

Response to paragraph 4.18

Q 18a. The government should set out a clearer policy for professionals including the health service... on when to share information with social; services and police to protect sexually active children from harm and abuse

Level of agreement - Agree

Comments

The British Association for Sexual Health and HIV (BASHH) welcomes this timely consultation and its laudable aim of protecting young people from sexual abuse and exploitation. We have major concerns that this important aim will not be met if some of the proposals are implemented, and that young people will actually be more at risk and less able to be protected. Our three areas of concern which we will address in this response are that young people

- will not disclose abuse or exploitation
 - opportunity to intervene to stop abuse will be lost
- will not access sexual health services
 - increased pregnancy rates and sexually transmitted infections/ HIV
- will not disclose names of sexual contacts
 - partner notification systems for the control of sexually transmitted infections will collapse

The production of national guidance would be of benefit as currently there are conflicting thoughts on how best to achieve the protection of children. Having a single set of guidance for all groups is, however, fraught with difficulties as there is a huge variation in expertise, levels of support, training, availability of records in which to record conversations, and professional codes and standards. There is potential for conflicts with the professional's role e.g. as healthcare provider, teacher, youth worker. Supplementary guidance would be valuable for different professional groups, which take into account their roles, experience and professional codes, rather the great difficulties which would be encountered in a one-size fits all policy.

The remainder of this response will relate to those providing sexual health services.

Sexual activity at a young age is to be strongly discouraged. The young need to be protected from sexual abuse and exploitation. Young people are becoming sexually active at a younger age and having more, and concurrent, partners (NATSAL 1991-2001). Some become sexually active earlier than others and will require sexual health services in order to protect their physical and emotional health.

- Teenage pregnancies in the UK are currently the highest in Europe at 9/1000 aged 13-15 years and 63/1000 16-19 years.
- STI rates in young people are increasing.
 - 42% of gonorrhoea in females is in the under 20 years age group and 36% of chlamydia cases.
 - Gonorrhoea rates in England are 22 per 1000,000 in girls under 16 years and 196 for 16-19 year olds.
 - Chlamydia rates are 129 and 1454 for the same groups (Health Protection Agency).
 - 66% of under 16 year olds attending a London GUM clinic have an STI
 - 25% of under 16 year olds will have a further episode of an STI in the year, highlighting the need for ongoing access to, and confidence in, sexual health services.

The dangers of sexually transmitted infections are well documented and have long term effects on fertility. Even more important are the life-threatening effects of HIV, Hepatitis B and C and ectopic pregnancies. Early pregnancy has long term psychological and social impacts on young people. There are also the often forgotten dangers to health and risk of death associated with pregnancy itself.

Young people need to be able to access SH advice and care in order to prevent, diagnose and treat sexually transmitted infections and provide protection against unwanted pregnancy. It is essential these services are confidential in order to encourage young people to come forward for care. Because of the confidential nature of their service, sexual health clinics are accessed by homeless, socially excluded young people who may not engage with any other social or health care providers. This gives them a unique opportunity to intervene and facilitate transfer to mainstream health care and social services. Without confidentiality, these young people (who are usually already highly suspicious of the mainstream child services) are unlikely to attend.

- Research has repeatedly shown the importance of confidentiality to young people
- Recent work shows that 54.6% of 295 14 year olds questioned would not access services if they were not confidential (N Thomas et al).
- Work in the USA has highlighted the detrimental effect of compulsory notification of statutory rape in some US states, with regard to STIs and teenage pregnancies (Franzini et al).
- STI rates in England are higher in those areas with greatest deprivation therefore any reduction in access caused by loss of confidentiality would disproportionately affect the poorest and most disadvantaged young people.

Sexual health service providers are aware of child protection issues and take very seriously the possibility that a young person is being exploited or abused. BASHH has national guidelines on the management of young people attending Genitourinary clinics (clinics for the diagnosis and treatment of sexually transmitted infections) and these include the need to consider abuse as well as issues around confidentiality (A Thomas et al). These are in the process of being updated.

