GUIDELINES ON THE MANAGEMENT OF SEXUAL HEALTH ISSUES IN CHILDREN AND YOUNG PEOPLE

3rd Edition
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Acknowledgements

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Note: While every effort has been made to ensure all references to the terms *Department of Health and Families (DHF), Northern Territory Families and Children (NTFC)* and *Family and Children Services (FACS)* have been updated to the newly formed Department of Health (DoH)and Department of Children and Families (DCF), there are some instances within these Guidelines where the former name is quoted as it makes direct linkage to current legislation.

If clarification is needed, please call the number above.

Contents

Abbreviations

AHW	Aboriginal health worker
AIDS	Acquired immunodeficiency syndrome
BBV	Blood borne virus
CAT	Child Abuse Taskforce
CIT	Central Intake Team
CDC	Centre for Disease Control
CT	Chlamydia trachomatis
DHF	Department of Health and Families
DoH	Department of Health
DCF	Department of Children and Families
FME	Forensic Medical Examinations
FNQ	Far North Queensland
HBV	Hepatitis B virus
HIV	Human immunodeficiency virus
HSV	Herpes simplex virus
NAAT	Nucleic acid amplification test
NG	Neisseria gonorrhoeae
NT	Northern Territory
NTFC	Northern Territory Families and Children (formerly FACS)
PATS	Patient Assisted Travel Scheme
PCR	Polymerase chain reaction
PHCP	Primary health care practitioner
PID	Pelvic inflammatory disease
SARC	Sexual Assault Referral Centre
SHBBV	Sexual Health and Blood Borne Virus
STI	Sexually transmissible infection
SWOP	Sex Worker Outreach Program
TOP	Termination of pregnancy
TMA	Transcription Mediated Amplification
TV	Trichomonas vaginalis

Introduction

This document provides guidelines on the management of children and young people who present for care relating to sexual health issues, or who may be the victims of sexual abuse or exploitation. The document has been developed as a reference for health professionals working in remote and urban clinical situations. The document clearly defines the statutory requirements for primary health care providers in the area of sexual health.

As outlined in these guidelines, the appropriate and recommended responses vary with the age of the young person. Broadly, these differ for people aged 13 years or younger, those aged 14 to 15 years, and those aged 16 to 17 years. Once people attain the age of 18 years they are legally considered to be an adult.

Through following these Guidelines, and with a clearer understanding of the systems working in the field of child sexual abuse, it is hoped that a better outcome will be achieved for the survivors of sexual abuse and for other young people with sexual health issues.

Section One:

Background

1. Sexual Activity and Young People

1.1 Understanding the Context

Sexual Debut

In western countries, including Australia, young people are becoming sexually active at an earlier age than ever before.[1,2] Data from the 4th National Survey of Australian secondary school students (2008) indicated that 27% of Year 10 students and 56% of Year 12 students had had sexual intercourse, and that the total number of students who had experienced sexual intercourse increased from 35% in 2002 to 40% in 2008.[3] The 2002 survey of secondary students indicated that 23% of students were under the influence of drugs or alcohol their first time.[4]

Early onset of sexual activity has been found to be considerably more prevalent in the Australian Indigenous population when compared to estimates for the broader Australian population.[5] Data, collected in 2000-2001 in the Western Australian Aboriginal Child Health Survey, indicated that 74% of Aboriginal 17 year olds, 44% of 16 year olds and 33% of 15 year olds had had sexual intercourse.[6] A later survey of Indigenous young people in remote Far North Queensland (FNQ) in 2009 indicated that 82% of 15 to 19 year olds reported ever having sex and 62% reported an age at first sex of less than 16 years. Of the sexually active group, 34% of the males and 7% of the females reported an age at first sex of less than 14 years.[7]

Such earlier debut of sexual activity in Indigenous people may be attributable to cultural factors such as their earlier social maturity, in that they tend to finish school and leave home at an earlier age. Further, in older girls, not using contraception may reflect a socially acceptable desire to start a family, as opposed to irresponsible sexual behaviour.[6] Conversely, early sexual debut in Indigenous young people may reflect social factors such as higher rates of substance abuse, sexual abuse, and the sexualisation of children through abuse.[8] The high rates of early sexual onset in Indigenous communities appear to contribute to the disproportionately high rates of sexually transmissible infections in those communities.[9] These rates also add to the disparity between teenage pregnancy rates in non-Indigenous (13 per 1000) and Indigenous populations (69 per 1000).[10, 6] It is also notable that early onset of sexual behaviour is associated with a number of long term health risks, especially for females.[5, 11, 12]

Patterns of Sexual Behaviour

Patterns of sexual behaviour in young people are changing. Data from the National surveys of Year 10 and 12 secondary students indicated that, among those engaging in sexual intercourse, there has been a substantial increase in the proportion reporting three or more partners in a year, between in 2002 (20%) to 2008 (30%).[3, 4] The numbers of sexual partners were found not to differ significantly between year levels, or gender.[3] Data from the FNQ study suggests the frequency of partner change seems to be greater in the Indigenous sample, with almost half (49%) the sexually active group reporting three or more partners in the past 12 months.[7]

The proportion of young people who report oral sex and same sex experiences is also increasing. Just under half the secondary students surveyed in 2008 had experienced oral sex, and the proportion of those reporting having oral sex with 3 or more people in a year had increased by 19% since the 2002 survey. Almost 1 in 10 students surveyed reported their most recent sexual encounter was with someone of the same sex.[3]

Unwanted Sex

Whilst the majority of sex in young people is consensual, they experience an unacceptably high level of unwanted sex. Just under one third of the students in the 2008 national survey reported ever having experienced sex they did not want. Young women were more likely than young men to have experienced sex when they did not want to (38% vs.19%), and for young women the rate of unwanted sex increased significantly between the 2002 and 2008 surveys (28% to 38%).[3] In the FNQ study, 23% of the males and 33% of the females reported that their most recent sexual encounter was 'not wanted'.[7] Young people cited pressure from their partner (18%) or being too drunk (17%) as the most common reasons for having unwanted sex.[3, 4, 5] The role of alcohol in unwanted sex is becoming increasingly prominent.[3, 13]

Condom Use

The proportion of students using condoms remains high, however this declines post school-age.[14] Whilst 69% of secondary students reported using a condom the last time they had sex and half of those always used a condom when they had sex in the previous year, 43% reported they only sometimes used condoms.[3] The most common reasons for failing to use a condom at the last sexual encounter were being unprepared and not expecting sex ('it just happened', 39%), trusting a partner (31%) and knowing a partner's sexual history (27%).[3] Other rates of contraceptive use reported were that 50% used the oral contraceptive pill, 8% the emergency contraceptive pill, and approximately 1 in 10 sexually active students used the withdrawal method at their last sexual encounter.[3] There appears to be several reasons for overall fewer sexually active students reporting using no contraception. These may be that in general they have more information about the risks associated with unprotected intercourse, they may be more amenable to changing their sexual practices, or they have improved skills in negotiating safe sexual practices.

In the FNQ study, 66% of the males and 55% of the females who reported having sex stated they always used a condom. However, when asked about condom use at last sex, only 58% of them reported that a condom was available for use on that occasion. Fifty-four per cent (males 30%, females 63%) said they did not use a condom at the last encounter because they trusted their partner; this applied regardless of whether the relationship was of a steady nature or not.[7]

STI Knowledge

Research on the HIV/STI knowledge levels of young people has shown that, while most in the general population have high levels of HIV knowledge, generally awareness of other STIs tails off rapidly, particularly the younger they are.[14] Males under the age of [20], living in non-metropolitan regions, with less schooling have been found to have the poorest knowledge.[15] Younger people also have lower symptom recognition than their older counterparts, which increases the chances of unwitting transmission.[14, 3, 16]

The respondents in the FNQ study appear to have a similar level of knowledge as the national sample in relation to hepatitis, but were unaware of a high risk for STI and had little knowledge of HIV/AIDS.[7]

Young people have a range of false beliefs about STIs. These misconceptions include that STIs have obvious symptoms and characteristics that would allow easy identification of infected individuals. This belief is commonly associated with an underlying view that STIs occur in 'other people', and who are 'promiscuous' or 'dirty', and are unlikely to be found among 'my social group'.[14, 7] Another common misconception is that individuals perceive their risk of getting an STI as low. In a national survey, almost four out of five participants highlighted that someone like them is either "unlikely" or "very unlikely" to get an STI. [14]

The FNQ study found 88% of the young people surveyed had either a low or no sense of personal risk from STI/HIV, and they reported that STIs were not regarded as a "big problem" where they lived, considering them more common elsewhere, usually in larger towns. [7]

Finally, concern about STIs and sexual health is thought to be a low priority for most young people.[17] Consequently there are significant issues regarding young people's knowledge about STIs and testing, which have implications for sexual health education and services.

Sources of Sexual Health Information

Most students (88%) in the national survey had sought information regarding sexual health. The most common sources were their mothers (56%), female friends (55%), the school sexual health program (49%) and pamphlets (44%). Despite not being used as frequently by students, doctors were the most trusted source of information on sexual health (39%). Compared to young male students, young women were more likely to consult their doctor (44% vs. 30%), their mother (62% vs. 44%) and female friends (63% vs. 38%) for sexual health information. In contrast, young men were more likely than young women to confide in either their father (40% vs. 27%) or a male friend (41% vs. 31%) for advice regarding sexual health. While the use of the Internet is nearly universal, young people are appropriately dubious of the quality of internet-based information regarding sexuality or sexual health.[3]

Of Indigenous 12 to 17 year olds in the 2001-2 study, 74% had received information about how to prevent pregnancy and sexually transmitted diseases, with school being the source most frequently reported source.[6] In 2006, they identified the role health professionals, older family members and school, and videos and friends as sources of information on techniques for sex. The Indigenous youth in the FNQ study reported sources for future advice on sexual health matters were nurses/health workers (74%), doctors (70%), family member (60%) followed by youth workers, friends and school.[7] It is a concern that school-based sexual health education in these remote settings was minimal and there were anecdotal reports of frequent high risk behaviour occurring.[7]

In summary, sexual activity in young people is occurring at an earlier age, and the number of sexual partners in secondary school students is increasing. While the majority of sex in young people is consensual, partner pressure and alcohol are the main reasons for unwanted sex. Patterns of sexual activity in students are changing: amongst those who are sexually active there are increasing numbers of sexual intercourse and oral sex partners.

Fewer students reported using no contraception the last time they had sex, and the majority of students access a variety of information sources about sexual health.

1.2 Sexually Transmitted Infections

Since 1995 notifications of gonorrhoea and chlamydia have been steadily increasing in Australia. In the last ten years in the NT, the numbers of notifications of gonorrhoea and chlamydia in those under 16 years of age have on average represented 8 per cent and 7 per cent of total notifications respectively. However from 1997 to 2004, the rates of increase in people aged between 14 and 17 were considerably greater than the increases in the total notifications for the same period, for both gonorrhoea and chlamydia. The notifications for gonorrhoea were 2.9 times greater in those aged 14 to 15 years, and 2.3 times greater in those aged 16 to 17 years compared with 1.6 times in the total population.

Regarding chlamydia the notifications were 3.7 times greater in those aged 14 to 15 years, and 2.7 times greater for those aged 16 to 17 years, compared with 2.6 times in the total population.[9]

In the NT, rates of gonorrhoea and chlamydia are significantly higher in Indigenous young people than in non-Indigenous young people.[17] Younger age, female sex, lower socio-economic status, the use of alcohol and tobacco, and the structure of community health services, have all been associated with a higher prevalence of bacterial STIs in Indigenous populations.[18]

STI-related pelvic inflammatory disease (PID) is an important and preventable cause of morbidity particularly among young Aboriginal women.[19]

To date, there have been relatively few cases of HIV in under 25 year olds in the NT. This is consistent with the national Australian data.[17] The overall number of Hepatitis B notifications in the NT showed a decreasing trend between 2007and 2009 although the number of newly acquired cases remained low and stable. Without complete testing data, it is not possible to know if this represents a decrease in its prevalence or it reflects a decrease in testing.[20]

1.3 Issues for Consideration

Although people under the age of 16 years may be involved in consensual sexual activity, other issues need to be considered, including:

- past and continuing sexual abuse/assault
- unplanned or unwanted pregnancy
- risk of STIs
- undiagnosed mental health problems including self harm, eating disorders, alcohol and substance misuse
- risk of involvement in transactional sex or commercial sex work
- vulnerability of those living away from home
- vulnerability of those with physical and/or learning disabilities irrespective of age.[2]
- the degree to which the adolescent's parents monitor their behaviour (parental laxness)
- risk-taking behaviour [5]

1.4 Sexual Health

The incidence of STIs is increasing in many parts of the world including Australia.[21] Young sexually active teenagers are at high risk of Chlamydia trachomatis genital infection and its complications.[22] Overall, few young people aged 16-29 years of age undergo STI testing. Reported reasons for this included a perceived lack of susceptibility to STIs, feelings of embarrassment or lack of privacy (particularly notable in remote areas or where a family doctor is involved), and a general lack of knowledge about options and locations for testing.[14]

Young people are exposed to two potentially conflicting sexual health messages: one emphasising the prevention of STIs and the other stressing prevention of pregnancy.[23] For young heterosexuals, pregnancy is often the greatest concern and being on 'the pill' is frequently and misguidedly considered as being protective for STIs as well as pregnancy.[24] As a result, where other methods of pregnancy prevention are in place the perceived need and likelihood of condom use falls.[14]

Given their level/lack of detailed knowledge around STIs, their attitudes towards condom use, and/or the increased risk of contracting STIs arising from their sexual behaviour, young people need to be educated about the distinction between safe sex and contraception, and about how to prevent both STIs and pregnancy. This needs to particularly target people under 18 years old, those with multiple sexual partners, females, and men who have sex with men.[14]

1.5 Sexual Health Services for Young People

Research has shown that the provision of sexual health care for adolescents in Australia is far from adequate.[22] There are numerous reasons that primary health care services do not provide targeted sexual health services at the level required, including competing health issues, lack of resources, and perceived cultural issues. In addition there is often reluctance by qualified health professionals to work in this health field because of perceived limited expertise and personal discomfort. Factors such as workload, time, and difficulty accessing professional development exacerbate these issues in rural and remote areas.

In Australia, a number of inherent barriers prevent young people accessing health services, and one such example is lack of 'user friendliness'. Unfortunately, this is often a feature of those health services that deal with their sexual and reproductive health. Further, other factors have a negative impact on young people's STI knowledge and utilisation of services. Young people in general lack knowledge about STIs, and receive inconsistent and inadequate sexual health education in schools (in remote settings), and display low health-seeking behaviours. Health services in remote areas, such as many of those in the NT, present additional barriers. Frequently there may be only a male or a female health care provider available at remote health centres at any particular time, which can create difficulties for young people. Concerns about confidentiality, as well as cultural and language issues, may also prevent young people from presenting to remote health services.

