GOVERNMENT OF WESTERN AUSTRALIA

WA Health

Working with Youth

A legal resource for community-based health professionals

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1. Introduction

This resource is primarily written as a reference for health professionals working in the public health sector in Western Australia and who provide health care in community settings for minors up to the age of 18 years. Health professionals working in health service providers need to be aware of any applicable Australian and Western Australian legislation, common law principles, policies (including Policy Frameworks issued under section 26 of the *Health Services Act 2016* (WA)) and procedures.

The recognition and consideration of legal issues is fundamental to health care practice and professional conduct. Working with children and adolescents raises many legal challenges, and 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 adolescents requires careful consideration of a range of matters including the developmental stage of the individual and the legal status of that person. Health concerns which are of most importance to adolescents often involve sensitive psychosocial issues. Therefore, the development of trusting relationships between health professionals 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 minors 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 certain individuals who have reached adult age.

This resource outlines common law principles and legislation which are likely to be useful for health professionals working with minors. 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 as young people move through adolescence – child abuse, domestic violence, sexual health, mental health, drugs and poisons and online safety.

It is hoped that *Working with Youth* will provide a good, general background of the relevant law to assist with sound decision-making. It should not however, be relied upon as a substitute for legal or professional advice.

2. Definition of terms

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

Adolescent	A person who is in the developmental stage of 'adolescence', which occurs approximately between 10 and 24 years of age.
Common law	Law derived from judgments made in court.
Competence	The capacity or capability, at law, of an individual to make decisions on their 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 the disclosure of confidential information.
Child or Minor	A person under 18 years of age.
Client	Is synonymous with 'patient'.
HEADSS assessment	Tool used in community health nursing practice that provides a framework for an adolescent psychosocial assessment.
Health care	An intervention or service provided by a health professional, 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.
Health service provider	A health service provider established under section 32 of the *Health Services Act 2016* (WA). This may include (as the context requires) the WA Country Health Service, North Metropolitan Health Service, East Metropolitan Health Service, South Metropolitan Health Service, Quadriplegic Centre, Child and Adolescent Health Service, Health Support Services and PathWest Laboratory Medicine WA.
Health professional	Includes medical practitioners, nurses, midwives, psychologists and allied health professionals who provide health care to clients.
Legal guardian	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 *Children and Community Service Act 2004* (WA)). In relation to a young adult, means the person formally appointed as a legal guardian of that young adult under the *Guardianship and Administration Act 1990* (WA).
Parent	In relation to a child, means a person having parental responsibility for that child.
Parental responsibility	In relation to a child means all the duties, powers, responsibilities and authority which, by law, parents have in relation to their children.
Young adult	A person who is 18 years or older (legally defined as an adult) but who is in the developmental stage of 'adolescence'.

3. Duty of care

The special nature of the relationship between health professionals and their clients has been recognised at law as giving rise to a duty of care. Whether the client is a child or adolescent, a minor or adult, the principle is that the health professional must take all reasonable care for the welfare of that person.

Generally, a duty of care will arise when the child or adolescent 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 individual. The duty means that health professionals must ensure that individuals they care for do not come to reasonably foreseeable harm by their actions or failure to act. The health professional must exercise appropriate skill and judgment in respect of the assessment, diagnosis, treatment or other health care of the minor, including the provision of advice and information. A health professional 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 professional for a person under their care.

A health professional (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 an individual 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 professional 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 professional will only be liable in negligence where they have not acted reasonably, the breach has caused injury or loss to the child, adolescent 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 professionals will, in general, be determined according to whether the health professional's conduct (at the time it occurred) was widely accepted by their professional peers as competent professional practice.

Health professionals should act reasonably at all times, and in accordance with relevant standards and practices that govern their conduct. Health professionals 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 professionals 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 adolescents, depending on their age, maturity and circumstances, may be more vulnerable than others. Health professionals should be mindful of the individual needs and circumstances of the individuals 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 professional's conduct falls below expected standards.

In addition, health professionals should ensure that children or adolescents under their care are given all necessary information regarding the health care being provided. This should include allowing the individual sufficient time to reflect on the information presented. To ensure they have understood the information provided the young person should be encouraged to repeat what they have been told, in their own words. Refer to section 4 for more information.

3. Duty of care

Health professionals working with children and adolescents require skills, knowledge and training to work effectively with young people. It is important to understand the developmental stages of childhood and adolescence and to be able to make judgements about the physical and psychosocial status and the care an individual requires in the context of their development and circumstances.

Health professionals working in health service providers with adolescents should be familiar with the ***WA Youth Health Policy 2018-2023*** produced by the Western Australian Department of Health. The Policy aims to drive equitable, effective and coordinated health services that optimise the health and wellbeing of young people in Western Australia.

3.1. Referral and waiting lists

Health professionals are often involved in linking clients to other health professionals or health services that can provide specific health care required by clients.

When health professionals 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 where the required expertise and care can be provided. The point at which the duty of care is transferred to the new service or health professional is not always clear and depends on the circumstances of the client.

Each health professional (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 service or health professional, 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 service or health professional, the duty of care (of the referring health professional) is usually discharged when the client makes contact with the new provider. Once the client is accepted into the care of the new 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 new service or health professional 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 their duty of care to the client. Referring health professionals are expected to follow-up clients placed on waiting lists and, if circumstances change, take appropriate action for the client's welfare.

Some children and adolescents may be more vulnerable than others because of their emotional or cognitive immaturity, or disadvantaged circumstances. There may be a lack of appreciation by the individual of the need to take further action, or an inability to take steps to seek further help. In such cases the health professional may need to take additional steps to ensure that the child or young adult makes contact with the service or health professional to which they have been referred.

The health professional's duty may require them to follow-up with the individual. 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.

3. Duty of care

In some cases the child or adolescent may be vulnerable because of the acuteness of the health issue and the requirement for urgent action. A health professional 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 professional will be greater than in other less urgent circumstances.

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 their 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.

Community-based health professionals require access to supervision, mentoring support and advice to support good practice and optimal care for clients. This support is also required for health professionals to maintain their psychological wellbeing, especially in relation to working with vulnerable or complex clients and difficult cases.

Local and other applicable procedures for identifying and managing risks must be implemented and monitored.

Hypothetical case study 1:

Teen with suspected eating disorder

You are a community health nurse working in a secondary high school. Fifteen year old Jayden visits you twice in one week, complaining of headaches. You judge that there is possibly something else of concern for Jayden.

You decide that a thorough HEADSS assessment is warranted and explain this to Jayden. He agrees to come to an hour-long appointment the following day. When he arrives for the appointment, you start by explaining the limitations of confidentiality and seek Jayden's permission to continue with the assessment.

After conducting the assessment you determine that Jayden may have an eating disorder. He asks you not to tell his mother as she is unwell. His father lives in another state and has little contact with the family. How could you proceed with his care?

- Make an assessment about Jayden's competence to make decisions about his own care.
- Discuss Jayden's reservations about 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 (or 'safe adult') who could provide support to Jayden.
- Discuss the need for Jayden to access a medical assessment. Provide information about care options available to him.
- With Jayden's consent, make a referral to the local medical service.
- Organise an appointment with Jayden (in two or three days) to review his progress.
- Document the consultation including the process and factors relied upon in assessing Jayden's competence, your observations and any decisions and actions.

At the follow-up appointment, Jayden says that he still has headaches and doesn't feel like eating. He is evasive about making an appointment to see the doctor. When questioned, you suspect that Jayden has not taken any action to make an appointment nor told his mother or anyone else about his health issue. What could you do?

- Explain the limitations of confidentiality.
- Explain that you are concerned for Jayden's health and wellbeing and will need to talk with his mother or a 'safe adult', today.
- Jayden agrees to ring his older sister who he has identified as his 'safe adult'. Together you ring his sister to discuss your concerns and the need for a referral to a doctor for further assessment.
- Jayden and his sister agree for you to share relevant information with the student service coordinator in order that Jayden can be supported at school.
- Follow-up with Jayden to determine engagement with appropriate care and to offer support and brief intervention as required.

Hypothetical case study 2:

Young male (in care) at risk of suicide

You are a community health nurse working in a secondary high school. Fifteen year old Josh is known to you, having visited the health centre a number of times for various issues. Josh has been in foster care for several years. He has recently been diagnosed with anxiety and depression, and is waiting for his first appointment with Child and Adolescent Mental Health Service (CAMHS).

It is a Friday afternoon when Josh comes to you in a very anxious state and says that he doesn't think he will make it through the weekend. What should you consider?

- Commend Josh for seeking help. Explain the limits of confidentiality.
- Conduct a suicide risk assessment if within your scope of practice OR access (immediate) assistance from an appropriate member of the student services team (e.g. school psychologist) or a mental health emergency advice line to do this.

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

You assess Josh to be at risk of completing suicide. He says that he doesn't want you to make contact with foster carers. How should you proceed?

- Reiterate the limitations of confidentiality when there is imminent risk of harm.
- Explain that information related to Josh's immediate risk needs to be divulged with his case manager (or duty manager) and his foster carers so that he can access the care he needs.
- Seek immediate assistance from a member of the school administration or student services team to contact Josh's case manager.
- Inform and engage the school principal as soon as possible.
- Ensure Josh is closely supervised at all times until his care is handed over.
- When possible, contact your line manager.

The case manager advises that Josh is to be taken to the hospital by one of his foster carers.
You provide an ISOBAR handover to the hospital Emergency Department.

Afterwards the school staff involved in the incident convene for a short debriefing session. A meeting is arranged for early in the next week to plan for ongoing care and monitoring for Josh when he returns to school. Plans will include communication with Josh's case manager and involvement of the local CAMHS team.

Hypothetical case study 3:

Young male who is depressed and receiving services at CAMHS

Tom, who is a 17 year old student, has come to the attention of the school student services team because of his poor attendance and performance at school. Tom is often tired and unwell, and a decline in his personal hygiene has been observed. Tom is referred to you, the community health nurse for assessment.

Following a HEADSS assessment and consideration of Tom's competence to make health care decisions, it is apparent that Tom is depressed and struggling with many aspects of his life. He says that he has seen the family doctor, was diagnosed with depression and was referred to Child and Adolescent Mental Health Service (CAMHS). He has been to one appointment with the CAMHS case manager.

You reassure Tom there are people in the school who can support him and suggest that a school plan could be developed to help him with his health, wellbeing and school work. You also suggest that Tom's parents should be involved in discussion and planning about support for Tom, and seek Tom's consent for you to make contact with his father. You discuss care options with Tom and he agrees for a case conference to be organised that will include one of the CAMHS staff (if possible), school psychologist, community health nurse, Tom's father and Tom himself. Tom consents to you making contact with the CAMHS case manager and sharing information about his attendance and performance at school.

You contact the CAMHS case manager, share information as agreed to with Tom, and request that the case manager attends the case conference. The CAMHS case manager agrees to support if there is consent from Tom and his father, which they discuss and agree to at the next CAMHS consultation with Tom.

The case conference is organised for three weeks later, and in the meantime you suggest that Tom returns weekly for support to look at short-term health and lifestyle goals. You also ask Tom to think about the case conference and what he would like to gain from it.

At the case conference, the aims of the care plan are discussed, and roles and responsibilities are identified. Tom agrees that he will provide feedback to you about the progress of his care. It is confirmed that Tom is to manage information relating to his care in the future, unless it is judged that he is unsafe. Factors that may indicate that Tom is unsafe are discussed and agreed. Tom identifies how he would like school staff to respond and support him when he feels unsafe, and this is supported.

Tom's father was unable to attend the case conference due to work commitments. Provided Tom provides consent, let Tom know that you (or another individual at the meeting) will ring Tom's father to let him know what is planned. Offer Tom's father resources or information about how parents and families can support a teen with depression.

You document assessments, observations, summaries of discussions, and decisions after each interaction.

4. Parental responsibility and the 'mature minor'

4.1. Children or minors (under 18 years)

It will usually be in a child or adolescent's interests to have their parents involved in health care decisions. However, there will be times when young people seek health care without the knowledge or consent of their parents. An individual may also specifically request that their 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 individual's 18th birthday. There are, however, some exceptions to this rule.

'Parental responsibility' in relation to a child (or minor) 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 health/medicals and authorise the release of confidential information to third parties on behalf of the child.

The parental power to make decisions on behalf of the child is only recognised in law to the extent this is needed for the protection of the child. This power is limited by consideration of the child's best interests.

Protection orders made by the Children's Court under the *Children and Community Services Act 2004* (WA) (CCS Act) can vary parental responsibility, depending on the type of protection order made.

4.1.1. Family breakdown situations

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

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. Whether parental responsibility is varied in any particular case will depend on the specific orders made by the court.

4.2. Mature minors

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

4. Parental responsibility and the 'mature minor'

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 individual's experience, emotional maturity and intellectual capacity. The development of these attributes is a continuum and varies from one person 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 professionals must assess each child's competence on a case-by-case basis.

In assessing the competence and maturity of a minor, 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 life.
- Child's level of schooling.
- Child's level of independence from parental care. Any moral and family issues involved.
- Health professional's prior knowledge of the child.
- Reason the child came to see the health professional about the clinical or other problem without parental involvement.
- Whether the child is acting freely in attending the health professional and making their own 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 professionals must assess each client's circumstance on a case-by-case basis.

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

Health professionals should ensure that the process, and factors relied upon in assessing a child's competence, are documented in the child's health/medical record.

