Te Poari Kaimātai
Hinengaro o Aotearoa

NEW ZEALAND PSYCHOLOGISTS BOARD

Updated Informed Consent Guidelines
Ngā Aratohu Whakaae

May 2024

Acknowledgements

Drafting guidelines for a health profession takes a village approach. It is important that the guidelines are culturally, ethically, and legally sound, are understandable and most of all useful for the field. A range of practitioners and advisors contributed to the update of the Informed Consent Guidelines. Te Poari Kaimatai Hinengaro o Aotearoa / New Zealand Psychologists Board are very grateful to Sarah Whitcombe-Dobbs, Paul Oxnam, Claire Troon and William Louw for their time, effort, and expertise. Brian Emery provided valuable cultural advice and input. Tūmāia Kaiārahi were also critical in the feedback stage and provided advice, both collectively and individually, to produce the final version of this document. Claro Law provided helpful legal guidance and feedback regarding the information contained in these guidelines.

Purpose of the Guidelines - Kōrero timata: Te kaupapa o ngā aratohu

1. Legally, the Health Practitioners Competence Assurance Act (**the HPCA Act**) mandates Te Poari Kaimatai Hinengaro o Aotearoa / New Zealand Psychologists Board (**the Board**) to assure the public that psychologists are fit to practise and that they provide competent, high quality and safe services. To meet these obligations, the Board has adopted the Code of Ethics for Psychologists Working in Aotearoa New Zealand 2002 (**the Code of Ethics;** developed in conjunction with the New Zealand Psychological Society and the New Zealand College of Clinical Psychologists) as a guide to ethical practice. The Code delineates the manner or the tikanga in which psychologists should conduct their practice. All other statements, including the current guidelines, of how psychologists should conduct their practice must be consistent with the Code of Ethics and its ethical principles of respect for the dignity of persons, whānau, hapū and iwi, responsible caring, integrity in all relationships, and responsibility to society.

2. Guidelines adopted by the Board support psychologists in providing competent and ethical practice by translating or expanding on the Code of Ethics in relation to more specific aspects of their professional behaviour. Guidelines are recommendations rather than mandatory standards but supplement the Code of Ethics which is the highest and most aspirational regulatory document. Consideration and the application of such guidelines are considered an essential component of continued professional development and of delivering "best practice" and may be used by the Board, the Health and Disability Commissioner, and the Health Practitioners Disciplinary Tribunal as a standard in evaluating a psychologist's knowledge, mātauranga, competency and tikanga.

3. In accordance with the Code of Ethics, a psychologist's professional relations with others promote beneficence or wellbeing and manaakitanga, are based on respect for the other's autonomy, should not cause harm, and should be guided by principles of justice and fairness. These principles apply to all professional services and research endeavours. *It is fundamental to the respectful relationship with the client (whether individual, group or whānau, hapū, iwi) that the client and where relevant whānau is informed and participates as fully as they are capable of in consenting to psychological services, research participation and/or determining the purpose of engagement with the psychologist.*

4. The central purpose of the current Informed Consent Guidelines (**the guidelines**) is to promote practice consistent with ethical principles and legal requirements. Clearly, every consent scenario must be taken on its own merits by the psychologist, with critical thought and judgement applied to each individual circumstance. It is not possible for the guidelines to provide the exact guidance on what to do in the infinite number of possible consent scenarios and contingencies that might exist. However, it is intended that the

guidelines will assist psychologists in their critical thought and judgement that they will apply in all consent scenarios that could arise in their practice, research, or supervision.

5. The structure of the guidelines presents ten broad principles related to Informed Consent with detailed content organised under each.

The Ten Informed Consent Principles

1. **The informed consent process demonstrates whakawhanaungatanga**
2. A psychologist is legally and ethically required to gain informed consent before proceeding with any service
3. **Consent is a dynamic process and can change over time**
4. People require information that is relevant to their circumstances in order for consent to be informed
5. **Consent is practically related to confidentiality**
6. Capacity to make an informed choice is decision specific and may fluctuate over time
7. **Consent must be voluntarily given**
8. Informed choice does not mean unfettered choice
9. **Consent can be made on behalf of others in certain circumstances**
10. Consent in research and teaching requires special consideration

1. The consent process demonstrates whakawhanaungatanga

1.1. Engaging in the informed consent korero (conversation) is a clear sign of relationship building for clients and their whānau and respect for their human dignity and autonomy/self-governance. This includes where relevant checking with the client whether they want to involve whānau or significant others in consent discussions and decisions. This is an integral part of the initial engagement process with clients and establishing a working partnership with them, rather than a one-off event (Cargo, Waitoki & Feather, 2016). Gaining informed consent means that the client has the right to choose whether to receive the psychological service or to take part in research based on the best information available, and to withdraw that consent should their opinion change. Informed consent should occur at the beginning of an engagement, should be documented so that there is a written record retained, and is often a dynamic process of partnership as the unfolding process requires revision of mutual understanding and agreement.

1.2. Respect for the diversity of persons is fundamental to the Code of Ethics. The Code recognises that Te Tiriti o Waitangi sets out the basis of respectful relations between Māori and Non-Māori. Although there is also wide variation among Māori, gaining informed consent in a manner that empowers involvement is an important start on establishing a professional engagement that enhances well-being and delivers the required service. Cargo, Waitoki and Feather (2016) discuss the application of Te Tiriti principles to the process of informed consent. Partnership involves a collaborative relationship between the psychologist and the client where the client feels empowered. This may include discussions with, and participation of, whānau at the client's discretion. Participation is a culturally safe process of korero and protection enables access to services where the duty to provide safety is the responsibility of the psychologist. Providing an environment of trust is critical for Māori to be able to fully engage in the informed consent process.

1.3. A focus on individuality is not necessarily appropriate within some collectives. Māori and Pasifika families place more emphasis on shared responsibility and permission giving, as do many in the Asian and Arabic communities. When a Māori person and their whānau are seen, it may be more appropriate to offer the option of providing relevant information to the whānau, hapū and iwi, as well as the client, and allow time for the collective involvement from the wider group in the consent process (Cargo, Waitoki & Feather, 2016). The client may agree or not to involving whānau in their consent process and can change their position or consent at any time. The client's decision should be supported and adhered to.

