COUNSELLORS AND THEIR CHILD CLIENTS

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THE NATIONAL CHILDREN'S AND YOUTH LAW CENTRE

PROFILE

The National Children's and Youth Law Centre (NCYLC) is Australia's only national community legal service dedicated to promoting the rights and freedoms of our young people. Since 1993, the NCYLC has been at the forefront of using the law to improve the conditions and opportunities of children and young people throughout Australia. Our volunteers and staff work exclusively for and with Australia's children and young people to provide them with relevant and accurate legal information, advice and education.

The Centre undertakes casework for specific complaints, promotes policy and practices that support youth and children and provides information and advice about the law in an easy to understand way. The touchstone of the NCYLC is the United Nations Convention on the Rights of the Child and we aim to improve understanding of and adherence to children's rights.

Key to the Centre's provision of information about the law is our website www.lawstuff.org.au This award-winning site attracts around 10,000 visitors a year and incorporates an interactive facility, LawMail. This enables young people to contact us by email, independently and confidentially, from anywhere across Australia. We then provide up to date legal advice and referral to a local service as needed. LawMail relies on a national network of Cyber Volunteers who are lawyers and legal students who answer legal queries via a password secured website.

The Centre undertakes specific projects from time to time, resulting in resources for schools and young people such as the Listen Up kit, which provides information about mobile phones.

The Centre ensures that policy makers consider the perspective of children and young people by preparing submissions to inquiries conducted by State and Federal Government and major organisations. We also have an extensive research program and regularly publish discussion papers.

AUTHORS

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"A trustworthy person is someone who can tell things and they will keep it a secret. And there aren't too many people like that around. You don't tell a loudmouth..." (Boy, 11, Broken Hill)

"It's more about who you can trust than who you can tell. Because if you don't have trust there, then you're not going to go to them because you're going to get a bad deal. But if you trust them, it's different. For me, if it was a really serious thing and I wanted help, I would go to an older person who I trust. It may not be family, it could just be a friend..."
(Girl, 16, Wollongong)

"I always feel really insecure telling my friends because I think that they're going to tell someone. When you're a teenager, gossip just flies around like that! So I just tell my Mum, she's like my best friend."
(Girl, 15, Young)[1]

[1] NSW Commission for Children and Young People, *Report of an Inquiry into the Best Means of Assisting Children and Young People with No-one to turn to,* 2002 at 45.

Synopsis

This paper examines the legal relationship between counsellors and their clients who are children.[2] *It commences with an overview of the current practices of counsellors in retaining confidences and the expectations of children and the public as to when confidences should be maintained. This overview reveals that there may be a divergence between the practices of counsellors and the expectations of children. The legal and ethical obligations of confidentiality for counsellors are also discussed.*

The paper then explores three issues in the legal relationship between counsellors, children and their parents. The first issue considers whether children have the legal capacity to enter a client relationship with the counsellor independently of their parents. The paper concludes that the law recognises the capacity of 'mature' children to consent to counselling and to undergo counselling of their own volition.

The second issue considers whether children are owed a duty of confidentiality analogous to adults, so that counsellors would be in breach of their duty if they informed parents that their child is being counselled or of the contents of the counselling session. The paper concludes that the law may recognise that children who are capable of consenting to a confidential relationship are owed a duty of confidentiality by counsellors.

The third issue considered is whether parents have the authority to force an unwilling child to undertake counselling. Despite English cases that have held to the contrary, the paper suggests that Australian law would accept that parents are unable to force an unwilling child to counselling. Possibilities for reform are suggested to improve certainty in the law and to educate

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[2] 'Children' includes children and young people who have not yet attained the age majority, which is 18 years of age in every state and territory in Australia. *Minors (Property and Contracts) Act* 1970 (NSW) s 9; *Age of Majority Act* 1974 (Qld) s 5; *Age of Majority (Reduction) Act* 1970 (SA) s 3; *Age of Majority Act* 1973 (Tas) s 3; *Age of Majority Act* 1977 (Vic) s 3; *Age of Majority Act* 1972 (WA) s 5; *Age of Majority Act* 1974 (ACT) s 5; *Age of Majority Act* 1974 (NT) s 4.

counsellors, children and their parents, of the obligations of confidentiality owed by counsellors to their child clients.

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Introduction

There are a number of ethical and legal dilemmas that will arise for counsellors who have children as clients. The first issue to be considered is whether children have the legal capacity to consent to counselling, and to what extent this is analogous to competence to consent to medical treatment. However, the central issue to be considered here is whether a child may be owed the same duty of confidentiality that adults enjoy, or whether third parties, including parents and teachers can have access to information provided by the child in the course of counselling. Counsellors may also feel some obligation to disclose certain information obtained during counselling when requested by a concerned parent, especially when the parent has arranged and paid for the service. Also, counsellors may be uncertain as to whether to counsel an apparently unwilling child.

These difficulties are not merely ethical issues. They concern the professional and legal obligations and liability of counsellors. Counsellors may be concerned about whether a child may sue for breach of confidence and conversely, whether a parent may sue for keeping a confidence, for example, if a child later commits suicide. The quandary about seeing a child without parental consent is exacerbated by the fact that parents unable or unwilling to communicate effectively with their troubled child may be the very ones most readily disposed to seek redress against the counsellor for 'interfering' in their private, intrafamily difficulties[3]. Counsellors may also be concerned about their legal position when parents request the services of a counsellor and the child is involuntary.

Part One of the paper gives a brief overview of counselling, the current practice of keeping confidences by counsellors, the expectations of confidentiality held by children and the expectations of confidentiality held by the broader public. Possible problems arising from disparity in the practices of counsellors and the expectations of children will also be discussed.

Part Two considers the legal relationship between counsellors, child clients and their parents and explores whether children can consent to counselling without the knowledge or consent of their parents. The ability of children to understand the nature of counselling treatments will also be canvassed.

Part Three looks at whether children are owed a duty of confidentiality and firstly outlines the sources of the obligation of confidentiality, namely, professional standards and legal duties to retain confidences. The remedies and defences for breach of confidence will then be discussed. The application of the test for competency to give informed consent to medical treatment to counselling and entering into a confidential relationship is also considered.

Part Four outlines whether parents have the authority to force an unwilling child into counselling.

Part Five considers responses to the uncertainty that exists in the law. Suggested reforms include, guidelines for counsellors to assist them in determining competency to consent to counselling, legislation to recognise a duty of confidentiality owed to competent minor clients and the dissemination of information among children and their parents about their entitlement to confidentiality whilst receiving counselling and about the limits of confidentiality.

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[3] J. E. B. Myers, 'Legal issues surrounding psychotherapy with minor clients' *Clinical Social Work Journal,* (1982) 10(4), 303-314

Part One: 'Counselling' and keeping confidences with children

1.1 Definitions of 'counselling' and 'counsellors'

Counselling is a generic term that describes a range of therapeutic services provided in a wide variety of occupations and vocations.[4] Ludbrook provides a 'working definition' of counselling as

> a therapeutic process involving interaction between a counsellor and one or more clients aimed at enhancing the quality of the client's life by assisting the client to overcome relationship difficulties, to deal with the consequences of trauma or to cope better with personal, family, social or workplace difficulties or to change patterns of behaviour that are actually or potentially harmful to the client or others.[5]

In this paper 'counsellor' is used to refer to non-medical professionals who may provide counselling services exclusively or in part to children. It therefore excludes psychiatrists, doctors and health workers, but includes counsellors, school counsellors, counsellors employed by the Family Court, social workers, psychologists and psychotherapists.

The use of the term 'counsellor' is not regulated and it does not indicate any particular qualification or experience. Many counsellors do have specific training and are also eligible for membership of the professional bodies regulating their field, for example, the Australian Association of Social Workers, the various state Psychologists' Registration Boards and The Royal Australian and New Zealand College of Psychiatrists. Only those with the appropriate qualifications can use these titles.

1.2 Practice of counsellors in keeping confidences with children

While there has been no research in Australia on confidentiality and counselling children, there has been research conducted on the perceptions of psychologists on the importance of confidentiality generally.

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[4] For example, people who may consider themselves 'counsellors' include school counsellors, counsellors appointed by the Family Court, Ministers of Religion, youth workers, social workers and psychologists.

[5] R. Ludbrook, *Counsellors and the Law*, Hamilton, NZ Association of Counsellors, 2002

This was in the form of a 1993 Victorian study evaluating the attitudes of 220 psychologists on the importance of confidentiality. By far the largest proportion (81%) thought that confidentiality in their relationships with clients was important, but could be breached in some circumstances. A minority (15%) believed it was essential and should never be breached. A few (2%) thought confidentiality was marginally important.[6]

There is some recent American research exploring the attitudes and practices of psychologists in keeping the confidences of children.[7] Table 1 shows the responses of psychologists when asked whether or not they would breach the confidence of a child in certain circumstances. The researchers found that two factors were influential in this decision. The first factor was age, which the researchers concluded was an attempt at gauging the competence of the child. The second factor was the seriousness of the issue.

Great caution must be exercised when examining the research from another country, particularly where the laws are different. It should also be noted that this research was conducted only with psychologists whose training and skills do not necessarily reflect the approach of all who work as counsellors. However, there are a few observations that can be made.

Firstly, the practice of the American psychologists in the study was to retain the confidences of children who were considered competent to deal with the particular issue. This finding is supported by research by Slovenko, who found that 'in all cases, confidentiality is linked to the factual or legal competency of the patient to consent to treatment'.[8] It is also interesting to note the variability between psychologists in response to particular issues.

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[6] The unpublished study was conducted by McMahon and Knowles in 1993, quoted in M. McMahon and A. Knowles, 'Confidentiality in Psychological Practice: A Decrepit Concept' (1995), 31(3), *Australian Psychologist*, p. 164 at 165.

[7] M. Isaacs and C. Stone, 'Confidentiality with Minors: Mental Health Counsellors' Attitudes Toward Breaching or Preserving Confidentiality', (2001), 23(4), *Journal of Mental Health Counselling*, p. 342 (15).

[8] R. Slovenko, 'Psychotherapy and Confidentiality: Testimonial Privileged Communication, Breach of Confidentiality and Reporting Duties', (1998) in M. Isaacs and C. Stone, 2001, above n6.

TABLE 1

Situations	Would Breach (%)			Would not breach (%)			Undecided (%)		
	11 yrs	14 yrs	17 yrs	11 yrs	14 yrs	17 yrs	11 yrs	14 yrs	17 yrs
Smoking cigarettes	12	7	3	80	88	94	8	6	3
Sneaking out to meet boy/girlfriend	35	21	7	48	66	87	17	14	7
Having sexual intercourse	45	23	7	33	57	87	21	20	7
Smoking marijuana	45	32	21	39	54	70	16	14	9
Using crack cocaine	72	63	48	16	23	38	12	14	15
Seeking an abortion next day	61	57	28	21	25	53	19	18	18
Has shoplifted	15	12	10	75	78	82	11	10	8
Depression and life is too tough for living	62	60	54	21	23	27	17	18	19

TABLE 1. **THE RESPONSES OF PSYCHOLOGISTS WHEN ASKED WHETHER OR NOT THEY WOULD BREACH THE CONFIDENCE OF A CHILD OF DIFFERENT AGES IN CERTAIN CIRCUMSTANCES.**

The study also found that ethical dilemmas regarding confidentiality regularly arose for the psychologists. A large number of the psychologists (82%) had experienced one of the dilemmas presented in the study at least once in the past two years and the majority had encountered five or more dilemmas over the past five years.[9] It is likely that similar ethical dilemmas are a regular occurrence in Australia.

[9] M. Isaacs and C. Stone, 2001, above n6.

1.3 Expectations of confidentiality by children

The doubts children have about the confidentiality of consultation have long served as a barrier preventing their use of health services.[10] They are more likely to access services where confidentiality is preserved and where young people's rights are respected.[11]

In 1995, a study was conducted in Melbourne on adolescents' expectations of confidentiality.[12] The participants were 557 school students at six non-government schools that employed a school counsellor. The students were asked how important confidentiality was and whether it should be breached in a number of circumstances.

In response to the question on the importance of confidentiality, 52% of students said confidentiality was essential, 46% said it was important and 2% said it was not really important. Table 2 shows the attitudes of students about whether the school counsellor should breach confidentiality and tell parents in certain situations and Table 3 shows the attitudes of students regarding whom information should be disclosed to.

TABLE 2

Situations	Should breach (%)		Should not breach (%)		Undecided (%)	
	Males	**Females**	**Males**	**Females**	**Males**	**Females**
Contraception	33	13	52	79	16	8
Pregnancy	41	15	43	74	17	11
Physical or sexual abuse	61	47	9	16	30	37

[10] I. O'Connor and A. McMillan, 'Youth, the law and health: Emerging issues in service delivery' (1987) *Queensland Law Society Journal*, April, 95-106

[11] NSW Commissioner for Children and Young People (2001) *Consent by Minors to Medical Treatment*

[12] N. Collins and D. Knowles, 'Adolescents' Attitudes Towards Confidentiality Between the School Counsellor and the Adolescent Client', (1995), 30(3), *Australian Psychologist*, pp. 179-182.

