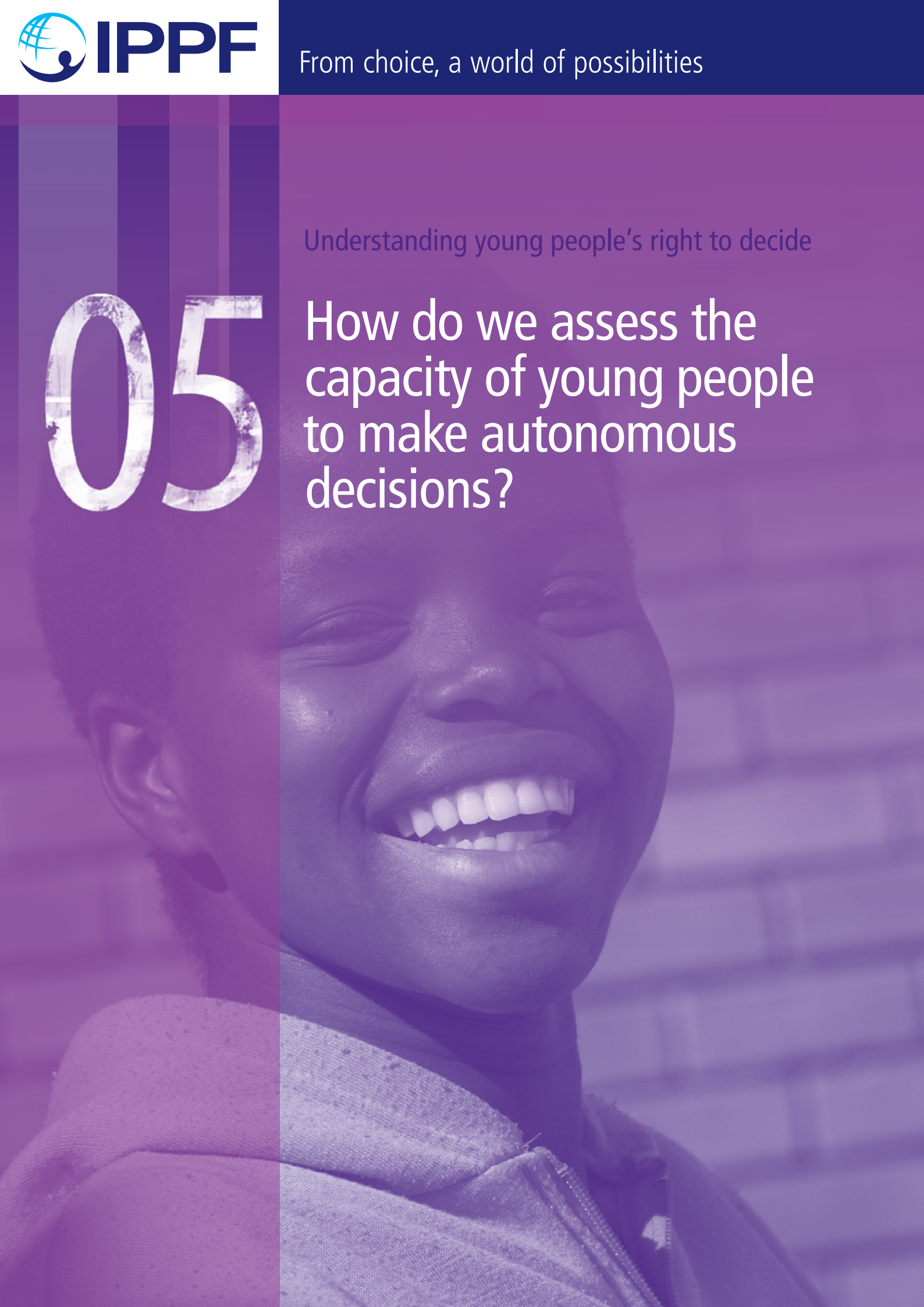
IPPF

From choice, a world of possibilities

Understanding young people's right to decide

05

How do we assess the capacity of young people to make autonomous decisions?



About the Right to Decide series

The International Planned Parenthood Federation (IPPF) works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. We defend the right of all young people to enjoy their sexuality free from ill-health, unwanted pregnancy, violence and discrimination.

IPPF believes that all young people have the right to make autonomous decisions about their sexual and reproductive health in line with their evolving capacities. We also recognize that the estimated 1.7 billion young people in the world are sexual beings with diverse needs, desires, hopes, dreams, problems, concerns, preferences and priorities. Amongst the 1.7 billion, there are young people living with HIV; young women facing unwanted pregnancy and seeking abortion services; young people with an unmet need for contraception; people with sexually transmitted infections and lesbian, gay, transgender and bisexual young people. IPPF advocates for the eradication of barriers that inhibit access to comprehensive sexuality education, information and sexual and reproductive health services that respond to all young people's needs and realities.

One such barrier that impedes young people's access to education and services is the widely-held and historically-rooted belief that young people are incapable of making positive decisions about their own sexual and reproductive health. IPPF's experience providing education, information and services around the world for the past 60 years tells us that this is untrue. Thus, in 2010 IPPF initiated a year-long project to learn more about young people, autonomy and sexual rights from experts working on these topics in various fields. We wanted to understand the theory behind the laws, policies and practices that both facilitate and restrict young people's autonomy as well as the key factors contributing to the development of young people as autonomous decision-makers.

IPPF commissioned five experts to answer the following questions that form the basis of the papers you find in the Right to Decide series:

1. What is childhood? What do we mean when we say 'young person'?
2. Why is it important to develop young people's capacities for autonomous decision making?
3. Are protection and autonomy opposing concepts?
4. How can parents support young people's autonomous decision making?
5. How do we assess young people's capacity to make autonomous decisions?

With an enhanced understanding of young people, autonomy and sexual rights, we hope to be better placed to promote and fulfill our vision of a world where young people are recognized as rights-holders, decision-makers and sexual beings whose contributions, opinions and thoughts are valued equally, particularly in relation to their own sexual and reproductive health and well-being.

About the authors

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Simon Blake is Chief Executive of Brook, the young people's sexual health charity in the UK whose mission is to enable young people to enjoy their sexuality without harm. Simon is an educator, writer, trainer and campaigner for young people's sexual rights and an advocate for high quality health services and education for young people. In 2011 Simon was awarded an OBE for services to the voluntary sector and young people.

