

SECTION 3.5

MEDICO-LEGAL ISSUES

3.5 MEDICO-LEGAL ISSUES

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Legal and ethical frameworks are fundamental to the professional conduct and practice of health care. Working with young people involves additional considerations 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 major legal and ethical issues as they might apply to young people, particularly those under 18. They include:

- The capacity of adolescents to consent to medical treatment on their own behalf
- Parental consent to treatment
- Confidentiality, privacy and access to medical records
- Child protection and mandatory reporting

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, you can seek legal advice through your employer or insurer.

UNDERSTANDING MEDICO-LEGAL TERMINOLOGY

The terminology used to describe recipients of health care and health care providers is different in different pieces of legislation. In this chapter:

Medical treatment may not necessarily refer only to 'treatment' performed by a medical practitioner. In some contexts, 'treatment' may include health care or advice provided by other practitioners such as nurses or counsellors. In general, health information and education is not subject to the same laws as medical treatment, and may be provided to children regardless of their age.

Patient is used to reflect the terminology used in much of the relevant legislation although in some health care settings, the term 'client' might be used instead.

Medical practitioner and **health practitioner** are used based on the legislative source of the obligation. Many obligations, such as the obligation to privacy, may be covered by several pieces of legislation that apply to both medical and non-medical health professionals. To make sure it is clear, in this chapter a medical practitioners is a health practitioner.

Children or **child** will be used often in this chapter when referring to the legal definition of a child – which is anyone under 18 years.

UNDERSTANDING CONSENT

When can a young person under 18 years make his or her own decisions about medical treatment? Can parents or guardians make decisions about medical treatment for young people under 18? In what situations will it be necessary to seek an order from a court or tribunal?

Health practitioners may have concerns about these 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 about where they stand from a legal perspective if they assess a young person as having capacity to consent to medical treatment and then proceed to provide that treatment;
- They are unsure whether they can, or should, involve parents in decisions about consent.

No matter the patient's age, 'consent to medical treatment' means that the patient makes a decision about their treatment, usually based on information and advice given by the health practitioner. You must have consent before commencing treatment. Lack of consent may expose a health practitioner to the possibility of civil or criminal liability.

To be valid, consent requires certain qualities:

- The patient must have the capacity to give consent
- The patient must be able to understand the general nature of the treatment
- The consent must cover the act performed
- The consent must be voluntary

INFORMED CONSENT

'Informed consent' is a separate concept to consent, but it is related.

Informed consent means consent to treatment after having been informed of all significant risks associated with the treatment. All health practitioners should try to ensure that patients are fully informed of the risks and benefits of any treatment before obtaining consent.

THE CAPACITY OF ADULTS TO CONSENT OR TO REFUSE TREATMENT

Across Australia, 18 years is the legal age of majority ('adulthood'). The law assumes that adults

are competent to make decisions (either consent or refusal) about their medical treatment even if their decision is deemed not to be in their best interests.

There is an exception for adults who lack the capacity to make treatment decisions, such as people with intellectual disabilities or those affected by certain forms of mental illness. All states and territories in Australia have laws that allow others (e.g. family members, guardians, courts or tribunals) to make decisions for people who lack the capacity to make decisions on their own behalf.

THE CAPACITY OF YOUNG PEOPLE TO CONSENT TO TREATMENT

Young people under 18 are minors under Australian law. Minors have the legal capacity to make their own decisions, independently of their parents, in a variety of situations (Lennings 2013).

In general, if the patient is under the age of 14 years, the consent of the parent or guardian is necessary.

Minors aged 14 and above may have the capacity to consent to medical treatment depending on their level of their level of maturity; their understanding of the proposed treatment and its consequences; and the severity of treatment. A health practitioner must make a case-by-case assessment of whether the young person has sufficient understanding and intelligence to enable him or her to fully understand what is proposed.

PARENTAL CONSENT FOR TREATMENT

If a child under 18 does not have the capacity to consent to treatment, in general a parent may consent on their behalf.

In many cases, even if a child is competent to consent on their own behalf, a parent may still validly consent on their behalf. However, if a health practitioner considers that a child is competent, it may be appropriate to obtain both parental and patient consent. For some types of major and special treatment (such as sterilisation) parental consent is not sufficient, and a court order is required.

