

Adolescent Health GP Resource Kit

Practice Points

section two - chapter six

Medico-Legal Issues

GPs need to have a broad understanding of the law as it applies to adolescents, in particular:

- ◆ The **capacity** of adolescents to consent to medical procedures on their own behalf
- ◆ **Parental authority** for treatment
- ◆ **Confidentiality**
- ◆ **Child Protection and Mandatory Reporting**
- ◆ **Privacy and Medical Records**

The Capacity of Adolescents to Consent *see page 67*

- ◆ Across Australia, anyone over the age of 18 years is deemed competent to make decisions about their medical treatment
- ◆ Under the common law, young people under 18 *might* be capable of giving informed consent – although GP must consider the **nature of the treatment** and the **ability of the young person to understand** the treatment
- ◆ For a doctor to obtain consent to treatment from a minor (a person under the age of 18 years), they must make a *competency assessment*
- ◆ This means that a medical practitioner *does not have to seek parental consent* to treat a minor who is deemed competent
- ◆ Generally, consent from a parent or guardian is asked for if the young person is *14 years or under* – *unless the young person objects*

Making a Competency Assessment *see page 69*

- ◆ A minor may be legally competent to consent to medical treatment if he or she *'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'*
- ◆ You should be satisfied that the adolescent has a full understanding of the following:
 - what the treatment is for and why the treatment is necessary
 - any treatment options
 - what the treatment involves
 - likely effects and possible side effects/risks
 - the gravity/seriousness of the treatment
 - consequences of not treating
 - consequences of discovery of treatment by parents/guardians
- ◆ If you are unsure whether a minor is competent:
 - seek the opinion of a colleague
 - or obtain the consent of the minor's parents/guardians
- ◆ Make a file note on the patient's medical record about the competency assessment

Informed Consent

- ◆ The term '**consent to medical treatment**' means the patient makes a decision about their treatment based on information and advice given by the GP:
- ◆ Consent must have certain qualities to be valid:
 - the patient must have **capacity**
 - the patient must have **ability to understand** the treatment proposed
 - the consent must cover **the act performed**
 - consent must be **voluntary**

Confidentiality *see page 70*

GPs are legally and ethically bound to keep information that is divulged by the patient confidential, unless an exemption applies – for example:

- ◆ Where the client consents to disclosure
- ◆ Where the GP is compelled by law to disclose, including Mandatory Reporting
- ◆ Best interests of the client – e.g. where a GP believes there is a real risk of serious harm the client – such as suicide risk
- ◆ Public interest – where a GP is made aware by a patient that they have committed, or intend to commit, a serious criminal offence
- ◆ Where disclosure is necessary to treat a client – e.g. where multiple providers are involved in a person's health care – seek the patient's permission to disclose any non-urgent communications

Mandatory Reporting of Child Abuse and Neglect *see page 74*

An important component of legislation aimed to protect children and young people includes the mandatory reporting of known or suspected child abuse.

- ◆ Medical practitioners are mandatory reporters in all states and territories where mandatory reporting is legislated – that is, they are obliged report known or suspected child abuse to a designated authority
- ◆ GPs must report a child they suspect to be at risk of harm as soon as they form an opinion that there are current concerns for the child's safety, welfare or wellbeing

RESOURCES

- ◆ For further information about relevant laws applying to young people – see the following website – www.austlii.edu.au

chapter six

Medico-Legal Issues

Young People and the Law

- ◆ Legal and ethical issues are fundamental to professional conduct and practice in any area of health care
- ◆ Working with young people involves additional considerations in day-to-day practice, because of their legal status and their stage of development
- ◆ The law is not clear-cut in many aspects relating to young people under 18 years – much is left to the judgement of the medical or health professional as to the maturity of the young person and their capacity to consent

This chapter provides a broad overview of the following legal and ethical issues as they might apply to young people, particularly those under 18:

- The **capacity of adolescents** to consent to medical treatment on their own behalf
- **Parental authority** for treatment
- **Confidentiality**
- **Child Protection and Mandatory Reporting**
- **Privacy and Medical Records**

NB: This chapter is *not* a prescriptive statement of the law. If you are faced with a situation in which you are unsure about how the law applies – consult with your **Medical Defence** organisation.