Those providing SH advice/care are well placed to protect young people from harm. The Sexual Offences Act 2003 states that sexual health care providers are protecting a child if they are preventing STIs or pregnancy, if they are under 16 or under 13 years old. They also detect abuse because of the confidential nature of the service providing an environment where young people are more likely to disclose abuse (Holkar). Research has shown that

- 68% of 14 year olds would not discuss certain issues if a SH service was not confidential.
- 63% would not use the service if child protection services would be informed, and a further 20% would not answer all questions honestly (N Thomas et al).

Experience has shown that if possible or actual abuse is disclosed, working with the young person usually allows disclosure to be made with their consent, thus preventing a breakdown in the healthcare professional/patient relationship. Where consent is refused and there may/is a risk to the young person or others, multi-disciplinary discussion occurs within the team as to assess whether disclosure is in the best interests of that person or others. Informal discussions, without breaking confidentiality by naming the young person, with a specialist in community paediatrics or a senior member of the local ACPC are helpful in some cases. This already occurs in

some parts of England and an extension of this facility to all areas would be extremely valuable to SH services.

Any guidance for those working in sexual health (SH) services should take into account their views and working practices. Guidelines which go against professional codes of practice or against the interests of young people are likely to be unworkable. The views of young people should also be sought and they should be involved in the development of any guidance.

Partner notification is an integral and essential component in the management of an individual with an STI and its importance has been highlighted by the World Health Organisation (WHO). It enables information on sexual partners to be given and these partners to be contacted either by the patient or the healthcare worker so they can be tested and treated for STIs. This prevents re-infection, treatment of the partner and reduction of onward transmission in the community. The Partner notification system in the UK is highly regarded throughout the world. An essential component is that information is confidential. If confidentiality was no longer possible because of compulsory police checks or requests for information by social workers, information on partners would not be given by the young person, to the detriment of their and the public health. If information was not given then the objective of protecting the young person from an exploitative (usually older) partner would be unachievable. There would also be repercussions for partner notification in the over 16 and over 18 year olds. Patients are highly unlikely to give details of sexual partners who are under 16, or advise them to attend GUM clinics, if they would then be police checked and their partner referred to social services. It is not unreasonable to believe that pressure would be put on young people by their sexual partners not to attend STI or contraceptive clinics, or that there would be a risk of violence in some cases if they did so.

Guidelines referred to by Bichard had not been endorsed or implemented by sexual health services. The grave concerns of health care workers, because of the risk to confidentiality and loss of rights of young people, were ignored when the guidelines were drawn up, and Bichard was not made aware of this. Similarly the pan-London protocol was released despite the written concerns of sexual health providers in the city (Minutes of London ACPC), and the British Medical Association (letter to Barry Quirke, Minutes of London ACPC). Bichard himself has expressed concern about how his comments have been miss-interpreted in documents such as the pan-London protocol (Guardian 2005).

The guidance which is to be produced must be workable and achieve the stated objectives. There is the potential for child protection services to be overwhelmed by the reporting of sexual activity in the 25% who are engaging in sexual intercourse before they reach their 16th birthday, and that serious abuse cases will therefore become lost in the system. Whilst the aim is to protect young people, we believe that compulsory notification to police and social services will actually have the opposite effect and increase the risk of harm. We believe that room for professional judgement and discretion in SH multi-disciplinary teams as occurs currently is essential.

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Q18b. should there be... a graded approach to information sharing according to professional judgement of the risk to the child and other children?

Comments A graded approach should be used to put together a picture of risks and vulnerability for that young person, to suggest which services they may require and to determine their health and social care needs. This should be individualised. Genitourinary medicine clinics, where most STIs are diagnosed and treated, have national guidelines on screening under 16 year olds for risk factors for unwanted sexual activity. In under 16 year olds a risk assessment is performed, and further in depth assessment undertaken by a second healthcare professional as required. The guidelines have been well utilised and audited.

Those who are aged 16 years or older are legally able to consent to sexual activity. A risk assessment for abuse in this older group should only be done where concerns arise during the consultation for sexual health services. Routine questioning in this situation is intrusive.