PHOTO CREDIT: Nancy Durrell McKenna/SafeHands for Mothers

01 Introduction

The decisions that young people make in relation to their sexual and reproductive health can transform their personal relationships, identities, and the future opportunities and choices available to them.[i] At different ages, circumstances and contexts, children and young people are required to make decisions and take responsibility for their bodies, their health and their futures. This includes setting boundaries around relationships, intimacy and sexual experiences; negotiating consent, desire, gender and sexual identity; and taking responsibility for decisions about contraception, pregnancy and parenthood. This process of making decisions is part of a young person's personal development and when young people are given the rights and support to make autonomous and consensual decisions, can be a positive and empowering experience.

The international context

The United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child recognizes the right for all children and young people to participate in the decision-making processes that affect their lives and to have their views and opinions listened to and respected by parents and other adults.[ii] The links between human rights and sexual health, and the importance of adopting rights-based approaches to young people's sexual health programming, are increasingly well documented and operationalized.[1]

The United Nations Convention on the Rights of the Child provides the clearest rationale for the need for governments to protect and enable children to fulfil their sexual rights.[iii] The Convention places a duty on governments to provide children with access to the health care services (article 24), education (articles 28 and 29) and information (article 17) that they need in order to achieve a good standard of health and well-being. It also requires governments to protect all children and young people from all forms of violence, abuse (article 19), sexual exploitation (article 34), trafficking, child prostitution and involvement in pornography (article 35).

The Convention also addresses the tension between parental and children's rights in the concept of the 'evolving capacities' of the child (article 5). This concept recognizes that the need for state and parental protection of children diminishes as the child's competency and capacity to take responsibility for decisions affecting their lives increases. The principle of a child's 'evolving capacity' has far-reaching implications for the delivery of services to young people, as it challenges assumptions about the priority of parental over children's rights.[iv]

It places an obligation on states to provide varying levels and types of support for young people that are sensitive to the young person's evolving level of maturity and competence. This presents a challenge to providers of sexual and reproductive health and youth services since it requires that services are able to first understand and assess a young person's capacity in order to facilitate appropriate service provision. According to this principle, the assessment of a young person's capacity therefore becomes a necessary part of providing services that will both protect and empower young people in their sexual decision-making processes.

How to implement the ideals of the Convention

One of the many challenges for providers of sexual and reproductive health, education and youth services is how to implement the ideals of the Convention in policy and practice. These services share with other occupations working with the welfare and medical systems "the classic dilemma between respecting individual choice and promoting the public good, between empowering and controlling, balancing the roles of carer, protector, advocate and liberator."[v] How can sexual and reproductive health service providers respect and enable a young person's views and choices in situations where those views and choices could be harmful to the young person or to others? How can services support young people to develop their capacity for autonomy in situations where protecting their right to safety from harm may mean limiting and controlling the choices they have?

1. For the importance and complexities involved in adopting a rights-based approach to international sexual health programming, see Petchesky 2000. For a summary of relevant international legislation, see Wood et al 2006. For examples of rights-based approaches, see International Planned Parenthood Federation 2008, or Wood et al 2006 for case study examples of international projects that place young people's rights at the heart of HIV prevention work with vulnerable young people.

In this paper I aim to address these questions through discussing examples of research, policy and good practice from the UK that can be utilized to enhance the understanding, assessment and development of young people's capacity for autonomous decision-making. Young people's capacity to exercise autonomy, choice and independence in relation to their sexual and reproductive health varies enormously between and within different countries, cultures and contexts, as do the legal systems that support or diminish these rights. Making cross-national comparisons of research, policy and practice is complex since it requires knowledge of the specific national social, demographic and economic contexts.[vi,vii] It is also important to recognize the cultural, social and national distinctions in understandings of 'youth' and the fact that broad conceptualizations of 'youth' may mean that the experiences and voices of certain marginalized and vulnerable groups of young people remain silenced.[viii] Addressing the rights of 'young people' in general, however, is a valuable way to recognize the importance of 'youth' as a conceptual category and social status that has been previously marginalized and poorly understood in both academic research and international and national policy making.[ix–xii]

The UK context

Legal and policy framework

The legal and policy framework in the UK is broadly supportive of young people's sexual rights and provides a favourable administrative context within which to support the development of young people's sexual autonomy. A range of UK government policy and service delivery documents now recognize young people's right to participate in decision-making processes and the need for public services to provide opportunities for young people to obtain the knowledge and skills required to make informed decisions.[xiii,xiv] Young people have the right to access confidential sexual health services that must provide information and advice on sexual and reproductive health as well as access to contraception and legal abortion. (Abortion remains illegal in Northern Ireland.)

In the last decade there has been significant legislative progress in relation to young people's sexualities in the UK such as the equalization of the age of consent between gay and straight young people and between the different countries within the UK. The last UK government (1997–2010) focused on teenage pregnancy as a central policy concern which led to increased funding for sexual health services and initiatives for young people, and for young parents in particular. As a result, there are now more sexual health services, more targeted and outreach work with young people, and more training for staff.[xv]

Comprehensive sexuality education

There are, however, limitations to UK policy and practice in relation to young people's sexual rights, particularly with respect to the design and delivery of sexuality education in schools. The academic literature remains highly critical of UK policy relating to comprehensive sexuality education as outlined in section 03 of this paper. A recent survey of young people's experiences of comprehensive sexuality education found that young people are not satisfied with the sexuality education that they receive.[xvi] The provision of sexuality education in schools is non-statutory outside of the science curriculum, and the content and quality of sexuality education delivery across schools remains highly variable.[xvii–xix]

Teenage pregnancy rates remain high in the UK relative to other European countries,[xx] and the rates of sexually transmitted infection rates are increasing among young people, particularly in young women.[xxi] Despite these limitations and much-needed areas for improvement, the UK offers examples of sound legislation and excellent practice relating to how services can support the assessment and development of young people's autonomous sexual decision-making.

Outline of this paper

02: Socio-cultural factors

In this section, I explore the socio-cultural factors that have been found to impact on a young person's capacity to exercise autonomy and choice in their sexual decision-making practices. I draw on findings from the research literature to highlight the importance of gender practices in shaping young people's experiences of choice, agency and autonomy. I then discuss the implications of this research for sexual health programming and service delivery.

03: Comprehensive sexuality education

In this section, I explore the possibilities and limitations of comprehensive sexuality education as a tool for supporting young people to develop their capacity to make autonomous decisions about their sexual health. There is a large body of research literature on the design and delivery of comprehensive sexuality education in the UK, much of which highlights the limitations of current sexuality education models and makes recommendations for improved policy and practice. I summarize these critiques as a way of outlining models of good practice in using comprehensive sexuality education to increase young people's capacity to make autonomous decisions.

04: Assessing decision-making capacity

In the final section of the paper I explore how practitioners can assess a young person's capacity for decision-making in the context of a clinical consultation. I consider the legislation, training and support required by practitioners in order to assess a young person's capacity and offer some examples of good practice in this area. In this final section I present examples of organizational policy and practice from Brook – one of the UK's leading providers of sexual health services for young people.