TABLE 2. **THE RESPONSES OF MALE AND FEMALE STUDENTS AGED 14-18 YEARS WHEN ASKED WHETHER THE SCHOOL COUNSELLOR SHOULD TELL PARENTS ABOUT CONTRACEPTIVE USE, PREGNANCY AND PHYSICAL OR SEXUAL ABUSE.**

TABLE 3

Situations	Parent (%)	Teacher (%)	Police (%)	No-one
Shoplifting	45	7	11	51
Arson	44	12	20	46
Heroin or cocaine	54	10	16	39
Serious harm to another	48	22	27	18
Suicide	75	14	13	19

TABLE 3. **THE RESPONSES OF MALE AND FEMALE STUDENTS AGED 14-18 YEARS WHEN ASKED WHETHER INFORMATION ABOUT CERTAIN SITUATIONS SHOULD BE DISCLOSED TO A THIRD PARTY.**

A strong conclusion from this study is that the students clearly believe in the importance of confidentiality, with 98% stating it to be important or essential[13]. The strongest support for disclosure was in relation to suicide and physical or sexual abuse (by males). Students felt that when disclosures where made, they should be made to parents rather than teachers or police. Interestingly, the researchers found an 'almost complete lack of age difference between students from 12 to 18 years in their beliefs about disclosure'.[14]

[13] N. Collins and D. Knowles, 1995 above n12.
[14] N. Collins and D. Knowles, 1995 above n12 at 182.

1.4 Expectations of confidentiality by the public

Knowles and McMahon conducted an Australian study into the expectations and preferences of confidentiality in a relationship with a psychologist.[15] The public expected and preferred that confidentiality would be retained when a client reported illegal drug use or major theft. Significantly, the public believed that psychologists should not disclose to parents without the teenager's permission. Disclosure to colleagues or parents was expected and preferred when a client revealed murder (committed or planned), suicidal intention, child abuse and where the client was younger than 13 years.

1.5 Comment on current practice

The Australian research shows that both the general public and adolescents support the disclosure of specific situations such as, suicide and child abuse. It also highlights that there is broad recognition of the importance of confidentiality for children and indicates that the public believe that children deemed sufficiently mature should have the same right to confidentiality as adults. This mirrors the support of American psychologists for confidentiality for mature children.

It is important to note that there may be inconsistency between these opinions and the actual practices and attitudes of psychologists. It should also be kept in mind that much of this research was specific to psychology.

A concern arising from this research is that some adolescents in Australia will have an expectation of confidentiality that may later be breached by the counsellor. A further concern is that fear of disclosure to third parties will prevent children from entering counselling or if they do, that they will withhold relevant information from the counsellor. Gustafson and McNamara comment:

> Whether confidentiality will be ensured may influence the adolescent's decision to enter psychotherapy. An adolescent not guaranteed confidentiality may decide not to enter therapy or may reluctantly participate without disclosing his or her concerns.[16]

Finally, the research indicates significant disparity in opinion and if counsellors are unsure of their ethical and legal obligations with regard to children, they may be unsure whether confidentiality can be assured.

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[15] The opinions of 265 members of the public were canvassed and reported in A. Knowles and M. McMahon, 'Expectations and Preferences Regarding Confidentiality in the Psychologist-client Relationship', (1995), 30(3), *Australian Psychologist*, pp. 175-178.

[16] K. Gustafson and J. McNamara, 'Confidentiality with Minor Clients: Issues and Guidelines for Therapists', (1987), 18(5), *Professional Psychology: Research and Practice*, pp. 503-508.

Part Two: Consenting to Counselling

There are three issues of interest to counsellors regarding the rights of parents and their children:

1) Whether children have the capacity to consent to counselling,
2) Whether children are owed a duty of confidentiality by counsellors, such that parents or other third parties are not permitted access to information obtained by the counsellor without the consent of the child and
3) Whether parents have a right to force an unwilling child to counselling.

Before we discuss these specific issues, it is useful to discuss the law on the rights of parents and children generally.

2.1 The legal relationship between parents and their children

There are two main case law decisions that are relevant to the legal relationship between parent and child. The first is the English decision by the House of Lords in *Gillick,* which redefined the common law legal relationship between parent and child.[17] The second is the decision of the majority of the Australian High Court in *Marion's case,* which confirmed that *Gillick* is binding on Australian courts.[18]

2.1(a) House of Lords in *Gillick*

The House of Lords held that parental authority over a child was a dwindling right that existed only for the benefit and welfare of the child and that the duration of parental authority could not be determined by reference to a fixed age, but depended upon the maturity and intelligence of the child and a judgment as to the child's best interests. In regard to children's rights, the

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[17] *Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security* [1986] 1 AC 112, per Lord Fraser of Tulleybelton at 174, Lord Scarman at 180-1, Lord Bridge of Harwich at 195.

[18] *Secretary, Department of Health and Community Services and J.W.B. and S.M.B.* [1991-1992] 175 CLR 219, at 238-239, hereafter '*Marion's case*'.

House of Lords held the child might consent to medical treatment when they are capable of understanding what is proposed.

Lord Scarman directly stated the broad principle that the child can consent to *any* matter when they have sufficient understanding of what is proposed. His Lordship held:

> The underlying principle of law was exposed by Blackstone and can be seen to have been acknowledged in the case law. It is that parental right yields to the child's right to make his own decision when he reaches a sufficient understanding and intelligence to be capable of making up his own mind *on the matter requiring decision.*[19] [italics added]

The broad principle is also supported by the reasoning of Lord Fraser of Tullybelton who found that the ability of a child to exercise a right to consent began when the child had sufficient maturity and understanding. His Lordship stated:

> Provided the patient, whether a boy or girl, is capable of understanding what is proposed, and of expressing his or her wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises.[20]

The reasoning of the majority of the House of Lords can therefore be seen as an application of a broader principle that children have the right to consent to any matter, which is not regulated by statute law, when they have sufficient maturity and intelligence to understand what is proposed.

Moreover, the House of Lords also held that the right of a child to consent to medical treatment was merely *one* of the rights, which a child may exercise under law. Lord Fraser gave examples where children were able to exercise certain rights, such as the right to enter into contracts (within limits), the right to sue and be sued and the right to consent to sexual intercourse such that the man involved would not commit the crime of rape. Lord Scarman emphasized the same point, 'nor has our law ever treated the child as other than a person with capacities and rights recognised by law'.[21]

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[19] *Gillick* [1986] 1 AC 112 at 186.
[20] *Gillick* [1986] 1 AC 112 at 169.
[21] *Gillick* [1986] 1 AC 112 at 184.

2.1(b) High Court in *Marion's case*

Three justices of the High Court endorsed the broad principle from *Gillick*. Justice McHugh stated:

> the parent's authority is at an end when the child gains sufficient intellectual and emotional maturity to make an informed decision *on the matter in question*.[22] [italics added]

Recognition of the broad principle is also found in Justice Deane's judgment:

> The effect of the foregoing is that the extent of the legal capacity of a young person to make decisions for herself or himself is not susceptible of precise abstract definition. Pending attainment of full adulthood, legal capacity varies according to the gravity of the particular matter and the maturity and understanding of the particular person.[23]

When speaking about the limits of parental authority Justice Brennan also adopted the broad principle in recognising the legal capacity of children to make decisions on matters for themselves:

> Limits on parental authority are imposed by the operation of the general law, by statutory limitations or by the independence which children are entitled to assert, without extra-familial pressure, as they mature.[24]

2.2 Rights of children to consent to counselling

There are two main, potential sources of the right for children to consent to counselling. Firstly the World Health Organisation (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. As counselling addresses the mental and social well-being of clients, counselling services may be seen by law to come within the area of medical or health care.[25] This would therefore bring counselling within the right of a *Gillick* competent child to consent to medical treatment.

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[22] *Marion's case* (1992) 175 CLR 218 at 316.
[23] *Marion's case* (1992) 175 CLR 218 at 293.
[24] *Marion's case* (1992) 175 CLR 218 at 278.
[25] J. E. B. Myers, 1982, above n3

Alternatively, while neither *Gillick* nor *Marion's case* specifically address the capacity to consent to counselling, the principle of understanding what is proposed can be applied to the rights of children to consent to any matter. Therefore one application of the broad principle is that children have the right to consent to counselling when they have the intelligence and maturity to understand fully what is proposed.

2.3 Drawing the medical analogy

This shifts the focus of the issue from whether children have a general right to consent to counselling, to whether specific children are mature and capable enough to understand and consent to being counselled. This issue will arise for counsellors questioning whether they can counsel a specific child without the knowledge or consent of a parent or guardian. There has been no judicial consideration of the requirements that must be fulfilled before children will be recognised as having the legal capacity to consent to counselling. Therefore the principles established by the High Court in regard to the competency to consent to medical treatment will be applied here.

However, further issues may need to be kept in mind in the following sections, as there are still significant differences between medical treatment and counselling which may affect the usefulness of this analogy. Parents and guardians may wish to exercise parental authority in refusing permission for their child to see a counsellor, since a vast array of professions from family therapists, psychoanalysts to hypnotherapists may label themselves counsellors and the results are uncertain. The courts may find that this is a justifiable exercise of parental authority to protect their children from the risk of harm caused by recounting traumatic times. It cannot simply be assumed that all counselling is necessarily in the best interests of the child.

It may also be difficult to look at medical practitioners' obligations to outline alternative treatments and disclose the risks of treatment, and then compel counsellors to do the same, if the nature of counselling generally involves the counsellor uncovering previously unknown information *through* treatment.

However, while these are important issues raised in discussion, the courts are most likely to consider questions of children's informed consent to counselling in the context of previous cases regarding medical treatment, so this approach will be taken here.

2.4 Giving informed consent

The principle of informed consent was defined by the High Court in *Marion's case* in the following terms:

> A minor is ... capable of giving informed consent when he or she achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.[26]

Lord Donaldson in *Re R* described the requirement of 'understanding' as:

> what is involved is not merely an ability to understand the nature of the proposed treatment ... but a full understanding and appreciation of the consequences, both of the treatment in terms of intended and possible side effects, and equally important, the anticipated consequences of a failure to treat.[27]

Therefore for a child to be judged competent they must have the ability to understand the nature of the treatment, any risks and benefits as well as alternatives to the proposed treatment.

2.5 Consent to counselling

This principle of informed consent may be applied to counselling and a child would be found competent to consent to counselling if they have the ability to understand the nature of the treatment, any risks and benefits as well as alternatives to the proposed treatment. Swain has attempted to describe how the principle of informed consent might apply in the social work context:

> In the social work setting, this suggests that service users need to be advised not just about what services or forms of intervention are available from the agency or professional worker concerned. They also need information about any costs involved, the implications of refusal or agreement ... and the alternatives if any available from both within the agency and elsewhere. In relation to involvement with a particular worker, the service user should be made aware of the particular skills or expertise

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[26] *Marion's case* (1992) 175 CLR 218 at 237, per Mason CJ, Dawson, Toohey and Gaudron JJ.
[27] *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 3 WLR 592 at 602.

> claimed by the worker, and of the goals sought through the intervention proposed, and of the time period over which the intervention will be offered.[28]

2.6 Ability of children to consent to counselling

In their article, Gustafson and McNamara cite examples of American research into the ability of children to make 'well-informed decisions about psychotherapeutic treatment'.[29] One example given is Weithorn who concluded that children who have developed formal operational thinking, usually between the ages of 11 and 14 years, are able to 'conceptualise abstract possibilities and hypothetical outcomes of multiple courses of action and therefore are competent to consent'.[30]

A second example provided is research by Weithorn and Campbell who tested the competency of children to make informed decisions about alternatives in medical and psychological treatment[31]. They found 14 year olds were generally as competent as adults in making treatment decisions when measured against four standards; expressing a choice, reasonable outcome, rational reasons and understanding. Nine year olds were found to be less competent than adults in two standards; rational reasons and understanding, but were as competent as adults in the other two; reasonable outcome and evidence of choice.[32]

The article also mentions research conducted in 1985 by Kaser-Boyd, Adelman and Taylor who found older children with therapeutic experience were able to identify risks and benefits and to describe those risks and benefits more abstractly than younger children and those without therapeutic experience.[33]

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[28] P. Swain, *In the Shadow of the Law: The Legal Context of Social Work Practice* (2nd ed), Sydney, The Federation Press, 2002, p.36.
[29] Gustafson and McNamara, 1987 above n16, p.504.
[30] Gustafson and McNamara, 1987 above n14, p.504.
[31] Gustafson and McNamara, 1987 above n14, p.504.
[32] Gustafson and McNamara, 1987 above n14, p.504.
[33] Gustafson and McNamara, 1987 above n14, p.504.

More recent research indicates that children and young people, especially those under the age of 15, may be vulnerable to being influenced by the opinions of those in positions of authority, such as a parent, the police, a teacher or a counsellor.[34] Counsellors should therefore be ever mindful of their position of authority and the inherent responsibility attached to this power when working with children and young people.

