care plan, may be subject to a contractual term which allows or even requires the counsellor to report certain information to the third party payer.

Usually this type of disclosure is minimal and does not require that the counsellor provide detailed or explicit confidential information; only enough information to satisfy the payer that the services were justified and covered under the terms of the plan.

If a counsellor was sued by a client for allegedly breaching counsellor-client confidentiality by providing general information to the third party payer about the services the counsellor was being paid to provide, the counsellor should be able to point to a provision in the applicable service or insurance contract which either requires the counsellor to provide that information or (also) requires the client covered under that plan to agree to such disclosures.

A client who is a beneficiary of a service or insurance plan cannot later claim that the counsellor should not have made such disclosures. Indeed, Canada's new privacy legislation states that a client is *deemed to have consented* to the disclosure of personal information for the purposes of enrollment and coverage under an insurance, pension, benefit or similar plan if the client is a beneficiary or has an interest under such a plan.

Disclosing a client's personal information to a supervisor

There are two ways under Canada's new privacy legislation that allow a counsellor to disclose personal information about a client to a clinical supervisor.

First, the legislation allows for disclosure "for purposes that a reasonable person would consider are appropriate in the circumstances" and that are also necessary to "fulfill the purposes that the [counsellor] discloses [at the time that information was first collected]" (section 17(a) *PIPA*).¹⁶ Therefore, if the supervision or consultation is for a good therapeutic purpose or for some other reasonable purpose that has been disclosed to the client, we believe this section would allow the counsellor to make that subsequent disclosure, although we did not locate any authoritative ruling on point.

The legislation also allows a counsellor to disclose a client's personal information without consent only if "the disclosure is clearly in the interests of the [client] and [the

¹⁶ Other privacy statutes may have worded this allowable disclosure in somewhat different terms than BC's Act, *PIPA*.

client's] consent cannot be obtained in a timely way" (section 18(1)(a) *PIPA*). Under this option, a counsellor could argue that it was necessary and in the client's interest to consult with another counsellor or a supervisor, and also that it was not possible to get the client's consent quickly in the circumstances.

Disclosing client information when buying or selling a practice

Canada's new private sector privacy legislation also allows a counsellor to disclose confidential information to a potential buyer of that counsellor's practice and do so without the consent of each current or past client. However, these are specific and narrowly defined circumstances when additional statutory protections and limitations are activated which are designed to protect the client from the adverse effects of such unauthorized disclosures.

If a counsellor want to buy or sell a clinical practice that includes the transfer of client files from the selling to the buying counsellor, the new privacy legislation allows a counsellor to disclose personal information about his or her clients or employees without their consent, to a prospective purchaser of that counsellors practice, but only if two pre-conditions are *both* met:

- The personal information to be disclosed is necessary for the prospective purchaser to determine whether to proceed with the business transaction;
- The counsellor and prospective purchaser have entered into a separate agreement that requires the prospective party to use or disclose the personal information solely for purposes related to the prospective business transaction.

On completion of their business transaction, additional but limited disclosures are also permitted. If the transaction fails, then other protective requirements apply to both parties. (For those interested in the details, they should consult the privacy legislation that applies in their province or territory; see Chapter 10.)

Disclosing client information for research purposes

Canada's new privacy legislation also allows a counsellor to disclose certain limited information about their clients for a research purpose, including statistical research. This may occur in narrowly defined circumstances and, again, only if each of the following conditions apply:

- The research purpose cannot be accomplished unless the personal information is provided in a personally identifiable form;
- The disclosure is on condition that it will not be used to contact persons to ask them to participate in the research;
- Any linkage of the personal information to other information will not be not harmful to the clients identified by the personal information, and the benefits to be derived from the linkage are clearly in the public interest;

- The person to whom the personal information is to be disclosed has signed an agreement to comply with the *Act*, the practitioner's policies and procedures, the practitioner's security and confidentiality conditions, a requirement to remove or destroy individual identifiers at the earliest reasonable opportunity, and a prohibition of any subsequent use or disclosure of that personal information in individually identifiable form without the express authorization of the practitioner that disclosed the personal information;
- It is impracticable for the practitioner to seek the consent of the client for the disclosure.

Notwithstanding these conditions, a counsellor cannot disclose personal information for market research purposes without the expressed consent of the client, which is best documented in writing.

Disclosing client information for archival or historical purposes

A counsellor may also disclose personal information for archival or historical purposes if *at least* one of four specific conditions is met:

- A reasonable person would not consider the personal information to be too sensitive to the client to be disclosed at the proposed time;
- The disclosure is for historical research and is done accordance with the *Act*;
- The information is about someone who has been dead for 20 or more years;
- The information is in a record that has been in existence for 100 or more years.

6) A CLIENT'S RIGHTS TO ACCESS AND CORRECT PERSONAL INFORMATION

Under both the common law and Canada's privacy legislation, a client has certain rights to access his or her personal information that the counsellor has collected from the client. Under the personal information protection legislation, a counsellor must provide a client with his or her personal information that is under the counsellor's (or the counselling agency's) control.¹⁷

In the landmark 1992 case of McInerney v. MacDonald, the Supreme Court of Canada (SCC) distinguished between a client's personal information and the way that a health care practitioner records or stores that information. Canada's highest court went on to find that while the client "owns" his or her personal information, the practitioner owns the way that the client's information has been recorded or stored. Therefore, in order to allow a client to act on his or her rights over his or her personal information, a practitioner must allow a client to have reasonable access to the clinical records or other ways that the client's information was stored. After making that decision, the court went on to comment that a practitioner can only deny a client access to his or her information in particular and very narrow circumstances.

Canada's new private sector privacy legislation has effectively replaced the right to access identified by the SCC in the McInerney case, but it has also identified a new right – to seek corrections to the clinical record. We will begin by considering the client's right to access.

What should a counsellor do when faced with a request/demand from a client for a copy of or access to the information in the client's clinical file?

