

Risk management Young people and the Fraser guidelines: confidentiality and consent

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Key content:

- Under the Sexual Offences Act 2003, sexual intercourse and all forms of sexual touching of a minor are illegal in England and Wales.
- There is no legal obligation to report underage sex unless exploitation is suspected.
- Under the Fraser guidelines, a doctor is able to give contraceptive treatment or advice to a person under the age of 16 years, provided certain criteria are met.
- The duty of confidentiality owed to a person under 16 years of age is the same as that owed to any other person.
- All staff who deal with minors in a health setting need to be able to weigh up the conflicting priorities of the need for confidentiality and the possibility of sexual exploitation.

Learning objectives:

- To learn about the legal issues concerning consent and confidentiality with regard to minors.
- To learn how to apply the Fraser guidelines and assess risk of exploitation when issuing sexual health advice or treatment to minors.

Ethical issues:

- How can a doctor working with young people make health services user-friendly while needing to identify and report abusive situations and respect parental rights?

Keywords child protection / confidentiality / consent / Fraser guidelines / Sexual Offences Act

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Introduction

Teenage sex is common. About 25% of teenagers in the UK have had sexual intercourse by the age of 16 years.¹ In Wales, the mean age of sexual debut is 14 years.² The Department of Health³ has set targets to reduce teenage pregnancy rates and sexually transmitted infection and recognises the need to make sexual health services user-friendly. There is no legal obligation to report underage sex. There is good evidence that young people are reluctant to use services that they do not perceive to be confidential.⁴ Although most teenage sexual activity is mutually agreed, sexual abuse in childhood is common. The Victoria Climbié⁵ and Richard⁶ inquiries and the Department of Health⁷ have made it necessary for all professionals working with children to be alert to clues of abuse. The health care professional working with young people faces the difficult balancing act of making services user-friendly while needing to identify and report abusive situations and respect parental rights. The case below illustrates many of the issues.

Natalie, a 14-year-old, attends a party, gets drunk and has unprotected sex with John, a 16-year-old from school whom she knows and 'fancies'. This is her first experience of sex. While she did not enjoy it much she is pleased she is better informed about sex and does not regret it.

Her parents are strict Roman Catholics and she cannot tell them. The next day Natalie attends an Accident and Emergency (A&E) department for emergency hormonal contraception. The staff nurse tells her she cannot be treated without the consent of her mother. Four weeks later a home pregnancy test shows a positive result. Several weeks later Natalie confides in her 18-year-old sister, who instigates a referral for an abortion. The doctor in the clinic wants Natalie to inform her parents, but she feels she cannot. The sister thinks she ought to be able to sign the consent form on Natalie's behalf.

The Sexual Offences Act 2003

In England, Wales and Scotland the age of consent to any form of sexual activity is 16 years for males and females. In Northern Ireland it is 17 years.

Under the Sexual Offences Act 2003,⁸ sexual intercourse and all forms of sexual touching of a minor are illegal in England and Wales, including kissing a minor or kissing between minors. An activity is considered 'sexual' if a reasonable person would always consider it to be so, or if it may be deemed to be depending on the circumstances and intention. 'Touching' covers a wide range of behaviour: touching any part of the body with anything else, including through clothing.

'Consent' to sexual activity implies that the person agrees to it by choice and has the freedom and

capacity to make that choice. It implies that the person realises they have a choice, understands the nature and consequences of the activity, realises it is different from personal care and can communicate their decision.⁹ However, early sexual encounters are inevitably exploratory and many teenagers do not know much about the nature of sexual intercourse until it happens. While some people with mental or learning disabilities clearly lack the capacity to consent, it can be difficult to establish whether 'informed consent' to sexual intercourse has been given by a normally developed teenager, particularly if they have drunk alcohol. Teenagers under 13 years of age are deemed not to have the capacity to consent to sexual activity and any agreement to do so is not recognised in law.⁸

Although the Sexual Offences Act aims to protect young people from exploitation, many agencies are concerned that normal exploratory behaviour has effectively been criminalised.¹⁰ From the definitions above it can be seen that the law does recognise that teenagers under the age of consent can agree mutually to sexual activity. The Sexual Offences Act allows that, if both partners are aged between 13–15 years, discretion can be exercised by the Crown Prosecution Service, provided there is no evidence of abuse or exploitation. The Department of Health¹¹ has also assured that mutually agreed sex should not be prosecuted.