1.4. The Māori connecting principle, the whakawhanaungatanga, addresses the question “who are you?” and “where are you from” which needs to be developed before the purpose of engagement is discussed (Gilgen & Stephens, 2016). The establishing of relationship allows the client to make an informed decision whether or not this service is appropriate for them, and whether or not they wish to involve whānau, hapū or iwi. This may involve sharing mihi, whakapapa, karakia and waiata to create a safe place “of joining in aroha” (Cooper & Rickard, 2016). The psychologist must also be prepared to share “who they are” and “where their whānau are from” as well, as this process is not one way. Once the relationship is established, like on a marae, then the tasks of engagement can be discussed, to facilitate achieving informed consent.

1.5. The domain of the psychologist was referred to by one author as an “unfamiliar kaupapa” (Gilgen & Stephens, 2016). Many clients and whānau may be apprehensive or fearful prior to an assessment or engagement with a psychologist. The cultural divide may be even greater for Māori and their whānau. Providing information in advance may help a Māori person and whānau to feel more comfortable and to know what to expect. A culturally appropriate greeting in te reo and where possible, offering a drink or refreshments may help create a sense of relationship. The psychologist may also have to be prepared to go meet their client and whānau at their marae, which means they should have the cultural competency to do this or have kaumātau with them who can manaaki them onto a marae.

2. A psychologist is legally and ethically required to gain consent before proceeding with any service

2.1. The Code of Ethics provides ethical guidance to the profession about establishing consent in Principle 1.7:

> *Psychologists recognise that obtaining informed consent from those with whom they are working is a fundamental expression of respect for the dignity of persons and peoples.*

2.2. Psychologists are also legally bound to uphold the Health and Disability Commissioner's (**the HDC**) Code of Health and Disability Services Consumer's Rights (**Code of Rights**), in which Right 5 gives consumers a right to effective communication, Right 6 gives consumers the right to be fully informed and Right 7 gives consumers the right to make an informed choice and to give informed consent. The High Court has upheld that informed consent is a fundamental right on the part of consumers of health services, and that whether or not the information is adequate is to be assessed from the viewpoint of the client. An Aotearoa New Zealand court (B v Medical Council of New Zealand [2005] 3 NZLR 810) considered that the provision of inadequate information, in a situation where the client needs that information for their decision affecting treatment or investigation, will almost always amount to professional misconduct.

2.3. Legally effective informed consent means that a client with decision-making capacity freely consents to (or refuses) a plan aimed at a mutually agreed goal. The consent is informed when the psychologist discloses to the client sufficient relevant information to enable the client to make an informed decision about the relevant options for treatment (including no treatment). Under Right 6(1) of the Code of Rights this includes providing an explanation of: their condition; any options available including an assessment of expected risks, side effects, benefits and costs of each option; advice as to the estimated time within which the service will be provided; notification of participation in teaching or research, results of tests and procedures and any other information required by legal, professional or ethical standards.

2.4. A third party contracting a psychological service may have obtained consent from the client who is the intended recipient of the service. However, the psychologist must undertake their own informed consent process with the client rather than relying on what may have been a generic consent process. The onus is on the psychologist to establish that they have provided the client with sufficient information to enable their client to understand what is proposed prior to proceeding with any psychological service or research.

2.5. Where a client wishes whānau or any other support persons to be involved in discussions and the informed consent process this should be respected and be recorded as part of the process. Even though whānau and/or other support persons may be heavily involved in the discussions and decision whether to proceed with a proposed service, the client, where competent, must give informed consent before the service can proceed.

The consent process and decision must be recorded

2.6. The informed consent process used in any professional engagement should be transparently evident in the records arising. This <u>may</u> be covered by a standard consent form which states the generic terms of engagement and is signed by the client after the client has had the opportunity to ask questions and consider the information provided. Preferably the records should include the discussion notes which summarise the information given and what has been agreed to. Any revisions to the consent content or terms should also be recorded so that there is an evolving report in the records regarding what has been agreed and the terms of engagement.

2.7. If a video or other recording is taken or a one-way screen is used explicit written consent for this must be gained. In this situation the psychologist should explain why this is necessary and what will be done with any recording that arises.

2.8. Additional explicit consent should also be requested if a psychology student wishes to sit in on a session with a client (discussed further in the tenth principle: *Consent in research and teaching requires special consideration*).

3. Consent is a dynamic process and can change over time

Consent decisions can be reviewed at any time, including withdrawal of consent

3.1. In all scenarios the client should feel free to decline to engage in the psychological service and, if they do, any negative effects of that choice should be minimised as much as possible. Furthermore, the client may withdraw earlier consent at any stage of the engagement. This means that they do not have to continue with any part of the interaction with the psychologist.

3.2. However, in the event of withdrawal of consent, the information collected to date must stay on the psychologist's file; the client and whānau cannot require that it be destroyed (e.g., the psychologist may need to refer to these notes in the eventuality of a future complaint about the service provided to date).The Health (Retention of Health Information) Regulations 1996, requires all health information to be retained for 10 years following the last engagement with the client. The client can request access to their information (as per Rule 6 of the Health Information Privacy Code 2020), and they can request that information they believe to be incorrect is corrected. Whether this latter request should be granted will depend on the purpose the information was collected for and whether it is believed that the information was correct at the time it was collected. If the psychologist does not believe the information is incorrect or should be changed the client can request to have a statement of correction be placed on their file with the disputed information.

3.3. Any significant change in the nature of the service will require a need to re-visit informed consent. The client should be encouraged to ask questions and raise any concerns so that open and honest communication is established. This protects the dignity of the client and makes explicit their autonomy within the power imbalance that is inherent in the consultation setting. People have the right to change their mind, whether due to gathering more information, having second thoughts or because they try an option and it does not work out. They also have the right for others to respect their decision, regardless of whether others agree with their decision. The psychologist should not impose their own values and attitudes on the person and their whānau.