Because counsellors may record or store client information in many different ways, it is difficult to come up with a list of specific steps that a counsellor should take that would be applicable to all circumstances. Instead, we offer the follow list of questions as a way for counsellors to develop their own access policies and procedures, which in any event should be part of the policies that all counsellors are now required to have in place under Canada's new privacy legislation.

- Is the person requesting access a client or former client, or does that person have the authority to act on behalf of the client? If acting as the agent of the client, what proof has the agent provided of that authority?
- Where is the client's information recorded or stored? How accessible is that information? How long will it take to either provide direct access or a complete copy of that information? What reasonable costs are associated with retrieving or copying that information?
- If the counsellor has determined that he or she will permit the client to review the original file materials instead of providing a copy, should that review be done under supervision to ensure that the client will not tamper with the counsellor's

¹⁷ In addition, the counsellor may have to explain how that information has or is being used, and identify to whom the client's information may have been disclosed.

file? What arrangements will be made to allow the client to make a copy of all or part of the counsellor's file? What are the associated costs? And has the client been informed of these details prior to the viewing?

What should a counsellor do if giving the client access to his clinical file would reveal information about someone else and that other person has not consented to that disclosure?

While Canadian privacy legislation allows a client to have access to his or her personal information, some noteworthy exceptions are also provided. For example, a counsellor must not allow a client access to his or her personal information if that disclosure would reveal personal information about another individual or would reveal the identity of an individual who has provided personal information about another individual and the individual providing that information has not consent to the disclosure of his or her identity.

Best practice would be for the counsellor to remove information from the client's file (or black-out those parts of a document) that would reveal information about a third party, unless that party first agrees to such disclosure.

What should a counsellor do if the counsellor believes that the client or someone else may be harmed by the client gaining access to the information in the clinical file?

Two other exceptions set out in Canada's privacy legislation may have significance for counsellors:

- a) *Risk to others*: The first directs that a counsellor must not disclose a client's personal information if the disclosure could reasonably be expected to threaten the safety or physical or mental health of an individual *other than* the individual client who made the request.
- b) *Risk to the client*: The second exception provides that a practitioner must not disclose client personal information if such disclosure can reasonably be expected to cause immediate or grave harm to the safety or to the physical or mental health of the individual client who made the request.

Before relying on either one of these exceptions, the practitioner would first have to determine if the person requesting the information is at risk, or if some third party might be at risk if the requested information was disclosed.

Of course, a practitioner may not have sufficient information or competencies to decide if a sufficient harm may result if a client is given access, be this harm to either the requesting client or a third party. Therefore, Canada's privacy legislation allows a practitioner to disclose otherwise confidential client information to a healthcare professional so that other professional to assess whether the disclosure of that information may would reasonably be expected to result in grave and immediate harm to either the client's or some other individual's safety or mental or physical health. So, for example, if a psychiatrist advised the counsellor that grave and immediate harm was likely to result

to a third party if the client was given access, then the counsellor could rely on the first exception to deny the request.¹⁸

The privacy legislation also tries to strike a balance by requiring that, if the problematic information can be removed from the requested clinical documents, then the client must be given access to the remaining information. This is an important condition, because denying access is not always going to be an all-or-nothing proposition that applies to all information in the practitioner's records.

If after consulting with an appropriate professional where necessary, a counsellor has a reason to believe that serious risk of harm will result to the client (or to others) from the client accessing the clinical notes, there is a further step that the counsellor should take. Before access to or copying of the record is denied, the counsellor should try to sever or block-out the problematic information in the clinical records to the extent necessary to reduce the potential risk of harm, if that is possible. It is probably a rare situation when all the information in a practitioner's records would meet the threshold tests set out above so as to justify a refusal to access the entire record.

What should a counsellor do if a third party requests access to his information that a counsellor may have in a client's clinical record?

Canada's new privacy legislation does not differentiate between client information that might be requested and information about third parties that might be requested. For example, section 23 of *PIPA* simply says that, if a person makes a request, the counsellor must provide that person with access to his or her personal information that the counsellor has under his control, including how that information is being used.

The privacy legislation does, however, provide some exceptions when such a request can be denied, but none of those would appear to apply in a typical clinical situation. A counsellor is also directed not to disclose personal information in specific circumstances, such as harm to the requesting person or others (see above). But there are two further conditions when a counsellor could deny access that may be applicable:

- If disclosure would reveal personal information about another individual;
- If the disclosure would reveal the identity of an individual who has provided personal information about another individual and the individual providing that information does not consent to disclosure of his or her identity.

However, if a counsellor is able to remove the other person's information from the record, or prevent the identify of the other person from being revealed, then the counsellor must then grant that access to such de-identified information to the person (client or otherwise) who is making the request for access to their personal information.

So, bearing in mind the limits re: disclosing both the identify and personal information of the other person without their consent, a counsellor should be circumspect

¹⁸ A counsellor may also have sufficient competencies to undertake their own risk assessment. In that case, a counsellor may find the framework provided by Bryce, 2002, to be a useful template for their assessment.

if faced with a request from a third party for access to information the counsellor may have about that non-client party.

What should a counsellor do if the client demands that the counsellor correct what the client believes is incorrect information or add missing information?

Canada's privacy legislation also contains rules that a counsellor and a client should follow if the client requests a counsellor correct an error or omission in the collected personal information. Normally, such requests must be implemented as soon as possible, with copies of the corrected information being then sent to others to whom that information was disclosed during the year before the correction is made.

However, a request by a client to correct personal information does not mean that the counsellor must automatically comply. If the counsellor does not believe that the correction is justified and thus decides not to make the requested correction, the counsellor need only note in the file that a correction was requested but not made. The legislation does not go further and require the practitioner to notify the client that the requested change was not made. It only requires that the refusal be noted in the file, along with the accompanying request.

To what extent has Canada's privacy legislation supplanted McInerney v. MacDonald in relation to defining a client's right to access clinical records and make requests to correction same?

A fair summary of the Supreme Court of Canada's (SCC's) ruling in McInerney v. MacDonald is that, unless there is good evidence that access to a client's clinical records would cause harm to the client or a third party, the client is entitled on request to examine and copy all information in her clinical records which the counsellor considered in administering advice or treatment, including records prepared by others that the counsellor may have received about that client.

