Working with Youth

A legal resource for community based health workers
Table of contents

List of hypothetical case studies 4
Acknowledgements 5

1. Introduction 6

2. Definition of terms 7

3. Duty of care 8
   3.1. Referral and waiting lists 9
   3.2. Duty to take reasonable care of self and colleagues 10

4. Parental responsibility, the ‘mature minor’ and the young adult 12
   4.1 Children (under 18 years) 12
      4.1.1 Family breakdown situations 12
      4.1.2 Mature minors 13
   4.2 Special situations 15
      4.2.1 Children who are married, in a de-facto relationship or are parents 15
      4.2.2 Children with an intellectual disability 15
      4.2.3 Children with a mental illness 15
      4.2.4 Specific statutory situations 15
   4.3 Young adults (18 years and over) 15

5. Consent to service provision 16
   5.1 What is consent? 16
   5.2 Requirements of valid consent 17
   5.3 Information to be given to clients 17
   5.4 Therapeutic privilege 18
   5.5 Who can give consent? 18
      5.5.1 Children (under 18 years) 18
      5.5.2 Young adults (18 years or over) 19
      5.5.3 Information to be given to substitute decision-makers 19
   5.6 Duration of consent 20
   5.7 Failure to obtain consent 20
   5.8 Emergency treatment 21
   5.9 Refusal of treatment 21
      5.9.1 Young adults (18 years and over) 21
      5.9.2 Children (under 18 years) 21
   5.10 Forms of treatment prohibited by law 22
   5.11 Court authorisation for treatment of a child in special situations 22
## Table of contents

6. **Client confidentiality and information sharing** 24
   6.1 Sharing confidential information 24
   6.2 Sharing confidential information in specific circumstances 25
      6.2.1 With the child’s parents 25
      6.2.2 With other health workers 27
      6.2.3 With the police 27
      6.2.4 Cultural considerations 27
      6.2.5 Notifiable infectious diseases 27
   6.3 Mandatory Reporting of Child Sexual Abuse 27
      6.3.1 The duty to report 27
      6.3.2 The process for reporting 28

7. **Child abuse and domestic violence** 29
   7.1 Protecting children at risk of abuse or neglect 29
   7.2 Reporting allegations, suspicions or concerns of child abuse or neglect 29
   7.3 Confidentiality of notifier’s identity 30
   7.4 DCPFS access to a child at hospital, school or child care service 30
   7.5 Sharing confidential client information with DCPFS 30
   7.6 Domestic violence
      7.6.1 For young adults 30
      7.6.2 For minors under the age of 18 years 31

8. **Medical record-keeping and accessing medical records** 33
   8.1 Creation and maintenance of records 33
   8.2 Retention and disposal of records 34
   8.3 Freedom of information 34
   8.4 Electronic records 34

9. **Sexual health** 35
   9.1 Age of consent and underage sex 35
   9.2 Sexual offences against the mentally impaired 35
   9.3 Sexuality 36
   9.4 Contraceptive advice and treatment 36
   9.5 Termination of pregnancy (induced abortion) 36
   9.6 Sexually transmissible infections (STIs)
      9.6.1 Sexually transmissible infections (STIs) acquired through (suspected) child sexual abuse 38
   9.7 Testing for HIV/AIDS 38
   9.8 Female genital mutilation 38
   9.9 Sexual assault 38
   9.10 Sexting 39
## 10. Mental health

10.1 *Mental Health Act 1996 (WA)*

10.2 Referral for examination

10.3 Examination by psychiatrist
   - 10.3.1 Involuntary detention
   - 10.3.2 Voluntary patients
   - 10.3.3 Community treatment orders

10.4 Emergency psychiatric treatment

10.5 Police powers to take mentally ill person into protective custody

## 11. Drugs and poisons

11.1 Schedule of drugs and poisons
   - 11.1.1 *Therapeutic Goods Act 1989 (Commonwealth)*
   - 11.1.2 *Poisons Act 1964 (WA)*

11.2 Restricted drugs
   - 11.2.1 Administering restricted drugs in schools

11.3 Prohibited drugs
   - 11.3.1 Use of illicit drugs by young people
   - 11.3.2 Reporting the supply of illicit drugs
   - 11.3.3 Drug testing

11.4 Tobacco

11.5 Alcohol

## 12. Relevant laws and legislation

## APPENDIX – Access to Medicare
# List of hypothetical case studies

<table>
<thead>
<tr>
<th>Case Study</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young woman intoxicated and aggressive at youth health service</td>
<td>11</td>
</tr>
<tr>
<td>Fourteen-year-old girl requests access to contraceptive pill</td>
<td>14</td>
</tr>
<tr>
<td>Student who is depressed</td>
<td>20</td>
</tr>
<tr>
<td>Refusal at school-based immunisation clinic</td>
<td>23</td>
</tr>
<tr>
<td>Young male at risk of suicide</td>
<td>26</td>
</tr>
<tr>
<td>Thirteen-year-old girl asks about pregnancy testing</td>
<td>32</td>
</tr>
<tr>
<td>Sixteen-year-old concerned about unprotected sex</td>
<td>40</td>
</tr>
<tr>
<td>Young man presents at health clinic in a highly agitated state</td>
<td>44</td>
</tr>
<tr>
<td>Pregnant young woman with crystal methamphetamine dependence</td>
<td>48</td>
</tr>
<tr>
<td>Student who is suspected of being intoxicated at school</td>
<td>50</td>
</tr>
</tbody>
</table>
Acknowledgements

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This resource is based on:
Working With Young People – Ethical and Legal Responsibilities for Health Workers with permission from the NSW Association for Adolescent Health Inc., 2005. Website: www.naah.org.au

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1. Introduction

The recognition and consideration of legal issues is fundamental to health care practice and professional conduct, and working with children and young adults raises many legal challenges. The nature of health law often results in judgements having to be made by the health professional. This can be particularly challenging for those working in community settings where collegiate support is not readily accessible.

Working with children and young adults requires careful consideration of the developmental stage of the individual and the legal status of that person. Health concerns which are of most importance to young people often involve sensitive psychosocial issues. Therefore, the development of trusting relationships between health workers and young people is highly important in the provision of effective care. It is imperative that health professionals understand the legal principles which relate to children under the age of 18 years, and are able to communicate information about rights, responsibilities and relevant limitations. Also of importance is the recognition of vulnerability among many who have reached ‘adult’ age in the eyes of the law.

This resource outlines common law principles and legislation which are likely to be useful for Western Australian health professionals working with children and young adults. The first part of the document deals with foundational legal principles, including duty of care, consent, confidentiality and competence. Later sections address issues which may arise among children and young adults as they move through adolescence – child abuse, domestic violence, sexual health, mental health, drugs and poisons.

It is hoped that this resource will provide a good, general background of the relevant law to assist with sound decision-making. It is, however, strongly recommended that legal advice is sought for assistance with specific cases.
### 2. Definition of terms

Set out below is a list of terms, and their associated meanings, as used in this resource:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Law</td>
<td>Law derived from judgments made in court.</td>
</tr>
<tr>
<td>Competence</td>
<td>The capacity or capability, at law, of an individual to make decisions on his or her own behalf. Questions relating to the competence of clients usually arise in relation to children and intellectually disabled people and in the context of giving consent to treatment or disclosure of confidential information.</td>
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<tr>
<td>Child or Minor</td>
<td>A person under 18 years of age.</td>
</tr>
<tr>
<td>Client</td>
<td>Is synonymous with ‘patient’.</td>
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<tr>
<td>Health Care</td>
<td>An intervention provided by a health worker, which aims to promote, maintain, monitor or restore health. Interventions can include assessment, diagnosis, treatment, counselling, therapy, provision medication, and/or provision of information and advice.</td>
</tr>
<tr>
<td>Health Service</td>
<td>Public health services, hospitals, clinics or health centres within Western Australia, that provide health care.</td>
</tr>
<tr>
<td>Health Worker or Health Professional</td>
<td>Includes medical practitioners, nurses, psychiatrists, psychologists, social workers and all other allied health workers or health professionals who provide health care to clients.</td>
</tr>
<tr>
<td>Legal Guardian</td>
<td>In relation to a child, means the person having parental responsibility for that child. Such person will usually be the parent of the child unless parental responsibility had been varied by an order made by the court (e.g. a parenting order made by the Family Court or certain types of protection orders made under the <em>Children and Community Service Act 2004 (WA)</em>). In relation to a young adult, means the person formally appointed as a legal guardian of that young adult under the <em>Guardianship and Administration Act 1990 (WA)</em>.</td>
</tr>
<tr>
<td>Parent</td>
<td>In relation to a child, means the person having parental responsibility for that child.</td>
</tr>
<tr>
<td>Parental Responsibility</td>
<td>In relation to a child means all the duties, powers, responsibilities and authority which, by law, parents have in relation to their children.</td>
</tr>
<tr>
<td>Young Adult</td>
<td>A person who is between 18 and 25 years of age.</td>
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</tbody>
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3. Duty of care

The special nature of the relationship between health workers and their clients has been recognised at law as giving rise to a duty of care. Where the client is a child or young adult, the principle is that the health worker must take all reasonable care for the welfare of that child or young adult.

Generally, this duty will arise when the child or young adult is received into the health service for medical treatment or other health care, and that health service expressly or implicitly accepts responsibility for the treatment or care of that child or young adult. The duty means that health workers must ensure that children or young adults they care for do not come to reasonably foreseeable harm by their actions or failure to act. The health worker must exercise appropriate skill and judgment in respect of the assessment, diagnosis, treatment or other health care of the child or young adult, including the provision of advice and information. A health worker may also owe a duty to others (non-clients) who may suffer reasonably foreseeable harm as a result of the actions or omissions of the health worker or a child or young adult under his or her care.

A health worker (and/or their employing health service) may be liable for negligence where they fail to take steps that a reasonable person would have taken to prevent a reasonably foreseeable risk of harm to a child or young adult under their care or other person to whom they owe a duty of care.

In civil actions for negligence, the court will consider all the circumstances of the case when deciding whether the health worker acted reasonably, including the magnitude of the risk, the degree of probability of its occurrence and the difficulty and cost of alleviating the risk. The health worker will only be liable in negligence where they have not acted reasonably, the breach has caused injury or loss to the child, or young adult or other person to whom the duty is owed, and that injury or loss is not insignificant.

When determining liability for negligent treatment or diagnosis, the standard of care of health workers will, in general, be determined according to whether the health worker’s conduct (at the time it occurred) was widely accepted by their professional peers as competent professional practice.

Health workers should act reasonably at all times, and in accordance with relevant standards and practices that govern their conduct. Health workers should ensure they are familiar with the policies and decision-making protocols of their workplace and of their professional codes of ethics/conduct. Registration boards and/or professional associations to which health workers may belong usually endorse professional codes of ethics/conduct. Such standards or codes are important in ascertaining whether any breach of duty has occurred.

It is important to realise that some children and young adults, depending on their age, maturity and circumstances, may be more vulnerable than others. Health workers should be mindful of the individual needs and circumstances of the children or young adults under their care. The standard of care owed to children is high and factors such as the child’s age, physical and mental capabilities or impairment will be relevant to the court in assessing whether a health worker’s conduct falls below expected standards.

In addition, health workers should ensure that children or young adults under their care are given
3. Duty of Care

all necessary information regarding the health care being provided. This should include allowing the child or young adult sufficient time to reflect on the information presented. To ensure they have understood the information provided the child or young adult should be encouraged to repeat what they have been told, in his or her own words. (Refer to section 4 for more information.)

3.1. Referral and waiting lists

Health workers are often involved in linking clients to other health workers or health services that can provide specific health care required by clients. When health workers identify a health issue which is outside their scope of practice or the scope of their service, referrals are usually made to another health service or health professional (‘health service provider’) where the required expertise and care can be provided. The point at which the duty of care is transferred to the new health service provider is not always clear and depends on the circumstances of the client.

Each health worker (or health service) has a responsibility to define the scope of the service that can be expected by clients. This needs to be clearly communicated to clients, families and others involved in the health care process. In making a referral to another health service provider, there needs to be adequate information provided to the new provider in order that decisions can be made about the relative priority of the client’s need.

In cases where there is referral to another health service provider, the duty of care (of the referring health worker) is usually discharged when the child or young adult makes contact with the new provider. Once the client is accepted into the care of the new health service provider, or placed on its waiting list, the new provider owes a duty to prioritise clients and provide care in a timely manner.

However, there may be some circumstances where a duty of care is owed simultaneously both by the referrer and by the health service provider to which the client has been referred but has not yet consulted. If the waiting list for a particular referral is known to be lengthy, the client should be informed of other service options and, if appropriate, be linked to a General Practitioner (GP) for assistance in managing the client’s care while on the waiting list. The involvement of a GP does not necessarily relieve the referrer of his or her duty of care to the client. Referring health workers are expected to assertively follow-up clients placed on waiting lists and, if circumstances change, take appropriate action for the client’s welfare.

Some children and young adults may be more vulnerable than others because of their emotional or cognitive immaturity. There may be a lack of appreciation by the child or young adult of the need to take further action, or an inability to take steps to seek further help. In such cases the health worker may need to take additional steps to ensure that the child or young adult makes contact with the health service provider to which they have been referred. The health worker’s duty may require him or her to assertively follow-up with the child or young adult. It may also be desirable (within the constraints of the duty of confidentiality) that a parent, guardian or other relevant person is informed and involved in the process. Refer to 6.2.1 for more information about duty of confidentiality in relation to minors.