In summary, most researchers in developmental psychology find no evidence to support the pre-*Gillick* legal conclusion that all children and young people are incompetent to give informed consent to medical intervention, including counselling.[35]

As a general guide, it is unlikely that a child under the age of 11 would be considered competent to give independent consent to counselling. Children aged 11 to 14 appear to be in a transition period in the development of important cognitive abilities and perceptions of social expectations, but there may be some circumstances that would justify independent consent by these children. Significantly there appear to be no psychological grounds for maintaining the assumption that children older than 14 cannot provide competent consent.[36]

2.7 Assessing the competency of children to consent to counselling

Determining competency can be complex and factors that could be used to make the assessment include:

1) Consideration of the child's ability to understand the current issues and circumstances,
2) The child's maturity,
3) Degree of autonomy,

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[34] S.J. Ceci, M. Bruck and D.B. Battin, 'The Suggestibility of Children's Testimony', in D.F. Bjorklund (ed), *False Memory Creation in Children and Adults: Theory, Research and Implications*, Mahwah, Lawrence Erlbaum Associates, 2000, pp.169-201.
[35] T. Grisso and L. Vierling, 'Minor's Consent to Treatment: A Developmental Perspective', (1978), 9, *Professional Psychology*, pp.412-427.
[36] Grisso and Vierling, 1978.

4) Type and sensitivity of information involved,
5) The amount of time spent reflecting on decisions to be made,
6) Attentiveness and awareness regarding details of the problem situation and
7) The degree to which the child actively attempts to acquire information on decisions to be made.

Children should be assessed individually to determine their capacity to give informed consent, and counsellors need to be aware of the position of authority they may hold in the eyes of children and young people, and the possible consequences of this.

Part Three: Obligations of confidentiality

Once the issue of consent to counselling has been examined, we can now turn to the issue of a confidential relationship. First, the ability of children to consent to a confidential relationship of 'secrets' and 'trust' will be examined. Then the various ethical and legal sources of obligations of confidentiality owed to child clients will be explored.

3.1 Consent to a confidential relationship

Bartholomew described when an 'immature minor' has the competence to consent to a confidential relationship in the following terms:

> A non-competent child has this capacity when she or he is in a position to give rise to a confidential relationship (i.e. discloses information ... in private) and is of sufficient understanding and intelligence to understand the nature of the relationship of confidence.[37]

In addition to understanding the nature of the relationship, in uniformity with the test for informed consent, the child might be expected to understand the risks and benefits of a confidential relationship with the counsellor. For example, the risks of disclosure could include the limitations of a confidential relationship, such as any requirements for counsellors to disclose to third parties in specified circumstances. Also the child could demonstrate awareness of alternatives, such as not revealing the type of information that would require disclosure.

3.2 Ability of children to consent to a confidential relationship

The competency of children needs to be assessed individually and not determined simply by age.[38] It is useful however, to consider opinions on when children are generally competent to consent to a confidential relationship, as this will provide guidance for counsellors in their assessments.

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[37] T. Bartholomew, Young People and Informed Consent Project (YPICP) *Minors, Competency and Confidentiality: A Guide for General Practitioners*. Unpublished paper. 2001, p. 16.
[38] *Marion's case* (1992) 175 CLR 218 as 237.

Whilst there has been little direct research on the development of children's capacity to participate in a confidential relationship, research on friendship formation and children as court witnesses provide useful insights into children's understanding of secrets. Confidentiality is a special form of a secret, and like secrets, has certain limitations on maintaining its integrity.

3.2(a) Secrets

The concept of a secret involves two aspects. Firstly, conscious concealment, that is knowing how to conceal information. Secondly, knowing how to tell a secret so that it is likely to be kept. Therefore a secret may be defined as knowledge which is intentionally concealed but which may be shared with a restricted audience.[39]

The mature telling of a secret involves trust that the other will be discreet. Trust involves the expectation that the promise of another can be relied on and that a promise is a stated (or understood) *intention to act*. Therefore, in order to have a mature grasp of a secret and secret telling, a child must have an understanding of trust and of the intentions of others.[40]

A further challenge when revealing secrets is to have an understanding of the outcome of revealing the information. In order to fully consider whether or not to tell a secret, the revealer must integrate both their own intentions in telling the secret, including their trust of the other person, and the potentially adverse implications in disclosing the secret.[41]

Children's understanding of secrets and confidentiality develops with their cognitive and social skills. The development tends to move in a step-wise

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[39] A.J. Watson and R. Valtin, 'A Structural Analysis of Children's Concepts of Secrecy', (1997), 49(1), *Australian Journal of Psychology*, pp.49-54.
[40] T.A. Croxton, S.R. Churchill and P. Fellin, 'Counselling Minors Without Parental Consent', (1988), 67(1), *Child Welfare*, pp.3-14.
[41] B.L. Bottoms, G.S. Goodman, B.M. Schwartz-Kenney and S.N. Thomas, 'Understanding Children's Use of Secrecy in the Context of Eyewitness Reports, (2002), 26(3), *Law and Human Behaviour*, pp.285-313.

manner towards a mature understanding of secrets.[42] However, it is important to remember that children are individuals and that each child's rate of development may be different to other children.[43]

Children under the age of four or five have only a weak understanding of a secret.[44] One of the reasons for this is that children come to know that their thoughts are not accessible to others at about five years of age.[45] Thus the application of secrets research to the concept of confidentiality would imply that children of this age are unlikely to be able to participate in a confidential relationship.

Children between the ages of five and six may only have a limited comprehension of secrets. That being, an understanding of concealment and sharing from only one point of view and a limited concept of the conditional nature of secrets. For example, six year olds tend to say that all secrets must be kept, whether 'good' (birthday surprise) or 'bad' (accidental breakage) secrets.[46]

Five and six year olds also tend to judge trustworthiness on the basis of a person's behaviour, that is, whether they do good things and whether they say 'nice' things, thus relying purely on external behaviour.[47] Therefore, although these children may be able to identify a secret, they have a superficial understanding of trust and it is unlikely that these children will be able to participate in a confidential relationship.[48]

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[42] Croxton, Churchill and Fellin (1988)
[43] L.E. Berk, *Child Development* (3rd Ed), Boston, Allyn and Bacon, 1994.
[44] M-E. Pipe and G.S. Goodman, 'Elements of Secrecy: Implications for Children's Testimony', (1991), 9, *Behavioural Sciences and the Law*, pp.33-41; J. C. Wilson and M-E Pipe, 'Children's Disclosure of Secrets: Implications for Interviewing' in G.Davies, S. Lloyd-Bostock, M. McMurran and C. Wilson (eds), *Psychology, Law and Criminal Justice: International Developments in Research and Practice*, Berlin, Walter de Gruyter, 1996, pp181-187.
[45] J.W. Astington, *The Child's Discovery of the Mind*, Cambridge, Harvard, 1993.
[46] Pipe and Goodman, 1991.
[47] K.J. Rotenberg, 'A Promise Kept, a Promise Broken: Developmental Bases of Trust', (1980), 51, *Child Development,* pp.614-617.
[48] Pipe and Goodman, 1991; see also M-E Pipe and J.C. Wilson, 'Cues and Secrets: Influences on Children's Event Reports, (1994), 30(4), *Developmental Psychology,* pp. 515-525.

Children aged nine to twelve are beginning to understand the contextual and conditional nature of secrets. They have developed a more substantial cognizance of trustworthiness, which they tend to judge by the consistency of a promise and the associated behaviours.[49] Studies have shown that in this period of childhood, secret keeping, usually as an expression of trust, becomes an important element of friendship.[50]

This indicates that these children are likely to understand their intentions in revealing a secret to another, and they may also understand that the receiver has intentions towards that secret. They may not, however, have the capacity to integrate these two intentions, giving them a somewhat restricted understanding of a confidential relationship and its limits.[51]

Thus whilst the child may not be considered competent to engage in a fully confidential relationship, they may be able to participate in decisions regarding the use and disclosure of confidential information with the facilitation of the counsellor.[52] In this way, the child's opinions, needs and privacy are acknowledged and given value.

Children and young people aged twelve and over have a significantly better developed understanding of secrets than younger children and may be competent to participate in a confidential relationship with a counsellor.[53] For example, they demonstrate resistance to adult pressure to conceal, which may be the result of a greater independence of mind stemming from an appreciation of trust and an understanding of the integration of intentions.[54]

3.3 Children who are not competent to give consent

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[49] Rotenberg, 1980.
[50] For example, K.J. Rotenberg, *Children's Interpersonal Trust: Sensitivity to Lying, Deception and Promise Violations,* New York, Springer-Verlag, 1991; see also Watson and Valtin,1997, AJP.
[51] A.J. Watson and R. Valtin, 'Secrecy in Middle Childhood', (1997), 21(3) *International Journal of Behavioural Development,* pp.431-452.
[52] G.B. Melton, 'Children's Participation in Treatment Planning: Psychological and Legal Issues', *Professional Psychology,* (1981) 12(2), pp.146-152.
[53] Watson and Valtin, 1997, IJBD.
[54] Watson and Valtin, 1997, AJP.

The views of children and young people who are determined not to be competent to give informed consent and participate in a confidential relationship should not be automatically ignored or overlooked. There is also support for involving the child client in treatment goals and alternatives even where they have entered into counselling via parental consent or coercion.[55]

Whilst it is difficult to generalise about the practices of various counsellors, the involvement of the child in goal setting is important both ethically and psychologically and respect for the human dignity of a child would mandate assigning them as much autonomy as appropriate within the relationship. Such personal control most likely facilitates therapeutic benefits as well.[56]

3.4 United Nations Convention on the Rights of the Child

International legal instruments also identify the inclusion of children as being of paramount importance. For example, the *United Nations Convention on the Rights of the Child* (the Convention), which has been ratified by Australia, demands that

> State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.[57]

The Convention also includes the rights of children to receive information of all kinds and to protection from interference with their privacy under Articles 13 and 16 and provides for the rights and duties of parents to be respected in relation to the evolving capacity of their child.[58]

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[55] G.P. Koocher, 'A Bill of Rights for Children in Psychotherapy', in G.P. Koocher (ed), *Children's Rights and the Mental Health Professions*, New York, Wiley, 1976; E. A. Seagull, The Child's Rights as a Medical Patient. *Journal of Clinical Child Psychology. Vol 7(3) Fal 1978, 202-204. Lawrence Erlbaum, US*

[56] G.B. Melton, 'Children's Concepts of Their Rights', (1980), 9, *Journal of Clinical Child Psychology*, pp.186-190.

[57] *United Nations Convention on the Rights of the Child*, Article 12.

[58] *United Nations Convention on the Rights of the Child*, Articles 5, 14.

The *Children and Young Persons (Care and Protection) Act 1998* outlines a 'principle of participation' in section 10 which aims to ensure that children and young people are able to participate in decisions made under the Act that have a significant impact on their lives. The Act suggests that counselling or treatment services may constitute a significant impact on the life of a child or young person. The Act also emphasizes the need for the participation of the child to be at a level reflecting their age and developmental capacity.

Moving from international conventions to domestic regulations, we now consider the ethical and legal sources of the duty of counsellors to retain the confidences of clients. This may arise from five areas:

1) Ethical duties imposed by the organisation the counsellor is associated with,
2) Express or implied contractual obligations,
3) A common law duty in tort,
4) An equitable duty of confidentiality, and
5) Statutory duties.

3.5 Ethical codes

In Australia, counsellors who are members of a particular professional body will be subject to that association's code of ethics.[59] A common obligation for members arises in relation to confidentiality and following are some examples of the confidentiality requirements of various professional associations.[60]

The **Australian Counselling Association's** sample consent form states that all personal information gathered by the counsellor 'will remain confidential and secure' except when it is subpoenaed by a court or where failure to disclose the information would place the client or another person at risk or where consent has been obtained.

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[59] Note that not all counsellors in Australia belong to a professional association.
[60] See Appendix 1 for a detailed description of these obligations.

The Ethical Principles of the **Psychotherapy and Counselling Federation of Australia** contain an obligation that counsellors 'respect the privacy of their clients and preserve the confidentiality of information' unless exceptional circumstances arise which give the Counsellor good grounds for believing that the client will cause serious physical harm to others or themselves.

The confidentiality obligation on members of the **Australian Guidance and Counselling Association** is to 'safeguard confidential information'. As the Association consists of school counsellors, guidance officers and school psychologists, it makes special provision for children. While consent is generally negotiated with parents, in some circumstances counsellors 'may obtain consent from students before releasing information to parents or professionals in other agencies'. The Association therefore places an obligation on counsellors to retain the confidentiality of some students, to the exclusion of their parents. They state:

> The *need* to obtain consent from students should take into account the age at which at person is legally defined as being independent as well as the level of student's mental and moral development. [italics added]

Exceptions to this principle are when the counsellor believes the client is in immediate danger to themselves or to others.