KEY POINTS

- Young people are becoming sexually active earlier than ever before.
- While the majority of sex in young people is consensual, partner pressure and alcohol are the main reasons for unwanted sex.
- Young people are engaging in significant amounts of unprotected intercourse.
- Patterns of sexual activity in students are changing.
- Concern about STIs and sexual health is thought to be a low priority for most young people.
- There are significant issues regarding young people's knowledge about STIs and testing, and these have implications for sexual health education and services. Young people need to be informed about the distinction between safe sex and contraception, and about how to prevent both STIs and unwanted pregnancy.
- Since 1995 notifications of gonorrhoea and chlamydia have been steadily increasing in Australia.
- In the NT the numbers of notifications of gonorrhoea and chlamydia in the 14 to 15 and 16 to 17 years age groups have increased at a greater rate than for the general population.
- There are barriers to young people accessing health services in Australia in terms of 'user friendliness' of health services.

2. Relevant Legal Framework

There are several Acts that pertain to the sexual health and wellbeing of young people. They can be accessed via the following link: NT Legislation. The following information lists the relevant sections from each Act.

2.1 The NT Care and Protection of Children Act

The purpose of the Care and Protection of Children Act is to ensure that young people under the age of 18 years are adequately protected by their families and live in safe care environments.

Section 26 of the Act states:

(1) A person is guilty of an offence if the person:

(a) believes, on reasonable grounds, any of the following:

(i) a child has suffered or is likely to suffer harm or exploitation;
(ii) a child aged less than 14 years has been or is likely to be a victim of a sexual offence *refer to Section 2.3 of this document for definition);
(iii) a child has been or is likely to be a victim of an offence against section 128 of the Criminal Code; and

(b) does not, as soon as possible after forming that belief, report (orally or in writing) to the CEO or a police officer:

(i) that belief; and
(ii) any knowledge of the person forming the grounds for that belief; and
(iii) any factual circumstances on which that knowledge is based.

Example for subsection (1)(a)(iii): The victim of an offence against S128 is a child who is of or over the age of 16 years and under the offender's special care as mentioned in that section (for example, because the offender is a step-parent or teacher of the victim).

DHF note for subsection (1)(b): The delegate of the Minister is NT Families and Children (NTFC) is the Central Intake Team (CIT).

(2) A person is guilty of an offence if the person:

(a) is a health practitioner or someone who performs work of a kind that is prescribed by regulation; and

(b) believes, on reasonable grounds:

(i) that a child aged at least 14 years (but less than 16 years) has been or is likely to be a victim of a sexual offence; and
(ii) that the difference in age between the child and alleged sexual offender is more than 2 years; and

(c) does not, as soon as possible after forming that belief, report (orally or in writing) to the CEO or a police officer:

(i) that belief; and
(ii) any knowledge of the person forming the grounds for that belief; and
(iii) any factual circumstances on which that knowledge is based.

Example for subsection (2)(b)(ii): A health practitioner believes, on reasonable grounds, that a child who has just turned 14 is likely to be a victim of a sexual offence committed by someone aged 16 and a half.

Section 27(1) protects people who make a report in good faith from any legal consequences for breach of confidence or professional ethics and from civil or criminal liability, even if they are mistaken in their belief.

Section 30 states that managers must make their staff aware of their reporting obligations.

Reporting Requirements

In summary, the NT Care and Protection of Children Act mandates that all people in the NT must report to Department of Health and Families (DHF) i.e. the Central Intake Team (CIT) on 1800 700 250 or the Police if they have a belief of actual or likely:

1. harm or exploitation in any person under 18 years
2. sexual relationship between a person aged under 18 years and a person who has a relationship of special care with them; or
3. sexual activity in any person under 14 years

In addition,

4. registered health practitioners must report 14 and 15 year olds who are, or are likely to be sexually involved with persons who are more than two years different in age.

Once a person has formed a belief of actual or likely harm etc, which is reached from forming a logical conclusion on the basis of the available evidence, he/she must report. People making a report in good faith are protected from any legal consequences for breach of confidence or professional ethics and from civil or criminal liability, even if they are mistaken in their belief.

It is DHF policy that reports are made to the NTFC Central Intake Team (CIT). It is preferable that reports are made by telephone as this enables the intake worker to actively seek or clarify information from the reporter at the time. Written reports can be made, but may be treated with less priority.

2.2 The Criminal Code Act (NT)

The Criminal Code Act (as in force at May 2010) makes all sexual acts involving people under 16 years of age illegal (subject to various defences available under the Act). This is known as the 'age of consent'.

There is no legal obligation arising from this or any other Act to report that a sexual act involving a person less than 16 years has taken place, even when a person admits to having committed such an offence. However, under the mandatory reporting requirements contained in the Care and Protection of Children Act, there are legal requirements to report sexual offences according to the age of the young person, and where there is cause to consider harm or exploitation has occurred.

Section 128(1) states that any adult who has sexual intercourse with; or commits any act of gross indecency upon a child who is of or over the age of 16 years; and under the person's special care is guilty of a crime.

Section 128(3) states a person (the victim) who is under the special care of another person (the offender) if the offender:

a) is the step-parent, guardian or foster parent of the victim;

b) is a school teacher and the victim is a pupil of the offender;

c) has established a personal relationship with the victim in connection with the care, instruction (for example, religious, sporting or musical instruction) or supervision (for example, supervision in the course of employment or training) of the victim;

d) a correctional services officer at a correctional institution at which the victim is detained; or

e) is a health professional or other provider of health care or treatment and the victim is a patient or client of the offender.

Section 128(4) states it is a defence to a charge of a crime defined by this section to prove that the accused person was, at the time of the alleged offence, the husband, wife or de facto partner of the child.

Section 192(1) defines consent as free and voluntary agreement.

Section 192(2) states circumstances in which a person does not consent to sexual intercourse or an act of gross indecency include circumstances where:

(a) the person submits because of force, fear of force, or fear of harm of any type, to himself or herself or another person;
(b) the person submits because he or she is unlawfully detained;
(c) the person is asleep, unconscious or so affected by alcohol or another drug as to be incapable of freely agreeing;
(d) the person is incapable of understanding the sexual nature of the act;
(e) the person is mistaken about the sexual nature of the act or the identity of the other person;
(f) the person mistakenly believes that the act is for medical or hygienic purposes; or
(g) the person submits because of a false representation as to the nature or purpose of the act.

People under 16 are not legally able to give consent to sexual intercourse, nor are those under 18 in a special care relationship. However the above information is provided in order to assist PHCPs to better understand consent as this is relevant when considering coercion/equality/harm in sexually active 14 and 15 year olds where their partners are within two years of their age.

2.3 The Sexual Offences (Evidence and Procedures) Act

Section 3 of the Sexual Offences Act defines sexual offence as including

> "sexual intercourse, oral/anal sex, a sexual relationship, indecent touching or dealing or assault, sexual abuse, gross indecency, sexual servitude or any other form of sexual exploitation, making or collecting indecent material with a child under 16 or exposing such a child to indecent material, or an attempt to commit, an act of procuring, or any other act preparatory to the commission of any of the above."

The difference between sexual activity and a sexual offence is one of consent. With children under the age of 16 years, they are not capable of giving consent.

2.4 The NT Notifiable Diseases Act

Section 10 of the Notifiable Diseases Act (NT) states that:

A medical practitioner who diagnoses that a person is an infected person or who considers a person to be a suspect person –

(a) shall advise, where the person is an adult – the person;
(b) shall advise, where the person is a child who has not attained the age of 16 years – the parents or the guardian of the child; or
(c) as he thinks fit, may also advise, where the person is a child who has attained the age of 16 years – the parents or the guardian of the child, of the nature of the notifiable disease, the measures needed to be taken to prevent the spread of that disease and the treatment, if any, required.

In short, if a medical practitioner diagnoses a notifiable disease in a person under 16 years of age, that practitioner is required by law to inform the child's parents or guardian.

2.5 Consent to Medical Treatment and the Gillick Decision

In the NT there is no statutory age of consent to medical procedures. Although a young person under the age of 18 is legally considered a 'child', this does not mean that parents have the power to consent to treatment until the child is 18. They only have the power to consent until the child has the capacity and maturity to provide informed consent. The ages of adulthood and consent therefore do not have a direct relationship.

The common law deriving from a case in the UK (Gillick v West Norfolk and Wisbech Area Health Authority 1986) established that young people can consent to medical treatment and procedures if they have sufficient understanding and intelligence to enable them to understand fully what is being proposed. Before proceeding with treatment of a person under the age of 18 without parental consent, a practitioner should specifically consider and document the following:

- that the young person understands the advice; and
- that the practitioner discussed the pros and cons of informing the parents but that the young person did not wish to do so.

The net effect is that a child has the full powers of consent, which override the parents' powers, at an age determined by the nature of the treatment or procedure, and their capacity and maturity to provide informed consent. This is therefore a matter of judgement for the treating practitioner.

There are exceptions to this, where certain Acts specify an age for consent. In relation to sexual health issues, in the NT the Medical Services Act states that a young woman under the age of 16 years cannot consent to a termination of pregnancy (TOP). The consent of each person having legal responsibility for her (in most cases both parents or official guardians) is required for this procedure. (The Criminal Code, however, permits TOP in certain circumstances for minors with substituted consent, for example when the young person has applied to the court and the court has considered the case and determined the outcome.)

2.6 Consent

It is illegal to engage in sexual intercourse with a child under the age of 16 years. This is because they are not considered to have the understanding, maturity or sexual literacy to make an informed decision about engaging in sexual activity.

Application of the concepts in relation to consent to sexual intercourse can assist the Primary Health Care Practitioner (PHCP) in determining whether harm or exploitation exist. To be able to consent to sexual activity each young participant must:

1. have the capacity to consent under the law;
2. understand the proposed sexual behaviour;
3. know the societal standards related to the behaviour;
4. be aware of the potential consequences;
5. have mutual respect for agreements or disagreements related to the behaviour;
6. voluntarily participate in the behaviour; and
7. be mentally competent. [25]

Another a key aspect of consent is that willingness to be involved can be withdrawn at any time. However under the law, even with agreement and active participation of the young person, the apparent 'giving of consent' is not even a consideration where the young person is under the age of consent.

Under Section 26 of the Care and Protection of Children Act there is no obligation to report 14 – 15 year olds in casual sex or 'young love' situations as long as the sexual relationship between the parties meets the following specific criteria:

1. Participants are peers of or over the age of 14 years, and
2. Participants are aged within two years of each other, and
3. There is no harm or exploitation. This means:
    - Participants are willing to be involved in the sexual activity;
    - Each person is able to say 'No', or change their mind, and that is respected;
    - There is no coercion, pressure, or force;
    - There is equal power, control and developmental maturity;
    - Neither participant is temporarily under the influence of substances.

It is important not to assume that sex between two adolescents of much the same age means that sexual activity is consensual. Any sexual activity between peers aged within two years of each other is harmful if it does not meet the specific criteria above, and it must be reported to the CIT, or the Police.

Whilst the law makes it clear people under 16 years of age cannot give their consent to sexual intercourse, and establishes reporting obligations on people, it is recommended that PHCPs explore whether any sexual activity in 14-17 year olds was or is likely to be harmful.

2.7 Remote Indigenous Communities

In Indigenous communities PHCPs, and in particular nurses and Aboriginal Health Workers (AHWs) may often be confronted with the possibility of abuse and so be obliged to assess the situation and if necessary report it. However, in many such situations, a decision to report abuse might result in possible adverse consequences that may affect the young person, the family, the community, or the PHCP. They may also include the deterioration of community relations, including relations between the PHCP and community members.[8]

The PHCP may have valid fears for their own safety, as well as that of the young person, when the process of reporting and substantiating abuse and dealing with the perpetrators puts them at risk of retribution. In some community situations there may be no safe place for the young person to go. Further, there may be fears for the perpetrator from, for example, community retribution or gaol. Valid fears of breakdown of family and/or community relations resulting from intervention by agencies (Child Protection or Police) or by community members, and fears of inflaming existing community and/or family tensions, may also be present.[26]

In small communities PHCPs may face particular difficulties in dealing with possible abuse. For example, if the perpetrator or victim is a relative, colleague, employer or employee of the PHCP, the relationship may pose intense difficulties for the PHCP and might require the support of an external person and/or agency. For similar reasons, it may be difficult or impossible for community members to disclose abuse to a PHCP who is related to either the victim or the perpetrator. In communities where 'everyone is related to everyone' this can make confronting suspected abuse even more difficult. PHCPs who are not local may have a special role in offering professional 'distance' and perceived confidentiality that community 'insiders' might not be entrusted with.[26]

Because the reporting of abuse may have serious ramifications for the safety of the young person and other community members, there is a strong need for adequate services and support to back up mandatory reporting. The perceived lack of support services and the vulnerability of young people, community members and health care workers when abuse is reported, may also contribute to PHCPs finding reasons not to report.[8] However, concern about the possible ramifications of taking a particular path in response to a disclosure must not take precedence over the fundamental right of the young person to safety.[26] Community

silence about child sexual abuse allows it to continue and places the young person concerned, as well as other young people, in danger of suffering further abuse.

When making a report of child sexual abuse it is important that any fears held by PHCPs about their own safety or the safety of others are communicated immediately to CIT or Police and to their line manager, to ensure these factors are considered when determining the timing and strategy for investigation. For example, children may need to be interviewed out of their community, and strategies may need to be implemented to ensure the protection of the PHCP or others in the community.

2.8 Indigenous Cultural Legitimacy

Sexual abuse in the Indigenous context is not acceptable in any form and has no cultural legitimacy.[26, 27] PHCPs need to be aware that 'culture' is sometimes used as a reason for ignoring abuse in Indigenous communities and should ensure that 'cultural' explanations of abusive behaviours are not used in justifying harm to young people.