Terminology Used In This Chapter

- ◆ Terminology varies across different pieces of legislation to describe ‘recipients’ of health care and ‘providers’ of health care
- ◆ Some phrases such as ‘medical treatment’ may not necessarily refer only to ‘treatment’ performed by a medical practitioner
- ◆ The term ‘patient’ will be used to reflect the terminology used in much of the relevant legislation although it is well understood that the term ‘client’ might be used in practice in some health care settings; ‘medical practitioner’ will be used where this is the term used in legislation and ‘[health care] provider’ where applicable due to multiple pieces of legislation that may encompass medical and non-medical health professionals

Informed Consent

For any age group, the term ‘consent to medical treatment’ means that the patient makes a decision about their treatment based on information and advice given by the medical practitioner:

- ◆ The patient must be given information as to the general nature of the treatment and also on ‘material risks’ to consider – which they may regard as significant in deciding whether or not to undergo treatment
- ◆ If the medical practitioner does not give this information to the patient, they may be held to be negligent

Consent must have certain qualities to be valid:

- the patient must have capacity
- the patient must have ability to understand the treatment proposed
- the consent must cover the act performed
- consent must be voluntary

The Capacity of Young People to Consent

Across Australia, 18 years is the legal age of majority (‘adulthood’). The law assumes that adults are competent to make decisions about their medical treatment, either consent or refusal, even if their decision is deemed not to be in their best interests. Thus, the specific legal issues surrounding consent to medical treatment for young people applies to legal minors, those under 18 years.

Clinically relevant questions include:

- ◆ When can a young person under 18 years make their own decisions about medical treatment?
- ◆ Can parents or guardians make decisions about medical treatment for young people under 18?

General practitioners may have concerns about these two questions because:

- they are unsure how to assess a young person’s capacity to give their own consent even if, strictly speaking, the law allows them to
- they are unsure how they stand legally if they accept a young person’s capacity to consent
- they are unsure whether they can, or should, involve parents in decisions about consent

Laws About Consent To Medical Treatment

The Common Law applies across Australia:

The common law states that young people under 18 *might* be capable of giving informed consent, although the health professional must consider the **nature of the treatment** and the **ability of the young person to understand** the treatment.

Background to the Common Law

- ◆ The common law position relating to a minor's competency to consent to treatment was established by the English House of Lords decision in a case known as '**Gillick**' and was approved by the High Court of Australia in a case known as "Marion's case". The 'Gillick case' holds that the **authority of a parent decreases as their child becomes increasingly competent**. 'Gillick' prescribes that the parental right to determine their child's treatment terminates once a child under the age of 16 is capable of fully understanding the medical treatment proposed. ¹
- ◆ Note that in recent times the term "Fraser guidelines" has been substituted for 'Gillick test' for competence. Lord Fraser was one of the Law Lords involved in the Gillick case. However the Fraser guidelines are different from the Gillick test as they only relate to the provision of contraception; the Gillick test is broader. ²

Victoria, Australian Capital Territory, Western Australia, Queensland, Tasmania and Northern Territory

There are no specific laws about minors and consent to medical treatment. Thus the Common Law applies for those under 18 years.

Additional Statutory Laws apply in NSW & South Australia ³

New South Wales

- ◆ Specific NSW law means that young people aged 14 and over can consent to their own treatment in so far as medical practitioners are protected from charges of assault and battery against a civil action (as distinct from a criminal action) if the young person has given consent. [Minors (Property and Contracts) Act 1970 s49 (2)]
- ◆ This needs to be applied with caution, as health professionals should still consider how capable

a young person 14 and over is to giving full informed consent

- ◆ This NSW law also allows for parents to give consent to medical treatment for an adolescent child under 16 years, even if the young person is themselves competent to consent
- ◆ The Guardianship Act in NSW also implies that a young person aged 16 can consent to their own treatment [Guardianship Act 1987 (NSW)]
- ◆ Finally the Common Law allows for the mature minor assessment to be applied to young people even younger than 14 if relevant.