In some cases the child or young adult may be vulnerable because of the acuteness of the health issue and the requirement for urgent action. A health worker may need to take additional action to ensure that any foreseeable risk of harm to the client is eliminated or minimised. For example, in the case of suicide risk, the standard of care expected of the health worker will be greater than in other less urgent circumstances.
3. Duty of Care

3.2. Duty to take reasonable care of self and colleagues

Generally speaking, an employer has a duty to take reasonable care for the health, safety and welfare at work of all employees. More specifically, under the Occupational Safety and Health Act 1984 (WA) [the OSH Act], employers have a duty to, so far as is practicable, maintain a working environment in which the employees are not exposed to hazards.

The OSH Act defines ‘practicable’ as meaning ‘reasonably practicable having regard, where the context permits, to –

(a) the severity of any potential injury or harm to health that may be involved, and the degree of risk of it occurring

(b) the state of knowledge about –
   (i) the injury or harm to health referred to in paragraph (a);
   (ii) the risk of that injury or harm to health occurring; and
   (iii) means of removing or mitigating the risks or mitigating the potential injury or harm to health; and,

(c) the availability, suitability and cost of the means referred to in paragraph (b)(iii) above’.

The OSH Act also places responsibilities on an employee to take reasonable care to ensure his or her own safety and health at work, and to avoid adversely affecting the safety or health of any other person through any act or omission at work. This includes reporting hazards, which could result in harm to any person, and that the employee cannot correct.

Employees working in community settings face unique risks such as working in an environment, which is not controlled by the employer, or working alone with little or no ready support from colleagues. The OSH Act equally applies to staff in such settings, and those rights and responsibilities remain relevant. Local procedures for identifying and managing risks must be implemented and monitored.
3. Duty of Care

Hypothetical case study:
Young woman intoxicated and aggressive at youth health service

You are working in a youth health service when a 15-year-old female arrives in an obvious state of intoxication. The girl is verbally aggressive towards other young people and staff, and you are concerned for the safety of people at the clinic. You are also concerned about what might happen if you ask the girl to leave the premises on two grounds;
1. She is so intoxicated that she could be hurt/injured or harm someone else; and,
2. She has been prescribed antipsychotic drugs for amphetamine related psychosis and is in possession of her medication. However, you are concerned about safe management of the medication.

What is your course of action?
- Consider your duty of care to other clients and staff. If feasible take the girl to a consulting room. Ensure any staff involved follow safety protocols. Consider having a second worker present during the interview.
- Attempt to calm the girl.
- Assess the girl's level of intoxication and her competence (bearing in mind her age) to make decisions.
- Document carefully the process and factors relied upon in assessing level of intoxication and competence.
- Inform the girl of your concerns for her safety and develop a safety plan with her.
- If the girl is unwilling or unable to participate in the development of a safety plan, undertake a risk assessment and implement a safety plan, taking into account her personal circumstance, her physical and mental state, involving parent/caregiver (ensuring obligations of confidentiality are complied with).
- Call an ambulance if you suspect that the girl is at high risk of overdose and/or collapse.
- If appropriate inform parent/caregiver of relevant services available to them.

The girl continues to be aggressive, threatening to assault one of the supervising staff. She insists on leaving the premises. What is your course of action?
- Watch the girl to observe where she goes after leaving the premises.
- Make urgent contact with a next of kin or suitable community service to pick her up and take her home.
- Inform other agencies involved in her care of the incident, ensuring obligations of confidentiality are complied with.
- If the girl appears to be at immediate risk of harm to herself or others, consider contacting an ambulance, and involving police if the girl is non-compliant with ambulance officers.
- Proactively follow up the girl after the incident, to re-establish contact, assess the situation and reschedule further appointments to continue health care provision.
- Review her current medication management regime, and suggest a plan to ensure safe provision. Consider the involvement of a responsible person.

This scenario is underpinned by legal concepts covered in sections 4, 5, 6, 7, 9, 11 and 12. Refer to these sections for more information.
4. Parental responsibility, the ‘mature minor’ and the young adult

4.1. Children (under 18 years)

It will usually be in a child’s interests to have his or her parents involved in health care decisions. However, there will be times when a child seeks health care without the knowledge or consent of his or her parents. A child may also specifically request that his or her parents not be informed about the health care being sought or otherwise demand confidentiality in respect of the matters discussed.

Children begin life as wholly dependent on their parents for protection and nurturing, gradually developing into adults (as defined by law) at the age of 18 years. In general, each parent of a child has full parental responsibility for the child by virtue of the relationship, which does not cease until the child’s 18th birthday. There are, however, some exceptions to this rule.

‘Parental responsibility’ in relation to a child means all the duties, powers, responsibilities and authority that, by law, parents have in relation to their children. This includes the power to consent to medical treatment or make other health care decisions concerning the child, access the child’s medical records and authorise the release of confidential information to third parties on behalf of the child.

Parental responsibility continues even if the parents separate, divorce or remarry so that either parent is able (legally) to make decisions on behalf of his or her child unless provision has been made to the contrary by a parenting order.

4.1.1. Family breakdown situations

In a family breakdown situation (such as separation or divorce), parental responsibility may be varied where the Family Court makes an order stipulating that one parent has certain responsibilities to the exclusion of the other parent. The court can make four types of parenting orders: residence orders, contact orders, child maintenance orders and specific issues orders. The court may make any combination of these orders:

- A residence order or specific issues order may stipulate that one parent has sole responsibility for the child’s day-to-day care, welfare and development. If this type of order has been made, that parent will be the only parent that can make decisions for that child (for example, this may relate to the ability to make health care decisions on behalf of the child).

- If there is an arrangement for the child to live with one parent for part of the time and the other for part of the time, this is a residence order. Both parents retain full parental responsibility for the child and either parent may make decisions for the child.

- A maintenance order provides for the financial support of the child. Both parents retain full responsibility for the child and either parent may make health care decisions for the child.

- If a specific issues order is made granting one parent the sole responsibility for health care decisions, that parent will be the only parent that can make health care decisions for the child.

Protection orders made by the Children’s Court under the *Children and Community Services Act 2004 (WA)* can (depending on the type of protection order made) vary parental responsibility. Parental responsibility for children placed in or
4. Parental responsibility, the ‘mature minor’ and the young adult

taken into provisional protection and care or who are subject to a negotiated placement agreement generally remains with the parents. However, the Chief Executive Officer of the Department for Child Protection and Family Support has statutory authority to make decisions on behalf of such children in specific circumstances.

4.1.2. Mature minors

Between infancy and the child reaching adulthood, a parent’s powers and responsibility dwindle proportionately with the child’s maturity and intellectual capacity to understand concepts and make up his or her own mind on matters requiring a decision. Generally, a child under the age of 18 years can consent to medical treatment and make other health care decisions, authorise the sharing of his or her confidential information and demand confidentiality (in relation to anyone including his or her parents or guardian) if assessed to be sufficiently mature and intelligent to make such decisions on his or her own behalf.

The law in Australia recognises this concept of the ‘mature minor’, which is founded in common law. The High Court of Australia has adopted the test set out in the English case *Gillick v West Norfolk Area Health Authority* for determining a child’s competence, namely, that a child under the age of 18 years is capable of giving effective consent if they fully comprehend the nature, consequences and risks of the proposed action, irrespective of whether a parent consents. A child that is assessed as being a mature minor is often referred to as ‘Gillick competent’.

The assessment of a child as a ‘mature minor’ is not made on the basis of the child’s chronological age alone and does not need to involve an accompanying parent or guardian. It is based on the child’s experience, emotional maturity and intellectual capacity. The development of these attributes is a continuum and varies from one child to another. There is no cut-off point, other than the time when an individual reaches the age of 18-years and is recognised by law, as an adult.

Consequently, health workers must assess each child’s competence on a case-by-case basis.

In assessing the competence and maturity of a child, the following factors may (depending on the individual circumstances) be important:

- Age of the child.
- Nature of the clinical or other problem.
- Ability of the child to explain the clinical or other problem by providing an appropriate history.
- Nature and purpose of the proposed health care or other action.
- Ability of the child to understand the gravity and complexity of the proposed health care or other action.
- Ability of the child to understand and rationalise health care or other relevant options.
- Consequences of the proposed health care (including side-effects of proposed treatment) or other action.
- Ability of the child to understand fully the nature, consequences, risks and implications of the proposed health care or other action and of non-action.
- Emotional impact on the child of either accepting or rejecting the proposed health care or other action.
- Child’s general maturity of expression.
- Child’s level of functioning in other aspects of his or her life.
- Child’s level of schooling.
- Child’s level of independence from parental care.
- Any moral and family issues involved.
- Health worker’s prior knowledge of the child.
- Reason the child came to see the health worker about the clinical or other problem without parental involvement.
- Whether the child is acting freely in attending the health worker and making his or her decision.
Note: The above list is provided for general guidance only. The items specified will not apply to every circumstance. Nor is the list exhaustive. Other issues may need to be taken into account in the individual circumstances. As such, health workers must assess each client’s circumstance on a case-by-case basis.

Where a health worker is unsure about the maturity or competence of a child, he or she should confer with a line manager and/or follow a defined service protocol for consultation and decision-making.

Health workers should ensure that the process, and factors relied upon in assessing a child’s competence, are carefully documented in the child’s medical record.

Hypothetical case study:

**Fourteen-year-old girl requests access to contraceptive pill**

You work in a sexual health clinic where a sexually active 14-year-old girl consults with you about access to the oral contraceptive pill. What steps should you take to ensure you meet any legal and ethical obligations owed to this girl?

- Conduct a psychosocial assessment including sexual activity and relationships.
- Assess the girl’s competence to consent to health care.
- Carefully document the process and factors relied upon in assessing the girl’s competence.
- Encourage and support the girl to discuss the issue with her parents.
- Discuss the law in relation to underage sex.

If you judge the girl to be at risk because of her immaturity or other circumstances, what should you consider?

- Discuss conditional confidentiality and the need to share certain information in some circumstances, preferably with the girl’s knowledge and consent.
- Assess ongoing risk i.e. child protection or coercion, and notify DCPFS if appropriate.
- If appropriate, make contact with parent/guardian or assist the girl to do so.
- Provide appropriate health care, including discussion about safe sex and self care.

If you judge this girl to be a mature minor, what should you consider?

- Provide appropriate health care, including discussion about safe sex and self care.
- Make a referral if appropriate.
- Suggest the girl discusses her health care with her parents, and provide her with strategies to do this.
- Arrange another appointment to monitor and review.
- Assess ongoing risk, i.e. child protection or coercion, and notify DCPFS if appropriate.

This scenario is underpinned by legal concepts covered in sections 2, 4, 5, 6, 7, 8, 9 and 10. Refer to these sections for more information.
4. Parental responsibility, the ‘mature minor’ and the young adult

4.2. Special situations

4.2.1. Children who are married, in a de facto relationship or who are parents

The legal position concerning parental responsibility for a child who is married, in a de facto relationship or unmarried with a child is unclear. Such children should be assessed for competency like any other child. However, the fact a child is married, living in a de facto relationship or has a child of his or her own will be important factors to take into account when assessing competency.

Where issues arise as to the competency of a child to give consent to medical treatment on his or her own behalf, or where there is a dispute between the children who are married or in a de facto relationship and the parents of the child in need of treatment, legal advice should be sought, as it may be necessary to obtain a court order authorising the treatment.

4.2.2. Children with an intellectual disability

The parents of a child with an intellectual disability will, in general, be the appropriate persons to make medical and other health care decisions on behalf of that child. However, such decisions are subject to the child’s best interests and the consent of the court will be necessary in certain circumstances (e.g. non-therapeutic sterilisation procedures).

4.2.3. Children with a mental illness

A child who would otherwise be competent to make decisions about his or her health, but who has a psychiatric illness that affects his or her competency, may not be able to make his or her own medical or other health care decisions. If the child is an ‘involuntary patient’, there are special provisions under the Mental Health Act 1996 (WA) that provide for the provision of psychiatric and medical treatment without consent in certain circumstances.

4.2.4. Specific statutory situations

It should be noted that there are specific statutory provisions relating to the capacity of parents, guardians and children to consent to certain medical procedures concerning a child. These statutory provisions override the common law principles discussed above in section 4.1. For example, section 334(8) of the Health Act 1911 (termination of pregnancies); section 21 of the Human Tissue and Transplant Act 1981 (blood transfusions).

4.3. Young adults (18 years and over)

Upon his or her 18th birthday, a child is recognised by the law as being an adult with full legal capacity to make decisions on his or her own behalf. At the same time, parental responsibility for the young adult automatically ceases.

At law, every young adult is presumed to be competent to make his or her own decisions (such as making health care decisions or authorising the release of his or her confidential information to third parties) unless there is evidence or knowledge that the young adult is incapable of doing so. This situation may arise if, for example, the young adult is suffering an intellectual disability, mental illness or acquired brain injury that renders the young adult incapable of understanding the nature, consequences and risks of the proposed action and the consequences of non-action.

If a young adult is not competent to make his or her own health care decisions, an application may need to be made to the Court for the appointment of a guardian under the Guardianship and Administration Act 1990 (WA). There is, however, limited provision under that Act for a substitute decision-maker to consent to medical treatment in certain circumstances. Even where a legal guardian has been appointed, the consent of the court is still necessary for certain types of procedures, for example, sterilisation procedures.
5. Consent to service provision

Health professionals can only undertake physical examinations, medical or surgical management, care, therapy, tests or procedures (‘treatment’) for clients who give consent.

Young adults are generally presumed to be competent to give consent to treatment on their own behalf unless they suffer from an impaired decision-making ability rendering them incapable of doing so. In such circumstances, the Guardianship and Administration Act 1990 specifies those people authorised to give consent to medical and dental treatment on the young adult’s behalf.

Where children are concerned, the general rule is that the child’s parent (or legal guardian) must give consent to treatment of the minor. However, there will be times when a child seeks advice or treatment without the knowledge or consent of their parents. It may also arise that the child disagrees with his or her parents’ views about a proposed treatment.