KEY POINTS

- Sexual intercourse, with or by a person under the age of 16 years is illegal.
- In the NT all people are legally required to report to the Children Protection Hotline / Central Intake Team on 1800 700 250 or the Police if they have a belief of actual or likely:
  a) harm or exploitation in any person under 18 years; or
  b) sexual relationship between a person aged under 18 years and a person who has a relationship of special care with them; or
  c) sexual activity in any person under 14 years
- In addition to the above, registered health PHCPs must report
  d) 14 and 15 year olds who are, or are likely to be sexually involved with persons who are more than two years different in age.
- Whether or not correct, making a report in good faith will not breach confidentiality and will not incur civil or criminal consequences.
- In the NT there is no legal requirement to report sexual intercourse where:
  - Participants are peers of or over the age of 14 years, and
  - Participants are aged within two years of each other, and
  - There is no harm or exploitation. This involves:
    - Participants being willing to be involved in the sexual activity;
    - Each person being able to say 'No', or change their mind, and that is respected;
    - Absence of coercion, pressure, or force;
    - Equal power, control and developmental maturity
    - Neither participant being under the influence of substances.
- If there is uncertainty about whether harm may be taking place, informal advice and assistance may be obtained from the Children Protection Hotline / Central Intake Team.
- In the NT there is no statutory age of consent to medical treatment. Young people can consent to medical treatment if the practitioner believes that they have the emotional maturity and intellectual capacity to do so.
- An exception to this is termination of pregnancy in a young woman under the age of 16 years, for which the consent of her parents or legal guardians must be obtained.
- Concerns about the possible ramifications of taking action in response to harm or possible harm, must not take precedence over the fundamental right of a young person to safety.
- When making a report of child sexual abuse, a PHCP should immediately communicate fears about one's own safety or the safety of others to DCF or Police and to their line manager, to ensure they are considered when determining the timing and strategy for investigation.
- Sexual abuse in the Indigenous context is not acceptable in any form and has no cultural legitimacy.

3. Agencies Dealing with Sexual Health Issues

There are several agencies involved in the management of sexual health issues in children and young people. This chapter briefly describes the roles and responsibilities of each agency to assist PHCPs in understanding how 'the system' operates and the agencies work together. Actions and events may occur concurrently.

3.1 Child Protection Services (CPS)

DCF, Regional Services Branch provides a range of services to families and children in the NT, either through direct service provision or by funding other agencies to provide specific services. The Care and Protection of Children Act authorises Child Protection Services (CPS) to intervene to protect children in situations where they are being, or are at risk of being harmed, within their families. e.g. where the parents or guardians of the child are either involved in the abuse or have not adequately protected the child from abuse by others. CPS clinical staff include Psychologists, Social Workers, Welfare Workers, Aboriginal Health Workers, and Aboriginal Community Workers.

In relation to sexual abuse issues, the role of CPS is to:

- respond to sexual abuse of children within the family
- ensure children who have been reported are living in a safe environment and are being protected from sexual abuse
- investigate cases by gathering information from other government and non-government agencies or individuals. CPS does not investigate criminal matters but assists Police to do so
- develop a child protection plan and take action to keep the young person safe, including removing the child from the situation / environment to alternative safe environments as a last option, where necessary
- ensure that families are assisted to provide adequate care for their children
- provide material and other support to abused children, and their families
- as a last option, remove children to alternative safe environments

In fulfilling its responsibilities DCF works closely with other agencies including Police, SARC, health and education services.

3.2 Children Protection Hotline / Central Intake Team (CIT)

The Central Intake Team is the main point of entry for all reports of harm, exploitation and neglect of people under the age of 18 years. The Central Intake Team operates an NT-wide 24-hour telephone service, reached on 1800 700 250.

The role of the Central Intake Team is to:

- receive and record reports on the client management database
- assess the information in the report and conduct child protection and police history checks in relation to the family to build a fuller picture of the child's situation
- refer all cases of sexual offences to the Police because they are criminal matters
- provide information and advice in relation to child protection matters and crisis management to those who report
- direct practitioners to SARC if there is uncertainty about the clinical basis for a concern prior to a report being made

- in all cases of sexual abuse, advise the reporter that SARC personnel will be in contact to discuss the case and to coordinate a Forensic Medical Examinations (FME)
- refer cases to CPS regional case workers and other specialist teams for a coordinated response and ongoing management

3.3 Child Abuse Taskforce (CAT)

The Child Abuse Taskforce is a joint agency investigation team comprised of specially trained NT Police, Australian Federal Police, and CPS staff. All reports relating to sexual abuse are directed to the Officer in Charge of the CAT, who decides if a criminal investigation is warranted, and which area of the Police Force is most appropriate to undertake it. The CAT takes on the more complex investigations, such as reports of serious physical and/or sexual harm/exploitation where there are multiple children and/or multiple offenders involved.

The role of the Child Abuse Taskforce is to:

- collect evidence to prosecute the offender/s
- conduct child forensic interviews with victims
- work with the victims to increase their level of safety
- collaborate with other agencies e.g. CPS, SARC, Paediatric Department RDH, Mobile Outreach Service, Education, and Police to provide the child, family and community with support throughout the investigation and potential court case
- provide debriefing and education to communities where appropriate

The CAT places the safety and wellbeing of children above the prospect of a formal investigation. With other agencies, it uses a community development approach to assist 'at risk' communities to prevent and respond to child sexual abuse. CAT and CPS are bound by very strict confidentiality provisions under Section 97 of the Care and Protection of Children Act, and may be unable to share information with PHCPs/reporters.

3.4 Sexual Assault Referral Centre (SARC)

The DCF Sexual Assault Referral Centre is a specialist service responsible for the management of victims of sexual abuse in the NT. It provides a 24-hour crisis response service, counselling, specialist forensic and medical care and case management services for children and adults who have been sexually assaulted, and for their families/ significant others. SARC responds to acute, chronic, past or on-going sexual assaults or suspicions of sexual assault.

The role of SARC is to:

- assess for urgency of the presentation and forensic specimen collection
- develop a management plan with the treating doctor and health centre staff. In acute cases where a young person needs to be evacuated, SARC coordinates case management, transport for the young person and appropriate escort, and accommodation with the health care team and Patient Assistance Travel Scheme (PATS)
- conduct Forensic Medical Examinations (FME), and coordinate these with the child forensic interviews undertaken by Police and CPS, as required. SARC acts on referrals from the Central Intake Team for cases that involve a forensic medical examination as part of the statutory response. In many cases where sexual abuse is alleged, an examination is not required e.g. non acute cases with history of prior sexual activity or pregnancy in a minor, where the question of whether penetration has occurred is not disputed.

- provision of support and information to the child and family where, with the consent of the family, there is a direct referral from PHCP, police or DCF, or the family/child self-refer
- If the FME is not urgent families may be given the choice of having a forensically trained doctor travel to their community or nearest regional centre to perform the FME under the Forensic Medical Examinations of Children in your Community (FMECC) program
- guide PHCPs in determining if it is reasonable to believe that sexual abuse has occurred, and whether or not to proceed with a report to CIT
- provide crisis counselling, support, follow up and information to the child and family and make referrals to appropriate agencies e.g. MOS Plus (Mobile Outreach Service) for further counselling. Undertake client advocacy
- act as a community resource in relation to sexual assault matters for collaboration and consultation, referral, and community education
- provide support to PHCP who are involved in managing cases of CSA, provided the family consent
- provide professional training and consultation

In some cases, when Child Protection Services or Police do not undertake an investigation, the child or young person may still be referred to SARC medical and counselling services for a clinical opinion and management.

3.5 Mobile Outreach Service (MOS Plus)

MOS Plus is a DCF service that provides therapeutic community-based counselling to remote Indigenous children and families who have experienced trauma as a result of child abuse and neglect. They service victims and other children who have been traumatised. In addition, they can talk with communities, schools and other workers to increase understanding of the effects of abuse, how they can support the child, and assist to keep other children safe. MOS Plus is staffed by counsellors and Aboriginal Therapeutic Resource Officers who provide services in the local remote community. Referrals to MOS Plus can be made directly by primary health care providers, (as CIT cannot refer cases to MOS). All referrals must be with the consent of the child and/or their carer.

3.6 Sexual Health and Blood Borne Virus Unit (SHBBV)

The Sexual Health and Blood Borne Virus (SHBBV) Unit is a section of the NT Centre for Disease Control (CDC). The Unit has a broad public health role in educational and clinical services related to STI, HIV, Hepatitis C and related diseases across the NT.

Clinical services are provided through the Unit's Clinics 34. There are five of these clinics – in Darwin, Alice Springs, Katherine, Tennant Creek and Nhulunbuy. The clinics provide free and highly confidential services in all aspects of STIs and blood borne viruses (BBVs) such as diagnosis, treatment and care as well as prevention education and ongoing support. Clinic 34 has a key role in the collection and monitoring of pathology reports for HIV/AIDS, STI and BBV testing.

The role of the SHBBV Unit is to:

- provide clinical services for clients who attend a Clinic 34, who are seeking testing, treatment and advice for STI, HIV, Hepatitis C and related diseases
- be available to relevant service providers to guide appropriate treatment, follow up, and contact tracing of those who may be at risk of infection
- provide a range of SHBBV support activities around prevention, diagnosis, treatment and care, surveillance and reporting, and quality control audits to urban and remote health centres.

- provide health promotion and health education for schools and community groups, and clinical in-services for rural/remote and urban health professionals, in collaboration with other government and non-government organisations
- receive and record all positive pathology test results in accordance with the Notifiable Diseases Act, for surveillance purposes. In the event of a positive STI result in a person under 16, contact the medical practitioner who authorised the pathology request in order to verify the demographic data and to remind them of their mandatory reporting obligations. Under the Notifiable Diseases Act, SHBBV Unit staff are prohibited from contacting DCF directly about a case on the basis of a pathology report, as it breaches privacy provisions.

3.7 The Northern Territory Police Force

The NT Police Force is responsible for assessing and investigating all reports of physical and sexual abuse against children. The primary consideration for all police is to place the protection and welfare of children above the prospect of a formal investigation. Cases of child sexual abuse that do not fit the CAT criteria are investigated by Police units such as Major Crime and Regional Investigation units. These matters are generally investigated by detectives and plain-clothed officers.

The role of the Police is to:

- identify where a criminal offence has been committed
- collect evidence to prosecute the offender/s. This includes forensic evidence from medical examinations, weapons, interviewing victims, witnesses and suspects
- provide victims with support throughout the reporting process, investigation and court case by working closely with other agencies such as DCF, SARC, other counselling services, and the Director of Public Prosecutions' Witness Assistance Service

There is no time limit on the reporting of any type of abuse and Police are only too willing to assist victims and their families through this process.

KEY POINTS:

NT agencies dealing with sexual health issues in young people include:

- DCF: responsible for protecting children from abuse within their families.
- The DCF Central Intake Team (CIT): the main point of entry for all reports of all types of child harm. This team operates the reporting hotline 1800 700 250.
- The Child Abuse Taskforce (CAT): undertakes the more complex investigations of harm to children, such as serious physical and/or sexual harm/exploitation where there are multiple children and/or multiple offenders involved, and prosecutes offenders.
- The Sexual Assault Referral Centre (SARC): provides a 24-hour crisis response service, counselling, specialist forensic and medical care, and case management services for children and adults who have been sexually assaulted. SARC responds to acute, chronic, past or on-going sexual assaults or suspicions of sexual assault.
- The Sexual Health and Blood Borne Virus Unit (SHBBV): has a broad public health approach to control of STIs, HIV and related diseases, including diagnosis, treatment and care, surveillance and reporting, as well as prevention education and ongoing support.
- The Northern Territory Police Force: responsible for assessing and investigating all reports of physical and sexual abuse against children.

Section Two:

Consulting About Sexual Health Issues

4. The Sexual Health Consultation

The PHCP will see a wide range of different clinical presentations when managing the sexual health of young people. Presenting young people will vary from pre-pubescent children who are brought to the health centre by a family member, to post-pubescent adolescents who may present by themselves. The adolescents that the PHCP sees will range from those who are mature in terms of having the emotional and intellectual capacity, to consent to medical treatment and procedures, to those who are less mature in making these judgements.

This chapter guides aspects of the consultation process when the pre-pubescent child is brought by a family member, or post-pubescent young person presents with a sexual health concern. Subsequent chapters examine the important associated issues of 'consent' and 'confidentiality'.

This chapter examines the following aspects of the consultation in order:

1. selecting the consulting area
2. selecting the member of the health-care team to conduct the consultation
3. the consultation mode
4. deciding which members of the family should be included in the consultation
5. taking a history and exploring the presenting sexual health issues
6. undertaking a physical examination of a young person who presents with a sexual health concern
7. negotiating a management plan and appropriate follow up
8. advice on safe sexual practice, early self-presentation and condom use
9. documentation

4.1 The Consulting Room

To ensure confidentiality and trust, a consultation addressing a sexual health issue needs to be conducted in a room that ensures privacy. Health centres are normally busy centres of activity: consultations often occur in an open room or in a setting where interruptions by other staff members or by the telephone occur on a regular basis. These frequent interruptions can be quite intrusive for the client, particularly if the consultation is about a sensitive or emotive issue. The interruptions are also disruptive to the consultation process itself.

It is important therefore that any consultation addressing a sexual health issue related to a child or young person is undertaken in a consultation area where the door can be closed and privacy can be assured. In addition, it is important that other staff be advised that there are to be no interruptions, including phone calls, for the duration of the consultation.

4.2 The Appropriate Health Care Practitioner

It is important that the most appropriate member of the health care team to conduct the consultation is selected. Where possible this will be an experienced practitioner, although it is recognised that in some circumstances, particularly in small health centres, this will not be possible. Also where possible, it is recommended that a PHCP of the same gender conducts the consultation. For Indigenous young people there needs to be careful consideration of the inclusion of an AHW in the consultation, particularly if language or cultural barriers may be present. While a good concept in principle, it may be that the family or young person has concerns about confidentiality with a member of the community present.

4.3 The Consultation Mode

The consultation mode needs to be open, supportive and non-judgemental, whether it is addressing a sexual health issue of a young person, or of a child presenting with a family member. It is important that the young person, or the family of the child, should have choices in the consultation process and remain in control of the process wherever possible.2

The following points are intended to remind PHCPs of how to communicate effectively with young people [28]

- Build a relationship – humour, respect, honesty, non-judgemental warmth empathy. Begin the consultation by asking questions about positive or neutral topics so that a relationship can be developed before difficult material is introduced
- Consider your style – be non-confronting and patient, use a conversational or 'yarning' style, and appropriate body language
- Allocate adequate time. If there is disclosure of abuse a consultation can be lengthy, and will require adequate closure
- Privacy
- Focus on positives. Reinforce that the young person came to see you and encourage them to feel good about themselves
- Active listening – respond to cues, restate and draw out the meaning of what is said
- Language - explain things in age-appropriate language e.g. feeling 'yukky', 'no good in the tummy'; use their words back
- Less talk is more when talking to teenagers - they may tell us more if you are silent long enough to give them the opportunity; don't interrupt
- Advice/information - assist them to find solutions; include them in decision making

4.4 The Presence of Family Members

In the case of a child brought to the health centre by a family member with a specific sexual health issue or concern about possible sexual abuse, it is appropriate that the family decides which family members will be involved in the consultation.

Conversely, it is important to clarify with a young person presenting alone whether he/she would like to have a parent or other person present during the consultation. While it is preferable that young people have the support of a parent or guardian, they may not wish their carers to be informed of a medical consultation or its outcome. The PHCP should discuss the value of parental support with the young person but respect their wishes, views and confidentiality if they are considered able to give informed consent to medical treatment and do not want parental involvement. Their response to this suggestion should be documented. Establishing a trusting relationship between the young person and the PHCP will do more to promote health than to refuse to see the young person without involving the parents or carers.[2]

4.5 Exploring Sexual Health Issues

It is important that PHCPs opportunistically talk about and test for sexual health issues, and provide information on safe sexual practices and the importance of early self-presentation during unrelated consultations.