If an individual over 16 years of age has sexual activity with someone under 16, it is the older individual who commits an offence. Offences for which there can be charges are:

- sexual assault (intentionally touching another person sexually without their consent)
- assault by penetration (intentional penetration of the vagina, anus or mouth of another person with a part of their body other than the penis, or any object, without consent and with a sexual purpose)
- rape (a man intentionally penetrates with his penis the vagina, mouth or anus of another person without their consent, or is reckless as to whether they consented. The charge does not depend on deep penetration or ejaculation).⁸

If an individual has intercourse with a child under 13 years of age they can automatically be charged with rape. There is no defence whatsoever.

In the example, Natalie's sexual intercourse was illegal and John could be charged with rape, even though Natalie agreed to it. It could be argued that, since Natalie was drunk, John was reckless as to whether she consented. In practice, sexual encounters like Natalie's and John's are very common and are usually not exploitative. The police and Crown Prosecution Service will only get

involved if someone lodges a complaint about the sexual activity and, even then, unless one of the partners alleges assault or there is clear evidence of exploitation, it is unlikely the case would be taken further.

Consent to treatment

In 1985, Wisbech Health Authority was taken to court for providing a minor with contraceptive treatment without parental knowledge.¹² The legality of someone under 16 years of age consenting to medical treatment had not been established at that time. Lord Fraser ruled in the High Court that a doctor could give contraceptive treatment or advice provided the following criteria were met:

- the girl was mature enough to understand his advice and the implications of treatment
- the girl was likely to begin or continue to have sex with or without treatment
- the doctor had tried to persuade the girl to inform her parents, or to allow him to inform them
- her health would suffer without treatment or advice
- her best interests required him to give treatment or advice.¹³

Fraser competence can now be assessed by professionals other than a doctor. These criteria still apply. If a young person meets them they are termed 'Fraser ruling competent'. The principles of this judgement are now central to consenting minors for all health treatments.^{9,14} In Scotland and Northern Ireland different laws apply,¹⁵ although the implications are similar.

A recent survey in Gwent¹⁶ identified that 87% of teenagers under 14 years of age attending contraceptive clinics saw a nurse and clerk only. The Sexual Offences Act specifically allows a professional to provide sexual health care to minors provided the intention is to protect the minor from sexually transmitted infections, pregnancy, physical harm or to promote the minor's wellbeing. This new ruling also applies to teachers, nurses and youth workers. Professionals providing treatment to minors must continue to assess competence within the Fraser guidelines. Children under 13 years of age have the same rights as older people to seek confidential sexual health advice.

The nurse in the A&E department was wrong to say that Natalie could not be treated without her mother's consent. Emergency hormonal contraception is safe, simple to take and without significant side effects. Any teenage girl who has found her way to an A&E department for treatment has the capacity to understand that emergency hormonal contraception is likely, but not guaranteed, to prevent pregnancy. In the example, Natalie has already had intercourse and, clearly, her

best interests were to receive treatment. The nurse only had to discuss parental involvement and the Fraser guidelines would have been met. Even if Natalie had been 12 years old the same would have been true. The application of the Fraser guidelines in issuing sexual health advice or treatment is quite separate from identifying unlawful sex or abuse.