02 Socio-cultural factors

Autonomy in decision-making

Late modern social theorists such as Anthony Giddens and Ulrich Beck have made the transformation of personal relationships the focus of their analysis of 20th century social change in Western societies[xxii–xxv] arguing that there has been a decline in the importance of relationships based on the social obligations of class or community and an increase in relationships that are freely chosen and based on personal fulfilment. Adopting this approach would suggest that a young person in contemporary Western society has greater autonomy to make decisions and choices about their relationships than was experienced by previous generations.

Empirical research with young people on their sex and relationship experiences, however, critiques this notion of free choice in sexual and romantic practices and suggests that young people's material experiences, educational trajectories, family and community ties, faith and ethnicity all impact on the decisions that they make about sex, relationships, parenthood and marriage.[xxvi,xxvii] For example, strong class differences in the UK continue to shape gender and sexual practices on key decisions such as motherhood. The evidence that many young middle class women are choosing to delay motherhood, as they attempt to first establish careers and independence, lies in stark contrast to the reality that the UK has among the highest numbers of teenage mothers in Europe, the majority of whom are from lower socio-economic backgrounds without the educational and career opportunities afforded many of their middle class counterparts.[2] [xxviii,xxix]

Gender and gender relations

The body of qualitative research generated over the last two decades has contributed to our understanding of how social, structural factors, power relations and inequalities impact on young people's sexual experiences. A key thread that has emerged from this empirical work is the importance of gender and gender relations in understanding sexuality and young people's sexual experiences.[xxx,xxxi] This body of work has contributed to our understanding of the social construction of sexuality and central to this process has been an analysis of gender and an attempt to understand how the way in which young people understand and experience their gender identity impacts on the decisions that they make, their ability to put these decisions into practice, and in particular on their capacity to negotiate safe, consensual and pleasurable sexual activity.

A young person's gender identity is central to their developing sense of themselves and their sexuality and is closely interwoven with other forms of social identity such as class, ethnicity and sexuality.[3] Since poverty is both a cause and consequence of gender and sexual inequality,[xxxii] the gendered constraints on young people's capacity for 'safety' and autonomy described below may be more acutely experienced by young people who have limited economic freedom and resources.

The sexual double standard

Over three decades of research with young women has demonstrated how the double standard of sexual morality impacts on women's daily lives, sexual interactions and on their capacity to keep themselves safe.[xxxiii–xxxix] In her seminal study in London in the 1980s, Sue Lees identified these dominant gendered ideas about sexuality as the 'slag/drag dichotomy' and the myth of uncontrollable male sexuality.[xl] She found that these pervasive ideas about sexuality were used to justify sexual violence against women, and to judge and discipline young women's talk, dress and sexual interactions.[xli]

Numerous other qualitative studies on young people's sexuality both in the UK and internationally have echoed these findings, demonstrating the persistence of the sexual double standard and the difficulties that this presents for young people in negotiating their daily and sexual interactions.[xlii] Recent research with young people supported

2. Research on experiences of young motherhood in other countries has similarly found that economic inequality and levels of education have impacted on decisions and experiences relating to motherhood (see Sánchez Buitrago 2005). Two recent reviews of the global literature on sexual behaviours drew different conclusions on the degree of regional similarity and disparity in research findings but both concluded that structural social factors, in particular gender inequality, are highly significant in shaping sexual behaviour (see Marston and King 2006, and Wellings et al 2006). The data presented in both reviews make a powerful case for a sexual and reproductive health intervention focus on the broader determinants of sexual health, such as poverty and mobility, but especially gender inequality.

3. For discussion of the relationship between class and gender and the impact on young people's negotiation of their sexualities in the UK, see Walkerdine et al 2001. See Frosh et al 2002 for discussion of the intersection of ethnicity and class with masculine identities.

by UNICEF and the Terrence Higgins Trust demonstrated young people's awareness of the way that social attitudes about gender and sexuality impact on the decisions that they make about their sexuality, with the young female participants claiming that fear of being judged or labelled a 'slag' or a 'slut' impacts directly on their use of condoms and sexual health services.[xliii]

The Women Risk and AIDS Project (WRAP), a study of heterosexual relationships in the UK in the 1990s, demonstrated the impact of dominant conventions of heterosexual femininity and masculinity on the ability of young women to initiate and negotiate safer sex in relationships.[xliv] Conducted in the context of rising HIV infections among young heterosexuals, this study demonstrated that the dissemination of knowledge about contraception and sexual health does not necessarily translate into safer sexual practices.[xlv] The interviews conducted with young women showed that a decision to use condoms was not a rational choice about personal safety, but part of a contested process of negotiation in which young people have to manage expectations and uncertainties about being masculine and feminine.[xlvi]

> "To be conventionally feminine is to appear sexually unknowing, to aspire to a relationship, to let sex 'happen', to trust to love and to make men happy. Safe sex is not just a question of using protection, avoiding penetration, or being chaste, it brings questions of power, trust and female agency into sexual relationships."[xlvii]

The young women interviewed for the Women Risk and AIDS Project study understood the risks of having unprotected sex and frequently had the intention of 'choosing' safe sex. However, in their sexual interactions with partners they found that insisting on contraception use or refusing penetrative sex threatened to disrupt notions of love and trust and presented a risk to their feminine identity.[xlviii] Sexual decision-making was not "an issue of free choice between equals, but as one of negotiation within structurally unequal social relationships."[xlix] The authors' analysis of the young women's interviews demonstrates how dominant understandings of heterosexuality that systematically privilege masculinity and silence female agency, power and pleasure, create an 'unsafe' gender identity for young women by making it difficult for them to resist male dominance or avoid colluding with male power.[l,li]

The social construction of masculinity and femininity in terms of structurally unequal relationships has problematic implications for young men, as well as for young women. The dominant framing of masculinity privileges notions of male performance, success, experience and power over women, while denying male vulnerability and homosexuality.[lii] This model of masculinity is reinforced in schools through sex education and peer group cultures, and through young people's media and pornography consumption. Research with young men has shown that watching pornography contributes to young men's development of dominant understandings of masculinity, based on the identification of men with each other through the exclusion and objectification of women.[liii] This model of masculinity dictates that male bodies should always be wanting, ready and able to perform penetrative, heterosexual sex, creating unrealistic standards against which young men may measure themselves and separating sexual activity from its emotional and relationship context.[liv]

The social construction of sexuality: implications for policy and practice

The theoretical gender analysis discussed above is rooted in empirical work with young people and has been instrumental in demonstrating the link between social empowerment, sexual autonomy and gender practices. This evidence of the powerful impact of gender on young people's capacity for sexual agency, choice and sexual decision-making has important implications for sexual health programming and service delivery. The research suggests that sexual health service programming for young people must take into account the multiple ideologies of gender that exist and the ways in which these are influenced by class, ethnicity and sexuality.[lv] Furthermore it suggests that in doing so, sexual and reproductive health services will be able to better support young people to develop their capacity to make positive, autonomous decisions about their sexual health.