This may arise in the case of older children encountering health issues in relation to adolescence and the many physical, mental, sexual and psychosocial changes, which occur during this phase of life. This is a time when children are becoming increasingly independent of their parents, and conflict can develop between the adolescent and his or her parents on matters of independence and decision-making generally.

During adolescence, children may seek health care intervention for ‘sensitive’ issues such as sexual development and sexual behaviour, mental health, and the use of drugs and alcohol. Many adolescents develop a strong need for privacy, placing considerable importance on confidentiality and trust in health professionals. Children may specifically request that their parents are not informed about their health care issues. At times, this desire for privacy may conflict with parental concerns and interests.

While it is usually in a child’s interest to have his or her parents involved in the health care process, children may have the right to give consent for treatment, and may have the right to demand confidentiality, including refusing to inform their parents. This will largely depend on the child’s level of maturity, competence to make decisions and what is in the child’s best interests.

Health professionals must make a judgement about a child’s ability to give valid consent whenever they seek medical advice, treatment or health care. (Refer to section 4 for more information).

5.1. What is consent?

The general rule is that health professionals can only provide treatment to clients who give consent. In other words, it is the client’s decision as to whether or not treatment is to take place.

Consent to treatment may be expressed (verbal or written) or implied. The concept of implied consent requires consideration of circumstances including verbal and non-verbal communication, and whether this communication leads the health professional to conclude, without doubt, that consent has been given to the proposed treatment. For example, a client rolls up his or her sleeve in readiness for a health professional to take a blood sample. Consent cannot be implied where the client is not otherwise competent to give consent or where he or she expressly objects to the proposed treatment.
5. Consent to service provision

Consent to non-routine treatments and procedures and to major invasive procedures should be explicit and (as a matter of policy) be documented on an appropriately worded consent form.

5.2. Requirements of valid consent

The requirements for valid consent are that:

- The client must be competent (legally capable) to give consent to the proposed treatment. To have legal capacity to give consent to treatment, a client must be capable of understanding in broad terms the nature and consequences, including the material risks, of the proposed treatment.
- The client must have received sufficient information to make a decision as to whether to give consent. The client must be appropriately informed beforehand and have a broad understanding of the proposed treatment, including its risks and side-effects.
- It must relate to the specific treatment to be undertaken.
- It must be freely and voluntarily given. This means that consent must truly be that of the client who must not be coerced, pressured or forced into making the decision.

5.3. Information to be given to clients

Irrespective of whether or not a health professional has obtained the client’s consent to the specific treatment in writing or verbally, he or she must provide the client with sufficient information to enable him or her to make an informed decision. Health professionals have a duty to inform clients in broad terms about the general nature of the proposed treatment, including any material risks inherent in the same; so that the client understands what it is he or she is consenting to.

Before providing any treatment, health professionals should:

- Use plain, non-technical language to communicate information about the proposed treatment to the client.
- Assure themselves about the client’s understanding of the proposed treatment by, for example, encouraging the client to repeat in his or her own words what the health professional has said.
- Allow clients sufficient time and opportunity, when possible, to reflect on the information provided and their options, ask questions and discuss issues with persons close to them.
- Use an appropriately skilled interpreter when this is necessary.

Information given to clients must be in terms that will be understood by the client and should include:

- An explanation of the client’s condition.
- The reasons for the proposed treatment.
- The expected benefits of the treatment, including that the results of treatment can never be guaranteed.
- The risks involved in the treatment, including any side-effects, significant long-term physical, emotional, mental, social, sexual or other risks.
- The expected outcomes of the treatment, including whether the treatment is ‘irreversible’ and the likely result of ‘no treatment’.
- The time involved in the treatment, including the likely recovery period.
- Any follow-up treatment or care which may be required.
- Details of any additional expenses that may be incurred as a result of the treatment, including any ‘out of pocket’ expenses.

Clients may be provided with written information outlining any risks the health professional believes may be considered significant to the client. However, such material should not be a substitute for clear and frank discussion with the client.

Requests by the client for further information or specific anxieties expressed by the client require full and frank answers and discussion.
5. Consent to service provision

Matters that have been discussed with the client, including the fact the client has given consent to the treatment, should be accurately documented in the client’s medical file. The notation must include details of any material risks discussed with the client, any questions asked by the client and the answers to those questions.

5.4. Therapeutic privilege

A health professional’s duty to warn clients of the material risks of treatment is subject to therapeutic privilege. The principle of therapeutic privilege recognises that there are situations where a health professional is entitled to withhold information from a client where it is in the client’s best interests not to receive that information. For example, where the disclosure of particular information may cause such anxiety to the client that the chances of successful treatment would be prejudiced.

Health professionals should not lightly decide to withhold information. The courts interpret therapeutic privilege narrowly. The governing consideration is the right of human beings to make the decisions that affect their own lives and welfare, and to determine which risks they are willing to undertake. Accordingly, health professionals must be on very firm ground before withholding information that is otherwise ‘material’.

5.5. Who can give consent?

5.5.1. Children (under 18 years)

The appropriate person to give consent to treatment of children will ordinarily be the child’s parent or duly appointed legal guardian. However, the power of parents or legal guardians to consent to treatment on behalf of a child is limited by the overriding criterion of the ‘child’s best interests’.

A child can consent to treatment if he or she is assessed to have sufficient understanding and intelligence to enable him or her to understand fully what is proposed and the consequences of it. Health professionals must make a judgement about a child’s ability to give valid consent to treatment whenever they seek medical advice or treatment. Competency should be tested for each new treatment being considered, except in an emergency when consent from the child or his or her parents or legal guardian is not necessary. The form of assessment will accord with the child’s experience and psychological state, and will depend on the nature of the presenting problem, the degree of complexity of the treatment proposed, the health professional’s prior knowledge of the client and any previous assessments.

For more information on assessing children as ‘mature minors’, see section 4.1.2.

Once a health professional has assessed that a child is competent to consent to treatment on his or her own behalf, the child’s confidentiality must be respected and permission must be obtained before the proposed treatment is discussed with another person, including the child’s parent or legal guardian.

Any assessment of a child as a ‘mature minor’ and that child’s consent to treatment should be clearly documented in the child’s medical file.

Health professionals who are unsure about a child’s maturity or competence to give consent should not proceed with treatment on the basis of the child’s consent as it may not be valid. The health professional should confer with a line manager and/or follow a defined service protocol for consultation and decision-making.

While in principle a competent child can consent to treatment, he or she may not be able to give consent to treatment that is very complex or which may have serious consequences. There are some medical procedures for which a competent child or the parent or legal guardian of an incompetent child cannot give valid consent and which require court authorisation. Examples include procedures for the sterilisation of a child or a sex change operation.
5. Consent to service provision

5.5.2. Young adults (18 years or over)

In general, young adults are presumed to be competent to give consent to treatment on their own behalf.

The Guardianship and Administration Act 1990 (GAAA) allows for substitute decision-makers to be appointed by the State Administrative Tribunal to make decisions on behalf of young adults who are not capable of making reasoned decisions for themselves because of conditions such as an intellectual disability, psychiatric illness or an acquired brain injury (‘incompetent young adults’).

**Formal appointment of a legal guardian**

The State Administrative Tribunal is authorised by the GAAA to appoint guardians to make personal decisions regarding medical and dental treatment on behalf of incompetent young adults. A guardian will only be appointed if it is considered necessary to safeguard the best interests of the incompetent young adult and if other less restrictive options are not available or appropriate.

Incompetent young adults for whom a guardian is appointed lose the right to make decisions either completely or in part.

**Substitute decision-maker under section 110ZD of the GAAA**

It is not always necessary to apply to the State Administrative Tribunal to have a guardian appointed on behalf of incompetent young adults. The GAAA details a procedure to be followed by a medical practitioner or dentist when treating an incompetent young adult who is incapable of consenting to the proposed treatment.

A hierarchy of people who can give consent in these circumstances are listed in section 110ZD of the GAAA and include: a guardian, spouse or de facto partner, person who regularly provides or arranges support without remuneration, nearest relative with close personal relationship, any other person who maintains a close personal relationship.

**Circumstances that may lead to formal guardianship order**

Circumstances that may lead to a formal guardianship order being sought include when:

- There is a conflict about a young adult’s capacity to consent to the proposed treatment.
- Ethically contentious treatment is proposed for a young adult with impaired decision-making ability (e.g. clinical drug trials).
- It is unclear whether the proposed treatment is for an underlying medical condition or restraint.
- The proposed treatment has significant risks.
- The person authorised to consent to treatment under section 110ZD of the GAAA is unwilling or unable to perform this role or cannot be contacted.
- There is no one who comes within the description of the persons listed in section 110ZD of the GAAA.
- Despite the priority list in section 110ZD of the GAAA, there are disagreements among potential substitute decision makers as to what treatment will be in the best interests of the incompetent young adult for whom it is proposed.
- The incompetent young adult for whom the treatment is proposed objects to the treatment.

Note: Under the GAAA ‘special treatments’, such as sterilisation, must be consented to by the State Administrative Tribunal before they can be carried out on an incompetent young adult.

5.5.3. Information to be given to substitute decision-makers

Health professionals must obtain consent for the treatment of a person who is considered not to be a mature minor, or is an incompetent young adult under the GAAA, by providing the parent, legal guardian or other proper substitute decision-maker with all necessary information about the client to enable the substitute decision-maker to provide informed consent.
5. Consent to service provision

5.6. Duration of consent

The health professional’s duty to discuss material risks and obtain the client’s consent for treatment is a continuing obligation. The discussion should occur both before the decision to proceed with treatment and as close as is reasonably practical to commencement of the treatment process. If there is a delay in starting the health care process by more than three months, or if the circumstances of the client change, the process for disclosing material risks and obtaining the client’s consent to treatment should be repeated.

If it is possible that the health intervention may occur at some point beyond three months, it should be stated that the duration of consent may need to vary. For example, when eliciting parental consent for school-based immunisation programs or school entry health assessments, it should be stated that the intervention date may occur within a school term or school year.

5.7. Failure to obtain consent

A client treated without consent, or whose consent does not cover the treatment given, may be able to sue a health professional (and the employing health service) for assault or trespass. A failure to disclose material risks to a client may give rise to a civil action in negligence.

Hypothetical case study:

Student who is depressed

You are a community nurse working in a secondary high school. A 15-year-old male student visits you on a number of occasions with headaches. You decide to conduct a psychosocial assessment and find that he is depressed and at some (although not high) risk of suicide. The student asks you not to make contact with his mother as she is unwell. His father lives in another state and has little contact with the family. How should you proceed with his care?

- Given the psychosocial assessment you have already conducted with the student, and bearing in mind his age, make an assessment about his competence to make decisions about his own care.
- Carefully document the process and factors relied upon in assessing the student’s competence.
- Explain the limitations of confidentiality in situations where there is imminent risk of harm.
- Discuss the care options available to the student, and make a referral to an appropriate agency.
- Provide clear details of your assessment and concern to the service, unit or practitioner with whom you have negotiated further assessment.
- Discuss the student’s reservations regarding not informing his mother. Assist him to plan a strategy to communicate with her at a suitable time. Discuss whether there is another significant person that could provide support to the student.
- Seek consent from the student to share relevant information with the school student services team so key people can support him at school.
- Make an appointment to provide ongoing review and support.

This scenario is underpinned by legal concepts covered in sections 4, 5, 6, 7 and 9. Refer to these sections for more information.
5. Consent to service provision

5.8. Emergency treatment

Where urgent treatment is required to prevent a serious and imminent threat to a client’s life or physical or mental health and the client (or, where incompetent, the client’s parent or legal guardian) is not able to consent to the required treatment at the time (e.g. because the client is unconscious), the client is deemed by law to have consented to treatment. The circumstances constituting the emergency and the client’s lack of competency must be clearly documented in the client’s medical record.

It should be noted that the treatment to be carried out in these circumstances must be necessary and not merely convenient.

5.9. Refusal of treatment

5.9.1. Young adults (18 years and over)

In the event that a competent young adult refuses to consent to non-urgent treatment, the health professional should not proceed with treatment until valid consent has been obtained.

In such circumstances, the health professional may provide further explanation of the young adult’s condition and the proposed health care intervention. If necessary, the health professional may suggest that the young adult obtain a second opinion from another health professional.

Any refusal of treatment should be clearly documented in the young adult’s medical record.

5.9.2. Children (under 18 years)

Refusal of treatment by competent child

The law in Australia is unclear about whether a competent child can refuse medical treatment, particularly when that treatment is considered important for the child’s health.

Where a competent child’s refusal of recommended treatment does not pose a significant threat to health, the health professional may suggest that the child discusses the matter with his or her parents, or returns to discuss the treatment decision further.

Where a competent child refuses consent for treatment that the health professional considers necessary and in the child’s best interest, the child should be encouraged to discuss the matter with his or her parents and to involve them in the decision. If the child refuses to involve his or her parents, and the health professional cannot persuade him or her to do so, a decision about treatment must be made based on the risk of consequences to the child from not having the treatment. Possible responses to the situation may include:

- The health professional reviewing his or her decision about the child’s competence to make a valid decision on consent in the specific circumstance.
- Suggesting that the child return after giving further thought to the decision.
- The health professional suggesting that the child seeks a second opinion from a professional whom he or she trusts.
- The child being encouraged to return with someone such as a parent, older sibling, another family member or friend, who might be more effective in persuading the child to consider the consequences of refusal of treatment.
- If the child’s life is in danger (e.g. a client at risk of suicide or the progression of a potentially life-threatening condition), the health professional considering whether there are lawful grounds for breaching confidentiality.
- Making an application to the court for authorisation to proceed with the treatment.

Refusal of treatment – parental involvement

If a parent is involved and supports their child’s decision to refuse treatment or cannot persuade their child to have the treatment, or if a parent otherwise refuses treatment on behalf of an incompetent child, the health professional can,
5. Consent to service provision

in general, accept the decision as valid and would normally not be excepted to take the matter further.

