My Health, My Say?

Confidentiality, consent and the transition to managing one's own healthcare in Australia.

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Abstract. At what point does a young person's health become their own business? In Australia, the answer is not a single birthday. The law recognises that many teenagers can consent to their own care well before 18, Medicare and My Health Record privacy settings shift at 14, and a young person can hold their own Medicare card from 15. Yet these changes happen quietly, often without anyone explaining them to the young person they are designed to protect. This evidence brief synthesises 17 sources, including Australian legislation and policy from Services Australia, the Australian Digital Health Agency, the RACGP and the Royal Children's Hospital Melbourne, alongside peer-reviewed research on adolescent confidentiality and care-seeking. It is organised around two themes: knowing the rules of consent and confidentiality, and the practical shift from time alone with a clinician to fully managing one's own care in adult services.

Keywords: young people; adolescent health; knowing the rules; time alone and the handover

1. Introduction

Adolescence is when many lifelong health patterns begin, and when young people start to face health concerns they may not want to discuss in front of family. Whether a young person feels safe to speak openly with a clinician can shape whether they seek care at all. Four issues make this urgent.

1.1 Sensitive concerns start early

Mental health, sexual health, substance use and eating concerns often emerge in the teenage years. NSW Health guidance notes that about half of lifetime mental illness begins by age 14 and about three-quarters by age 25 (NSW Health, 2018). These are exactly the topics young people are least likely to raise with a parent in the room.

> About 50% of lifetime mental illness begins by age 14, and about 75% by 25.
> (NSW Health, 2018 (citing Kessler et al., 2005))

1.2 Young people keep health secrets, and some go without care

In a large survey of high school students, 58% had health concerns they wanted to keep from their parents, and 25% said they would forgo care in some situations if their parents might find out (Cheng et al., 1993). Australian focus groups found the same worry, especially in rural towns where being seen at the clinic or pharmacy can feel like being "found out" (Quine et al., 2003).

1.3 The rules are complex and poorly communicated

Consent and privacy rules come from common law, state legislation and federal agencies, and they do not all change at the same age. Clinicians are advised to explain confidentiality and its limits early in each consultation (Royal Children's Hospital Melbourne [RCH], n.d.-a), but this does not always happen, and parents may hold different expectations again (Duncan et al., 2011).

1.4 Diverse young people face extra barriers

For young people from culturally and linguistically diverse families, LGBTQIA+ young people and those in small communities, a breach of privacy can carry high social costs. NSW Health (2018) identifies LGBTI, Aboriginal and Torres Strait Islander and homeless young people, and those in out-of-home care, as at higher risk of falling out of care during transition.

Table 1. Key terms used in this review

Term	Definition
Mature minor	A young person under 18 who is judged to have enough understanding and intelligence to fully understand a proposed treatment, and can therefore consent to it themselves.
Gillick competence	A legal test, from a 1985 English case, asking whether a person under 16 understands a treatment well enough to consent to it without their parents.
HEEADSSS	A structured conversation guide that helps clinicians ask young people about home, school, eating, activities, drugs, sexuality, mood and safety.

2. Method

This evidence brief is a narrative literature review drawing on peer-reviewed literature and grey literature, including Australian government agency guidance, clinical guidelines and professional college position statements. Sources were identified through searches of PubMed, Google Scholar and the Cochrane Library, and through the websites of Services Australia, the Australian Digital Health Agency, the RACGP, the RACP, the Royal Children's Hospital Melbourne and state health departments. The review focused on young people aged approximately 10 to 24, English-language sources, and both Australian and international evidence, with priority given to Australian legal and policy sources for all statements about rights and entitlements.

3. Conceptual model: The Stepping-Into-the-Room Model

Taking ownership of one's health is a gradual process rather than a single handover at 18. This report proposes a five-stage model describing how a young person moves from being a passenger in their parents' healthcare decisions to being the person in charge. Each stage depends on the one before it: young people cannot use rights they do not know about, and they will not disclose sensitive concerns unless they trust that privacy is real. The final stage, self-managed adult care, is only reached safely when the earlier stages have been practised.

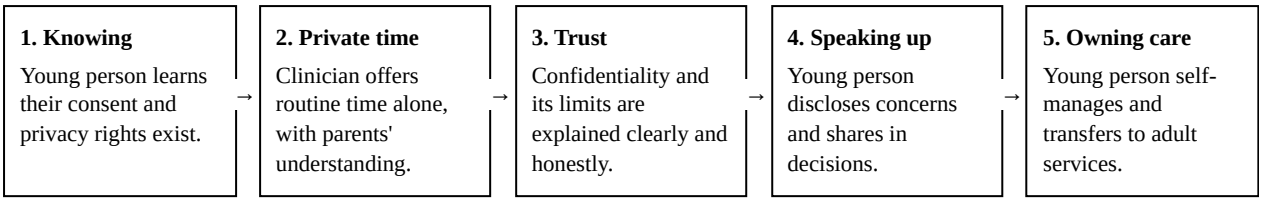


Figure 1. The Stepping-Into-the-Room Model: conceptual model developed from the literature reviewed.

