Guide to offering Sexually Transmissible Infection (STI) testing to people aged less than 16 years attending clinical services

Effective from 5 September 2017

Version 1.2

Queensland Government

Contents

Rationale

This guide aims to clarify issues for clinicians when considering offering STI testing to an individual aged less than 16 years. Its aim is to reduce the risks of undiagnosed STIs and their complications, but with an awareness of potential social and emotional impacts of testing and/or a positive diagnosis.

The development of this guide was requested by the Steering Committee for Sexual Health in Aboriginal and Torres Strait Islander people in North Queensland, which includes the Chief Executives of the five north Queensland Hospital and Health Services (Torres and Cape, Cairns and Hinterland, Townsville, North West and Mackay). It was requested in the context of a syphilis outbreak across northern Australia, predominantly affecting young Aboriginal and Torres Strait Islander people. A summary guide, intended as a ready reference guide for clinicians, is provided in appendix 1.

This guide is not:

- a guide to use for population level screening
- to be used to look for evidence of sexual abuse
- a guide to respond to suspected sexual assault.

Related Documents

- Queensland Health: Guide to Informed Decision-making in Healthcare (https://www.health.qld.gov.au/consent/documents/ic-guide.pdf)
- Department of Health: Guideline for Reporting a Reasonable/Reportable Suspicion of Child Abuse and Neglect (https://www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-948.pdf)
- *Child Protection Act 1999* (Qld) (https://www.legislation.qld.gov.au/Acts_SLs/Acts_SL_C.htm)
- Queensland Health and the Royal Flying Doctor Service (Queensland Section) 2016. Primary Clinical Care Manual. Cairns. Section 5. Sexual and Reproductive Health.

Indications for offering testing

In some situations, there is information provided by a young person to a clinician that explicitly or implicitly suggests that a young person is sexually active and at risk for STIs.

Situations where clinicians should offer STI testing to a person aged less than 16 years:

- young person request
- STI symptoms- may include: discharge, lower abdominal pain in females, dysuria, inter-menstrual or post-coital bleeding, genital sores, rash, genital itch
- pregnancy or suspected pregnancy
- contact of a person with an STI
- request for contraception or termination of pregnancy.

Situations where clinicians might consider raising the issue of sexual activity and offering STI testing to a person aged less than 16 years:

- young person is identified as part of a network/group amongst whom STIs have been diagnosed; it is important for clinicians to be cautious of reacting to rumour and innuendo
- in an outbreak-declared region
- sexualised behaviour
- alcohol or illicit drug use

Underlying considerations

1. 'Gillick competence' – Children and young people (under the age of 16 years) may have sufficient capacity to consent to particular healthcare, without requiring consent from their parent/s or guardian/s. However, major, invasive and irreversible treatments may require court authority before being carried out, for example, pregnancy termination [1]. Factors for clinicians to consider, in determining whether a child or young person has sufficient capacity, are outlined below under 'Consent', and in Part 3 of the QH Guide to Informed Decision-making in Healthcare.
2. Health professionals have the capacity, and are well placed, to provide sexual health services for young people.
3. There is substantial evidence that some people aged less than 16 years engage in consensual and appropriate sexual activity.
4. Sexual activity places young people at risk for contracting STIs and/or pregnancy.
5. Sexually active young people require access to appropriate health services that support prevention, testing and treatment.

6. Early diagnosis and treatment of STIs can reduce or prevent associated morbidity.
7. Young people require education and information in order to make informed decisions about sexual debut, sexual activity, pregnancy and relationships.
8. Ideally all young people should be able to talk about sexual activity and relationships with parents and/or guardians, however there will be situations when this is not possible.
9. A young person should be encouraged to discuss their testing and results with their parent or guardian.
10. Young people have a right to confidentiality. In some circumstances these will be over-ridden by child protection concerns.