However, if the health professional considers that refusal by the child and/or the parent poses a serious threat to the child’s health or is otherwise in the best interests of the child, the health professional may refer the matter to the court. The court has the power to override a parent’s decision. Advice from Legal & Legislative Services should be sought where such action is being contemplated.

5.10. Forms of treatment prohibited by law

There are some forms of treatment which are prohibited by law. Examples of treatment prohibited by law include:

- female genital mutilation
- non-regenerative tissue removal from a child
- deep sleep therapy
- insulin coma or sub-coma therapy.

There are also some forms of treatment, which are prohibited by law, unless certain requirements are met. Examples of such treatment include:

- termination of pregnancy
- regenerative tissue removal from a child
- removal of blood from a child
- psychosurgery
- electroconvulsive therapy
- sterilisation of a represented person under the GAAA.

5.11. Court authorisation for treatment of a child in special situations

Occasionally, a child’s parents may disagree on the treatment to be provided to their child, with one parent willing to consent and the other refusing consent. Disagreement may also arise between the parents and child, with the former wanting the treatment to proceed and the latter objecting. Further difficulty can arise where neither the parents nor the child are competent to give consent to the treatment of the child.

When dealing with these situations, health professionals should bear in mind that (except in an emergency) they are not obliged to give any treatment they consider unnecessary or unwise.

However, in non-emergency situations where the child’s life or long-term health is at risk, it may be necessary for the health professional to seek court authorisation for treatment of the child. Such authorisation is obtained by applying to the Supreme Court in its parens patriae jurisdiction and requesting that the Court provide its consent to the treatment.

The parens patriae jurisdiction is part of the inherent jurisdiction of the Supreme Court and springs from the responsibility of the Crown for those who cannot look after themselves.

Health professionals who decide to seek court involvement are advised to seek legal advice from Legal and Legislative Services.
5. Consent to service provision

Hypothetical case study: Refusal at school-based immunisation clinic

You and a colleague are conducting an immunisation clinic for year seven students at a local primary school. You have been careful to collect informed consent from parents, have prepared well for the clinic and are ready to commence administering the vaccinations. A female student becomes agitated about receiving the vaccination and refuses to enter the room. Your colleague tells the student that she should go through with it because her mother has signed the form. The student becomes more agitated and starts to cry. What should you do?

- Ask the student to accompany you to a quiet place and calm her. Explain that even though her mother has consented to the vaccination, the procedure can only continue if she consents.
- Ask the student to expand on why she doesn’t want the vaccine. Allow her to vent her fears.
- Tell the student about the benefits of having the vaccination, and explain the alternatives (i.e. mother takes her to the GP at a later date).

A little later the student tells you that she is still not ready to receive the vaccination. How should you proceed?

- Contact the mother to explain what has occurred.
- Explain that it is unsafe to do the procedure if her daughter is agitated and refusing treatment.
- Explain how the mother can access alternative services to access vaccination.
- Recommend a psychosocial assessment if there is suspicion of an underlying problem.
- Document the outcome.

This scenario is underpinned by legal concepts covered in sections 4, 5, 6, 7 and 9. Refer to these sections for more information.
6. Client confidentiality and information sharing

Health workers owe a duty to maintain the confidentiality of all information obtained in the course of providing health care to clients of any age. The duty is also owed by administrative staff coming into contact with the information as part of the health care process. The duty does not cease when the therapeutic relationship ends, nor when the client dies.

The duty means that information cannot generally be released to others without the client’s permission or, where incompetent, the permission of the client’s legal guardian. However, not all information is confidential. Information that is in the public domain or trivial can be exempt from the duty.

Confidentiality is important in establishing and maintaining a relationship of trust between health workers and clients. Studies have consistently found that confidentiality is highly valued among children, and the fear of breach of confidentiality often prevents children accessing health services.

The health worker’s duty of confidentiality primarily arises under the common law. However, some legislative provisions have been enacted enforcing the duty of confidentiality by statute (e.g. section 206 of the Mental Health Act 1996 (WA)).

An unauthorised disclosure of confidential information can have a number of potential consequences. It may result in an action for damages in negligence, the imposition of a fine, or disciplinary action by the health worker’s employer or professional association.

6.1. Sharing confidential information

There may be times when a child’s or young adult’s confidential information will need to be shared with other persons or organisations. Indeed, there are times where statutory provisions require that information must be shared, for example, mandatory reporting of notifiable diseases to the Department of Health under the Health Act 1911 (WA) and the mandatory reporting of child sexual abuse by doctors, nurses and midwives under the Children and Community Services Act 2004 (WA).

It is generally good practice to inform a child or young adult early in the initial consultation about the duty of confidentiality and about its potential limits. This should include an explanation of when information may be disclosed without the child or young adult’s consent. This might include situations when there is a risk of suicide, or sexual, physical or emotional abuse and serious risks to others.

In the event such a situation eventuates in the future, it will generally be prudent to tell the child or young adult and discuss the fact of the impending disclosure with him or her first.

Circumstances in which a client’s confidential information may be shared with others include:

- Where a competent client consents to the sharing of his or her confidential information.
- Where an incompetent client’s legal guardian consents to the sharing of that client’s confidential information.
- Where a valid subpoena or summons is served on a health worker compelling him or her to disclose clinical or other information to a court by, or on, a specified date. Failure to
comply with a valid subpoena or summons may constitute contempt of court, which can lead to a fine or a prison sentence.

- Where there is a statutory reporting obligation, for example, mandatory reporting of notifiable diseases to the Department of Health under the Health Act 1911 (WA) and the mandatory reporting of child sexual abuse under the Children and Community Services Act 2004 (WA).

- Where a statutory provision permits or provides protection from liability for the disclosure of confidential information. For example, section 129(1)(a) of the Children and Community Services Act 2004 (WA) which permits the reporting of child welfare concerns to the Department for Child Protection and Family Support.

- Where a statutory provision provides protection from liability for the disclosure of confidential information relevant to the wellbeing or a child or group of children to State authorities for the facilitation of effective cooperation in child protection matters. (delegated authority)

- Where there is an overriding public interest justifying disclosure to a proper authority. Such disclosure will only be justified in exceptional circumstances where there is a serious, imminent and identifiable risk of harm or danger to the health or life of any person (including the client) requiring immediate action. It is recommended that where possible and practicable legal advice be sought from Legal and Legislative Services prior to a ‘public interest’ disclosure being made.

When disclosing confidential information in any of the above circumstances, care should be taken to ensure that only ‘authorised’ information is disclosed. For example, a disclosure made with the client’s consent or under a statutory provision must be limited to the release of information falling within the scope of the consent given or the statutory provision applicable, including the person or organisation by and to which the information can be released. Similarly, in the case of a public interest disclosure, only confidential information that is necessary to enable the immediate danger to be averted can justifiably be disclosed. Such information can only be disclosed to an organisation or person who is in a position to take the necessary remedial action. Depending on the circumstances, this may include the police, the Department for Child Protection, parents or other next-of-kin.

**6.2. Sharing confidential information in specific circumstances**

**6.2.1. With the child’s parents**

A child or minor may access a health service and demand that a health worker does not contact his or her parents or give them information. A competent child’s demand that the health worker not divulge any information to his or her parents should be respected, even if it would have been desirable for the parents to become involved.

Whether incompetent children (i.e. those judged not to be mature minors) are owed a duty of confidentiality is unclear. There is some support for the view that depending on the individual circumstances (including whether the child concerned is capable of forming a confidential relationship with the health worker), incompetent children may attract the legal right of confidentiality.

The most prudent course for health workers to take is not to reveal confidential and personal matters communicated in the course of the professional relationship to any other person, unless there is consent or it is essential to safeguard the wellbeing of the ‘incompetent’ child. If a health worker concludes that such a disclosure does need to be made, generally it is good practice to tell the child and discuss it with him or her first.

Where the parent is the person responsible for giving consent to service provision because the child is incompetent to do so, the health worker should provide all information that is necessary to enable the parent to make an informed decision in the best interests of that child.
6. Client confidentiality and information sharing

Hypothetical case study:

Young male at risk of suicide

You are a community health nurse working in a secondary high school, and have an existing professional relationship with a 15-year-old student in relation to mental health issues. The student has previously been referred to the local Child and Adolescent Mental Health Service (CAHMS) where he has been placed on a waiting list. It is a Friday afternoon when the student comes to you and expresses that he is considering suicide. What should you do?

- Conduct a suicide risk assessment, or access (immediate) assistance from a more appropriate member of the student services team (e.g. school psychologist) or a mental health professional to do this.

Note: Act within the boundaries and limitations of your own knowledge and competencies. Suicide prevention training is highly recommended.

Note: You should have prior knowledge of services available in the community.

- If you are competent to assess suicide risk, develop and document:
  - The nature and degree of risk.
  - The relationship between risk and mental health disorder, current social circumstances or other contextual factors.
  - Factors likely to increase risk and factors likely to decrease risk.
  - A care plan that is appropriate to the level of risk, and the likely effectiveness of this plan in containing risk.

You assess the student to be at moderate to high risk of completing suicide. The student asks you not to make contact with his parents.

- Explain the limitations of confidentiality in situations where there is imminent risk of harm.
  - Explain that only information related to his immediate risk needs to be divulged, other information can remain confidential. Ensure the student is empowered as much as possible during this process.
  - Inform and consult with a member of the school administration, student services team and/or local mental health team to develop an agreed course of action, and to assist in the implementation of a care plan, ensuring obligations of confidentiality are complied with. Involve staff from the CAHMS team with which he is waitlisted if at all possible.

- Inform the parents (or other significant adult where appropriate) of your assessment and negotiate with them for immediate and appropriate further specialist assessment and/or treatment of their son, having regard to the principles of least restrictive care, time and availability of service providers, student’s level of cooperation etc.

- Provide clear details of your assessment and concern to the service, unit or practitioner with whom you have negotiated further assessment (MHERL*, Emergency Department, local mental health team, general practitioner).

- Ensure adequate supervision of the student until you hand over care.

- Liaise with the student service team and other service providers to provide up to date information, to review the outcome of your referral and to provide ongoing care and monitoring, ensuring obligations of confidentiality are complied with.

This scenario is underpinned by legal concepts covered in sections 4, 5, 6, 7, 9 and 10. Refer to these sections for more information.

Access to medical records held by public sector agencies is covered by the Freedom of Information Act 1992 (WA). Although the Act does not specifically address the situation where a parent applies for access to a child’s medical records, it is generally acceptable for a parent to make such an application on a child’s behalf unless a court order has relevantly varied parental responsibility. However, because medical records contain the child’s ‘personal information’, the child will need to be consulted in certain circumstances before the information is released.

6.2.2. With other health workers
Consent to share information may be implied, and not expressly given, when other health workers within the health service have a legitimate therapeutic interest in the care of the client (i.e. where multiple health workers within the organisation are treating the client). In this situation, consent will generally be implied.

Implied consent cannot apply where the client has expressly objected to the particular disclosure. Further, implied consent does not generally permit disclosure to health workers outside of the organisation concerned. If in doubt whether a client has consented to the release of the confidential information, express consent should be sought.

6.2.3. With the police
There is no general legal obligation on health workers to provide information to the police, and requests can generally be declined without committing an offence. Where information is provided, it must not be false or misleading.

Confidential client information may be disclosed to the police upon submission of an express written consent signed by the client or by an incompetent client’s legal guardian, where there is an overriding public interest, or where a statutory provision permits or requires the same. A client’s confidential medical records must be produced to the police where a valid search warrant is provided expressly seeking access to such documents.

6.2.4. With other public authorities
Exchange of information with other public authorities (i.e. school principals) is supported in section 24A of the Children and Community Services Act 2004 (WA), if it is likely that the information is relevant to the wellbeing of a child, class or group of children. The information exchange may occur between prescribed authorities.

6.2.5. Cultural considerations
The principles of confidentiality are the same for all young adults and children, including those from culturally and linguistically diverse backgrounds. Health workers may need to make arrangements for an interpreter to be present to ensure non-English speakers are able to understand the communication. In addition, health workers may need to explain that certain legal obligations may override particular cultural practices.

6.2.6. Notifiable infectious diseases
Under the Health Act 1911 (WA), medical and nursing practitioners are required to notify the Department of Health’s Executive Director, Public Health of specified infectious diseases. The general purpose of the statutory notification requirement is the control of infectious diseases. (Refer to section 9.6 for more information).

6.3. Mandatory Reporting of Child Sexual Abuse
6.3.1. The duty to report
Under the Children and Community Services Act 2004 (WA) doctors, midwives and nurses are required to make a report if they have formed a belief, on reasonable grounds and in the course of their work, that a child:

- has been the subject of sexual abuse that occurred on or after 1 January 2009; or,
- is the subject of ongoing sexual abuse.

Reporters who fail to report a belief that a child is being sexually abused commit an offence and can be fined up to $6000.
6. Client confidentiality and information sharing

Sexual abuse in relation to a child includes sexual behaviour in circumstances where:

1. the child is the subject of bribery, coercion, a threat, exploitation or violence; or,
2. the child has less power than another person involved in the behaviour; or,
3. there is a significant disparity in the developmental function or maturity of the child and another person involved in the behaviour.

6.3.2. The process for reporting

Reports can be made:

1. In writing to the Department for Child Protection and Family Support Mandatory Reporting Service.
   Forms can be accessed via a link from the WA Health website at www.health.wa.gov.au/mandatoryreport or directly through the Department for Child Protection and Family Support website at www.mandatoryreporting.dcp.wa.gov.au. Hard copies can be faxed through to the Mandatory Reporting Service on 1800 610 614.

   If the reporter believes the child may be at immediate risk of harm or that there are other circumstances that require urgent action, a report should be made by telephone to the 24 hour Mandatory Reporting Service at the Department for Child Protection and Family Support on 1800 708 704. The Service will provide the reporter with a unique mandatory reporting number for the records.

