Confidentiality versus child protection for young people accessing sexual health services: "To report or not to report, that is the question."

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Introduction

One of the greatest current concerns of staff providing sexual health services is whether they have to report sexually active young people to child protection services. The young need to be protected from sexual abuse and exploitation, and local safeguarding children boards (LSCBs) are responsible for drawing up protocols to ensure child protection and make recommendations on who should be referred. Over the past few years there has been some conflict between services about the need for confidentiality for young people versus the need to report. Anecdotal evidence suggests that some providers have been threatened with withdrawal of funding for services, and individuals threatened with possible dismissal, for failure to comply with local guidelines for compulsory reporting. Essentially both sides want the same thing, that is to protect children, but differences arise in how best to achieve this. What are the arguments?

To report

The Sexual Offences Act 2003[1] makes sexual activity in under 16-year-olds illegal. Those aged under 13 years are deemed by law to be unable to give consent, thus penetrative sexual activity is rape. The Bichard Enquiry into the Soham murders and the Laming Report into the death of Victoria Climbié both raised the issue that better information sharing between services – health, social services and the police – may have avoided tragedy, and recommended better communication. Sexual health services are often the only agency with the knowledge that a young person is engaged in sexual activity. It has been argued that if social services were made aware then they could protect the young person from further activity and investigate with the police the sexual partner, thus preventing others from being exploited or sexually abused.

Not to report

Health care providers have maintained that confidentiality is an essential component of sexual health care. Without confidentiality, it is believed that young people (who may already be highly suspicious of mainstream child services) are unlikely to attend. Research has repeatedly shown the importance of confidentiality to young people and recent work shows that 55% of 14-year-olds questioned would not access services if they were 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.[2] 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 seven patients per week. Reverting back to a non-registration scheme increased requests to 35–50 per week (Priestly and Winterburn, personal communication). Work in the USA has highlighted the detrimental effect of compulsory notification of statutory rape in some US states with regard to sexually transmitted infections (STIs) and teenage pregnancies.[3]

The reality

Young people are becoming sexually active at a younger age and having more, and concurrent, partners; 25% of young people are sexually active by their 16th birthday.[4] Teenage pregnancies in the UK are currently the highest in Europe and STI rates in young people are increasing; 41% of gonorrhoea and 39% of chlamydia cases in females are in the under 20-year-old age group. Gonorrhoea rates in England are 16 per 100 000 in girls under 16 years and 133 per 100 000 for 16–19-year-olds. Chlamydia rates are 116 and 1359 per 100 000, respectively.[5] Pregnancy at a young age has long-term psychological and social impacts and it is often forgotten that there are health risks and mortality associated with pregnancy itself. The dangers of STIs are well documented and can have long-term effects on fertility, in addition to the life-threatening effects of HIV, hepatitis B and C and ectopic pregnancies.

The answer to the question

The answer to the question is as follows: a young person orientated, individualised approach considering child protection in its broadest sense, in a team setting with close links to other agencies.

How can this be achieved?

A young person centred approach means that every case is considered separately. This is more difficult and time consuming but provides better care. The document *Working Together to Safeguard Children* provides guidance in paragraph 5.8 on child protection for the sexually active young person.[6] Much of it is in keeping with the British Association for Sexual Health and HIV (BASHH) guidelines on the management of children and young people with suspected STIs,[7] which have been utilised successfully in several genitourinary medicine (GUM) clinics for a number of years.[8] The Government has an expectation that LSCBs will base their local guidelines on *Working Together to Safeguard Children*,[6] although some areas appear to be producing documents not in the spirit of national recommendations.

Essentially, all young people aged between 13 and 16 years accessing sexual health services should be assessed for sexual abuse and exploitation. The use of a proforma is the easiest way to ensure that relevant issues are covered. Services can use those developed by Lancashire[9] or BASHH (currently being updated) or develop their own. Issues that should be covered include, among others, age, competency (as currently assessed using the Fraser Guidelines) partner's age, maturity (physical and emotional), drug and alcohol use, evidence of 'grooming' and number of partners. The lower the age of the young person, the higher should be the level of concern.

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If concerns arise then consideration should be given to referring to social services. Any decision to refer should ideally have the consent of the young person; if the reasons for this are explained carefully it is likely most will agree. Where consent is refused, a decision must be made whether to refer without consent. This is an extremely serious decision and should not be made lightly. The need for that person to retain confidence in the sexual health service, and the need for her or him to access treatment and prevention for STIs and pregnancy, needs to be balanced against the need to protect them from sexual abuse or exploitation. The decision-making process also needs to consider whether other young people are in danger. If referral is thought essential but consent is refused, and there is immediate danger, then the young person should be informed of that decision, unless to do so would put them at greater risk. However, if there is no immediate danger, a follow-up appointment allows further discussion and the young person may then agree to referral.