Children may be brought to the health centre with a number of possible sexual health issues, including the development of a specific symptom such as a vaginal discharge or vulval rash, or a concern about possible sexual abuse. In each presentation a careful history needs to be taken, with the possibility of sexual abuse always needing to be considered amongst other differential diagnoses.

For many young people presenting with a sexual health issue, concerns will often relate to the need for contraception, or to a possible pregnancy. Occasionally, the presenting concern will be that of a physical symptom such as a vaginal discharge. Sometimes the presentation may be of abdominal pain and, as part of a careful assessment; conditions such as acute PID or pregnancy need to be considered in the differential diagnosis.

Although for many young people presenting with a sexual health issue sexual activity will be consensual, the possibility of sexual abuse needs to be considered. An important component of the consultation with a young person is to sensitively assess whether sexual activity is voluntary,[2] and whether it meets the criteria outlined in Section 2.6. Important pointers in the history that may suggest sexual assault are the occurrence of depression, avoidance of people and activities, multiple partners, or the inability/unwillingness to identify the partner responsible. Sometimes, particularly if the initial consultation suggests the possibility that sexual activity was not voluntary, it may be necessary to conduct several consultations with the young person to attempt to establish the circumstances leading to the presentation. However if a disclosure is made the PHCP must not probe for more information as questions may be leading and the information obtained will not be admissible in a prosecution.

Not infrequently, young people accessing a primary health care service will present with mental health, substance and alcohol misuse, lifestyle or learning difficulties that may put them at increased sexual, emotional, or physical risk.[2] Such young people need to be referred to the appropriate specialist agencies for assessment and management.

4.6 Physical Examination

A physical examination is not required in order to conduct a sexual health check-up. If there is a possibility of sexual abuse or harm, a forensic examination should only be carried out by medical personnel specifically trained to do so. In such a circumstance the PHCP should always contact the Central Intake Team on 1800 700 250, who will arrange for the SARC doctor to discuss the matter with them, including whether the PHCP conducts a non-forensic physical examination. In cases of acute sexual assault this may involve looking for injuries (including the genitals) and treating as necessary. A vaginal or rectal examination should not be undertaken unless serious injuries need treatment. Should further investigation be judged necessary, a decision can then be made about the best time and place for the SARC doctor to conduct the clinical and forensic examinations to ensure, wherever possible, that the child is examined only once. In non-acute cases of sexual assault, STI testing can be performed by the PHCP if the child or carer gives informed consent. A forensic examination (to look for evidence of prior injury/penetration) may then be arranged by SARC at a later date depending on the outcome of the investigation. Refer to Appendix 2 for general information on Forensic Medical Examinations, and the PHCP's role.

A formal physical examination of the genito-urinary system in both children (external only) and adolescents, together with taking samples for laboratory investigations for STIs, is always indicated in the following presentations:

In females:

- lower abdominal pain suggesting either acute pelvic inflammatory disease or a pregnancy related condition
- a urethral or vaginal discharge or genital rash or genital ulcer
- evidence or belief of sexual abuse/assault. The PHCP should make a report to CIT and discuss the case with SARC

In males:

- a urethral discharge, genital rash or genital ulcer
- testicular related conditions such as acute epididymitis or orchitis
- evidence or suspicion of sexual abuse/assault. (The PHCP should always consult the CIT and discuss with SARC before proceeding.)

The physical examination, including the taking of laboratory tests if appropriate, needs to be sensitively conducted by the PHCP, with the support of another appropriate member of the health team who can assist and also act as a chaperone. In undertaking laboratory tests in the young person, informed consent needs to be obtained from either the young person or his/her parents or guardian.

For young people presenting with a sexual health issue such as the need for contraception, or with a concern about possible pregnancy, a thorough sexual history should be taken and STI tests should be offered if unprotected sex has occurred. If young women are reluctant to undergo a speculum examination, they can be given the option of self-collected samples via swabs/tampons.

4.7 Management Plan and Follow-up

Following the history taking and physical examination it is important that sufficient time is allowed in the consultation to enable clear communication with either the family of the child or the young person, about the most likely nature of the presenting symptoms. It is particularly important to clarify any questions or concerns that the family or the young person may have. A management plan, with a further follow up visit if indicated, also needs to be carefully communicated.

4.8 Safe Sexual Practices

When seeing a young person who presents with a sexual health concern, one must take the opportunity to give health information on safe sexual practices including condom use and the importance of early self-presentation. Although this will take time, and another appointment may need to be scheduled so there is sufficient time, at a minimum an offer of STI testing should be made to sexually active young people. It is recommended that the following areas of sexual health be covered in this advice:

- STIs and their transmission
- contraceptives protect against pregnancy, however they are generally not protective for STIs
- only condoms will protect against the majority of STIs
- the importance of sexual health checks following unsafe sex practices due to asymptomatic nature of many STIs
- the importance of early self-presentation if STI symptoms are present
- safe and unsafe sexual practices
- how and where to obtain condoms
- the correct way to use a condom
- discussion of contraceptive options
- negotiation techniques and the right to say no to unwanted or unprotected sex
- consent may be withdrawn at any time

4.9 Documentation

All consultations addressing a sexual health issue of a child brought to the health centre by a family member or of adolescents presenting by themselves need to be fully documented.[2]

KEY POINTS

- Privacy should be ensured in consultations
- Where possible, young people with a sexual health concern should be seen by an experienced PHCP of the same gender.
- For Indigenous young people, consideration should be given to the inclusion of an AHW in the consultation, particularly if language or cultural barriers are present.
- The consultation mode needs to be open, supportive and non-judgemental.
- It is appropriate that the family of a child decides which family members will be involved in the consultation.
- The PHCP should discuss the value of parental support with an adolescent, but respect the wishes, views and confidentiality if he/she is considered mature enough to consent to treatment and does not want parental involvement.
- It is important that the PHCP sensitively assesses whether the young person's sexual activity is voluntary, and that there is no coercion, sexual exploitation, rape, or other sexual abuse.
- A number of sexual health presentations require a formal physical examination of the genitourinary system be conducted.
- In a presentation of possible sexual assault or abuse, the PHCP should immediately discuss the case with the SARC doctor (via the Central Intake Team), who will advise about the procedures for any physical examination, including any formal forensic medical examination.
- It is important to clearly communicate to the presenting young person or the family the most likely nature of the presenting symptoms, and to clarify any questions or concerns that they may have.
- A management plan needs to be carefully communicated, with a further follow up visit if indicated.
- PHCPs should opportunistically offer information on safe sexual practices and STI testing for sexually active young people at each consultation.
- All sexual health consultations need to be fully documented.

5. Obtaining Consent to Medical Intervention

Consent is required before undertaking any examinations, procedures and laboratory investigations, and for any medical treatment that is subsequently prescribed.

Some sexual health consultations will be with children who are brought in by a family member who has a specific sexual health concern about the child, and the child is clearly too young to give their own consent to treatment. In this situation the consent of an adult will be required. If consent is given by other than a parent, the name of the person and their relationship to the child should be documented in the case notes.

Other sexual health consultations will be with young people attending alone who may or may not have the maturity and intellectual capacity to consent to medical treatment. Before providing medical treatment, including counselling or advice, PHCPs are required to make a judgement as to the maturity and capacity of the young person to give informed consent. The more serious the medical procedure proposed, the better the grasp of the implications is required by the young person. The practitioner needs to be convinced that the young person understands the advice and nature of the treatment, does not wish his or her parents to be informed, that his or her health would suffer without treatment, and that proceeding without the consent of the parents is in the best interests of the young person. If the young person is judged mature enough to authorise or refuse treatment independent of the knowledge or wishes of the parents, the parents' right to authorise or decline treatment ceases. Once judged competent, a young person has the right to receive treatment by the PHCP.

The exception in the NT is that a young woman under the age of 16 years cannot consent to a termination of pregnancy. Her parents or legal guardians must give consent to the procedure.

Therefore, with the exception of TOP, a mature adolescent may seek treatment or counselling without involving his or her parents. The PHCP may then be better able to ascertain the nature of the sexual relations that resulted in the consultation.

KEY POINTS

- Consent is required for any examinations, procedures, laboratory investigations and medical treatment:
  - In the case of a child too young to give his/her own consent, consent will be required from an accompanying family member.
  - A young person may consent to his or her own treatment and procedures if the PHCP is satisfied that the young person is able to understand the advice and nature of the treatment, does not wish his or her parents to be informed, that his or her health would suffer without treatment, and that proceeding without the consent of the parents is in the best interests of the young person.
- An exception in the NT is that a young woman under the age of 16 years cannot consent to a termination of pregnancy. Both parents or legal guardians must give consent to the procedure.

6. Confidentiality

6.1 Confidentiality and Children or Young People

The concept of maintaining confidentiality applies equally to a sexual health consultation with a presenting child or young person as with any other consultation between a PHCP and a patient. The assurance of confidentiality between the young person and the practitioner encourages an open and trusting relationship, ensuring presenting sexual health issues may be more easily identified and treated. The issue of confidentiality should be discussed explicitly with all clients under 18 years of age early in consultations. This must be done in a positive manner, emphasising the young person's rights to confidentiality. Reference should also be made to the conditions under which confidentiality would be broken - specifically, disclosure of harm or being at risk of harm, and mandatory reporting provisions.

In a clinical presentation of a child who is brought to the health centre by a family member who has a specific sexual health concern about the child, confidentiality of the consultation between the PHCP and family member is implicitly recognised and respected.

Young people who are deemed to be able to give their own consent to medical treatment and procedures are also assured of confidentiality in their consultation with the PHCP. However the PHCP is strongly encouraged to discuss the value of parental/guardian support with the young person, but respect his/her wishes, views and confidentiality if parental involvement is not wanted.

Reporting a young person does not preclude the practitioner from providing care such as contraception, STI/BBV management, or advice about self-protection.

6.2 Confidentiality and a Notifiable Disease

As noted previously, an important exception to the requirements for confidentiality is the disclosure of a notifiable disease. Under the Notifiable Diseases Act, regardless of the wishes of the young person, medical practitioners must inform parents or guardians if their children under the age of 16 years have a notifiable disease. It is Department policy that a delegate of the medical practitioner may inform the parents/guardians.

6.3 Confidentiality and Suspected Sexual Abuse

The Care and Protection of Children Act creates an obligation for all people, including PHCPs, to report any belief that a person under the age of 18 years has been sexually harmed or exploited. This mandatory requirement applies regardless of the wishes of the young person or his/her parents or guardians. Failure to report is not defensible on the grounds of breach of client confidentiality as protection is more important than keeping information in confidence. The Care and Protection of Children Act protects people from civil and criminal liability for reports made in good faith.

It is important that any disclosure or report of sexual harm is only revealed to those absolutely necessary. Strict confidentiality can be crucial to services such as DCF and the Police gathering evidence. Also, be aware that these agencies are often unable to discuss details of any investigations with the reporter for the same reason. However it is important that PHCPs inform their manager or in some situations a different trusted senior colleague, so they can provide support.

6.4 Confidentiality in the Remote Health Setting

Confidentiality is a major concern for victims, families and workers in the area of child sexual abuse, particularly in the remote health setting. The close networks in Indigenous communities make confidentiality an even greater issue and significant efforts need to be made by the PHCP in the remote health centre setting to ensure confidentiality is maintained.[26]

6.5 Recommended Approach

As described above, the current legislation in the NT is such that in certain circumstances confidentiality between the young person or family of a child and the PHCP will be breached. If this occurs after the young person/family has been offered unqualified assurances of confidentiality, then a significant betrayal of trust will have occurred. It is therefore recommended that at the commencement of the consultation the young person/family is assured of confidentiality, but is also informed of those circumstances in which confidentiality might be broken.

Where relevant and appropriate, the young person or family of the child should be made aware that:

- The following must be reported to DCF or the Police:
  - sexual harm or exploitation of a person under the age of 18 years; or
  - a sexual relationship between a person aged under 18 years and a person who has a relationship of special care with them; or
  - any person under 14 years is sexually active; or
  - any 14 and 15 year olds who are, or are likely to be sexually involved with persons who are more than two years different in age.
- for a young woman aged under 16 years, a TOP will require parental or guardian consent
- if a STI is diagnosed in a person aged under 16 years, it is a legal requirement in the NT for medical practitioners or delegates to notify the parents or guardian
- if a STI or pregnancy is diagnosed or suspected in a person 13 years or younger, it is DoH policy that the PHCP informs the Central Intake Team to ensure there is appropriate medical and social assessment and support . (This is not the same as a formal report of harm required under the Care and Protection of Children Act.)

KEY POINTS

- The concept of maintaining confidentiality applies equally to a sexual health consultation with a presenting child or young person as with any other consultation between a PHCP and a patient.
- PHCPs need to make significant efforts to ensure confidentiality in remote health centre settings.
- The young person or family of a child should be informed of the circumstances in which confidentiality will be breached, regardless of their wishes, i.e.:
  - beliefs of harm and exploitation and other situations listed in the Care and Protection of Children Act;
  - children under the age of 16 years with a notifiable disease - their parents must be informed, as per the Notifiable Diseases Act
- A young woman under the age of 16 years cannot consent to a termination of pregnancy. Her parents or legal guardians must give consent to the procedure.

Section Three:

The Management of Sexually Abused Children and Young People

7. Identifying and Responding to Sexual Abuse

7.1 Recognising Child Sexual Abuse

The Care and Protection of Children Act defines any person under the age of 18 years as a 'child', and this definition applies to any type of sexual abuse/harm/exploitation.

Child sexual abuse is any sexual act or threat that exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards.[8] It occurs where a child is not mature enough to understand the concept of consent, or to exercise consent, in relation to the sexual activity.

Child sexual abuse occurs when a person, regardless of gender, exploits the dependency and immaturity of children by using their authority, either by using force or not, to get a child to participate in activities that are for the sexual gratification of a young person significantly different in age or adult. This physiological or psychological coercion differentiates such abuse from consensual peer sexual activity.