The obligations of members of the **Australian Association of Social Workers** are to
'respect' the right of clients to a relationship of trust and confidence. Social workers are restricted to using the confidential information 'for the purposes for which it was acquired; or, with the consent of service users, for a directly related purpose; or with lawful excuse...' The social worker must seek the informed consent of service users when their information is to be used, to inform service users about the limits of confidentiality and to reveal confidential information only when compelling ethical or legal reasons prevail.

Similarly, the members of the **Australian Psychological Society** must 'respect' the confidentiality of information obtained from clients. They are

restricted to disclosing information to others only with the consent of the client. In circumstances however, where failure to disclose may result in clear risk to the client or to others, members may disclose sufficient information to avert risk. In regards to children, the Code states that 'when working with minors or other persons who are unable to give voluntary, informed consent, psychologists must protect these persons' best interests and will regard their responsibilities as directed to the parents, next of kin or guardians, in accordance with the normal legal formulae.'

All of these associations state that the duty of confidentiality should only be breached under exceptional circumstances. Only one, the Australian Guidance and Counselling Association appears to make provisions for preserving confidentiality for children deemed to have the capacity to participate in a confidential relationship.

Clients can complain about breaches of confidentiality to the relevant professional body or association and this can lead to disciplinary action such as, suspension from clinical work or deregistration. Counsellors who are not members of such associations or professional bodies are not subject to the ethical codes or disciplinary proceedings. Therefore clients who are receiving services from counsellors who are not members of professional associations do not have the option of this form of redress.

Also while these ethical codes do not have the force of law the courts may consider them in determining the legal standard of confidentiality. For example, the English Court of Appeal in *W v Egdell* referred to the ethical codes of the General Medical Council (the professional body to whom the psychiatrist belonged) when considering whether the breach of confidence fell within any exceptions to their duty of confidentiality.[61]

3.6 Legal obligations

[61] *W v Egdell* [1990] 1 All ER 835.

An action for a counsellor's breach of confidence may arise in equity and contract law. Lord Goff of Chieveley stated:

> I start with the broad general principle... that a duty of confidence arises when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice, or is held to have agreed, that the information is confidential, with the effect that it would be just in all the circumstances that he should be precluded from disclosing the information to others... The existence of this broad general principle reflects the fact that there is such a public interest in the maintenance of confidences, and that the law will provide remedies for their protection.
>
> I realise that in the vast majority of cases ... the duty of confidence will arise from a transaction or relationship between the parties, often a contract, in which event the duty may arise by reason of either an express or implied term of that contract... But it is well-settled that a duty of confidence may arise in equity independently of such cases.[62]

A separate action in tort may also arise if there has been a negligent breach of a duty of confidence.

3.6(a) Common law duty in tort

Four legal elements must be satisfied to found an action in tort:

1) The counsellor owed a duty of care to the client,
2) The counsellor breached that duty of care,
3) The client suffered damage and
4) The damage was caused by the counsellor's failure to take reasonable care.

Unless a client suffers physical injury or economic loss, it will be necessary for them to satisfy the court they have suffered 'nervous shock'. This requires proving that the damage the counsellor caused was a 'lasting impairment to their mental health', which excludes 'transitory emotional distress' suffered by clients.[63] While difficult to establish, it is not impossible.

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[62] *A-G v Guardian (No 2)* [1988] 3 All ER 545 at 658.

[63] J. Milne, 'An Analysis of the Law of Confidentiality with Special Reference to the Counselling of Minors, (1995), 30(3), *Australian Psychologist*, pp. 169-174 at 170.

The plaintiff in the New Zealand case of *Furniss v Fitchett* was awarded damages for suffering nervous shock for the negligent breach of confidence on the part of a doctor.[64] In this case, the family doctor, upon request, provided a written report to the husband on the mental instability of the wife. The husband produced this report in proceedings for marital separation. The court held the doctor had a duty not to disclose the information to a third party and the doctor should have foreseen that such a disclosure would cause the wife to suffer harm.

3.6(b) Contracts

As Lord Goff observed above, clients may rely on express or implied contractual terms of confidentiality. Lord Diplock (as he then was) described the duty as a

> contractual duty of confidence, generally implied though sometimes expressed... subject to, and overridden by, the duty of any party to that contract to comply with the law of the land.[65]

(i) Express contractual terms

An example of an express contractual term is the confidentiality clause of the Australian Counselling Association in its standard form of contract.[66]

(ii) Implied contractual terms

The law implies a term of confidentiality in the contracts of professionals where it is 'so obvious it goes without saying'.[67] The courts would imply such a term in a counselling relationship, as the retaining of confidences is implicit in this relationship.

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[64] *Furniss v Fitchett* [1958] NZLR 396.
[65] *Parry-Jones v Law Society* [1969] 1 Ch 1 at 9.
[66] See Appendix 1.
[67] *AB v CD* (1851) 14 Dunlop 177; *AB v CD* (1904) 7 F 72; *Tournier v National Provincial & Union Bank of England* [1924] 1 KG 461 (CA), per Scrutton LJ MR at 480-481; *Parry-Jones v Law Society* [1969] 1 Ch 1 (CA), per Lord Denning MR at 7 and Lord Diplock LJ at 9; *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 (HC), per Jeffries J at 520.

The imposition of implied terms and the use of express terms however, may depend upon the ability of the child to enter a contract. Two jurisdictions permit children entering into legally binding contracts with judicial supervision. In New South Wales, minors can apply to the Supreme Court for capacity to enter into a contract. The court will grant that capacity on such terms the court thinks fit and only if the court finds the contract is for the benefit of the child.[68] In South Australia, judicial approval of the terms of a contract made with a minor means that the contract has the effect in law as if the minor had attained the age of majority.[69] Both minors and counsellors may apply under this section.[70]

An issue arises as to whether a contract may exist where parents pay the fee for the service or where a counsellor employed by a school provides the service.[71] However, there is support for the proposition that a contract may exist between counsellor and child notwithstanding that payment is provided by the parents of the child. Lord Justice Barrowclough in *Furniss v Fitchett* seemed to accept that a contract could exist between a doctor and client notwithstanding the fact the patient's husband paid the doctor's fees.[72]

3.6(c) Equitable duty not to breach a confidence

There are three elements a plaintiff must establish to enforce a duty of confidence:

1) The information had the necessary degree of confidence,
2) It was imparted in circumstances giving rise to an obligation of confidence and

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[68] *Minors (Property and Contracts) Act* 1970 (NSW) s 29.
[69] *Minors Contracts (Miscellaneous Provisions) Act* 1979 (SA) s 6. Applications can be made to the Supreme Court or Local Court exercising full jurisdiction.
[70] *Minors Contracts (Miscellaneous Provisions) Act* 1979 (SA), ss 6(2) allows applications to be made by the minor, parent or guardian or other party to the proposed contract.
[71] See Australian Law Reform Commission, *Privacy*, Report No.22, Volume 1, 1983, pp. 414-415.
[72] *Furniss v Fitchett* [1958] NZLR 396.

3) There was an unauthorised use of the confidential information to the detriment of the party communicating it.[73]

(i) Necessary degree of confidence

The information may be personal and intimate. Cases where the court have held there was a necessary degree of confidence include; the private drawings of Queen Victoria,[74] personal confidences including personal details in letters,[75] information on the private affairs and lives of a married couple[76] and the sources of a correspondent.[77]

(ii) Imparted in circumstances of confidence

Gowan J held that the obligation of confidence might arise

> by reason of the terms of an agreement, or what is implicit in them, by reason of the nature of the relationship between the persons, or by reason of the subject-matter and the circumstances in which the subject matter has come into the hands of the person charged with the breach.[78]

Therefore an obligation of confidence is most likely to arise in a counselling relationship by reason of a special relationship or by reason of the circumstances in which the subject matter came into the hands of the person charged with breach.

Special relationship

While some have suggested that a relationship between counsellor and client may be recognised by Australian courts as a fiduciary relationship and that

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[73] *Coco v A.N. Clark (Engineers) Ltd* [1969] RPC 41, per Megarry J at 47; this test has been approved in *Australia in Commonwealth of Australia v John Fairfax and Sons Ltd* (1980) 147 CLR 39 at 51 per Mason J.
[74] *Prince Albert v Strange* (1849) 18 LJ Ch 209.
[75] *Philip v Pennell* [1907] 2 Ch 577.
[76] *Argyll v Argyll* [1967] 1 Ch. 302.
[77] *Beloff v Pressdam* [1973] RPC 765.
[78] *Ansell's case* [1967] V.R. 37 at 40.

this may provide another potential liability for counsellors,[79] a similar line of reasoning was rejected by the High Court of Australia in 1996.[80]

There is support however, for the proposition that a counsellor-client relationship may be considered a special relationship. Lord Denning considered that professional-client relationships were the broader category of special relationships:

> The law implies a term into the contract whereby a professional man is to keep his client's affairs secret and not to disclose them to anyone without just cause.[81]

Circumstances

While there is no direct authority, it would be expected that the courts would find a duty exists between counsellor and client, especially given the application of breach of confidence in equity to personal and intimate relationships.[82] Justice Ungoed-Thomas emphasised the court's policy of protecting confidences in personal relationships:

> The policy of the law, so far from indicating that communication in between husband and wife should be excluded from protection against breaches of confidence given by the Court in accordance with *Prince Albert v Strange*, strongly favour their inclusion, and in view of that policy it can hardly be an objection that such communications are not limited to business matters.[83]

(iii) Unauthorised use

Failure to obtain consent to disclose information obtained during counselling by the person who has received counselling is an 'unauthorised use' as the information is used for a purpose which is inconsistent with the purpose for which it was given.

3.6(d) Statutory duties

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[79] P. Finn, 'Professionals and Confidentiality', (1992), 14, *Sydney Law Review*, pp. 317-339.
[80] *Breen v Williams* (1996) 186 CLR 71.
[81] *Parry Jones v Law Society* [1969] 1 Ch 1 at 7, per Lord Denning.
[82] See cases cited above in 3.2(c)(i) Necessary degree of confidence.
[83] *Argyll v Argyll* [1967] 1 Ch. 302 at 624.

The work of some counsellors is governed by legislation that imposes statutory duties in relation to confidentiality. For example, Family Court counsellors providing family and child mediation services are under a statutory duty not to disclose any communication made in the capacity of mediator.

There are exceptions to this duty where the mediator reasonably believes it is necessary to do so to protect a child; to prevent or lessen a serious and imminent threat to the life, health or property of a person; to report the commission (or likely commission) of an offence involving violence or a threat of violence to a person or intentional damage to property of a person or a threat of damage to property; to enable the mediator to discharge properly his or her functions as mediator; or, if a child is separately represented by a person under an order for separate representation (under section 68L of the *Family Law Act* 1975), to assist the person to represent the child properly.[84]

Examples of other statutory obligations of confidentiality upon counsellors include:

1) Obligations upon Commonwealth Officers to keep records confidential;[85]
2) A duty of confidentiality applying to information in relation to HIV/AIDS patients[86] and
3) A duty of confidentiality on people involved in the care of the mentally ill.[87]

Further, school counsellors may be required under government policy to adhere to principles of confidentiality. For example, in NSW, the policy guidelines state:

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[84] Private mediators are governed by Reg 67, *Family Law Regulations* 1984. Court mediators or community mediators are governed by s 19K, *Family Law Act* 1975 and Reg 66, *Family Law Regulations* 1984.
[85] (Cth) *Privacy Act* 1988 Pt VIII.
[86] For example, *Public Health Act* 1991(NSW), ss 17(1), (2).
[87] *Mental Health Act* 1990 (NSW) s 289; *Mental Health Act* 1993 (SA) s 34; *Mental Health Act* 1986 (Vic) s 120A.

> School counselling is a confidential service and school counsellors will check with students, parents or carers before passing on information (such as the results of learning difficulties) to others. Confidentiality will be maintained unless legal requirements, e.g. child protection legislation, override it. Nor will confidentiality be maintained where someone may suffer serious harm from information being withheld.[88]

3.6(e) Privacy Legislation

The *Privacy Amendment (Private Sector) Act* (2000), which amended the *Privacy Act* (1988), includes ten National Privacy Principles (NPPs). These principles set the minimum standard that health service providers must abide by when they collect, use, disclose and store clients' health information. The new legislation covers health information about clients held by counsellors, including social workers and psychologists, who are being paid for their services. Health information includes any information or an opinion about a client's health or disability either past, present or future. As well as any other personal information collected while a client is receiving a health service.

Counsellors need to be aware of and comply with the NPPs regarding:

1) The collection of health, personal and sensitive information – NPP1 and NPP10,
2) The use and disclosure of such information – NPP2,
3) The quality (accuracy and completeness) of the data held – NPP3,
4) Data security – NPP4,
5) Openness in how health information is handled – NPP5,
6) Clients' access to health information, clients can ask for information about them to be corrected, if inaccurate, incomplete or out-of-date – NPP6,
7) Restrictions on how Commonwealth government identifiers can be adopted, used or disclosed – NPP7,
8) Client anonymity – NPP8 and
9) Transference of health information out of Australia – NPP9.