4. Knowing the Rules: Consent, Confidentiality and the Law

Australia gives young people meaningful legal rights over their health information and treatment, but these rights are spread across case law, state legislation and federal agency policy. This theme examines what those rules are, and what young people and parents actually understand about them.

4.1 Many teenagers can legally consent to their own care before 18

Under Australian common law, the "Gillick competence" principle from English law was endorsed by the High Court in Marion's case in 1992 (Sanci et al., 2005). It means a young person can give informed consent if they have sufficient understanding and intelligence to fully comprehend the proposed care. The Royal Children's Hospital's clinical guideline states that most adolescents aged 14 to 18 are presumed to be mature minors, and that younger adolescents may sometimes qualify depending on the type of care involved (RCH, n.d.-a).

Rules differ between states. In South Australia, people aged 16 and over can consent to their own medical treatment by statute (Legal Services Commission of South Australia, n.d.). In Victoria, Youth Law Australia (n.d.) explains that a young person can consent without a parent if the doctor considers them capable of understanding the nature, risks and consequences of the treatment, taking into account factors such as maturity and how serious the treatment is.

4.2 Privacy over health records shifts at 14 and 15, often without young people knowing

At 14, parents and guardians are automatically removed as authorised representatives on a child's My Health Record. The young person can then choose to give a parent or other trusted person access as a nominated representative (Australian Digital Health Agency [ADHA], n.d.). The RACGP describes this as "consistent with the legal rights of a competent minor to seek medical care" (RACGP, n.d.). Also from 14, a young person can create their own myGov account, and no one else can see their Medicare claims history online through their own myGov account (Youth Law Australia, n.d.). From 15, a young person enrolled in Medicare can have their own Medicare card (Services Australia, n.d.).

These are significant protections, yet they largely operate in the background. The RCH guideline advises clinicians to encourage adolescents over 15 to obtain their own card (RCH, n.d.-a), and the RACP has long urged clinicians to tell young people about this option (Royal Australasian College of Physicians [RACP], 2010).

Table 2. Summary of evidence discussed in this section

Age	What changes	Source
Under 14	Parent usually manages My Health Record as authorised representative	ADHA; RACGP
Under 14	Some younger adolescents may be mature minors, depending on the care	RCH
14	Parent removed from My Health Record; young person can nominate someone	ADHA
14	Own myGov account; Medicare claims history no longer visible to others online	Youth Law Australia
14–18	Most presumed mature minors (varies by State)	RCH
15	Can hold own Medicare card	Services Australia
16 (SA)	Can consent to own medical treatment by statute	SA Law Handbook

4.3 Confidentiality has limits, and young people deserve to hear them up front

Confidentiality is not absolute. The RCH guideline explains that it may be broken if a young person cannot be considered a mature minor, or if there is significant risk of harm to themselves or others, or of physical, emotional or sexual abuse (RCH, n.d.-a). Certain infectious diseases must also be reported by law (Youth Law Australia, n.d.). Guidelines agree that these limits should be explained early, and that young people should be told if others need to be involved (RCH, n.d.-a; Klein et al., 2014).

Being honest about limits does not appear to undermine trust. In a randomised trial with 562 high school students, hearing a doctor promise confidentiality, whether conditional or unconditional, increased willingness to disclose sensitive information from 39% to 46.5%, and willingness to return for future care from 53% to 67% (Ford et al., 1997).

4.4 Parents often misunderstand what a confidential consultation means

In a survey of 86 parents at a Melbourne adolescent medicine clinic, 30% believed information from a confidential consultation would "always be shared with me" regardless of their child's views, and only 6% thought seeing a doctor alone was normal practice (Duncan et al., 2011). Most parents wanted to be told about depression (87%) and eating disorders (81%) even against their child's wishes.

Yet parents also recognised benefits: 71% valued the chance for their child to discuss sensitive matters, and 61% saw value in practising talking to a doctor alone (Duncan et al., 2011). This suggests that explaining the purpose of private time to families, rather than avoiding the conversation, may make confidential care easier to accept (Klein et al., 2014).

4.5 Implications and recommendations

Make the milestones visible

- *"Turning 14" health letter.* Services Australia and ADHA send young people a plain-English notice explaining their new privacy rights.
- *Medicare-at-15 prompts.* Schools and GPs routinely remind students they can apply for their own card.
- *Multilingual family guides.* Translated resources explain mature minor rights and privacy changes to CALD parents.

Explain the limits honestly

- *Confidentiality script at every visit.* Clinicians state what stays private and when it cannot, in youth-friendly words.
- *Visible privacy posters.* Waiting rooms display a short summary of young people's rights and confidentiality limits.

Build youth legal literacy

- *Health rights in the curriculum.* Health and PE classes cover consent, privacy and how to book a GP appointment.
- *Peer-led workshops.* Youth organisations co-design sessions so young people hear about their rights from people their age.

5. Time Alone and the Handover: From Private Consultations to Adult Care

Knowing one's rights is only the first step; young people also need practice using them. This theme looks at how time alone with clinicians and structured psychosocial assessment build that practice, and what happens when young people with ongoing conditions move from paediatric to adult services.