4. Parental responsibility and the 'mature minor'

4.3. Special situations

4.3.1. Minors who are married, in a de facto relationship or who are parents

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

Where issues arise as to the competency of a minor to give consent to medical treatment on their own behalf, or where there is a dispute between the minors 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.

4.3.2. Minors with an intellectual disability

Minors with an intellectual disability should be assessed for competence like any other minor. There are a range of intellectual disabilities and whether the minor is competent to make a particular health care decision will depend on the particular circumstances. Parents of a child with an intellectual disability will, in some circumstances, 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).

4.3.3. Minors with a mental illness

In most instances, minors access care, including treatment for a mental illness as they would for any health issue and competence is assessed like any other minor. However, in some cases, the *Mental Health Act 2014* (WA) may be applicable.

Under the *Mental Health Act 2014* (WA), a 'voluntary patient' cannot be provided with treatment without informed consent being given to the provision of the treatment (with certain exceptions). Under the *Mental Health Act 2014* (WA), minors are not considered to have capacity, unless they are shown to have that capacity. For a minor to have the required capacity under the *Mental Health Act 2014* (WA), they need to be able to:

a. understand any information or advice about the decision that is required under that Act to be provided to the person

b. understand the matters involved in the decision

c. understand the effect of the decision

d. weigh up the factors referred to in paragraphs (a), (b) and (c) for the purpose of making the decision

e. communicate the decision in some way

For the purposes of the *Mental Health Act 2014* (WA), a decision made by a minor about a matter relating to themselves must be made freely and voluntarily.

If the minor is an 'involuntary patient', there are special provisions under the *Mental Health Act 2014* (WA) that provide for the provision of psychiatric and medical treatment without consent in certain circumstances, for example, to alleviate or prevent the deterioration of a mental illness.

For further information about the *Mental Health Act 2014* (WA) see Part 10 of this publication.

4.3.4. 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 minor. These statutory provisions override the common law principles discussed above in section 4.1. For example, section 334(8) of the *Health (Miscellaneous Provisions) Act 1911* (WA) (termination of pregnancies); section 21 of the *Human Tissue and Transplant Act 1982* (WA) (blood transfusions).

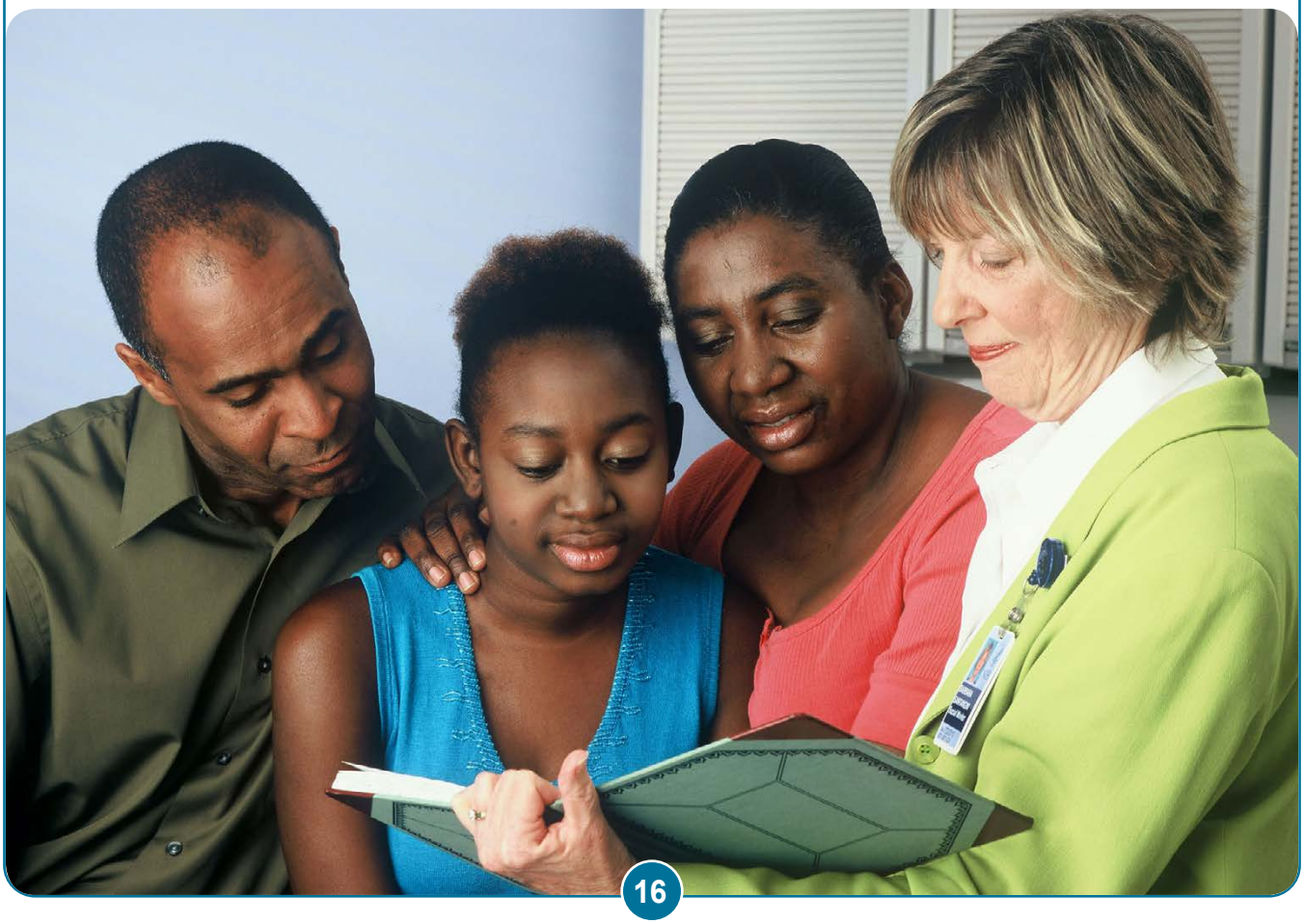
4. Parental responsibility and the 'mature minor'

4.4. Young adults (18 years and over)

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

At law, every young adult 18 years and over is presumed to be competent to make their own decisions (such as making health care decisions or authorising the release of their 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 their own health care decisions, an application may need to be made to the State Administrative Tribunal 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 State Administrative Tribunal is still necessary for sterilisation procedures.



Hypothetical case study 4:

Girl with intellectual impairment involved in a sexual relationship

Shauna, mother of 16 year old Mandi, rings you in your capacity of a community health nurse to talk about her concerns about her daughter. Shauna explains that Mandi has a mild intellectual impairment and is immature for her age. Lately, Mandi has been talking about her boyfriend Jez and Shauna is worried about sexualised behaviour she has observed.

You suggest that Mandi comes for an appointment at the health centre for an assessment. You explain the nature of a HEADSS assessment to Shauna, and the likely need to plan care and education for Mandi. Shauna agrees to you arranging an appointment with Mandi for the HEADSS assessment and Mandi agrees to come to an appointment. At the appointment you:

- Explain the limits of confidentiality in a way that Mandi understands.
- Conduct a HEADSS assessment in a way that is suitable for Mandy's cognitive development.
- Assess Mandy's capacity.
- Explore her understandings about sexual activity, protective behaviour and safe sex.
- Document your assessment and plan of action.

You find that Mandi has recently become sexually active with her boyfriend Jez. She is happy to have a boyfriend and says she likes having sex. Mandi does not appear to know very much about concepts in relation to conception, sexually transmitted infections or safe sex. You consider that Mandi lacks competence in this area and believe Mandi to be at risk of pregnancy and STIs. You judge that Shauna should remain informed and involved in Mandy's care.

- Discuss with Mandi your concerns for her and that you need to share some of the information you have talked about with her mum, preferably with her consent.
- Include Mandi in the phone call to her mother and encourage open communication between the two of them.
- Make a referral to the local medical clinic for STI and pregnancy tests.
- Arrange for another appointment to continue with support for Mandi.
- Offer Shauna further support for Mandi in relation to safe sex and protective behaviour. Provide information and useful resources for talking to Mandi about safe sex.
- Suggest that Shauna and perhaps a male member of the family talks to Jez about keeping Mandi safe.

If there is concern that Mandi has been coerced into sexual activity or has been the subject of sexual exploitation or sexual abuse, discuss with Shauna about making a report to the Police and discuss with line manager about making a mandatory report to the Department of Communities.

Hypothetical case study 5:

Young male who has left home and is 'couch surfing'

Seventeen year old Leo is referred to you in your capacity as a community health nurse, by a teacher because he often falls asleep in class and appears to be "not his usual self". You believe a HEADSS assessment would be helpful and discuss this with Leo. You also explain the limitations of confidentiality and seek Leo's permission to continue with the assessment.

During the assessment you find that Leo has left home after a fight with his step father. He says his mother is always drunk and that there are often fights at home. Leo says he has had enough and is not going back. Leo has been staying with friends, but only for two or three nights at each place because he doesn't feel welcome. Leo says "no one wants him around".

Throughout the assessment, you provide positive feedback about things that Leo is managing well in his life. Together you thoroughly explore the family and friends who Leo feels that he can trust.

Leo says that he has an aunty who lives nearby who he sometimes sees on the weekend and "might give a damn about him". You encourage him to contact his aunty to tell her about his new circumstances and seek her support.

Leo says that he wants to stay at this school and agrees to involve the year 11 coordinator, deputy principal and two of his teachers. Together, you prepare an email communication with relevant information. Leo agrees to return to the health centre in two days to talk about his options for finding a more permanent living arrangement.

During the assessment, Leo tells you that he has two younger siblings who live in his home and he sometimes worries about them when his mother has been drinking too much. If Leo is home, he helps the younger siblings with simple meals and to get ready for bed.

Later, you contact your line manager to discuss the duty of care for Leo's younger siblings who may be at risk, and what actions may be required.

When Leo returns you talk with him about options available through Centrelink, and help him to locate contact details and online information to start a Youth Allowance application. You also put him in touch with the local non-government agency which assists young people with accommodation and/or a social worker at Centrelink. You tell Leo that the school staff have responded to the email and are ready to provide support if he needs it.

You ask Leo if he would like regular support from within the school. He nominates you, so you offer Leo a weekly catch-up time. You continue to liaise with the year coordinator and deputy principal with Leo's consent.

Leo has expressed that he doesn't want to communicate with his mother, however you encourage and support Leo to contact his mother to let her know what is happening.

You document assessments, observations, summaries of discussions, and decisions after each interaction.

5. Consent to service provision

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

Health professionals working in public health services should be familiar with the ***WA Health Consent to Treatment Policy*** (under the Clinical Governance, Safety and Quality Policy Framework) regarding the requirements set out in that Policy.

Young adults 18 years and over 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* (WA) (GAAA) 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 minor seeks advice or treatment without the knowledge or consent of their parents. It may also arise that the minor disagrees with their parents' views about a proposed treatment.

This may arise in the case of minors 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 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. Individuals 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 their parents involved in the health care process, minors 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 individual's best interests.

Health professionals must make a judgement about an individual'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 their 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 the client expressly objects to the proposed treatment.

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. Consent to service provision

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. Consent must truly be that of the client who must not be coerced, pressured or forced into making the decision. The client's decision must not be unduly influenced by health professionals, friends or family.
- It must be current. Consent must be reviewed if, after consent was obtained, the client's circumstances (including treatment options and risks) have changed.

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, they must provide the client with sufficient information to enable them 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 they are 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 their 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, as relevant to the circumstances:

- 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'.
- Alternative options for investigation, diagnosis and treatment.
- The client's right to refuse or withdraw their consent at any time prior to the 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.

5. Consent to service provision

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.

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/health record. 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 may be 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.

Health professionals should not lightly decide to withhold information. The courts interpret therapeutic privilege very 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, it would be prudent for health professionals to seek legal advice before withholding information that is otherwise 'material'.

5.5. Who can give consent?

5.5.1. Minors (under 18 years)

The appropriate person to give consent to treatment of minors will ordinarily be the 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 minor can consent to treatment if they are assessed to have sufficient understanding and intelligence to enable them to understand fully what is proposed and the consequences of it. Health professionals must make a judgement about an individual'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 parent 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 4.2.

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

Any assessment of an individual as a 'mature minor' and that individual's consent to treatment should be clearly documented in the medical/health record.

Health professionals who are unsure about an individual's maturity or competence to give consent should not proceed with treatment on the basis of the individual'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 generally a competent minor can consent to treatment, they 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. An example includes procedures for the sterilisation of a child.

5.5.2. Young adults (18 years or over)

In general, young adults 18 years and over are presumed to be competent to give consent to treatment on their own behalf.

The 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

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.

In certain circumstances, a substitute decision maker known in the GAAA as a 'person responsible' can provide consent on the patient's behalf. The hierarchy of decision makers for treatment identifies the criteria and the order of priority for the 'person responsible' empowered to make treatment decisions for a patient (with the exception of sterilisation). See the *Consent to Treatment Policy* for further details.

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).
- The proposed treatment has significant risks.
- The person that would otherwise be authorised to consent to treatment 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.
- 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, 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 when consent is obtained, the duration of consent should be explicitly outlined. For example, when eliciting parental consent for school-based immunisation programs or school entry health assessments, it should be stated that the intervention or assessment may occur within a school term or school year. If the intervention or assessment is delayed beyond the date given, obtaining parent's consent should be repeated.

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.