Tackling gender inequalities and practices in sexual health involves a multi-faceted approach; it includes addressing national laws and policies relating to equalities, poverty reduction, health and education, mainstreaming the delivery of sexuality education that effectively addresses gender issues, as well as providing training opportunities and resources for staff on gender identities and practices. In the context of international HIV programming for young people, Kate Wood and others argue that sexual health programming needs to tackle gender issues in the long and the short term – in the short term, gender-sensitive programmes and targeted initiatives may offer some hope but will not radically change the unequal gender relations that fuel the HIV epidemic and make young men and women differentially vulnerable.[lvi] They argue therefore that in order to challenge the foundations of the HIV epidemic, socially transformative and empowering programmes must also be implemented.[lvii]

In the UK, policy measures such as the Gender Equality Duty that came into force in April 2007 and which places

a duty on all public services to promote gender equality and tackle gender discrimination, and the Healthy Schools requirement that all schools address gender as part of an equalities-based approach to health and well-being make important contributions to this multi-level approach.[lviii] Equally important is the provision of training for professionals on gender practices, such as the UK Family Planning Association's training course, Moving the Goalposts: Working with Young Men, that addresses issues relating to masculinity and the impact that societal and personal values can have on professional practice (see www.fpa.org.uk). The provision of sexuality education in schools, youth and community settings provides the opportunity for services to work with young people to challenge many of the gender practices and inequalities outlined above, such as the sexual 'slag/drag' double standard and how gender identities relate to choice and responsibility in contraceptive decision-making.

In the following section I further explore the role of sexuality education in delivering these opportunities for young people to develop their capacity to understand and negotiate the complex socio-cultural factors that shape their sexual experiences, choices and decision-making.

03 Comprehensive sexuality education

Using comprehensive sexuality education to develop capacity

School-based[4] sexuality education offers one of the most promising means of improving young people's sexual health competence[lix] through creating opportunities for young people to develop the knowledge and skills required to make informed and autonomous decisions about their sexual health. There is a large body of literature relating to the provision of sexuality education in the UK and elsewhere that offers critical analysis of policy frameworks, evaluations of sex education interventions, and survey and interview data on young people's experiences of sexuality education. Much of this literature is critical of current approaches to sexuality education in the UK and goes beyond the scope of this paper. I will however draw on these critiques and on some of the empirical work with young people to explore the sexuality education approaches and practices that could best support the development of young people's capacity for making autonomous, informed and positive decisions about their sexual and reproductive health.

Adopting a rights-based approach

In the UK, despite examples of excellent practice, young people, parents and government regulatory bodies have identified that the quality of sexuality education delivered in schools is variable and often inadequate.[lx–lxiii] Comprehensive sexuality education programmes delivered in UK schools have succeeded in providing young people with knowledge of reproduction, infections and condoms but have been much less successful in addressing the skills that young people require to manage this information and to use it to make decisions in relation to their own lives and relationships.[lxiv–lxvi]

Decades of feminist analysis of young people's experiences of sex education has shown that sexuality education programmes have focused on young women's reproductive capacity and vulnerability to unwanted pregnancy, disease and sexual violence from men who are 'only after one thing'.[lxvii–lxiii] These 'official' discourses of sexuality position women as potential victims of a predatory male sexuality and create a silence around female embodied pleasures and potential for desire.[lxiv] This offers young women a model of sexuality that disadvantages their capacity for agency, autonomy and enjoyment in sexual practices and fails to provide young men or young women with holistic models of egalitarian, safe, and diverse sexual and gender practices.[lxxv,lxxvi]

Commentators on UK government guidance and legal frameworks on comprehensive sexuality education have noted that since the 1980s, UK governments and policy makers have used sexuality education provision to respond to perceived crises in public health and to help manage the risks associated with young people's sexuality, namely teenage pregnancy, sexual violence and the transmission of HIV and other sexually transmitted infections.[lxxvii,lxxviii] This risk management approach, combined with the highly politicized, morally authoritarian agendas that dominate debates about comprehensive sexuality education,[lxxix] has led to the narrowing of the sexual health agenda to a focus on negative health outcomes and the dangers of sexual activity, rather than the holistic sexual health needs and sexual agency of young people.[lxxx–lxxxviii]

An alternative to this risk management approach would be to draw on rights-based approaches that take account of young people's needs and interests and that affirm young people's right to experience pleasure and choice in their sexual identity and practices.[lxxxix–xcii] This approach is consistent with the principles outlined in the United Nations Convention on the Rights of the Child, and with the World Health Organization definition of sexual health that embraces a positive and holistic model of health and well-being.[xciii]

In the UK, although government guidance on comprehensive sexuality education acknowledges the need for sexuality education to relate to young people's 'real life situations' and 'daily lives', this is compromised by the focus on exploring the sexual situations and benefits that a young person will experience 'as an adult'.[xciv] An alternative to this framing of youthful sexuality in terms of futurity would be to use sexuality education programmes to legitimate young people's sexuality as a positive and integral part of personhood.[xcv,xcvi] Critics of contemporary comprehensive sexuality education argue that in order to provide effective sexuality education that will enable young people to make autonomous decisions, it is essential that programmes position young people as autonomous sexual subjects with

4. The analysis and literature discussed in this section refer largely to comprehensive sexuality education programmes delivered in secondary schools, but it is important to note that sexuality education is delivered in a range of home, community, youth, secure and other educational settings (see SEF 2003). Might be useful to spell out 'SEF'.

the right to experience desire and pleasure in their daily lives and to have control and agency over their bodies – whether they are sexually active or not.[xcvii–c] This can be particularly important in relation to young people whose rights and sexualities are further socially stigmatized or denied, such as gay, bisexual and trans young people,[ci] and young people with disabilities.[cii,ciii]

Including pleasure, diversity and 'real life situations'

In order to support the development of young people's capacity to make decisions and affirm their right to make choices about when and where they have sex, and what kind of sex they have, comprehensive sexuality education must offer young people a diverse and realistic account of sexuality.