Canada's privacy legislation establishes a similar right of access, including setting out the "harm exceptions" that were articulated by the SCC. That said, in the privacy legislation the threshold for denying access is set fairly high: (a) in relation to harm to others - "[if] the disclosure could reasonably be expected to threaten the safety or physical or mental health of an individual..."; and (b) in relation to harm to the requesting client - "[if] the disclosure could reasonably be expected to cause immediate or grave harm to the safety or to the physical or mental health of the individual who made the request." (These two examples come from BC's *PIPA*.)

Therefore, Canadian privacy legislation has largely if not completely supplanted McInerney v. MacDonald on the issue of access. The same cannot be said about the issue of a client who seeks a correction after having access.

The SCC in McInerney v. MacDonald said nothing about the right of a client to request corrections to information in a clinical record. It was simply an access case. Therefore, Canada's new privacy legislation appears to speak to an issue that was not considered by Canada's highest court in this case.

7) THIRD-PARTY DEMANDS FOR A COPY OF A CLIENT'S FILE

From time to time, counsellors are faced with requests or demands from third parties to be provided with access to a client's confidential information as recorded in the counsellor's clinical record or a copy of such a record. In this chapter, we will consider what a counsellor should do in the face of such a request, and how that response may vary depending on the authority of the requesting party.

What should a counsellor do when faced with a request/demand for a copy of a client's file?

As we will note later in Chapter 7, there is no automatic counsellor-client privilege in Canada, and - consequently - there is no formal recognition of absolute confidentiality. Instead, privacy legislation applies and legal arguments can be made relating to relevancy and the appropriate balancing of interests in the face of a demand for a copy of a client's file. The legal system may well determine that the benefits of having the confidential information recorded by the counsellor release to the requesting part are necessary to obtain justice in a particular case.

A request for a copy of a client's clinical file is likely to be made in one of three general contexts:

- a) Accompanied by a release signed by the client authorizing the counsellor to disclose the information to a named third party;
- b) Supported by a court or tribunal order;
- c) In reference to a statutory investigation.

Signed releases

A release signed by the client is always the best option and – in most cases - the counsellor should have the original of the signed release before sending a copy of the file to a third party. Furthermore, it is wise to review the release to ensure that it was signed by the client and that the date and the scope of the consent cover the requested information. The counsellor should contact the client and ask whether he or she consented to the release of the information, and whether or not the client in fact signed a release (Turner and Ullheman, 2006, p. 628).

Often requests for clinical records can be excessive for the purpose for which the records are intended, so the amount of information provided can be limited from their original scope (Smith Bell and Winslade, 1994, p. 184). This is because, for example, lawyers may be unclear on what information is actually available and so tend to expand the scope of their requests so as not to miss any potentially relevant material.

Court or tribunal order

If the client does not agree to the release of the information (or is unable to provide such authorization), the party who wants access to the counsellor's records may

obtain a court order directing the release of that information. (Some tribunals may also have the statutory powers to issue orders for the release of otherwise confidential client information.) In the hearing that is usually required before the order is given, the requesting party must demonstrate to the court (or tribunal) the necessity of obtaining that confidential information.

Statutory investigations

In some cases, an investigative body or authority has been given the legislative powers to conduct an investigation or undertake an inquiry, and – to facilitate that investigation or inquiry – the body or authority may also hold the authority to require individuals (like counsellors) to provide the authority with specific information, which can include a client’s confidential information. While some of these powers may be described as being equivalent to a court order, they may be exercised without the authority having to apply to the court for an order. All that the counsellor may know is that the authority is requesting information pursuant to some particular statute.

A counsellor cannot guard a client’s privacy interest where the client has consented to or has been ordered to make disclosure, or has otherwise waived the right to privacy (and the client’s disclosure to any other person is often sufficient to negate the privacy interest). Only the client is entitled to assert privacy interests in his or her own records. Judicial bodies can, however, assert the privacy interest on behalf of clients who do not have the capacity to do so, and if the counsellor is of the view that the client does not have capacity, then independent legal advice should be obtained by the counsellor.

What if the request/demand comes from the client’s lawyer? What should the counsellor do to confirm the requesting lawyer represents the client?

Even when a requesting lawyer claims to represent the client, the counsellor should not assume that the client consents to disclose the information to that lawyer. Again, a release signed by the client must be obtained, or - in the absence of a signed release - a court order is required. A conversation with the client should also occur to ensure that the client does consent to the release of this information to his counsel, and to confirm the counsellor’s understanding as to whom the lawyer represents.

What if the request/demand comes from opposing counsel? (And how does the counsellor distinguish between these two types of lawyers?)

If it is not clear whom the lawyer represents, the counsellor can certainly ask. Lawyers are not permitted to act in misleading or “sneaky” ways, pursuant to their own ethical codes and standards. For example, in British Columbia, “A lawyer must not, in . . . professional practice, engage in dishonourable or questionable conduct that casts doubt on the lawyer’s professional integrity or competence, or reflects adversely on the integrity of the legal profession or the administration of justice” (The Law Society of British Columbia, 1994). If the counsellor is not satisfied with the answer, the counsellor may wish to seek independent legal advice.

The requirements for a signed release and for a conversation with the client remain the same. As always the client should be informed of the request and the identity of the person making it and should confirm whether or not the client consents to release of the information. Clients should be encouraged to consult with his or her legal counsel and advise if any legal objections will be taken to disclosure.

What should the counsellor do if the request/demand is not supported by a release form signed by the client?

If there is no consent or signed release form, the counsellor can either have the client sign one, or require the requesting individual to obtain one.

If there is no signed consent but an accompanying court order, the counsellor should respond according to the terms of that order. If there is no signed consent, but the request is made by an investigative authority, the counsellor may want to consult with a lawyer to confirm that authority and the scope of its powers. *The bottom line in these circumstances is that a counsellor should never release information without clear authorization.*

Can the counsellor charge for complying with a request/demand supported by a signed release?