It is important to point out that there is no absolutely clear cut, single, law about consent to medical treatment for a minor in NSW. For an in-depth discussion about the relevant legislation in NSW see the NSW Law Reform Commissions Issues Paper 24 (2004) at

<http://www.lawlink.nsw.gov.au/lrc.nsf/pages/ip24toc>

South Australia

- ◆ A young person 16 years and over can consent to medical treatment "as validly and effectively as an adult"
- ◆ For those under 16, a young person can validly consent to treatment if and when two medical practitioners believe and state in writing that certain treatment is in the best interests of the child and the child is 'capable of understanding the nature, consequences and risks' involved (Consent to Medical Treatment and Palliative Care Act 1995; See:

<http://www.legislation.sa.gov.au/lz/c/a/consent%20to%20medical%20treatment%20and%20palliative%20care%20act%201995/current/1995.26.un.pdf>

- ◆ The Common Law allows for the mature minor assessment to be applied to young people even younger than 14 if relevant.

The right to refuse treatment

- ◆ The legal right to refuse treatment for minors is unclear. The Gillick principle that allows for a competent minor to consent to treatment does not allow for a corresponding right to refuse treatment
- ◆ Hence, a young person who is competent according to the principles established by Gillick, will generally lack the capacity to refuse life-saving treatment if his/her parents are prepared to consent to it

A minor's capacity to consent

- ◆ This applies to young people:
 - under the age of 18 in Victoria, Queensland, Tasmania, ACT, NT and Western Australia
 - under the age of 16 in South Australia
 - under the age of 14 - 16 in NSW (this is not absolutely clear, see above)
- ◆ For a medical practitioner to obtain consent to treatment from a minor, they must make a **competency assessment** (see below):
- ◆ This means that a medical practitioner *does not have to seek parental consent* to treat a minor who is deemed competent.
- ◆ Generally, consent from a parent or guardian is asked for if the young person is *14 years or under* – *unless the young person objects*.

The capacity of a young person to consent is also considered to be related to the *gravity* of the treatment being proposed. Thus, procedures such as sterilisation and gender reassignment require court approval because of the need to consider a young person's ability to fully appreciate the consequences of a certain treatment and impact on their life into the long term. Parental consent in these cases is not sufficient.

Making A Competency Assessment

Medical practitioners must form their own opinion about a patient's *'intelligence and understanding'*.

- ◆ A minor may be legally competent to consent to medical treatment if he or she *'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'* (the Gillick test). This particularly involves considerations about their:
 - age
 - level of independence
 - level of schooling
 - maturity
 - ability to express own wishes

Note: The medical practitioner's assessment about these factors could be influenced by cultural differences between the doctor and the young person. A cognitively mature adolescent may come across as socially or emotionally immature (or vice versa) because of different cultural expectations about their

roles in the family/society (e.g. they may seem less independent), or differences in the way their thoughts or wishes are communicated. If in doubt, seek advice from a colleague or an appropriate agency.

- ◆ You should be satisfied that the young person has a full understanding of the following:
 - what the treatment is for and why the treatment is necessary
 - any treatment options
 - what the treatment involves
 - likely effects and possible side effects/risks
 - the gravity/seriousness of the treatment
 - consequences of not treating
 - consequences of discovery of treatment by parents/guardians
- ◆ If you are unsure whether a minor is competent:
 - seek the opinion of a colleague or
 - obtain the consent of the minor's parents/guardians
- ◆ Make a **file note** about your assessment:
 - Make a note on the young person's medical record about the competency assessment – particularly if you found the young person to be competent and subsequently administered treatment on the basis of his/her consent

Dealing with special circumstances

English language

- ◆ Be aware that informed consent can only be obtained if the young person understands what is being presented in a language with which they are fluent
- ◆ Health care interpreters should be used where appropriate - particularly if you are working with a family from a non-English speaking background (see Section 4 for contact details)
- ◆ Over the telephone interpreting is available through the *Translating and Interpreting Service (TIS)* – Telephone 131 450. This is a national service provided through the Department of Immigration and Multicultural and Indigenous Affairs and is free to GPs
- ◆ TIS is available 24 hours a day, 7 days a week, and is accessible from anywhere in Australia for the cost of a local call.
- ◆ Children should not be used as interpreters for their parents

See Section Four – for contact details of relevant services

Young people with intellectual disabilities

- ◆ A young person with an intellectual disability is not automatically deemed incompetent to consent to treatment
- ◆ The competence of such an individual should be assessed in each case and each situation