4. People require information that is relevant to their circumstances in order for consent to be informed

4.1. The minimum information required to ensure informed consent is set out in Right 6(1) of the Code of Rights.

4.2. Right 6(1) states:

> Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including:
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> (a) an explanation of his or her condition: and
> (b) an explanation of the options available including an assessment of the expected risks, side effects, benefits, and costs of each option; and
> (c) the expected time within which the services will be provided; and
> (d) notification of participation in teaching or research, including whether the research requires and has received ethical approval; and
> (e) any other information required by legal, professional, or other relevant standards; and
> (f) the results of tests; and
> (g) the results of procedures.

Any constraints on the confidentiality of the records arising should also be discussed with the client, as should any restrictions the client wants to place on their consent, and how consent may be reviewed or rescinded at any time. The understanding of what information is deemed to be relevant is likely to evolve as the engagement with a client and whānau unfolds.

4.3. The initial information may also include the limitations of the service offered. For example, a private practitioner may choose to state that their service is not intended to be a crisis or emergency service, and to provide details of how to access emergency services.

4.4. Discussing options may include acknowledging alternative experts in the field (if available), less expensive options, public versus private services, and how to access these alternatives. Engagement for a contracted service (e.g., assessment for a third party) may involve discussion of the consequences of not complying.

4.5. The nature of the psychological activity and the likely outcome of the service or research should be described, without overstating any anticipated benefits. By offering the service the psychologist is implicitly claiming expertise in that field, but care should be taken to not overstate their competence or the range of their experience. As noted above, it may be relevant to identify any alternative intervention approaches and how these other services could be accessed.

4.6. The Code of Rights states (at Right 6.3) that, if asked, a psychologist is obliged to inform the client of their professional status and qualifications, their recommendation for any proposed action, how to obtain a second opinion, and the outcomes of relevant research.

4.7. The client and where relevant whānau should be informed of the intended aims and objectives of the engagement, using language, form of information, and manner that promotes understanding. Information may need to be adjusted to allow for any language or cultural barriers, as well as any cognitive or communication difficulties. The psychologist should communicate and share information in a way that enables the client to understand the purpose and process of the engagement. This may mean adapting and presenting information in a more accessible manner, for example using simpler wording. In some circumstances the psychologist may need to assess the client's understanding (e.g., by asking the client to relate back their perception of the situation in their own words).

4.8. It may be appropriate to inform the client of the consequences of not consenting to proceed. Any potential risks arising from psychological services or research participation should also be discussed so that the client is forewarned as much as possible. This would include any fees payable, time estimates, and any privacy and confidentiality issues. Where the treatment or therapy being proposed is still being developed and therefore there is not yet a strong evidence base for it, the client should be informed of this. Any departure from established methods should also be carefully discussed and consent for any alternate approach sought.[1]

4.9. The client and whānau (if involved) should be given adequate time to consider the information given and consult with trusted people, and/or legal representation. In some settings, this may mean having a separate session to discuss the proposed services before consent is obtained and any formal provision of services commences.

4.10. Given the nature of psychological services, it is anticipated that a written consent form, offering the information in verbal/visual form would be appropriate in <u>most</u> circumstances. This allows the client to have something tangible to take away with them to refer to at a later stage, rather than having to rely on memory.

4.11. The reciprocal contractual details of the engagement, such as the expectations around payment for services, what notice of non-attendance applies, whether contact between sessions is applicable, and the service offered for the fee should be discussed with the client before consent is

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[1] The inclusion of some alternative or natural healing approaches and faith-based approaches are considered departures from evidence-based psychological interventions and have been the basis of complaints received by the Board. While some natural healing approaches may have an evidence base, it should be declared as part of the informed consent process as outside the mainstream of what consulting a psychologist involves.

obtained and should be recorded in writing. This may be included in the informed consent statement or in a separate document. In addition, the client should be informed that they have the right to complain if they are not satisfied with the services they receive, and how they might go about making a complaint.

5. Consent is practically related to confidentiality

Particular care to be taken in discussing the parameters of confidentiality

5.1. The psychologist should clearly explain the parameters of confidentiality during the informed consent process and what could occur if there are disclosures that indicate another person is at serious risk, or concern that the client may be at risk to themselves or from others. The discretion to release relevant information without consent in these risk related circumstances is provided for in Rule 11(2) of the Health Information Privacy Code 2020, various statutes,[2] and is also supported by the Code of Ethics.

5.2. In addition, the informed consent stage allows the client and their whānau (where relevant) to understand what the purpose of the engagement is, and what other parties are going to, or may receive information about the client as part of that purpose. This is a crucial point for clients and their whānau to understand, as they are essentially consenting to the parameters of confidentiality.

5.3. The consent discussion should include the client and where relevant whānau being informed of who will (or could) have access to information held on file, including what other health professionals or staff members will see notes in the case of multi-disciplinary teams. This also includes informing the client and where relevant whānau that professional supervision occurs, which means that client information is routinely discussed for quality assurance purposes. The name of the supervisor should be disclosed to the client and where relevant whānau. Even though the psychologist may not name clients when discussing with the supervisor, the circumstances of the client and whānau may be recognisable should the client and supervisor be acquainted.

5.4. The explanation to the client and where relevant whānau regarding confidentiality should also include what personal health information will be collected from the client, how this will be stored and for how long (in accordance with the Health Information Privacy Code 2020 and Health (Retention of Health Information) Regulations 1996). The client should also understand that there are limited times[3] when the law can require or permit a psychologist to release relevant information without authorisation from the client. This can be referred to in the confidentiality limits by stating 'or if otherwise required or permitted by law.'

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[2] For example, the Oranga Tamariki Act 1989, the Family Violence Act 2018, and the Health Act 1956.