Contemporary research with young people suggests that there is a striking difference between young people's actual sexual experiences and the ways in which sexual experience is constructed in sexuality education lessons.[civ] A recent study of young people in Sheffield found that young people's sexual experiences were often furtive, rushed, outdoors and in the vicinity of others.[cv] Contrary to the impression created by sexuality education lessons, sex was not a private act restricted to indoor locations such as the bedroom, and tended to occur outdoors as part of a public socializing event. This study showed that the lack of privacy, time and weather conditions impacted on sexual decision-making and competence, but also that the contrast between the actual settings for sexual activities and the hypothetical, sometimes idealized, romantic settings created in sexuality education imagery contributed to feelings of regret and fear of condemnation, particularly for young women.[cvi] This research emphasizes the need for young people to be involved in the design and evaluation of sexuality education programmes to ensure that the curriculum content is meeting young people's needs and interests, and providing them with the information and skills that they need to make informed and positive decisions about their sexual health.

Recent studies in the UK have demonstrated that the domination of public health outcomes in comprehensive sexuality education programming frequently make invisible other aspects of sexuality that need attention.[cvii] It is argued that the emphasis in sexuality education on discussion of reproductive vaginal penetrative sex occurs at the expense of discussion of other sexual practices and same sex experiences.[cviii–cx] Research with young people demonstrates that they are engaging in a range of sexual activities that are not covered or represented in sexuality education.[cxi] It is important for sexuality education to acknowledge the range of sexual behaviours that young people engage in – such as kissing, mutual masturbation and oral sex – as a means of promoting safer, and sometimes preferred, sexual alternatives to vaginal penetration.[cxii,cxiii] It also challenges the mainstreaming of heterosexual and reproductive accounts of sexuality in comprehensive sexuality education and to challenge the dominant notion that vaginal penetration constitutes 'proper sex'.[cxiv,cxv, cxvi]

Informing young people about the diversity of sexual identities and practices, and the different levels of risks involved with particular practices such as oral or anal sex, enables young people to make informed decisions, as well as emphasizing that sexuality should always involve choices and decision-making, rather than adherence to an acceptable and 'proper' sexual script.

Studies of sexuality education practices and experiences have also demonstrated that comprehensive sexuality education programmes fail to acknowledge the pleasurable aspects of sexuality or to affirm the rights of all young people to have pleasurable sexual experiences.[cxvii,cxviii] Recent empirical work on young people's sexual relationships suggests that considerations of pleasure and enjoyment are an important part of young people's sexual motivations, decision-making and contraception use.[cxix–cxxi] These findings, and an understanding of pleasure as an intrinsic part of sexuality,[cxxii] are used to advocate that pleasure should form an integral part of sexual health programming and the delivery of educational and clinical practice.

In the UK, the Sheffield Centre for HIV and Sexual Health now runs training courses for professionals on how to include pleasure messages in sexual health work with young people, and distributes its pamphlet for professionals and parents on how and why to raise the issue of sexual pleasure with young people. In this resource and in the academic literature it is suggested that communicating to young people their right to pleasure and what they can gain from safer and consensual sexual practices will help to decrease the potential for regret, coercion and unsafe sexual practices and increase young people's capacity for autonomy and agency.[cxiii–cxv]

Challenging gender and sexual stereotypes

Sexuality education presents the opportunity to enable young people to explore issues of gender, sexuality, peer and media pressure that could act as barriers to safer sexual health decision-making. It is an important forum for challenging gender and sexuality stereotypes such as the 'slag/drag' dichotomy referred to earlier and for exploring positive ways of framing sexuality, masculinity and femininity.[cxvi–cxviii] The academic literature is critical of

the absence of gender from school-based comprehensive sexuality education policy and practice in the UK and highlights the need for sexuality education to build on best practice in taking a positive approach to young men and young women's sexualities and support young people to challenge narrow gender stereotypes.[cxxix–cxxxii]

As discussed earlier, however, there have been some positive developments in UK policy in relation to challenging gender inequality in public service provision. The gender equality duty and schools guidance states that schools are required to play a key role in challenging gender stereotypes across the curriculum, and in addressing sexual and sexist bullying and violence.[cxxxiii] For example, the guidance sets out measures that schools can take to tackle sexual bullying and violence and provides a case study example of a project by Womankind in Cardiff that worked with year 11 students (aged 11–12) to develop role plays, posters and leaflets to raise awareness of the issue across the school.[cxxxiv]

Although there are limitations in the policy and guidance relating to the provision of gender and sexuality education in the UK, there are many examples of good practice in working positively and holistically on issues of gender and sexual bullying, as well as the provision of relevant training for professionals and sharing of best practice. For example, Brook's 3rd Annual Conference – BoyGirlManWoman: Putting Gender at the Heart of Improving Sexual Health and Reducing Teenage Pregnancy – included a range of best practice seminars such as A Holistic Approach to Addressing the Needs of Straight and Gay Girls and Boys: Working Effectively with Boys and Men, and Empowering Young Women Through 'Down-to-earth' and Creative Education and Information.

Other leading organizations in sex education have produced resources for professionals to support gender work in sexuality education such as the Family Planning Association's publication and training course *Beyond Barbie: Community Based Sex and Relationships Education with Girls and Young Women: A Workers' Compendium*, and the Sex Education Forum's *Boys and Young Men: Developing Effective Sex and Relationships Education in Schools*, that outlines some of the key issues and practice approaches required when working with young men and highlights the importance of using resources that represent a wide range of positive images about sexuality.

Confronting and addressing pornography

There are increasing concerns from diverse parties about the sexualization of popular and consumer cultures and the increased availability of pornography to young people through rapidly changing global media technologies.[cxxxv–cxxxix] These concerns centre around the possible impact of media and pornography consumption on young people's sexual understandings and practices. Young people state that they feel pressured to conform to the sexual behaviours and values seen in sexualized and pornographic media content,[cxl–cxlii] and practitioners working with young people have noted examples of the way in which pornography can normalize ideas about bodies and sexual behaviour in young people.[cxliii–cxlv] In the UK, organizations working in the area of young people's sexual health have responded to these concerns about sexualization and pornography, and its impact on young people's sexual decision-making, through developing training programmes and resources to support professionals to feel confident in working with young people around issues of pornography.[5]

Sexuality education offers a forum for young people to understand and make sense of the images, practices, norms and sexual scripts that they observe in pornography and to learn about the aspects of sexuality absent from pornography such as emotional intimacy, negotiating consent discussing contraception. Supporting young people to understand that they have choice, agency and autonomy in their sexual practices is an essential part of developing their capacity for negotiating safe, consensual and enjoyable sexual experiences.[cxlvi]

What works in comprehensive sexuality education?

There is a large body of literature relating to the methodologies for evaluating the effectiveness of different approaches to sexuality education that are beyond the scope of this paper. Involving young people in the design, delivery and evaluation of sexuality education programmes is essential in order to establish whether the programme is supporting the development of young people's capacity or not. Research suggests that young people often feel excluded from societal decision-making processes and perceive efforts to increase their involvement in the design and delivery of services as tokenistic.[cxlvii,cxlviii] Providing genuine opportunities for young people to participate in programming will not only help to produce programmes and resources that relate to young people's 'real life situations', but will also support young people's participation in decision-making processes.