In general, counsellors cannot disclose personal information to other people or organisations without the client's consent. Although, there are exceptions where

[88] NSW Department of Education and Training, *School Counselling Service*, 2001.

disclosure is authorised or required by or under law (for instance: a subpoena or court order, or legislation requires a child at risk to be reported – see 3.4 (d) below) (NPP2 s. 2.1 (g)). Also, the counselling organisation may use or disclose personal information if it believes this is necessary to lessen or prevent:

(i) a serious and imminent threat to an individual's life, health or safety; or

(ii) a serious threat to public health or public safety (NPP2 s. 2.1(e)).

Furthermore, if the organisation has reason to suspect that unlawful activity has been, is being or may be engaged in, and uses or discloses the personal information as a necessary part of its investigation of the matter or in reporting its concerns to relevant persons or authorities, this is permitted under the Act (NPP2 s. 2.1 (f)). Other limited exceptions are also outlined in the Act.

Complaints about alleged breaches of privacy can be made to the Federal Privacy Commissioner. The Commissioner can investigate, conciliate and, if necessary, make determinations about complaints. However, the Commissioner will not investigate, unless the complainant has first complained formally to the health service provider concerned. However, the Commissioner may decide to investigate the complaint if he or she considers that it was not appropriate for the complainant to complain to the respondent, so there is some discretion.[89]

3.7 Remedies

3.7(a) Damages

Damages are available in tort for the negligent disclosure of confidential information resulting in nervous shock.[90] Damages or equitable compensation are also available for breach of confidence in contract or equity.[91] Traditionally

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[89] *Privacy Amendment (Private Sector) Act* (2000), ss36, 40(1A).
[90] *Furniss v Fitchett* [1958] NZLR 396.
[91] *Seager v Copydex Ltd* [1967] 2 All ER 415.

damages for breach of confidence were not awarded for mental distress or embarrassment. It is now the law that damages may be awarded for mental distress where the purpose of the contract was to provide the plaintiff with peace of mind.[92] Damages have also been awarded for embarrassment,[93] loss of privacy[94] and fear of physical harm.[95]

3.7(b) Injunction

Injunctions are available either to restrain an initial breach or to prevent further breaches.[96] Where the claim is equitable, relief may include an order for delivery up of documents containing the confidential information.[97]

3.8 Defences

There are five defences, which may be raised by a counsellor accused of breaching their duty of confidentiality:

1) The information was not obtained in confidence,
2) The client consented to disclosure,
3) Disclosure was required to inform a court of law,
4) Law required mandatory disclosure or
5) Disclosure was made in the public interest.

3.8(a) The information was not obtained in confidence

Information is not obtained in confidence if it is already in the public domain.[98]

3.8(b) The client consented to disclosure

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[92] *Baltic Shipping Co v Dillan* (1993) 176 CLR 344.
[93] *Pollard v Photographic Co* (1888) 40 Ch D 345.
[94] *Foster v Mountford* (1976) 12 ALR 71.
[95] *G v Day* [1982] 1 NSWLR 24; *Falconer v Australian Broadcasting Corp.* (1991) 22 IPR 205.
[96] *A-G (UK) v Observer Ltd* [1990] 1 AC 109; *Wheatley v Bell* [1982] 2 NSWLR 544.
[97] *Saltman Engineering Co Ltd v Campbell Engineering Co. Ltd* (1948) 65 RPC 203; *Ansell Rubber Co Pty Ltd v Allied Rubber Industries Pty Ltd* [1967] VR 37; *British Steel Corporation v Granada Television Ltd* [1981] AC 1096.
[98] *Saltman Engineering Co Ltd v Campbell Engineering Co. Ltd* (1948) 65 RPC 203.

A client may expressly or impliedly consent to disclosure. For example, consent may be implied in an agency where the care of one person is shared between various counsellors. The duty of confidentiality however, will be imposed upon all people with access to those records containing confidential information.[99]

3.8(c) Disclosure was required to inform a court of law

Communications between counsellors and their clients are not covered by professional privilege and counsellors may be required to disclose confidential information during court proceedings. Courts may also require the production of confidential records by subpoena or discovery.[100]

Some types of counselling records have extra legislative protection. For example the sexual assault communications privilege, which is contained, in the *Criminal Procedure Act* 1986 (NSW) provides discretionary protection for a wide range of counselling confidences made in connection with services provided to victims of sexual assault.[101]

3.8(d) Disclosure required by Law

All states and territories in Australia, except for Western Australia, provide for the mandatory reporting of suspected child abuse.[102] The legislation compels specified persons to report suspected child abuse, provides an immunity from professional or legal duties of confidentiality where the suspicion of child abuse was reasonable and generally imposes a penalty on those persons who fail to report where required. The laws vary according to type of abuse,

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[99] *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 at 521.

[100] While no direct authority for counsellors, medical practitioners have been required to produce documents containing confidential information where a summons has been issued: *Hill v Minister for Community Services and Health* (1991) 102 ALR 661.

[101] For further information see, D. Brown et al, *Criminal Laws: Materials and Commentary on Criminal Law Process in New South Wales*, Sydney, The Federation Press, 2001, p.915; NSW Legislative Council, *Criminal Procedure Amendment (Sexual Assault Communications Privilege) Bill*, Second Reading Speech, Hansard (07/05/2002).

[102] See Appendix 2 for details of the mandatory reporting provisions in the States and Territories.

the groups of persons required to report, the standard of suspicion or belief and the age group of the child covered by the laws.[103]

However, even in situations where a counsellor is not mandated to report, moral and ethical responsibilities to act in the client's best interests may necessitate reporting suspected abuse or neglect.

TABLE 4

Jurisdiction	Relevant Act	Mandated employment in which counsellors might work	Government department overseeing child protection
ACT	*Children and Young People Act* 1999	School counsellor; child care centre employee; co-ordinator of home-based child care or family day care; public servant providing services related to the health or well-being of children, young people or families	Department of Family Services
Commonwealth	*Family Law Reform Act* 1995	Family and child counsellor; family and child mediator	Relevant state department
NSW	*Children and Young Persons (Care and Protection) Act* 1998	Persons employed to deliver health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly to children. Persons in management with direct responsibility for, or direct supervision of, above services to children.	Department of Community Services
NT	*Community Welfare Act* 1983	All members of the public are mandated to report	Department of Family Youth and Children's Services
QLD	*Child Protection Act* 1999	Employees of DFYCC. Staff in residential care services for children.	Department of Families Youth and Community Care

[103] For an excellent discussion of mandatory reporting laws see D. Sandor, 'Mandatory Reporting Laws: Adolescents and their Right to be Heard, (1994), 5(4) *Criminology Australia*, pp. 17-22.

SA	*Children's Protection Act* 1993	Psychologists; employee of the Public Service who supervisors young or adult offenders in the community; social worker; teachers; family day care providers; employees and volunteers of Government departments, local government and non-government agencies, that provide health, welfare, education, child care or residential services wholly or partly for children; both workers and management of these services.	Department of Human Services
TAS	*The Children Young Persons and Their Families Act* 1997	Registered psychologists; managers of child care centres; an employee of a government agency that provides health, welfare, education, child care or residential services wholly or partly for children; and an organisation that receives any funding from the Crown	Department of Health and Human Services
VIC	*Children and Young Persons Act* 1989	Registered psychologists; a person permitted to teach; the proprietor or, or a person with a post-secondary qualifications in the care or education of children who is employed by a children's service; a person with tertiary qualifications in youth, social or welfare work who works in the health, education or community or welfare services field; public service youth and child welfare workers.	Department of Human Services
WA	Nil	Department of Health	

Table 4. *Child protection reporting requirements across Australia*

3.8(e) Disclosure was made in the public interest

Where the public interest in disclosure outweighs the public interest in confidentiality disclosure of confidential information is permitted,[104] but only to those persons who have an interest in the disclosure.[105] The English courts have defined the defence quite widely. Lord Denning found the defence extended to

[104] *W v Edgell* [1990] 1 All Er 835.
[105] *Initial Services Ltd v Putterill* [1968] 1 QB 396 at 405-6; *Attorney-General (UK) v Heinemann Publishers Australia Pty Ltd* (1987) 8 NSWLR 341 at 380-1.

> any misconduct of such a nature that it ought in the public interest to be disclosed to others... The exception should extend to crimes, frauds and misdeeds, both those actually committed as well as those in contemplation provided always - and this is essential - that the disclosure is justified in the public interest.[106]

Justice Ungoed-Thomas described the kinds of 'misdeeds' covered by the defence as

> matters carried out or contemplated, in breach of the country's security, or in breach of law, including statutory duty, fraud or otherwise destructive of the country or its peoples, including matters medically dangerous to the public; and doubtless other misdeeds of similar gravity.[107]

The English Court of Appeal has even extended the defence to include disclosure where the public interest was to correct a false image in the public mind.[108]

Public interest disclosure has not been as widely interpreted in Australia and it has been held that the defence does not extend to disclosure of actual or threatened breaches of security of the law or misdeeds of similar gravity relating to matters such as public health.[109] However information regarding serious crimes, such as sexual abuse of a child, has been recognised as falling within the public interest defence in Australia.

For example, in *Brown v Brooks & Ors*, a client who was receiving counselling for anxiety and depression, revealed that he had been sexually abusing his stepdaughter.[110] The client was later charged with sexual assault and police requested that the counsellor provide information about the abuse obtained during the course of counselling. The client sought an injunction, which was refused by the NSW Supreme Court on the grounds it was contrary to public policy to enforce a duty of confidentiality which would impede the investigation of a serious crime.

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[106] *Initial Services Ltd v Putterill* [1968] 1 QB 396.
[107] *Beloff v Pressdam* [1973] 1 All ER 241.
[108] *Woodward v Hutchins* [1977] 2 All ER.
[109] *Castrol Australia v Emtech Associates* (1980) 33 ALR 31, per Rath J.
[110] *Brown v Brooks & Ors* (1988) unreported, NSW SC, 18th August.

In the United States, courts have held that counsellors have a duty to warn others of impending serious danger when the risk is toward an identifiable person and is foreseeable.[111] There is uncertainty over whether a duty to others would be recognised in Australia. McMahon gives a comprehensive overview of the law in England and Australia on this point and argues it is unlikely Australian or English courts would recognise such a duty given a judicial reluctance to impose affirmative duties to act.[112]
Nevertheless, she suggests Australian courts may hold such a duty exists where the victim is clearly identifiable and reasonable steps may be taken to prevent imminent risk of danger.

As Finn states, the law will permit, rather than require disclosure of confidential information where 'the information relates to serious wrongdoing which is in the public interest to disclose' and most probably 'if the disclosure will avert apprehended serious harm to the public or members thereof'.[113]

3.9 Explaining the limits of confidentiality

A frequent problem for counsellors arises in relation to informing clients of the limits to confidentiality, such as mandatory disclosure laws. Assuring absolute confidentiality may enhance the client's opportunity for free disclosure, but providing appropriate information about the limits to confidentiality is more respectful of the client's autonomy and allows them choice over what information to reveal.

It is commonly thought that in making a client aware of any limits to confidentiality the therapeutic relationship will be undermined and important information may be withheld.[114] Alternatively if the counsellor fails to inform

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[111] *Tarasoff v Regents of the University of California*, 551 P.2d 334 (Cal. Sup. Ct. 1976) where a client disclosed their intention to kill their girlfriend to a psychologist and later did so.
[112] M. McMahon, 'Dangerousness, Confidentiality, and the Duty to Protect', (1992) 27(1), *Australian Psychologist*, pp. 12-16.
[113] P. Finn, 'Professionals and Confidentiality', (1992), 14, *Sydney Law Review*, pp. 314-339 at 323.
[114] M. Smith-Bell and W. J. Winslade, 'Privacy, Confidentiality, and Privilege in Psychotherapeutic Relationships. *American Journal of Orthopsychiatry*. Vol 64(2) Apr 1994, 180-193

the client about the limits at the outset, later disclosure of a confidence could result in feelings of betrayal and cause the client to distrust other counsellors, leaving them isolated from support services.

Often the ethical codes of professional associations will require members to inform their clients about any limits to confidentiality prior to the commencement of therapy.[115] Some organisations also request that clients sign a consent form at the commencement of therapy, which indicates that they have been provided with information regarding limits to confidentiality, and privacy and that they agree to those terms.[116] Many agencies view such practices as essential as they provide legal protection in the event of a future need to breach confidentiality.

3.10 Children and legal options

An equitable action for breach of confidence may provide the best legal redress for children who have their confidences breached by a counsellor, as action in contract requires the existence of a contract and action in tort may be difficult to establish.

To succeed the child plaintiff must establish the three elements of the equitable duty not to breach a confidence. These are, that the information had the necessary degree of confidence, that it was imparted in circumstances giving rise to an obligation of confidence and that there was an unauthorised use of the confidential information. Determining whether there has been an 'unauthorised disclosure', may depend upon whether parents have the right to consent to disclosure.