It covers a continuum from:

- non-contact forms of harm, such as flashing, having a child or young person pose or perform in a sexual manner, exposure to sexually explicit material or acts (including pornographic material), communication of graphic sexual matters (including by email and SMS), or encouraging young people to behave in sexually inappropriate ways.
- a range of contact behaviours, such as kissing, fondling and/or masturbation of the child; having the child touch, fondle or masturbate the abuser; penetration of the vagina or anus either by digital, penile or any other object; or coercing the child to perform any such act on themselves or anyone else.[29]

Child sexual abuse should not be confused with affectionate or playful physical contacts between an adult or a child which are essential to a child's healthy growth and development.[30] Appropriate sexual exploration is when there is mutual agreement between same- or similar-aged peers, it is non-coercive and all participants have the control to participate, continue or stop the behaviour. [31]

There are a number of important facts about sexual abuse, which include:

- sexual abuse in the Indigenous context is not acceptable in any form and has no Indigenous cultural legitimacy [2, 32]
- Male and female adults, adolescents, as well as older children can perpetrate sexual abuse.
- Sexual abuse is rarely a one-off incident, and usually occurs over a period of years
- More than 90% of child sex perpetrators are male. Most commit their first child sex offence during adolescence and usually continue until they are caught.[32]
- All sexual abuse is potentially harmful to the child. The younger the child, the more vulnerable they are, and the more serious the consequences are likely to be
- It is rare for children to lie about sexual abuse [33]
- Young people may often suffer from more than one type of abuse
- Sexual abuse and consensual sexual activity may coexist [2]
- STIs occur in very few cases of reported sexual abuse, so it is important not to wait for confirmation of an STI before reporting [34]

- Under-reporting of abuse by practitioners, victims and the general public is a significant issue as this allows it to continue and places the child, as well as other children in danger of further abuse
- failure to report is not defensible on the grounds of breach of client confidentiality, as mandatory reporting laws take precedence over client confidentiality principles

Adults, adolescents or other children who sexually abuse children exploit their dependency or immaturity. Coercion, which may be physical or psychological, is inherent in child sexual abuse and distinguishes it from consensual sex with a peer. While a young person may perceive sexual activity as consensual because of the way the other person has promoted it, the situation may in fact be one of sexual abuse and exploitation. The apparent consent of a young person does not mean that sexual abuse did not occur.[8]

A large disparity in the age of a couple is more likely to trigger concerns about differential power relationships and coercion into undesired sexual activity. However, it should by no means be assumed that sex between two adolescents of much the same age means that sexual activity is wanted or consensual. It is apparent that there are many young males who engage in sexual behaviour of a predatory nature.[8]

Young sexually abused people may present in a variety of ways with a wide range of symptoms that are summarised in Table 1 below.[2]

Table 1 Modes of Presentation of Child Sexual Abuse [2, 35, 36]

INDICATORS	CHILD or YOUNG PERSON
Physical	Injuries, bleeding, discharge, soreness, itching, inflammation or infection in urethral, vaginal or anal areas Trauma to breasts, buttocks, lower abdomen, or thighs Pain on urination/defecation; urinary dysuria and frequency; frequent UTIs Pregnancy especially in very young adolescents; where the girl refuses to reveal any information about the father; denial of the pregnancy by the girl and her family STI, (the presence of an STI in a preadolescent is most likely the result of sexual abuse and formal assessment should always be initiated)
Psychosomatic	Recurrent abdominal pain/migraine Multiple vague physical complaints Encopresis/enuresis School refusal
Emotional and behavioural	Sexualised behaviours or knowledge inappropriate to their age and developmental level E.g. sexually touching other children, simulation of sexual acts. Refer to Appendices 5 and 6 for information about normal and concerning sexual behaviours in children aged 0-7 years. Shows excessive fear when having nappy changes or being bathed Neglect of personal hygiene (i.e. making themselves unattractive in an act of self preservation) Depression, anxiety, self-harm, withdrawal from peers Drug and alcohol abuse, eating disorders Prostitution, overtly seductive behaviour Delinquency, criminal behaviour, tantrums, aggressiveness

Other	Direct or indirect disclosures
	Child implies that he/she is required to keep secrets
	Other reliable sources might reveal the young person is sexually active
	Sudden accumulation of money or gifts

7.2 STIs and Sexual Abuse

It is important to understand that the majority of victims of sexual assault or abuse, whether adults or children, do not have or present with STIs.[34] Although an STI may be a marker of abuse, STIs in young people often occur as a result of consensual sexual activity.

Many young people begin normal consensual sexual activity at around 14 to 16 years of age: some older and some younger. In general, the younger the person the more likely it is that sexual activity represents abuse. However, there is a 'grey zone' of age within which it may be very difficult to determine whether sexual activity might be consensual or abusive. Therefore, in order to minimise the number of children in whom possible abuse could remain undetected, the threshold for considering STIs or pregnancy in children to be the result of sexual abuse until proven otherwise has been set (in legislation) at under 14 years of age. As such, they are to be reported to the Central Intake Team so that appropriate social and medical assessment can take place. For young people 14 years and older with STIs, a more discriminating approach is taken and action should be determined in the context of available clinical and social information. Refer to Section 2.6 and 2.7 for relevant legislative requirements for different age groups.

7.3 Diagnosing Sexual Abuse

Sexual abuse may be voluntarily disclosed by a victim or reported by a family member. Frequently however, sexual abuse is not reported and is only brought to light through the presentation of the abused young person to a health service with one or more physical, psychosomatic, or emotional and behavioural indicators, as outlined in Table 1 above. The signs of sexual abuse are rarely diagnostic, but need to be interpreted within the context of the presenting clinical situation.[2]

In addition to the indicators outlined in Table 1, other factors to consider in the assessment of possible sexual abuse include:

- the age of the young person's sexual partner(s)
- the care environment in which the young person lives
- the cognitive and social maturity of the young person
- the 'power' of the young person in the situation and the capacity to say 'no'
- what the young person wants to happen.

If there is an inconsistency in the explanation of the cause of the presenting signs or symptoms, then sexual abuse may be suspected. Following advice from the Central Intake Team if necessary, the suspicion of sexual abuse may need to be sensitively explored by the PHCP with the young person and his or her family, possibly over several consultations.

7.4 Responding to Sexual Abuse

A complex situation unfolds when a PHCP believes sexual abuse has occurred. The direct or indirect repercussions can affect the child and family, the perpetrator, the PHCP, members of the immediate and broader health care team and agencies, as well as the community and others connected to it.

Because the child may be vulnerable, many agencies work together closely to assist the child to cope, and to protect him or her from future assault.

PHCPs are required by law to report to 1800 700 250 or the Police if they have a belief of harm/exploitation, or certain other sexual offences involving persons under 18 years.

This number reaches the Child Protection Hotline / Central Intake Team (CIT). This number is used when reporting any form of child abuse, such as physical or emotional abuse, neglect, or nutritional deprivation, as well as sexual abuse.

When a PHCP suspects sexual abuse and is with the child or young person, he or she should receive the young person's story and provide support, and not request or probe for more information. This is because questions may be leading and the information obtained will not be admissible in a prosecution. Also, the child should only be questioned once, and then only by specially trained interviewers from the Police Force. It is also important that the examination and taking of laboratory specimens is not undertaken by the PHCP but deferred, pending the forensic medical assessment. However PHCPs can play an indirect role in preserving evidence, such as by collecting body fluid or clothing. Refer to Appendix 2 regarding Preservation of Forensic Evidence. In addition, the PHCP is unable to discuss with the family any aspect of the formal investigation into the allegations of abuse.

There is no legal obligation to inform the parents (or the child) that a report is being made. The PHCP must make a judgement about whether to inform the child/family that he/she is reporting the case to the Central Intake Team, or that they suspect abuse has occurred. Three principles should be considered when making that decision:

- the safety of the child
- respect for the parent/guardian
- the safety of the reporter.

In a situation where it is unclear if sexual abuse has occurred or not, and a notification is made, the family and young person will need support and communication lines needs to be open.

7.5 When Sexual Abuse is Reported

When a PHCP makes a report regarding child sexual abuse to the Central Intake Team several agencies become involved. All reports of sexual offences made to CIT are directed to the Child Abuse Taskforce (CAT) because these are criminal matters. Using information from the report and Police and DCF databases the CIT and Police decide whether a Child Protection or Police investigation is warranted and will commence.

Not every report will be investigated. The critical factors in deciding whether a matter will be investigated are:

- There must be sufficient evidence for Child Protection Services (CPS) and the Police to act on a case;
- The alleged incidents have caused serious harm to the child;
- The child is likely to suffer further harm without the intervention of CPS; and
- There are sufficient resources available to ensure that the matter can be fully and properly investigated.

In addition, investigations may be delayed until such time as adequate resources become available.

If the young person needs support before Child Protection or Police involvement or if those agencies do not become involved, the child can be referred to MOS Plus if there is the appropriate consent. MOS provides counselling and support to victims, their families and others affected by abuse and trauma. Also consider referring to any local agencies that may be able to provide support, such as Anglicare.

CPS generally becomes involved in cases where the perpetrator is a family member, or the family is not protecting the person from harm. In some cases only the Police are involved. Police cannot take action if there is no evidence, e.g. if a young person does not disclose abuse in a Police interview.

Many young people are not evacuated from their community following a report to CIT. Reports are often historical and there may be no immediate forensic value in examining the young person. Nevertheless a forensic medical examination may still be required and this can occur at SARC in Darwin or Alice Springs, at a closer regional centre, or in the child's community through the Forensic Medical Examinations for Children in your Community (FMECC) program.

Some young people need to be evacuated urgently. This can be because of an acute sexual assault requiring immediate forensic and/or medical examination and treatment; there are concerns for the child's safety; or it is necessary to conduct the interview and examination away from the community.

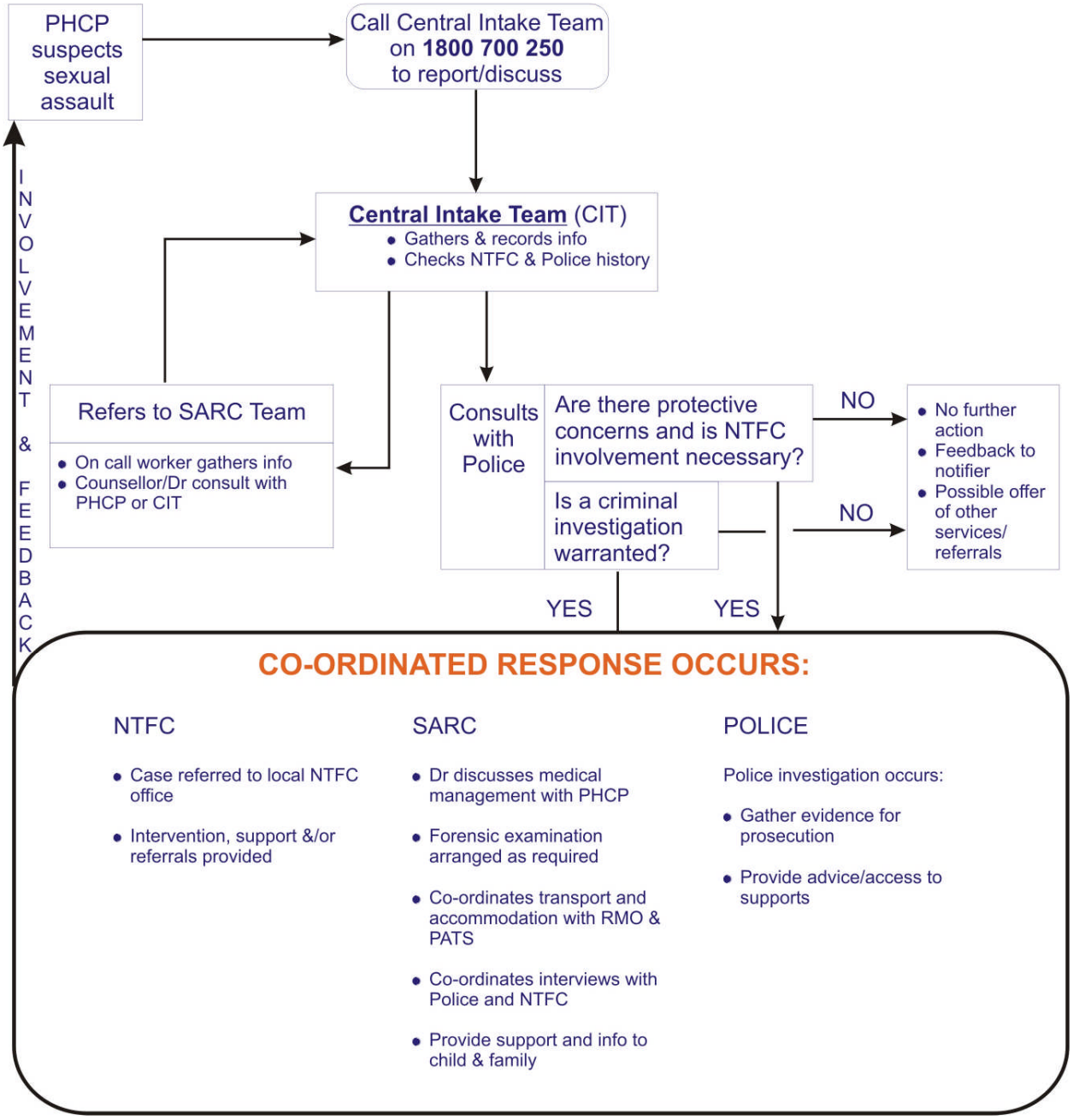
Sometimes a young person will be brought to Darwin or Alice Springs following an event because they may speak more openly away from their community, for counselling, or to access a range of services, including SARC.

From a Police perspective, where a 14 or 15 year old is judged to be engaging in consensual sexual activity with a partner who is more than two years different in age, there may be no direct repercussions for either the child or the partner even though he/she is under the legal age of consent to sexual acts. The Police may decide not to intervene because doing so is not in the best interests of the child, or the public.

PHCPs can gain an understanding of how 'the system' operates, and how the agencies work together by referring to the roles of agencies in Section 3. The practitioner's role is to work with the child to ensure his/her current safety, and to provide education and support regarding protective behaviours.

The following flowchart summarises what occurs when a report is received by the Central Intake Team on 1800 700 250. Note that actions and events may occur concurrently.

WHAT HAPPENS WHEN A REPORT IS MADE?



KEY POINTS

- Child sexual abuse is any sexual act or threat that exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards (a child is defined as a person under the age of 18 years).
- Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. It may involve physical contact, including penetrative or non-penetrative acts, or it may include non-contact activities.
- Important facts about sexual abuse include:
  - Young people may often suffer from more than one type of abuse.
  - STIs occur in very few cases of reported sexual abuse, so it is important not to wait for confirmation of an STI before reporting.
  - Sexual abuse and consensual sexual activity may coexist.
- It is important to be aware of the clinical presentations that should alert a PHCP to the possibility of sexual abuse.
- Frequently, sexual abuse is not reported by the victim or family, and may only be suspected through the clinical presentation of the abused young person with one or more physical, psychosomatic, emotional or behavioural indicators.
- It is Department policy that all occurrences of STIs or pregnancy in children aged under 14 years are considered to be the result of sexual abuse until proven otherwise. For young people 14 years and older a more discriminating approach is taken and action should be determined in the context of available clinical and social information.
- The Central Intake Team must be notified if in the mind of the PHCP reasonable grounds exist to believe sexual abuse has / will occur.
- When a PHCP suspects sexual abuse he/she must not probe for information or undertake a formal physical examination. Trained police and/or medical specialists must undertake interviews and forensic examination.
- The PHCP must use his/her judgement to decide whether to inform the child/family of the belief of sexual abuse, or that he/she is reporting the case to the Central Intake Team, taking into account the safety of the child, respect for the parent/guardian, and the safety of the reporter.
- An outline is provided of the roles and responsibilities of the different agencies involved after a decision has been made to investigate possible child sexual abuse.
- Information about forensic examination of children is contained in Appendix 2.
- A flowchart summarises what happens when a report is made to the Central Intake Team.