5. Examples include the UK Family Planning Association training course *Fantasy vs. Reality: The Impact and Influence of Pornography on Young People*, and the *Young People and Pornography* programme run by the Sheffield Centre for HIV and Sexual Health. Also see the collaboratively produced resource *Young People and Pornography: A Briefing for Workers* that outlines why and how professionals should approach the subject of pornography with young people (produced by Brook, the National Youth Agency, Centre for HIV and Sexual Health, and the UK Family Planning Association).

03 Assessing decision-making capacity

How can practitioners assess young people's capacity to make autonomous decisions?

The above discussion has focused on how the social construction of sexuality impacts on young people's capacity to make decisions. It has also looked at how education services might address some of the challenges that this raises and support the development of young people's capacity for autonomy and decision-making through providing sexuality education for young people. In the following section I will discuss how sexual health practitioners working with young people can assess young people's capacity to make autonomous decisions about their sexuality and what training, resources and protocols a practitioner may need to do this. To do this I will outline the 'Fraser Guidelines' as a model of good practice in assessing a young person's sexual health competence and then go on to explore how these guidelines can be applied in practice through drawing on policy and practice case study examples from Brook.

A model of good practice: the Fraser Guidelines

In the UK, young people under the age of 16 have the legal right to access sexual health services, consent to treatment, and make decisions relating to their sexual health without parental involvement if they are assessed as having the level of maturity and judgement required to enable them to understand what is proposed. This legal position was clarified in England and Wales by the House of Lords in 1985 in the legal case of *Gillick v. West Norfolk and Wisbech Area Health Authority and the Department of Health and Social Security*. In England, Wales and Northern Ireland[6] it is now broadly accepted that it is good practice to follow the criteria set out by Lord Fraser in that case, which have subsequently become known as the Fraser Guidelines.

The Fraser Guidelines:

1. The young person understands the advice being given.
2. The young person cannot be convinced to involve parents/carers or allow the medical practitioner to do so on their behalf.
3. It is likely that the young person will begin or continue having intercourse with or without treatment/ contraception.
4. Unless he or she receives treatment/contraception their physical or mental health (or both) is likely to suffer.
5. The young person's best interests require contraceptive advice, treatment or supplies to be given without parental consent.

(*Gillick versus West Norfolk and Wisbech Area Health Authority and the Department of Health and Social Security*)[cxlix]

Although initially intended to apply to doctors, the Fraser Guidelines are widely used in all health care, and a range of social care and youth services contexts, to assist professionals in assessing whether a child has the maturity to make their own decisions and to understand the implications of those decisions.[7] [cl,cli] The Fraser Guidelines place the young person's interests at the centre of the decision-making process and the Law Lords in this case were clear that the child's right to consent and to confidentiality supersedes parental when the child has developed 'sufficient understanding':

> Per Lord Scarman:
> "I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have a medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed."[clii]

The guidelines and judgements set out in this high profile and controversial legal case provide a model of practice for balancing parental and children's rights that is consistent

6. In Scotland, the relevant legislation is contained within the Children (Scotland) Act 1995 and Age of Legal Capacity (Scotland) 1991.

7. These guidelines are not applied in school settings where parents may be contacted or informed by professionals without a young person's approval or consent (see Allred and David 2007 p.119) and the right of the child to sex and relationships education yields to the parental right to withdraw their child from personal, social and health education lessons.

with the principle of the 'evolving capacities' of the child subsequently introduced by the United Nations Convention on the Rights of the Child.[cliii] In this principle, a young person's capacity to make decisions and give consent depends upon an assessment of the young person's maturity, understanding and 'situation', rather than on their age or legal status.

The difficulty that the Fraser Guidelines present for professionals is the prevailing uncertainty about how to assess whether a young person has developed the 'sufficient understanding' to be capable of making autonomous decisions and about how to balance the duty of confidentiality to the young person and the need to respect their autonomy, with the need to safeguard the young person from risk of harm. The guidelines depend upon a professional assessment of a young person's individual level of maturity and competence and although they place the young person's best interests at the centre of the decision-making process, the power to define 'competence' and determine right of access to health care services lies with the professional. There is therefore a possibility that through acting to protect the young person or others from risk or harm, the professional could undermine a young person's capacity for autonomy in decision-making processes.

Given the complexity of this issue there is surprisingly scarce research literature on how the Fraser Guidelines can be applied and operationalized in different professional contexts. Although there is limited academic literature in this area, there is a wealth of examples of good practice from organizations working in the field of young people's sexual health. In the following discussion I will draw on examples of practice and procedure provided by Brook to explore how the Fraser Guidelines can be applied in the context of a clinical consultation and how a practitioner can assess a young person's understanding and capacity for decision-making while taking due consideration of the risk to the young person's health and well-being.

Putting the Fraser Guidelines into practice: assessing understanding, capacity and risk

Establishing understanding

The Fraser Guidelines state that in order to assess a young person's capacity to make autonomous decisions, a practitioner must first establish whether the young person has understood the advice being given. A young person's capacity to understand sexual health advice can be affected by numerous factors such as their age, lack of familiarity with the English language, poor mental or emotional health, being under the influence of drugs or alcohol, or having a learning disability. Brook guidance relating to the assessment of a young person's decision-making capacity emphasizes that professionals should not assume that young people lack the ability to make decisions if they have a learning disability.[cliv]

The key factor is the young person's ability to weigh up the information needed to make a decision and, if information is presented in an appropriate format, many people with learning disabilities will be able to consent to their own treatment.[clv] For professionals who are unfamiliar in working with young people with learning disabilities, there is a range of training and resources specifically designed to assist professionals to work effectively with young disabled people in the area of sex and relationships (for example, see Leonard Cheshire Disability's training and resources at www.lcdisability.org/?lid=11901).

As discussed in section 02, the ways in which sexuality, femininity and masculinity are socially constructed can impact differentially on young men and young women's capacity to seek sexual health advice, and communicate their capacity for autonomy and enjoyment of sexual activity in the context of a consultation. For example, young women may find it more difficult to communicate a sense of agency and pleasure in their sexual practices for fear of being labelled a 'slag' (see earlier). Equally, young women may appear to be well informed and assertive about their sexuality in the context of a sexual health consultation, but in the context of their sexual relationships they may be unable to exercise agency and negotiate condom use.[clvi,clvii] Although some young men may be able to talk confidently about their capacity for autonomy and enjoyment in their sexual practices, dominant notions of masculinity can make it more difficult for young men to express vulnerability and emotions or to ask for help and information about relationships or contraception.[clviii–clx] Professionals need to be sensitive to these differences and may need to draw on the training and resources available on tackling gender issues and on working with young men and young women, as outlined earlier.