When a young person discloses that they are sexually active, or their presentation indicates to the clinician that STI testing might be warranted, the clinician needs to consider:

1. The capacity of the young person to have consented to sexual activity (if capacity is impaired this would lead to consideration of child protection); and
2. The capacity of the young person to consent to STI testing, including understanding the testing process, potential implications of results and the possible need for treatment
3. The possibility of non-consensual sexual activity. The clinician should provide information to the young person about the importance that any sexual activity should always be consensual. If the young person has experienced non-consensual sex, refer to Department of Health: Guideline for Reporting a Reasonable/Reportable Suspicion of Child Abuse and Neglect

Consent to testing

- Regardless of the age of the person, informed consent to testing and treatment must be obtained.
- For people aged between 16 and 18 years, consent is normally obtained from the patient and the young person should be encouraged to discuss this with a parent or guardian.
- A person aged less than 16 years who is assessed by the treating clinician as being 'Gillick competent' (refer to appendix 4, '*How to assess whether a child or young person is 'Gillick competent' and has capacity to give consent to health care'*) may give informed consent to STI testing, and separately, give informed consent to low risk treatment, without the involvement or knowledge of a parent or guardian. However, where appropriate, the child or young person is encouraged to discuss this with a parent/guardian. This needs to be documented in patient notes.

- Informed consent from a young person cannot be given unless they are mature enough to comprehend the clinician's explanation, provided the explanation is delivered appropriately given the age, education, language and cultural considerations.
- If a clinician is unsure whether a young person is able to give informed consent, and it is not considered in the best interests of the young person to request consent from a parent or guardian, there are circumstances in which testing (and treatment) may be provided by a health professional. In these circumstances:
    - discuss the circumstances/concerns with another health professional (e.g. health worker/nurse/doctor)
    - consider whether concerns reach a threshold to report a suspected child in need of protection to the Queensland Department of Communities, Disability and Child Safety Services (Child Safety Services).
- The following matters should be taken into consideration when determining whether a child or young person under the age of 16 years has capacity to consent to STI testing or treatment:
    - the age, attitude and maturity of the young person, including their physical and emotional development
    - the psychiatric, psychological and emotional state of the young person
    - the young person's level of intelligence and education
    - the young person's social circumstances and social history
    - the nature of the young person's condition, and the young person's level of understanding of this
    - the complexity of the proposed healthcare, including both physical and emotional impacts, and the need for follow up or supervision after the healthcare, and the young person's level of understanding of this
    - the seriousness of the risks associated with the healthcare, and the young person's level of understanding of this
    - the consequences if the young person does not have the healthcare, and the young person's level of understanding of this
    - the ability of the young person to understand wider consequences of any decision they make, including impact on others.

The clinician must clearly and comprehensively document in the patient's clinical record the assessment they have carried out, including the details which influenced their decision as to whether the young person has capacity to consent to testing or treatment.

Nuances of age

As a general guide:

1. a young person aged between 14 and 16 is reasonably likely to be able to consent to STI testing, and low risk treatment. However, this is not to be presumed without considering the factors described above.
2. a young person under the age of 14 may not have the capacity to consent to STI testing and low risk treatment. However, this is not to be presumed without considering the factors described above. Every effort should be made to involve a parent or guardian in such decisions. Consult with a Child Protection Liaison Officer, the Child Protection Advisor or local paediatrician.

STI testing discussion

Information that the clinician should provide to the young person before STI testing, includes:

- why the test is being offered
- limitations of testing (e.g. window period)
- when the results will be available and how the person will be informed
- confidentiality
- implications of not being tested; STIs can be asymptomatic but can result in adverse outcomes if not treated
- need for recall and treatment if STI diagnosed
- preventive health advice- condoms, contraception if indicated.

There is a balance between providing sufficient information and overwhelming the young person. However, the young person must be fully informed regarding the testing, before a clinician makes a determination about whether the young person has capacity to consent to the testing.

STI testing guidelines

See Primary Clinical Care Manual for current testing recommendations.