[3] For example, section 66 of the Oranga Tamariki Act 1989

6. Capacity to make an informed choice is decision specific and may fluctuate over time

6.1. Gaining informed consent is a process of ongoing discussion, evaluation, and participation with the client and where relevant their whānau, and consideration of their particular circumstances. The psychologist needs to be mindful that they work in such a way that promotes equity and equality in achieving informed consent. Beauchamp and Childress (2013) indicate that there are seven elements to the initial informed consent (or informed refusal) process. These are:

- Capacity to understand and decide
- Voluntariness in deciding
- Disclosure of material information
- Recommendation of a plan
- Understanding
- Decision in favour for or against the plan
- Authorization of the decision,

and in the Aotearoa New Zealand context:

- The ability to whanaungatanga and manaakitanga the client and whānau, should they be invited to their marae or if they arrive at their service to see the psychologist.

Individuals should be supported to achieve capacity where possible

6.2. The Code of Ethics requires psychologists to obtain as full and active participation as possible from all clients.

6.3. Under Right 7 of the Code of Rights:

- all recipients of health and disability services must be presumed competent[4] to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the person lacks capacity.
- Where a client has diminished competence, they retain the right to make informed choices and give informed consent to the extent appropriate to their level of competence.

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[4] Whilst the words capacity and competence are often used interchangeably, they are different legal constructs. Capacity refers to a person's ability to engage in a process of listening, attending, understanding, and reasoning through a decision, which a psychologist either informally or formally is assessing as part of the initial engagement. Competence is a legal term that refers to a decision (usually by a Judge) that a person has the mental capability to make decisions/act on their own behalf or participate in legal proceedings or transactions.

- Where a client is not competent to make an informed choice and give informed consent **and** no person legally entitled to consent on their behalf is available the psychologist may provide services following the process set out in Right 7(4) of the Code of Rights. (Discussed further in the ninth principle: *Consent can be made on behalf of others in certain circumstances).*

6.4. Douglas, Young and McMillan (2020) define capacity as the ability to understand, retain, use, or weigh and communicate a decision. Furthermore, capacity is decision and time specific, such that capacity is assessed for a particular decision at a particular time, rather than in a global sense.

6.5. The United Nations Convention on the Rights of Persons with Disabilities[5] obliges all spheres of life, both public and private, to be consistent with its principles of the full realisation of all human rights and fundamental freedoms for disabled persons. Article 12 of the Convention refers to equal legal rights, including respecting the rights, will, and preferences of the person without undue influence. The Convention affirms the individual's right to make their own decisions and to the need to respect their dignity and freedom of choice. This places the obligation on those in the roles of delivering services to lift the level of support to enable and empower those with reduced capacity to exercise their legal rights.

6.6. The Victorian Government disability services have produced a particularly useful supported decision-making framework[6] which is based on the decision-making principles:

- Everyone has the right to make decisions about the things that affect them.
- The competence to make decisions must be assumed (unless there is good reason not to).
- Every effort should be made to support people and their whānau to make their own decisions.
- **Capacity to decide is decision specific.**
- People and whānau have the right to learn from experience.
- People and whānau have the right to change their mind.
- People and whānau have the right to make decisions that others might not agree with.

6.7. The client and where relevant whānau may need additional assistance to understand and communicate the client's choice. It may be helpful to use different formats, communication aids, translators, or longer time frames to make decisions. Decision making capacity means understanding the situation and the decision required. It means understanding what the choices are,

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[5] Signed by New Zealand in March 2007 and ratified September 2008.

[6] See Department Human Services Victoria (2012)" Disability services: Supporting decision making".

weighing up the consequences of the choices, how different choices may affect them, and then communicating their decision.

6.8. Psychologists should explain matters in a way that helps the client, and where relevant whānau, understand what they are discussing and the decision that needs to be made. It may be helpful to explicitly check understanding of the relevant information, by asking the client to paraphrase what they have heard and understand. Client comprehension can be easily over-estimated. For example, an individual who is cognitively functional in normal circumstances may not absorb information in an unfamiliar context due to anxiety or preoccupation. Ability to understand can be impacted by a range of factors including (but not limited to) education, intelligence, cultural unfamiliarity, and age as well as a host of acute or dynamic factors (e.g., psychosis, intoxication, sleep deprivation). A sensory disability such as deafness or blindness also may be a barrier to comprehension. English as a second language is also a possible constraint on understanding. The use of a translator may be advisable with some referrals, both with regard to gaining consent to proceed and possibly throughout the service provision. Care should be taken to ensure the client and where relevant whānau agrees to the translator being present and that the translator understands the parameters of confidentiality.

Capacity is decision specific and may fluctuate over time

6.9. The capacity to decide is specific to each decision, and relative to the particular decision to be made. It may fluctuate depending on the current health and stress levels of the client, familiarity with the subject matter, complexity, and any other factors that impact on that person and whānau. Optimally, the client grasps the condition and the nature of the intervention or service proposed, understands the procedure and any risks/benefits identified, and can make a reasoned and considered informed consent decision. Capacity requires the individual to understand the relevant information, appreciate the significance of the information in their particular circumstances, and to demonstrate reasoning by considering alternatives and then to be able to express choice. The psychologist may have to make a judgement call, and then document the basis for that decision.

6.10. If capacity to give informed consent is being questioned, there are four levels of cognitive abilities commonly distinguished (Knight & Linscott, 2007):

- The ability to make a clear and stable choice between alternatives.
- An ability to understand the treatment or research being proposed.
- The ability to make a reasoned judgement.
- The ability to understand the context and consequences of the decision.

6.11. Impairment in ability to comprehend the purpose and therefore to give informed consent may arise from cognitive impairment, cognitive decline due to old age, psychosis, head injury, or any other mental disability/impairment.

Even where a person is considered impaired, they and where relevant their whānau should be given the information and be supported to participate in giving consent to the extent that they are capable. The presence of a support person, advocate, communication assistant or carer may assist the process of informing the client and where relevant whānau, but care should be taken to ensure that the third party does not inadvertently coerce or impose their will on the client regarding participating in the assessment or receiving treatment.

7. Consent must be voluntarily given

Consent must be voluntarily given, without undue influence or coercion

7.1. There are many issues which may compromise a client's ability to freely make their own autonomous choice about whether to engage in psychological services. Compromise may occur because of the power imbalance implicit in the situation, a client's desire to please, or because of the situation. The psychologist may also be susceptible to overstating the expected positive outcome in their desire to help the client. It behoves the psychologist to be sensitive to these issues and to the vulnerabilities of any parties to the engagement, to strive to promote the wellbeing of clients and whānau, and to minimise any infringement of their freely given choice. Consent should not be based on suggestion or persuasion but on comprehension.