EMERGENCY TREATMENT

In general, treatment may be performed without the consent of either the parent or the child if the health practitioner is of the opinion that the treatment is necessary, as a matter of urgency, in order to save the child or young person's life. In practice, that means that emergency medical and first aid treatment may be provided without the consent of the minor or a parent or guardian.

THE LAW ABOUT CONSENT TO MEDICAL TREATMENT FOR CHILDREN

Australian law is a mixture of statute law (Acts and Regulations, also known as statutes or legislation, made by Parliament) and common law (which is made by the courts when they make decisions which set a precedent for future cases).

In all Australian states and territories except South Australia, there is no legislation specifying when a child may consent to medical treatment on their own behalf. Instead, the common law applies.

At common law, a child under 18 may legally consent to most types of medical treatment on their own behalf if they are competent to do so. If the child is not competent, parental consent must usually be obtained (Bird 2005).

The common law position relating to a minor's competence to consent to treatment was established by the English House of Lords decision in a case known as 'Gillick' (*Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112) and was adopted by the High Court of Australia in a case known as 'Marion's case' (*Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218).

The Gillick case concerned an application by a mother for an order to prohibit the local health authority from giving contraceptive advice to her teenage daughters without parental consent. The court dismissed Mrs Gillick's claim and held that parental authority over their child diminishes as the child becomes increasingly mature. The court held that a child with the maturity to understand the nature and consequences of the treatment has the legal capacity to consent on their own behalf, without the necessity for parental consent or knowledge.

The term 'Gillick competence' is now widely used by lawyers and health practitioners dealing with young people (Wheeler 2006). It is also common to refer to the 'mature minor principle'.

For a child to be 'Gillick competent' he or she must have "sufficient understanding and intelligence to enable him or her to understand fully what is proposed". This must be assessed on a case-by-case basis depending on the nature of the treatment proposed.

SOUTH AUSTRALIA

Section 6 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides:

"A person of or over 16-years-of-age may make decisions about his or her own medical treatment as validly and effectively as an adult." This means that

a child aged 16 or over has the capacity to refuse treatment as well as consent to it.

A child under 16 can validly consent to treatment if:

"The medical practitioner is of the opinion that the child capable of understanding the nature, consequences and risks of the treatment and that the treatment is in the best interest of the child's health and well-being, and

That opinion is supported by the written opinion of at least one other medical practitioner who personally examines the child before the treatment is commenced. (Section 12, Consent to Medical Treatment and Palliative Care Act 1995 (SA))"

If emergency medical treatment is required "to meet an imminent risk to life or health" and the patient is incapable of consenting (e.g. because they are unconscious or lack competence), treatment may proceed without their consent. However, if the patient is 16 or over, they have the right to refuse treatment (*Consent to Medical Treatment and Palliative Care Act 1995 (SA)* Section 13).

NEW SOUTH WALES

New South Wales does not have any legislation specifying when a child has the capacity to consent to medical treatment (NSW Law Reform Commission 2008).

However, under the *Minors (Property and Contracts) Act 1970*, if a minor aged 14 and above consents to their own medical treatment, the minor cannot make a claim against the medical practitioner for assault or battery. Also, where medical treatment of a minor aged less than 16 years is carried out with the consent of a parent or guardian of the minor, the minor cannot make a claim against the medical practitioner for assault or battery.

This law is intended to protect doctors and dentists from liability, but it does not alleviate the need for a practitioner to make an assessment of the young person's competence in each individual case. A child younger than 14 may be competent to consent to treatment. Conversely, a child aged 16 or over may lack competence.

MAKING A COMPETENCY ASSESSMENT

Health practitioners need to make an assessment of competency to consent for all young people aged under 18 years (or 16 years in South Australia).

Competency will depend on age, maturity, intelligence, education, level of independence, and ability to express their own wishes. It will also depend on the gravity of the treatment proposed. For more drastic, invasive or risky types of treatment,

a medical practitioner will need to take special care to ensure that the young person possesses the required competence to consent to treatment.

Health practitioners must form their own opinion about a patient's 'intelligence and understanding'. For a young person, a full understanding involves appreciating:

- What the treatment is for and why the treatment is necessary
- Any treatment options or alternatives
- 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 a health practitioner is unsure whether a minor is competent they can:

- Seek the opinion of a colleague.
- Seek the consent of the minor's parents or legal guardians. Keep in mind, however, the young person's right to privacy and confidentiality and the risks of disclosing sensitive information to a parent, particularly in challenging family situations, or with sensitive areas such as contraception and pregnancy.
- Obtain legal advice about applying for a court or tribunal order if the practitioner considers the treatment to be necessary and in the patient's best interests.