Counsellors should check the fee schedule of their registering association, but, in general, counsellors faced with a request from a third party that is supported by a signed release form can charge for any necessary review or search of records, and for the cost of photocopying the applicable records. They may even require pre-payment for a reasonable estimate of such costs.

What should a counsellor do if faced with a court order for disclosure of a client's file?

In these circumstances, the counsellor has a number of options:

- a) Comply with the order and release the documents as required. When complying with a court order the counsellor does not risk being found in breach of legal/ethical requirements, provided that the only material disclosed is that outlined in the order.
- b) Retain legal counsel to file a motion for the court to consider quashing the order. A court will only do this if it is convinced that there is no relevant information in the order. In general courts are more likely to limit the scope of the order if it deems that not all the requested information is relevant.
- c) If the client does not wish to disclose the information, it may be more appropriate for the client's lawyer to argue over the privacy rights attached to the material.
- d) It may be possible to negotiate with the parties and with the court a partial disclosure, based on an assessment of what is actually relevant.

(Turner and Uhleman, 2006, pp. 627-9)

Usually, the courts do not require parties to pay for obtaining copies of records, but the terms of the order may require the requesting party pay the counsellor's reasonable search and copying costs. If the order is silent on such costs, and they are going to be expensive, the counsellor may apply to the courts for direction on that issue.

Or a request/demand from an investigative authority?

It is useful to consider a specific example of a request from an investigative authority that a counsellor may receive and which is made pursuant to a specific statute. For the purposes of this section we will consider demands for information that may be made by a coroner's office.

The powers granted to the coroner's office include the jurisdiction over certain deaths and the ability to hold an inquest to determine the identity of the deceased person, and how, when and where the person died. The coroner's office has certain statutory powers available to compel disclosure and to also issue subpoenas or orders, and these powers may vary slightly by jurisdiction.

If a counsellor receives a letter from the coroner's office for disclosure of a client's file, the counsellor should ascertain the scope of governing legislation in his or her own province or territory, and seek independent legal advice when in doubt. Generally, however, as part of its investigatory power, a coroner's office is given broad powers to inspect information in records relating to the deceased or the deceased's circumstances.

If a counselor is of the view that the scope of the request goes beyond the deceased or the deceased's circumstances, then the counselor should obtain independent legal advice prior to releasing any information.

Particular scrutiny should be given to requests for records where the client is not the deceased. The client should be informed, encouraged to obtain legal advice if appropriate, and asked if there is any objection to disclosure. Some jurisdictions have Medical Examiners as opposed to Coroners, and the chief distinction is that the former system is physician-based, while a coroner's office has components of judicial and administrative elements as well. Thus, a coroner may hold a courtroom style inquest; in jurisdictions where there is a medical examiner instead these inquests can still occur, but they are not normally under the auspices of a medical examiner's office.

Fault and liability are not typically within the jurisdiction of the coroner, although a witness giving evidence to a coroner's inquest may refuse to answer, or, in some jurisdictions, is deemed to have refused to answer, any question that may incriminate the witness or establish the witness' civil liability. Frequently legislation may prohibit the use of evidence given during an inquest in any criminal or civil trial (other than perjury in giving the evidence in the first place). This right may be exercised only in relation to the witness, not in relation to a client of the witness.

During an inquest, the coroner can normally admit any evidence, including documentary evidence, which it deems to be relevant and that is not subject to some other statutory limitation on disclosure.

Typically there is no specific provision requiring the coroner's office to pay for obtaining copies of records. If the costs of searching the counsellor's files and making copies are going to be substantial, the counsellor may try to negotiate for the office to pay for those activities.

What should the counsellor do if the request/demand is not appropriate?

If the counsellor believes that any request or demand for a copy of or access to all or part of client's file is not appropriate and, therefore, should be refused, the counsellor may then be able to raise a claim of privilege over the requested information. We will consider this issue in the next chapter.

8) COUNSELLOR-CLIENT PRIVILEGE

As we noted above, privilege is often confused with confidentiality. However, privilege cannot exist unless there is a pre-existing duty of confidentiality. More to the point, privilege is a claim that a counsellor can assert against a third party to deny that party access to the information that the counsellor has obtained from the client and has agreed to keep confidential.

What is privilege?

Privilege is a legal argument that a counsellor would assert (often in a court of law) as a way to prevent a third party from getting a court to order that the counsellor disclose his/her client's confidential information.

A claim of privilege cannot be asserted unless there is a pre-existing duty of confidentiality that applies in relation to the information in question. If the counsellor does not have a duty of confidentiality in relation to the requested information, then the counsellor cannot assert a claim of privilege over that information.

While it is most often the case that the holder of the information (e.g. the counsellor) would assert the claim of privilege, it is also possible for the person who gave the confidential information to the counsellor to assert the claim. Thus, either the counsellor or the client could argue that the information in question is confidential and should not be disclosed to the party demanding that it be divulged.

Privilege has two basic forms, what can be described as an "automatic" privilege and as a "case" (or "granted") privilege.

- a) *Automatic privilege*: An example of an automatic privilege is solicitor-client privilege. Under this form of privilege, it is assumed that all information a client provides to his or her lawyer is privileged and, therefore, no one can have unauthorized access to that information without first obtaining a court order. The courts are reluctant to over-turn a claim of solicitor-client privilege, and the examples of situations when solicitor-client privilege has been set aside are – relatively speaking – rare.
- b) *Case (or granted) privilege*: There is no such thing as an automatic privilege over counsellor-client communications. A counsellor who claims counsellor-client privilege over clinical notes, documents or just the information that the client provided to the counsellor in confidence during a clinical session must prove in a court of law that the requested information should not be released to the requesting third party. Such a counsellor faces a legal hurdle. There is a *prima facie* assumption at law that his or her communications with client are *not* privileged and thereby are admissible and should therefore be provided to the requesting third party.

Unlike the automatic nature of solicitor-client privilege (a privilege which must be challenged in the courts before it is set aside), counsellor-client privilege must first be

claimed or asserted, and then evaluated by the courts on a case-by-case basis; it is not “automatic”. If the court agrees, then the privilege is “granted” and applies to the information being requested.