5.8. Emergency treatment

In an emergency, urgent treatment may be required to save a person's life or to prevent serious injury to an individual's health. Consent should be sought if possible and in a way that meets the key principles of valid consent, with consideration of time pressures presented by the emergency situation.

In an emergency, where the individual is incapable of giving consent, then treatment may be provided without consent. For example, an auto adrenaline injector may be used without consent in a case of anaphylaxis or risk of anaphylaxis.

The treatment in these cases is that which is;

- reasonably required to meet the emergency
- in the patient's best interests
- the least restrictive of the patient's future choices.

The emergency exception (to the requirement to obtain consent prior to treatment) only applies where a person;

- is unable to give consent
- does not have an Advance Health Directive (AHD) or common law directive that is known, immediately available and applicable in the circumstances
- does not have a substitute decision maker (parents or guardian) who can be readily identified and immediately available to consider.

The circumstances constituting the emergency and the individual's lack of competency must be clearly documented in the client's medical/health record.

Please note this section does not address emergency psychiatric treatment.

5.9 Special circumstances for health assessment of a child without parent consent

Pursuant to section 337(1) of the *Health (Miscellaneous Provisions) Act 1911* (WA), the Chief Health Officer may authorise a medical practitioner or nurse to examine medically and physically any child attending a school and child care centre, and such child shall submit to, and the parents of guardians of such child shall permit such examination as the medical practitioner or nurse deems necessary.

Prior to relying on this provision to examine a child, community-based health professionals working in a health service provider should check whether an applicable authorisation is in place and whether it applies to them. It is recommended the community health nurse discuss the situation with the school principal or line manager (as appropriate) prior to conducting an assessment on this basis.

5. Consent to service provision

In instances where concerns about the health of a child have been identified by a community health or school or child care staff, and the parent's consent cannot be obtained through the usual means, special authorisation is made. In such cases, the community health nurse is to discuss the situation with the school principal or line manager prior to conducting an assessment.

Where parental engagement is an ongoing concern, thus preventing the child from receiving adequate care, contact with the Department for Communities, Child Protection and Family Support (Department of Communities) should be considered.

5.10. Refusal of treatment

5.10.1. Young adults (18 years and over)

In the event that a competent young adult 18 years or over 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 individual's health record.

5.10.2. Children (under 18 years)

Refusal of treatment by competent child

A minor who fully understands the nature and consequences of the proposed treatment is generally capable of giving valid consent and also of withholding consent.

Where a competent minor'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 their parents, or returns to discuss the treatment decision further.

Where a competent minor refuses consent for treatment that the health professional considers necessary and in the individual's best interest, the individual should be encouraged to discuss the matter with their parents and to involve them in the decision. If the individual refuses to involve their parents, and the health professional cannot persuade them to do so, possible responses to the situation may include:

- Suggesting that the individual return after giving further thought to the decision.
- The health professional suggesting that the minor seeks a second opinion from a professional whom they trust.
- The minor 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 individual 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 disclosing confidential information.
- Seeking legal advice.
- Making an application to the court for authorisation to proceed with the treatment, which should only be done after seeking legal advice.

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, in general, accept the decision as valid and would normally not be expected 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. Legal advice should be sought where such action is being contemplated.

5. Consent to service provision

5.11. 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 cutting/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.

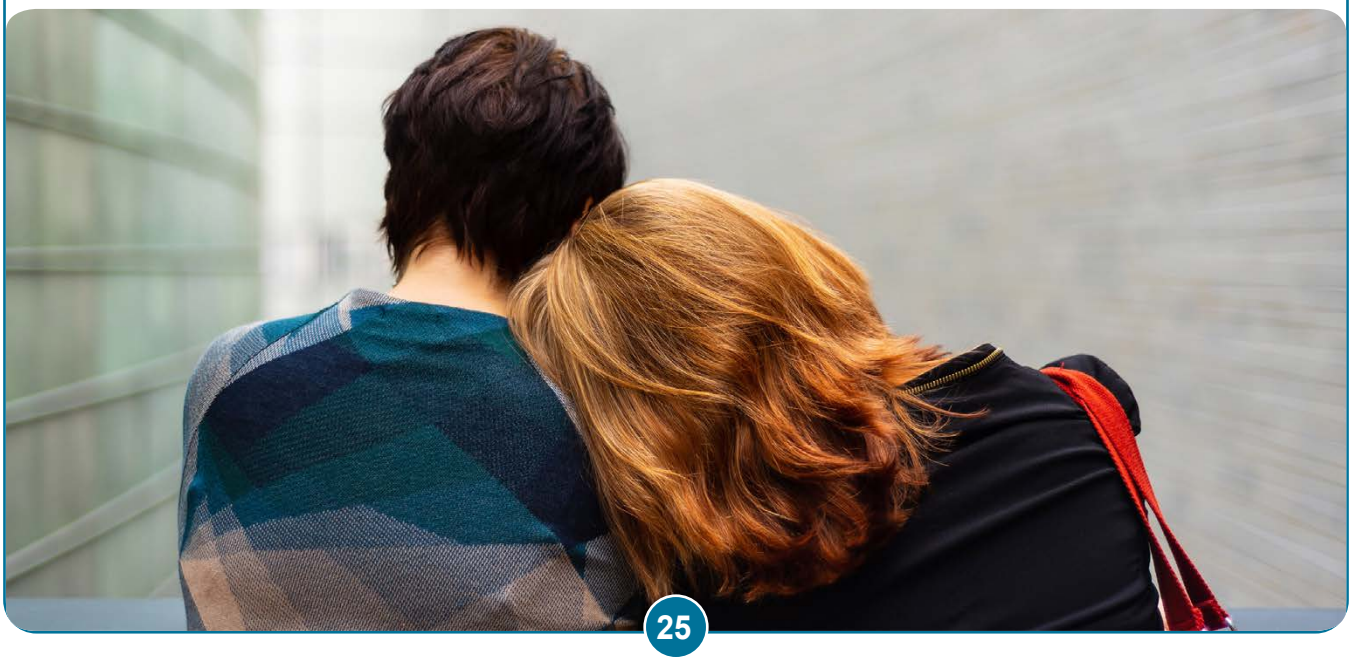
5.12. Conflict about consent between parents or between parent and minor

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 minor, with the former wanting the treatment to proceed and the latter objecting or vice versa. 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.

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 make a report to Department of Communities or seek legal advice regarding court authorisation for treatment of the child.

Some medical procedures on children can only be authorised by a court acting in its parens patriae jurisdiction. This requires the court to determine whether or not the proposed treatment is in the child's best interests.



Hypothetical case study 6:

Teen and parent disagree over HPV immunisation

You are a nurse conducting a school-based immunisation clinic at a rural secondary college, vaccinating students with Gardasil.

Marty, a 14 year old student presents for vaccination, but there is no record of parent consent. Marty insists that he wants to be given the vaccination, saying that his mother would not sign the consent form because she believes the vaccination is not necessary.

With Marty's consent, you ring the mother, who states that she does not want her son to be vaccinated. Marty continues to say that he wants to have the vaccination and it is his right to make the decision.

The health service policy states that only mature minors 16 years and over can provide their own consent for vaccinations. This policy position has been discussed with and is supported by the secondary college principal. Although you judge Marty to be a mature minor who fully understands the situation, you are unable to give him the vaccination at the school-based immunisation clinic because he is under 16 years.

You acknowledge Marty's maturity and initiative to manage his own health care. You explain the situation to him, including that you are unable to vaccinate him due to policy requirements. You explain to Marty that he can make an appointment with the local doctor to discuss obtaining the vaccination.

Hypothetical case study 7:

Young female visits the community health clinic (suspected STI)

Kiara, a 17 year old, visits a rural community health clinic with concerns about her sexual health. How could you proceed?

- Commence an assessment including a detailed assessment of Kiara's sexual activity and health history.
- Assess Kiara's maturity and competence to consent to health care.
- Provide information about safe sex and self-care.
- Document the process and factors relied upon in assessing Kiara's competence.

You find that Kiara is a mature young woman who has been engaging with consensual sex with her boyfriend. Kiara has symptoms which suggest a sexually transmitted infection (STI). What could you do?

- Consider local options for STI testing. Discuss a referral with Kiara.
- Explain to Kiara that her boyfriend should also get tested.
- Ask Kiara to return for an appointment next week to review her progress with the referral for testing, and continue with discussion about safe sex and self-care.

Kiara does not attend the follow-up appointment and it is suspected that she has not followed up with the referral. What could you consider?

- Attempt to contact Kiara again to follow-up on referral.
- Contact line manager to discuss circumstances and actions.
- Consider seeking advice if there is concern that Kiara's boyfriend's health is at risk.
- Consider contacting Kiara's parent or guardian if there are any concerns for her safety and wellbeing other than the suspected STI.

6. Client confidentiality and information sharing

Health professionals 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 owed by any person who comes into contact with a client's health information in the course of their work with a health service provider, including professionals performing non-clinical duties. 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 parent or legal guardian.

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

The health professional's duty of confidentiality arises under the common law. However, some legislative provisions have been enacted enforcing the duty of confidentiality by statute.

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 professional's employer or professional association.

Health professionals working in health service providers (or with contracted health entities providing services on behalf of health service providers) need to be familiar with the Department of Health ***Patient Confidentiality Policy.***

6.1. Sharing confidential information

There may be times when a child or adolescent'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 infectious diseases and notifiable infectious disease-related conditions pursuant to the *Public Health Act 2016 (WA)* and the mandatory reporting by doctors, nurses and midwives (and specified others) of child sexual abuse under the *Children and Community Services Act 2004* (WA) (CCS Act).

It is generally good practice to inform a child or adolescent 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 young person's consent. This might include situations when there is a risk of suicide, or sexual, physical or emotional abuse and serious risks to others.

If disclosure to another person is deemed necessary, it will generally be prudent to tell the young person and discuss the fact of the impending disclosure with them first.

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

- Where a competent client consents to the sharing of their confidential information.
- Where an incompetent client's parent or legal guardian consents to the sharing of that client's confidential information.
- Where a valid subpoena or summons is served on a health professional compelling them 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 infectious diseases pursuant to the *Public Health Act 2016 (WA)* and the mandatory reporting of child sexual abuse under the CCS Act.

- Where a statutory provision permits or provides protection from liability for the disclosure of confidential information. For example, section 129 of the CCS Act which provides protection from liability in relation to the reporting of child welfare concerns to the Department of Communities, Child Protection and Family Support (Department of Communities).
- 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 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.

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 professional does not contact their parents or give them information. A mature minor's demand that the health professional not divulge any information to their 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 professional), incompetent children may attract the legal right of confidentiality.

The most prudent course for health professionals 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 or there is another clear legal basis to disclose such information in the circumstances. If a health professional concludes that such a disclosure does need to be made, generally it is good practice to tell the child and discuss it with them first.

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

Access to health/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 health/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.

6.2.2. With other health professionals

Consent to share information may be implied, and not expressly given, when other health professionals within the health service have a legitimate therapeutic interest in the care of the client (i.e. where multiple health professionals 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 professionals 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 professionals 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.

A health professional must comply with any valid search warrant or compulsive notice in respect of confidential health/medical records. If there is a concern about the search warrant or other compulsive notice, it would be prudent to consider whether legal advice is warranted. 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 the same. Legal advice should be sought before relying on public interest as a basis for disclosure of confidential information. A public interest disclosure will only be justified in exceptional circumstances.

6.2.4. With other public authorities

Exchange of relevant information between the CEOs of prescribed authorities is supported in certain circumstances in the CCS Act to safeguard the wellbeing of children and adolescents. Prescribed authorities include health service providers established by an order made under the *Health Services Act 2016* (WA), section 32(1) as well as the Department of Education and the Police Force of Western Australia.

A Memorandum of Understanding between Department of Education; Child and Adolescent Health Service; and the WA Country Health Service for the provision of school health services for students attending public schools supports sharing limited, specific information between health service providers and school staff where the safety and wellbeing of a child or adolescent is considered to be at significant risk and such disclosure is permitted by law. Such circumstances may include when an individual is experiencing one or more of the following: non-suicidal self-harm, attempted suicide or suicide ideation, bullying, child abuse or neglect.

In the general provision of school health services, routine personal and health information about an individual remains confidential and is not shared with school staff.

6.2.5. Cultural considerations

The principles of confidentiality are the same for all children and adolescents, including those from Aboriginal communities and other culturally and linguistically diverse backgrounds.

Health professionals may need to make arrangements for an interpreter to be present to ensure that those who speak little or no English are able to understand the communication. In addition, health professionals may need to explain that certain legal obligations may override particular cultural practices.

6.2.6. Notifiable infectious diseases

Under the *Public Health Act 2016* (WA), medical and nurse practitioners are required to notify the Chief Health Officer of notifiable infectious diseases or notifiable infectious disease-related conditions. The general purpose of the statutory notification requirement is the control of infectious diseases.

In addition, the *Interagency Management of Children Under 14 Who are Diagnosed With a Sexually Transmitted Infection (STI) Policy* under the Public Health Policy Framework provides for the reporting by the Communicable Disease Control Directorate of particular notifications of sexually transmissible infections in children to the Department of Communities and the Western Australian Police pursuant to an interagency protocol. This is in addition to the mandatory reporting requirements of doctors, midwives and nurses (and specified others) in relation to child sexual abuse. For further information see 6.3.