A verbal report must be followed by a written report in the form outlined above. Failing to provide a written report after lodging a verbal report is an offence with a fine of up to $3000. The Department of Health requires that the written report be made within 24 hours of the verbal report.

Health practitioners who require further information on mandatory reporting of child sexual abuse should contact the Statewide Protection of Children Coordination Unit on 9216 7700 or visit the WA Health mandatory reporting website: www.health.wa.gov.au/mandatoryreport
7. Child abuse and domestic violence

Children and young adults who experience abuse or neglect are highly vulnerable to a range of social and mental health problems. There are different contexts in which children and young adults may be abused or neglected, reflecting that youth is a time of transition. Some children and young adults may experience physical, sexual, emotional or psychological abuse from their parents, family members or other adults. As they grow into adulthood, children and young adults can also face such abuse from partners with whom they form intimate relationships.

7.1. Protecting children at risk of abuse or neglect

Through the Children and Community Services Act 2004 (WA) (CCSA), the Department for Child Protection and Family Support (DCPFS) in Western Australia has been given statutory powers to act where a child is in need of protection. The CCSA enables the DCPFS to receive and assess concerns for a child's wellbeing and conduct investigations when it is believed a child may be in need of protection. The DCPFS must take action to promote and safeguard the child’s wellbeing.

A child will be in need of protection where:

- The child has been abandoned by his or her parents and after reasonable enquiries, neither the parents nor another suitable adult (i.e. relative) can be found who is willing and able to care for the child.
- The child’s parents are dead or incapacitated and after reasonable enquiries, no suitable adult (i.e. relative) can be found who is willing and able to care for the child.
- The child has suffered (or is likely to suffer) harm as a result of physical, sexual, emotional or psychological abuse or neglect and the child’s parents have not protected (or are unlikely or unable to protect) the child from further harm; or,
- The child has suffered (or is likely to suffer) harm as a result of the child’s parent’s inability to provide or arrange for adequate care, or effective medical, therapeutic or remedial treatment for the child.

7.2. Reporting allegations, suspicions or concerns of child abuse or neglect

Apart from the mandatory requirement for doctors, midwives and nurses to report any reasonable belief of child sexual abuse to the DCPFS, the reporting of allegations, suspicions or concerns of child abuse or neglect is not mandatory in Western Australia. However, there is a duty for all health professionals to appropriately manage child abuse or neglect, and no breach of confidentiality will arise where a health worker voluntarily and in good faith reports an allegation, suspicion or concern of child abuse or neglect to DCPFS officers.

If an urgent referral is required, health workers should notify the DCPFS Crisis Care Unit or its local district office.

In less urgent circumstances, a health worker should consult with his or her line manager or other designated (health service) officer, about local reporting procedures. A child need not be at imminent, likely or serious risk of harm or neglect in order to justify reporting a concern to DCPFS.

Note: Wherever possible and practicable, it is recommended that health workers seek legal advice from Legal and Legislative Services before referring a child to the Police Child Abuse Investigation Unit.
7. Child abuse and domestic violence

Any decision to report a child to DCPFS or the police should be well documented including the reasoning that led to the decision to notify DCPFS or the police.

Any request by DCPFS for medical records or the preparation of medical reports or witness statements should be made, in the absence of client consent, under authority of section 23 of the CCSA.

### 7.3. Confidentiality of notifier’s identity

Subject to certain exceptions, the CCSA protects the identity of any person who in good faith notifies DCPFS of his or her suspicions or concerns of child abuse or neglect.

### 7.4. DCPFS access to a child at hospital, school or child care service

An authorised officer of DCPFS (‘authorised DCPFS officer’) may access a child without parental consent or knowledge for the purpose of investigating whether the child is in need of protection where it is in the best interests of the child or, alternatively, notifying the child’s parents in advance would likely jeopardise the investigation. The authorised DCPFS officer must notify the person in charge of the facility before exercising this power.

Note: An ‘authorised officer’ is a specific statutory office under the CCSA. Authorised officers have a number of statutory powers not available to other DCPFS officers, including the power described above. When appointed, authorised officers are issued with identity cards. Health workers should request production of the identity card of any DCPFS officer purporting to be an ‘authorised officer’ of DCPFS or otherwise attempting to exercise a power given to authorised officers under the CCSA. Health workers should check the identity card to verify the person’s identity, status as an authorised officer of DCPFS and powers. A notation confirming that such checks have been carried out should also be made in the client’s medical record.

### 7.5. Sharing confidential client information with DCPFS

Section 23 of the CCSA allows authorised DCPFS officers to release to and request from public health services and health workers any information they consider relevant to the wellbeing of the child or the performance of a function under the CCSA. Compliance (by the health worker) with a request for relevant information is voluntary, except for the mandatory requirement for doctors, midwives and nurses to make reports of child sexual abuse.

In non-urgent situations, DCPFS should where possible make requests for confidential client information in writing. This is particularly important where DCPFS is requesting a copy of medical records or the preparation of medical reports and similar documents. In the absence of valid client consent, DCPFS’s written request must be signed by an authorised DCPFS officer and state that the information is being requested under authority of section 23(3) of the CCSA.

Confidential client information may be released when requested verbally in emergency situations. However, health workers should ensure they sight the identity card of the person making the request to verify that he or she is in fact an authorised DCPFS officer.

### 7.6. Domestic violence

Intimate partner abuse can include physical or sexual assault, psychological abuse, emotional, spiritual or cultural abuse, social isolation and neglect. It may occur in a heterosexual or same sex relationship.

#### 7.6.1. For young adults

There is no mandatory reporting obligation for domestic violence between intimate partners. Where domestic violence involves a criminal offence (e.g. sexual or physical assault), in order to report it to police without breaching confidentiality, health workers have two options;
Seek consent from the client, or where incompetent, seek consent from the client’s legal guardian; or,

Consider and satisfy themselves that the ‘public interest’ exception to the duty of confidentiality justifies disclosure. Wherever possible and practicable, it is recommended that health workers seek legal advice from Legal and Legislative Services before making a public interest disclosure.

7.6.2. For minors under the age of 18 years

In the case of a minor involved in domestic violence as an intimate partner, the same applies as described in section 7.6.1 above. Medical practitioners, nurses and midwives should however, ensure that they assess the circumstances to determine if they have a duty to report to DCPFS relating to the mandatory reporting obligations in the Children and Community Services Act 2004 (WA). See 6.3 above for further information. Other health professionals with concerns about the minor’s wellbeing should also consider the option of making a report to DCPFS.

7.6.2a Domestic violence and minors under 18 years

In the case of a minor under the age of 18 years who is a dependent child living in a household with domestic violence the child should be considered as a child at risk of abuse or neglect and Sections 7.1 and 7.2 should be referred to. Refer to Guidelines for responding to family and domestic violence for further information.
7. Child abuse and domestic violence

Hypothetical case study
Thirteen-year-old girl asks about pregnancy testing

You work in a secondary high school as a community health nurse where the school chaplain brings a 13-year-old girl to consult with you about access to a pregnancy testing kit. What steps should you take to ensure you meet any legal and ethical obligations owed to this girl?

- Conduct a psychosocial assessment including sexual activity and relationships.
- Assess the girl’s competence to consent to health care.
- Carefully document the process and factors relied upon in assessing the girl’s competence.
- Discuss conditional confidentiality and the need to share certain information in some circumstances, preferably with the girl’s knowledge and consent.
- Assess ongoing risk, i.e. child protection or coercion, and notify DCPFS if required.
- If appropriate, make contact with parent/guardian or assist the girl to do so.
- Provide appropriate health care, including discussion about safe sex and self care.
- Discuss how pregnancy testing works and guide the girl to access a kit.
- Discuss the law in relation to underage sex.

Note: It is recommended that community health nurses working in schools do not conduct pregnancy tests with students. Check local protocols for access to testing kits.

It is confirmed that the girl is pregnant and she expresses that she wants to have the pregnancy terminated.

- Inform the girl about the legal requirements to consult with a doctor, receive counselling and involve her parents.
- Determine whether the girl is a ‘dependent minor’ for the purposes of abortion provisions of the Health Act 1911 (WA) and take appropriate steps. (Refer to section 9.5 for further information).
- Assist the girl to inform parents about the pregnancy and her wish to have the pregnancy terminated.
- Make a referral to appropriate provider.
- Assertively follow-up, to continue discussions about safe sex, self care and other psychosocial issues.
- Liaise with school chaplain about provision of ongoing support, or negotiate for another member of school student services team (preferred by the girl), to provide support, ensuring obligations of confidentiality are complied with.

Later, the school principal approaches you explaining he had heard a rumour that one of the students is pregnant. He asks for more information. What is your responsibility in relation to providing information to the principal?

- Explain your duty of confidentiality to the girl (and her parents). Your explanation should be such that the girl cannot be identified.
- Consider if circumstances suggest that it is in the girl’s best interests to share the information with the Principal. You must obtain consent from the girl (or parent) before the information can be shared.

This scenario is underpinned by legal concepts covered in sections 4, 5, 6, 7, 8, 9 and 10. Refer to these sections for more information.
8. Medical record-keeping and accessing medical records

8.1. Creation and maintenance of records

The importance of accurate record keeping cannot be overemphasised. Client (patient) medical (health) records are, in general, contemporaneous records of events that have taken place and reflect the facts of health care interventions. They primarily serve as clinical records for continuity of care and good management of clients; however, they can also be useful tools in court proceedings.

In court, witnesses are often required to give evidence many years after an event. Recalling events can be problematic for health professionals, and the ability to rely on detailed and accurate records is very important.

Many legal disputes have been lost or rendered indefensible simply because the records of the defendant (e.g. a health service or health professional) were poor.

Health professionals must make relevant, accurate, legible and comprehensive records of any health care provided to clients. When creating or making an entry in a client record it is recommended that:

- All documentation be filed in chronological sequence.
- Each record page be clearly identified with the patient identification.
- All entries in the record be legible and clear.
- All entries be dated, timed, signed and include the position/office of the author. Where signatures are illegible, the surname should be printed alongside the entry.
- All entries be concise, accurate and relevant.
- All records be treated confidentially.
- Leaving applicable data items blank on form be avoided.

- Non-specific terms such as ‘had a good day’ be avoided.
- All entries be objective, i.e. facts only. Subjective or emotional statements and moral judgements should be avoided.
- Wherever possible, only those events the author had direct knowledge of (e.g. matters that the author saw, heard, did, said or felt) be recorded.
- Gaps not be left between entries.
- When using ‘progress notes’, pages be clearly numbered to indicate chronological order.
- Only authorised or approved forms be used to document client information.
- Every client encounter be documented, including telephone conversations and failed attempts to make telephone contact.
- Wherever possible, entries be contemporaneous. Document as closely as possible to the time the event occurred. Indicate the date of the intervention and the date the notes were written.
- If additional information is added later, note ‘late entry’ with time and date of addition, and then sign.
- Avoid the practice of writing notes ahead of time.
- When a word or line or extra note is written in error do not erase, ‘white out’ or otherwise totally obliterate the entry. Draw a single line through the entry and write ‘mistaken entry’ next to it before initialling, dating and signing the correction.
- Blue/black pen be used for recording information, not pencil.
8. Medical record-keeping and accessing medical records

8.2. Retention and disposal of records
Under the State Records Act 2000 (WA) (‘SRA’), public sector agencies and staff must not destroy any records of their employing agency (e.g. health service) except in accordance with the agency’s record-keeping plan approved by the State Records Commission.

The Patient Information Retention and Disposal Schedule (the Schedule) forms part of the formal record-keeping plan for Western Australian public health services.

The Schedule sets minimum standards for the retention and disposal of client records created and received by Western Australian public health services. The Schedule applies to the records held by public health services including non-hospital and community-based services.

It is expected that public health service staff will familiarise themselves with the Schedule and, in particular, the minimum retention and disposal standards applicable in their field of operation.

8.3. Freedom of information
The Freedom of Information Act 1992 (WA) gives people the right to apply for access to documents held by public health services subject to certain exemptions under the Act. Individuals may apply for access to public health service records by submitting a written request to the relevant health service’s Freedom of Information Officer or similar.

It is important to be aware that other processes exist whereby medical (health) records can be obtained by a court or third party, for example, by subpoena or warrant or in the discovery stage of legal proceedings. Legal assistance should be sought if there are any concerns where such a request is made.

8.4. Electronic records
Client information stored electronically by health services and their staff is considered to constitute ‘records’ for the purpose of the SRA. As such, electronic records are required to be retained and disposed of in accordance with the minimum standards set by the Patient Information Retention and Disposal Schedule.
9. Sexual health

9.1. Age of consent and underage sex

In Western Australia, it is unlawful for a person of any age to engage in sex with a minor under the age of 16 years. However, where at the time of the alleged offence the minor was aged between 13 and 16 years and consented, it will be a defence if:

- The accused person was no more than 3 years older than the minor and believed on reasonable grounds that the minor was at least 16 years’ old, or
- The accused person was lawfully married to the minor.
- Both are under age.

Once a minor turns 16 years of age, he or she can legally have sex with another person who is 16 years or older (unless that person is in a position of care, supervision or authority) provided both parties agree to it.

It is unlawful for an adult (someone 18 years or over) to have sex with a minor where the adult is in a position of care, supervision or authority over the minor (for example, if they are a school teacher, step-parent, youth worker, doctor or sports coach). However, it will not be unlawful if at the time of the alleged offence the minor was 16 years or over, gave consent and was lawfully married to the accused person. In all other circumstances, it will not be a defence that the accused person believed (reasonably or otherwise) that the minor was 18 years or over.

The law in Western Australia is the same for heterosexual sex and homosexual sex.