The courts undertake evaluations to decide whether or not to grant a claim of counsellor-client privilege by apply what is now commonly referred to as the Wigmore Test. It is useful to consider this test, before considering how privilege relates to confidentiality.

What is the Wigmore Test?

The Wigmore Test was articulated by a law professor named Wigmore in 1961 as an attempt to set out a series of questions that a reviewing court should ask before it decided whether or not to support a claim of privilege that was being made by one party in a dispute or a particular witness to the effect that the information they were given by another person should not be disclosed to the requesting third party (most often a litigant in a legal proceeding) who was demanding that the information or documents be disclosed.

The Wigmore test has been a part of Canadian law for many decades.¹⁹ It is often referred to in reported decisions, including those involving counsellors who are arguing that the information they obtained from their client during a clinical session should not be disclosed to some third party.

As a recent example, in 2006 the Ontario Superior Court noted in the case of Duits v. Duits²⁰ that:

The common law has an established history of considering whether privilege attaches to communications between individuals and persons acting in the capacity of marriage counselors. The general approach has been to view communications made with a marriage counselor as privileged.

¹⁹ For example, the Supreme Court of Canada in R. v. Gruenke, 1991, accepted that the four criteria established by Wigmore could be applied to determine the admissibility of evidence, given by a pastor and lay counsellor of a fundamentalist Christian church, regarding their communications with the appellant about her involvement in a crime.

²⁰ In this case, the respondent wife's applied to the courts to have the parties' former marriage counsellor called as a witness and give evidence in their custody/access trial as to which parent ought to be granted custody of the children. The wife contended that the counsellor would corroborate her evidence concerning emotional and verbal abuse suffered by her and the children by the words and conduct of the applicant husband. While the court applied the Wigmore Test, it did not order the counsellor to give evidence. The court found that his notes and any evidence he could give would be of a minimal evidentiary value to the court because of its lack of a reliable factual foundation. Concerns included that his observations were and opinions were partially founded only on what the parties told him, that they may have been the result of planning and manipulation, both parties had taped the sessions for some ulterior purpose, etc. While his evidence was possibly relevant to some issues, it would be inherently unreliable and would be accorded little or no weight.

The criteria that a court must consider in deciding whether or not to uphold a claim of counsellor-client privilege can be summarized as follows:

1. The communications must originate in a confidence that they will not be disclosed.
2. The element of confidentiality must be essential to the full and satisfactory maintenance of the relationship between the parties.
3. The relationship must be one, which in the opinion of the community, ought to be sedulously fostered.
4. The injury that would inure to the relationship by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.

It is often the forth and last criteria of the Wigmore Test that forms the basis of most litigation and judicial analysis. The Supreme Court of Canada has ruled that a claim of privilege should not be an absolute bar to justice. Thus the courts must determine if a document or class of documents must be produced so as to allow the courts to get at the truth and prevent an unjust verdict or outcome.

Disclosure resulting from a rejection of a claim of privilege is not necessarily an all or nothing proposition. Overall, where the balancing of interests favours disclosure, the court will also consider whether partial disclosure of only certain information may be sufficient to achieve the appropriate goals of preventing an injustice. Thus it is possible to obtain a limited granted privilege.

How does privilege and the Wigmore Test relate to the client's duty of confidentiality? To its exceptions?

As should be evident from the above, the Wigmore Test is a way for the courts to ascertain whether or not to uphold or grant a claim of privilege in the face of a demand by a third party for disclosure of particular information. For such a claim to be sustained by a counsellor (or a client) faced with a demand for disclosure of client information, the first hurdle for the counsellor (in some cases the client) is to prove that the communications the client had with the counsellor originated in a confidence or an expectation that the information would not be disclosed. Thus, the counsellor must first prove that he or she owed the client a duty of confidentiality in relation to the subject information.

It is usually not too difficult for a counsellor to assert a duty of confidentiality. In applying the first of the Wigmore criteria, the courts usually look to see whether or not the counsellor was a *bona fide* professional, and take into consideration (for example) the counsellor's educational qualifications, professional affiliations or registration. Confidentiality agreements (signed by at least the client) are often helpful in finding that a duty of confidentiality existed. However, the courts will look closely at the purposes of such agreements, as well as their specific terms and conditions, before accepting that there was such a contract in place. Finally, the courts will look at details of client's

relationship with the counsellor, and even how others may have perceived or understood that relationship.

Sometimes it is necessary for the court to consider the specific confidential information that being requested before making a final decision as to whether or not to grant the claim of privilege. This is done in a closed, *voir dire* hearing.²¹ It is often during such *voir dire* hearings that a counsellor would assert a claim of privilege over the information the client provided to the counsellor in confidence.

A claim of privilege is unlikely to be sustained in the face of a duty to disclose that is imposed on a counsellor by statute, such as the duty to report suspected child abuse/neglect which is set out in provincial legislation across Canada.

Finally, with the coming into force of Canada's new private sector privacy legislation, an argument can be made that - given the duties and criteria set out in this new legislation - there is no long a need for the courts to consider or apply the Wigmore Test. In other words, the new privacy legislation has largely replaced the need for the Wigmore Test and provides a replacement set of rules to governing the disclosure of a client's confidential, personal information.

²¹ A *voir dire* hearing is a special hearing where a judge decides whether evidence can be presented at trial. A *voir dire* is a trial within a trial, where a decision is made that can later be applied to the main legal proceeding.

9) INFORMED CONSENT AND CONFIDENTIALITY

In this chapter, we will explain the dynamic nature of informed consent then consider its importance in relation to counsellor-client confidentiality.

A Brief Explanation of Informed Consent

Informed consent is the end product of a dialogue between counsellor and client. Before a counsellor can provide counselling services to a client, that client must consent to participating in those services. However, it is often the case that a counsellor cannot provide a particular clinical service or therapy without first obtaining confidential information from the client. Often such personal information must be provided before the counsellor can identify what service should be provided and then inform the client of the risks/benefits before letting the client decide. Therapy is a process, and as such the exchange of information continues throughout. Consequently, consent to therapy is not a static one-time event; it is a continuous process and it also can find expression in different ways.