6.3. Mandatory reporting of child sexual abuse

6.3.1. The duty to report

Under the CCS Act doctors, midwives, nurses, teachers, police officers and boarding supervisors are required to make a report if, on reasonable grounds, they form a belief, in the course of their paid or unpaid work, that a person under the age of 18 years:

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

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

- The child is the subject of bribery, coercion, a threat, exploitation or violence
- The child has less power than another person involved in the behaviour
- 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

Written mandatory reports of child sexual abuse

All mandatory reports **must** be made in writing to the Department of Communities Mandatory Reporting Service, preferably via its secure online portal, the Mandatory Reporting Web System (MRWeb). This site encrypts reports and is monitored 24 hours a day, 7 days a week. The ***mandatory reporting form*** is available on the Department of Communities website.

Mandatory reporters will be provided with a receipt number when submitting their report, which can be used as proof of the mandatory report made. Mandatory reporters should retain a copy of the receipt number for the organisation's records.

Verbal reporting and consultation

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 on 1800 708 704. On some occasions the Department of Communities will provide a verbal report with a receipt number which should be attached to the subsequent written report.

Failing to provide a written report after lodging a verbal report is an offence with a fine of up to $3000. The CCS Act requires that the written report be made as soon as practicable, and preferably within 24 hours of the verbal report.

Health professionals who require further information on mandatory reporting of child sexual abuse should contact the Statewide Protection of Children Coordination Unit on 6456 0030, spoccunit@health.wa.gov.au.

Hypothetical case study 8:

Adolescent experiencing non-suicidal self injury and does not want parents to know

You are a nurse working in a secondary school. While 17 year old Pia is attending an appointment to talk about asthma management, you notice scars and new wounds that appear to be self-inflicted. You decide to extend the appointment to commence a HEADSS assessment to explore concerns around the injuries and Pia's mental health. Pia agrees to the assessment, and understands the explanation about the limits of confidentiality. You are able to build rapport and trust with Pia to gain a comprehensive psychosocial assessment.

You judge that Pia is a competent minor. She appears to be depressed and has been self-harming for some months. You judge that she is not at risk of suicide, but her parents do not know about her injuries and she has not seen any other health professional about her issues. Pia says that she does not want to tell her parents because she thinks they have too many problems of their own. What could you do?

- Explain that you are concerned about Pia's health and safety, and remind her of the limits of confidentiality.
- Tell Pia that you will need to ring one of her parents to talk about your concerns and the need for medical assessment. Reassure Pia that you will not share all of the information she has shared, only that is relevant to the self-harm and depressed mood.
- Suggest ways that Pia can discuss the issues with her parents.
- Discuss the need to share certain information with the student service team and seek Pia's support for this.
- Invite Pia to make another appointment with you.
- Document your observations, decisions and actions.

Pia is adamant that she does not want her parents informed. What could you do?

- Explore Pia's reasons for not wanting to involve her parents. Help her to identify another family member or 'safe adult' who can provide support.
- Discuss a strategy for Pia to talk with her chosen 'safe adult'. Seek Pia's consent to contact this person. Negotiate a timeline so Pia has the opportunity to speak with her 'safe adult' first.
- Discuss with your line manager to plan a course of action.
- Ensure discussions and outcomes are clearly documented.

Hypothetical case study 9:

Girl asks about pregnancy testing

You work in a high school as a community health nurse where the school chaplain brings 13 year old Abbey to ask 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?

- Discuss confidentiality and the need to share certain information in some circumstances, preferably with Abbey's knowledge and consent.
- Conduct a HEADSS assessment with a focus on exploring Abbey's knowledge and behaviour in relation to sexual activity, relationships and safe sex.
- Assess Abbey's understanding of the situation and competence to make decisions about her health care.

You find that Abbey had consensual sex with a 14 year old male at a party a few weeks ago. They did not use contraception and it is possible that Abbey could be pregnant. What could the next steps involve?

- Provide appropriate health care information. Discuss how pregnancy testing works and how Abbey can access a kit.
- Discuss the law in relation to underage sex.
- Assess ongoing risk i.e. child protection or coercion, and notify the Department of Communities if required.
- Suggest that Abbey tell a parent or 'safe adult' about the suspected pregnancy. Offer to help her do this, to which Abbey agrees.
- Together you phone Abbey's mother from your office to discuss Abbey's situation and health care options. Offer ongoing support and further information in the coming days.
- Document your observations, decisions and actions.

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

A few days later Abbey's mother rings you to confirm that Abbey is pregnant and she wants to know about pregnancy termination. What could you consider?

- Explain in brief about the legal requirements concerning termination of pregnancy (e.g. to consult with a doctor, receive counselling and for a parent to be involved).
- Discuss options in the local area. Offer to contact the doctor to provide relevant information.
- Arrange for a follow-up appointment with Abbey to continue discussions about safe sex, self-care and other issues of relevance to Abbey.

Abbey and her mother make it very clear that they do not want anyone in the school community to know about Abbey's pregnancy or planned termination. Later, the school principal approaches you explaining he had heard that one of the students is pregnant and asks for more information. What is your responsibility in relation to providing information to the principal?

- Explain your duty of confidentiality to young clients and their parents, which sometimes involves explicit requests not to share any information with the school. Your explanation should be that the girl cannot be identified.
- Reassure the principal that appropriate information and support is provided to students, and also their families when it is appropriate.

7. Child abuse and family and domestic violence

Children and adolescents who experience abuse or neglect are highly vulnerable to a range of social and mental health problems. There are different contexts in which young people may be abused or neglected, given that adolescence is a time of significant transition and challenge. Some young people may experience physical, sexual, emotional or psychological abuse from their parents, family members or other adults. As they grow into adulthood, young people can also face 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) (CCS Act), the Department for Communities, Child Protection and Family Support (Department of Communities) in Western Australia has been given statutory powers to act where a child is in need of protection. The CCS Act enables the Department of Communities 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 CCS Act sets out a framework of possible action where it is identified that action should be taken to safeguard or promote the child's wellbeing.

A child will be in need of protection where:

- The child has been abandoned by their 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 or emotional abuse or neglect and the child's parents have not protected (or are unlikely or unable to protect) the child from further harm.
- 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 (and teachers, police officers and boarding supervisors) who on reasonable grounds form a belief of child abuse must report to the Department of Communities, 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 respond to concerns of all forms of child abuse, and no breach of confidentiality will arise where a health professional voluntarily and in good faith reports an allegation, suspicion or concern of child abuse or neglect to the Department of Communities.

If a health professional determines there is an immediate threat to a child or any other person, they should urgently consult with a line manager, Department of Communities or the WA Police. If it is considered an emergency, proceed to making contact with Police emergency (000) or Crisis Care, Department of Communities (phone 1800 199 008).

In less urgent circumstances, a health professional should consult with their line manager or other designated (health service provider) 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 the Department of Communities. The Child Protection Unit at Perth Children's Hospital (phone 6456 4300) is available for consultation.

7. Child abuse and family and domestic violence

Any decision to report a child to the Department of Communities should be well documented including the reasoning that led to the decision to make a report. Any request by the Department of Communities for health/medical records or the preparation of reports or witness statements should be made, in the absence of client consent, under authority of section 23 of the CCS Act.

7.3. Confidentiality of notifier's identity

Subject to certain exceptions, the CCS Act protects the identity of any person who in good faith notifies the Department of Communities of their suspicions or concerns of child abuse or neglect (see section 240 of the CCS Act).

7.4. Department of Communities access to a child at hospital, school or child care service

An authorised officer of the Department of Communities 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, if notifying the child's parents in advance would likely jeopardise the investigation. The authorised officer must notify the person in charge of the hospital, school or child care service before exercising this power.

Note: An 'authorised officer' is a specific statutory office under the CCS Act. Authorised officers have a number of statutory powers not available to other Department of Communities officers, including the power described above. When appointed, authorised officers are issued with identity cards. Health professionals should ask to see the identity card of any Department of Communities officer purporting to be an 'authorised officer' or otherwise attempting to exercise a power given to authorised officers under the CCS Act. Health professionals should check the identity card to verify the person's identity, status as an authorised officer and powers.

A notation confirming that such checks have been carried out should also be made in the client's health/medical record.

7.5. Sharing confidential client information with Department of Communities

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

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

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

7.6. Family and domestic violence

Family and domestic violence, known in some context as 'intimate partner abuse', can include physical or sexual assault, psychological abuse, emotional, spiritual or cultural abuse, social isolation and neglect. It may occur in heterosexual, same sex or other sexual relationships.

7.6.1. For young adults 18 years and older

There is no mandatory reporting obligation for domestic violence between intimate partners. In order to report domestic violence to police without breaching patient confidentiality obligations, health professionals should ensure that an exception to the duty of confidentiality applies. Exceptions to the duty of confidentiality include where:

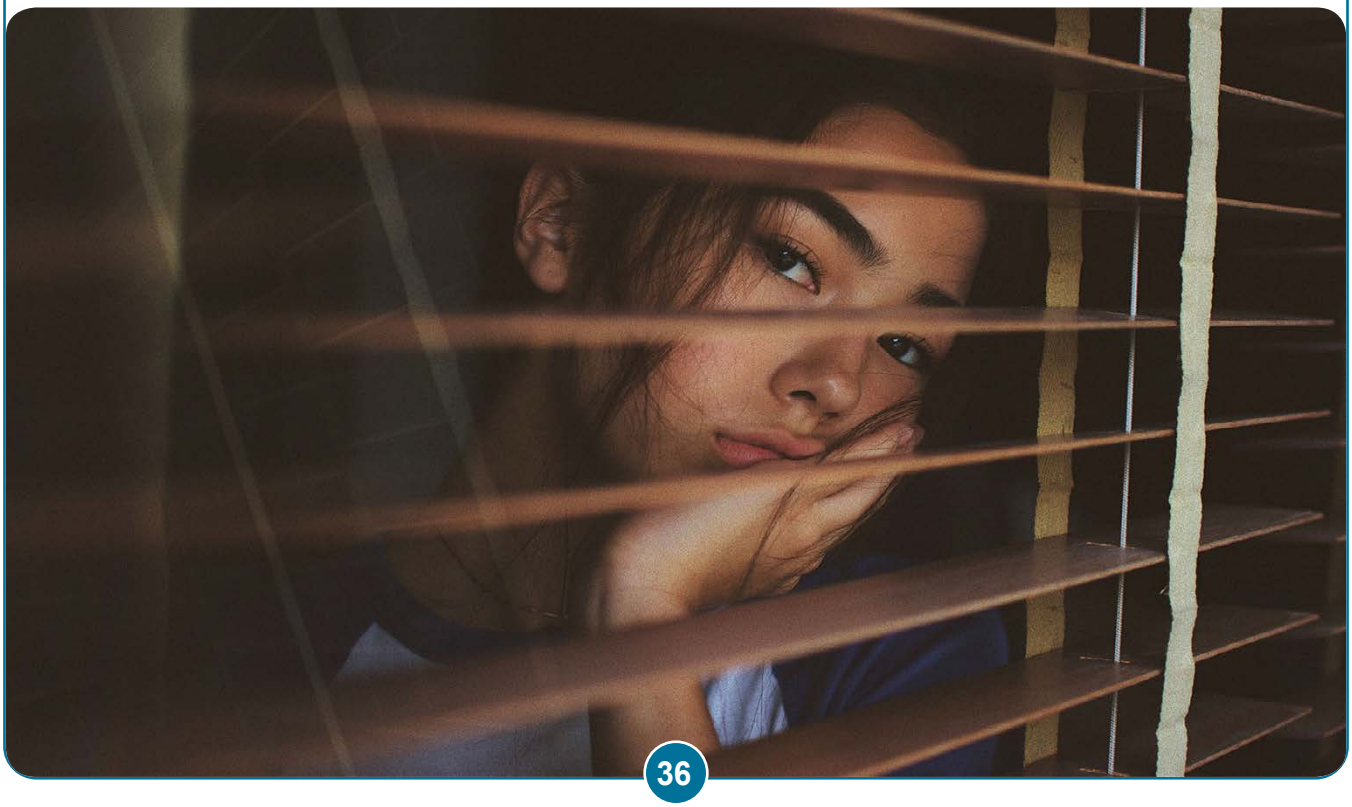
- the patient (or a person authorised to make decisions on their behalf) has given their consent to the proposed disclosure
- the law requires disclosure
- the law permits disclosure
- there is an overriding 'public interest' which justifies disclosure to an appropriate person or authority.

The *Patient Confidentiality Policy* (see the Policy Frameworks) has further information. It may be prudent to seek legal advice in appropriate cases.

7.6.2. For minors under the age of 18 years

In the case of a minor under the age of 18 years who is a dependent living in a household with domestic violence, the minor should be considered as a child at risk of emotional abuse or other abuse (see sections 7.1 and 7.2).

In the case of a minor involved in domestic violence as an intimate partner, the same applies as described in 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 Department of Communities relating to the mandatory reporting obligations in the CCS Act. See 6.3 for further information. Health professionals with concerns about the minor's wellbeing should also consider the option of making a report.



Hypothetical case study 10:

Physical assault of a young adolescent by a family member

At an immunisation clinic in a rural district high school, one of the nurses notices that 12 year old Zac has a split eye brow, and asked how it happened. Zac doesn't hesitate to disclose that his uncle hit him, and it is not the first time.