8. Uncertainty about Sexual Abuse

8.1 When Uncertain about Sexual Abuse

Deciding whether one has a belief about child sexual abuse is often difficult. Sometimes the decision will be obvious, especially in situations of a direct disclosure, or where there is unambiguous physical evidence. Mostly however, a professional judgement about whether to make a report will be required.

Sometimes the PHCP is faced with a clinical presentation that raises the possibility of sexual abuse in a young person, but where the evidence and circumstances leave the PHCP uncertain. In this situation it may be useful to sensitively explore the circumstances around this presentation over several consultations. If despite this, the question of whether sexual harm or exploitation is occurring has not been satisfactorily resolved in the mind of the PHCP, then the PHCP is strongly advised to discuss the case informally with the Central Intake Team. As stated previously, in an informal discussion it is not necessary to disclose the identity of the people involved, however, doing so may be of benefit to the young person.

If the uncertainty relates to a clinical issue, the PHCP can obtain advice from a Sexual Assault Referral Centre (SARC) doctor, or a paediatrician. If there is a behavioural issue the PHCP may wish to discuss the case with disability or early childhood services.

The PHCP should consider collaborating with a peer and/or a more experienced clinician in reaching conclusions on “reasonable belief” or “risk of harm”. However, if there is a decision to discuss the case with a colleague it is important to be mindful that there will be people in the community who have an interest in ensuring that a report is not made, and/or convincing the child to retract their statement. Therefore, advice should be sought from someone who is not related to the child or the alleged offender. Note that consultation with another health team member is not a substitute for making a report to CIT.

The trigger for making a report exists where the PHCP has a belief on reasonable grounds of any of the four factors listed in S26 of the Care and Protection of Children Act. The belief does not need to be completely without doubt, and proof is not required. However when deciding whether to report, the PHCP must not rely on a ‘hunch’ or ‘gut feeling’ that has no basis. A useful approach is to ask oneself,

“Would another person with my training and experience, given similar information be more likely to accept than to reject the notion?”

If the answer is ‘yes’ then a belief has been formed, and so it must be reported. PHCPs are not responsible for investigating or proving this belief – that is the role of Child Protection workers and Police.

If the PHCP is in doubt about whether to report, informal advice can be sought from the CIT who can determine whether a formal report is indicated or not. In such a discussion the identity of the people involved does not have to be disclosed. However, doing so may benefit the child as the CIT may already have information concerning him/her, their siblings, or the alleged perpetrator, which will give a deeper understanding of the situation, and enable an informed assessment of the case to be made. In general, it is recommended that when in doubt PHCPs report the child as it is better to err on the side of caution.

If, after consideration, the PHCP decides not to report a case, it is advisable to document the situation, describing what triggered the initial concern, and why it was not reported. Such a record will be useful if another incident arises that leads the PHCP or another colleague in contact with the child or family to again be concerned about the child’s wellbeing. It may also be helpful to sensitively explore the young person’s situation over several consultations.

Many PHCPs have concerns about the consequences for children and young people following a report of sexual abuse. These are no excuse for failing to report it. In considering whether a child should be reported, PHCPs should keep in mind that the primary

consideration is the welfare of the child. One's relationship with community members and the health service's relationship with the community should not override that consideration.

8.2 Responses for Different Ages of Young People

Where the PHCP is uncertain about the possibility of sexual assault or abuse, but where sexual activity, sexually transmitted infections, or pregnancy are evident or possible in a young person, different responses are required according to the age of the client.

Clients Aged Under 14 Years:

All sexually active under 14 year olds must be reported to the Central Intake Team. This applies even if they come to the health centre with a parent / guardian. This is because young people under 14 years of age are extremely vulnerable to abuse as they are immature, they lack understanding about the meaning of sex, and saying 'No' is difficult and is often not respected. They are not able to make an informed decision about engaging in sexual activity and so whether or not it may be consensual is irrelevant.

It is helpful if the notifier can gather as much information as possible regarding the child's situation prior to making the call. This will assist with determining the most appropriate response, which may include evacuation.

In situations where a child 13 years or younger is judged to be willingly engaging in sexual activity with a partner who is no more than two years different in age, there may be no direct repercussions for either the child or the partner, even though both are under 16 (the legal age of consent to sexual acts). Police will not intervene where it is not in the best interests of the child, or of the public to do so. In this case the PHCPs role is to work with the child to ensure his/her current safety, and to provide education and support regarding protective behaviours, contraception and STI treatment and advice.

Clients Aged 14 to 15 Years:

The PHCP must explore the age difference between the sexual partners by asking the young person the age of their boyfriend/girlfriend. If there is no response, ask them another way, explain why they are being asked, or allow a bit more time. If the young person still does not provide any indication of the age difference or if exact birth dates aren't known, the PHCP should try to deduce the age difference using common sense. PHCPs are prohibited from looking up the partner's health record to find out his/her exact age because of privacy laws. If there is considerable doubt about the age difference or if the young person does not respond to the enquiries – which is in itself a concern - it is recommended that the PHCP reports the child as it is best to err on the side of caution. If there is more than two years age difference, even by only one day, the case must be reported.

PHCPs must also explore whether any sexual activity in 14-15 year olds was or is likely to constitute harm or exploitation. As the law makes it clear that people under 16 years of age cannot consent to sexual intercourse, whether or not there was consent is not a consideration. However application of the concepts relating to consent to sexual intercourse can assist the PHCP in determining whether harm or exploitation do or are likely to exist. In applying these concepts, the PHCP must consider whether the young person understands the social meaning of sexuality and its potential consequences, and if they are able to protect and advocate for themselves sexually. They must also consider whether:

- Participants are willing to be involved in the sexual activity;
- Each person is able to say 'No', or change their mind, and that is respected;
- There is no coercion, pressure, or force;
- There is equal power, control and developmental maturity;
- Neither participant is temporarily under the influence of substances.

If the PHCP assessment identifies that the sexual activity is between developmentally normal peers aged within two years of each other, and if the sexual relationship between the parties meets the above specific criteria, a report is not required.

If sexual activity between peers aged within two years of each other does not meet the specific criteria above it is harmful, and it must be reported. It is important not to assume that sex between two adolescents of much the same age means that it had the characteristics of consent.

This age group was singled out because young people of this age are very vulnerable to sexual abuse as they do not have adult knowledge about sex and sexual relations, they are also less mature, generally have little knowledge about keeping themselves safe, and it is difficult for them to negotiate or say no to sex.

Where a 14 or 15 year old is judged to be engaging in consensual sexual activity with a partner who is more than two years different in age, there may be no direct repercussions for either the child or the partner even though he/she is under the legal age of consent to sexual acts. In such situations, although the sexual activity is unlawful, it is unlikely that any action would be taken by authorities because to do so would not be in the best interests of the young people. However it is possible that some form of investigation will occur and the teenagers may be interviewed to come to the conclusions that both are safe from harm or exploitation.

The PHCP must also investigate and manage the young person for any STIs including education regarding protective behaviours and safe sexual practices. This may involve liaising with the Sexual Health Teams at Clinic 34 or SHBBV Unit. The PHCP is responsible for notifying the parents or guardians that their child has a notifiable disease. The PHCP is also responsible for contact tracing.

As outlined in Chapter 9, in the event of pregnancy the PHCP should liaise with the local Obstetric Unit for support in managing the case, due to a higher risk in young age pregnancy.

Clients Aged 16-17 Years:

Young people of this age have reached the age of consent so are legally able to engage in consensual sex. The exception to this is if the sexual relationship is with a person who has a ‘special care relationship’ with that young person. A relationship of special care is where an adult cares for, supervises, or instructs a child e.g. step-parent, guardian, foster carer, health practitioner, correctional services officer, teacher, boss, coach, priest. A relationship of special care can also include members of the extended family.

This law applies because although people of this age have reached the ‘age of consent’, they are still vulnerable to sexual abuse by people in positions of influence / authority, as it can be difficult for them to withstand sexual pressures from such people. If through the PHCP’s conversation with the young person a suspicion is formed that they may be in such a relationship, ask them about their boyfriend/girlfriend and if the suspicion is confirmed, the case must be reported.

PHCPs must also assess whether the sexual activity was consensual and if not, the PHCP is required to call the Central Intake Team.

On a clinical note, the PHCP must work with the young person to ensure his/her current safety, and to provide education and support regarding protective behaviours, STI / HIV prevention and contraceptive advice. In the event of pregnancy, the PHCP should follow regular protocols (as outlined in Chapter 9).

Clients Aged Under 18 Years:

When a PHCP sees any person under the age of 18 they need to consider whether the young person is at risk of, or is being harmed or exploited – not just sexually. This is because all people under 18 are vulnerable to harm and exploitation due to their limited life experience and limited ability to promote, protect, and advocate for their own well-being.

If any person under 18 has been involved in non-consensual sexual activity, harm has occurred and it must be reported. Even if an adult accompanies a young person in a consultation the practitioner must consider issues of harm.

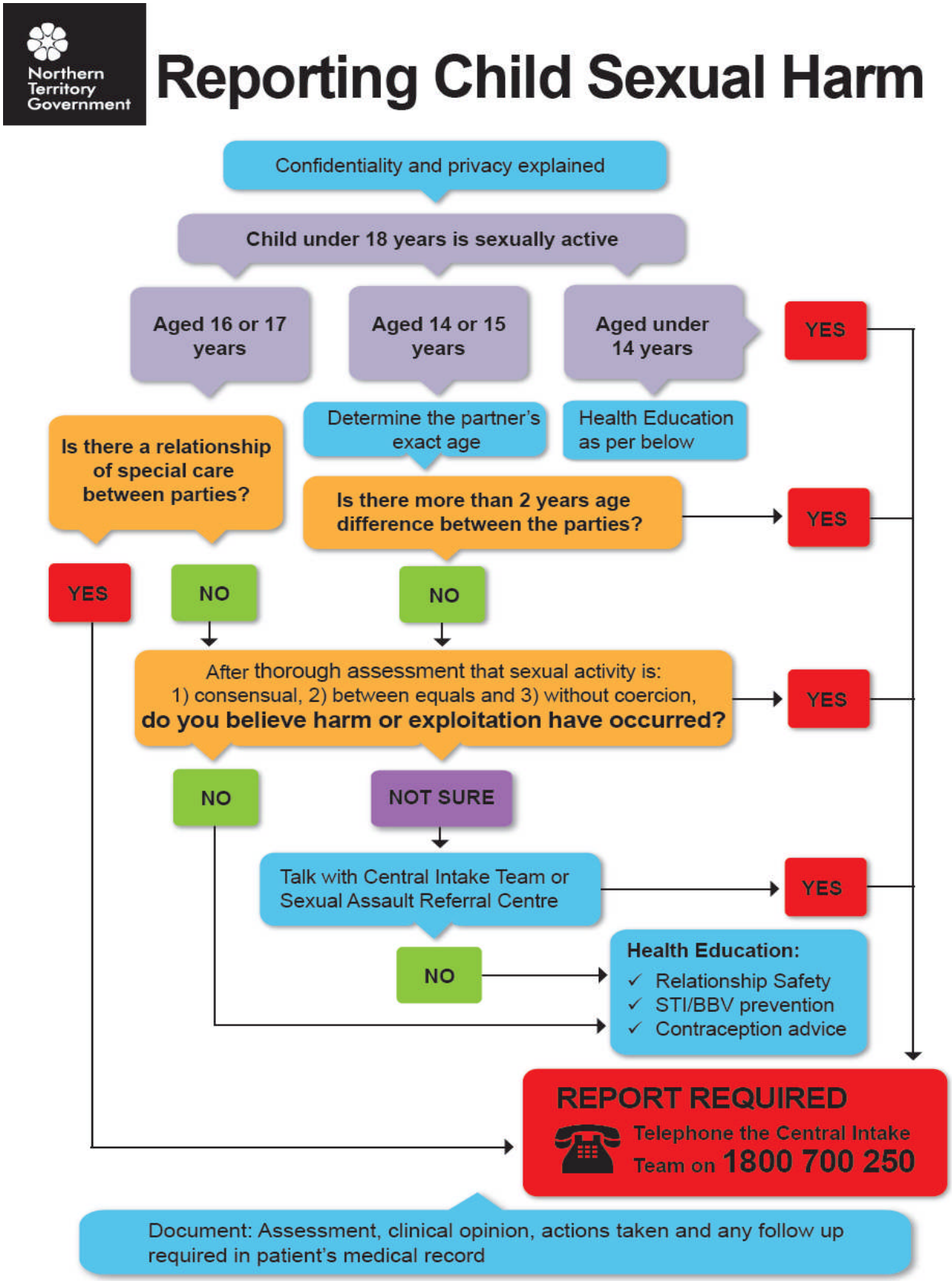
Where a PHCP believes that a sexual relationship involving a young person:

- is non-consensual (consider willingness, equality, coercion) and/or
- occurs between family members, or
- there are physical, emotional or behavioural signs that trigger concerns of actual or risk of harm,

the case must be reported to the Central Intake Team on 1800 700 250.

Regardless of the age of the young person, or whether the young person is being reported, staff should consider the possibility that the sexually active young person may have contracted an STI and/or become pregnant. In the event of an STI, it should be managed according to the organisation's clinical protocols, which should include investigation, treatment, contact tracing, education regarding safe sex practices and relationship safety. In the case of pregnancy, this should be managed according to regular clinical protocols.

The following chart outlines the required practitioner responses in relation to potential sexual harm.



KEY POINTS

- If the question of whether or not sexual harm or exploitation is or is likely to occur cannot be satisfactorily resolved in the mind of the PHCP, then the PHCP is strongly advised to discuss the case with the Central Intake Team.
- The PHCP should consider obtaining clinical and other advice relating to the need to report from appropriate sources.
- All sexually active under 14 year olds must be reported to the Central Intake Team, even if they attend with an adult.
- PHCPs must also explore whether any sexual activity in 14-15 year olds was or is likely to constitute harm or exploitation, and they must explore the age difference between the sexual partners.
- PHCPs must also consider whether:
  - Participants are willing to be involved in the sexual activity;
  - Each person is able to say 'No', or change their mind, and that is respected;
  - There is no coercion, pressure, or force;
  - There is equal power, control and developmental maturity;
  - Neither participant is temporarily under the influence of substances.