Sexual history taking

In order to establish whether a young person meets the criteria set out in the Fraser Guidelines, and is capable of understanding and consenting to sexual health advice and treatment, the professional will need to establish the young person's level of knowledge about sex, relationships and contraception, their personal and family circumstances, their sexual history and future intentions relating to sex, and whether there are any additional needs or vulnerabilities with which the young person requires support. This will involve having detailed and sensitive discussions with the young person and will require considerable professional skills,

training and experience, as well as good supervisory support when required.

Sexual history taking can be inhibited by professional anxieties and communication difficulties relating to talking to younger people about sex or certain sexual practices. Practitioners may require specific training and support that addresses attitudinal issues relating to young people's sexual behaviour[clxi] or on developing particular skills or approaches in building rapport and communicating effectively with young people. Empirical work with young people demonstrates that young people can feel alienated by the medical and scientific language and terminologies used in some clinical and education settings.[clxii] This means that in order to develop a shared language with the young person, professionals may need to use a mixture of professional and colloquial language, and to explain professional terms to the young person and check their understanding.[clxiii]

More general models of advice-giving practice – such as the Skilled Helper Model[clxiv] and the Motivational Interviewing techniques[clxv] – may be useful for professionals to draw on, particularly when working with more vulnerable clients and complex situations, to assist with the development of different strategies for encouraging client self-responsibility and self-efficacy, or for approaches to establishing rapport and relationship building.

To give full and accurate information about themselves, young people need to feel confident, positively valued and respected and that their decisions, actions and experiences will not be judged, condemned or shared with anyone else. Research with young people suggests that the qualities that they most respect and value, and are most likely to seek from sexual health professionals, are a positive attitude towards sex, an awareness of and interest in the issues that concern young people, and a genuine interest in the young person's point of view.[clxvi] A briefing produced for Brook on sexual history taking suggests that sensitivity, time and care are particularly important when taking a young person's sexual history because of their increased need for reassurance about confidentiality and affirmation of their rights to make choices about sex.[clxvii]

Certain young people, such as gay young people, may have particular concerns about being judged and about who might find out about the information that they disclose.[clxviii,clxix] Without appropriate training and supervision, staff working in sexual health clinics may compound socio-cultural prejudices and ignorance around homosexuality by making assumptions about a young person's heterosexuality, resulting in the young person being forced to 'out' him or herself in order to get relevant information and support. It is therefore important that all staff working in the field of sexual health have training and supervision opportunities to explore social prejudice about homosexuality and how social attitudes and ignorance can impact on their own values and practice.

Some of the questions that a clinical practitioner will need to ask in order to assess whether a young person is 'Fraser competent' – such the number, age or gender of current and recent partners – could be perceived by the young person as intrusive and judgemental. The Brook briefing on sexual history taking suggests that in a sexual health consultation it is best to start with easy non-sexual questions to establish rapport with the young person before asking anything sensitive or intimate.[clxx] This briefing identifies some of the questions that Brook staff use as 'old favourites' with young people to draw out useful information from young people and generate discussion about their relationships (see Figure 1).

Figure 1[clxxi]

- What is the main thing that worries or concerns you?
- Are you in a steady relationship?
- When did you last have sex?
- Was that with someone you've been seeing for a while?
- Do you think you will be going on seeing them?
- When did you last have sex with someone other than that?
- What contraception have you used in the past?
- What age were you when you first had sex?
- Have you ever been pregnant?
- Do your parents know you're here at the clinic today?
- Do your parents know about your partner?

Assessing capacity and assessing risk

In assessing the young person's competence or capacity to make autonomous decisions, the professional is also required to assess the level of risk of harm to the young person. The professional will need to carefully balance the young person's right to confidentiality and autonomy in making decisions about their sexual health, with the duty to protect the young person, or others, from harm or abuse. Achieving this balance and protecting a young person's right to decide and their right to protection from abuse and exploitation requires considerable professional training, experience and management support. All practitioners working with young

people in sexual and reproductive health services need training on national, local and organizational safeguarding procedures and protocols for managing disclosures and suspected instances of abuse or harm. This needs to include knowledge of local agencies that can provide support if there is a risk or concerns about the young person's safety or well-being.

Brook's 'Protecting Young People: Brook Policy'[clxxii] includes an Under-16s and Vulnerable Young People Assessment Form that provides a list of questions that practitioners should ask themselves in order to establish whether there are concerns about the young person that mean that confidentiality needs to be breached (see Appendix 1). This includes questions such as: Is the young person withdrawn or anxious? Are they in a peer relationship (of similar ages or two years' difference)? Is the young person overtly secretive of a sexual partner, beyond what we would consider usual in a teenage relationship?

The assessment form provides a useful list of factors that professionals need to consider when assessing a young person's capacity to make autonomous decisions and to help to highlight any vulnerabilities or concerns about their capacity to do so. Brook's Protecting Young People Policy also provides a series of case study examples of how to apply risk assessment procedures in specific contexts. For example, case study A relates to a young woman under 16 with a suspected ectopic pregnancy who is refusing hospital treatment in order to prevent her mother finding out. The case study outlines a practice example for how to assess the risk of harm to the young woman and to support her to make autonomous decisions about accessing treatment and talking to others about her situation (see Appendix 2).

Assessing capacity and risk: young people under 13

Practitioners may have particular concerns about the vulnerability of very young sexually active people and experience difficulties in assessing whether they meet the Fraser competence criteria and have the capacity to make safe and autonomous choices about their sexual health. In the UK, practitioners are not required to mandatorily report cases of sexually active young people under 13 to social services but they are required to discuss such cases with the organization's child protection lead in order to assess whether or not to breach the young person's confidentiality and make a social services referral.[clxxiii] The government guidance on sexually active young people under 13 instructs practitioners that the decision to breach a young person's confidentiality is "a judgement for a professional to make, in which the child's interests are the overriding consideration."[clxxiv] For vulnerable or very young clients in particular it is important to establish a mutually trusting and preferably ongoing relationship that will work towards helping clients to disclose the circumstances of their relationships with parents, carers and family members.[clxxv] The Brook Risk Assessment of Sexually Active Under-13-year-olds outlines best practice that the practitioner should follow and stipulates a list of questions that the practitioner should ask in order to assess whether the young person is at risk (see Appendix 2). The document states that practitioners should explain to the young person that they are very young to be sexually active and that they need to ask some questions to ensure that they are safe. The practitioner should reassure the client that they have done the right thing in visiting Brook and that Brook will provide the best support that they can (see Appendix 2).