See also: The Aboriginal and Torres Strait Islander Adolescent sexual health guideline (Queensland Health, 2013).

Only for sexual health services where approved: Health Management Protocols and Guidelines for Sexual and Reproductive Health Nurses

Where these are in place: Healthpathways

Reporting of reasonable/reportable suspicion of child in need of protection

In 2015, changes were made to the reporting of suspected child abuse in Queensland. One of these changes is that, reporting about a 'child in need of protection' is reporting about 'significant harm', whereas previously, it was reporting about 'harm'.

Mandatory reporting applies to doctors and registered nurses (s.13E of the *Child Protection Act 1999*). However, any person, including any health professional, may notify Child Safety Services if they reasonably suspect a child may be in need of protection (s.13A of the *Child Protection Act 1999*).

For doctors and registered nurses regarding mandatory reporting:

- a **reportable suspicion** is defined at s13E(2) of the *Child Protection Act 1999* to mean: 'a reasonable suspicion that a child has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse; and may not have a parent able and willing to protect them from harm'.

Matters to take into consideration when forming a 'reasonable suspicion' about 'significant harm' are outlined in s.13C of the *Child Protection Act 1999*, and include (refer to: 'Department of Health: Guideline for Reporting a Reasonable/Reportable Suspicion of Child Abuse and Neglect'):

- whether there are detrimental effects on the child's body or the child's psychological or emotional state that are evident or likely to become evident in the future
- the nature and severity of the detrimental effects
- the likelihood that the detrimental effects will continue
- the child's age.

The 'Guideline for Reporting a Reasonable/Reportable Suspicion of Child Abuse and Neglect' outlines considerations for determining parental ability and willingness to protect a child from harm, and for assessing whether sexual activity reaches a threshold of 'significant harm' (see appendix 2).

In practical effect, this means that a person below the legal age of consent (16 years of age) may be sexually active, yet the clinician may not form a reasonable suspicion that the child is at risk of 'significant harm'. In such a situation, no mandatory reporting about the young person needs to be made.

Working Group

Working Group to develop guide for STI testing for people aged less than 16 years.

Organisation	Representative
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Consultation

Stakeholders consulted to develop the Guide to STI Testing for people aged less than 16 years attending clinical services:

Organisation	Proposed representative
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Approval Governance Pathway

Document author

The following Officers are the authors of this procedure:

- Public Health Medical Officer, Tropical Population Services, Cairns and Hinterland Hospital and Health Service
- Men's, Women's and Sexual Health Coordinator, Family Health Unit Torres and Cape Hospital and Health Service

Document Custodian

The following Officer will have responsibility for implementation of this procedure:

- Public Health Medical Officer, Cairns and Hinterland Hospital and Health Service

Endorsing Committee or Position

The following Officer/Committee will have responsibility for implementation of this procedure:

- North QLD STI Implementation Group
- Clinical Quality and Safety Governance Committee – Torres and Cape HHS
- Clinical Quality and Safety Governance Committee - Townsville HHS
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Approving Officer

The following Officer has approved this document:

- Michel Lok, Health Service Chief Executive, Torres and Cape Hospital and Health Service, Chair Sexual Health in Aboriginal and Torres Strait Islander people in North Queensland Chief Executive Steering Committee, established under the North Queensland Sexual Transmissible Infections Action Plan 2016-2021

Signature: _____ Date: ____3/04/2017____

Effective Dates

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Effective from:	14 March 2017
Next Date of review:	14 March 2018
Superseded guideline:	New