  If the PHCP assessment identifies that the sexual activity is between developmentally normal peers aged within two years of each other, and if the sexual relationship between the parties meets the above specific criteria, a report is not required.
- PHCPs must report cases where a 16-17 year old is in a sexual relationship with a person who has a 'special care relationship' with that young person.
- When a PHCP sees any person under the age of 18 they need to consider whether the young person is at risk of, or is being harmed or exploited – not just sexually
- Any non-consensual sexual activity involving a child is harmful and must be reported.

Section Four:

The Management of the Pregnant Young Woman

9. Pregnancy

The presentation of a pregnancy in a young woman under the age of 18 years is not uncommon, but the PHCP must carefully assess her to exclude the possibility of sexual abuse and to consider whether she is mature enough to consent to medical care. If there is any doubt about this, informal advice can be sought from the Central Intake Team.

Any PHCP who is involved in the management of a pregnant girl who is 13 years of age or younger, must report the case to the Central Intake Team. The CIT can provide advice so that a thorough assessment of both the clinical and social situation can occur.

9.1 Suggested Management Plan

It is necessary for the PHCP to spend time consulting with the young woman to build a relationship and to establish the circumstances under which the pregnancy occurred. This may need to be accomplished over several consultations.

As a result of this consultation process the PHCP will reach one of three possible conclusions:

1. The pregnancy was the result of a consensual sexual relationship.
2. The pregnancy occurred as a result of sexual abuse.
3. It is unclear if sexual abuse occurred.

9.2 Liaison and Reporting to Central Intake

Liaison and reporting to the Central Intake Team by the PHCP is indicated if:

- there is evidence of physical or sexual abuse
- there is uncertainty if there has been physical or sexual abuse
- the pregnancy has occurred in a girl under 14 years of age
- there is evidence of other factors that may affect the ability of the young mother to care for her child, such as immaturity, substance abuse, intellectual impairment or mental illness.

9.3 Ongoing Management of the Pregnancy

In the ongoing management of the pregnancy it is important that:

- Screening for STIs is offered in accordance with the routine antenatal protocols. Young people should be considered at high risk of STIs during pregnancy and repeated screening should be performed.
- The young woman is managed in the routine manner and delivered in the regional hospitals as appropriate to the clinical situation.
- Higher risk pregnancy in young women 13 to 14 years is managed in close consultation with the regional Obstetric Unit.
- Appropriate escort and support for confinement are arranged, especially for young people living in remote areas.
- The young person is referred to the hospital social work department at the time of confinement if DCF/Police and SARC are not involved.
- Contraceptive advice and safe sex counselling are offered at the time of confinement.

9.4 Terminations of Pregnancy in the Young Woman Under the Age of 16 Years

If a TOP is being considered it is important that counselling is offered to the young woman. As required by the Medical Services Act, the consent of the parents or guardians is required for the termination of a pregnancy in a young woman under the age of 16 years. (Should this not be possible or is difficult within a timeframe, the PHCP should discuss the situation with the Department legal department.)

KEY POINTS

- The presentation of a pregnancy in a young woman under the age of 18 years requires a careful assessment by the PHCP to exclude the possibility of sexual abuse.
- A thorough consultation needs to be undertaken in which the PHCP will reach one of three possible conclusions:
  1. The pregnancy was the result of a consensual sexual relationship.
  2. The pregnancy occurred as a result of sexual abuse.
  3. It is unclear if sexual abuse occurred.
- Reporting to the Central Intake Team is required if:
  - there is evidence that sexual abuse has occurred
  - there is uncertainty if sexual abuse has occurred
  - the pregnancy has occurred in a young woman under 14 years of age.
- In the ongoing management of the pregnancy it is important that:
  - investigations are undertaken for any STIs
  - higher risk pregnancy in young women 13 to 14 years should be managed in close consultation with the regional Obstetric Unit.
  - appropriate escort and support for confinement are arranged, especially for young people living in remote areas
  - the young person is referred to the hospital social work department at the time of confinement if DCF/Police and SARC are not involved
  - contraceptive advice and safe sex counselling are offered at the time of confinement.
- In the NT a young woman under the age of 16 years cannot consent to a TOP: this requires the consent of her parents or guardians.

Section Five:

Young People and Transactional Sex or Commercial Sex Work

10. Transactional Sex or Commercial Sex Work

Whilst commercial sex work occurs infrequently in young people under 18 years in the NT, anecdotal evidence suggests that significant numbers may be involved in transactional sex or 'sex-for-favours' arrangements.

'Sex-for-favours' is a practice engaged in by women, transgender people and men, for money, alcohol or other drugs, a place to stay, or other commodities such as food. Often younger women are more susceptible to being engaged in this behaviour. Young people who are involved in 'sex-for-favours' may not identify as sex workers or label their behaviour as an economic exchange. This makes it difficult for sexual health service providers to access this group.

Transactional sex is a high risk factor for STI/HIV in young people. Where transactional sex involves inter-generational relationships between older adults and young people the risks are exacerbated because of the relative powerlessness of young people to negotiate condom use and to avoid sexual coercion and violence.[23]

Although young people aged 16 years and over are considered legally of an age to consent to sexual activity, in the circumstances of transactional sex the ability to consent may be compromised by the manipulation of young people by adults for the purpose of exploitation. Young people under the age of 18 who are involved in transactional sex or in commercial sex work should be treated primarily as the victims of abuse under the definition of the Care and Protection of Children Act and reported to the Central Intake Team. The needs of these young people require careful assessment with consideration of the same issues regarding the sexual activity of young people as in Chapter 1 of these Guidelines.

As part of DCF strategy, these at-risk young people will then be referred to the Sex Worker Outreach Program (SWOP) to allow for education intervention around sexual health risks and safe sex practices. There must be a multi-disciplinary approach to provide these young people with STI screening, treatment of STI detected, vaccination against Hepatitis B and advice on contraception and on acquisition of HIV and other STIs.[2]

A sensitive non-judgemental approach is needed in order to establish a relationship of trust and confidence in the PHCP so that the circumstances that led to the behaviour can be explored. Associated health and social problems which may put these young people at future risk also need to be recognised and appropriate management strategies put in place, including referral to specialist services and other agencies.[2]

Young people involved in transactional sex or in commercial sex work must also be provided with strategies to assist them in avoiding this behaviour.[2] This will be one of the important foci of the specialist management of these young people.

KEY POINTS

- Young people under the age of 18 years involved in transactional sex or commercial sex work should be treated primarily as victims of abuse and be reported to the Central Intake Team. Their needs require careful assessment.
- A sensitive non-judgemental approach is needed in order to establish a relationship of trust and confidence in the PHCP and so that the circumstances that led to the young person's involvement in this work can be explored.
- Young people involved in transactional sex or commercial sex work need to be seen on a regular basis by either SWOP or by a PHCP.
- There must be a multidisciplinary approach to provide these young people with STI screening, STI treatment and advice, vaccination against hepatitis B, advice on acquisition of HIV, and contraception.

Section Six:

The Diagnosis and Management of Sexually Transmitted Infections in Children and Young People

11. STI in Children and Young People

Young people are at high risk of STIs and as a group are under tested. Therefore PHCPs should actively screen young people for STIs whenever possible, even in consensual apparently monogamous situations.

For information regarding causative agents, symptoms, investigations and contact tracing for each of the common STIs, refer to the 'Northern Territory Guidelines for the Management of STIs in the Primary Health Care Setting'.[19] Treatment protocols for adults and older young people are outlined in the same reference.

For information relating to children under 12 years, refer below in these Guidelines:

- Recommended laboratory tests for prepubertal children and non-sexually active young people – Appendix 3
- Practical Aspects of Laboratory Investigations for STIs – Appendix 4
- Treatment Protocols for children under 12 years – Appendix 5

11.1 Recommended Laboratory Tests

Refer to Appendix 3 in these Guidelines for recommended laboratory tests for prepubertal children and non-sexually active young people. For information regarding investigations for post-pubescent sexually active young people, refer to the 'NT Guidelines on the Management of STIs in the PHC Setting'.[37]

For prepubertal children and non-sexually active young people, the PHCP should only use a speculum for examination and collection of samples for laboratory tests as a last resort, and only after discussion with SARC.

As noted previously, in a clinical presentation of suspected child sexual abuse physical examination and the taking of laboratory specimens must not be conducted by the PHCP but deferred, pending advice from the Central Intake Team on whether a formal assessment is indicated. PHCPs must report all STIs to CIT, whether clinically apparent or laboratory proven, in people aged 13 years or younger. This is mandatory for Department employees and strongly recommended for employees of other services.

11.2 Interpreting STI Results

Sometimes the PHCP is faced with the dilemma of having a positive laboratory result for a STI in a child or young person for whom there was no other previous information or evidence regarding consensual sexual activity, sexual abuse or maltreatment. This underlines the importance of not undertaking tests without prior discussion with the SARC medical officer and prior consent from the young person or family member, which includes counselling about the possible implications of a positive result, and the possibility of a false positive result.

It is important to recognise that a positive laboratory result for a STI in a child or young person may be the result of one of the following circumstances:

- A STI has been contracted as a consequence of sexual abuse.
- The infection has been acquired as the result of peer sexual activity.
- The infection has been acquired as the result of inadvertent non-sexual spread, such as autoinoculation or non-sexual contact with another person.
- The infection has been acquired as a result of vertical spread from the mother (in children three years of age or younger).
- A 'false positive' has occurred as a consequence of either cross contamination of the specimen, or the specificity of the laboratory test that has been used.

STIs may be transmitted during sexual abuse. In children and young people the isolation of a sexually transmitted organism may be the first indication that abuse has occurred. Although the presence of a STI in a child beyond the neonatal period is suggestive of sexual abuse, exceptions do occur.[38]

Where a child of three years or under has tested positive for a STI, vertical transmission is a possibility, but sexual abuse will need to be considered.[2] In this age group a rectal or genital infection with Chlamydia Trachomatis (CT) may be the result of a perinatally acquired infection which may persist for as long as three years.[38] Where a prepubertal young person above the age of three years has tested positive for a STI, sexual abuse must be considered as the most likely mode of transmission, however perinatal transmission should also be excluded as far as it is possible or feasible.[2]

It is also important to understand that a STI that has been diagnosed in a child or young person may be a pre-existing infection that has remained undiagnosed for months or years. Such a pre-existing infection may be related to prolonged colonisation immediately following a vaginal birth or as an infant, or may be related to inadvertent non-sexual spread, prior peer sexual activity, or prior abuse.[39]

11.3 Intervention for Confirmed Cases of STIs

As stated previously, it is a Department policy requirement for PHCPs to immediately inform the Central Intake Team when they become aware of positive laboratory results for a STI in a person aged 13 years or younger. A SARC medical officer will then liaise with the PHCP from whom the positive laboratory result has originated to determine whether the sexual activity is likely to have been consensual and in need of no further action, or whether the positive STI result may possibly indicate harm and so require further investigation.

Positive laboratory results for young people 14 years or older need not be routinely reported to the Central Intake Team unless sexual abuse is suspected. If sexual abuse cannot be excluded or there is uncertainty, the PHCP should seek advice.

It is important that test results are carefully communicated to the young person and family, with follow-up consultations arranged to ensure that the information has been correctly understood.

When the only indicator of sexual abuse in a child is a possible STI, it is not always apparent who a possible offender may be. The PHCP is unable to discuss with the family any aspect of a formal investigation into the allegations of abuse. Where appropriate, it can be explained that the Police and DCF will be informed of the positive STI result and will be involved in the investigation into the possibility of child sexual abuse. The PHCP is limited to providing medical information on the management of the STI and assisting the family to understand the possible causes. The child and family can be referred to SARC for support and counselling.

11.4 Treatment Protocols

Appendix 5 outlines STI treatment protocols for children under 12 years.

Young people who have symptoms of a STI should have the appropriate tests taken and then be offered immediate treatment. If not already done, young people with positive results who did not have symptoms at the time of the test should be offered a full STI screen immediately prior to starting treatment.

11.5 Contact tracing of the young person who has an STI

Contact tracing means informing an infected person's sexual partners of the need for testing and treatment of STIs. The purpose of this is to reduce re-infection and detect asymptomatic cases, who may be at risk of complications and further transmission. Responsibility for

contact tracing lies with the PHCP. Contact tracing may be done by the PHCP directly, or by assisting the client to notify their partner themselves.

Contact tracing has a high priority for sexually active young people. Female partners of young men are a particular priority due to the relative absence of symptoms and high-risk of complications such as infertility. The PHCP should offer all of an adolescent's sexual partners in the last 3 months a sexual health check-up. The same tests and treatment as for the presenting adolescent should be commenced immediately, even if they are asymptomatic and test results are not confirmed. Safe sexual practices should also be discussed.

Any person who is a possible sexual contact and who has symptoms of a possible STI should be offered a full STI check-up as per standard protocol recommendations. (Refer to either the CARPA Standard Treatment Manual, the Nganampa Health Council/Congress Alukura Women's Business Manual or the NT Government Centre for Disease Control website.)

In pre-pubertal children, and following non-consensual sexual activity, contact tracing should be performed with caution and only in conjunction with advice from a SARC medical officer. While a positive STI result in a child 3 years and younger may possibly be the result of vertical transmission, in a prepubertal child over 3 years, sexual abuse is the most likely cause of transmission. Therefore, contact tracing forms a part of the child sexual abuse investigation and should not be performed by the PHCP.

Key Points

For information regarding causative agents, symptoms, investigations and contact tracing for each of the common STIs, refer to the NT Centre for Disease Control 'Northern Territory Guidelines for the Management of STIs in the Primary Health Care Setting'.[27] Treatment protocols for adults and older young people are outlined in the same reference.

- For information regarding STI investigations for prepubescent children and non-sexually active young people, including contact tracing, refer to Appendix 3.
- For details of the practical aspects of laboratory Investigations for STIs, refer to Appendix 4.
- For treatment protocols for children under 12 years, refer to Appendix 5.
- It is important to recognise that a number of different circumstances may lead to a positive laboratory result for a STI. However, the isolation of a sexually transmitted organism may be the first indication that sexual abuse has occurred.
- In a clinical presentation of suspected child sexual abuse, physical examination and the taking of laboratory specimens must not be conducted by the PHCP but deferred, pending advice from the Central Intake Team regarding whether a forensic medical examination is indicated.
- PHCPs must report people aged 13 years or younger who have STIs, whether clinically apparent or laboratory proven. This is mandatory for Department employees and strongly recommended for employees of other services.
- Contact tracing requires informed consent. It is the responsibility of the PHCP and has a high priority.

Contact tracing is important not only to detect STIs in the contacts of a child or young person, but also to determine whether the more unlikely event of vertical transmission has occurred.