A health practitioner should make a file note about the outcome of the competency assessment. The file note should form part of the patient's medical record.

YOUNG PEOPLE WITH INTELLECTUAL DISABILITIES

A young person with an intellectual disability is not automatically deemed incompetent to consent to treatment. The competence of a young person with an intellectual disability must be assessed on a case-by-case basis.

YOUNG PEOPLE WHO ARE PARENTS

A 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.

LANGUAGE AND CULTURAL ISSUES

A medical practitioner's assessment about a child's competency 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.

Valid consent can only be obtained if the young person understands what is being presented in a language in which they are fluent. Health care interpreters should be used where appropriate, particularly when working with a family from a non-English speaking background.

Children should not be used as interpreters for their parents.

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 Border Protection and is free to GPs and pharmacists. The 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.

THE RIGHT TO REFUSE TREATMENT

The Gillick principle that allows for a competent minor to consent to treatment does not allow for a corresponding right to refuse treatment.

In many cases, a health practitioner would be reluctant to perform treatment over a young person's objection, especially if the young person is relatively mature and it is not major or life-saving treatment.

However, treatment may be performed against a child's wishes, even if they are Gillick competent where the treatment is urgent. In such cases, treatment may proceed without obtaining parental or patient consent. Otherwise, parental consent to refuse treatment or a court order would be necessary.

COMMON AND NOT-SO-COMMON MEDICAL ISSUES

PROVIDING SEXUAL HEALTH EDUCATION, INFORMATION AND CONDOMS

There is no restriction on providing these to children of any age, although health workers should ensure that these are being provided in an age-appropriate way.

PRESCRIBING CONTRACEPTION

Hormonal contraception (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').

STERILISATION

Sterilisation for contraception purposes cannot generally be performed without a court or tribunal order, even if the parent or child gives consent (see further discussion of sterilisation below).

Each state and territory has slightly different laws. In NSW, for example, sterilisation is regarded as a "special medical treatment" and may not be performed on a child under 16 without an order from the Guardianship Tribunal, unless it is performed to remediate a life-threatening condition.

If sterilisation is an unwanted consequence of another treatment which is necessary to save a young person's life or prevent serious damage to their health, treatment can generally be performed with the child's consent (if deemed Gillick competent) or otherwise with parental consent.

However, if sterilisation is sought for contraceptive purposes, or for other purposes (such as menstrual management for a young woman with an intellectual disability) then a court or tribunal order may be required.

For a child who does not have the capacity to consent to non-therapeutic sterilisation (i.e. the sterilisation is not for the purpose of treating a disease), parental consent is not sufficient and a court or tribunal order is required.

This is the effect of the decision of the High Court of Australia in 'Marion's case', which concerned a young woman with an intellectual disability. Her parents were gravely concerned not only about the risk of pregnancy, but also about her ability to cope with menstruation. The court held that where the child is not Gillick competent and the medical procedure is non-therapeutic, a court order is required. This is because there is a significant risk of making a wrong decision about the child's capacity to consent or the child's best interests, and the consequences of making a wrong decision are grave.

In most states and territories, it seems that a Gillick competent child aged 16 or over may be able to consent to sterilisation. However, in accordance with the Family Court's decision in *Re: Jamie* (see the discussion of this case under *Treatment of transgender children*), there may be a need for a court to determine whether or not the child is Gillick competent.

TREATMENT OF TRANSGENDER CHILDREN

The law about treatment of transgender children has been uncertain for some time. It has recently been clarified by the full court of the Family Court of Australia in the case of *Re: Jamie* [2013] FamCAFC 110.

The issues surrounded a child seeking treatment to transition from one gender to another.

The court drew a distinction between stage 1 treatment (which involves hormonal treatment, is reversible and is considered to have few, if any, side effects) and stage 2 treatment (which involves additional treatment with oestrogen and may also involve surgical intervention).

The court held that stage 1 treatment may proceed without court authorisation if the child, parents, and treating medical practitioners agree.

However, stage 2 treatment is another matter. Because there is a significant risk of the wrong decision being made as to a child's capacity to consent to treatment, and the consequences of such a wrong decision would be particularly grave, the court held that:

- If a child *is not* Gillick competent, the court must decide whether or not to authorise stage 2 treatment.
- If a child *is* considered Gillick competent, the child can consent to stage 2 treatment without court authorisation; however, only the court can determine whether the child is Gillick competent.