For example, by the simple act of entering the counsellor's office, the client has given implied consent to speak to the counsellor and, at the least, have the counsellor listen to what the client is saying about their problem. It may not be for some period of time before the counsellor proposes a specific course of therapy, to which the counsellor should obtain the client's consent before initiating. But, again, consent to therapy can be implied or expressed.

It is useful to look at informed consent as an on-going process or duty that a counsellor has in relation to the relationship the counsellor develops with each client. The duty to obtain a client's consent can arise many times during counselling. While a counsellor may be able to rely on implied consent at the start of the clinical relationship, it may be necessary for the counsellor to obtain expressed consent for particular proposed therapies. The critical factor is that a counsellor cannot involve him or herself with a client without acting on the duty to obtain consent.

Confidentiality, like consent, is also not a static, one-time event. It also exists as a continuous process, and it is a duty that can arise at different times, often without the counsellor knowing in advance that his or her duty will be activated.

To illustrate these points, consider the following description of events and the discussion of a counsellor's resulting duties.

<i>Event</i>	<i>Resulting duty</i>
1. The client enters the counsellor's office and sits down to speak to the counsellor.	The counsellor has a duty to obtain the client's consent to begin counselling. By entering the office, the client has given implied consent to begin the counselling process by talking to the counsellor. The counsellor does not yet have to obtain the client's expressed or written consent.

<p>2. The client starts to explain to the counsellor why he or she has come to see the counsellor. In the process, the client provides the counsellor with personal information, some of which causes the client great anguish.</p>	<p>By giving the counsellor personal information, the counsellor's duty of confidentiality has been activated. The client does not have to ask the counsellor to keep information confidential; this duty is automatic (and is expressed in both statute and the common law).</p>
<p>3. After listening to the client and asking questions to help identify the nature of the client's problem and to narrow the range of possible therapies that could be employed to help the client deal with that identified problem, the counsellor proposes a course of action for subsequent clinical sessions, including options for therapy.</p>	<p>The counsellor now has a new duty to obtain the client's consent to a proposed course of therapy. Depending on the nature of the proposed therapy, the counsellor may have to spend some time explaining to the client the risks/benefits, allowing the client to ask questions before consenting, etc. The counsellor may even need to obtain the client's expressed (if not written) consent before commencing that therapy.</p>
<p>4. While engaged with the counsellor in therapy, the client refuses to participate further and demands the counsellor stop.</p>	<p>The counsellor is now faced with a client who has by word or action expressly withdrawn either implied or expressed consent to the therapy. The counsellor thus has a duty to stop providing the therapy, at least until such time as client again consents to continuing the therapy.</p>
<p>5. The client calms down and continues with the therapy, and eventually comes to an understanding as to how he or she can deal with the root cause of their problem. The clinical sessions end.</p>	<p>With the end of the clinical sessions, the counsellor's duty to obtain consent is no longer active.</p> <p>The counsellor continues to have a duty to keep confidential any information that the client has provided to the counsellor during the clinical sessions and therapy. This duty does not stop, even after the clinical relationship has ended.</p>
<p>6. The counsellor sends the client an invoice for payment concerning the clinical services that were provided. The client refuses to pay the counsellor.</p>	<p>While the counsellor still has a duty of confidentiality, the counsellor is also allowed to make disclosures concerning the services he or she has provided to the client but only to the extent that is necessary for the counsellor to secure payment from the client of the unpaid invoice.</p>

Informed Consent in Therapy

Informed consent is not merely about getting the consent form signed. The basis for informed consent from a therapeutic perspective is the need to establish trust in the therapeutic bond. This trust has more than one dimension. The client must be in a position to decide whether and what to disclose to the counselor and to know of and accept or decline treatment options.

The therapist must assess whether the client in fact has the *ability* to give informed consent. This is not merely a question of capacity, although that is one component of ability. It also includes whether the client has sufficient information to make an informed decision, and can reason through the consequences of that decision. Finally, even when the client has achieved all of that, does the client have the ability to act in accordance with their own sense of what is best for them (Weiss Roberts et al, 2002)? The onus is on the therapist to provide relevant information to the client. The therapist may also provide the client with any necessary assistance in considering the potential consequences of consenting to treatment or a particular modality thereof.

With regard to confidentiality, certainly where legally imposed third party disclosures occur, there is inevitable damage to the level of trust and to the therapeutic alliance. In one study, it was determined that “almost all clients wanted to be informed of exceptions to confidentiality; and most reported that they would react negatively to unauthorized breaches of confidentiality” (VandeCreek et al, 1987, p. 62). From this perspective, informed consent to therapy is a tool to minimize – not avoid – the resulting harm of any necessary confidentiality breach through a process of education and discussion early in the relationship (Smith Bell and Winslade, 1994). Informed consent, or the lack thereof, cannot however be used as a justification for avoiding a legal duty to breach confidentiality, or as a justification for breaching confidentiality in violation of privacy legislation or ethical standards.

Limitations on confidentiality should be disclosed early in the therapy, proactively rather than reactively (Nicholai and Scott, 1994, p. 154), while the client still has some degree of reasonable choice regarding whether to enter into the therapeutic relationship. The trade-off is that when the limitations of these arrangements for the purpose of confidentiality are made known to the client, they may well become less willing to disclose therapeutically relevant information (Kremer and Gesten, 1998). The counsellor (and the client) essentially must accept the possibility that disclosure will be less complete, along with any potential impacts on the therapy itself.

Some studies have indeed shown that individuals made aware of required reporting of child abuse do not disclose as many child punishment and neglect behaviours as individuals who were not informed of them (Taube and Elwork, 1990 as cited in Nicolai and Scott, 1994). It is unclear whether this suggests either that these behaviours happen less frequently when it is known they will be reported, or that they are simply not disclosed to the counsellor when it is known that the counsellor will then be obliged to make a report.