While he is sitting in the post-vaccination recovery area, the nurse talks to Zac and says that he would like to check the wound. The nurse visits the school regularly and is authorised under the applicable Examination of School Children Authorisation (made by the Chief Health Officer under the *Health (Miscellaneous Provisions) Act* 1911 (WA)). He proceeds with an examination of Zac in another room to ensure Zac's privacy, after informing the school principal.

The nurse examines the wound, asking if there are any other wounds or bruises. The nurse explains that he would like to ask Zac a few questions about his life and how he is going generally, and also about the incident when his uncle hurt him. Zac agrees that he would like to talk about things. He understands the explanation about the limits of confidentiality and that some of what he says might be shared with people who can help to stop his uncle hurting him. Zac says that his mum is worried about what happened but doesn't know what to do.

The nurse conducts a HEADSS assessment with a focus on Zac's home situation and safety risks. Later, the nurse documents the consultation and informs his line manager, who supports making a report to Department of Communities and to communicate with Zac's mother and the school principal.

The nurse makes a follow-up appointment with Zac and helps him to make a simple safety plan. He also advocates for the school to start an education program on protective behaviour and respectful relationships.

Hypothetical case study 11:

Young woman experiencing intimate partner violence

Sixteen year old Jilly presents to the health centre, looking very tired and upset, to see you in your capacity as community health nurse. You notice that she has large bruises on each of her forearms. When you ask Jilly about the bruises she starts to cry, but won't talk. What actions could you consider?

- Explain that she has a right to be safe and if anyone is harming her, then we can work together to get some help.
- Discuss the limits of confidentiality.
- Ask Jilly if she needs help with any other wounds.
- Ask about parent or family support available to Jilly, and assess her maturity and competence to make decisions about her health care.
- Check that Jilly is safe to go home.
- Provide Jilly with the phone number of a local domestic violence support service.
- Let Jilly know when you will be at the health centre, and encourage her to come back.
- Assess ongoing risk and contact the Department of Communities if necessary.
- Document observations, decisions and actions.

Jilly returns to the health centre three days later. You acknowledge her courage to come back, and commence a HEADSS assessment with a focus on Jilly's home and living situation, home background and relationships with supportive family and friends. Jilly tells you that she has recently moved in with her boyfriend (18 year old), and when you ask her how that is going, she starts to cry, disclosing that he has been hitting her. Jilly shows you bruising on her abdomen. She says that most of the time her boyfriend is kind, but when he drinks alcohol he can get very angry. Jilly says that she is happy to go home today but is worried about next week when she knows her boyfriend will be going out drinking with his brother. What could you consider in this situation?

- Prioritise and arrange for Jilly to stay for a longer appointment.
- Explain to Jilly that if anyone causes physical harm to another person, it is not acceptable and is illegal.
- Reassure Jilly that help is available. Provide the contact details for a local support service. Offer to ring and make an appointment with Jilly joining in to the phone call.
- Work together on a simple safety plan for Jilly. Help Jilly to involve a supportive family member in the safety plan.
- Arrange a follow-up appointment.
- Discuss with your line manager to plan further action and to consider referral to services, and whether a notification to Department of Communities should be made.
- Document observations, decisions and actions.

Follow-up with Jilly to check on her wellbeing, and to discuss respectful, safe relationships. Offer brief interventions to develop self-esteem and personal risk assessment. Support Jilly to explore and consider alternative living arrangements.

If she does not attend her follow-up appointment or her appointment with the local support service and/or there are indications that Jilly has been harmed again, discuss the case with your line manager to consider informing Jilly's mother or the police or taking other action appropriate in the circumstances.

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. 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 generally 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 the 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 are not 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.

However, please ensure the records are made and kept in accordance with any applicable legal and policy obligations.

8. Medical record-keeping and accessing medical records

8.2. Retention and disposal of records

Under the *State Records Act 2000* (WA), 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 health service providers.

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

It is expected that public health service staff in health service providers will familiarise themselves with the Schedule and, in particular, the minimum retention and disposal standards applicable in their field of operation. Please note that on 5 April 2018, the then State Archivist and Executive Director State Records issued a freeze on disposal of government records relating to children.

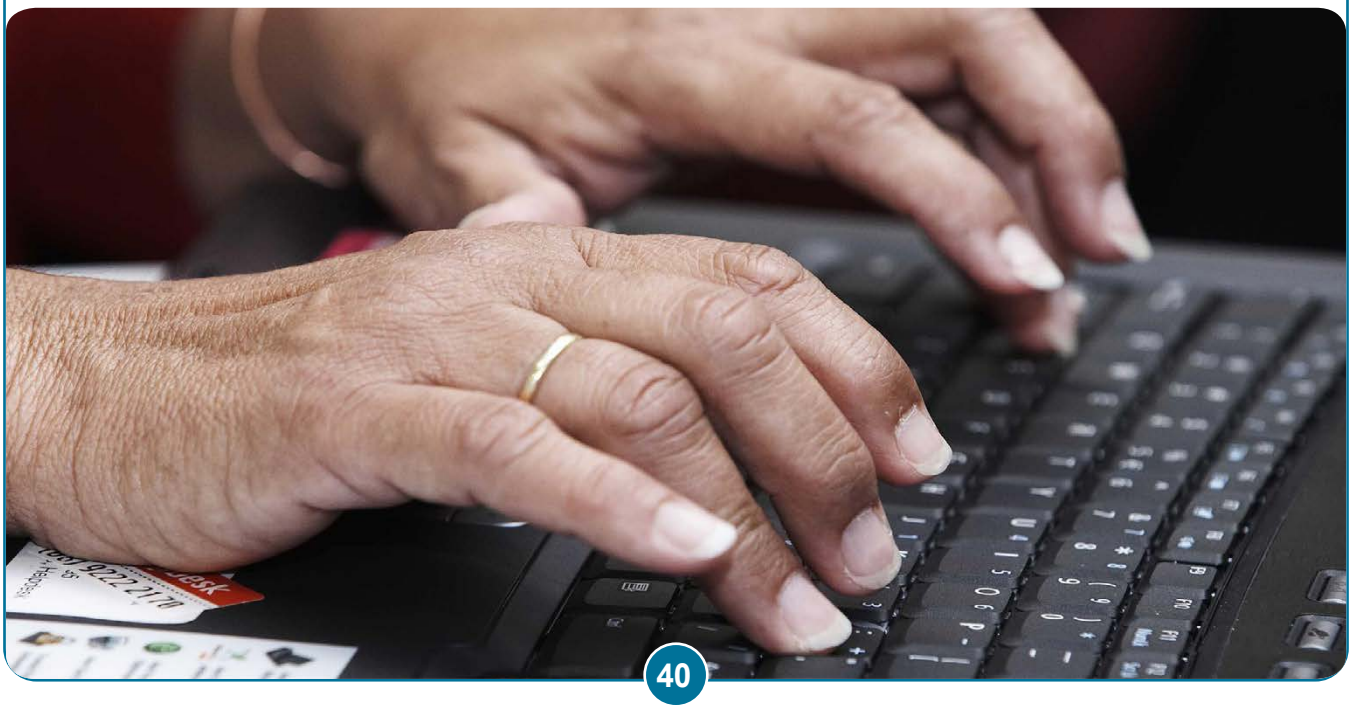
8.3. Freedom of information

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 that 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 in those circumstances.

8.4. Electronic records

Client information stored electronically by health services and their staff is considered to constitute 'records' for the purpose of the *State Records Act 2000* (WA). As such, electronic records are required to be retained and disposed of in accordance with the applicable record keeping plan approved by the State Records Commission.



9. Sexual health

9.1. Age of consent and underage sex

In Western Australia, a child under the age of 13 years is incapable of consenting to sex. It is unlawful for a person of any age to engage in sex with a minor under the age of 16 years. However, it is a defence to sexual offences against a child of or over 13 and under 16 years that:

- the offender believed on reasonable grounds the child was of or over the age of 16 years
- the offender was not more than 3 years older than the child.

Once a minor turns 16 years of age, they 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 professional, 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 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 professionals 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 professional should respond in accordance with the Department of Health's ***Guidelines for Protecting Children.***

Under the *Children and Community Services Act* (WA) (CCS Act), if a medical practitioner, midwife or nurse (and specified others) 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 Department for Communities, Child Protection and Family Support (Department of Communities). 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 an incapable person. An incapable person is a reference to a person who is so mentally impaired as to be 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.
- Guarding themselves 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 incapable person.

9. Sexual Health

9.3. Sexuality

There are legislative protections against unlawful discrimination on the basis of sexual orientation and gender identification in certain areas of public life, including the provision of health services.

When working with children and adolescents who are same sex attracted or who identify as gay, lesbian or bisexual, or who are transgender or intersex, it is important to ensure the individuals feel comfortable accessing services. This includes use of respectful, non-judgemental and inclusive language such as the use of appropriate pronouns and gender neutral expression. Health professionals should reassure individuals about issues of confidentiality, 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 adolescents who identify as same sex attracted or transgender. Research highlights that individuals of diverse sexuality and gender 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 professionals assume that everyone is heterosexual.

9.4. Transgender and gender transitioning

The term 'transgender' describes people who do not identify (in part or exclusively) with the gender they were assigned at birth based on their sexual anatomy. The *Sex Discrimination Act 1984 (Cth)* makes it unlawful to treat a person less favourably than another person in a similar situation because of the gender identity of the person. The *Sex Discrimination Act 1984 (Cth)* makes discrimination against the law in many areas of public life including employment, education and in relation to the provision of goods, services and facilities, for example renting or buying a house or unit. There are some limited exemptions. The *Equal Opportunity Act 1984* (WA) makes discrimination on the basis of gender history unlawful in certain areas of public life with limited exceptions.

Gender transitioning refers to steps undertaken by an individual to become socially or physically more aligned with their gender identity. Social transitioning may involve a change of name, requesting others to use preferred pronouns, or asking to participate in gendered activities, sports or facilities.

Physical transitioning involves a person altering the way they look to express their preferred gender, for example, by choice of clothing and hair style. Some transgender people seek hormone or surgical treatment to alter their appearance. Whether an application to court is required prior to a child having medical or surgical treatment for the purpose of transitioning will depend on the circumstances of the case.

Individuals who have undergone a gender reassignment procedure may apply for a recognition certificate and be legally recognised as belonging to their new gender, by application to the Gender Reassignment Board of WA.

9. Sexual Health

9.5. 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 individual 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 certain forms of treatment to which, neither a 'mature minor' nor their parent, can give valid consent and where prior court approval must be obtained. An example is the sterilisation of a minor.

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. Sexual Health

9.6. WA Abortion legislation changed on 27 March 2024. See Abortion (health.wa.gov.au)
THE INFORMATION BELOW IS NOT CURRENT and will soon be updated.

9.6. 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 severe 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 than 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 young 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.

9.7. Sexually transmissible infections (STIs)

Under the *Public Health Act 2016* (WA), if a medical practitioner or nurse practitioner forms the opinion that a patient of the practitioner has, or may have, a notifiable infectious disease or notifiable infectious disease-related condition, the practitioner must notify the Chief Health Officer. The general purpose of the statutory notification requirement is the control of infectious diseases.

The Western Australian Department of Health has Infectious and Related Diseases Notification Forms. 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 Public Health Unit (for residents in country areas) as soon as practicable, and in any event within 72 hours (or 24 hours in the case of an urgently notifiable infectious disease or an urgently notifiable disease-related condition).

9. Sexual Health

Sexually transmissible infections required to be notified to the Chief Health Officer include chancroid (soft sore), chlamydia (genital infection), donovanosis (granuloma inguinale), gonococcal infection, syphilis and HIV infection.

For more information on statutory notifiable diseases, together with relevant forms, visit the Department of Health's ***Infectious diseases webpage.***

Under the Public Health Policy Framework, there is an Operational Directive titled 'Interagency Management of Children Under 14 years who are diagnosed with a Sexually Transmitted Infection (STI)'. This Operational Directive sets out processes to be followed in reporting a confirmed sexually transmitted infection in a child under 14 years.

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

Where a nurse, midwife or medical practitioner tests or treats a child with an STI and the health practitioner forms a belief, on reasonable grounds, that the child is or has been the subject of sexual abuse, the practitioner must make a mandatory report of child sexual abuse to the Department of Communities as stipulated in the CCS Act. See section 6.2.6 and 6.3 for details.

9.8. Testing for HIV

Administration of a test for human immunodeficiency virus (HIV) is considered to be medical treatment or other health care intervention, and the same requirements for informed consent generally apply. Refer to section 5 for more information. In certain situations test orders for compulsory testing may be made under the *Public Health Act 2016* (WA).

9.9. Female genital cutting/mutilation

In Western Australia, it is unlawful for a person to perform female genital cutting/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 cutting/mutilation overseas.

'Female genital cutting/mutilation' 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 cutting/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 professionals 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. It is important to refrain from using the word 'mutilation', as this terminology is offensive to many.

Female genital cutting/mutilation is considered physical abuse, and therefore if it is identified in a child or adolescent under the age of 18 years, a notification to the Department of Communities should be made. A referral to paediatric gynaecological services or uro-gynaecology for any ongoing medical treatment/management should be arranged.

If there are concerns a child is at risk of being subjected to female genital cutting/mutilation contact should be made and a referral submitted as soon as possible to the Department of Communities Crisis Care or district office.

9. Sexual Health

9.10. Sexual assault

Sexual assault describes a broad range of sexual crimes committed against a person.

Health professionals who become aware that a child or adolescent 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.