TERMINATION OF PREGNANCY

In most Australian states and territories, abortion is not completely legal. There are minor variations from state to state, but in general abortion is legally available if it is necessary to avoid serious danger to the woman's life or physical or mental health. Performing an abortion in other circumstances can amount to a criminal offence.

The Australian Capital Territory, Victoria and Tasmania are the only jurisdictions in Australia where abortion has been decriminalised (i.e. where abortion is not referenced in any criminal laws). In those states, medical practitioners are permitted to carry out abortions under the following legislation:

- Australian Capital Territory: *Medical Practitioners (Maternal Health) Amendment Act 2002*
- Victoria: *Victoria Abortion Law Reform Act 2008*
- Tasmania: *Reproductive Health (Access to Terminations) Act 2013*

In most Australian states and territories, 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. However, in some states and territories parental consent for women under 18 is required:

- Northern Territory – parental consent is required if the young woman is under 16 (section 11, *Medical Services Act*)
- Western Australia – If the young woman is under 16, her parents must be informed and be given the opportunity to be involved in counselling and medical consultations. If the young woman does not wish her parents to be informed, she must apply to the Children's Court to maintain confidentiality (section 334, *Health Act 1911 (WA)*)
- South Australia – if the young woman is under 16 and can't talk to her parents, she can still give consent for the procedure; however, two doctors will need to certify that she understands her decision and the procedure, and that it is in her best interests.

The legal onus falls on the medical practitioner who will conduct the abortion to ensure that informed consent is obtained from the woman seeking the termination, regardless of her age.

In order to allow the woman to make an informed choice about the decision to terminate the pregnancy, thorough pre-termination counselling and explanation of all possible adverse effects should be provided.

A doctor (or other health provider) can refuse to discuss, refer or assist a termination based on his or her own religious or personal beliefs, without risk of anti-discrimination action. However the provider would have a duty to take appropriate action to explain and offer alternatives, including referral to another practitioner.

These legal principles are the same regardless of whether a young woman is having a surgical or a medical abortion.

MENTAL HEALTH

All states and territories have their own mental health legislation governing voluntary and involuntary treatment for patients with mental illnesses.

In NSW, the Act specifies the surgical procedures and special medical treatments which require consent and who may provide that consent, including, where relevant, the need to get a court or tribunal's authorisation for treatment.

CONFIDENTIALITY, PRIVACY AND ACCESS TO HEALTH RECORDS

CONFIDENTIALITY

All health practitioners have a duty of confidentiality that arises from the nature of the information provided in the course of the therapeutic relationship with the patient. A patient is entitled to expect that information discussed during a consultation will not be shared with other parties without their explicit permission.

If a child has the capacity to consent to medical treatment on their own behalf, they are generally also entitled to confidentiality. This includes the right for the child's health information to be kept confidential from their parents.

If a child is not competent to consent to treatment, and a parent has consented to treatment on their behalf, the parent would be entitled to information about the child's health care.

EXEMPTIONS TO CONFIDENTIALITY

The exemptions to the duty to maintain confidentiality are both legal and ethical.

WHERE THE PATIENT CONSENTS TO DISCLOSURE

A patient can give express 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 and should be adequately documented. It is important to discuss and clarify with the young person whether they consent to others having access to their health information, and under what circumstances.

WHERE DISCLOSURE IS NECESSARY TO TREAT A CLIENT

If there are multiple providers involved in a young 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.

WHERE THE PROVIDER IS COMPELLED BY LAW TO DISCLOSE

Note that in these instances, information disclosed is usually 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. However, the

provider may be able to claim privilege over this information and should not simply disclose them to the court without obtaining legal advice.

- Notifications – medical practitioners have specific requirements to notify public authorities of matters such as:
 - » 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 of child abuse (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 – if information is not disclosed to a third party. Such a decision and the basis upon which it is made should be well documented in the patient's medical record, especially in circumstances where the patient has not consented to the disclosure.
- Public interest – in practice, this could include a situation where a provider is made aware by a patient that they have committed, or intend to commit, a serious criminal offence. Practitioners should obtain legal advice about whether or not they have an obligation to disclose the information depending on the circumstances.

PRIVACY AND ACCESS TO HEALTH RECORDS

Privacy and confidentiality are very similar concepts. As well as a common law right to confidentiality, patients have a statutory right to privacy over their health information and health records.

