

## Child protection issues and sexual health services in the UK

The Victoria Climbié enquiry and subsequent report has brought the issue of child protection into sharp focus. For those of us working in contraception and sexual health, there can sometimes be conflict between professional codes of confidentiality, the expectations of the client/young person, a young person's needs for sexual health services, and child protection guidance.

We recently represented the Faculty of Family Planning and Reproductive Health Care (FFPRHC) and the British Association for Sexual Health and HIV (BASHH) [previously the Medical Society for the Study of Venereal Diseases (MSSVD)] at a working party of the Royal College of Paediatrics and Child Health (RCPCH) looking into Child Protection and Confidentiality. We contributed a paper outlining the dilemmas for our specialties. Much of this paper has been incorporated into a draft document submitted to the RCPCH, and it forms the basis for this editorial.

Increasing numbers of young people aged under 18 years (children, as defined by the Children Act 1989)<sup>1</sup> are sexually active, with the proportion of young people who report heterosexual intercourse before the age of 16 years rising in the 1990s compared with the previous decade.<sup>2</sup>

Sexual intercourse may be voluntary or may occur as a result of sexual abuse or sexual exploitation, all of which may co-exist. The age of consent for heterosexual and homosexual sex is 16 years in England, Wales and Scotland and 17 years in Northern Ireland. However, sexual exploitation, such as involvement in prostitution, remains a child protection issue until the young person reaches the age of 18 years.

Children involved in sexual activity require input from sexual health services for:

- screening, treatment and prevention advice for sexually transmitted infections (STIs)
- emergency and ongoing contraception and advice
- access to pregnancy termination or antenatal services
- psychosexual/emotional/relationship advice.

They usually attend contraception and genitourinary medicine (GUM) services without their parents or carers who may be unaware that they are utilising such services or are sexually active. There are difficulties in providing sexual health services to young people as they are entitled to the same degree of confidentiality as adults<sup>3,4</sup> and can consent to examination and treatment if judged to be Fraser-competent.<sup>5</sup> However, according to the law their sexual activity may be defined as unlawful either due to their age, the age of their partner or if they are involved in prostitution. Sexual activity is particularly an issue for the under-13s in that they can be judged Fraser-competent to consent to examination and treatment but are regarded as incapable of consenting to sexual activity, requiring referral to child protection services or the police.

The care of children and young people is guided by the standards laid down in statute for sexually transmitted disease services,<sup>6</sup> the Children Act 1989,<sup>1</sup> the European Convention on Human Rights<sup>7</sup> and the Human Rights Act.<sup>8</sup> This will be further affected by the Sexual Offences Bill,<sup>9</sup> which defines any penetrative sexual activity under the age of 13 years as rape and any sexual activity between an adult aged 18 years or over with a child under 16 years as an offence with a maximum sentence of 14 years' imprisonment.

The British Medical Association (BMA) has requested and been successful in getting an amendment to the Sexual Offences Bill tabled to make it clear in statute that a person does not commit an offence if they act for the purpose of:

- protecting the child from STIs, or
- protecting the physical safety of the child, or
- preventing the child from becoming pregnant, or
- promoting the child's emotional well-being by the giving of advice as long as he/she does not act for the purpose of causing or encouraging the activity constituting an offence or the child's participation in it.

However, the Bill is currently at the Committee stage and therefore the final version may be different.

Discussion with clinicians reveals that most are comfortable dealing with disclosures of definite abuse. More often, however, they are faced with ambiguous situations, particularly involving under-13s.

That such young people are sexually active is considered undesirable and presents special problems to sexual health providers. These vary from case to case and must be dealt with on an individual basis.

National guidelines have been produced on the management of suspected STIs in children and young people, which discuss this issue in more detail and make recommendations for those working in GUM services.<sup>10</sup>

Clinicians providing these services cannot and should not ignore the child protection issues for these young people. However, they must also consider the needs and rights of the young person for confidential and appropriate medical care. If a service is not seen to be confidential there is a risk that either it will not be accessed, or that those attending will not be honest about their age and/or sexual activity and may not disclose abuse or exploitation. This can have serious health implications and mean that abuse/exploitation might go unrecognised and the opportunity for supporting the young person and intervening to stop the abuse/exploitation would be lost.

Currently many contraceptive services provide a confidentiality statement that specifies if abuse is disclosed this will be reported. The effect of such statements on a young person's willingness to then disclose important information about sexual abuse/exploitation and about their partner for contact tracing purposes is unknown. The GUM guidelines<sup>10</sup> recommend the use of a risk assessment proforma to ensure abuse is detected and stresses the importance of multidisciplinary teamwork.

Where under-13s are concerned it is especially important to establish clear local referral pathways, involving local paediatricians, experienced child protection professionals, the Area Child Protection Committee (ACPC) and others, e.g. school nurses, learning mentors and social workers. Sexual health clinicians should be proactive in establishing these local care pathways and ensuring that all staff are well supported. It is useful if one or more named clinicians are available to give advice and build up expertise within services.

Doctors and nurses working in sexual health services need to be able to discuss clients without initial disclosure of names. The distinction between the need for advice/discussion and referral is an important one. If referral is necessary then the child's consent should be obtained, and if this is refused it may be possible to work with the young person over a period of time in order to

obtain consent, unless there is evidence of immediate danger or risk to another child. If disclosure is refused by the young person they should be made aware of the referral, except in exceptional circumstances. It is essential that every case is dealt with on an individual basis and that close collaboration between services exists.

Although parents/guardians of children being referred to child protection services via paediatricians are usually made aware of the referral, this is not standard practice in sexual health services if the young person has presented without their carer.

Because of the conflict between the medical/confidentiality needs of the young person and child protection issues doctors are becoming increasingly concerned. The additional clause in the Sexual Offences Bill<sup>9</sup> should help but the final version of this Bill is not yet determined. There is a real danger that unless doctors are allowed to provide a confidential service to young people then sexual health care may in the future be jeopardised for those who are most in need.

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#### References

- 1 *The Children Act 1989*. London: Her Majesty's Stationery Office, 1989.
- 2 Wellings K, Nanchahal K, Macdowall W, et al. Sexual behaviour in Britain: early heterosexual experience. *Lancet* 2001; **358**: 1843–1850.
- 3 British Medical Association (BMA). *Consent, rights and choices in health care for children and young people*. London: BMA, 2000.
- 4 General Medical Council (GMC). *Confidentiality: protecting and providing information*. London: GMC, 2000.
- 5 Gillick v West Norfolk and Wisbech AHA (1986) AC 112, (1985) 3 WLR 830, (1985) 3 All ER 402, HL.
- 6 The NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000 pursuant to Sections 17 and 126(3) of the National Health Service Act 1977(a).
- 7 European Convention on Human Rights, 1950. [www.hrcr.org/docs](http://www.hrcr.org/docs)
- 8 British Medical Association (BMA). *The impact of the Human Rights Act 1998 on medical decision-making*. London: BMA, 2000.
- 9 Sexual Offences Reform Bill. London: Home Office, 2003. [www.publications.parliament.uk](http://www.publications.parliament.uk)
- 10 Thomas A, Forster G, Robinson A, et al. National guidelines for the management of suspected sexually transmitted infections in children and young people. *Sex Transm Infect* 2002; **78**: 324–331. [www.bashh.org](http://www.bashh.org)