

Adolescent sexual and reproductive health: practical implications for clinical practice in Victoria

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Introduction

Many factors influence sexual and reproductive health. They include whether or not the relationship is equitable; whether sexual fulfilment is achieved; whether services and information are accessible; the degree to which behaviour is affected by attitudinal, cultural and societal influences; and whether fertility is controlled effectively (1, 2, 3, 4). In reality, sexual health is often clinically defined by rates of unplanned pregnancy and sexually transmitted infections (STIs).

Sexually transmitted infections

STIs affect young people predominantly. In Australia, notification rates for *Chlamydia trachomatis* and gonorrhoea have increased significantly in the last decade (5). In Victoria, *C. trachomatis* notification rates have doubled during this time. Most infections are in women and more than half of these are in those under the age of 25 years (6). In contrast, gonorrhoea is most prevalent amongst men who have sex with men (MSM). STIs result in significant reproductive morbidity and mortality, both for the individual and the community as a whole, with major economic implications. In addition to these direct costs, many STIs have been shown to increase the transmission of HIV (7, 8, 9).

The asymptomatic nature of many STIs presents a challenge for their prevention, diagnosis and treatment. For example, many individuals with herpes simplex virus (HSV2) are unaware that they are infected (10). Adolescents are at high risk of STIs, partly as a result of their sexual behaviour, and partly by the difficulty they have in accessing services (11, 12). It is important that sexual health services are easily accessible to those most at need (13).

Unplanned pregnancies

The majority of teenage pregnancies are unplanned and approximately half of them result in termination. In 1999 the teenage birth rate was 18.1 per 1,000 women per year, ranging from 10.8 in Victoria to 66.7 in the Northern Territory (14). Only in states where there is specific abortion legislation (such as South Australia) is the number of abortions accurately recorded (15). In Victoria, where this is not recorded, estimates based on Medicare claims indicate a rate of 13 per 1,000 teenagers per year.

The determinants of teenage unplanned pregnancies are largely socio-economic. Preventing teenage, unplanned pregnancies is therefore more complex than simply providing accessible contraceptive services and sex education (16-19).

However, the provision of accessible sexual and reproductive health services for adolescents will be an important part of any program aiming to reduce the teenage pregnancy rate. Health professionals face many barriers to their providing accessible services for adolescents within the mainstream health service. Similarly, adolescents face barriers in accessing them (11, 12, 19-23). A common barrier for health professionals is being unsure of the medicolegal position with regard to treating adolescents under the age of 18 years without the knowledge of their parents. Victorian practitioners working in the area of adolescent sexual and reproductive health need to be clear about the professional, legal and ethical constraints within which they practice.

References

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Structural, legal and professional influences for practitioners in the provision of sexual and reproductive health services to adolescents in Victoria, Australia.

Legal age of sex in Victoria

Sex is legal in Victoria from the age of ten years, as long as the partner is less than two years older. Below this age, consent is not valid and is never a defence. From the age of sixteen years, sexual intercourse is legal with another person of any age, as long as that person is not in a supervisory position for the young person. This includes teachers, guardians and youth workers amongst others. From the age of eighteen years, consensual sex is legal with a partner of any age. These ages are the same for opposite sex and same sex partners (1).

Implications for practice

Remember, there is not necessarily any obligation to report a crime that you are informed about by a patient during a confidential consultation. This may mean that, although a young person may be engaging in an illegal sexual act (i.e. a fourteen year old having sex with a seventeen year old), it does not *necessarily* mean that the young person is at risk of significant harm as a result of this. Whether this belief is formed may vary between professionals. If you believe that the young person is at risk of significant harm, it is mandatory that you report the matter to the Department of Human Services.

References

Sexual Offences Sections 45- 49 of Crimes Act 1958 (Vic.).
www.dms.dpc.vic.gov.au

Resources

www.lawstuff.com.au Website for advice on legal age for different activities.

Am I old enough? Free booklet for young people produced by Victoria Legal Aid.

Child protection and mandatory reporting

Certain professionals (e.g. doctors, nurses and teachers) are mandated to report to the Child Protection Office of the Department of Health and Community Services if they form a belief (whilst undertaking professional duties) on reasonable grounds that a child (i.e. a person who is seventeen years of age and under) has suffered, or is likely to suffer, significant harm as a result of physical or sexual abuse and is in need of protection.