A person must be 18 years of age to marry; however, the court can give permission for 16 and 17-year-olds to marry in exceptional circumstances.

Health workers are expected to monitor the care and protection of any minor under their care whom they know to be engaging in sex. Where there is any concern regarding the minor’s wellbeing, the worker should respond in accordance with the Guidelines for Protecting Children, Western Australian Department of Health (2009). If a minor is assessed to be at risk of harm from sexual assault or abuse due to coercion, intimidation or other risk factors such as age, disability or lack of support, then consideration should be given to advising the person with parental responsibility (within the constraints of the duty of confidentiality). If there are concerns that the person with parental responsibility has not taken action, the worker should consider whether it is appropriate to notify DCPFS.

Under the CCSA, if a medical practitioner, midwife or nurse forms a belief, based on reasonable grounds and in the course of their work, that a child or young person has been the subject of sexual abuse or is the subject of ongoing sexual abuse they must report that belief as soon as practicable to DCPFS. See section 6.3 for further details.

9.2. Sexual offences against the mentally impaired

In Western Australia, it is an offence for a person to have sex with another person whom the accused person knows or ought to know is mentally impaired. Mental impairment refers to permanent or temporary impairment from intellectual disability, mental illness, brain damage or senility, as to render an individual incapable of:

- Understanding the nature of the act which is the subject of the charge against the accused person, e.g. sexual penetration, indecent dealing etc.
9. Sexual health

- Guarding himself or herself against sexual exploitation.

However, it will be a defence to the above if at the time of the alleged offence, the accused person was lawfully married to the alleged victim.

9.3. Sexuality

It is unlawful to discriminate against individuals seeking access to health service provision on the basis of their sexual orientation.

When working with children and young adults who are same sex attracted or who identify as gay, lesbian or bisexual, or with people who are transgender, it is important to ensure these individuals feel comfortable accessing services. As with other children and young adults, the health worker should: reassure individuals about issues of confidentiality; offer information about safer sex options; and, if appropriate, offer counselling or referral to counselling.

It is important to be aware of the possible additional barriers to accessing health services for children and young adults who may identify as same sex attracted or transgender. Research highlights that individuals of diverse sexuality may be particularly at risk of isolation, depression, suicide, substance abuse and injury through violence. Furthermore, many individuals of diverse sexuality feel particularly vulnerable with accessing health care as they may believe that health workers assume that everyone is heterosexual.

9.4. Contraceptive advice and treatment

Providing a minor under the age of 16 years with safer sex advice is not an offence. Indeed it is important that children and young adults of all ages are provided with accurate and appropriate information regarding safer sex practices where sought. Further, it is not an offence to provide a minor under the age of 16 years with condoms and lubricant.

Health professionals must exercise clinical judgement when deciding whether contraceptive advice and treatment should be provided to minors, especially those under 16 years. Minors seeking contraceptive advice and treatment without parental knowledge or consent must be assessed to determine whether or not they are a ‘mature minor’ capable of understanding the nature and consequences of the proposed treatment.

Where the child is assessed as being a ‘mature minor’, the additional consent of the minor’s parent or guardian will not be necessary before contraceptive advice and treatment can be given. However, parental consent is required where the minor is assessed as not being a ‘mature minor’ (i.e. not being competent to consent to treatment), except in the case of an emergency.

There are also certain forms of treatment to which neither a ‘mature minor’ nor his or her parent can give valid consent and where prior court approval must be obtained. An example is the sterilisation of a minor or a sex change procedure.

Emergency contraception, otherwise known as the ‘morning after pill’, which needs to be taken within 72 hours of unprotected sexual intercourse, can be purchased over the counter from pharmacies. There is no age limit at which a person can purchase this medication. Pharmacists will ask those requesting the contraception some routine questions in a private location. If the pharmacist has concerns about a younger adolescent requesting contraception they may refer them to a doctor or clinic.

9.5. Termination of pregnancy (induced abortion)

In Western Australia, a woman may have her pregnancy terminated on request up to 20 weeks gestation, provided she gives informed consent. After 20 weeks, termination may only be carried out if two medical practitioners, who are
members of a panel appointed by the Minister for Health, agree that the mother or the unborn child has a serious medical condition which justifies the termination.

Although termination is available on request up to 20 weeks, it should be noted that the risk of complications increases with increasing gestation, and the safest time for termination is early in pregnancy, ideally less that 12 weeks from the last menstrual period.

Legally, a woman cannot have a pregnancy terminated without consulting with a medical practitioner beforehand. The medical practitioner is responsible for obtaining informed consent by providing information and counselling the woman about the medical risks both of termination of pregnancy and of continuing with the pregnancy. The medical practitioner must also offer the woman the opportunity of referral to further counselling. This relates to counselling both at the time of decision making and after the termination or carrying the pregnancy to term.

Medical practitioners opposed to termination because of moral or religious beliefs should inform their patient of their position, so that the patient has the opportunity to seek care from another practitioner.

If the woman seeking the pregnancy termination is under 16 years of age and is being supported by a custodial parent (including a legal guardian), she is a ‘dependant minor’. For a dependant minor to give informed consent, the custodial parent must be informed and be given the opportunity to participate in the counselling process and to be involved in consultations with the dependant minor’s medical practitioner as to whether or not the pregnancy is to be terminated. Note that this is a requirement for involvement of the custodial parent in the counselling process, not a requirement for permission of the custodial parent.

A dependant minor may apply to the Children’s Court for an order to waive this requirement. It should be noted that the decision as to whether to inform the custodial parent or to seek to waive the requirement by applying for a Children’s Court order, is one for the dependant minor herself to make. The normal requirements of doctor-patient confidentiality apply. (Refer to section 6 for more information).

Where the woman is not a dependant minor (i.e. over 16 years of age OR under 16 years of age but not being supported by a custodial parent), there is no requirement to involve a custodial parent in the consent process, although a young adolescent in this situation should be encouraged to involve her parents and gain their support.

It is unlawful for any person who is not a medical practitioner to perform a termination. It is a legal requirement that any medical practitioner who performs or assists with an abortion must not be the practitioner who provides the girl or woman with counselling or with a counselling referral for the purpose of informed consent.

9.6. Sexually transmissible infections (STIs)

Under the Health Act 1911 (WA), medical and nurse practitioners are required to notify the Department of Health’s Executive Director, Public Health of specified infectious diseases. The general purpose of the statutory notification requirement is the control of infectious diseases. The Western Australian Department of Health lists notifiable infectious diseases on a Notification Form. Medical and nurse practitioners are required to send completed notification forms to the Communicable Disease Control Directorate (for residents of the Metropolitan area), or to the regional Population Health Unit (for cases resident in country areas).

Sexually transmissible infections required to be notified to the Department include Chancroid (soft sore), Chlamydia (genital infection), Donovanosis (Granuloma inguinale), Gonorrhoea, Syphilis and HIV/AIDS infection.
9. Sexual health

For more information on statutory notifiable diseases, together with relevant forms, visit www.public.health.wa.gov.au/2/245/3/statutory_medical_notifications_department_of_health.ppm

The Communicable Disease Control Directorate may report particular notifications of sexually transmissible infections in children to the Department for Child Protection and Family Support and the Western Australian Police pursuant to an interagency protocol. For further information on the interagency protocol, please contact the Communicable Disease Control Directorate.

9.6.1. Sexually transmissible infections (STIs) acquired through (suspected) child sexual abuse.

Where a nurse, midwife or medical practitioner treats a child with a STI and the health practitioner believes, on reasonable grounds, that the STI may indicate that the child is or has been the subject of sexual abuse, the practitioner must report to DCPFS as stipulated in the CCSA. See section 6.3 for further details.

9.7. Testing for HIV/AIDS

Administration of a test for HIV/AIDS is considered to be medical treatment or other health care intervention, and the same requirements for informed consent apply. (Refer to section 5 for more information).

9.8. Female genital mutilation

In Western Australia, it is unlawful for a person to perform ‘female genital mutilation’ on any other person. The fact that the person or (in the case of a child) the person’s parent or guardian has given consent is no defence.

It is also unlawful for a person to take a child from Western Australia, or arrange for a child to be taken from Western Australia, with the intention of having the child subjected to female genital mutilation.

‘Female genital mutilation’ for the above purposes includes any procedure that involves the excision, mutilation, suturing or sealing of the female genital organs or narrowing of the vaginal opening other than a medical procedure carried out for a proper medical purpose or a reassignment procedure carried out in accordance with the Gender Reassignment Act 2000 (WA).

‘Female genital mutilation’ is not a term that persons considering such practices for themselves or their family members are likely to use in consultations and its use can be offensive and counterproductive to the therapeutic relationship. Health workers therefore need to be careful in the terminology they use when discussing such matters with clients and their families. The terms ‘cutting’, ‘circumcision’ or ‘female circumcision’ are suggested for use.

The Department for Child Protection and Family Support has defined FGM as physical abuse and a child protection referral is required. A mandatory report of child sexual abuse is not required.

If there are concerns a child is at risk of being subjected to FGM contact should be made and a referral submitted as soon as possible to the local DCPFS district office or to Crisis Care.

If a child is found to have already had FGM then referral to paediatric gynaecological services or urogynaecology for any ongoing medical treatment/management should be arranged.

9.9. Sexual assault

Sexual assault is a crime involving an attempt, threat or actual application of force of any kind to the person of another without that person’s consent which has a sexual connotation, or that is accompanied by an intention to obtain sexual gratification.

Health workers who become aware that a child or young person has been sexually assaulted should assist the person to address immediate health concerns such as injury, emergency contraception and STIs. Sexual assault referral centres provide a free 24-hour 7 days a week emergency service, offering assistance and support to any person, female or male, over the age of 13 years, who has been the victim of a sexual assault.
9. Sexual health

Medical treatment, counselling and forensic services can be accessed through these centres.

Client consent should generally be obtained prior to reporting, to a third party such as a parent or the police, a crime disclosed in confidence. In Western Australia, there is no mandatory obligation to report a crime to the police or other authorities. Health workers need to be mindful of their obligations of confidentiality before disclosing any information about clients who are victims of crimes.

If there is a serious, imminent and identifiable risk of harm or danger to the health or life of a person (including the client) requiring immediate remedial action, it may be permissible to report the crime on the basis of an overriding public interest without the need to obtain the client’s permission. In such situations, the disclosure must be made only to the person or authority (e.g. police) capable in the circumstances of taking remedial action and only such information as is necessary to achieve the same should be disclosed. It is recommended that where possible and practicable legal advice be sought from Legal and Legislative Services prior to making a ‘public interest’ disclosure.

Where the victim of the sexual assault is a child, then consideration should be given to advising the person with parental responsibility (within the constraints of the duty of confidentiality). If there are concerns that the person with parental responsibility has not taken action, the worker should consider whether it is appropriate to notify DCPFS.

Medical practitioners, nurses and midwives should be aware that a sexual assault of a child is likely to give rise to a duty to report to DCPFS relating to the CCSA. Please refer to section 6.3 for further details. Other health professionals with concerns about the minor’s wellbeing should also consider the option of making a report to DCPFS.

Any decision to disclose confidential client information to DCPFS, the police or other person should be well documented including the reasoning that led to the decision to notify DCPFS or the police.

9.10. Sexting

Sexting refers to the use of social media, the internet or a mobile phone to take, send or receive a sexually explicit image.

Under the Criminal Code 1913 (WA) it is a crime to take a sexually explicit photograph or image of a person under 16 years of age. In addition, the Criminal Code Act 1995 (Cwlth) makes it an offence to send a sexually explicit photograph or image of a person under the age of 18 years. These laws include individuals taking and sending photographs or images of themselves, and those exchanged between two young people who are in a consensual, intimate relationship, and have consented to the taking or sending of sexually explicit photographs or images.

The Criminal Code 1913 (WA) allows that individuals who receive a sexually explicit photograph or image of a child under the age of 16, are committing a crime by possessing child exploitation materials, whether or not the photograph or image had been sought or requested.

Case study over page.
Hypothetical case study:
Sixteen-year-old concerned about unprotected sex

You work as a community health nurse in a rural community. A 16-year-old approaches you with concerns in relation to becoming drunk the previous night and having unprotected sex. You judge the young woman to be a mature minor.

The young woman is concerned about being pregnant but has not taken the morning after pill. She is very concerned about purchasing the medication at the local chemist because a family member works there. What advice and assistance can you offer her so that she can promptly access the morning after pill?

- Conduct a psychosocial assessment including sexual activity and relationships.
- Assess the young woman’s competence to consent to health care.
- Carefully document the process and factors relied upon in assessing the girl’s competence.
- Provide information about how the morning after pill works and the local options for accessing it.
- Provide appropriate health care, including discussion about safe sex and self care.

You are concerned about the possibility of the young woman having contracted a sexually transmitted disease. What steps would you take to provide appropriate care?

- Consider local provision of STI testing, discuss this with the young woman and make a referral.
- Assertively follow-up, to continue discussions about safe sex, self care and other psychosocial issues.

During the consultation, the young woman indicates that she believes the sexual activity was not consensual. What steps do you take?

- Discuss sexual assault and associated issues.
- Assist the young woman to access a sexual assault referral centre, GP, hospital, Family Planning WA or sexual health clinic.
- Provide ongoing review and support.

This scenario is underpinned by legal concepts covered in sections 4, 5, 6, 7, 8, 9 and 10. Refer to these sections for more information.
10. Mental Health

10.1. Mental Health Act 1996 (WA)

The Mental Health Act 1996 (WA) (MHA) aims to balance the needs of individuals with mental illness who require appropriate care and treatment with the least restriction of their civil rights. It promotes the sharing of responsibility across the community to assist individuals with mental illness, and aims to ensure the proper protection of clients as well as members of the public.