7.2. The dignity of the client and their right to refuse engagement must be respected, even in situations where the psychologist does not agree with their choice.

7.3. There is a difference between undue influence and coercion, with both behaviours rendering an individual's consent invalid. Coercion generally refers to the use of physical threats or force, or the use of illegal means of blackmail to secure someone's agreement. In contrast, undue influence refers to someone using manipulation or excessive means of persuasion in order to secure agreement. Whilst the latter is not a criminal offence it is still negatively impacting a client's autonomous decision-making. In circumstances where a psychologist believes their client is being coerced or unduly influenced to give consent (or refusal) to a psychological service or research they should not proceed until the person is supported to make an autonomous decision, commensurate with their capacity.

7.4. Clients may not wish to make an individually autonomous decision, instead preferring to defer to, or to make decisions in collaboration with their whānau or support network. The psychologist should respect this process when the client has made this decision (for a collective choice to be made) voluntarily. However, the client, if competent, must actually make the final decision and consent to the services being provided or participation in research.

8. Making an informed choice does not mean unfettered choice

8.1. There are particular considerations for informed consent with certain populations of clients and whānau. Often these scenarios result from a tension between considering the rights of clients and whānau and other interested parties.

Consent with clients in the care of the Department of Corrections

8.2. A person who has been convicted of a criminal offence may be court-ordered to undergo a psychological assessment (e.g., a pre-sentence risk assessment for a hearing where an indefinite sentence of preventive detention is being considered under s88 of the Sentencing Act 2002). Gaining informed consent from the person in the care of the Department of Corrections will require careful clarification of the consequences of participating versus not participating in the assessment and these should be clearly spelt out in the consent process. Information about consequences of participation is likely a critical point in the client's decision-making process about whether to participate in the interview or not. The assessing psychologist should also make a full disclosure on the reason for the assessment, to whom the information will be given, how the assessment will be undertaken (e.g., sources used for collateral information, psychometrics to be administered), the risks and benefits arising, the alternatives to consenting, and who will have access to the report. If the client refuses to consent and participate in the court-ordered assessment, the psychologist may need to proceed, drawing only on file data (that is not medically privileged) and collateral sources. This highlights that, in such a case, there are competing interests of safety overriding an instance of respecting an individual's autonomous choice, although their decision to not participate directly is always respected. In such a situation, the conclusions and judgements drawn would be stated in the psychologist's report, along with the person's refusal to consent to participation in the assessment and the limitations arising from the person's choice to not participate. The record documenting the process used to attempt to gain informed consent could be considered should there be a subsequent complaint or judicial challenge.

8.3. It is important to note that this applies to assessments only and not to psychological treatment. The New Zealand Bill of Rights explicitly states in section 11 that everyone (deemed competent) has the right to refuse medical treatment (this likely includes psychological treatment). This includes people who are convicted of a criminal offence. In some cases, there may be a difficult choice between two scenarios (e.g., participate in psychological treatment or continue to serve the original prison sentence), but this difficult choice does not invalidate the voluntariness of the decision, as it is recognised that most healthcare decisions are not unfettered in choice, but involve deciding between two, often unpleasant, options (Murphy, 1981).

8.4. In any setting where a psychologist is preparing an assessment for a criminal court proceeding, they need to clearly understand and communicate to the client the concept of medical privilege and ask whether the client wishes to waive this privilege as part of the informed consent process. Medical privilege is legislated for in s59 of the Evidence Act 2006 and applies only in criminal proceedings and only in limited circumstances.[7] It grants a privilege for certain communications with, and information obtained by, clinical psychologists (and medical practitioners), and provides, like other legal privileges, that specific information may be withheld from the court if the client does not wish this information to go before the court.

8.5. Medical privilege only attaches to certain information a psychologist may have access to and not all potential health information held for that person on their file. The privilege applies in a criminal proceeding in respect of:

(a) any communication made by the person to a clinical psychologist that the person believes is necessary to enable the medical practitioner or clinical psychologist to examine, treat, or care for the person for drug dependency or any other condition or behaviour that may manifest itself in criminal conduct; or

(b) in respect of information obtained by a clinical psychologist as a result of consulting with or examining the person to enable the clinical psychologist to examine, treat, or care for the person for drug dependency or any other condition or behaviour that may manifest itself in criminal conduct.)

The psychologist may not refer or even know about information covered by this privilege during their assessment for a criminal court proceeding if the client decides to not waive this privilege. For a client to give valid authorisation regarding this decision they need to clearly understand what a privilege is, and the benefits and risks of their decision. This is also a situation where the client should be given adequate opportunity to consult with their whānau and legal counsel about this particular decision.

8.6. The area of medical privilege is recognised as a narrow legal construct and psychologists who are preparing reports for criminal court proceedings

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[7] The privilege in s 59 of the Evidence Act 2006 does not apply in the case of a person who has been required by an order of a Judge, or by other lawful authority, to submit himself or herself to the medical practitioner or clinical psychologist for any examination, test, or for any other purpose (s59(1)(b)). This exception to the privilege only applies to communications, observations, and information solicited or generated during the court ordered assessment, and not to other medical records of the privilege-holder (s59(1A)).

are urged to get specialist training in this area, so that they can a) adequately explain this to their clients to ensure an informed choice regarding the potential waiving of privilege and b) understand the application of medical privilege in their work.

Consent with court ordered assessments of adults who may have mental impairment

8.7. There are a number of statutes which enable the Courts to order that a person undergo a psychological examination where their mental condition is relevant to any matter in question in a proceeding, most commonly reports prepared under s33, s35 and s38 of the Criminal Procedure (Mentally Impaired Persons) Act 2003.

8.8 The principles of informing and gaining informed consent still apply in this mandated assessment scenario. The psychologist should give adequate information about the nature and scope of the assessment, the ways in which the report is likely to be used, and to whom the report will be made available. Information should also include the likely consequences of not cooperating with the report preparation.