It is suggested that the law may not permit parents to access information obtained during the course of counselling without the consent of the child, where the child is sufficiently mature to consent to a confidential relationship, even though they may not be sufficiently mature to consent to counselling.

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[115] For example the AASW and APS codes, see Appendix 1.

Exceptions arise where the information to be disclosed comes within one of the defences to an action for breach of confidence.

Counsellors should also inform the child client of the limits to confidentiality before commencing counselling as this means that any information the child reveals which is outside those limits is not given in circumstances of confidence. It is submitted that it is only then that the equitable duty not to breach confidences will be discharged.

3.11 Children's right to confidentiality

There has been no judicial consideration in Australia of the duties of confidence owed by counsellors to children. The broad principle from *Gillick* could be applied to grant an entitlement to confidentiality. Children who are unable to consent to counselling but have the intelligence and maturity to enter into a confidential relationship may be able to consent to a relationship of confidence.

This idea has the support of a number of medico-legal commentators with regard to 'immature minors' in medical cases.[117] For example, Kennedy and Grubb state that competence to enter into a confidential relationship is the guiding principle in establishing whether there is a duty of confidence.[118]

They suggest that once the child is capable of consenting to a confidential relationship an obligation of confidentiality arises which is analogous to the duty applicable to adults. They claim that exceptions to this principle will exist 'where the child's life is threatened or the child is exposed to a demonstrable risk of serious harm'.[119]

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[116] J.E.B. Myers, 'Legal issues surrounding psychotherapy with minor clients' *Clinical Social Work Journal,* (1982) 10(4), 303-314.
[117] I. Kennedy and A. Grubb, *Medical Law: Text with Materials* (2nd ed), London, Butterworths, 1994, p.642; Montgomery, op cit pp.101-104; J. Milne, 'An Analysis of the Law of Confidentiality With Special Reference to the Counselling of Minors', (1995), 30(3), *Australian Psychologist*, p.173.
[118] Kennedy and Grub, p.642.
[119] Kennedy and Grub, p.642.

Milne has also noted the possibility that a duty of confidentiality may arise when a child enters a confidential relationship:

> ...the *Gillick* decision would suggest that, should an adolescent voluntarily approach a counsellor and request that any information disclosed not be communicated to their parent/s or indeed to any other specified third party, the counsellor must respect and abide by this request. Arguably ...it would be possible for civil proceedings to be initiated against a counsellor on behalf of the minor if this confidence were to be breached.[120]

It could also be argued that even if a child does not specifically ask for their information to remain confidential, if they have been assessed by the counsellor to have the capacity to engage in a confidential relationship, then their confidentiality should be respected.

The issue for consideration is therefore whether an argument can be sustained that the effect of a child consenting to a confidential professional relationship is that the counsellor concerned comes under a legal obligation to retain the confidences of the child.

3.11(a) Arguments for a legal obligation to retain confidences

There are three main justifications for the existence of a legal obligation:

1) Policy considerations
2) Human dignity of children
3) Unexaminable discretion of counsellor

(i) Policy considerations

Policy considerations were relied upon in *Gillick* to establish that competent minors have the right to consent to medical treatment. Lord Fraser of Tullybelton stated:

> ...to abandon the principle of confidentiality for contraceptive advice to girls under 16 might cause some of them not to seek professional advice at all, with the consequence of exposing them to 'the immediate risks of pregnancy and of sexually transmitted diseases'.[121]

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[120] J. Milne 1995 above n95, p.173.
[121] *Gillick* [1986] 1 AC 112 at 173.

Similar policy considerations apply to counselling. If children and young people are concerned about the potential breach of confidentiality, they are likely to forgo counselling or fail to disclose information for which they may need assistance. Gustafson and McNamara comment:

> Whether confidentiality will be ensured may influence the adolescent's decision to enter psychotherapy. An adolescent not guaranteed confidentiality may decide not to enter therapy or may reluctantly participate without disclosing his or her concerns. Thus as with adult clients, ensuring confidentiality serves the interests of society in that it induces individuals in need of treatment to seek that treatment.[122]

If children fear their trust will be breached, they may end up struggling alone with their problems. There can also be significant consequences for the child's health and well being as they lose the opportunity to access preventative information and support services. Conversely, the assurance of a confidential environment, subject only to any specified limits to confidentiality, ensures a better outcome for the child who receives the assistance of the counsellor.

(ii) Human dignity of children

An important objective when working with children is to respect their autonomy and human dignity. Justice Brennan made the following comments in *Marion's case*:

> Human dignity is a value common to our municipal law and to international instruments relating to human rights. The law will protect equally the dignity of the hale and hearty and the dignity of the weak and lame; of the frail baby and of the frail aged; of the intellectually able and of the intellectually disabled...Human dignity requires that the whole personality be respected...[123]

Recognition of the right of children to have confidences protected in a confidential relationship is consistent with legal acknowledgement of the importance of preserving human dignity.

(iii) Unexaminable discretion of counsellor

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[122] K. Gustafson and J. McNamara, 'Confidentiality With Minor Clients: Issues and Guidelines for Therapists', (1987), 18(5), *Professional Psychology: Research and Practice*, p.503 at 505.
[123] *Marion's case* (1992) 175 CLR 218 per Brennan J at 266-267.

The absence of a legal obligation to retain the confidences of a child results in a counsellor having an 'unexaminable discretion' to disclose information when it is considered in the best interests of the child to do so. As Brennan J observed:

> ...in the absence of legal rules or a hierarchy of values, the best interests approach depends upon the value system of the decision-maker. Absent any rule or guideline, that approach simply creates an unexaminable discretion in the repository of the power.[124]

3.11(b) Arguments against a legal obligation to retain confidences

There are three possible arguments that a duty of confidentiality does not arise simply by a child consenting to a confidential relationship:

1) Act to be performed
2) Pre-conditions to confidentiality
3) Resources of the child

(i) Act to be performed

It has been held that a valid consent must cover the 'act to be performed'.[125] Therefore it is argued that a child's consent to a confidential relationship may not cover the actual 'act to be performed'. For example, it may be argued that the 'act to be performed' is counselling and that consequently there is a legal requirement that the child is sufficiently mature to consent to counselling. Thus determining whether there is a valid consent is very dependent on the interpretation of 'act to be performed'.

This can be illustrated by asserting that the actual 'act to be performed' is the keeping of confidences and that the child does not need to consent to counselling, only to entering a confidential relationship. This argument is convincing as it makes a literal translation of the requirement for the consent to cover the act.

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[124] *Marion's case* (1992) 175 CLR 218 per Brennan J at 271.
[125] *Walker v Bradley* (unreported, NSW Dist Ct, Kirkham J, 1919 of 1989, 15 Dec 1993); *Murray v McMurchy* [1949] 2 DLR 442.

(ii) Pre-conditions to confidentiality

In *Gillick* the majority view of the House of Lords could be interpreted to impose conditions to be met prior to a duty of confidentiality arising with competent minors in medical treatment. Lord Fraser of Tullybelton held that a doctor might give contraceptive advice and treatment to a girl under 16 without the knowledge and consent of her parents, if satisfied that:

(i) the girl will understand the advice,
(ii) the girl cannot be persuaded to inform her parents or will not allow him or her to inform her parents that she is seeking contraceptive advice,
(iii) the girl is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment,
(iv) unless the girl receives contraceptive advice or treatment her physical or mental health or both are likely to suffer, and
(v) her best interests require him or her to give contraceptive advice, treatment or both without parental consent.[126]

On this view once these conditions are met, confidentiality must then be observed with child clients.

The facts of the case appear to anticipate the application of such conditions to medical interventions that may be very intrusive as well as being potentially risky. That is, the nature of the procedure will import a higher threshold for establishing a duty of confidentiality. On this basis it may be submitted that such pre-conditions are not equally applicable to the context of counselling. The rationale being that counselling is less invasive and hazardous than medical intervention.

In other words it could be argued that it should be easier to establish the right of a child to confidentiality in counselling. Though this position is flawed in that

it assumes that such pre-conditions will not be applicable to counselling because the therapeutic relationship is harmless.

A further problem in such an argument is that the focus is on the nature of the treatment rather than the capacity of the child. Rather it should be that where a child can demonstrate the ability to consent to either a confidential relationship or to give informed consent to a treatment (which includes having the capacity to engage in a confidential relationship) a duty of confidentiality will arise automatically regardless of the context.

Therefore ideally a duty of confidentiality should arise whenever a child is capable of engaging in a confidential relationship. Also once the child has demonstrated such capacity the duty should exist whether or not it was the child who consented to the treatment. There is some support for this idea, albeit confined to 'exceptional cases' in the judgement of Lord Scarman in *Gillick*:

> ...in exceptional cases the parental right to make decisions as to the care of their children, which derives from their right of custody, can lawfully be overridden, and that in such cases the doctor may without parental consultation or consent prescribe the contraceptive treatment in the exercise of his clinical judgment. And the guidance reminds the doctor that *in such cases he owes the duty of confidentiality to his patient, by which is meant that the doctor would be in breach of his duty to her if he did communicate with her parents.*[127] [italics added]

(iii) Resources of the child

The third argument against a duty of confidentiality arises from concerns about the particular resources and skills of the individual child. For example, where the child is able to engage in a confidential relationship, but is not competent to consent to counselling this may indicate that they will also be unable to cope with the situation disclosed, even with the assistance of the counsellor.

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[126] *Gillick* [1986] 1 AC 112 at 174.
[127] *Gillick* [1986] 1 AC 112 at 180-1.

Such concerns will be simply resolved where the matter falls into an exception to confidentiality, such as mandatory disclosure or risk of immediate harm.[128] While ideally any other confidences given by the child should not be disclosed to avoid any further inroads on the principle of confidentiality there may be some areas of uncertainty for counsellors. For example, the disclosure of information that may indicate health concerns, such as an eating disorder where the intervention of third parties has been recognised as beneficial.

Ideally the process of counselling will involve encouraging children to disclose information to parents and third parties where appropriate, but in a manner which enables the child to have control over this decision. Thus confidentiality does not necessarily mean parents will always be excluded. Rather the role of parents in the counselling relationship is determined in a manner, which respects the right of the child to autonomy.[129]

In conclusion, the law in Australia should be interpreted as supporting the proposition that children who have the capacity to engage in a confidential relationship are owed a duty of confidentiality. The reasons for this position include policy considerations such as ensuring that children access services in times of stress and disadvantage and respect for the autonomy of children in line with the principle respecting human dignity as recognised by Justice Brennan in *Marion's case*.

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[128] See Appendix 2.

[129] L. Rew, M. Taylor-Seehafer, N. Thomas, 'Without Parental Consent: Conducting Research with Homeless Adolescents' *Journal of the Society of Pediatric Nurses*. Vol 5(3) Jul-Sep 2000, 131-138. Nursecom, US

Part Four :Capacity of Parents to Force an Unwilling Child to Counselling

The final issue here is whether the law recognises the capacity of parents to have a concurrent authority to consent on behalf of the child. Even if capable of consenting to counselling, the child may refuse. While *Gillick* remains the common law precedent, two English Court of Appeal decisions have found that such a concurrent authority exists and that parents may consent on behalf of a child who refuses treatment.[130] It is to be noted, that analogies with medical treatment may not be as relevant here because counselling may have less impact on a client who does not wish to be there than medical treatment. However, this point is debatable, and the medical analogy will be drawn below.

It is useful to briefly examine the two English decisions before returning to consider whether Australian courts will follow that approach in regard to counselling. If this represents the state of the law, then parents could by analogy consent to a child seeing a counsellor where this is against the wishes of the child.

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[130] *Re R (A Minor) (Wardship: Medical Treatment)* [1991] 3 WLR 592; *In Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1992] 3 WLR 758.

In *Re R* the issue was whether a 15 year old girl with severe mental disturbances could refuse the administration of drug therapy.[131] The evidence was that the girl had periods of lucidity, during which she refused the administration of drugs. The court held R was not '*Gillick* competent', as it was not clear that she understood the implications of her treatment.

Lord Donaldson, in obiter, used a 'key' analogy to define the rights of children and their parents to consent or refuse medical treatment. His Lordship stated that all that was required was one valid consent (one key to unlock the door) and either a person with parental responsibility or a '*Gillick* competent' child could consent to treatment (as both were key holders). Consequently, a child's refusal to consent to treatment could not override parental consent. He stated

> I do not understand Lord Scarman to be saying that, if a child was "*Gillick* competent", ... the parents ceased to have an independent right of consent as contrasted with ceasing to have a right of determination, that is, a veto. In a case in which the "Gillick competent" child refuses treatment, but the parents consent, that consent enables treatment to be undertaken lawfully, but in no way determines that the child shall be so treated. In a case in which the positions are reversed, it is the child's consent which is the enabling factor and again the parent's refusal of consent is not determinative.[132]

In *Re W* the case concerned whether a 16 year old girl could refuse medical treatment for anorexia nervosa.[133] The relevant legislation provided that 'the consent of a minor who has attained the age of sixteen years to any ... medical treatment ... shall be as effective as it would be if he were of full age'.[134] The issue therefore was whether a right to consent extended to a right to refuse treatment.