Young people who are parents

- ◆ A legal minor who is a parent has the legal capacity to consent to treatment for his or her child, in the same way as adult parents
- ◆ However the minor may not necessarily have legal capacity to consent to his or her own treatment

practice points

- ◆ Obtaining informed consent applies for all patients, not just young people
- ◆ Young people under 18 years require a special assessment of competency to consent. In NSW and SA, additional laws allow for those 14 years (NSW) and 16 years (SA) and over to consent to their own treatment. See below for important detail about these additional laws.
- ◆ Capacity to consent for minors will depend on age, maturity, intelligence, education, level of independence and also on the gravity of the treatment proposed

Confidentiality

Confidentiality can be defined in the health care setting as “an agreement between [young person] and provider that information discussed during or after the encounter will not be shared with other parties without the explicit permission of the [young person]”.

Exemptions

The exemptions to the duty to maintain confidentiality are both legal and ethical. These are listed below:

Where the patient consents to disclosure

- ◆ A patient can give expressed verbal or written permission or implied permission for their health provider to disclose information to a third party – e.g. a parent, or another professional involved in their care – such consent should not be coerced

- ◆ It is probably best to make explicit implied consent in case health providers make an incorrect assumption where disclosure to parents or other health professionals is involved, i.e. discuss and clarify with the young person

Where the provider is compelled by law to disclose

Note that in these instances, information disclosed is kept in confidence and not divulged to outside parties:

- ◆ **Court proceedings** – these may involve a provider giving evidence in court or producing health records under subpoena
- ◆ **Notifications** – Medical practitioners have specific requirements to notify the following (*note these may vary between States and Territories and this is not necessarily complete*):
 - evidence of a notifiable disease (including HIV infection, AIDS, all forms of hepatitis, tuberculosis, and several others)
 - reporting of blood alcohol level test results for patients admitted to hospital after a motor accident
 - births and deaths
- ◆ **Mandatory reporting**

See Mandatory Reporting below

Best interests of the patient

- ◆ This exemption relates to a situation where a provider believes there is a real risk of serious harm to the patient – e.g. a young person at risk of suicide

Public interest

- ◆ In practice, this could translate into a situation where a provider is made aware by a patient that they have committed, or intend to commit, a serious criminal offence

Where disclosure is necessary to treat a client

- ◆ If there are multiple providers involved in a person's health care, it can be considered reasonable that communication between providers would serve in the best interests of the patient – the concept of ‘team confidentiality’ can be explained to patients when working within a multidisciplinary team. However, it is advisable to seek a patient's permission to disclose any non-urgent communications outside these parameters

practice points

- ◆ Confidentiality is legally part of the general duty of care to patients
- ◆ Health care providers must keep information divulged by the patient confidential, unless an exemption applies
- ◆ Special care may need to be taken in explaining to parents of young people from a CALD background about their adolescent child's right to confidentiality

A Common Medical Issue – Prescribing Contraception

- ◆ **Hormonal contraception** (e.g. the oral contraceptive pill, injectable and implantable hormones) can be prescribed for a minor, regardless of the reason/s why, without parental consent, provided that the young woman is deemed competent by her doctor to give informed consent
- ◆ This is also true for emergency hormonal contraception ('morning after pill')

Note: That legislation in NSW changed between 2000 and 2005 to remove injectable progesterone from the 'Special Medical Treatment' category that required Guardianship Tribunal approval for women under 16 years – thus NSW is now in line with other states and territories as regards this contraceptive.

- ◆ **Sterilisation** – e.g. tubal ligation, vasectomy – these procedures cannot be performed on a minor without the authority of the Guardianship Tribunal, Family Court of Australia or Supreme Court

Case Example: Josie

A 15 year old young woman requests a prescription for the oral contraceptive pill and doesn't want her parents to know. A thorough history reveals that she is involved in her first sexual relationship, it is consensual and with a young man of the same age and at the same school.