8.9. If the consent to proceed is not freely given, the psychologist should record that and any constraints on the information available but proceed to the best of their ability in the circumstances.

9. Consent can be made on behalf of others in certain circumstances

Consent can sometimes be valid from a legally authorised person

9.1. In some circumstances, a legally authorised person or guardian may provide consent on the client's behalf. For an adult who is deemed not competent, this must be a Welfare Guardian or a person holding an Enduring Power of Attorney for personal care and welfare for the client (in accordance with the Protection of Personal Property Rights Act 1988) if this has been legally arranged for. For a child who is deemed not competent, it is the child's legal guardians who can provide consent (in accordance with the Care of Children Act 2004.).

Where consent cannot be obtained due to incapacity or lack of a legally authorised person able to consent

9.2. The psychologist has an ethical duty to take particular care to act in the client's best interests given the extraordinary vulnerabilities inherent when the client lacks capacity and does not have a person legally authorised to consent on their behalf. If the person lacks capacity to make their own decision and there is no-one legally entitled to consent on their behalf available, the psychologist may provide the service under Right 7(4) of the Code of Rights if:

a. the proposed service is in the person's best interests; **and**
b. reasonable efforts have been made to ascertain the views of the person and the psychologist believes that the person is likely to have consented if they had been competent to do so; **or**
c. if the person's views have not been able to be ascertained, the psychologist has taken into account the views of other persons who have an interest in the client or proposed client's welfare.

9.3. The grounds for holding such beliefs, including any input received from others should be recorded in the client's record. Services provided under Right 7(4) are provided without consent – while the views of other persons who have an interest in the client's welfare are considered the decision to proceed with the proposed service is made by the psychologist - the other persons cannot provide lawful consent. The "duty of care" requires the psychologist "to ensure evidence-based practice is followed in the best interest of the client, using the least restrictive option, with the best quality of life outcome" (Webb, Verhoeven & Eggleston, 2007). Other available persons and whānau who have an interest in the welfare of that person should also be consulted.

Compulsory assessment and treatment under the Mental Health (Compulsory Assessment and Treatment) Act

9.4. The Mental Health (Compulsory Assessment and Treatment) Act (**MH(CAT) Act**) sets out the circumstances in which a person may be subject to compulsory assessment and treatment for mental disorder. A person who is being assessed as to their suitability for compulsory status under the MH(CAT) Act can be assessed and treated for a mental disorder without consent. Within the first month of a compulsory treatment order being issued, the patient may be required to undertake psychiatric assessment and treatment for the mental disorder as ordered by the responsible clinician, whether or not the person has consented. After the first month, the patient is only required to accept treatment if:

(a) having had the treatment explained to them, consents in writing; or
(b) the treatment is considered to be in the interests of the patient by an independent psychiatrist appointed by the Review Tribunal.

9.5. While the MH(CAT) Act provides for assessment and treatment to be provided without the patient's consent in the circumstances set out in the Act, the responsible clinician wherever practicable, must seek to obtain the patient's consent to any treatment even though the treatment may be authorised without the patient's consent (section 59(4) of the MH(CAT) Act).

9.6. If a patient who is subject to a compulsory treatment order is competent to consent to treatment, and treatment other than treatment for their mental disorder is thought to be necessary, the patient's consent must be obtained before the treatment can be provided. If a patient who is subject to a compulsory treatment order lacks capacity to consent to treatment, and treatment other than treatment for their mental disorder is necessary, that treatment can be provided in accordance with general legal principles for treating patients who lack capacity and Right 7(4) of the Code of Rights.

9.7. Consent is not required where treatment is immediately necessary to save the person's life; prevent serious damage to their health; or prevent the person from causing serious injury to themselves or others.

Consent with children and young persons

9.8. The law relating to consent and children or young persons is primarily found in the Care of Children Act 2004 (**COC Act**) and the Code of Rights.

9.9. For the purposes of the COC Act a "child" is a person under 18 years of age. Under the COC Act a child who is 16 years or over, or who is or has been married or living in a defacto relationship, can consent, or refuse consent, if they are competent, to any medical treatment or procedure. The

COC Act is silent on the right of a child under 16 years to consent or refuse consent to medical treatment or procedures. The exception to this is a female child of any age may consent, or refuse consent to any medical or surgical procedure for the purpose of terminating her pregnancy by a person professionally qualified to carry it out.

9.10. The overriding principle in the COC Act is that the best interests and welfare of the child should be paramount. The Act sets out the role of a guardian and how that role must be exercised, including “that a guardian of a child must act jointly with the other guardians.” (Section 16(5) COC Act). Guardians have the right and responsibility to determine for or with the child, or help the child to determine questions about important matters affecting the child. This includes medical treatment that is non routine in nature, which will include psychological assessment and therapy. If a child is deemed mature enough to choose for themself, the role of the parent or guardian ideally becomes one of advisor and supporter.

9.11. The general law in this area demonstrates a clear trend away from age-related thresholds and, instead, focuses on the competence of the individual child. The relevant question does not focus on the age at which a child may consent validly to services. Rather, it focuses on whether the level of understanding of a particular child enables them to consent to a particular service. A child may authorise medical treatment if they are mature enough to understand the nature and consequences of what is proposed and are capable of expressing their own wishes.

9.12. The House of Lords Gillick v West Norfolk and Wisbech Area Health Authority (1985) decision ruled that a child’s right to make their own decisions superseded parental rights of decision making when “a boy or girl is capable of understanding what is proposed and is capable of expressing his or her own wishes”. The Court in the Gillick decision also stated that practitioners should make every effort to encourage the child to involve the parents and whānau.

9.13. The Gillick decision is consistent with the Code of Rights. Under the Code of Rights, the starting point is that every person is presumed competent unless there are reasonable grounds for believing otherwise (such as a very young age). The United Nations Convention on the Rights of the Child (ratified by New Zealand in 1993) also recognises the rights of the child to be seen as having individuality and therefore some autonomy, in addition to the right to be protected. This includes involving children in decisions about their health and welfare.