Richard himself has said his comments were not meant to cover non-abusive teenage relationships (Guardian 2004). One sexual health care provider has found "condom requests have dropped dramatically" since the introduction of a registration scheme in which child protection questions are asked. Condom requests fell to 7 patients per week. Reverting back to a non-registration scheme increased requests to 35-50 per week (Priestly & Winterburn).

The "Best practice guidance for doctors and other health professionals on the provision of advice and treatment for young people under 16 on contraception, sexual and reproductive health" produced by the Department of Health in 2004 is a useful document with regards to confidentiality. It highlights the appropriate issues, allows for individualisation of care and has been welcomed by practitioners, and is utilised in conjunction with GMC and BMA guidance.

Q18c. what would be the main considerations in whether to share information?

Comments. Confidentiality is a major concern to young people and they have the same right to confidentiality as adults. However the need to break confidentiality may exceptionally arise, as is also the case with adult patients.

In considering the need to share information the overwhelming issue must be the care of that young person and to act in their best interests to protect their emotional and physical health. The young person's view on the sharing of information is essential. This view should only be ignored in very exceptional circumstances. If their trust is lost it is likely to have long-term repercussions for their current and future health

care, be that for SH or other services e.g. ante-natal and this is particularly relevant for the socially disadvantaged and vulnerable.

Issues that should be considered should include

Competency, as currently assessed using Fraser guidelines

Emotional maturity

Physical development e.g. pre or post pubertal

Drug or alcohol abuse

Age of partner(s)

Number of partners

Disclosure of current or previous sexual abuse or exploitation

Other young people who may be at risk

Social networks and support

Age of young person, with decreasing age causing higher concern. However there should not be a defined age cut-off as this can detract from other considerations. For example a physically and emotionally immature 16 year old may be far more at risk than a younger person with greater physical, emotional and intellectual development. In addition, a defined age cut-off for compulsory notification would result in those below that age not utilising services or giving false information, thus risking their health and losing opportunities to intervene in order to protect them.

Performing a police check on sexual partners of all under 16 year olds should not be undertaken. Partner notification (contact tracing) in the presence of a sexually transmitted infection is integral to, and an underlying principle of, good sexual health care. It is essential to prevent re-infection and onward transmission of sexually transmitted infections. An essential component of partner notification is confidentiality. If names of sexual partners were to be disclosed to the police then the information would not be given. The consequences include re-infection of the young person, inability to treat their sexual partner and the potential for ongoing transmission. The result would be major implications for the public health, with likely rises in HIV and other STIs. There is also the potential for discrimination as some demographic groups may be over-represented. The healthcare worker undertaking partner notification would have to inform the young person that any information given regarding sexual partners would be police checked.

18d. is there a case for information always being shared in some circumstances?

It is impossible to answer this question with a yes or no as by trying to define cases the opportunity to assess each case individually is lost. When a practitioner has any concern, information must be shared within the multi-disciplinary team in order to facilitate decision making. Information sharing outside the team should usually be done with the consent of the young person. If consent is not given and it is deemed confidentiality should be broken, it should be done after discussion with other members of the team and with the knowledge of the young person except in exceptional circumstances. The reasons and decision whether or not to disclose information should be summarised and documented.

18e if yes what would those circumstances be

Each young person should be assessed on a case by case basis. A framework which can be utilised to help the decision making process would provide guidance but there should be no absolute rule as this removes any professional judgement. No-one should act alone in the decision making process where there is cause for concern. Services should have an established process to discuss cases giving rise to concern with access to a network of colleagues. A nominated senior social worker (rather than a duty social worker) who has experience in the sexual health needs of young people

should be available to SH teams to discuss cases anonymously, informally and to accept referrals. Training for such social workers should include input by sexual health care providers e.g. Genitourinary Medicine (which could be developed via BASHH) and Contraceptive clinics. This would have the added benefit of fostering closer links in order to best protect young people. A reciprocal arrangement where social workers could speak to senior healthcare professionals about young people they believe to be at risk of STIs would also be advantageous.