Legal issues to consider:

- ◆ **Consent:** Is the young woman competent to give her own consent to treatment?
- ◆ If yes – there is no legal imperative to seek parental permission
- ◆ If *no, or unsure* – the GP may first seek advice from colleagues and/or may not prescribe the treatment, but this *does not mean* the GP has the legal obligation nor the right to breach confidentiality about the consultation – unless the young woman is deemed to be at risk of, or is being, abused.
- ◆ **Confidentiality:** The GP must maintain her confidentiality unless the young woman gives permission for others (e.g. parents) to know

Health care issues to consider:

- ◆ Building and maintaining a relationship of trust with Josie – this entails assurances of confidentiality, with the exceptions also explained
- ◆ Performing a comprehensive assessment and giving appropriate information and advice
- ◆ Working within the family context – although there may not be a legal imperative to involve the young woman's parents (and it may be illegal to do so due to breaches in confidentiality), it is still reasonable, if not favourable, to have a discussion with the young woman about her family relationships, e.g.:

“Josie, you've told me that you don't want your parents to know about your sexual relationship and going on the pill, and I can assure you that I will be able to maintain confidentiality as I explained earlier. However, I am still interested in talking to you about your parents and family particularly in relation to how you get on with them, what kind of support you feel you need from them, and so on. What would happen, for example, if your Mum discovered the pill in your school bag? Or if she found out somehow that you and (boyfriend) were having sex? Do you think you'd be able to talk

to her about it? Young people have the right to privacy, and sex is obviously a private matter, but when you still live at home with your parents, and they still want and need to care for you, then it can be useful to think about how to deal with issues like this if they arise.”

Cultural Considerations:

An issue like this can be strongly influenced by the young woman's family and cultural background:

- ◆ If Josie is a middle-class Anglo-Australian with ‘liberal’ parents, the issues of secrecy, discovery and teenage sex might not be as concerning to Josie as if she is from a migrant family from a Middle Eastern background with strong religious beliefs, particularly about female sexuality
- ◆ The legal issues facing the GP, however, will be the same
- ◆ The health care issues need to take into consideration possible reactions and consequences if Josie's sexual activity is discovered by her parents- you need to discuss this with her carefully
- ◆ Her cultural background may also present a source of emotional distress for her, as she may feel torn between the values of her family and community, and her own feelings towards her friends, boyfriend and herself as a young Australian

Termination Of Pregnancy

- ◆ In Australia abortion is legally available with minor variations from state to state, although the ACT is the only jurisdiction in Australia where it has been decriminalised ⁴
- ◆ In some states and territories parental consent for women under 18 is required: ⁵
 - **NSW** – parental consent *probably* required if under 14
 - **Northern Territory** – parental consent required if under 16
 - **Western Australia** – parents must be told if under 16 and must be given the opportunity to be involved in counselling and medical consultations, otherwise the young woman must apply to Children's Court to maintain confidentiality

- ◆ The same laws governing *consent and confidentiality* will apply in the case of a young woman seeking termination, as with any other form of health care
- ◆ The legal onus falls on the abortionist, invariably a medical practitioner, to ensure that *informed consent* is obtained from a woman on whom a termination is to be carried out, regardless of her age
- ◆ In order to make an informed choice about the decision to terminate pregnancy, the woman should be given thorough pre-termination counselling and explanation of all possible adverse effects
- ◆ A doctor (or other health provider) can refuse to discuss, refer or assist a termination based on their own religious or personal beliefs, without risk of anti-discrimination action. *However the provider would be obliged under duty of care, to take appropriate action to explain and offer alternatives to their client*

Child Protection And Mandatory Reporting

Child protection laws

Below is a list of the *principle* child protection laws in each state and territory:

Australian Capital Territory:

Children and Young People Act 1999

New South Wales:

Children and Young Persons (Care and Protection) Act 1998

Northern Territory:

Community Welfare Act 1983; Care and Protection of Children Draft Act (currently before Cabinet)

Queensland:

Child Protection Act 1999

South Australia:

Children's Protection Act 1993

Tasmania:

Children, Young Persons and their Families Act 1997

Victoria:

Child, Youth and Families Act 2005

Western Australia:

Children and Community Services Act 2004

- ◆ You can get more information about these and other relevant Acts of law from the following website: <http://www.aifs.gov.au/nch/resources/legislation/legislation.html>

- ◆ For information about which government department in your state or territory is responsible for the care and protection of children and young people, see the following website:
<http://www.aifs.gov.au/nch/resources/state.html>

Definition of a child or young person

- ◆ A *child* is a person under 16 years of age in NSW, and under 18 years in other states and territories
- ◆ In NSW, a *young person* is 16 or 17 years old

What is 'in need of protection'?