Appendices

Appendix 1: Important Contact Numbers

Child Protection Hotline / Central Intake Team (24-hour number) (DCF and Police child abuse reporting line)	**1800 700 250**
Police (24-hour number)	131 444
Via NT Government Switchboard	8999 5511
Sexual Assault Referral Centre (SARC)	
Darwin	8922 6472
Katherine	8973 8538
Alice Springs	8955 4500
Tennant Creek	8962 4100
Mobile Outreach Service (MOS Plus)	1800 993 064
Hospitals	
Royal Darwin Hospital	8922 8888
Katherine Hospital	8973 9211
Nhulunbuy Hospital	8987 0211
Alice Springs Hospital	8951 7777
Tennant Creek Hospital	8962 4399
Patient Assisted Travel Scheme (PATS)	
Darwin	
Maningrida, Oenpelli, Jabiru, Croker Is, Goulburn Is	8922 8134
Daly River, Peppimenarti, Wadeye, Tiwi Is, Woodycupildiya	8922 8391
Katherine	8973 9206
Gove 8987 0222	
Alice Springs	8951 7979
Tennant Creek	8962 4262
Witness Assistance Service	1800 659 449
Darwin	8935 7500
Alice Springs	8951 5800
DV/SA National Hot Line	1800 019 116
Ruby Gaea, Darwin Centre Against Rape	8945 0155
Catholic Care Katherine	8971 0777

Appendix 2: Forensic Examination of Children

The circumstances surrounding a sexual assault and the professional response to it can be very confusing, frightening and stressful for a child. If a forensic consult and examination are required, it is preferable that the child is examined only once.

If the PHCP has a belief of sexual assault of a child, it is important to discuss the best way to organise forensic and general clinical examinations with the SARC doctor, so that examinations are not repeated unnecessarily, and forensic evidence may be preserved. Discuss the case with the Sexual Assault Referral Centre (SARC) The SARC doctor will advise whether a general clinical examination and/or a Forensic Medical Examination (FME) is required, and the SARC case coordinator will liaise with the PHCP to organise the latter.

Practitioner Role

In cases of acute sexual assault it may be appropriate for PHCPs to:

- Conduct general clinical examinations. This would involve looking for injuries (including the external genitals) and treating as necessary. Do not do a vaginal or rectal examination (unless serious injuries need treatment);
- Do not wash the person;
- Collect any body fluid loss, e.g. via nappies, pads or clothing; and other specimens such as clothing, blankets etc. These must be placed in separate paper bags and signed and sealed. To maintain the chain of custody the name of the person who received the items (police, parent, flight nurse) must be documented and their signature obtained. Document all findings and anything the person has said in the notes.

Forensic Medical Examination

Where a FME in sexual assault is required, its purpose is to provide evidence:

1. that the event(s) occurred
2. that consent was not given
3. of the identity of the alleged perpetrator.

For example, in a case of alleged recent non-consensual vaginal penetration of a young woman taken to a beach there may be evidence of:

- the crime scene e.g. sand, shells, etc. on the person and clothing;
- vaginal penetration and ejaculation e.g. genital injury, semen and sperm from genital specimens and clothing;
- non-consensuality e.g. signs of injury, presence of alcohol or drugs; or
- the alleged perpetrator e.g. DNA from forensic specimens taken from victim's genital tract.

Useful forensic evidence is progressively lost from the time of the event, so if a FME is required it needs to be done as soon as possible. SARC, Police and Child Protection Services (CPS) will all be involved. The child should be interviewed by Police and CPS beforehand.

In contrast, where a child discloses past abuse it will not be useful to search for acute injuries or to collect genital specimens for DNA. However a FME may still be indicated in many such cases to detect signs of past penetration. It is important to note that in the majority of cases the findings from the examination will be 'normal', but this does not exclude the possibility that the abuse occurred as alleged, for which there are many reasons.

In general, a forensic examination of a child includes:

1. A general physical examination, looking for acute and healing or longstanding injury
2. An ano-genital examination, looking for acute and healing or longstanding injury (eg damage to the hymen), evidence of anal penetration +/- ejaculation
3. Collection of forensic specimens, guided by history:
    - prepubertal female: vulval, perineal, perianal, oral
    - pubertal female: as above plus, low vaginal, high vaginal, +/- cervical
    - male: urethral, head and shaft of penis, perianal, perineal, oral
    - swabs may be taken from other sites – for instance places where the alleged perpetrator may have sucked, bitten, kissed, and left DNA
    - very occasionally in assaulted children, examinations are conducted under anaesthetic, and additional forensic specimens may be collected at that time.
4. Collection of clothing the child was wearing at the time of the assault.

If indicated by the type of sexual contact disclosed, SARC doctors address the child's sexual health through testing for STIs and the provision of prophylactic medication, advising the health centre about treatment, 3-month checks etc.

In most cases, SARC doctors make video-recordings of genital examinations using a colposcope in order to avoid having the child re-examined. The colposcope provides magnification of the area being examined. Consent is required for this (and the entire consultation).These recordings are only ever viewed by other forensically trained doctors for the purpose of second opinions, and review prior to court cases, and contain no identifying information.

During the consultation and examination, young children are chaperoned by the SARC counsellor or his/her carer. Older young people may choose to be examined alone or not. Note that potential suspects are not appropriate chaperones.

The child and his or her carer may frequently be concerned that:

- the examination will include penetration or instrumentation – it is very uncommon to insert objects into the child's vagina or anus;
- the examination will be painful – it should not be painful - the doctor looks at the external genitalia only;
- the child will be restrained – this would only occur if there is an urgent medical reason (eg the child is bleeding) but it is likely that an examination under anaesthesia would be advised in these cases

(Modified from notes from 'Paediatric forensic medicine unit book'.[41])

Young people have traditionally undergone forensic examinations at a SARC facility in Darwin or Alice Springs, however where appropriate it is possible that these can be conducted locally, through Forensic Medical Examinations for Children in your Community (FMECC) For more information about accessing FMECC contact SARC.

Appendix 3: Recommended Laboratory Tests for Prepubertal Children and Non-Sexually Active Young People

Prepubertal children and non-sexually active young people who present with symptoms of a possible STI need the following standard laboratory tests taken. Testing should not be used to screen for infections in the absence of symptoms of disease or any specific concern about child sexual assault. The tests below are for STI screening only, other tests may also be indicated by the clinical presentation. If presumptive treatment for an STI is given it is important to consider testing other sites (eg throat/anus) as treatment may affect future test results.

Prepubertal Female

1.	A vulval swab	:	MCS
2.	Two vulval swabs	:	NAAT for CT, NG, TV
3.	First void urine	:	MCS, NAAT for CT, NG, TV
4.	Two throat swabs	:	MCS, NAAT for CT
5.	Mid stream urine	:	MCS (if symptoms of dysuria or frequency present)
6.	Blood test	:	Syphilis, HIV
	and, if a genital ulcer or other lesion (eg blister) is present:		
7.	Two swabs of the lesion	:	MCS for general bacteriology, NAAT for herpes, syphilis and donovanosis

Prepubertal Male

1.	A urethral meatal swab	:	MCS (only if urethral discharge if present)
2.	Two urethral meatal swabs	:	NAAT for CT, NG, TV (only if urethral discharge is present)
3.	First void urine	:	MCS, NAAT for CT, NG, TV
4.	Two throat swabs	:	MCS, NAAT for CT
5.	Mid stream urine	:	MCS (if symptoms of dysuria or frequency present)
6.	Blood test	:	Syphilis, HIV
	and, if a genital ulcer or other lesion (eg blister) is present:		
7.	Two swabs of the lesion	:	MCS, NAAT for herpes, syphilis and donovanosis

Appendix 4: Practical Aspects of Laboratory Investigations for STIs

1. Collection and Handling of Specimens

PHCPs should follow the laboratories' guidelines for preferred specimen collection and handling. Specimens collected for successful culture in the NT require swift and careful handling to preserve the organism's viability. Specimens for NAAT are more durable.

It is important to take swabs from multiple sites since infections are often asymptomatic and may be discovered at sites not indicated by the history.[40]

2. Diagnostic Methods

The mainstays of STI diagnostic methods used are culture, serology and NAAT. Specimens are sent from some Community Health Centres to private pathology providers. SARC specimens and hospital specimens are sent to the NT hospital laboratories. There may be variations in methods used in the laboratories.

Culture Methods

- Bacterial culture: Swabs need to be placed into appropriate transport media (e.g. Amies transport medium). Amies specimens should be stored and transported at room temperature to reach the laboratory as soon as possible. Refrigeration will kill the bacteria. (Chlamydia culture is not available in the NT.)
- Viral culture (HSV): HSV is intracellular so cells must be collected by rubbing the ulcers with swabs provided. (If blisters are present they should be ruptured.) Swabs should be placed immediately into viral transport medium, and should be stored at $4^{o}C$ and reach the laboratory within 24 hours. Herpes culture is not done in the NT and is referred to an interstate reference laboratory if required. In the NT time, temperature and travel reduce the sensitivity of this method considerably and therefore PCR is preferred.

Diagnostic culture is not available for HPV (the virus causing warts), nor for the Poxvirus (which causes molluscum contagiosum).

Nucleic Acid Amplification Testing (NAAT)

NAATs are the most widely used tests in the NT for the detection of chlamydia, gonorrhoea, trichomonas and herpes. There are several types of NAATs available: Polymerase Chain Reaction (PCR) and Transcription Mediated Amplification (TMA) are the two commonest. PCR and TMA are available for the diagnosis of gonorrhoea, chlamydia and trichomonas. In the prevailing conditions in the NT, these tests are sensitive and generally specific. NAAT tests are also available for the diagnosis of genital ulcers caused by donovanosis, herpes, and syphilis. NAAT tests for gonorrhoea, chlamydia and trichomonas can be done on first void urines as well as on genital swab specimens. Although NAAT testing is used diagnostically in children, it has not been fully validated, and results should be interpreted with caution.

NAATs detect the genetic material of the organism and are the most sensitive of available tests (that is, they will detect the largest numbers of infections), but can be prone to false positive results. This is particularly the case with NAATs for detection of Neisseria gonorrhoeae (NG), as genetic material from other Neisseria species is known to cross-react with the test. Cross-reacting normal commensal Neisseria species may be present at the site tested, especially for anal and pharyngeal testing, or can contaminate the specimen via contact with contaminated bench tops, door handles, fingers or hands or even by micro droplet splashing. Therefore, all positive N. gonorrhoeae results should be retested using a different type of NAAT test, and/or culture. In cases of possible sexual abuse, because of the gravity and medico-legal nature of the situation, this practice would also be followed to confirm a positive diagnosis of other organisms. This may require the collection of an extra specimen at the time of initial investigation. Due to the potential for false positive results from

cross contamination, it is essential that specimens are taken with gloves on and that the swabs are protected from touching any other surface such as bench tops.

Because of the potential difficulties interpreting results, along with the serious implications of any diagnoses, PHCPs should always discuss a positive result with SARC, where medical advice is available 24 hours a day. It is preferable that treatment is not commenced until a second test has been taken. However treatment is advisable before the results are known if the child/ young person is unwell.

3. Serology is Used in the NT for the Diagnosis of:

- Syphilis
- Hepatitis B
- HIV

The interpretation of syphilis and HBV serology is sometimes complicated and it is recommended that PHCPs contact the SHBBV Unit for advice.

Appendix 5: Treatment Protocols for Children Under 12 Years

- PHCPs should always discuss a positive result with SARC, which provides medical advice 24 hours a day
- Preferably do not treat until a second test has been taken
- Treatment is advisable before the results are known if the child/young person is unwell

TREATMENT PROTOCOL	
Condition/infection	***Suggested treatment for children under 12 years***
Chlamydia	Azithromycin, 20mg/kg as one dose (only if over six kg) or Erythromycin CARPA doses bd for 10 days (maximum 2 g/day) or Doxycycline 2mg/kg bd (max. 100mg bd) for 10 days (Doxycycline can be administered to children over eight years of age)
Acquired Syphilis	Benzathine penicillin 37.5mg or 50,000 units per kg (or 37.5 mg/kg) as a single injection given once or three times at weekly intervals depending on the stage of disease. 6kg to 12 kg 600,000 units 12kg to 18kg 900,000 units 18kg to 24kg 1.2 million units 24kg to 30kg 1.5 million 30kg to 36kg 1.8 million units 36kg to 42kg 2.1 million units over 42kg 2.4 million units
Congenital Syphilis	Refer to Clinic 34.
Gonorrhoea	The choice of antibiotic will depend upon the anatomical site and geographical location of the source of the infection **Genital *Neisseria Gonorrhoeae*** If the origin of infection is a person normally resident in the NT, treatment is with Amoxycillin and Probenecid. If it is from a person from outside the NT, Ceftriaxone is used instead because of the high prevalence of penicillin resistance outside the NT. Origin from person normally resident in the NT: Amoxycillin 50mg/kg (max 3g) stat orally in a single dose Probenecid 25mg/kg (max 1g) stat orally in a single dose

Gonorrhoea (cont'd)	Origin from outside the NT: Ceftriaxone < 45kg body wt 250mg IM or IV stat > 45kg body wt 500mg IM or IV stat **For penicillinase producing strains (PPNG)** Ceftriaxone < 45kg body wt 250mg IM or IV stat > 45kg body wt 500mg IM or IV stat **Pharyngeal or Rectal infections** Ceftriaxone as above according to weight in all cases **Gonococcal Ophthalmia** (in neonates and infants) Ceftriaxone 25mg/kg IM daily for three days up to a maximum dose of 1 gram **Disseminated Gonococcal Infection** (in neonates and infants) Arrange urgent transfer to paediatric in-patient team If systemically unwell give Ceftriaxone 25mg/kg up to 1 gram IV or IM stat In patients allergic to penicillin and cephalosporins, discuss with Clinic 34
Trichomonas	Tinidazole 50mg/kg up to 2g as single dose or Metronidazole 30mg/kg up to 2g as single dose or Metronidazole 20 to 30 mg/kg per day in three divided doses for five to eight days.
Pelvic Inflammatory Disease	**All children under 12 years of age with PID should be treated as hospital inpatients**
Anogenital Warts	Spontaneous regression normally occurs, but may take years. If extensive, or in tender areas, diathermy under general anaesthetic is recommended. Older children may tolerate cryotherapy with local anaesthesia. Recurrence after diathermy or cryotherapy is common. Topical paints and creams are available but should only be considered in consultation with a specialist paediatrician or sexual health physician.
Genital Herpes	**First Episode** Treat if within three days of start of episode or while new lesions are still developing Acyclovir 5mg/kg up to 200mg orally five times a day for five days **Recurrence** If episodic or suppressive therapy is required refer to the Darwin or Alice Springs Sexual Health Units. Valaciclovir and Famciclovir are not licensed for use in children.

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