10) CANADA'S NEW PRIVATE SECTOR PRIVACY LEGISLATION

This chapter will focus on Canada's privacy legislation that applies in the private sector. Counsellors who work for agencies or in the public sector should consult their employer for guidance on how the applicable public sector privacy legislation may impact on their duty of confidentiality, etc.

How does Canada's new private sector personal information protection legislation work?

The federal government and some of the provincial governments have enacted legislation that sets up a series of rules governing the collect, use and disposal of personal information in the private sector throughout Canada. The federal legislation is known as the *Personal Information Protection and Electronic Documents Act (PIPEDA)*. To date, only three of the provinces have enacted their own comprehensive private sector privacy legislation:

- Alberta: *Personal Information Protection Act (ABPIPA)*;
- BC: *Personal Information Protection Act (BCPIPA)*;
- Quebec: *An Act Respecting the Protection of Personal Information in the Private Sector (ARPPIPS)*.

In addition, Ontario has privacy legislation that applies only in relation to matters concerning health care: *Personal Health Information Protection Act (PHIPA)*.

The federal *PIPEDA* applies to regulate the collection, use and disposal of personal information in the private sector within all of the provinces or territories, *unless the federal Privacy Commissioner determines that a provincial statute is "substantially the same" to the federal legislation*. If the Commissioner makes such a determination, then the provincial rather than the federal legislation applies to the private sector in that province. There are two exceptions. The federal *PIPEDA* applies if:

- a) The organization or sector is subject to federal jurisdiction (e.g. it is a federal works, undertakings or businesses such as banks, radio, television, inter-provincial trucking, railway, airlines, etc.),²² or
- b) The collection, use and disclosure of personal information takes place across a provincial boarder, such as inter-provincial and international transactions involving personal information in the course of a commercial activity.

To date, the Commissioner has found that each of the four provincial statutes noted above are "substantially similar".

A counsellor in private practice working in a particular province should first determine if that province's privacy legislation has been found to be substantially similar

²² Organizations and counsellors working in the Northwest Territories, Yukon and Nunavut are considered federal works, undertakings or businesses and, therefore, are covered by *PIPEDA*.

to the federal legislation. If it has been found to be similar, then the provincial legislation applies rather than the federal. If it has not, then the federal legislation applies. However, because the rules within the provincial legislation must be substantially similar to those set out within the federal legislation, there is in effect a set of common national standards that regulate the collection, use and disposal of personal information in the private sector. As such, it is more important that counsellors understand these common rules than the specific name of the governing statute.

How has Canada's new protection of personal information legislation for the private sector impacted the counsellor's duty of confidentiality, its exceptions, privilege, etc.?

As noted in Chapter 1, to a large extent, the new private sector privacy legislation has codified much of the common law rules that apply to this aspect of clinical practice for counsellors working for themselves. Indeed, as one of us has observed (Bryce, 2003) Canada's new private sector personal information protection legislation can be viewed as simply codifying common sense and good counselling practice, rather than introducing a totally new set of standards.

The ten common principles set out in Canada's new private sector privacy legislation can be summarized as follows:²³

1. Counsellors are accountable for the protection of a client's personal information under their control (i.e. they have a duty of confidentiality).
2. The purposes for which the counsellor collects the client's personal information is being collected must be identified during or prior to the collection.
3. A client's personal information may only be collected, used or disclosed by a counsellor with the knowledge and consent of the client, with limited exceptions as specified in the legislation (i.e. the exceptions to the duty of confidentiality).
4. The collection of the client's personal information is limited to what is necessary for the identified clinical purposes and will be collected by fair and lawful means.
5. A client's personal information must only be used and disclosed for the purposes for which it was collected, except with the consent of the client or as required by law. Client information can be retained by the counsellor only as long as it is necessary to fulfill those purposes.
6. A client's personal information must be as accurate, complete and up-to-date as is necessary.
7. The counsellor must protect the client's personal information by employing

²³ This list is based on information posted at the website of the Office of the Privacy Commissioner of Canada (URL: www.privcom.gc.ca/fs-fi/02_05_d_26_e.asp). Because the definition of an "organization" as used in the privacy legislation includes an individual counsellor in private practice, we have used the term "counsellor" in this list instead of organization, and we have also used the term client personal information.

- adequate safeguards (i.e. employ a specific mechanism to meet the duty of confidentiality).
8. The counsellor must provide information about his/her privacy policies and practices and ensure that it is readily available to clients on request.
 9. A client has the right of access to personal information about him or herself and has the right to seek correction. Both these rights are subject to some exceptions as specified in each privacy statute.
 10. A counsellor must provide the means for a client to challenge the counsellor's compliance of the above principles, including making a complaint to the counsellor's professional body, if applicable.

Are there any differences in how the private sector privacy legislation applies in specific provinces?

There are a few subtle differences in two of the provincial privacy statutes:

- a) *Alberta*: Not all Alberta organizations are covered by *ABPIPA* in the same way. Certain classes of "non-profit organizations" need only follow *ABPIPA* in relation to their commercial activities. There are special provisions for professional regulatory organizations in Alberta to follow an approved privacy code in place of certain sections of *ABPIPA*. When Alberta organizations subject to *ABPIPA* engage in trans-border personal information flows for commercial reasons, they must follow the federal *PIPEDA* for those specific transactions.
- b) *British Columbia*: However, when British Columbia organizations subject to *BCPIPA* engage in the movement of commercial trans-border personal information, they also have to follow the federal *PIPEDA* for those specific transactions.

Can more than one privacy law apply to a counsellor for the same counselling service or information practice?

It is possible that more than one of the different privacy statutes may apply to the records created by a counsellor or counselling organization. This could be the case if a counsellor was on contract to another organization that had to follow a different privacy law than the counsellor ordinarily would. In this case, the counsellor would be obliged contractually to follow the other organization's rules that may be based on other legislation.