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

Client consent should generally be obtained prior to reporting a crime disclosed in confidence, to a third party such as a parent or the police. In Western Australia, it is generally not required to report a crime to the police or other authorities, however there are provisions in the CCS Act requiring the mandatory reporting of child sexual abuse. Health professionals need to be mindful of their obligations of confidentiality before disclosing any information about clients who are victims of crimes.

In certain circumstances however, disclosure of confidential information to third parties (e.g. the police) may be warranted in the absence of client consent. For example, in certain circumstances, confidential information may be disclosed pursuant to regulation 5(1)(a) of the *Health Services (Information) Regulations 2017* (WA) that provides that the disclosure is authorised where it is reasonably necessary to lessen or prevent a serious risk to the life, health or safety of any individual. It may be prudent to seek legal advice if you are unsure about the legal position in a particular case.

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 professional should consider whether it is appropriate to notify the Department of Communities.

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 relating to the CCS Act. 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 the Department of Communities.

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

Hypothetical case study 12:

Young teen requests access to contraception

After a classroom lesson on safe sex and contraception, 14 year old Jules drops into the health centre to ask how she can get the contraceptive pill. What steps should you take, as a community health nurse working in a school, to ensure you provide quality health care and meet any legal obligations?

- Acknowledge Jules' initiative to visit the health centre and take care of her health.
- Discuss confidentiality and the need to share certain information in some circumstances.
- Conduct a HEADSS assessment with a focus on sexual activity and relationships.
- Discuss the law in relation to underage sex.

You find that Jules has a 15 year old boyfriend and they have started having regular sexual relations. You notice that Jules has a good understanding of issues and judge her to be a mature minor. What could you consider in these circumstances?

- Provide appropriate health information, including information about safe sex and contraception.
- Suggest Jules discusses her health care with her parents and provide her with strategies to do this.
- Make a referral to a medical service or agency. Talk to Jules about what she should expect at the consultation.
- Offer another appointment for follow-up.

If you had judged Jules to be at risk because of her immaturity or other circumstances, what should you consider?

- Assess the risk of child sexual abuse or coercion.
- Talk with Jules about making contact with her parents in relation to safety concerns you have for her. Make contact with parent/guardian and involve Jules if possible.
- Provide appropriate health care, including discussion about protective behaviours, safe sex and self-care. Encourage Jules to be assertive and avoid situations which put her at risk.
- Arrange another appointment to monitor and review.
- Discuss case with line manager and consider a report to Department of Communities.

Hypothetical case study 13:

Young adolescent who is gender questioning

Thirteen year old Matilda (Matty) drops in to the school health centre saying she wants to talk to you about something private. You check that there are no immediate safety or wellbeing concerns, and make an appointment to see her in the next week.

When she returns for the appointment Matty is clearly upset and nervous. She says "I feel like a boy" and "I want to be a boy". What could you consider?

- Reassure Matty that you are here to help and other people can help too.
- Assess Matty's maturity and capacity.
- Discuss the limits of confidentiality.
- Seek Matty's consent to ask questions about her life to get to know Matty better.
- Commence a HEADSS assessment to explore Matty's life supports, strengths and protective factors, and risks to health and wellbeing.
- Ask what pronoun Matty would like to be referred (he/she/they).
- Provide Matty with information that is developmentally appropriate.
- Ask Matty to return to continue with the comprehensive assessment and health counselling. Refer to the school psychologist if this is outside your scope of practice.

You find that Matty is clear about wanting to be known as a boy in the new school community. Matty has already told Matty's parents about wanting to be a boy. Matty wants to be called 'Matt', be thought of as a boy and wants to wear the boy's uniform at school.

- Discuss with Matt the importance of engaging with Matt's parents about this issue.
- Offer to ring Matt's parents, describing the information that could be discussed with them.
- If Matt has consented, contact the parents to sensitively discuss Matt's wishes. Assess their support and if appropriate, seek their consent for sharing specific information with the student service team.
- Discuss a referral to a doctor with Matt and parents. Suggest an appropriate online resource for the parents.
- If Matt's parents provide consent, present the case to the student service team meeting to initiate a school response, acknowledging that processes will need to comply with any Department of Education policies on the issue.
- If there are any mental health and wellbeing concerns for Matt, inform the student service team of those concerns. Take care to only share information that is relevant and respectful of the consent provided by both Matt and parents.
- Offer regular appointments with Matt to monitor wellbeing.
- Ensure all discussion, assessment and decisions are clearly documented.
- Suggest that the school gives consideration to staff and students education on transgender issues.

A few weeks later Matt asks about gender transition treatment. How could you respond?

- Explain the processes and the law in relation to medical treatment for physical gender transition.
- Inform about Perth Children's Hospital Gender Diversity Service and suggest that Matt discusses this with Matt's parents and doctor.

10. Mental Health

In most instances, minors and adults access care, including treatment for a mental illness as they would for any health issue. When working with minors or adults with mental health issues, the legal principles outlined in early sections of this document are usually applicable. However, in some cases, the *Mental Health Act 2014* (WA) (MH Act) may be applicable. Please see also the *WA Health Consent to Treatment Policy* regarding consent to treatment for individuals with a mental illness.

10.1. *Mental Health Act 2014* (WA)

The MH Act addresses the treatment, care, support and protection of people who have a mental illness (amongst other matters). The objectives of the MH Act are to:

- Ensure that persons with a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity.
- Ensure the proper protection of patients as well as the public.
- Recognise the role of families and carers in the support and treatment of patients.
- Minimise the adverse effects of mental illness of family life.

The Charter of Mental Health Care Principles is central to the MH Act, guiding all service providers and agencies to ensure the rights of people experiencing mental illness, families and carers are maintained. A mental health service must make every effort to comply with the Charter of Mental Health Care Principles when providing treatment, care and support to patients. The fifteen principles are, in brief, that a mental health service must;

- Treat people experiencing mental illness with dignity, equality, courtesy and compassion and must not discriminate or stigmatise them.
- Protect and uphold the fundamental human rights of people experiencing mental illness.
- Uphold a person-centred focus with a view to obtaining the best possible outcomes for people experiencing mental illness.
- Be easily accessible and safe and provide people experiencing mental illness with timely treatment, care and support.
- Involve people in decision-making and encourage self-determination.
- Recognise, and be sensitive and responsive to, diverse individual circumstances.
- Provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices.
- Address physical, medical and other co-occurring health issues of people experiencing mental illness.
- Recognise a range of circumstances that influence mental health and wellbeing.
- Respect and maintain privacy and confidentiality.
- Acknowledge the responsibilities and commitments of people experiencing mental illness, particularly the needs of their children and other dependants.
- Provide and clearly explain information about mental health and treatments to people experiencing mental illness.
- Provide and clearly explain information about legal rights to people experiencing mental illness.
- Take a collaborative approach to decision making.
- Be accountable, committed to continuous improvement and open to solving problems in partnership with all people involved in the treatment, care and support of people experiencing mental illness, including their family members, carers and other personal and professional support persons.

10. Mental Health

10.2. Capacity

Under the MH Act patients will have capacity to give consent if, after being provided with relevant information, they are able to:

- understand the proposed treatment including alternative treatments and inherent risks
- understand the information involved in making the treatment decision
- understand the effect of the treatment decision
- weigh up the above factors for the purpose of making the treatment decision
- communicate the treatment decision in some way.

Under the MH Act, a child is presumed not to have the capacity to make decisions unless they have demonstrated otherwise. If a child does not have the capacity to make a decision about a matter relating to themselves, the child's parent or guardian may make the decision on the child's behalf. In performing a function under the MH Act in relation to a child, a person or body must have regard to which is in the best interests of the child as a primary consideration.

10.3. Voluntary patients

A voluntary patient is a person to whom treatment is being, or is proposed to be, provided by a mental health service but who is not –

(a) an involuntary patient

(b) a mentally impaired accused required under the *Criminal Law (Mentally Impaired Accused) Act 1996* to be detained at an authorised hospital.

Voluntary patients cannot be provided with treatment without informed consent being given to the provision of treatment.

10.4. Involuntary patients

An involuntary patient is a patient under an involuntary treatment order. Only a psychiatrist can make an involuntary treatment order. An involuntary treatment order is either:

- an inpatient treatment order
- a community treatment order.

A medical practitioner or authorised mental health practitioner can refer an individual to a psychiatrist for examination if the practitioner reasonably suspects:

- the person is in need of an involuntary treatment order
- if the person is under a community treatment order – the person is in need of an inpatient treatment order.

The referral must be in accordance with the MH Act requirements. A Form 1A is required. The MH Act also provides for the making of an order for a person's detention and transport orders in particular circumstances.

Once a person referred has been received at the place of examination, the patient can be detained there, to enable the examination to be conducted, for up to 24 hours from the time when the person is received.

On completing the examination, the psychiatrist must make one of these orders:

- an inpatient treatment order
- a community treatment order
- an order authorising the person's reception at an authorised hospital, and the person's detention there, to enable an examination to be conducted by a psychiatrist.
- an order that the person cannot continue to be detained.

If the individual becomes the subject of an inpatient treatment order, the order can be made for no more than 21 days, and no more than 14 days in the case of children.

An involuntary patient can be provided with treatment without informed consent being given prior to the treatment (with certain exceptions).
A person of any age can experience mental illness that creates risk, and a person of any age can be placed on an involuntary treatment order.

10.5. Community treatment orders

A community treatment order is an order in force under the MH Act under which a person can be provided with treatment in the community without informed consent being given to the provision of the treatment. Community treatment orders under the MH Act relate to treatment for involuntary patients in the community.

Community treatment orders allow individuals to continue living in their home or in a hostel, while abiding by the treatment prescribed by the supervising psychiatrist. This usually involves at least monthly, mandatory examinations by the supervising psychiatrist or another practitioner, and compliance to the treatment order.

Community treatment orders continue for up to three months, and may be continued if required. There is a defined process for patients who do not comply with their community treatment order.

10.6. Personal support person

A personal support person is entitled to be involved in the treatment and care of the patients (with some exceptions). This may involve considering options for treatment and care, providing support for the patients, and by being involved in treatment, support and discharge plans.

A voluntary patient can decide whether or not to have a personal support person involved or informed. However, if the voluntary patient is not well enough to be able to make this decision, the personal support person will be informed/involved unless this is not in the patient's best interests.

In addition, the MH Act provides that certain matters are a 'notifiable event' and any carer, close family member or other personal support person of a person is entitled to be notified on their occurrence (with exceptions).

Provision of treatment to a patient of Aboriginal or Torres Strait Islander descent

To the extent that it is practicable and appropriate to do so, treatment provided to a patient who is of Aboriginal or Torres Strait Islander descent must be made in collaboration with Aboriginal or Torres Strait Islander mental health workers and significant members of the person's community, including traditional elders and traditional healers.

Mental Health Advocacy Service

The statutory office of the Chief Mental Health Advocate is created by part 20 of the MH Act. The Mental Health Advocacy Service (MHAS) is created by the Chief Mental Health Advocate and is an independent body providing mental health advocacy services, and rights protection functions, to 'identified persons'.

Under the MH Act, mental health advocates can assist 'identified persons', which include;

- an involuntary patient
- someone who has been referred for examination by a psychiatrist
- a voluntary patient in hospital being detained for assessment
- a mentally impaired accused person under the *Criminal Law (Mentally Impaired Accused) Act* 1996 and are detained in an authorised hospital or living in the community
- a resident of a private psychiatric hostel.

A mental health advocate is required to contact or visit involuntary patients within 7 days of being made involuntary (and children under 18 within 24 hours).

10.7. Mental Health Tribunal

Under the MH Act a Mental Health Tribunal was established. The Tribunal reviews involuntary treatment orders. The reviews are conducted initially and periodically afterwards for every person placed on an involuntary treatment order. Participants in the hearing may include:

- the patient
- the patient's carer, close family member or other personal supporter
- someone chosen by the patient to attend
- the patient's representative (e.g. a legal practitioner or mental health advocate)
- the treating team.

10.8. Emergency psychiatric treatment

Emergency psychiatric treatment is treatment that needs to be provided to save a person's life, or to prevent a person from causing serious physical harm to themselves or another person.

Emergency psychiatric treatment can be given to a client with a mental illness, whether a voluntary or involuntary patient, and may be with or without consent. Consent for treatment 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.

10.9. Electroconvulsive therapy

Electroconvulsive therapy is treatment involving the application of electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent. Electroconvulsive therapy can be used to treat people with severe depression, bipolar disorder and some psychiatric illnesses. This treatment cannot be used for children under the age of 14 years. In order for this treatment to be provided in other cases, the applicable requirements set out in the MH Act must be complied with.

10.10. Seclusion and restraint

Seclusion is the confinement of a person who is being provided with treatment or care at an authorised hospital by leaving the person at any time of the day or night alone in a room or area from which it is not within the person's control to leave. A person is not secluded merely because the person is alone in a room or area that the person is unable to leave because of frailty, illness or mental or physical disability.

Bodily restraint is the physical or mechanical restraint of a person who is being provided with treatment or care at an authorised hospital.

A person of any age may be the subject of seclusion or restraint. However, there are strict criteria regarding when seclusion and restraint may be used under the MH Act as well as considerable regulation as to its use. Seclusion or restraint may be used in certain circumstances to stop the patient physically injuring themselves or another person; or persistently causing serious damage to property. Seclusion or restraint should only be used when there is no less restrictive alternative in the circumstances.