For specific information about how the legislation in your State or Territory defines 'a child in need of care and protection' see the following article:

<http://www.aifs.gov.au/nch/pubs/sheets/rs12/rs12.pdf>

- ◆ In some states and territories, certain incidents or circumstances may be registered as 'concerns' rather than 'at risk of harm'
- ◆ Once there is known or suspected **harm or 'risk of harm'**, the statutory response to protect the child or young person is effected (i.e. they become a child/young person 'in need of care and protection').

'Risk of harm'

The following is a broad summary of some of the issues that constitute *risk of harm* but it is important to note that there will be differences depending on the laws in your state or territory. If you feel a child or young person is at risk of harm, it generally means that you have *current concerns* about the safety, welfare or wellbeing of a child or young person because of the presence of any one or more of the following circumstances:

- ◆ Their **basic physical or psychological needs are not being** met or are at risk of not being met (*neglect*). A key indicator of *neglect* is where the care of the child is continually or persistently being ignored. These basic needs include:
 - food
 - shelter
 - hygiene
 - safety from harm
 - insufficient or inappropriate interaction or stimulation from parents/caregivers
 - emotional neglect
- ◆ They are not receiving **necessary health or medical care**
 - where parents/caregivers cannot or will not arrange required medical care
- ◆ They have been, or are at risk of being, **physically or sexually abused, or ill treated**. This includes:
 - *physical abuse* – an assault or non-accidental injury by parent/caregiver such as severe beating or shaking; excessive discipline; bruising; lacerations, burns; fractures; etc
 - *physical assault* – a hostile act by an adult towards a child or young person, even if the adult has not meant to harm – including pushing; shoving; hitting; throwing objects; rough handling, grabbing around the throat, any threatening behaviour. It is now illegal for a parent to hit a child above the shoulders or with an implement
 - *sexual abuse* – any sexual act imposed on a child or young person; that exploits their dependency or immaturity
- ◆ They are living in a household where they have been incidents of **domestic violence** and as a consequence, are at risk of serious physical or psychological harm:
 - domestic violence is violent, abusive and intimidating behaviour by one person against another in a personal intimate relationship – including physical, psychological, sexual, social and economic abuse
- ◆ They have suffered, or are at risk of suffering, *serious psychological harm* from the behaviour of a parent/caregiver:
 - *serious psychological harm* is behaviour by a parent/caregiver which results in emotional deprivation or trauma – e.g. continual scapegoating or rejection
 - *psychological abuse* involves serious impairment of a child/young person's social, emotional, cognitive or intellectual development; this might be because of their exposure to a parent's ongoing mental health problems
- ◆ They are **homeless** and at risk of harm; this may occur if they do not have access to food or shelter or if they are living in a situation where they are unsafe. This includes living without family assistance in any of the following circumstances:
 - no accommodation; 'roofless'
 - temporary or transient accommodation
 - emergency, refuge or crisis accommodation
 - accommodation where they do not have access to basic utilities (power; running water)

Recognising risk of harm

A number of things should be considered in determining whether a child/young person is at risk of harm, including:

- ◆ past professional experiences
- ◆ the age, development, functioning, and vulnerability of the child/young person
- ◆ behaviours of a child that suggest they may have been harmed by another person – e.g. mimicking violence; sexualised behaviour, unexplained physical complaints
- ◆ behaviour of another person which might have a negative impact on healthy development, safety or wellbeing (e.g. drug abuse; domestic violence)
- ◆ physical signs of abuse or ill-treatment – e.g. bruises; lacerations; burns; fractures or other injuries
- ◆ concern about other family members – such as recent abuse or neglect of a sibling, or parents experiencing mental health problems

Cultural issues

Some traditional cultural practices may place a young person at risk of harm. For example, the practice of female genital mutilation (FGM), which is practised in a number of countries, is a criminal offence which the GP is mandated to report.