For example, an organization in British Columbia provides counselling services to employees of a railway or airline under an employee assistance program. The counsellor who normally follows the *BCPIPA* for his practice in British Columbia may be obliged by contract to follow the federal *PIPEDA* rules regarding the personal information of the company's employees because the company is under federal jurisdiction.

Another example might be if the counsellor was involved in the movement of personal information across provincial borders and operated in a province with a private sector privacy law other than *PIPEDA*. In this situation, the counsellor would have to comply with the local legislation for most of his clinical practice, but with the *PIPEDA* for that information which moves from province to province.

11) CLOSING COMMENTS

Statutes and regulations concerning privacy can be helpful in creating some sort of universal and easily communicated standard, and following them is necessary and important for good clinical and ethical practice, but – as the research indicates – the creation of a rule is only part of the solution. Few would argue that the law around privacy and confidentiality is intended to be complete. That is why legal requirements, although significant, may only constitute the starting point in discussions of privacy and confidentiality.

Despite the complexities of law, and of individual or cultural variation, privacy demands confidentiality at some level and on some issues for everyone. Everyone has boundaries, whether they are fully aware of them or not, that delineate what is and is not private. Nevertheless, at least some of that private information must normally find its way into the therapeutic setting. Confidentiality is the bedrock of effective counselling practice and clients expect counsellors to keep in confidence the sometimes sensitive personal information they disclose.

As we have discussed in this paper, a counsellor's duty of confidentiality has its roots in the common law and finds expression in professional codes of ethics. More recently, Canada's new private sector privacy legislation establishes a legislative foundation for this duty and the limited circumstances when a counsellor must or may set this duty aside. The research provisionally suggests that counsellors may need to be much more vigilant in avoiding circumstances when they breach confidentiality, even if only inadvertently, such as discussing patients (named or un-named) at parties or with friends or family members. The failure of a counsellor to meet the duty of confidentiality without lawful excuse can result in a myriad of legal outcomes, not the least of which could be an investigation by the counsellor's professional body or a Privacy Commissioner, or both!

In the past, there was a wide-spread view that clients should not be allowed to view their clinical records. Counselling clients are becoming more aware of their rights to access their personal information as recorded in the counsellor's files, if not to also seek corrections to the recorded information that they believe needs to be made. Again, both of these rights are now entrenched in Canada's new private sector privacy legislation and need to be understood by all counsellors.

Care needs to be exercised when a counsellor receives a request from a third party for access to or a copy of a client's clinical records. If the request is not supported by a signed release or a court order, or is made without reference to a statutory authority, a counsellor should refuse to comply. It may be necessary to assert a claim of privilege over the requested documents, which must be adjudicated on a case-by-case basis, most likely applying the Wigmore test.

There is a need for counsellors to understand the distinction between the need to obtain a client's consent (and how that consent can be given), which is a dynamic and on-going process, and any consent form the counsellor may want the client to sign. In brief, consent is a process; it is not a form.

Final remarks: Challenges to the “traditional” practices around consent

It is common practice for counsellors to have their clients sign consent to treatment forms at the start of a clinical session. As we have discussed in Chapter 8, consent is not a form but a process of communication between a counsellor and client. From time to time, it may be necessary for the counsellor to obtain the client’s consent and document that consent in a form. But is this step *always* necessary?

In part to stimulate debate on the subjects that we have discussed in our presentation, we offer the following two propositions:

Client consent to counselling

We propose that counsellors should seek to document a client’s informed consent by having the client sign a consent to treatment form but *only* when the nature of that treatment or clinical service is such that a sufficient risk of harm to the client may result which thus creates the need for the counsellor to protect him/herself by documenting on the form the client’s expressed consent to that treatment or service. Therefore, if the nature of the treatment or service could be particularly traumatic or difficult for the client, and the counsellor does not believe the client has sufficient insight or personal resources to respond well to such an outcome, this may be a suitable situation to ask the client to sign a consent form.

In all other cases, we propose that a counsellor should not begin or disrupt the clinical sessions by asking the client to sign a legal form, but – instead – the counsellor could simply rely on the client’s implied consent, as evidence by his or her continued participation in the clinical sessions.

Only if it becomes apparent that the treatment or service is likely to result in serious risk of harm to the client should the counsellor then protect him or herself by documenting the client’s informed consent to that treatment or service.

Duty of confidentiality and its exceptions

We also propose that counsellors should *not* ask their clients to sign a form which does nothing more than state that the counsellor has a duty to keep information confidential, and then describe some of the rare situations when a counsellor may have to breach that duty and disclose confidential information to some third party or authority. As these are legal duties that are imposed on counsellors by legislation or the common law, there is in fact nothing for the client to consent to! The counsellor *must* act according to the law, whether or not the client agrees or not.

Instead of asking clients to sign such a form, we propose that a counsellor should instead simply provide the client with a pamphlet or handout that discusses the counsellor’s duty of confidentiality and its limited exceptions. In this way, client will be made aware of these legal requirements and can ask specific questions if concerns arise.

It contributes little if anything to the therapeutic setting to ask the client to sign a form that contains a summary of the counsellor's legal duties and the exceptions. There is certainly no legal requirement for the client to sign such a document.

As the duty of confidentiality and its exceptions should be the same across Canada, we would also suggest a single, common pamphlet containing the same information should be used by all Canadian counsellors.

12) REFERENCES AND READINGS

Our presentation (and this paper) is based in part on the following legal references, articles and publications, which are also useful sources for addition readings, and are listed by the chapter of this paper.

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Law:

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- *Personal Information Protection Act*, S.A. 2003, c. P-6.5, s.20.
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- R. v. Dymnt, [1988] S.C.J. No. 8, [1988] 2 S.C.R. 417, 55 D.L.R. (4th) 503, 89 N.R. 249, J.E. 89-77, 73 Nfld. & P.E.I.R. 13, 45 C.C.C. (3d) 244, 66 C.R. (3d) 348, 38 C.R.R. 301, 10 M.V.R. (2d) 1, 6 W.C.B. (2d) 78 (S.C.C.).
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2) Privacy and Confidentiality in the Therapeutic Context

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6) Client Access to and Correction of Personal Information

Law:

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