The *Privacy Act* 1988 (Commonwealth) applies throughout Australia and applies to personal and health information held by private sector providers. It does not cover state and territory public hospitals and clinics.

States and territories have their own laws covering privacy and health records. These apply to public sector agencies, and some apply also to the private sector (e.g. the NSW Health Records and Information Privacy Act 2002 applies to both)

In general, patients have a right of access to their health records, a right to demand that the records be corrected if inaccurate, and a right to ask for their health information not to be shared with other health providers or third parties.

There are exceptions to the right to privacy in certain circumstances, similar to the exemptions to confidentiality discussed above.

Young people under 18 can exercise their own privacy choices (e.g. not allow parents to see their records) once they are able to understand and make their own decisions. Generally, this will go hand-in-hand with competence to consent to medical treatment (Australian Law Reform Commission 2006).

MEDICARE AND PRIVACY

Children can apply for their own Medicare card (and number) when they turn 15, without parental consent. Those under 15 can apply with parental consent.

Young people do not necessarily have to have their own Medicare card to seek a health service that attracts a Medicare rebate independently of their parents. Health professionals may accept the Medicare number linked to the patient's parents without physically seeing the card.

Medicare records include the identity and specialty of the provider of a health service and the type of service received. If a young person has their own Medicare card, parents and guardians cannot access Medicare record information without the consent of the young person. If the young person is still on the family Medicare card and aged 14 or 15, generally their consent must be obtained before information about Medicare records is released to parents or guardians.

Parents and guardians have the right to request Medicare Australia to approach health providers about whether they will release information about their adolescent child.

Once a child is 16, Medicare can only give information to parents or guardians with the young person's consent.

EHEALTH RECORDS AND PRIVACY

The eHealth system is designed to contain an electronic summary of a person's key health information such as prescribed medications, allergies and treatments they have received. Health practitioners can upload health information to the eHealth record for individual patients and view the information in it uploaded by other practitioners.

Young people under 18 may have an eHealth record.

A person with parental responsibility for a person under 18 can register for an eHealth record on their child's behalf. The parent can then access and control the eHealth record of that young person

on their behalf as an "Authorised Representative", until the young person takes control of their eHealth record or turns 18.

If the young person has capacity to consent to treatment and confidentiality in their own right, a parent cannot be their "Authorised Representative" unless the child consents to this.

When a young person turns 14, information from both the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) will cease to be included in their eHealth record. This information will only be made available again if the young person takes control of their eHealth record and consents to the inclusion of MBS and/or PBS data.

If a young person is under 14 and would like to take control of their existing eHealth record or register for an eHealth record, they will need to prove to the System Operator that they can make decisions about their healthcare and can manage their eHealth record.

CHILD PROTECTION AND MANDATORY REPORTING

All states and territories in Australia have legislation pertaining to the care and protection of children and young people. All have mandatory reporting requirements for health professionals, and many extend the mandatory reporting requirements to a range of other people who work with children. Mandatory reporting refers to the legislative requirement imposed on certain people to report suspected cases of child abuse and neglect to government authorities.

Each state has its own laws concerning who has to report, what types of abuse and neglect need to be reported, and the threshold of concern of harm which triggers the obligation to report.

NEW SOUTH WALES

In NSW, for the purposes of child protection legislation a child is a person under 16 years of age, and a young person is 16 or 17 years old.

It is mandatory for any professional working with children to notify if they have reasonable grounds to suspect that a child under 16 is at risk of significant harm. In addition, health workers may make a report about a young person aged 16-17 or class of young people that they suspect are at risk of significant harm.

Factors that may indicate a child is at risk of significant harm include physical, sexual or emotional/psychological abuse, neglect, or exposure to family violence. (Sections 23 & 27, *Children and Young Persons (Care and Protection Act 1988 (NSW)*).

In NSW mandatory reporters are those who deliver the following services to children as part of their paid or professional work:

- Health care - doctors, nurses, dentists and other health workers
- Welfare - psychologists, social workers and youth workers
- Education - teachers
- Children's services - child care workers, family day carers and home based carers
- Residential services - refuge workers, community housing providers
- Law enforcement - police

Any person with direct responsibility to provide the services listed above must report risk of significant harm to children. Managers, including both paid employees and volunteers, who supervise direct services are also mandated to report. If you are a mandatory reporter, you can call the Child Protection Helpline on 133 627. Members of the general public should call 132 111.