- ◆ It is important to be aware of different cultural practices and to determine whether there is any risk of harm to the young person *before* reporting such practices
- ◆ Handle such situations sensitively – explain to patients that legal and ethical issues may override cultural considerations and that all Australians are bound by Australian law, regardless of cultural traditions

Note: Some children/young people from some ethnic communities have been wrongly assessed as suffering from abuse as a result of culturally determined health practices (e.g.: ‘coining’ or ‘cupping’ in Vietnamese; Lao communities) – which are in fact acceptable and safe practices within the Australian context

resources

If in doubt about a particular cultural practice *consult with a culturally appropriate or bilingual health professional, or contact:*

- ◆ **Diversity Health Institute**
– 02 9840 3800 – www.dhi.gov.au
- ◆ **Multicultural Mental Health Australia**
– 02 9840 3391 – www.mmha.org.au

See Section Four – for contact details of multicultural health services.

Mandatory Reporting

An important component of legislation aimed to protect children and young people includes the mandatory reporting of known or suspected child abuse.

- ◆ All States and Territories in Australia have legislation that makes it compulsory for certain professionals to report known or suspected child abuse to a designated authority
- ◆ Medical practitioners are mandatory reporters in all states and territories where mandatory reporting is legislated. In November 2007, Western Australia introduced a Bill to amend the Children and Community Services Act (sect 124B) to make medical practitioners and other professionals mandatory reporters. In the Northern Territory everybody is a mandatory reporter
- ◆ In NSW, mandatory reporting applies to young people up to the age of 16. In the other states and territories, it applies up to the age of 18 years
- ◆ Although each state and territory has slightly different procedures for mandatory reporting, they are broadly similar across Australia.

resources

The following list provides contact telephone numbers for each State and Territory to report incidences of child abuse:

- ◆ Australian Capital Territory – 133 427
- ◆ New South Wales – 132 111 (24 hours)
- ◆ Northern Territory – 1800 700 250 (24 hours)
- ◆ Queensland – Departmental Head Office:
(07) 3224 8045
Crisis Care: (07) 3235 9999
Rural areas: 1800 177 135
- ◆ South Australia – 131 478 (24 hours)
- ◆ Tasmania – Child and Family Services:
1800 001 219 (24 hours)
- ◆ Victoria – Child Protection Crisis Service:
131 278 (24 hours)
- ◆ Western Australia – Departmental Head Office:
(08) 9222 2555
After hours: (08) 9222 3111;
1800 199 008

Making a report

GPs must report a child they suspect to be at risk of harm as soon as they form an opinion that there are current concerns for the child's safety, welfare or wellbeing. The legislation protects GPs (and other mandatory reporters) from:

- ◆ disclosing your identity and the identity of your practice without your consent
- ◆ being sued for making a report
- ◆ breaching professional ethics or standards by making a report
- ◆ being sued for defamation if you make a report

Note:

- ◆ If you have any concerns or are uncertain about whether you should make a report, call the relevant authority in your state or territory and discuss it with them
- ◆ Over the past decade or so, legislation and accompanying policies and procedures across Australia have been increasingly taking a supportive and collaborative approach to child protection (rather than a punitive approach towards parents)
- ◆ Thus, you are encouraged to work with the relevant child protection authority to support young people

practice points

- ◆ All states and territories have legislation that protects the welfare of children
- ◆ Medical practitioners are mandatory reporters in all states and territories (see below for Western Australia)
- ◆ The definitions of 'child' and 'child in need of protection' vary slightly between states and territories.

Case Study: Leah

Leah is a 16 year old girl who lives at home with both parents, a paternal grandmother and 4 siblings. She is third out of 5 children. She is in Year 10 at the local high school. Both her parents are unemployed. She is brought to you by a youth worker from a local youth centre and tells you that she is 6 months pregnant. The only other person who knows is her school principal. She says that the father of the baby is a 17 year old boy, a family friend, who also doesn't know. Leah is quite tall (170cm) and of large build so that her pregnant

abdomen is quite well hidden. She tells you that she wants to give the baby up for adoption without anyone in her family or school knowing, and that she intends to 'run away' for a couple of weeks around the time of confinement. She is willing to be referred to the local hospital for booking in and antenatal care, and is willing to receive assistance to help her find accommodation and support necessary to deliver the baby and organise the adoption.

Leah strikes you as being somewhat emotionally detached from the whole situation and you are unsure as to whether she is an immature 16 yr old, whether she is in a strong state of denial, or whether she might have a mild cognitive impairment.