Version Control

Version	Date	Prepared by	Comments
0.1		Public Health Medical Officer, CHHHS	
0.2	21/11/2016	Public Health Medical Officer, CHHHS	Feedback incorporated from NQ STI Action Plan CE Steering Committee
0.2	12/12/2016	Public Health Medical Officer, CHHHS	Feedback incorporated from NQ STI Action Plan Implementation Group
1.0	14/03/2017	Approved by Clinical Quality and Safety Governance Committee Torres and Cape HHS	
1.0	28/03/2017	Approved by Clinical Governance Committee Mackay HHS	
1.0	16/02/2017	Approved by Executive Safety and Quality Committee Townsville HHS	
1.0	April 2017	Approved by Executive Management Group North West HHS	
1.0	May 2017	Approved by Patient Safety and Quality Committee Cairns and Hinterland HHS	

Audit Strategy

Risk	Low
Audit strategy	6 monthly surveillance reports
Audit tool attached	no
Audit frequency	6 monthly
Audit responsibility	Health Surveillance teams – Communicable Diseases Branch and Tropical Public Health Services -Cairns
Indicators / Outcomes	Trend of increased STI testing in people aged less than 16 years

Appendix 1. Clinical Guide to offering STI testing to people aged less than 16 years attending clinical services.

Considerations regarding consent to testing

→ Regardless of the age of the person, informed consent to testing (and treatment, if required) must be offered.

→ When a young person has sufficient capacity to comprehend the nature, consequences and risk of decisions relating to their health care, they may be able to give consent.

When assessing a young person's capacity to consent to health care (Gillick competence), the following should be considered and the rationale

- The age, attitude and maturity of the young person, including their physical and emotional development
- The psychiatric, psychological and emotional state of the young person
- The young person's level of intelligence and education
- The young person's social circumstances and social history
- The nature of the young person's condition, and the young person's level of understanding this
- The complexity of the proposed healthcare, including both physical and emotional impacts, and the need for follow up or supervision after the healthcare, and the young person's level of understanding this
- The seriousness of the risks associated with the healthcare, and the young person's level of understanding this
- The consequences if the young person does not have the healthcare, and the young person's level of understanding this
- The ability of the young person to understand wider consequences of any decision they make.

As a general rule:

- A young person aged between 14 and 16 is reasonably likely to be able to consent
- A young person under the age of 14 may not have the capacity to consent, except for healthcare that does not carry significant risk

Indications for offering STI

→
- Client request
- STI symptoms – may include: discharge, lower abdominal pain in females, dysuria, inter-menstrual or post-coital bleeding, genital sores, rash, genital itch
- Pregnancy or suspected pregnancy
- Contact of a person with an STI
- Request for contraception or termination of pregnancy

Other situations to consider raising the issue of sexual activity and offering STI testing to the <16 year old

→
- Young person is identified as part of a network/group amongst whom STIs have been diagnosed; clinicians should be cautious of reacting to rumour and innuendo
- Sexualised behaviour
- There may be other less clear indications to offer testing; in these circumstances a clinician should use their judgement or discuss with another

Discussion and information provision before testing should include:

- Why the test is being offered
- Limitations of testing (e.g. window period)
- When the results will be available and how the person will be informed
- Confidentiality and limitations of confidentiality
- Implications of not being tested
- Need for recall and treatment if an STI is diagnosed
- Preventative health advice – condoms, contraception – as indicated

Always raise the question of whether sex was consensual, if not, refer to the Department of Health: Guideline for Reporting a Reasonable/Reportable Suspicion of Child Abuse and Neglect.

Appendix 2. Reporting relevant to a child in need of protection

Below are extracts from the Department of Health *Guideline for Reporting a Reasonable / Reportable Suspicion of Child Abuse and Neglect* # QH-GDL-948:2015 (https://www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-948.pdf).

The *Child Protection Act 1999* provides that a doctor and a registered nurse are mandatory reporters in specified circumstances.

Section 4.2

A 'reportable suspicion' is defined at s13E(2) of the *Child Protection Act 1999* as a 'reasonable suspicion' that a child has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse; and may not have a parent able and willing to protect them from harm.