There are time limits set out in the MH Act in relation to seclusion and restraint. Only a psychiatrist, medical practitioner or mental health practitioners can authorise seclusion or restraint.

10.11. Police powers

In the community, it is often the police who have initial contact with individuals who have a mental illness and whose behaviour is putting themselves or others at risk. The MH Act 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 any individual they suspect has a mental illness and because of that mental illness, needs to be apprehended to protect the health and safety of that person or another person, or to prevent serious damage to property.

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 authorised mental health practitioner, for the purpose of deciding whether or next to refer the person for an examination to be conducted by a psychiatrist.

Police also have a role in transporting patients.

11. Drugs and poisons

11.1. Schedule of drugs and poisons

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

11.1.1. *Therapeutic Goods Act 1989* (Commonwealth)

The Commonwealth *Therapeutic Goods Act 1989 (Cth)* (TG Act) provides a national framework for the regulation of therapeutic goods, 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 TG Act 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 TG 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 TG Act, together with its supporting regulations and legislative instruments, set out the requirements for inclusion of therapeutic goods on the ARTG.

Medicines assessed by the TGA as having a lower risk (i.e. consumer medicines purchased over the counter such as complementary medicines including vitamins and herbal medicines) receive a lesser degree of initial assessment, than higher risk medicines. However, these products are still generally listed on the ARTG provided certain conditions are met.

For more information visit the Commonwealth Department of Health's ***TGA website***.

11.1.2. *Medicines and Poisons Act 2014* (WA)

In Western Australia, the *Medicines and Poisons Act 2014* (WA) is an Act that provides for the manufacture and supply of medicines and poisons.

Substances controlled through the current medicines and poisons legislation in WA (being the *Medicines and Poisons Act 2014* (WA) and the *Medicines and Poisons Regulations 2016* (WA)) are classified into a set of schedules. A substance is included in a particular schedule based on its risk to human health and the need for expert oversight. These schedules are generally consistent with the national approach to regulating medicines and poisons under the Standard for the Uniform Scheduling of Medicines and Poisons, known as the SUSMP. The SUSMP is contained in the current Poisons Standard (a Federal legislative instrument). Health professionals should be familiar with the schedules and associated restrictions.

The *Medicines and Poisons Act 2014* (WA) together with the *Medicines and Poisons Regulations 2016* (WA) contain detailed provisions governing the administering, dispensing, and selling, prescribing, purchasing, storage, transport and disposal, reporting a problem and working with medicines. Information for health professionals can be found on the Department of Health's ***Medicine and poisons webpage.***

11. Drugs and poisons

Health professionals who have responsibility to store and handle medicines or poisons must keep them secure and prevent unauthorised access. If at any time a health professional identifies that a scheduled medicine or poison has been stolen, they must inform the Department of Health immediately using the ***Notification of loss, theft or incident for investigation form.***

Health service providers develop local policies and procedures to assist health professionals to comply with applicable legal obligations as relevant to the service context and scope of practice. Health professionals must be familiar with these policies and procedures, in addition to system-wide policies.

Health professionals 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 providers are responsible for employing staff with appropriate qualifications, and for ensuring that health professionals develop and maintain relevant skills and knowledge in this area.

If a health professional 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 professional 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 (with limited exceptions). Refer to section 5 for more information.

11. Drugs and poisons

11.1.3. Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)

As stated above, medicines and poisons are classified according to the schedules in which they are included. The *Medicines and Poisons Act 2014* (WA) and the *Medicines and Poisons Regulations 2016* (WA) adopt the SUSMP contained in the current Poisons Standard with some variations. The following is a general description of the schedules of the SUSMP.

Table 1. General descriptions of the schedules under the SUSMP (from the Poisons Standard July 2020)

Schedule 1	This schedule is intentionally blank.
Schedule 2	**Pharmacy Medicine** – Substances, the safe use of which may require advice from a pharmacist and which should be available from a pharmacy or, where a pharmacy service is not available, from a licensed person.
Schedule 3	**Pharmacist Only Medicine** – Substances, the safe use of which requires professional advice but which should be available to the public from a pharmacist without a prescription.
Schedule 4	**Prescription Only Medicine**, or **Prescription Animal Remedy** – 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.
Schedule 5	**Caution** – 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.
Schedule 6	**Poison** – 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.
Schedule 7	**Dangerous Poison** – 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.
Schedule 8	**Controlled Drug** – 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.
Schedule 9	**Prohibited Substance** – Substances which 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 Health Authorities.
Schedule 10 (previously Appendix C)	**Substances of such danger to health as to warrant prohibition of sale, supply and use** - Substances which are prohibited for the purpose or purposes listed for each poison.

11. Drugs and poisons

11.2. Type of medicines authorities

Under the *Medicines and Poisons Act 2014* (WA) and the *Medicines and Poisons Regulations 2016* (WA) health professionals are legally authorised to do certain things with medicines. The main controls for handling medicines and poisons are through the authority afforded to defined groups of health practitioners, the issuing of licences and permits to supply or use, and controls on the labelling, package, storage and recording of medicines and poisons. For guidance for each profession, please see the Department of Health's ***Medicine and poisons webpage.***

In some specific circumstances a Structured Administration and Supply Arrangement (SASA) can be used to authorise a health practitioner to supply or administer a medicine.

A SASA may be issued by:

1. The Chief Executive Officer of Health that can apply to any practitioner working in WA. For example, for appropriately trained registered nurses to provide vaccinations.
2. A hospital or health service that may apply to health practitioners employed by that organisation.
3. A medical practitioner for a health practitioner employed by the medical practitioner.

11.2.1. Administering of medicines in schools

In school settings, it is common for children to require medicines during the course of the school day in order to comply with short or longer term treatment plans.

In Western Australia, the Department of Education publishes a *Student Health Care in Public School Policy*, procedures and associated forms. Health professionals providing services in schools should refer to these documents at ***www.policies.det.wa.edu.au***

11.2.2. 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 at 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.

If a health professional becomes aware or suspects that their client may have committed any drug offence, there is no general legal obligation on a health professional to provide information to the police or other authority in relation to the same (e.g. school administration or general practitioner). As health professionals 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 they 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 may provide information about access to needle exchange facilities (if appropriate in the circumstances).

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 professional suspects the client or other child is being abused or neglected. There are statutory protections in the CCS Act in respect of the reporting of child welfare concerns to the Department of Communities. 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 principal, as appropriate) without consent. Refer to section 6 for more information. Disclosure of confidential information to third parties should only be made where there must be a legal basis for such disclosure.

11.2.3. Reporting the supply of illicit drugs

There is no legal duty for a health professional to report a client or third party as a supplier of an illicit drug. A health professional owes clients a duty of confidentiality, and if they decide to make a report, then the health professional must be careful not to breach their duty of confidentiality to the client during that reporting process. Refer to section 6 for more information.

11.2.4. 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.

11.3. 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 they sell the cigarettes to the child.

To report breaches of the *Tobacco Products Control Act 2006* (WA) in Western Australia, contact the Tobacco Control Branch on 1300 784 892.

11.4. Alcohol

A person under 18 years commits an offence and can be fined if they:

- Buy or receive, or try to buy or receive, alcohol from any other person on licensed or regulated premises.
- Bring alcohol on to licensed or regulated premises.
- Drink alcohol on licensed or regulated premises.

It is illegal for a person to sell or supply alcohol to a person under the age of 18 years on licensed premises.

A person who sends a minor to a licensed premises to get alcohol knowing the minor is under 18 years also commits an offence. Where a person, acting at the request of a minor, purchases or obtains liquor on behalf of the juvenile on a licensed premises, that person and the juvenile each commit an offence.

11. Drugs and poisons

It is an offence for persons of any age to consume alcohol in any place or on any premises without the consent of the occupier or person in authority. This specifically includes parks and reserves, sport events for public exhibition, roads, within 400 metres of a public hall during any entertainment there, vehicles and any prescribed place.

In certain circumstances, minors of 16 and 17 years of age, who are employed on a licensed premises and have graduated from a prescribed training course, are permitted to serve alcohol to a person who is having a meal on the premises.

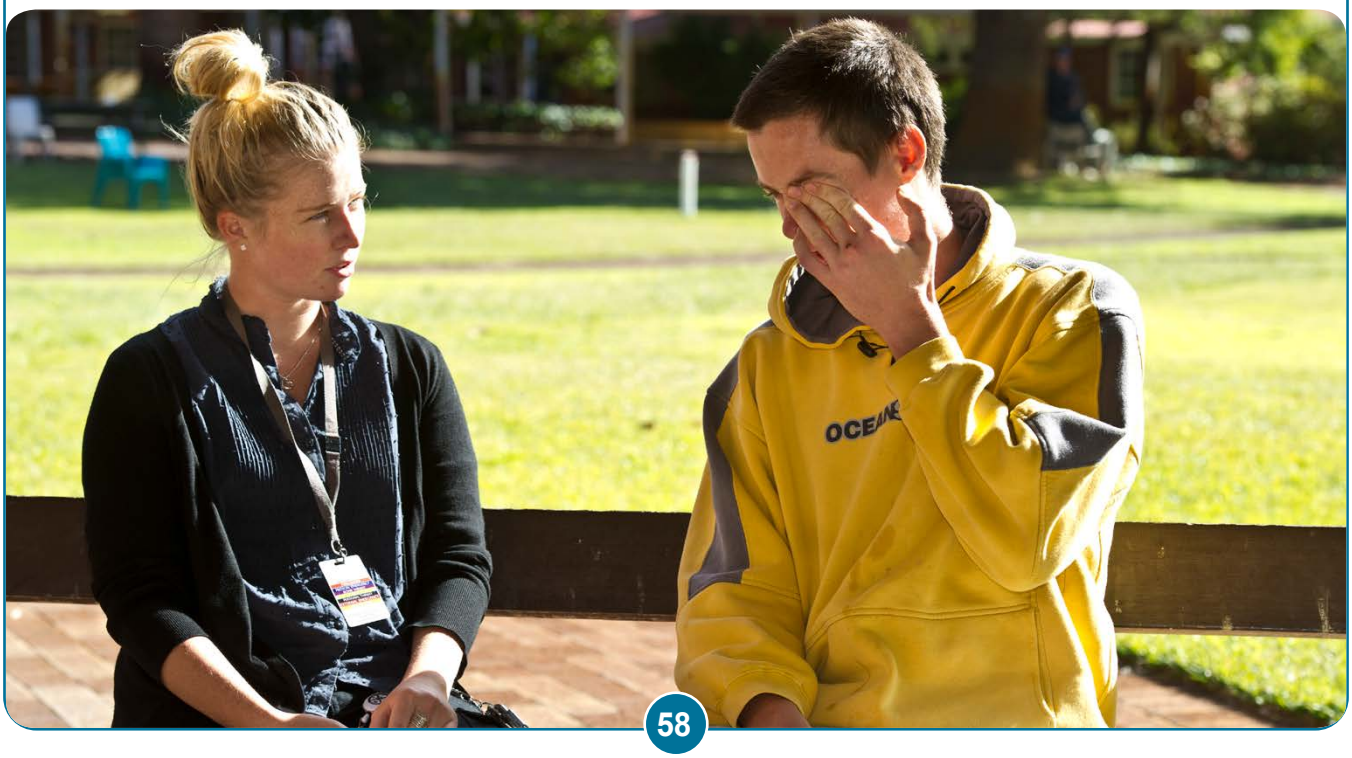
Blood Alcohol Concentration (BAC) is a measurement of the amount of alcohol in a person's body. BAC is measured in grams of alcohol per 100 millilitres of blood. A measurement of 0.05% BAC is equivalent to 50 milligrams of alcohol per 100 millilitres of blood.

It is against the law for any person to drive, or attempt to drive, while under the influence of drugs or alcohol or both to such an extent as to be incapable of having proper control of the 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 prescribed sample taker to take a blood sample from the individual for analysis under certain circumstances where (amongst other matters):

- The individual has provided a preliminary breath sample indicating a BAC equal to or exceeding 0.05%, or exceeding 0.00% in the case of a novice 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 to such an extent as to be incapable of having proper control of the vehicle.
- 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 in specified circumstances.



Hypothetical case study 14:

Student who is suspected of being intoxicated at school

You work as a community health nurse in a high school which you visit on a fortnightly basis. The deputy principal brings 15 year old Robbie to your office. The deputy claims that Robbie is intoxicated and suspects he has been smoking cannabis. The deputy asks you to assess Robbie and to report on his level of intoxication. What are your responsibilities in this situation?

- Gather further information from the deputy principal. Explain that you can provide an opinion about Robbie's health but cannot test for alcohol or drug use.
- Ask to consult with Robbie alone (unless there is a reason to be concerned about personal safety).
- Explain the limits of confidentiality to Robbie.
- Talk to Robbie to assess his health, wellbeing and competence to make decisions.

You judge that Robbie is likely affected by cannabis but not in need of immediate medical care. What action could you take?

- Let Robbie know what information you are required to report to the principal.
- Let him know that the school will contact his parent/guardian to take him home, as per school policy.
- Make a follow-up appointment with Robbie.
- Document your observations, decisions and actions.

Later that day you meet with the deputy principal to discuss Robbie and his case. What information could you share?