What are the legal and ethical issues that you would consider in this case?

Points to consider:

Leah's welfare

- ◆ It is concerning that Leah is so adamant about not telling anyone in her family. The reasons for this need to be more carefully explored and you should work towards ways of supporting Leah to tell her parents
- ◆ It is important to rally a comprehensive support network – the obstetric and relevant psychosocial support team and adoption agency, the youth worker, the school principal and hopefully family support
- ◆ It is critical to ensure that Leah is as fully informed about her adoption decision as possible – the antenatal team should be active in this as well
- ◆ With all the above in train, you must also decide whether Leah is a young person at risk – of homelessness, or physical and emotional harm (e.g. if she gives birth without proper medical or psychosocial care and support). She is 16 and, depending on which state or territory you are practising in, you may be mandated to report this situation. Even if you are not mandated (e.g. in NSW) you may report any of the above concerns for young people aged 17 or 18

The baby's welfare

In NSW, ACT, Victoria, Queensland, South Australia and Western Australia you can report concerns about an unborn child (not mandatory). These jurisdictions have legislation that specifically deals with such reports.

Cultural considerations

What if Leah is from a Pacific Islander background living with an extended family in a small community of other Islanders? She tells you that this is a highly significant factor in her wishing to maintain secrecy around her pregnancy and confinement. She says that she has made her own decision, knows that this is the best thing to do, and that she and her family could face harsh recriminations within her extended family and community otherwise. Legal and ethical issues, particularly as they relate to human rights conventions (eg Rights of the Child), should override other cultural considerations.

It is sometimes easy to 'hide behind culture', or to use 'culture' as an 'excuse' not to act. Leah's anxieties about the impact of her 'secret' upon her family and community may be well founded, and these can be explored, possibly with the assistance of transcultural experts. However, Leah's and her baby's safety remain paramount, and there may be many other reasons besides her cultural background, as to why Leah is anxious about secrecy.

Privacy And Medical Records

- ◆ Federal Privacy legislation passed in 2001 applies to the privacy of, and access to, personal and health information and medical records in the private sector, i.e. general practice
- ◆ This legislation does not apply to state and territory public health services
- ◆ This legislation is based on 10 National Privacy Principles, and is succinctly described in the following publication for health professionals: <http://www.privacy.gov.au/publications/hics1.pdf>
- ◆ Essentially, consumers of health services in the private sector:
 - have a right to access their medical records for information acquired after 21 December 2001
 - have a right to ask for information in medical records to be corrected if acquired after 21 December 2001
 - have a right to remain anonymous when accessing a health service if lawful and practicable
 - have a right to ask for health information not to be shared with other health providers

- ◆ Health professionals in the private sector:
 - can share health information for a treatment-related purpose, as long as it would reasonably be expected to happen
 - have the right to charge patients a reasonable fee for access to their medical records
 - can deny a patient access to medical records if giving access would pose a serious threat to the life and health of anyone or where legally required
- ◆ Young people under 18 years can exercise their own privacy choices (e.g. not allow parents to see their records) once they become able to understand and make their own decisions (i.e. become competent to consent) ⁶

resources

- ◆ For further information about relevant laws applying to young people see the following website – www.austlii.edu.au

References:

- 1 Bowles, K. (2003). Age of consent to medical treatment, FindLaw Australia. <<http://www.findlaw.com.au/articles/default.asp?task=read&id=10022&site=CN>> viewed 29 April 2008.
- 2 Wheeler, R.(2006). Gillick or Fraser? A plea for consistency over competence in children. *BMJ* 332:807.
- 3 Bird, S. (2005). Can children and adolescents consent to their own medical treatment? *Australian Family Physician* 34(1/2):73-74.
- 4 De Crespigny, L.J., Savulescu, J. (2004). Abortion: time to clarify Australian's confusing laws. *Medical Journal of Australia* 181(4): 201-203.
- 5 National Children's and Youth Law Centre. <www.lawstuff.org.au> viewed 28 March 2008.
- 6 Office of the Federal Privacy Commissioner (2002). My health, my privacy, my choice: a consumer's guide to privacy and health information. <<http://www.privacy.gov.au/publications/chib.pdf>> viewed 5 April 2008.

Additional References

Sanci, L. (2001) Adolescent Health Care Principles. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.