In NSW Child Wellbeing Units (CWUs) exist within four government departments – NSW Police Force, Department of Education and Communities, NSW Health and the Department of Family and Community Services. CWUs provide advice to mandatory reporters within the agency in which they are based. The NSW Health Child Wellbeing Units can be contacted on 1300 480 420. Agencies without a CWU can contact the Keeping Them Safe Support Line for information and advice on 1800 772 479.

FINDING OUT MORE...

In NSW, mandatory reporters are encouraged to use the Mandatory Reporter Guide to guide their decision making and determine whether or not to report to the Child Protection Helpline. The interactive online guide can be visited at www.KeepThemSafe.nsw.gov.au.

Find out more about mandatory reporting in NSW at www.Community.nsw.gov.au

Information and advice on domestic violence in NSW is available at www.DomesticViolence.nsw.gov.au.

A NEW APPROACH TO CHILD PROTECTION

Child safety and wellbeing is a whole of community responsibility. Therefore reporting children at risk of significant harm is only a part of the health worker role. Health workers participate in a shared system of child wellbeing and child protection by identifying risk of harm,

consulting the Mandatory Reporter Guide and their Child Wellbeing Unit if appropriate, and responding to the vulnerabilities, risks and needs of families, children and young people that they identify. For example, the Health worker may provide family support services and refer to other services for additional family support.

The role and responsibilities of NSW Health workers in the new approach to child protection are outlined in the fact sheet that can be found at:

http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_007.pdf

AUSTRALIAN CAPITAL TERRITORY

In the ACT, health professionals must notify if they believe on reasonable grounds that a child or young person has experienced or is experiencing sexual abuse or non-accidental physical injury (section 356, Children and Young People Act 2008 (ACT))

NORTHERN TERRITORY

In the NT, any person must make a report if they believe on reasonable grounds that a child of any age has suffered or is likely to suffer harm or exploitation, physical or sexual abuse, emotional/psychological abuse, neglect, exposure to physical violence (e.g. a child witnessing violence between parents at home) (sections 15, 16 & 26, Care and Protection of Children Act 2007 (NT)).

In addition, a registered health professional must report if they have reasonable grounds to believe a child aged 14 or 15 has been, or is likely to be, a victim of a sexual offence and the age difference between the child and the offender is greater than two years (section 26(2), Care and Protection of Children Act 2007 (NT)).

QUEENSLAND

In Queensland, a doctor or registered nurse must report if they become aware of, or develop a reasonable suspicion of, harm or risk of harm due to factors of physical, psychological/emotional abuse, neglect, sexual abuse or exploitation (sections 191-192 & 158, Public Health Act 2005 (Qld)).

SOUTH AUSTRALIA

In SA, doctors, pharmacists, registered or enrolled nurses, dentists, psychologists, employees/volunteers in a government department, agency or instrumentality, or local government agency that provides health services wholly or partly for children must report if they suspect or believe on reasonable grounds that a child has been or is being emotionally/psychologically abused or neglected (Children's Protection Act 1993 (SA)).

TASMANIA

In Tasmania, registered medical practitioners, nurses, midwives, dentists, dental therapists / hygienists, registered psychologists and employees/volunteers in a government department, agency or instrumentality, or local government agency that provides health services wholly or partly for children must report knowledge, belief or suspicion on reasonable grounds that a child has been or is being abused or neglected or is an affected child whose safety, psychological wellbeing or interests are affected or likely to be affected by family violence; or there is a reasonable likelihood of a child being killed, sexually/physically/psychologically abused or neglected by a person with whom the child resides (sections 3, 4 & 14, Children, Young Persons and Their Families Act 1997 (TAS)).

VICTORIA

In Victoria, registered medical practitioners, midwives or registered nurses must report a belief on reasonable grounds that a child is in need of protection because they have suffered, or are likely to suffer, significant harm as a result of physical injury, sexual abuse, emotional/psychological harm and the child's parents have not protected, or are unlikely to protect, the child from harm of that type or the child has been abandoned by their parents or the parents can't be found or are incapacitated /dead and there is no-one else willing to take the child (sections 182, 184 & 162, Children, Youth and Families Act 2005 (Vic))

WESTERN AUSTRALIA

In WA, doctors, nurses and midwives must report a belief on reasonable grounds that child sexual abuse has occurred or is occurring (sections 124A & 124B, Children and Community Services Act 2004 (WA)).