The court held that the legislation did not confer an absolute right to medical treatment, but was for the limited purpose of protecting the doctor from prosecution or a suit in trespass. Lord Donaldson traded the 'key' analogy for a 'flak jacket' one:

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[131] [1991] 3 WLR 592.
[132] *Re R* [1991] 3 WLR 592 at 600, per Lord Donaldson.
[133] [1992] 3 WLR 758.
[134] *Family Law Reform Act* 1969 (UK), Section 8.

> I now prefer the analogy of the legal "flak jacket" which protects the doctor from claims by the litigious whether he acquires it from his patient who may be a minor over the age of 16, or a "*Gillick* competent" child under that age of from another person having parental responsibilities ... no minor of any age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court.[135]

In conclusion, the Court of Appeal cases have appeared to narrow *Gillick,* as the refusal of a '*Gillick* competent' child to medical treatment can be overridden by the consent of someone with parental responsibility or a court. It is submitted however, that Australian courts should reject this trend. There are two arguments relied upon in support of the proposition that the law in Australia recognises the rights of competent children to refuse treatment.

The first argument is that to hold that children do not have the right to refuse treatment would create an inconsistency in the law. In *Marion's case*, the High Court held that children were able to exercise rights when determined competent to do so. The logical extension of this principle is that a competent minor should have the right to refuse treatment. Adults have the right to refuse medical treatment, even where such refusal may result in death.[136] To hold that competent children do not have a right to refuse treatment acts to reintroduce a status based discrimination, which the High Court rejected in *Marion's case*.

The second argument is that the judgments in *Gillick* and *Marion's case,* support the proposition that when a child is competent to make a decision, parental authority to make that decision ends. In *Gillick* Lord Scarman stated:

> The underlying principle of law ... is that parental right *yields* to the child's right to make his own decision when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.[137] [italics added]

Even more direct support is found in the judgement of Justice McHugh in *Marion's case*:

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[135] *In re W (A Minor), ibid* at 767 and 772.
[136] *Marion's case* (1992) 175 CLR 218; *Malette v Schulmann* (1990) 67 DLR (4th) 321; *Airedale NHS Trust v Bland* [1993] 2 WLR 316.
[137] Gillick [1986] at 186 per Lord Scarman.

> ... the parent's authority is *at an end* when the child gains sufficient intellectual and emotional maturity to make an informed decision on the matter in question. In so far as *Re R (A Minor) Wardship: Consent to Treatment)* suggests the contrary, it is inconsistent with *Gillick*[138] [italics added]

Justice Brennan views the competence of children as creating a limit on parental authority:

> Limits on parental authority are imposed by the operation of the general law, by statutory limitations or by the independence which children are entitled to assert, without extra-familial pressure, as they mature.[139]

This would suggest that parental authority is 'limited to' those decisions that the child is deemed not competent to make. Alternatively Justice Deane appears to submit that an overlap may exist, although His Honour found it unnecessary to decide on the issue:

> [Parental authority] is a "dwindling right" which diminishes as the legal competence of the child to make decisions for herself or himself increases. That means that the relationship between a child and her or his parents will ordinarily pass through a transitional stage in which authority is shared. It is, however, unnecessary to discuss that aspect of parental authority in the present case...[140]

The reference to authority being shared by parent and child may be read as meaning that decision-making power is shared in relation to the same decisions. A more accurate view is that it recognises an overlap may exist where the parent has the exclusive right to make some decisions and the child has the exclusive right to make others.

This second reading is more consistent with Justice Deane's acceptance of parental rights as 'dwindling' rights. Use of the phrase 'dwindling right' implies that the right fades away and does not re-emerge to override the decision of a competent child. The logical point at which parental rights will diminish are when the child is competent to make the decision in question.

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[138] *Marion's case* (1992) 175 CLR 218 at 316.
[139] *Marion's case* (1992) 175 CLR 218 at 278.
[140] *Marion's case* (1992) 175 CLR 218 at 294.

There are also indications that the majority in *Marion's case* considered that children and parents do not share a concurrent capacity to consent. This can be illustrated by their approval of the following passage from Lord Scarman in *Gillick* that parental rights do not exist when they are not needed for the protection of the child:

> The principle of the law ... is that parental rights are derived from parental duty *and exist only so long as they are needed for the protection of the person and property of the child.*[141] [italics added]

Therefore it should be accepted that there is legal support for the proposition that competent children have a right to refuse medical treatment and by extension that parents do not have the authority to force a competent, but unwilling child to counselling.

It is important to note that imposing treatment on an unwilling child is probably more significant in relation to invasive and physical medical treatments. That is, while a parent may be able to physically compel a child to attend counselling, most counsellors would be well aware that you are not then able to force the child to participate.

Counsellors often also have specific strategies for dealing with involuntary clients and may well refuse to accept a referral from a parent where they have indicated that the child has expressed that they do not wish to attend counselling.

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[141] *Marion's case* (1992) 175 CLR 218 per Mason CJ, Dawson, Toohey and Gaudron JJ at 237.

Part Five: Reforms

This paper has demonstrated that there is uncertainty in the legal relationship between counsellors, child clients and their parents. This can result in a range of unsatisfactory outcomes for all involved, such as the continued isolation and detriment for children who do not regard counselling to be a safe and confidential alternative.

Also, counsellors can be left exposed to risks of personal abuse and complaints for electing to provide services to children without parental consent. Myers makes the point that it is often the parents who are unable or

unwilling to communicate effectively with their children who would be more readily disposed to seek redress against the counsellor for 'interfering' in their private, intrafamily concerns.[142]

Suggestions for reform include the introduction of uniform legislation in Australia clarifying the legal position of counsellors, their child clients and parents, guidelines for counsellors and community education.

5.1 Legislation

On the basis of policy considerations and respect for the autonomy of competent persons it is recommended that the legislation:

1) Recognises that children have the capacity to enter a legal relationship with a counsellor when they are sufficiently mature to consent to counselling,
2) Recognises that children are owed a duty of confidentiality when they are mature enough to engage in a confidential relationship,
3) Clarifies the legal elements to be satisfied in assessing a child's ability to give informed consent to counselling and a confidential relationship and
4) Recognises that parents do not have the authority to force an unwilling competent child to undertake counselling.

There may be public support for the recognition of the rights of children that are sufficiently mature to understand confidentiality, as indicated by the study on the expectations of members of the public outlined in Part 1.

5.2 Guidelines

In order to achieve consistent, functional and accountable practice it is recommended that guidelines be issued to counsellors regarding their

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[142] Myers 1982, above n.3.

obligations to children and their parents. Maximum compliance would be best achieved by distribution via professional associations.

It is recommended that the guidelines state:

1) The legal obligations of counsellors to observe confidentiality, noting any relevant exceptions to confidentiality, such as the mandatory reporting provisions,
2) *Suggested* (because there are no across the board standards) ethical standards in dealing with child client confidentiality,
3) That the law recognises that children have the capacity to enter a legal relationship with a counsellor when they are sufficiently mature to consent to counselling,
4) That the law recognises that children are owed a duty of confidentiality when they are sufficiently competent to engage in a confidential relationship,
5) The general indicators of a child's ability to give informed consent and to engage in confidential relationships, and the ages children generally achieve these capabilities,
6) That children be made aware of the limits of confidentiality prior to counselling,
7) That clients be provided with privacy policies of the agency or individual and
8) That the law does not recognise the authority of parents to force an unwilling child to undertake counselling.

Other issues that may call for reform are the adequacy of record keeping in making difficult ethical and legal decisions regarding the consent and confidentiality of children and young people.[143] There is opinion that industry custom is to actually adopt the opposite in practice, that is many counsellors use a minimal record keeping style to avoid subjective opinions being misinterpreted in the event the case notes become involved in legal proceedings. This is both as a protective mechanism for themselves and for

clients, however this issues, and the issue of children's rights to access their records, will not be dealt with here.

5.3 Community education

Community education should contain the information issued in the guidelines and should inform counsellors, children and parents of their rights and obligations in regard to counselling. It would be expected that community education would reduce the current disparity between the practice of counsellors and the expectations of children concerning confidentiality. This will reduce fear in children who are concerned that they may not have control over disclosure of confidential information and will promote the trust that is necessary for a therapeutic process to be effective.

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[143] Myers, 1982, above n.3.

Conclusion

The effectiveness of counselling can be greatly influenced by the relationship of trust between client and counsellor. Fear of disclosure to third parties may undermine this relationship and the actual choice to access counselling services. Therefore, such uncertainty surrounding the obligations and practices of counsellors with regard to confidentiality can directly contribute to less successful outcomes for children.

There have been no case decisions in Australia that define the rights and obligations of counsellors, child clients and their parents. Nonetheless applying the law on medical treatment to the special context of counselling can find support for the following propositions. The first proposition is that children may consent to counselling without the knowledge of their parents when they are competent to do so. The second proposition is that children are owed a duty of confidentiality when they are sufficiently mature to enter into a confidential relationship. The third proposition is that parents do not have authority to force an unwilling child to receive counselling.

Legislative reforms are required so that children may rely upon the legal certainty of the above propositions. Guidelines are also required to inform counsellors of the extent of their legal obligations and to assist them in their judgment of when a child is competent to give informed consent. Community education on the obligations of counsellors to retain confidentiality should also be employed to reduce the concern children may have about disclosures of confidential information by counsellors.

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Appendix 1: Code of Ethics

1.1 Counsellors - General

1.1(a) Australian Counselling Association

(i) Confidentiality Charter for ACA Counsellors

All ACA registered counsellors must practice by the ACA Code of Conduct. Part of the Code of Conduct is client confidentiality. This charter explains confidentiality and the clients rights. Clients should be asked to sign a consent form prior to counselling.

As a client of a counsellor, you have a right to expect that:

1) You will be treated with respect,
2) You will receive a clear explanation of the service you will receive,
3) Your consent for any service will be sought by the counsellor prior to the service commencing and as it progresses and
4) You will receive an explanation about the nature and limits of confidentiality surrounding the service.

(ii) Sample consent form - confidentiality

All personal information gathered by the counsellor during the provision of the counselling service will remain confidential and secure except when:

1) It is subpoenaed by a court or
2) Failure to disclose the information would place you and another person at risk or
3) Your prior approval has been obtained to
    a) Provide a written report to another professional or agency, for example, a GP or a lawyer or
    b) Discuss the material with another person, for example, a parent or an employer.

1.1(b) Psychotherapy and Counselling Federation of Australia

The Psychotherapy and Counselling Federation of Australia is an umbrella association comprising affiliated professional associations that represent various disciplines of Psychotherapy and Counselling in Australia.

Members are:

- Adelaide Institute for Psychoanalysis,
- Association of Solution Oriented Hypnotherapists and Counsellors of Australia,
- Australian and New Zealand Association of Psychotherapy (NSW Branch),
- Australian and New Zealand Psychodrama Association Inc.,
- Australian Association of Marriage and Family Counsellors,
- Australian Association of Pastoral Counsellors,
- Australian Association of Somatic Psychotherapists (NSW),
- Australian Association of Somatic Psychotherapists (Vic),
- Australian College of Psychotherapists,
- Australian Hypnotherapist's Association,
- Australian National Art Therapy Association,
- Australian Radix Teachers Association,
- Australian Somatic Integration Association,
- Clinical Counsellors Association,
- Emotional Release Counsellors Association of NSW,
- Gestalt Australia New Zealand,
- Melbourne College of Contemporary Psychotherapy,
- Melbourne Institute for Psychoanalysis,
- Melbourne Institute of Experimental and Creative Arts Therapy,
- Music and Imagery Association of Australia,
- NSW Institute of Family Psychotherapy,
- Psychotherapists and Counsellors Association of WA,
- Queensland Association for Family Therapy,
- Queensland Transpersonal and Emotional Release Counsellors Association Inc.,

- Society of Counselling and Psychotherapy Educators,
- Victorian Association of Family Therapists,
- Western Pacific Association of Transactional Analysis.

It is expected that professional associations will establish their own codes, which cover the standards of ethical principals and responsibilities.

(i) Ethical Principles

1) Counsellors respect the privacy of their clients and preserve the confidentiality of information acquired in the course of their work and
2) Counsellors protect the rights of their clients including the right to informed consent.

(ii) Ethical Responsibilities – 3. Confidentiality

1) Counsellors treat with confidence any personal information about clients, whether obtained directly or by inference,
2) Counsellors and Supervisors are responsible for protecting the client's rights of confidentiality in the supervisory context by ensuring that shared information is disguised appropriately,
3) Exceptional circumstances may arise which give the Counsellor good grounds for believing that the client will cause serious physical harm to others or themselves. In such circumstances, the breaking of confidentiality may be required, preferably with the client's permission, or after consultation with a Counselling Supervisor and
4) Any breaking of confidentiality should be minimised both by restricting the information conveyed to that which is pertinent to the immediate situation and by limiting it to those persons who can provide the help required by the client.