The MHA’s purpose is not to dictate clinical practice, nor to remove the responsibility of clinicians to exercise proper skill and knowledge when making decisions about client care. However, a comprehensive understanding of the MHA and how it impacts on decision-making should enhance good clinical practice.

10.2. Referral for examination

A medical practitioner or Authorised Mental Health Practitioner (AMHP) can refer an individual to a psychiatrist for examination if there are reasonable grounds to suspect that the individual should be detained involuntarily. The referrer must have personally examined the individual and the referral must be made in writing (Form 1) within 48 hours of the examination.

Conveyance to an authorised hospital should be made in such a way that the individual’s welfare, safety and dignity are considered. The individual may be conveyed to hospital in a Department of Health vehicle, an ambulance, a police car, a police divisional van or, if appropriate, a private vehicle.

The police should be involved only if necessary and involving the police should not be a practice of first choice. However, the MHA makes provision for formal Transport Orders (Form 3) to be made by the referrer in circumstances where the individual’s condition is such that police assistance is required to take the person to the examination, and where no suitable alternative is available. A Transport Order authorises a police officer to apprehend the individual and take him or her to the place of examination.

Examination by a psychiatrist following a Form 1 referral, will take place at an authorised hospital or some other place such as a clinic, an emergency department or community mental health centre, as determined by the referrer.

Staff at these ‘other places’ have no power under the MHA to detain the individual referred. Generally speaking, where detention is thought appropriate, a medical practitioner or AMHP at these other places will need to complete another Form 1, to refer the individual to an authorised hospital. The exception is where the individual needs to be detained because he or she is posing an imminent risk to himself/herself or others. In these circumstances, the common law doctrine of necessity to protect the individual or others may override the rights of the person to leave the health care facility.

10.3. Examination by psychiatrist

Upon referral to an authorised hospital, a psychiatrist will examine the individual and assess whether he or she is suffering a mental illness. A mental illness is defined in the MHA as: ‘…a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgement or behaviour to a significant extent’. 
Where the individual is assessed as suffering a mental illness, the examining psychiatrist may decide to admit the individual as an involuntary client to the hospital or to make a community treatment order allowing the individual to be treated as an involuntary client in the community.

The MHA outlines details about how mental health professionals should aim to meet the best interests of the client while protecting the client and others in the community from harm.

10.3.1. Involuntary detention

Individuals suffering a mental illness can be detained in an authorised hospital only if all of the following is satisfied:

- The treatment can be provided through detention in an authorised hospital.
- The treatment is necessary to:
  - Protect the health or safety of that individual or any other person.
  - Protect the individual from self-inflicted harm, including serious financial harm and lasting or irreparable harm to any important personal relationships.
  - Prevent the individual doing serious damage to property.
- The individual has refused or (due to the nature of the individual’s mental illness) is unable to give consent to treatment.
- The treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary client.

A psychiatrist who has assessed an individual as being in need of treatment for a mental illness on an involuntary basis must consider whether treatment can be given while the individual is living in the community, if necessary under a community treatment order, before an order of involuntary detention can be made.

Involuntary clients can be detained for up to 28 days, after which the client can be discharged, placed on a community treatment order, or be detained for a period of up to six months. Leave from detention can be authorised on certain grounds.

10.3.2. Voluntary patients

Individuals may voluntarily present for admission into an authorised hospital for psychiatric treatment if admission is appropriate. Discharge will be dependent on psychiatric assessment, and if appropriate, a (previously) voluntary client may be detained involuntarily.

10.3.3. Community treatment orders

A psychiatrist who believes that an individual needs treatment for a mental illness must consider whether the treatment can be given while the individual is living in the community. If this is possible and the psychiatrist believes that the individual would not accept the treatment voluntarily or is unable to give consent to the treatment, then a community treatment order (CTO) may be made.

CTOs can be a less restrictive alternative to compulsory admission to hospital, or when being in hospital is no longer necessary. However, only clients at the greatest risk of non-compliance with treatment should be considered for CTOs.

CTOs are made and supervised by a psychiatrist in communication with community mental health professionals. They involve a defined treatment plan with details of where, when and by whom the treatment will be given.

CTOs allow involuntary clients to be treated in the community for up to three months, with the option to renew for a further three months, after which a new application is required. Clients treated under CTOs are still involuntary clients for the purpose of the MHA.

A breach of a CTO occurs when the client does not comply with the order, the supervising psychiatrist believes that all reasonable steps have
been taken to obtain compliance without success and a significant risk to the condition of the person deteriorating arises from the non-compliance. In such circumstances, the CTO can be immediately revoked (Form 11) by the supervising psychiatrist. However, it is usual practice for the supervising psychiatrist to warn the client (in writing) that a breach has occurred, giving him or her, the opportunity to comply.

If the client still fails to cooperate, the supervising psychiatrist can issue an Order to Attend (Form 14) at a time and place specified, so the client may receive treatment. Treatment under an Order to Attend can be given without consent, and if non-compliance continues, community mental health staff and/or police (Form 3) can be involved in ensuring the client attends for treatment.

The supervising psychiatrist may revoke (Form 8) a CTO following examination of the client where he or she believes the client should not continue to be an involuntary client. A CTO may also be revoked if the client on a CTO becomes unwell again and needs to be detained as an involuntary client in an authorised hospital, or fails to comply with the order and needs to be detained as an involuntary client in an authorised hospital (Form 11).

For more information, refer to the ‘Community Treatment Orders, A Practitioners’ Guide’ available from the Chief Psychiatrist’s website at: www.chiefpsychiatrist.health.wa.gov.au

**10.4. Emergency psychiatric treatment**

This type of treatment may occur when it is considered necessary to save a person’s life, or to prevent a person from causing serious physical harm to himself/herself or another person. Emergency psychiatric treatment can be given to a client with a mental illness regardless of their status under the MHA, with or without the client’s consent. However, consent should always be sought and only if consent is not freely given or the client is not capable of giving informed consent should emergency psychiatric treatment be given without consent. This type of treatment can be carried out by a psychiatrist, an authorised medical practitioner or mental health professional as appropriate.

**10.5. Police powers to take mentally ill person into protective custody**

In the community, it is often the police who have initial contact with individuals suffering from a mental illness and whose behaviour is putting themselves or others at risk. The MHA enables the police to take action where appropriate, ensuring that such individuals are directed to the health system to receive the treatment they need.

Police may apprehend and take into protective custody to await psychiatric examination, any individual they suspect has a mental illness and when they consider apprehension is necessary to protect the health and safety of that person or others, or to prevent serious damage to property. Under the *Criminal Code*, police officers may use reasonable force to apprehend a person if serious harm to the client or other person is likely. Police are entitled to enter premises where the individual is on reasonable grounds suspected to be, and seize any items which may assist in supporting the apprehension of that individual.

Once the individual has been apprehended, the police must arrange as soon as is practicable for that person to be examined by a medical practitioner or AMHP, the result of which could be referral for examination by a psychiatrist under a Form 1. In such cases, the individual has not been arrested but only apprehended in order that a medical practitioner or AMHP determine whether an examination by a psychiatrist is necessary.

*Case study over page.*
Hypothetical case study:
Young man presents at health clinic in a highly agitated state

You work in a health clinic which offers a range of services for young people. A 19-year-old man presents for an appointment in a highly agitated state.

- Assess physical, psychosocial and mental health factors that might be causing the client’s agitated presentation. Ensure this is conducted in a way that protects your own safety and that of your colleagues.
- Conduct a comprehensive psychosocial history including assessment of any disturbance of thought, mood, perception or behaviour (or access (immediate) assistance from a more appropriate staff member or a mental health professional to do this) Acting within the parameters and boundaries of your professional competence:
  - Undertake a risk assessment including risk of harm to self or others.
  - Develop a formulation of the factors contributing to his current presentation including formulation of risk.
- Develop a care plan consistent with situation and risk. Involve client in care planning congruent with his capacity for informed consent and compliance with any necessary assessment or treatment.
- Carefully document the process and factors relied upon in assessing competence
- Consider the need to take actions without the client’s consent or agreement in high risk situations.
- Consult with peers, managers or seek external specialist consultation if uncertain.
- Gather collateral information from family, carers, other service providers if client consents.

From your assessment you form the opinion that the young man’s agitation is most likely to represent some psychotic illness and/or process. You consider him to be in urgent need of mental health assessment. What steps should you take?

- Consider assessment by a general practitioner if the client can identify a general practitioner known to him.
- Consult and liaise with the local mental health service or mental health emergency lines regarding the most appropriate and least restrictive manner to access urgent assessment.
- Provide clear details of your assessment and concern to the service, unit or practitioner with whom you have negotiated further assessment, (MHERL**, hospital emergency department, local mental health team, general practitioner).
- Document your assessment, care plan and actions taken including rationale for actions that involve breach of confidentiality, (i.e. acting without client’s consent).
- Consider the need to inform police if client absconds prior to assessment.

This scenario is underpinned by legal concepts covered in sections 4, 6, 7, 9 and 11. Refer to these sections for more information.

11. Drugs and poisons

11.1. Schedule of drugs and poisons

In Australia, both Commonwealth and State legislation regulate and control drugs and poisons.

11.1.1. Therapeutic Goods Act 1989 (Commonwealth)

The Commonwealth Therapeutic Goods Act 1989 (the TGA) provides a national framework for the regulation of therapeutic goods in Australia and is upheld by the Therapeutic Goods Administration (The TGA). Its aim is to ensure the quality, safety, efficacy and timely availability of therapeutic goods in Australia. The TGA affects persons that import, export, manufacture and supply therapeutic goods in Australia.

A ‘therapeutic good’ is a good that is represented in any way to be for therapeutic use (unless specifically excluded or included under the Commonwealth Therapeutic Goods Act), including the prevention, diagnosis, curing or alleviating of a disease, illness or injury. Therapeutic goods include medicines (prescription as well as some non-prescription and complementary medicines) and medical devices.

Medicines assessed by the TGA as having a higher level of risk (prescription medicines and some non-prescription medicines) are required to be entered on the Australian Register of Therapeutic Goods (ARTG) before they can be supplied in Australia. The ARTG is a computer database of information about therapeutic goods for human use approved for supply in, or export from, Australia. The Commonwealth Therapeutic Goods Act, together with its supporting regulations and orders, set out the requirements for inclusion of therapeutic goods on the ARTG.

Medicines assessed by the TGA as having a lower risk (consumer medicines purchased over the counter such as complementary medicines including vitamins and herbal medicines) are assessed for quality and safety.

For more information visit the Commonwealth Department of Health and Ageing’s Therapeutic Goods Administration website at www.tga.gov.au

11.1.2. Poisons Act 1964 (WA)

In Western Australia, the Poisons Act 1964 (WA) is responsible for the regulation and control of the possession, sale and use of drugs and poisons.

The Poisons Act also categorises drugs and poisons according to various schedules set out in the Poisons Standard 2013 based on the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP), summarised over page. Health workers should be familiar with the drug categories and associated restrictions provided under the Poisons Act.

The Poisons Act together with the Poisons Regulations 1965 (WA) contain detailed provisions governing the labelling, storage, dispensing, disposal and administration of drugs. Health services should develop local policies and procedures to assist health workers to comply with applicable legal obligations as relevant to the service context and scope of practice. Health workers must be familiar with these policies and procedures.

Health workers also have responsibilities to develop and maintain skills and knowledge in order to properly administer drugs as relevant to their area of practice. This includes competence to recognise and respond to adverse reactions. Health service authorities are responsible for employing staff with appropriate qualifications, and for ensuring that health workers develop and maintain relevant skills and knowledge in this area.
If a health worker does not have the knowledge and skill to deal with a particular situation involving drug administration, they should not continue with the intervention. In such circumstances, it is recommended that the health worker makes contact with their line manager or another appropriate authority for guidance.

As with other health care interventions, the administration of therapeutic drugs requires consent from the client, their parent or guardian. (Refer to section 5 for more information).

### Summary of the *Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)*

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>At the time of publication of this document, Schedule 1 to the SUSMP was intentionally left blank.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Pharmacy medicine</strong>: Substances, the safe use of which may require advice from a pharmacist and which should be available from a pharmacy or, where a pharmacy is not available, from a licensed person.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Pharmacist Only Medicine</strong>: Substances, the safe use of which requires professional advice but which should be available to the public from a pharmacist without a prescription.</td>
</tr>
<tr>
<td>4</td>
<td><strong>Prescription-only medicine or Prescription Animal Remedy</strong>: Substances, the use or supply of which should be by or on the order of persons permitted by State or Territory legislation to prescribe and should be available from a pharmacist on prescription.</td>
</tr>
<tr>
<td>5</td>
<td><strong>Caution</strong>: Substances with a low potential for causing harm, the extent of which can be reduced through the use of appropriate packaging with simple warnings and safety directions on the label. (e.g. kerosene).</td>
</tr>
<tr>
<td>6</td>
<td><strong>Poison</strong>: Substances with a moderate potential for causing harm, the extent of which can be reduced through the use of distinctive packaging with strong warnings and safety directions on the label. (e.g. rat poison, lead compounds)</td>
</tr>
<tr>
<td>7</td>
<td><strong>Dangerous poison</strong>: Substances with a high potential for causing harm at low exposure and which require special precautions during manufacture, handling or use. These poisons should be available only to specialised or authorised users who have the skills necessary to handle them safely. Special regulations restricting their availability, possession, storage or use may apply.</td>
</tr>
<tr>
<td>8</td>
<td><strong>Controlled Drug</strong>: Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.</td>
</tr>
<tr>
<td>9</td>
<td><strong>Prohibited substance</strong>: Substances with may be abused or misused, the manufacture, possession, sale or use of which should be prohibited by law except when required for medical or scientific research, or for analytical, teaching or training purposes with approval of Commonwealth and/or State or Territory Authorities.</td>
</tr>
</tbody>
</table>
11. Drugs and poisons

11.2. Restricted drugs
Restricted drugs are those categorised under Schedule 4 or 8 of the SUSMP. They generally require a (legible) written prescription by a medical practitioner, dentist or nurse practitioner before supply and administration can occur. Wrongful possession of a restricted drug is unlawful.