VOLUNTARY REPORTING

In situations where a health practitioner does not consider that the threshold of 'risk of significant harm' is met, reporting is not mandatory. However, voluntary reporting is provided for under the relevant legislation (for example, in NSW, it is not mandatory to make a report in relation to a young person aged 16 or 17).

PROTECTION FOR HEALTH PRACTITIONERS

Under the relevant legislation, a health practitioner is protected from civil or criminal liability (e.g. breach of confidentiality litigation, professional misconduct action, defamation proceedings) if they make a report (whether voluntary or mandatory) in good faith to the relevant child protection authority.

They are also protected from having their identity disclosed to the extent that this is possible.

In NSW the legal framework for information exchange allows organisations to share information relating to the safety, welfare and wellbeing of children or young people without consent. The safety, welfare and wellbeing of children and young people is considered paramount and takes precedence over the protection of confidentiality or of an individual's privacy. While consent is not necessary, it should be sought where possible. Organisations should at a minimum advise children, young people and their families that information may be shared with other organisations.

FINDING OUT MORE...

In NSW there are specific policies which provide guidance and agreed interagency procedures for exchanging information related to the safety, wellbeing and welfare of children and young people, and which allow information exchange to occur irrespective of whether a report has been made to the Child Protection Helpline. Visit www.health.nsw.gov.au/policies (use child wellbeing as a search term) or www.KeepThemSafe.nsw.gov.au

RECOGNISING RISK OF HARM

In practice, because adolescence is a time of experimenting with high risk behaviours, it can be difficult to determine what constitutes a mandatory reporting concern. If a report is going to be made, it is nearly always advisable to inform the young person and to explain why you are going to make a report.

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

- The age, development, functioning, and vulnerability of the child or 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 (e.g. recent abuse or neglect of a sibling, or parents experiencing mental health problems)

Under-age sex does not necessarily equate to abuse, and is not automatically a ground for mandatory reporting.

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 your concerns with them.

FINDING OUT MORE...

The Australian Institute of Family Studies (AIFS) has a factsheet that examines legal provisions requiring specified people to report suspected abuse and neglect to government child protection services in Australia. It is available at www.aifs.gov.au/cfca/pubs/factsheets/a141787

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 in Australia.

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.

There have been cases in which a child or young person has been wrongly assessed by a mandatory or voluntary reporter as suffering from abuse from culturally determined health practices (e.g. “coining” or “cupping” in Vietnamese and Laotian communities) which are in fact acceptable and safe practices within the Australian context. If you are in doubt about a particular cultural practice, consult with a culturally appropriate or bilingual health professional.

FINDING OUT MORE...

There is a wide range of resources available to help health practitioners understand and navigate medico-legal issues.

For further information about relevant laws applying to young people the Australasian Legal Information Institute (AustLII) provides an online database of Australian legislation and case law - www.austlii.edu.au

For information on a range of legal issues affecting young people in each Australian state and territory, visit the National Children's and Youth Law Centre's lawstuff at www.lawstuff.org.au

The Shopfront Youth Legal Centre is a free legal service for disadvantaged young people. It provides fact sheets on legal issues, including young people and health care in NSW. Visit www.theshopfront.org

For information on Medicare – www.medicareaustralia.gov.au

For information on sexual health and family planning issues - Sexual Health & Family Planning Australia - www.shfpa.org.au

The Office of the Australian Information Commissioner has factsheets on health, eHealth and privacy.

Queensland Health has produced a Guide to Informed Decision-making in Healthcare.

Community based workers may find this guide useful - Working with Youth: A legal resource for community based health workers. Child and Adolescent Health Service, WA. (2009).

Chapters by Kang and Sanders (2013) and Sanci (2001) also provide overviews of medico-legal issues for health professionals.

CHAPTER SUMMARY - WHAT TO REMEMBER

Medico-legal issues that arise when working with young people are rarely clear-cut. Much responsibility is placed on health practitioners to make an assessment of the young person's capacity to consent to treatment or to refuse treatment. There are, however, some circumstances where common law or legislation establishes exactly what is required.

REFLECTION QUESTIONS

How comfortable are you with your understanding of medico legal issues and how they affect the work you do with young people?

Are you a mandatory reporter? Do you understand your obligations in this area? Do you understand how to support families where children are at risk of harm?

Do you know where you can get advice about medico legal issues?

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