Assessing capacity to consent to an abortion is more complicated because the risks of an abortion are greater than emergency hormonal contraception and harder to understand. According to the General Medical Council,¹⁷ competence is demonstrated if the young person is able to:

- understand the proposed treatment, its purpose and nature and why it is being proposed
- understand the risks, benefits and alternatives
- understand in broader terms what the consequences of treatment will be
- retain the information long enough to make a decision.

However, it is unreasonable to expect an intelligent 15-year-old to understand more than a normally developed 16-year-old who, in law, is presumed competent to give consent. Clinicians may want parental involvement so that the young person can have parental support after an abortion. The need for support, however, is a different issue to getting consent. If the girl is Fraser competent and does not want her parents to be involved the clinician must respect her wishes. In the example, if Natalie can understand the implications of the treatment then she should be allowed to sign her own consent form. If she cannot sign, then the only people who can agree to the procedure on her behalf are those with parental responsibility or a court. Her sister cannot do so.

In 2004, the Department of Health¹¹ produced welcome guidance for health professionals on the provision of contraceptive, sexual and reproductive health services for those under the age of 16 years. This document states that it is good practice for doctors and other health professionals to establish rapport and give a young person support and time to make an informed decision by discussing the benefits of informing their general practitioner and a parent or carer. However, 'any refusal should be respected. In the case of abortion, where the young woman is competent to consent but cannot be persuaded to involve a parent, every effort should be made to help them find another adult to provide support, for example another family member or specialist youth worker.' In the example, the clinicians in the abortion clinic could well find the support of Natalie's sister to be adequate.

Confidentiality

Brook⁴ has shown that young people can be very reluctant to seek the support they need because of

worries about confidentiality and anxiety about being judged, often driven by concerns about the legality of their actions. The study⁴ found that 15% of general practices had a doctor who would refuse to see a girl under 16 years old for contraception without her mother. It is enshrined in professional practice that the duty of confidentiality owed to a person under 16 years of age is the same as that owed to any other person,¹⁸ and breaches of it should be treated as seriously as if the person were over 16.

The Department of Health¹¹ states that ‘all services providing advice and treatment on contraception, sexual and reproductive health should produce an explicit confidentiality policy which reflects this guidance and makes clear that young people under 16 have the same right to confidentiality as adults. Confidentiality policies should be prominently advertised, in partnership with health, education, youth and community services.’

If a particular professional cannot offer confidential services to young people because of personal belief or prejudice, the duty of confidentiality remains and they must make urgent arrangements for them to be seen by someone else.^{18,19}

However, no one has the right to absolute confidentiality. If a professional believes there is a risk to the health, safety or welfare of a young person (or any other minor) and that the risk is serious enough to override the young person’s right to privacy, then the professional must follow child protection protocols and refer to social services. In response to the Bichard Inquiry,⁶ some Area Child Protection Committees offered guidance that all minors’ partners should be police-checked and that if a professional becomes aware that someone under 13 years of age is having sexual intercourse,

they should automatically refer to social services. This guidance has been disputed by the British Medical Association, Brook, the Family Planning Association (FPA)²⁰ and the Medical Defence Union,²¹ who are concerned that it will deter young people from seeking advice. It is also at odds with the Sexual Offences Act, which specifically allows for people under the age of 13 to seek confidential sexual health advice.

The latest version of the Department of Health document ‘Working Together to Safeguard Children’⁷ states, ‘the child’s best interests must be the overriding consideration in making any decision (to share information)’. In cases where the child is under 13 there should always be discussion with a nominated child protection lead in the organisation and there should be a presumption that the case will be reported to children’s social care. In addition, ‘detailed reasons (should be documented) where a decision is taken not to share information.’

With regard to teenagers aged 13–15 it states, ‘consideration should be given in every case of sexual activity... as to whether there should be a discussion with other agencies and whether a referral should be made to children’s social care.’

With this guidance the potential number of referrals represents a substantial workload for health services, the police and social services. In the author’s service, 14 young people under 13 years of age were seen in 2005/2006 and a further 1172 young people aged between 13–15 years.