A Poisons Permit may be issued to emergency care personnel, or workers in community clinics on behalf of the Department of Health or a public hospital in special circumstances where restricted drugs are required to be available. A Poisons Permit authorises the holder to purchase specified drugs from a manufacturer and specifies the uses to which the drugs may be put. In such circumstances, the supply and administration of restricted drugs is supervised by a medical practitioner.

11.2.1. Administering restricted drugs in schools
In school settings, it is common for children to require restricted drugs during the course of the school day in order to comply with short or longer term treatment plans. In such cases, a designated adult can administer (or assist the child to administer) a drug when there is appropriate authorisation and information supplied by the parent.

In Western Australia, the Department of Education publish a Student Health Care Policy. Health workers providing services in schools should refer to this policy at [www.policies.det.wa.edu.au](http://www.policies.det.wa.edu.au)

11.3. Prohibited drugs
Prohibited drugs are those that are categorised under Schedule 9 of the SUSMP for which the use, possession, manufacture and supply is generally illegal. Schedule 9 drugs include illicit drugs such as heroin, hallucinogens, ecstasy and cannabis. Penalties for unlawful sale or supply of Schedule 9 drugs involve fines and/or imprisonment and a criminal record, which may in turn restrict employment, and applications for financial loans or credit and travel visas.

11.3.1. Use of illicit drugs by young people
Adolescence is a time when people seek new experiences, often experimenting with different behaviours and activities. For many, this may involve taking risks, which may put themselves and others at risk of harm, such as unsafe use of alcohol and other drugs. Some adolescents push family or societal boundaries and rebel against parental or community values. Many have a sense of immortality, are impulsive and inexperienced, and do not fully appreciate the possible consequences of their actions. Many also fear social penalties from their peers if they refuse to participate in risk behaviours. Some people will experiment and stop, or continue to use occasionally without significant problems. Others will develop a dependency, moving on to more dangerous drugs and causing significant harm to themselves and possibly others.

Young people may abuse a variety of drugs both legal and illegal including alcohol, tobacco, prescription medication, inhalants, marijuana, amphetamines, ecstasy, LSD, cocaine and heroin.

If a health worker becomes aware or suspects that his or her client may have committed any drugs offence, there is no general legal obligation on a health worker to provide information to the police or other authority in relation to the same (e.g. school administration or general practitioner). As health workers owe a duty of confidentiality to a client in relation to any information obtained in the course of providing health care, the provision of this type of information to third parties may be a breach of confidentiality. Such a breach may potentially deter the client and other young people from engaging in health care, and thus may not necessarily be in their best interests.
In such circumstances, the health professional has a responsibility to provide information to the client about the health risks associated with taking a particular illicit drug. This should include explaining to the client that he or she is or may potentially be committing a criminal offence that could lead to prosecution by the police. This information should be provided to the client in a way that suits the age, literacy and cognitive abilities of the client. In cases where the client is injecting drugs, the health professional should provide information about access to needle exchange facilities.

Hypothetical case study:
Pregnant young woman with crystal methamphetamine dependence

You are working in a youth health clinic where a 17-year-old girl is seeking help for her dependent use of crystal methamphetamine. During the consultation the girl reveals that she is pregnant, but is not ready to give up her daily use of the substance. What action should you take?

- Conduct a psychosocial assessment.*
- Check health care with regard to pregnancy and sexual health issues.
- Assess ongoing risk, i.e. child protection or coercion and notify DCPFS if required.
- Consider the girl’s competence to consent to health care.
- Carefully document the process and factors relied upon in assessing the girl’s competence.
- If assessed as incompetent, discuss involving parent/guardian/support person. Seek consent to discuss with parent/guardian. If consent refused, only discuss with parent/guardian where essential to safeguard the wellbeing of the girl.
- Undertake a review of her drug and alcohol treatment given knowledge of pregnancy.
- Discuss the options regarding the pregnancy including adoption, termination and carrying the baby to term.
- Refer to appropriate sexual health and/or family planning services for advice, information and support for decision making regarding the pregnancy.
- Provide relevant information to the girl of risk of drug and alcohol use to unborn child.
- Where appropriate refer the girl to the adolescent antenatal unit or antenatal chemical dependency clinic for specialist support.

This scenario is underpinned by legal concepts covered in sections 4, 5, 6, 7, 8, 9, 10, 11 and 12. Refer to these sections for more information.


It may be that a client’s use of illicit drugs raises concerns in relation to the wellbeing of a child. For example, if the client is a child or is the parent of a child and the health worker suspects the client or other child is being abused or neglected. No breach of confidentiality arises where a health worker reports suspicions or concerns regarding the wellbeing of the child concerned, in good faith, to a DCPFS officer. The suspicions or concerns must centre on concerns of child abuse or neglect, and not merely be a report of illicit drug use by a person who has responsibility for a child. (Refer to section 7 for more information.)

If the client who is using an illicit drug is a minor, the health professional should consider
the maturity level of the child and involve a parent as appropriate. (Refer to section 4 for more information).

There may be circumstances where, despite the duty of confidentiality, it is appropriate to disclose confidential information concerning a client’s drug activity to a third party (e.g. the police, a parent or school administration as appropriate) without consent on the basis of an overriding public interest. (Refer to section 6 for more information).

11.3.2. Reporting the supply of illicit drugs
There is no legal duty on a health worker to report a client or third party as a supplier of an illicit drug. A health worker owes clients a duty of confidentiality, and if he or she decides to make a report, then the health worker must be careful not to breach his or her duty of confidentiality to the client during that reporting process. (Refer to section 6 for more information.)

In relation to a third party (i.e. non-client) who is supplying illicit drugs, a health worker does not generally owe a duty of confidentiality.

11.3.3. Drug testing
Drug testing may occur in some health services as part of a treatment regime. It is a voluntary undertaking by the client requiring prior client consent, and may be part of a contract for pharmacotherapy or other medication provision. (Refer to section 5 for more information.)

11.4. Tobacco
It is illegal for anyone to sell or supply a tobacco product to a person under the age of 18 years. This includes shops that sell cigarettes to children and people who give them to, or buy them on behalf of, a child. Even if a child has written permission from a parent to buy cigarettes on the parent’s behalf, a shopkeeper will commit an offence if he or she sells the cigarettes to the child.

The Department of Health is responsible for the enforcement of the Tobacco Products Control Act 2006 (WA). This means the Department is responsible for charging people who break this law. To report breaches of the Act in Western Australia, contact the Tobacco Control Branch on (08) 9242 9633.

11.5. Alcohol
A person under 18 years commits an offence and can be fined if he or she:

- Buys or receives, or tries to buy or receive, alcohol from any other person on licensed or regulated premises;
- Brings alcohol on to licensed or regulated premises;
- Drinks alcohol on licensed or regulated premises.

It is illegal for a person to sell or supply alcohol to, or purchase alcohol on behalf of, a person under the age of 18 years.

A person who sends a minor to licensed premises to get alcohol knowing the minor is under 18 years also commits an offence. If an adult, acting on a minor’s instructions, buys the minor alcohol from licensed premises, both the minor and the adult commit an offence.

It is illegal for a person to drive, or attempt to drive, while under the influence of alcohol.
11. Drugs and poisons

drugs or alcohol or both to such an extent as to be incapable of having proper control of the vehicle. A person charged with being under the influence of drugs alone will have a defence if he or she can prove to the court that the drugs were prescribed, or given by a doctor, nurse practitioner or dentist for therapeutic purposes and that he or she was unaware the drugs were likely to make him or her incapable of having proper control of the motor vehicle.

Drivers with a full licence commit an offence if they drive, or attempt to drive, with a BAC that equals or exceeds 0.05%. Novice drivers holding a provisional licence (‘P’ plates) or a learner’s permit (‘L’ plates), are restricted to a zero BAC.

The police can require drivers of vehicles (or persons in charge of vehicles) to allow a medical practitioner or registered nurse to take a blood sample from the individual for analysis in the following circumstances:

- The individual has provided a preliminary breath sample indicating a BAC equal to or exceeding 0.05%, or 0.00% in the case of a ‘P’ plate driver.
- The individual has refused or failed to provide a breath sample.
- The police believe on reasonable grounds that the individual has been driving under the influence of alcohol or drugs; or
- The police believe on reasonable grounds that the individual’s motor vehicle has been involved in an incident that has caused injury to another person(s) or caused damage to property.

The individual concerned has the right to nominate the medical practitioner or registered nurse who is to take the blood sample, which must be taken within four hours of the time at which the driving or attempted driving is believed to have taken place. The police may also nominate the medical practitioner or registered nurse who is to take the blood sample in limited, specified circumstances.

Similarly, the police can require individuals in the above circumstances to give a nominated medical practitioner or registered nurse a urine sample for analysis.

A medical practitioner or registered nurse who takes a blood sample from such persons, or to whom a urine sample is provided by such persons, must take the blood sample, or collect the urine sample, in accordance with prescribed regulations and equipment.

Hypothetical case study:

**Student who is suspected of being intoxicated at school**

You work as a community health nurse in a district high school which you visit on a weekly basis. The deputy principal brings a 15-year-old student to your office. The deputy claims that the student is intoxicated and suspects he has been smoking cannabis. The deputy asks you to assess the student in order to report on his level of intoxication and the issues regarding his suspected substance use. What are your responsibilities in this situation?

- Gather further information as to the grounds for believing the student is under the influence of an illicit substance.
- Ask to consult with the student alone.
- Assess the student’s level of ‘intoxication’ and his competence (bearing in mind the student’s age) to make decisions.
- Carefully document the process and factors relied upon in assessing the level of intoxication and competence. This may include physical evidence of use, the student’s report of use, other reports of use, physical signs of use etc.

(Continued over page)
11. Drugs and poisons

If you judge the student to be intoxicated:

- Explain school protocol/policies regarding drug use at school.
- Explain that you are obliged to inform his parents and/or relevant care giver and that he will need to return home for the rest of the day.
- Explain the limits of confidentiality and what information you are required to report to the principal and parent and/or caregiver.
- Make contact with the parents and/or caregiver so they can take him home.
- Inform student and parents/caregiver of relevant services available to them.
- Inform the deputy principal that arrangements have been made for the student to go home.
- Make a follow up appointment with the student to conduct a psychosocial assessment and provide appropriate health care, including referral to specialist services.
- Ensure all follow up interventions are undertaken with the student’s consent unless he is a risk to himself and/or others.
- Suggest that the deputy principal makes a contract with the student, which could include:
  - Commitment from the student not to use substances on school grounds and outline consequences of further use.
  - Commitment from the student to participate in drug and alcohol treatment if appropriate.
  - Commitment from the school to support treatment, and ongoing education
  - If the deputy principal recommends that the student participates in drug testing, explore what the aims of this would be, and its limitations in the school environment.

If you judge the student as not intoxicated:

- Conduct physical and psychosocial assessments* as relevant, and provide appropriate health care, including education about drugs and harm reduction if necessary.
- Offer a follow-up appointment if necessary.

Communication with the deputy principal:

- Confirm whether the student is still at school or has been removed by his parent(s).
- Explain your duty of confidentiality to the student (and his parents/caregiver).
- Consider if circumstances suggest that it is in the student’s best interests to share the information with the deputy principal. You must obtain consent from the student (or parent) before the information can be shared.
- Discuss a plan for future situations of this kind.

This scenario is underpinned by legal concepts covered in sections 4, 5, 6, 7, 9, 11 and 12. Refer to these sections for more information.
12. Relevant laws and legislation

Age of Majority Act 1975 (WA)
Children and Community Services Act 2004 (WA)
Civil Liability Act 2002 (WA)
Criminal Code Act 1995 (Cwlth)
Criminal Code 1913 (WA)
Family Law Act 1975 (Cwlth)
Freedom of Information Act 1992 (WA)
Health Act 1911 (WA)
Human Tissue and Transplant Act 1982 (WA)
Gender Reassignment Act 2000 (WA)
Guardianship and Administration Act 1990 (WA)
Liquor Licensing Act 1988 (WA)
Mental Health Act 1996 (WA)
Misuse of Drugs Act 1981 (WA)
Occupational Safety and Health Act 1984 (WA)
Poisons Act 1964 (WA)
State Records Act 2000 (WA)
Therapeutic Goods Act 1989 (Cwlth)
Tobacco Products Control Act 2006 (WA)

Case law

Secretary, Department of Health and Community Services v. JWB and SMB [Marion’s Case] (1992) 175 CLR 218
Gillick v West Norfolk Area Health Authority, [1986] 1 AC 112 at 189
In order to gain reimbursement from Medicare for a consultation with a General Practitioner (GP), an individual must have their own Medicare card or be listed on a family Medicare card. The card or the details outlined on the card (card number, reference and expiry date) must be presented at the time of the consultation to obtain reimbursement from Medicare or bulkbilling services.

Minors between the age of 15 and 18 years may apply for their own card. Application forms are available at GP surgeries, chemists and Medicare offices. Minors can present their parents’ Medicare number and ask for their own card and number to be issued, or provide two types of identification showing their name and address, name and a photo, or name and date of birth. The minor must prove that they are at least 15 years of age. Acceptable forms of identification include a birth certificate, a bank book/statement and school registration or student card. The new Medicare card can be mailed to an address of choice if, for example, the individual does not want it sent to the family home.

If a minor under the age of 15 years wishes to consult with a GP, the family Medicare card (or the Medicare details) and a parental signature (or that of a guardian) is normally required. Some GPs may accept the minor’s signature against the family Medicare card.
This document can be made available in alternative formats such as computer disc, audio tape or Braille, on request.