Implications for practice

The important practical words in this for the professional are “*form a belief*”, “*reasonable grounds*” and “*significant harm*” (1). Forming a belief is subjective and, in some situations, certain professionals will legitimately form a belief that a young person is at risk of significant harm whilst other professionals, in the same situation, may not form this belief. If you have any doubt about whether you are mandated to report, you can discuss the case anonymously with your local Child Protection team. Alternatively you might discuss the case with a colleague who has experience in this area. If you do form the belief that the young person is in need of protection, best practice is usually to inform the young person that you are reporting to child protection services and why. However you are not obliged to do so and, in some circumstances, you may feel it is not appropriate to discuss this with the young person.

References

Sections 63-64 Children and Young Persons Act 1989 (Vic).
www.dms.dpc.vic.gov.au

Resources

Victorian Child Protection Crisis Service 131 278 (24 hours)

<http://www.aihw.gov.au/publications/cws/cpa02-03/cpa02-03-x01.pdf>:

article clarifying the term “in need of protection”.

Centres Against Sexual Assault (CASA): CASA House: 9344 2210.

Kang M., Sanci L., Chown P., Bennett D. Adolescent Health: enhancing the skills of general practitioners in caring for young people from culturally diverse backgrounds. A resource kit for GPs. Sydney: Transcultural Mental Health Centre and NSW Centre for the Advancement of Adolescent Health, 2004.

Competency to consent to medical interventions

In Victoria individuals under eighteen years of age need to be assessed for their ability to consent to treatment (1, 2). The degree of competency required is related to the complexity of the treatment requested (3). There is no simple and quick test to assess competency. In addition, there is no absolute age (for those under eighteen years) when an adolescent is automatically deemed to be competent (4). Each individual must be assessed in each situation in which he or she requests a new medical treatment or procedure. Special medical procedures are treatments to which neither competent minors nor their parents can consent. These procedures have permanent and significant consequences. An application to the Family Court is necessary for such procedures to be performed. These procedures include hysterectomy, sterilization and gender reassignment.

Implications for practice

Assessing competency may be difficult. The degree of competency needed to consent to a procedure is related to the complexity of the procedure. A young person may be appropriately assessed as competent to consent to being prescribed contraception, but not competent to consent to a two stage termination. In order to give informed consent, the young person must:

- Have the ability to understand there is a choice and that choices have consequences.
- Be willing to make a choice and have the ability to do so.
- Understand the nature and purpose of the procedure.
- Understand the procedure's risks and side-effects.
- Understand the alternatives to the procedure and the risks attached to the alternatives.
- Understand the consequences of no treatment.
- Be free from pressure from third parties.

Factors which may influence the level of competency include age, level of independence, level of schooling, maturity and ability to articulate own choices (5). In general, many young people from the age of fourteen years upwards are likely to be competent to consent to straightforward medical treatments (6,7).

Points to consider when assessing a young person for competency:

1. Is more time needed to establish a rapport and a trusting relationship with the young person? If yes, ask them to return for further discussion.

2. Do you need another opinion? Ask a colleague with expertise in the area to see the young person or refer them to a specialised adolescent service.
3. A minor with an intellectual disability may be able to consent and is not necessarily incompetent. This will depend on the degree of disability as well as many other factors. As with a fully able minor, every individual needs to have a competency assessment in every situation and for each medical treatment requested.

References

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2. Consent for treatment and confidentiality in young people. Melbourne: Medical Practitioners' Board of Victoria, 2004.
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Confidentiality

Professional codes of conduct around confidentiality emphasise that confidentiality should always be respected, if at all possible (1). Adolescents are also entitled to confidential health services, whenever possible. However, confidentiality can never be absolute. In exceptional circumstances, health professionals may be obliged to discuss a young person's situation with others i.e. to break this confidentiality. This may lead to the involvement of parents or the Department of Human Services. Adolescents will usually give their consent for this if time is taken to explain why it is necessary. However, in less common situations, it may be

necessary to involve others without the consent of the adolescent. Such situations include those where the young person is assessed to be at risk of harming themselves or someone else, to be a risk to the community, or to be at risk of harm from others. This also applies when the health professional has been subpoenaed.

Implications for practice

Confidentiality and privacy are major factors influencing young people's use of services (2,3,4). All young people should be made aware what the term "confidentiality" means and what the limitations of this concept are in practice. Adolescents should be reassured that their confidentiality will be respected whenever possible. In circumstances in which a young person is not found to be competent to consent to medical treatment, the young person may still be entitled to confidentiality about the consultation itself. Best practice dictates that all adolescent services should have a visible confidentiality policy specifically covering the rights of young people. All users of the service should be informed of this by means of a leaflet or poster (5,6,7).