Section 8.1.1

A staff member on becoming aware of sexual activity in a young person may report the sexual activity to Child Safety Services on the basis of this activity being considered to have reached the threshold of significant harm, if they reasonably suspect the sexual activity:

- is non-consensual and/or
- occurs between family members and/or
- is not fully comprehended by the young person and/or
- constitutes a significant age gap (five years or more) between the young person and partner and/or
- suggests and inappropriate power differential and/or
- is not fully comprehended by the young person and/or
- constitutes a significant age gap (five years or more) between the young person and partner and/or
- suggests and inappropriate power differential and/or
- involves coercion to engage in any unlawful sexual activity, including prostitution and/or
- exposes them to, or uses them in pornographic performances or material.

Section 8.1.2

There will be circumstances when the criteria listed above may not be met, but staff are concerned the young person may still be at risk of significant harm. The absence of specific indicators is not intended to restrict reporting concerns to Child Safety Services.

Section 8.1.3

Specific consideration must be given to the age of the child as well as the presence of developmental (especially intellectual) delays and or disabilities which may reduce the young person's ability to identify, report and/or consent to the sexual activity.

Section 8.1.4

Staff should undertake an appropriate assessment of the young person and document the basis for their decision making in relation to the sexual activity.

Appendix 3. At what age can children and young persons consent for themselves?

The following is an extract from pages 35-36 of the Queensland Health *Guide to Informed Decision-making in Healthcare* (https://www.health.qld.gov.au/consent/documents/ic-guide.pdf).

Section 3.1.1

- When a child or young person under the age of 18 years does not have capacity to consent, consent is obtained from a parent or other person with parental responsibility (ss 61A-61F of the *Family Law Act 1975 (Commonwealth*) [2] except in specific situations. Persons with parental responsibility have a responsibility to consent to healthcare that is in the best interests of the child or young person.
- Children and young persons under the age of 18 years are able to consent to healthcare where they have sufficient capacity to do so. However, unlike adults, a child or young person is presumed not to have capacity to give their own consent, unless there is sufficient evidence they have such capacity. This is often referred to as 'Gillick competence' after a legal case in the United Kingdom.
- In Queensland there is no fixed lower limit below 18 years of age at which children or young persons are deemed to be able to consent to healthcare, and so, as they mature, the child's capacity to consent generally increases. On the other hand, the authority of parents to consent on behalf of a child or young person is not absolute. Their parental responsibility decreases as the young person matures until it ceases to exist when the child reaches 18 years of age. As a result of this there may be times when both someone with parental responsibility and the child or young person simultaneously have the ability to provide consent to healthcare.
- If the child or young person has sufficient capacity to consent and does so, this is usually sufficient for giving routine medical/dental treatment, including contraceptive advice, without the need for parental consent. However, even though a child or young person may have capacity to consent on their own, it is good practice to encourage them to consider seeking the involvement of a parent or other adult of their choosing before reaching a decision. This may:
    - provide the adult with appropriate information (including any necessary supervision arrangements and of possible adverse effects) so they might support the young person in their decision and during the healthcare
    - give the adult the opportunity to provide information that the young person may not be aware of (for example, details of previous medical conditions and relevant family history) and to have questions answered in advance

- allow the adult the opportunity to attend when the healthcare (for example, immunisation) is provided with the agreement of the patient.

- If a child or young person does not wish to involve a parent or other adult, the reasons for this are explored.

If the child or young person has sufficient capacity to make a decision not to involve an adult, their wishes usually need to be respected, but may be overruled in some circumstances, for example, when there are potential child protection concerns arising from a pregnancy or a sexually transmitted infection.

A medical practitioner or registered nurse who becomes aware, or reasonably suspects during the practice of his or her profession, that a child has been, is being or is likely to be harmed, is required by law to report child protection concerns.

Appendix 4. How to assess whether a child or young person is 'Gillick competent' and has capacity to give consent to healthcare

The following is an extract from page 40 of the Queensland Health *Guide to Informed Decision-making in Healthcare* (https://www.health.qld.gov.au/consent/documents/ic-guide.pdf).