9.14. If a service is to be provided to a child, then consent may be obtained from the child’s guardians (usually their parents), where possible. However, if the child is regarded as a mature minor (see below), then that child is considered to have the capacity to consent (or to decline treatment) on his or her own behalf. As with adults, the level of capacity required is relative to the decision in question.

9.15. Under the age of 16, a psychologist may see a young person without parental authority or knowledge if that young person is considered to have sufficient understanding to make their own informed decision. However, in these circumstances it will mostly be appropriate to encourage the child or young person to involve their legal guardian(s) in the decision-making processes, unless there is good reason to not do this.

Consent from both parents or all legal guardians should be sought where the child does not have capacity

9.16. Ordinarily both parents will be the legal guardians of a child. While only the consent of "a" guardian is required under the COC Act, it is normally good practice to involve both parents, or all guardians, with regard to health matters that are not routine in nature. Of course, there are many situations where this is impossible or inadvisable. For example, when a parent is deceased, unable to be contacted after reasonable attempts, or when in attempting to gain consent there is increased risk to the child concerned. In these cases where consent from all legal guardians is judged impracticable, or inadvisable, a rationale for this decision and who was consulted (such as a supervisor or other agency) should be documented in the child's file.

9.17. If one parent or guardian refuses consent, under section 46R of the COC Act a parent can apply to the Court to make the case for why the best interests of the child should override this opposition. In addition, a child who has capacity to decide may make their own decision to either consent or to withdraw consent for a course of action or treatment. Again, processes of seeking consent and any decisions arising should be fully documented in the client records, including options explored and who was consulted.

9.18. If a parent or guardian is required to consent because the child lacks capacity, they will be entitled to the information necessary to make an informed choice and informed decision. However, care needs to be exercised where there is any concern that providing all or certain information to a parent or guardian may not be in the best interests of the child or young person. Neither the Code of Rights nor the Health Information Privacy Code distinguishes a person's rights based on their age. However, parents of a child under 16 years of age are the child's representative and will be entitled to request or be provided with their child's health information unless there are reasonable grounds to believe that it would not be in the best interests of the child to provide the information to the parent(s).

9.19. If the parents of a child are separated or divorced, there may be a court order in place which specifies which parent has the right to make decisions affecting the child's health. A psychologist should make reasonable enquiries to ascertain whether the parent or caregiver seeking treatment for their child has the right to consent to treatment and if any other person is also a legal guardian of the child. Where there is a court order establishing guardianship of a child, a copy of the actual order should be obtained and retained on the child's file. Unless the Family Court orders indicate otherwise, ordinarily both parents (or all guardians) should be consulted and reasonable efforts need to be undertaken to seek consent from all the child's guardians/both parents (even if one parent is incarcerated, or overseas and their contact details are reasonably available).

9.20. The issue of consent becomes more complicated when children are old enough to have strong views about the decision themselves that conflict with the views of one or more of their parents. New Zealand law presumes anyone, regardless of age, is capable of providing informed consent to treatment unless there are reasonable grounds to suggest otherwise. Children's views should always be taken into account by a court deciding such issues, although what a child wants may differ from what some other persons may deem to be best for the child's interests and welfare. Should a decision concerning a child or young person be disputed, the psychologist should fully document the process of seeking informed consent and record the reasons for the course of action (or inaction) chosen. A Court can also overturn parental refusal or consent if it is deemed not in the child's interests. Literature cited by Rucklidge and Williams (2007) observed that there are rare occasions where the court has been used to overturn a child's decision on the grounds that it is in their best interests to receive that treatment. Psychological treatments are unlikely to be of life preserving importance (although this may apply to severely eating-disordered clients), but a psychologist may be required to give evidence in such a case regarding their assessment of capacity.

Consent in the context of Family Court disputes

9.21. A psychologist who is contracted to assess, counsel, or to provide other psychological interventions to a child who is or has been the subject of a Family Court dispute should take care to gain consent in writing from all guardians before proceeding.[8] This would apply whether the contract was from the Court or any psychological service. Taking care to inform and gain consent is respectful of the rights of both parents and avoids the psychologist being drawn into one side of a parental conflict (which is unhelpful for the interests and welfare of the child). Section 16 of the COC Act makes it clear that both parents (guardians) have the right to be

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[8] In June 2016 the Health Practitioners Disciplinary Tribunal issued a finding against a psychologist who failed to do this.

involved in important matters – including non-routine medical treatment - affecting the child. While s36(3) allows one guardian to give consent, in a Family Court dispute there is already an acknowledged disagreement between the parties over the child's care arrangements. The psychologist has a professional obligation to avoid bias or giving the perception of bias, and therefore should in most situations collaborate with both parents to achieve the best possible informed consent. The consent of both parents is more likely to protect the child's best interests by enabling a better assessment and may promote psychological safety for the child through the awareness of the involvement of both parents and reducing the risk of resist-refuse dynamics. In the event that consent is not forthcoming, or one parent cannot be contacted, the matter should be referred back to the Family Court Judge for direction.

Court ordered assessments of a young person

9.22. Assessments ordered by the Court provide circumstances that allow psychologists to proceed without informed consent. Sections 178 and 333 of the Oranga Tamariki Act 1989 enable the Youth Court to order the provision of a psychological report regarding a child or young person to whom proceedings relate. The Court will order the child or young person to attend for a psychological examination and that the report be made available to the Court.

9.23. Although this provides a circumstance in which the psychologist may proceed without informed consent, the principles of providing information and seeking consent still apply. The psychologist is obliged to provide adequate information about the nature and scope of the assessment, about the use to which the resulting report will be put, and about the people who may have access to the report. The psychologist should then endeavour to obtain informed consent from the client and to ensure that the client has also spoken with their whānau and/or legal advisor regarding this process.