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www.fpv.org.au

Framework for psychosocial assessment of adolescents

In order to assess competency, it is helpful to be aware of and to understand the major influences on young people's lives. It is also helpful to establish a trusting relationship. The **HEADSS assessment** is a well established psychosocial assessment framework recommended by many experts in the speciality of Adolescent Health (1). This screening assessment affords the practitioner a vital psychosocial snapshot of the young person's life and a better understanding of the factors influencing the young person's decisions. It should be used as part of a routine consultation with an adolescent.

HEADSS: psychosocial assessment tool

Home: e.g. ask what is happening at home; who do they live with; is there excessive conflict; is the family on the verge of breakdown; etc.

Education/Employment: e.g. what school do they go to; what year level; are they doing well academically; have their grades recently declined; are there any problems with bullying; do they have good peer support; etc.

Activities and Peer Relations: e.g. what do they do outside school; are they involved in music or sport; etc.

Drugs/cigarettes/alcohol: e.g. how much do they drink; do they use recreational drugs; if so, what and how often; what effects do they experience; how do they fund this; etc.

Sexuality: e.g. do they have any concerns about their sexuality; are they attracted to the opposite sex only; sexual activity and sexual history if not already taken.

Suicide/depression e.g. have they ever been diagnosed with depression; have they ever self-harmed or seriously considered it; do they have appropriate emotional support from family, peers; etc.

References

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Resources

For a more detailed description of how to apply the HEADSS assessment see:

<http://www.cw.bc.ca/youthhealth/pdf/HEADSS%20Assessment%20Guide.pdf> which is the University of British Columbia's website.

Specific sexual and reproductive health considerations for adolescents in Victoria

The term ‘Gillick competency’ is often used in the literature (1, 2). This refers to a case in the United Kingdom in 1985 when Victoria Gillick took a health authority to court because, without informing the mother, a GP had prescribed contraception to the daughter who was under sixteen years of age. Judge Fraser found against Victoria Gillick and in favour of respecting the confidentiality of the young person. As a result, the Fraser Guidelines were issued. This ruling has been confirmed subsequently in Australia, when the Family Court stated that a minor, in order to be deemed competent, should have sufficient maturity and capacity to fully appreciate all aspects of the matter and should be able to assess objectively the various options available (3,4.). Fraser recommended that, when prescribing contraception to those under sixteen years of age, the doctor should:

- discuss with the young person the benefits of talking over the issue with her parents;
- be sure that the young person is able to understand the physical and emotional consequences of sex;
- believe that the young person is likely to have sex with or without contraception;
- believe that the physical or mental health of the young person is likely to suffer if the request is denied.
- believe that it is in the best interests of the young person to prescribe contraception and to respect their confidentiality, if the young person requests this.

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www.aifs.gov.au/institute/pubs/fm1/frm32mh.html

Resources

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(http://www.dfes.gov.uk/teenagepregnancy/dsp_Content.cfm?PageID=85) at
http://www.dfes.gov.uk/teenagepregnancy/dsp_showDoc.cfm?FileName=Confiden%2Epdf

Abortion in Victoria

Section 65 of the Crimes Act 1958 in Victoria prohibits unlawful abortion (1). The Menhennitt Ruling from the Supreme Court of Victoria in 1969 stated that “it is a defence to show the person honestly believes on reasonable grounds that the termination is necessary to preserve the woman from serious danger to her life or physical or mental health, and that the danger of the procedure is not out of proportion to the danger averted” (2). This ruling is still applicable in Victoria today. To be successfully prosecuted the court would need to show, beyond reasonable doubt, that the defendant lacked this belief.

References

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www.dms.dpc.vic.gov.au
2. Menhennitt Ruling from Supreme Court of Victoria 1969
<http://vsc.sirsi.net.au/Judgements/Civil/23129.pdf>

Resources

Victorian Legislation and Parliamentary Documents Home Page.
(<http://www.dms.dpc.vic.gov.au>).

Sexuality and the Law in Victoria: Fertility and Sexual Health. FPV and Victoria Law Foundation 1996.

Medicare cards for under eighteen year olds

Adolescents from fifteen years of age onwards can obtain their own Medicare card. Parents cannot obtain information about their children aged fourteen years and over unless the young person signs a release form for their parents to access this information from Medicare. However the young person may find it very difficult and compromising not to sign this if their parents ask them to. For those aged fourteen years and under, Medicare does not need permission, written or otherwise, from a young person to release information to parents.

Implications for practice

The young person needs to be informed about these issues and Medicare. They should be aware their parents may want access to their Medicare details and ask them to sign a release form. This may cause conflict between the young person and their parents.

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