Section 3.1.5

- To establish that a child or young person has capacity to consent to healthcare, the health practitioner can carry out an assessment to show the patient has sufficient understanding, intelligence and maturity to appreciate the nature, consequences and risks of the proposed healthcare, and the alternatives, including the consequences of not receiving the healthcare.
- When assessing a child or young person's capacity, the following issues should be considered:
    - the age, attitude and maturity of the child or young person, including their physical and emotional development
    - the child or young person's level of intelligence and education
    - the child or young person's social circumstances and social history
    - the nature of the child or young person's condition
    - the complexity of the proposed healthcare, including the need for follow up or supervision after the healthcare
    - the seriousness of the risks associated with the healthcare
    - the consequences if the child or young person does not have the healthcare
    - where the consequences of receiving the healthcare include death or permanent disability, that the child or young person understands the permanence of death or disability and the profound nature of the decision *they are* making.
- The more complex the healthcare or more serious the consequences, the stronger the evidence of the child or young person's capacity to consent to the specific healthcare will need to be. In these situations, it is recommended that the assessment is carried out by a medical practitioner.

The health practitioner documents fully in the patient's clinical record the assessment they have carried out, including the details which influenced their decision as to whether the child has capacity.

Maturity and intellectual development varies from one individual to another and an assessment of a child or young person's capacity is performed for each new healthcare decision. However, as a practical rule of thumb:

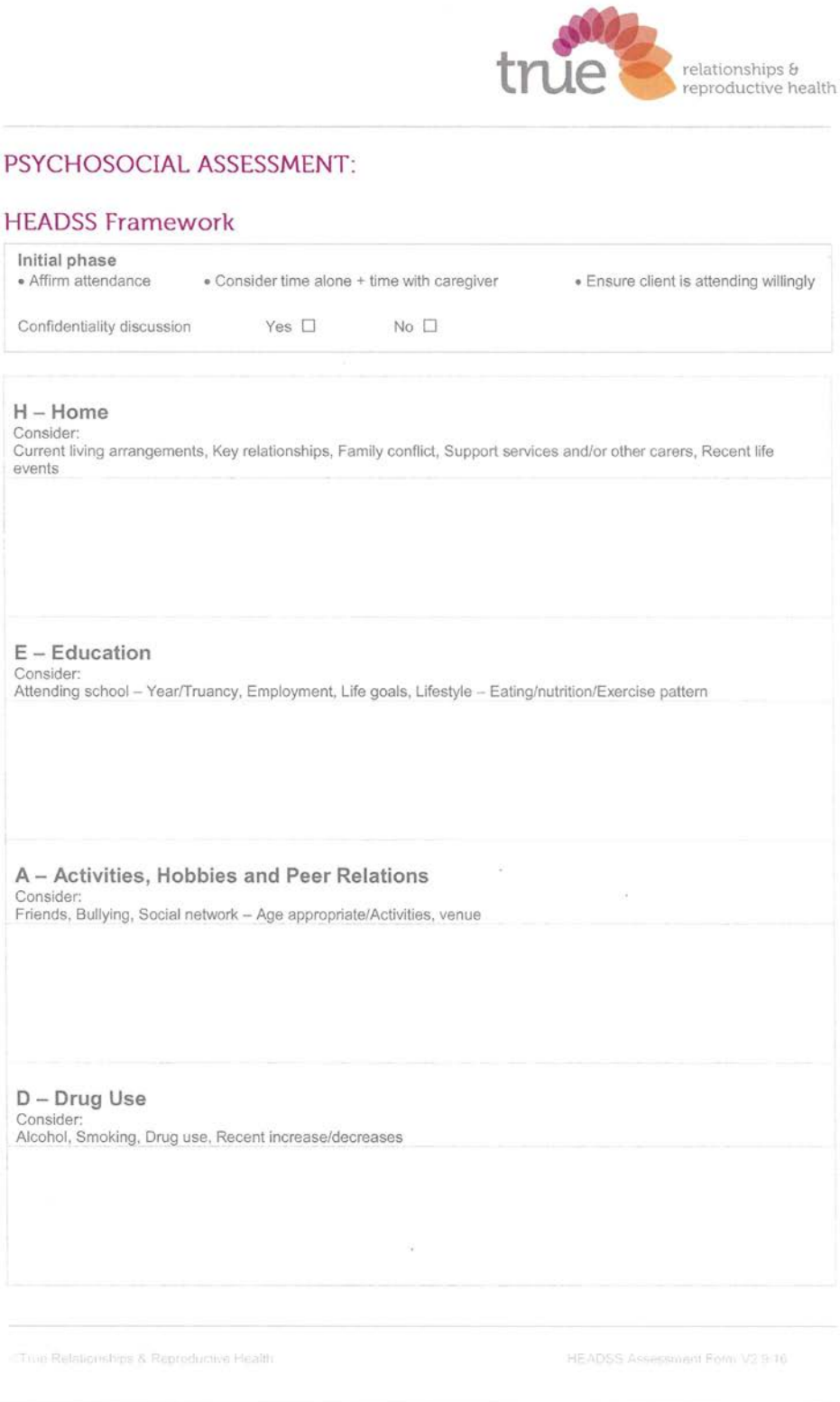
- a young person aged between 16 and 18 is most likely able to consent
- a young person aged between 14 and 16 is reasonably likely to be able consent
- a child under the age of 14 may not have the capacity to consent, except for healthcare that does not carry significant risk.