For those aged under 13 years, *Working Together to Safeguard Children* states that there should be a 'presumption' of reporting to social services.[6] Once this occurs, social services are obliged to report to the police. However, there is no recommendation for mandatory reporting to social services. Although it is likely that for most cases of sexual activity in a 12-year-old, after assessment and discussion, a referral would be appropriate, it is still necessary to consider each child individually. Automatic referral of all under-13-year-olds cannot be justified – every case should be individualised.

In assessing young people, there is no doubt that a prepubertal child irrespective of age requires referral, or when there is evidence of familial abuse. Problems arise when a girl or boy is fully sexually mature, is almost 13 years old, has a relationship with a partner of the same age and refuses referral. Older partners are a cause of concern, as are those children with learning difficulties aged 16 years or older (i.e. over the age of consent) but who could be victims of exploitation. *Working Together to Safeguard Children* also covers young people aged up to 18 years, and although it does not recommend routine assessment for this age group, it does suggest that consideration should be given to possible abuse or exploitation.[6]

Information sharing

Team working is an essential component of child protection. Services providing sexual health services should ensure that within the team there is a nominated senior professional responsible for child protection with whom cases can be discussed prior to disclosing information. In the case of under-13-year-olds, all cases must be discussed with the nominated professional. Reasons for sharing information outside the team must be documented, and reasons for disclosure or non-disclosure to child protection services clearly written in the notes. Trusts have child protection officers who are always available for advice. Access to senior social workers, to facilitate referrals, and to obtain advice without disclosing the name of the young person, is invaluable.

Further advice and guidance

Further advice and guidance is available from several sources. The Department of Health 2004 publication[9] is a useful document with a further question and answer sheet brought out after *Working Together to Safeguard Children*.

The British Medical Association (BMA) has highlighted the need to continue to provide a confidential service to young people.[10] The BMA statement on *Working Together to Safeguard Children* says: "It is clear that there is no requirement for mandatory reporting of sexually active young people, irrespective of their age. The guidance confirms established best practice that decisions about sharing confidential information about sexually active young people must be made on the basis of an assessment of their best interests. It is clear that young people place a very high value on a confidential sexual health service. Without an underlying presumption of confidentiality, young people will refuse to access such services and their interests could therefore be seriously harmed. Decisions in this area, which can often be challenging, must always be made on a case-by-case basis, taking into consideration all relevant information. Where health professionals believe that children may be subject to coercion or exploitation, existing child protection guidelines must be followed. Health professionals with concerns should seek advice and help, anonymously if necessary, from colleagues with expertise in child protection, such as named and designated professionals".[10]

The General Medical Council and nursing and midwifery regulatory bodies all have guidance for their members. The BASHH guidelines are currently being updated.

In summary: provide individualised care, base decisions on what is in the best interests of the young person, ask advice either within or outside the team, always be able to justify each decision to refer or not, and keep appropriate records.

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References

1 Sexual Offences Act 2003. London, UK: HMSO, 2003. http://www.opsi.gov.uk/ACTS/acts2003/20030042.htm [Accessed 16 November 2006].
2 Thomas N, Murray L Rogstad KE. How important is confidentiality to young people? *Int J STD AIDS* 2006; **17**: 522–524.
3 Franzini L, Marks E, Cromwell PF, Risser J, McGill L, Markham C, *et al*. Projected economic costs due to health consequences of teenagers' loss of confidentiality in obtaining reproductive health care services in Texas. *Arch Pediatr Adolesc Med* 2004; **158**: 1182–1184.
4 Wellings K, Nanchahal K, Macdowall W, McManus S, Erens B, Mercer CH, *et al*. Sexual behaviour in Britain: early heterosexual experience. *Lancet* 2001; **358**: 1843–1850.
5. Health Protection Agency. *A Complex Picture. HIV and Other Sexually Transmitted Infections in the United Kingdom:* 2006. http://www.hpa.org.uk/publications/2006/hiv_sti_2006/pdf/sup_tables/sti_sup_tab.pdf [Accessed 27 November 2006].
6 HM Government. *Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children*. London, UK: The Stationery Office, 2006. http://www.everychildmatters.gov.uk/_files/AE53C8F9D7AEB1B23E403514A6C1B17D.pdf [Accessed 16 November 2006].
7 Thomas A, Forster G, Robinson A, Rogstad K; Clinical Effectiveness Group (Association of Genitourinary Medicine and the Medical Society for the Study of Venereal Diseases). National guideline for the management of suspected sexually transmitted infections in children and young people. *Sex Transm Infect* 2002; **78**: 324–331.
8 Holkar S, Rogstad KE. Introduction of a proforma in the management of under age attendees at a genitourinary medicine clinic. *Int J STD AIDS* 2005; **16**: 278–280.
9 Department of Health. *Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People Under 16 on Contraception, Sexual and Reproductive Health*. London, UK: Department of Health, 2004. http://www.dh.gov.uk/assetRoot/04/08/69/14/ 04086914.pdf [Accessed 16 November 2006].
10 British Medical Association. Statement on information sharing in relation to sexually active young people. http://www.bma.org.uk/ap.nsf/content/childrensexualhealth [Accessed 16 November 2006].