1.2 School counsellors

1.2(a) Australian Guidance and Counselling Association

Members are guidance officers, school counsellors and school psychologists who provide educational guidance and counselling and school psychology services to children and school communities.

(i) Professional Standards – II Confidentiality

1) Members have an obligation to safeguard confidential information that has been obtained in the course of their practice, teaching or research,
2) Members obtain consent (preferably written) from parents before releasing confidential student information to professionals in other agencies. Under some circumstances they may obtain consent from students before releasing information to parents or professionals in other agencies. The need to obtain consent from students should take into account the age at which at person is legally defined as being independent as well as the level of student's mental and moral development. An exception to this policy exists when the member believes clients are in immediate danger to themselves or to others and
3) Confidential information obtained on children and young people is discussed only for professional purposes and only with persons clearly concerned with the case.

(ii) Professional Practice – B Students

1) Members consider the welfare of children and youth to be of primary importance and
2) Members ensure that children and youth understand the nature and purpose of any assessment or intervention to the best of their abilities.

1.3 Social Workers

1.3(a) Australian Association of Social Workers

(i) Code of Ethics - Clause 4.2.5: Information Privacy/Confidentiality

1) Social workers will respect the right of service users to a relationship of trust, to privacy of service users and confidentiality of their information and to responsible use of information obtained in the course of professional service and
2) Social workers will use confidential information only for the purposes for which it was acquired; or, with the consent of service users, for a directly related purpose; or with lawful excuse.

The social worker must seek the informed consent of service users when their information is to be used, to inform service users full about limits of confidentiality in any given situation, and to reveal what would otherwise be confidential information only when compelling ethical or legal reasons prevail.

1.4 Psychologists

1.4(a) Australian Psychological Society

(i) Code of Ethics - General Principles – III Propriety

The welfare of clients and the public, and the integrity of the profession, shall take precedence over a member's self interest and over the interests of the member's employer and colleagues.

1) Members must respect the confidentiality of information obtained from clients in the course of their professional work. They may reveal such information to others only with the consent of the person or the person's legal representative. However in those unusual circumstances where failure to disclose may result in clear risk to the client or to others, the member may disclose minimal information necessary to avert risk. Members must inform their clients of the legal and other limits of confidentiality.

Appendix 2: Mandatory reporting laws

2.1 Australian Capital Territory

2.1(a) *Children and Young People Act* 1999

Section 159

(1) This section applies to a person who is:

(a) a doctor; or

(b) a registered dentist ...; or

(c) a person who is an enrolled nurse or a registered nurse ...; or

(d) a teacher at a school; or

(e) a police officer; or

(f) a person employed to counsel children or young people at a school; or

(g) a person caring for a child at a child-care centre; or

(h) a person coordinating or monitoring the provision of home-based care on behalf of a family day care scheme license; or

(i) a public servant who, in the course of his or her employment, provides services related to the health or well-being of children, young people or families; or

(j) the community advocate; or

(k) the official visitor; or

(l) a prescribed person.

(2) If :

(a) an adult to whom this section applies suspects that a child or young person has suffered, or is suffering, sexual abuse or non-accidental physical injury and

(b) those grounds arise during the course of or from the person's work (whether from remuneration or otherwise),

the person must, as soon as practicable, report to the chief executive the name, or a description, of the child or young person and the grounds for the person's suspicion.

Maximum penalty: 50 penalty units, imprisonment for 6 months or both.

a 'child' is a person who is under 12 years old: s 7
a 'young person' is a person who is 12 years old or older, but not yet an adult: s 8.

2.2 Queensland

2.2(a) *Child Protection Act* 1999

Section 148

(1) If a responsible person becomes aware, or reasonably suspects, that harm has been caused to a child in residential care, the person must, unless the person has a reasonable excuse, report the harm, or suspected harm, to the chief executive:

(a) immediately and

(b) if a regulation is in force under subsection (2), in accordance with the regulation.

Maximum penalty - 20 penalty units.

(2) A regulation may prescribe the way the report must be given or the particulars that the report must include.

(3) It is a reasonable excuse for the person not to report a matter that reporting the matter might tend to incriminate the person.

(4) Subsection (1) does not apply if the person knows, or reasonably supposes, that the chief executive is aware of the harm or suspected harm.

A 'child in residential care' means a child who is (a) in the care of a departmental care service; or (b) residing in a licensed residential facility: sub-s(5)

A 'responsible person' means (a) an authorised officer or (b) an officer or employee of the department involved in administering this Act or (c) a person employed in a licensed care service: sub-s(5)

Section 9

(1) 'Harm', to a child, is any detrimental effect of a significant nature on the child's physical, psychological or emotional well being,

(2) It is immaterial how the harm is caused,

(3) Harm can be caused by:

(a) physical, psychological or emotional abuse or neglect; or

(b) sexual abuse or exploitation.

A 'child' is an individual under 18 years: s 8

2.3 New South Wales

2.3(a) *Children (Young Persons (Care and Protection) Act* 1998

Section 27

(1) This section applies to:

(a) a person who, in the course of his or her professional work or other paid employment delivers health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly, to children, and

(b) a person who holds a management position in an organisation the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly, to children.

(2) If:

(a) a person to whom this section applies has reasonable grounds to suspect that a child is at risk of harm, and

(b) those grounds arise during the course of or from the person's work,

the person must, as soon as practicable, report to the Director-General the name, or a description, of the child and the grounds for suspecting that the child is at risk of harm.

Maximum penalty: 200 penalty points.

Section 23

For the purposes of this Part and Part 3, a child or young person is 'at risk of harm' if current concerns exist for the safety, welfare or well-being of the child or young person because of the presence of any one or more of the following circumstances:

(a) the child's or young person's basic physical or psychological needs are not being met or are at risk of not being met,

(b) the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care,

(c) the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated,

(d) the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm,

(e) a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm.

2.4 Northern Territory

2.4(a) *Community Welfare Act*

Section 14

(1) A person, not being a member of the Police Force, who believes, on reasonable grounds, that a child has suffered or is suffering maltreatment shall, as soon as practicable after obtaining the knowledge that constitutes the reasonable grounds for his so believing, report the fact, and all material facts on which that knowledge is based, to the Minister or a member of the Police Force.

Penalty: $500.

Section 4

(1) 'child' means a person who has not attained the age of 18 years.

(2) For the purposes of this Act, a child shall be taken to have suffered maltreatment where:

(a) he has suffered a physical injury causing temporary or permanent disfigurement or serious pain or has suffered impairment of a bodily function, inflicted or allowed to be inflicted by a parent, guardian or person having the custody of him or where there is substantial risk of his suffering such an injury or impairment,

(b) he has suffered serious emotional or intellectual impairment evidenced by severe psychological or social malfunctioning measured by the commonly accepted standards of the community to which he belongs, because of his physical surroundings, nutritional or other deprivation, or the emotional or social environment in which he is living or where there is a substantial risk that such surroundings, deprivation or environment will cause such emotional or intellectual impairment,

(c) he has suffered serious physical impairment evidenced by severe bodily malfunctioning, because of his physical surroundings, nutritional or other deprivation, or the emotional or social environment in which he is living or where there is substantial risk that such surrounding, deprivation or environment will cause such impairment,

(d) he has been sexually abused or exploited, or where there is substantial risk of such abuse or exploitation occurring, and his parents, guardians or persons having the custody of him are unable or unwilling to protect him from such abuse or exploitation, or

(e) being a female, she:

(i) has been subjected, or there is substantial risk that she will be subjected, to female genital mutilation...; or

(ii) has been taken, or there is a substantial risk that she will be taken, from the Territory with the intention of having female genital mutilation performed on her.

2.5 South Australia

2.5(a) *Children's Protection Act* 1993

Section 11

(1) Where:

(a) a person to whom this section applies suspects on reasonable grounds that a child has been or is being abused or neglected and

(b) the suspicion is formed in the course of the person's work (whether paid or voluntary) or of carrying out official duties,

the person must notify the Department of that suspicion as soon as practicable after he or she forms the suspicion.
Maximum penalty: $2500.

(2) This section applies to the following persons:

(a) a medical practitioner,

(b) a registered or enrolled nurse,

(c) a dentist,

(d) a psychologists,

(e) a member of the police force,

(f) a community corrections officer (an officer or employee of an administrative unit of the Public Service whose duties include the supervision of young or adult offenders in the community),

(g) a social worker,

(h) a teacher in any educational institution (including kindergarten),

(i) an approved family day care provider,

(j) any other person who is an employee of, or volunteer in, a Government department, agency or instrumentality, or a local government or non-government agency, that provides health, welfare, education, child care or residential services wholly or partly for children, being a person who:

(i) is engaged in the actual delivery of those services to children; or

(ii) holds a management position in the relevant organisation the duties of which include direct responsibility for, or direct supervision of, the provision of those services to children.

Section 6

'abuse or neglect', in relation to a child, means:

(a) sexual abuse of the child or

(b) physical or emotional abuse of the child, or neglect of the child, to the extent that:

(i) the child has suffered, or is likely to suffer, physical or psychological injury detrimental to the child's well-being or

(ii) the child's physical or psychological development is in jeopardy.

and 'abused' or 'neglected' has a corresponding meaning.

A 'child' means a person less than 18 years of age.

2.6 Tasmania

2.6(a) *Child Protection Act* 1974

Section 8

(1) Any person who suspects upon reasonable grounds that a child has suffered maltreatment, or that there is a substantial risk that a child will suffer maltreatment, is entitled to report the fact to an authorized officer, and the report may be made orally or in writing.

(2) The Governor may, by order, declare that persons of specified classes, being persons following professions, callings, or vocations specified in the order or holding offices so specified, shall make such report as is referred to in subsection (1) when, in the course of practice of those professions, callings, or vocations or in exercising the functions of those offices, circumstances come to their notice that warrant such reports being made.

(3) A child shall be taken, for the purposes of this Act, to suffer maltreatment if -

(a) whether by act or omission or intentionally or by default, any person (including a parent, guardian, or other person having the custody, care, or control of the child):

(i) inflicts on the child a physical injury causing temporary or permanent disfigurement or serious pain,

(ii) by any means (including, in particular, the administration of alcohol or any other drug) subjects the child to an impairment, either temporary or permanent, of a bodily function or of the normal reserve or flexibility of a bodily function, or

(iii) neglects, or interferes with, the physical, nutritional, mental, or emotional well-being of the child to such an extent that:

(A) the child suffers, or is likely to suffer, psychological damage or impairment,

(B) the emotional or intellectual development of the child is, or is likely to be, endangered, or

(C) the child fails to grow at a rate that would otherwise be regarded as normal for that child;

(b) any person (including a parent, guardian, or other person having the custody, care, or control of the child) causes the child to engage in, be subjected to, sexual activity, or

(c) the child is, with or without the consent of the child or of a parent, guardian, or other person having the custody, care, or control of the child, engaged in, subjected to, sexual activity that:

(i) is solely or principally for the purpose of the sexual gratification of any other person,

(ii) is in whole or in part the subject of, or included among the matters portrayed in, any printed matter, photograph, recording, film, video tape, exhibition, or entertainment or

(iii) in any other manner exploits the child.

2.7 Victoria

2.7(a) *Children and Young Persons Act* 1989

Section 64

(1) Any person who believes on reasonable grounds that a child is in need of protection may notify a protective intervener of that belief and of the reasonable grounds for it.

(1A) A person referred to in any of the paragraphs of sub-section (1C) to whom this sub-section applies, who in the course of practicing his or her profession or carrying out the duties of his or her office position or employment as described in that paragraph, forms the belief on reasonable grounds that a child is in need of protection on a ground referred to in paragraph (c) or (d) of section 63 must notify the Secretary of that belief and of the reasonable grounds for it as soon as practicable:

(a) after forming the belief and

(b) after each occasion on which he or she becomes aware of any further reasonable grounds for the belief.

Penalty applying to this sub-section: 10 penalty points.

(1B) Grounds for a belief referred to in sub-section (1) or (1A) are:

(a) matters of which a person has become aware and

(b) any opinions based on those matters.

(1C) Sub-section (1A) applies to a person referred to in any of the following paragraphs:

(a) a registered medical practitioner ...;

(b) a registered psychologist ...;

(c) a person registered under the *Nurses Act* 1993;

(d) a person registered as a teacher ... or permitted to teach ...;

(da) a person appointed to an office in the teaching service ...;

(db) a person employed under section 15B(1)(a)(i) of the *Education Act* 1958viii;

(e) the head teacher or principal of a State school ...;

(f) the proprietor of, or a person with a post-secondary qualifications in the care, education or minding of children who is employed by, a children's service ...;

(g) a person with a post-secondary qualification in youth, social or welfare work who works in the health, education or community or welfare services field ...;

(h) a person employed [by the public service] to perform the duties of a youth and child welfare worker;

(i) a member of the police force;

(ii) a probation officer;

(iii) a youth parole officer;

(iv) a member of a prescribed class of persons.

(2) The following persons are protective interveners -

(a) the Secretary;

(b) all members of the police force.

The 'Secretary' is the Secretary to the Department of Human Services.