- Explain your duty of confidentiality to Robbie (and his parents/guardian).
- Consider if circumstances exist that it is in Robbie's best interests to share the information with the deputy principal. You must obtain the consent of Robbie or his parent/guardian (as appropriate based on his capacity) before the information can be shared. Where consent has been given:
  - Update the deputy with information concerning Robbie consistent with the consent given.
  - Let the deputy know that you plan to make a follow up appointment with Robbie to conduct an assessment, brief intervention, and referral to services, as appropriate.
  - Offer to talk to Robbie's parents/guardians about local services and programs that may be appropriate for Robbie and the family.
- Discuss a school process to deal with similar situations should they arise in the future if one is not already in place. Reiterate that drug testing is not part of your scope of practice or within the role of community health staff.
- Discuss the need for health education sessions to be conducted with the students.

If during your consultation with Robbie, he became aggressive and there was a risk of harm to yourself or any others in the vicinity, it is important to take action to protect yourself and others. The school principal is to be engaged as soon as possible to direct actions as necessary.

12. Online safety concerns

12.1. Internet safety

The internet provides access to vast amounts of information and has dramatically changed how we find, use and generate information. Using the internet for education purposes, entertainment and general interest, and using social media to socialise, are features of everyday life for most children and adolescents in Western Australia. While these online activities provide many benefits, they also open doors to undesirable, disturbing and possibly illegal information and activity.

Children and parents need to learn how to use the internet safely. Helpful hints are provided by a ***WA Police factsheet*** and the ***Australian eSafety Commissioner website.***

The Australian Communication and Media Authority is a statutory body that regulates communication and media in Australia, including the internet and phones. The Authority will investigate valid complaints and take action in relation to prohibited or potentially prohibited materials, including:

- material containing detailed instruction in crime, violence or drug use
- child pornography
- bestiality
- excessively violent or sexually violent material
- real depictions of actual sexual activity
- material containing excessive and/or strong violence or sexual violence
- material containing implied or simulated sexual activity
- material that deals with issues or contains depictions which require an adult perspective.

For more information, or to make a complaint, go to the ***Authority website.***

12.2. Social media

Many children and adolescents engage in social media frequently and for significant periods of time. Social media can enhance existing relationships and enable the development of relationships with people who, in real life or the offline environment, are only acquaintances or are not known to the young person. Relationships that develop in the online environment may be positive and enjoyable, however there is risk in forming relationships in this environment that is outside normal social circumstances, codes and controls.

The anonymity enabled by social media may lead some people to engage in cyberbullying or predative behaviour. Predators have been known to spend time 'grooming' young people by providing affection, attention, kindness and/or sending gifts. Online predators endeavour to gain the trust of a young person and slowly start to include sexual content to their conversations, before attempting to set up a meeting in real time.

It is important for parents and young people to learn and talk about safe use of social media, and to report any online behaviour that is suspicious or of a sexual nature. More information is available from the ***WA Police Force's Internet Safety webpage.***

12. Online safety concerns

12.3. Sexting

Sexting refers to the use of social media, the internet or a mobile phone to take, send or receive a sexually explicit image or messages. It is a crime under the *Criminal Code Act Compilations Act 1913* (WA) to distribute a sexually explicit image (called an intimate image in the *Criminal Code)* without the consent of the person in the image. An 'intimate image' can include an image of:

- a person naked, partially naked, or in their underwear
- a person engaged in a private act, such as using the toilet, showering or bathing.

Under the *Criminal Code Act Compilations Act 1913* (WA) a person under 16 years of age cannot consent to the distribution of an intimate image. It should be noted that there are relevant federal criminal laws that include using a carriage service to harass, menace or cause offence, with increased penalties for sharing private sexual material in this way (*Criminal Code Act 1995 (Cth)*).

The *Enhancing Online Safety Act 2015 (*Cth) established a civil penalties scheme to address the non-consensual sharing of intimate images, otherwise known as image-based abuse. This scheme allows victims of image-based abuse to make a report (complaint or objection notice) to the eSafety Commissioner, who may take removal action and, in some cases, also take action against the person who shared, or threatened to share, an intimate image without consent.

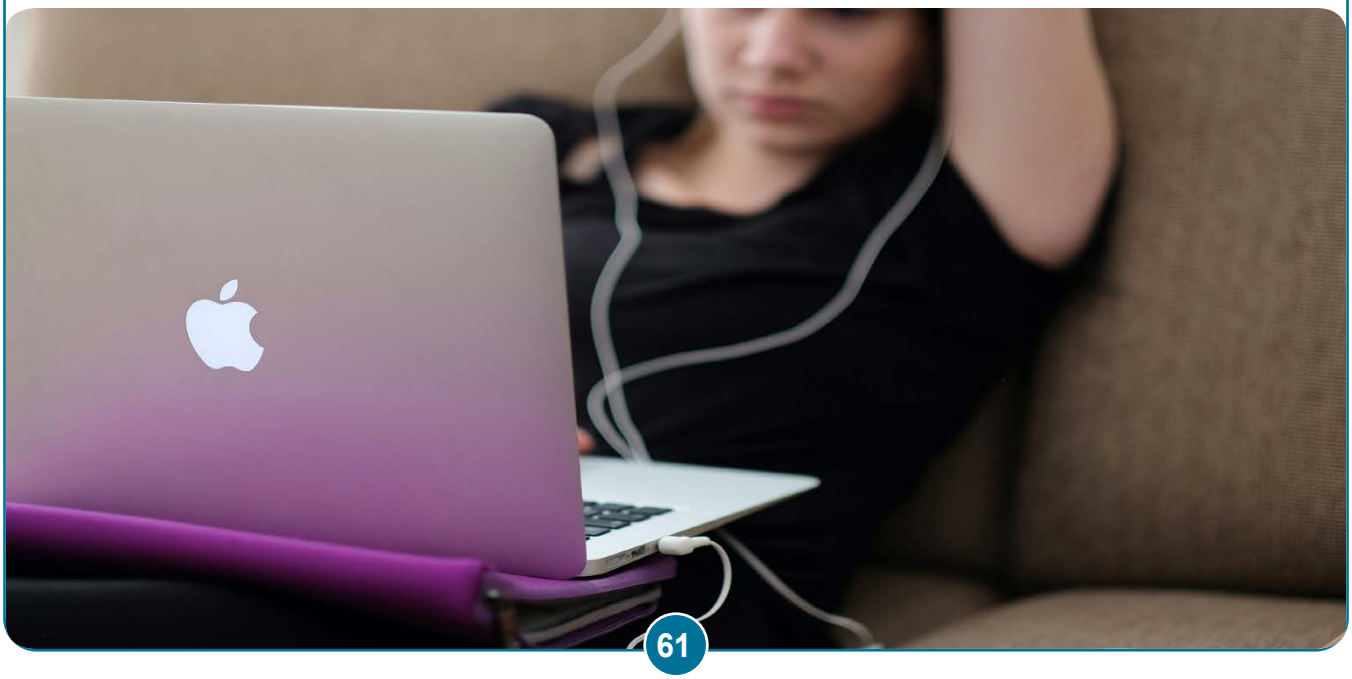
12.4. Cyberbullying

Bullying (including cyberbullying) occurs when an individual (or a group of people) repeatedly and intentionally cause harm to another person (or group of people), who is unable to avoid being targeted. Bullying can include:

- Physical bullying (hitting, tripping, damaging property)
- Verbal bullying (insults, teasing, intimidation)
- Social bullying (lying, spreading rumours, excluding, damaging someone's social reputation)
- Cyberbullying (hurtful texts, posts, images or videos, imitating others online).

Minors under the age of 18 (and adults who report on behalf of someone under 18 years) can make a complaint about cyberbullying to the ***eSafety Commissioner.*** The Commission can take action to remove serious cyberbullying items, and provide advice and support.

Bullying may be illegal in situations where someone is violent or damages property or stalks a person.



Hypothetical case study 15:

Young people involved with circulation of sexual images

You are a community health nurse who regularly provides services in a high school. You are approached by two distressed girls who say that their friend won't come to school because someone took compromising photos of her at a party on the weekend and has sent them to a lot of people in their year group.

You invite the girls to talk to you in private. After explaining the limits of confidentiality, you ask them to explain the circumstances in which the photos were taken and the nature of the photos. You thank the girls for bringing the welfare of their friend to your attention and advise what information will need to be disclosed to the school principal.

You arrange to meet with the school principal to discuss the issue and assess the known risk factors. It is found that the girl has been absent all week and appears to have the support of her parents to be away from school.

The principal makes contact with the parents and suggests they may make a report with the police.

A member of the student services team is assigned to work with the girl and her family to support a return to school and to develop strategies about staying safe. Another member of the team is assigned to meet with and monitor the student who was responsible for taking and distributing the photos.

The student service team organises a respectful relationship program for the year group, which also covers cyber safety and the law in relation to taking and distributing intimate images.

If a school does not have a well-defined process for handling distribution of sexual/intimate images, consider advocating that a process is established.

Hypothetical case study 16:

Young teen and cyberbullying

Fourteen year old Ruby has been the subject of bullying. Her 'friendship group' excluded her from weekend social activities and dropped her from the online chat group. Later she was invited back onto the group which allowed her to read several vindictive and hurtful comments made about her, before being excluded from the chat group again.

Ruby has started to avoid school and when she does attend, she frequently visits the student service office saying she is sick and wants to go home. The year coordinator makes an appointment for Ruby with you, the community health nurse. How could you help?

- Acknowledge that Ruby is having a difficult time at present, and explain that there are things we can do to help her.
- Discuss confidentiality and the need to share certain information in some circumstances.
- Conduct a HEADSS assessment focussing on relationships with family and friends, mental health, wellbeing and safety.
- Consider Ruby's maturity and capacity.

You judge that Ruby is very upset about the bullying she has experienced and has been avoiding the girls who "used to be her friends" by staying at home. She is at a loss about what to do, and is very hurt but appears not to be at risk of harming herself. What could you do?

- Provide Ruby with practical ways to manage social media and self-care. Give her information and suggest an appropriate website for her to read.
- Discuss Ruby's home situation and support from family members.
- Let Ruby know that you would like to ring her parent/guardian to help with ideas to support Ruby, and ask for Ruby's consent to do so.
- Let Ruby know that you will be reporting back to the year coordinator, and let Ruby know about what information will be shared.
- Indicate that the school will take action about dealing with the bullying as per the school policy.
- If the school does not have a well-defined process for handling bullying, advocate that the student service team collaborates to establish processes.
- Offer follow-up appointments to support Ruby's progress and wellbeing, and provide brief intervention as appropriate.
- Document all assessment, discussions and decisions in Ruby's health record.

13. Relevant laws and legislation

Children and Community Services Act 2004 (WA)

Criminal Code Act 1995 (Cth)

Criminal Code Act Compilation Act 1913 (WA)

Criminal Law (Mentally Impaired Accused) Act 1996

Enhancing Online Safety Act 2015 (Cth)

Equal Opportunity Act 1984 (WA)

Freedom of Information Act 1992 (WA)

Gender Reassignment Act 2000 (WA)

Guardianship and Administration Act 1990 (WA)

Health (Miscellaneous Provisions) Act 1911 (WA)

Health Services Act 2016 (WA)

Health Services (Information) Regulations 2017

Human Tissue and Transplant Act 1982 (WA)

Medicines and Poisons Act 2014 (WA)

Medicines and Poisons Regulations 2016 (WA)

Mental Health Act 2014 (WA)

Occupational Safety and Health Act 1984 (WA)

Public Health Act 2016 (WA)

Sex Discrimination Act 1984 (WA)

State Records Act 2000 (WA)

Therapeutic Goods Act 1989 (Cth)

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

Appendix

Access to Medicare, Immunisation records, the Australian Organ Donor Register and My Health Record

Medicare

Medicare provides access to a range of medical services and subsidised medicine prescriptions. 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.

From the age of 15, minors may apply for their own Medicare 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. Acceptable forms of identification includes 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.

Immunisation history statement

The immunisation history statement shows all vaccines recorded on the Australian Immunisation Register (AIR) by vaccination providers. It also shows any vaccines that are due or overdue. When a child turns 14, they can access their immunisation history statement through myGov. The statement can also be accessed using the Express Plus Medicare mobile app.

When a child turns 14, their parents can no longer access the child's immunisation history statement.

Australian Organ Donor Register

When a child turns 16, they can register an intention to donate organs and tissue for transplant. Full registration can be enabled from 18 years and over.

It is recommended that an intention to donate organs and tissue is discussed with family members.

My Health Record

My Health Record is a secure online summary of an individual's health information which can be viewed by authorised health professionals. An individual's My Health Record may include health summaries, hospitals discharge summaries, prescription records, pathology reports and other clinical reports.

Until the age of 14, a child's authorised representative (parent or guardian) manages the child's My Health Record on their behalf. From 14 years of age a child can manage their own My Health Record. When a child turns 14, all authorised and nominated representatives will be removed. If the individual chooses, they may give their parent/s or guardian access as a nominated representative. If the child is not able to make decisions for themselves, the parent/s or guardian may apply to become their authorised representative.

Before the age of 14, the parent or guardian can view their child's record and see health information that has been uploaded by doctors, nurses, specialists or Medicare, including information about medical tests and prescriptions. The parent or guardian can add and remove information and set privacy controls on the minor's record.

To access My Health Record, individuals need to create a myGov account, or sign into existing account. Instructions can be found easily online.

Individuals 14 years or over, can ***register for a My Health Record*** at any time, even if their parent or guardian previously opted-out for the individual.

Acknowledgements

The original resource is based (with permission) on:

NSW Association for Adolescent Health (2005). *Working With Young People – Ethical and Legal Responsibilities for Health Workers*.

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