5.1 HEEADSSS gives clinicians a structured, private conversation

The HEADSS framework, now commonly expanded to HEEADSSS, guides clinicians through Home, Education and employment, Eating and exercise, Activities, Drugs and alcohol, Sexuality and gender, Suicide, depression and mood, and Safety and strengths (RCH, n.d.-a). Questions move from less to more sensitive topics, and the RCH notes it is often not possible to cover everything in one visit.

Both the RCH and the HEEADSSS 3.0 authors recommend that the interview take place with the young person alone, as a parent's presence may limit what is shared (RCH, n.d.-a; Klein et al., 2014). Clinicians are advised to ask parents about their concerns before they leave the room, and to reassure them they will be included again afterwards.

5.2 Young people want time alone, but many never get it

In a Tasmanian school survey of 155 students, 85.2% said seeing a GP without a parent would be helpful or very helpful, and 74.8% rated reassurance about privacy as "really important" (Turner et al., 2017). One in three (32.9%) named confidentiality concerns as a barrier to seeing a GP.

Provision does not match demand. The RACP (2010) reports New Zealand survey data showing that, among students who had accessed care in the previous year, only about one-third had a private chance to talk to a health professional, and 45% had been told their care would be confidential. Australian authors note that young people who believe a service is confidential are more willing to disclose risky behaviours, seek care and return for follow-up (Sanci et al., 2005).

5.3 The paediatric-to-adult handover is often poorly prepared

For young people with chronic or mental health conditions, the move from children's to adult services is a high-risk point. NSW Health guidance warns that young people who do not transition well are more likely to disengage, present in crisis and need more hospital admissions, and quotes research describing transitions as

"poorly planned, poorly executed and poorly experienced" (NSW Health, 2018). The RCH Transition Support Service frames transition as a process that begins in adolescence, starts early, and builds skills in communication, decision-making, self-advocacy and self-care (RCH, n.d.-b).

5.4 Evidence on what makes transition work is still thin

A Cochrane review found only four randomised trials of transition interventions, with 238 participants in total (Campbell et al., 2016). Some programmes may slightly improve transition readiness, knowledge and independent contact with health professionals, but the certainty of evidence was low, follow-up was 12 months or less, and no trial tested changes to how services are organised. This gap suggests that the everyday practices described in this report, such as time alone, explained confidentiality and early skills-building, deserve stronger evaluation.

Box 1. Composite case: Mai, 16

Mai has managed asthma since childhood, always with her mum doing the talking. At 16, her GP asks to see her alone for part of the visit, explains what stays private, and walks through a HEEADSSS conversation. Mai mentions anxiety she had not told anyone about. Her GP helps her apply for her own Medicare card and practise booking her own appointments, so the move to an adult respiratory clinic at 18 feels familiar rather than frightening. (This is a composite, illustrative case.)

5.5 Implications and recommendations

Normalise time alone

- *Routine private time from early adolescence.* Practices adopt a default policy of time alone for every patient from around 12.
- *Parent pre-briefing.* A short handout explains why private time matters before the first visit.

Strengthen psychosocial screening

- *HEEADSSS training for GPs.* Practices support clinicians to use the framework confidently and inclusively.
- *Inclusive question wording.* Sexuality, gender and culture questions are asked in ways that feel safe for LGBTQIA+ and CALD youth.

Plan the handover early

- *Transition checklists from 14.* Young people with ongoing conditions build self-management skills step by step.
- *Youth co-designed evaluation.* Services measure transition outcomes beyond 12 months, with young people shaping what counts as success.

6. Conclusion

Six main conclusions emerge from the evidence reviewed:

1. *Rights arrive quietly.* Australian law treats many 14 to 18-year-olds as mature minors, and Medicare and My Health Record privacy shifts at 14 and 15. These protections largely operate in the background, so

many young people never learn they exist.

2. *Confidentiality opens conversations.* Trial evidence shows that hearing a clinician promise confidentiality makes adolescents more willing to share sensitive information and return for care. Explaining the limits honestly does not cancel out this benefit.
3. *Privacy fears keep young people away.* Surveys consistently find that a significant share of young people would skip care if parents might find out. Rural and small-community youth face extra visibility concerns.
4. *Parents need the explanation too.* Many parents misunderstand confidential consultations, yet most also see their value. Clear communication with families can turn suspicion into support.
5. *Time alone is a skill-building tool.* HEEADSSS conducted privately helps clinicians identify hidden concerns and gives young people practice speaking for themselves. Young people want this time, but too few receive it.
6. *Transition is a process, not a birthday.* Moving from paediatric to adult care is a high-risk point, and current trial evidence is limited. Building self-management skills early is the most consistent recommendation.

Support services (Australia)

Kids Helpline; Free, confidential 24/7 phone and webchat counselling for ages 5 to 25; 1800 55 1800

headspace; Mental health support for ages 12 to 25 online, by phone and at centres; 1800 650 890

Beyond Blue; Free, confidential support for all ages, 24/7; 1300 22 4636

Youth Law Australia; Free, confidential legal information for people under 25; yla.org.au

In an emergency, call 000. This article is health education, not medical advice.

Declarations

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