A child who has the capacity to consent for a low risk, simple procedure like receiving an x-ray or suturing of a small wound, may well not have capacity to give consent to a major heart operation with greater risks and more serious consequences.

A child who is intellectually disabled may still be capable of consenting to and possibly refusing specific healthcare depending on the specific circumstances.

Where a child or young person does not have capacity to give consent, this does not reduce the significance of their involvement in decision-making, and health practitioners would communicate with them and involve them as much as possible in decisions about their care.

Appendix 5. HEADSS Psychological Assessment



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PSYCHOSOCIAL ASSESSMENT:

HEADSS Framework

Initial phase

- Affirm attendance
- Consider time alone + time with caregiver
- Ensure client is attending willingly

Confidentiality discussion Yes ☐ No ☐

H – Home

Consider:
Current living arrangements, Key relationships, Family conflict, Support services and/or other carers, Recent life events

E – Education

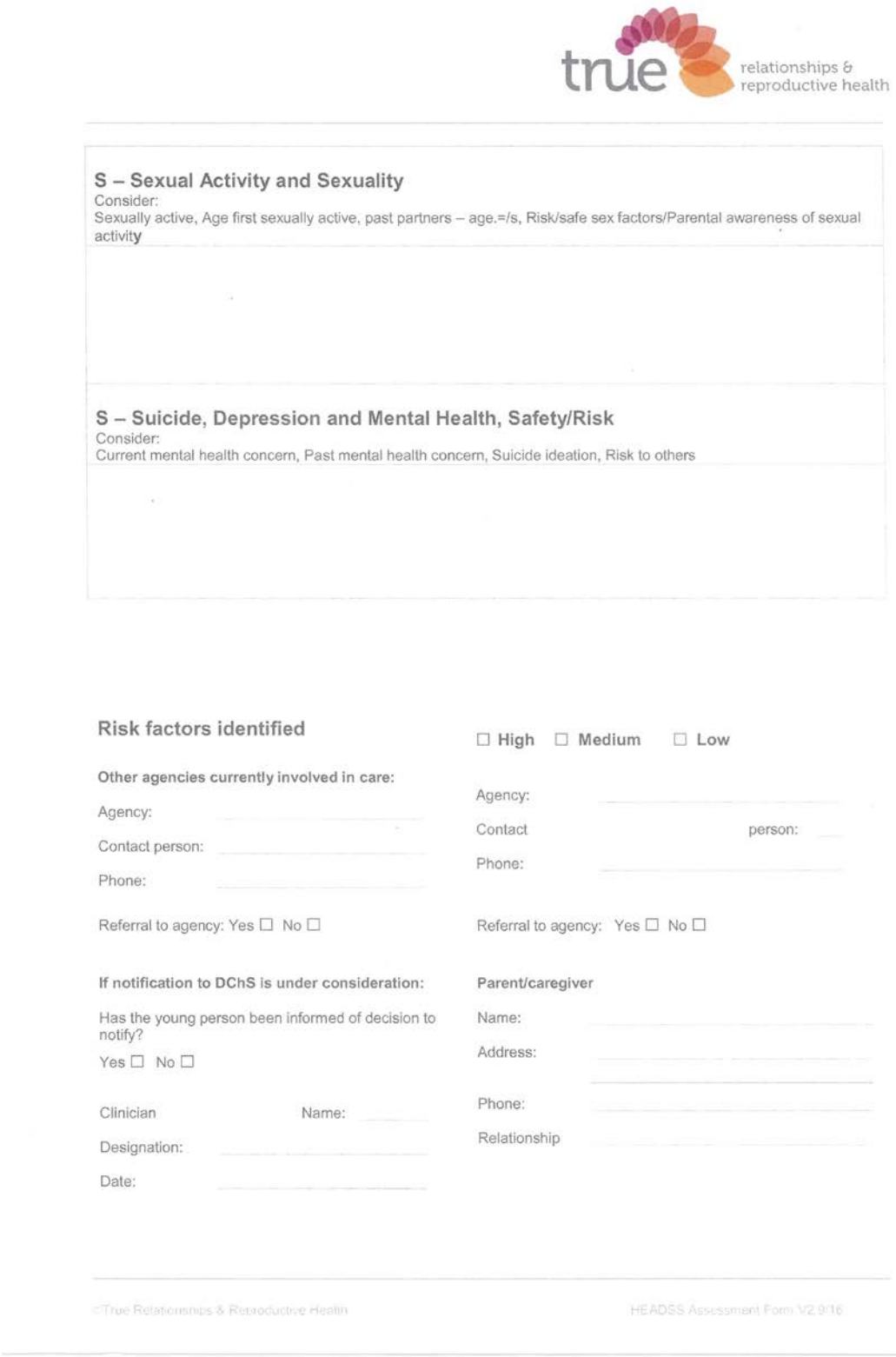
Consider:
Attending school – Year/Truancy, Employment, Life goals, Lifestyle – Eating/nutrition/Exercise pattern

A – Activities, Hobbies and Peer Relations

Consider:
Friends, Bullying, Social network – Age appropriate/Activities, venue

D – Drug Use

Consider:
Alcohol, Smoking, Drug use, Recent increase/decreases



S – Sexual Activity and Sexuality

Consider:
Sexually active, Age first sexually active, past partners – age.=/s, Risk/safe sex factors/Parental awareness of sexual activity

S – Suicide, Depression and Mental Health, Safety/Risk

Consider:
Current mental health concern, Past mental health concern, Suicide ideation, Risk to others

Risk factors identified

☐ High ☐ Medium ☐ Low

Other agencies currently involved in care:

Agency:
Contact person:
Phone:

Referral to agency: Yes ☐ No ☐

Agency:
Contact person:
Phone:

Referral to agency: Yes ☐ No ☐

If notification to DChS is under consideration:

Has the young person been informed of decision to notify?
Yes ☐ No ☐

Clinician Name:
Designation:
Date:

Parent/caregiver

Name:
Address:
Phone:
Relationship

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References

1. Harrison, M., *Parental authority and its constraints: the case of Marion,*. Family Matters, 1992. **32**(August).
2. Queensland Health *Guide to Informed Decision-making in Health Care,*. 2017.