9.24. If a young person refuses to participate in an assessment, the Court may (if there is sufficient justification requiring the assessment) insist on it regardless. In the face of a refusal or minimal cooperation by a young person held in a Youth Forensic Service to participate in an assessment, the psychologist should use their best endeavours to provide adequate information, including the possible consequences arising by not providing information, to encourage (but not unduly influence) consent. This may include the psychologist discussing in supervision ways to build rapport with the young person and revisiting consent again. It is desirable that the assessment is undertaken collaboratively in order to report to the Court as fully as circumstances allow. In the absence of consent from the young person concerned, the psychologist may need to report back to the Court within the constraints that this imposes.

Cognitive decline in the elderly

“Optimizing the potential for decision-making in persons with dementia contributes to the maintenance of identity, well-being, and quality of life in addition to promoting dignity, integrity, and personhood” (Smebye, Kirkevold & Engedal, 2012).

9.25. The individual’s capacity to understand and reason may fluctuate for a person suffering cognitive decline. Decisions vary in complexity, and it is important to determine decision-specific capacity rather than global judgements of capacity. Under the Code of Rights, a person with diminished capacity has the right to make informed choices and give informed consent, to the extent appropriate to their level of competence.

9.26. If the elderly individual has appointed a person as their enduring power of attorney for personal care and welfare that person should be involved in any health care decisions and will need to give informed consent if the elderly person lacks capacity to consent. If the elderly person lacks capacity and has not appointed an enduring power of attorney for personal care and welfare the steps set out in Right 7(4) of the Code of Rights should be followed when providing psychological services to the elderly person. Involvement of trusted others and whānau may assist the psychologist to better understand the values and preferences of the elderly person. The trusted other person and whānau may also be familiar with more skilled ways of presenting information to promote participation in decision-making. If there is more than one session with a person and their whānau, the process of giving information and gaining consent may need to be repeated as cognitive competence and recall is likely to fluctuate.

Intellectual disability

9.27. Although a client may have diminished capacity, an attempt should still be made to explain and inform the client, and their whānau about proposed services in terms that they can understand. A person with diminished capacity to comprehend, such as persons with intellectual or neurological disability, may be more susceptible to suggestions from authority figures than those without such disabilities. Where the individual has experienced dependence with limited choice or control in their life, their capacity to consent may be constrained (Webb, Verhoeven & Eggleston, 2007). Despite these barriers, it remains best practice to involve the individual to the extent that is possible. This is also a requirement under the Code of Rights. Participation may be promoted by presenting information in a format that is more amenable to being understood, breaking down the process into small steps, setting clear goals, and discussing the goals regularly. It may be helpful to present the information in various forms, for example, by laying out the options visually. It would also be advisable to involve a support person with whom the client has a trusting relationship with and/or who is skilled at presenting information to the client in ways they understand. After a decision has been made, it may be helpful to check back that the person remains happy with that choice and to give the option of changing their mind.

9.28. If the court has appointed a welfare guardian for the client, or there is a person appointed as an enduring power of attorney for personal care and welfare for the client, this person should be involved in the informed consent discussions and should provide informed consent if the client lacks the capacity to give consent before services are provided.

10. Consent in research and teaching requires special consideration

Consenting to research participation

a. The Nuremburg Code of Ethical Practice 1949 established in international law that human participants of research must give their voluntary consent based on information about the research study, the risks arising, and the potential benefits. In practice this means that full disclosure of the intentions of the study is required. Research participants who have consented must also be made aware of their right to withdraw at any time.

b. The Cartwright report which was developed by the Committee of Inquiry (1988) in New Zealand has been influential in establishing the principles that all research should be reviewed by an ethics committee and that the informed consent of participants must be recorded in writing. The recommendations of the Committee led to the Health and Disability Commissioner Act 1994, the appointment of the Health and Disability Commissioner, and the establishment of the Code of Rights, which also has implications for the ethical treatment of participants in health and disability research (Chamerblain, 2007).

c. The National Ethics Advisory Committee is a statutory committee charged with determining nationally consistent ethical standards across the health sector (in accordance with section 92 of the Pae Ora (Healthy Futures) Act 2022. The Committee has issued ethical guidelines for intervention studies and observational research for the health and disability sector, including the issue of informed consent. The regional Health and Disability Ethics Committees are established under section 87 of the Act.

d. Clauses 1.7.8 and 2.6.2 of the Code of Ethics require psychologist researchers to ensure that “the procedures and information provided meet the standards of a relevant human subjects’ ethics committee.” There is an ethical requirement for all research proposals involving human participants to be approved by an ethics committee prior to commencement. This may involve seeking approval through the regional committees referred to above or one of the Institutional Ethics Committees (usually under the auspices of a university).

e. If a client is requested to participate in a research study, the nature of the research activity should be defined, it should be confirmed that the study has gained ethics approval (and by what committee), and the potential theoretical gains arising from the research described. The information provided should be in writing and the consent formally recorded. Consent should be voluntary, without coercion and, if consent is withheld, there must be no negative consequences arising.

Children in research study

f. If a psychologist researcher wishes to proceed with research involving children, that practitioner is advised to discuss the planned research with an ethics committee and legal advisors. The principle to be applied is that any risks must not outweigh the anticipated benefits. A child's guardians (usually the parents) can give permission for their family or child to be involved in a research study. They must be provided with all the information necessary to make an informed choice and give informed consent to the family or child's involvement in the study. A competent child or young person can consent on their own behalf.

Consent for psychology students to observe practitioners

g. The observation and participation in the work of registered professionals is an essential part of learning to be a psychologist. Under Right 6(d) of the Code of Rights clients have a right to be notified of any proposed participation in teaching and have the right to refuse student participation. This should have no bearing on the treatment/service they receive. Walker, et al (2023) have considered the landscape of the consent conversation when medical students are involved in patient care, and produced an updated consensus statement of the process, to which the reader is directed. They discuss the primary responsibility for ensuring consent for any student involvement sits with the registered health professional who is responsible for the patient's care at that time, which the current Guidelines also endorse. They highlight that both students and supervising practitioners need to be aware and considerate of the ways a patient may feel pressured to consent to student involvement (e.g., the supervisor asking the patient while the student is already in the room) and avoid practices that may prevent an individual in feeling comfortable to refuse student observation and/or participation.

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