The Department of Health²² states, ‘if considering any disclosure of information to other agencies, staff should weigh up... what any disclosure is intended to achieve and what the potential benefits are to the young person’s well-being.’ In Natalie’s example, although the sex she had with John was illegal, staff in the abortion clinic would probably feel that little benefit would be gained by informing social services or the police.

Identifying coercive relationships

Illegal sex does not necessarily mean abusive sex. The vast majority of people having illegal underage sex have mutually agreed to it. However, it is estimated that one young person in 10 is subject to abuse.²³ Young people who are being abused rarely disclose it, and professionals frequently fail to act on information or clues given to them.^{5,23,24} The diagnosis of sexual abuse and protection from further harm depend in part on the clinician’s willingness to consider abuse as a possibility. There is little data validating symptoms of abuse in the adolescent population, but generally agreed indicators include: recurrent abdominal pain;

Box 1 Checklist of factors to consider in assessing the risk of coercion in relationships (Department of Health)⁷

- The age of the child. Sexual activity at a young age is a very strong indicator that there are risks to the welfare of the child... and possibly others
- The level of maturity and understanding of the child
- What is known about the child’s living circumstances or background
- Overt aggression or power imbalance
- Coercion or bribery
- Familial child sex offences
- Behaviour of the child i.e. withdrawn, anxious
- The misuse of substances as a disinhibitor
- Whether the child’s own behaviour, because of the misuse of substances, places him/her at risk of harm so that s/he is unable to make an informed choice about any activity
- Whether any attempts to secure secrecy have been made by the sexual partner, beyond what would be considered usual in a teenage relationship
- Whether the child denies, minimises or accepts concerns
- Whether the methods used are consistent with grooming
- Whether the sexual partner/s is known by one of the agencies

multiple, vague symptoms with negative investigations; eating disorders; self harming; drug and alcohol abuse; criminal behaviour; truancy; running away; and frequent changes of partner.²⁵

Box 1 shows the Department of Health's⁷ checklist of factors to consider in assessing the risk of coercion in relationships, which could be adapted for use within clinical settings.

An age difference of more than four years between partners is unusual.¹⁶ It is important for professionals to judge young people's sexual practices by current day standards, rather than their own of years earlier.¹ Professionals working with sexually active young people can be frustrated by how common excess alcohol use is in this age group, who regard getting drunk as normal.

Physical signs of sexual abuse in the sexually active teenager are generally absent. A recent study²⁴ of pregnant adolescents found that only two out of 36 showed evidence of vaginal penetration.

The Department of Health¹¹ suggests 'If a request for contraception is made, doctors and health professionals should establish rapport and give a young person support and time to make an informed choice by discussing... whether there may be coercion or abuse.' This can be challenging, especially with vulnerable young people. Grilling teenagers rarely makes them open up and failing to establish rapport scares them away, which benefits no one. Professionals may feel uneasy about a young person's social circumstances without being worried enough to make a direct referral to social services. It can be helpful to talk to someone else outside a clinic setting who knows more about the young person. A young person may well give permission for the professional to talk to a school nurse or a youth or community worker about their concerns. This may allay fears, but if the professional remains concerned, a referral should be made.

Conclusion

The application of the Fraser guidelines in issuing sexual health advice or treatment is quite separate from identifying unlawful sex or abuse. There is no legal obligation to report underage sex unless abuse is suspected. All staff who deal with minors in a health setting need to be able to weigh up the conflicting priorities of the need for confidentiality with the possibility of sexual exploitation. Training

should encompass the needs of clerical and nursing staff, who may be the only professionals the young person sees, and of senior clinicians, who may not be aware of recent changes in this area. The new Sexual Offences Act has done much to modernise outdated law on sex, but risks scaring young people away from seeking health care and criminalising normal sexual activity if applied too rigorously.

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Further reading

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