The government guidance on sexually active young people under 13 states that sex at this age indicates a risk of significant harm, but that there are cases where few or no risk factors to the young person will be identified and that in this circumstance a disclosure is not justified.[clxxvi] The Brook Protecting Young People Policy provides a case study of how this would work in practice (see Appendix 2). The case study is of a young male aged 12 who visits a sexual health centre for condoms and claims to be sexually active with his 15-year-old girlfriend.

After further discussion prompted by the practitioner about his girlfriend and the nature of their sexual relationship, the practitioner concludes that the young person does not actually have a girlfriend, is not sexually active and is, in fact, just testing the service. As the young person did not present any other cause for concern, the practitioner decided that there was no risk of harm to the young person. In this instance the practitioner explains the legal situation to the young person, gives him two condoms for educational purposes, and encourages him to return to the Brook centre if necessary. The practitioner discusses the case anonymously with the designated child protection lead as the young person was under 13 and records the decisions of the assessment. This case study provides an example of how practitioners can use risk assessment procedures and provide a young person with advice in a way that encourages the young person's autonomy and choice in accessing sexual health services and advice.

05 Conclusion

In this paper I have discussed the importance of agency and autonomy in young people's sexual health decision-making practices. I have outlined the socio-cultural factors that impact on a young person's capacity to make autonomous decisions about their sexual health and sexual practices and have suggested ways in which sexual health services could tackle some of these structural inequalities through programming, policy and practice.

I have discussed the importance of sexuality education in supporting young people to develop their capacity to make informed and autonomous decisions about their sexuality and sexual health. I have considered the impact that sexuality can have on supporting or undermining a young person's sexual rights and the usefulness of sexuality education in challenging some of the socio-cultural stereotypes and practices outlined in this paper.

The sections 02 and 03 provide a context for the last, which focuses on professional practices in sexual health consultations with young people. I have explored how practitioners can apply the Fraser Guidelines in practice in order to assess a young person's capacity to consent and decide about their sexual health and practices. I have suggested that practitioners will need expertise, training and support in managing the balance between protecting young people from harm and abuse, and optimizing their capacity for autonomy and asserting their right to decide.

Appendix 01

Brook's under-16s and vulnerable young people assessment form

Date	Client number	Staff member (print name and sign)
After completing the assessment, if you have any concerns please adhere to Brook's Protecting Young People policy		Yes/No
Does the young person understand Brook's confidentiality policy and the sharing of information with appropriate people should we have any concerns about any disclosures putting them at risk?		
Do they understand advice – Fraser competent?		
Are they in a peer relationship (of similar ages or two years' difference)?		
Is there a history/background – are they known to Brook?		
Are they aggressive or is unusual behaviour shown?		
Is there any coercion or bribery suggested?		
Any misuse of substances/alcohol as a dis-inhibitor?		
Is the young person withdrawn or anxious?		
Is the young person overtly secretive of a sexual partner, beyond what we would consider usual in a teenage relationship?		
Do any of the methods used appear consistents with 'grooming' – i.e. communicating with the intention of committing sexual acts?		
Does the young person deny, minimise or accept concerns?		
Does the young person's own behaviour of misuse place him/her where they are unable to make an informed choice about their activity?		
Does client have a social worker?		
Does client have any other professional support (for example key worker)?		
IN ADDITION		
Does the young person have learning needs or physical disabilities?		
Does the young person have a history of being missing from home?		
Does the young person have a lifestyle which makes them vulnerable?		
Is the young person known to other agencies (looked-after child/young person)?		
VULNERABLE ADULTS 19 YEARS OR UNDER		
Can the client consent to sex?		
Does he/she understand that sex is different to kisses and cuddles?		

Appendix 02

Case studies

Case study A	Risk assessment of 16-year-old with suspected ectopic pregnancy
A is under 16, her boyfriend is 16 and they have mutually consented to a sexual relationship. She has missed her period and is complaining of abdominal pain. A pregnancy test is positive. You suspect she could have an ectopic pregnancy. She does not want to tell her parents about the pregnancy and she refuses to go to hospital because she is afraid her mother will find out.	
Q: Is client or other young person at risk of harm?	Yes.
Q: Is abuse or risk to client or other young person ongoing?	Yes – there could be a risk if she really does have an ectopic pregnancy. There are no concerns about the nature of her relationship with her boyfriend.
Q: Is there immediate and serious risk of harm either to client (greater than already suffered) or to another young person?	Yes – it's not clear how immediate the risk is but could be serious risk if it was an ectopic therefore proceed as if it was. Support in realizing that she is at risk, provide clear information about what could happen if it really is an ectopic pregnancy (including if it is an ectopic which becomes an emergency there's a greater likelihood of her mother having to be told), what would happen if she went to hospital (e.g. scan, confidentiality rules etc), ask her if she is willing to go to hospital for scan if Brook arranges it and explains need for confidentiality.
Q: Is the young person willing to tell someone else about the abuse or risk or happy for you to make an external referral?	If yes, either arrange scan appointment or, if you believe the situation to be really urgent, call ambulance. Note the possibility of ectopic pregnancy in the file and the fact that client was referred to hospital. Arrange with client to come back if the scan is negative to talk about options. Inform designated member of staff. If no, explain that you need to talk to someone else. Keep the client with you while you contact the designated member of staff and explain the situation. Agree the best action to take.
	All of this should be noted as should the fact that she understood and accepted the risk (see suggested file note below). Ensure contact details are correct. NB: don't forget need to help client deal with pregnancy generally. Likely therefore to be having follow-up contact with her in the context of possible referral for termination of pregnancy or antenatal care.

Example file note

[Date] Positive pregnancy test. Client complaining of abdominal pain. Suspected ectopic pregnancy. Discussed risks with client and ensured she understood the situation. Suggested referral to hospital but client refused. Outlined the need for her to seek medical help if pain worsened. Arranged follow-up appointment for [date].

Assessed risk of harm from underage sexual activity. Consensual relationship with boyfriend of 16. No cause for concern. Explained legal situation.

Case study B	Risk assessment of sexually active under-13-year-olds
Client must be seen by counsellor or member of the clinical staff. Assess for Fraser competence as usual. Further information is required to assist the Designated Member of Staff for Client Protection and Action Planning Consultation in assessing whether or not confidentiality should be breached and what to include in any report to children's social care. Explain to the client that as they are very young to be sexually active we need to ask some questions, to ensure they are safe. Reassure the client that they have done the right thing coming to us and that we want to provide the best support we can.	

Date	Client number	Staff member (print name and sign)
Establish exact nature of sexual activity (explaining we need to assess the risk of pregnancy and/or sexually transmitted infections)		
If male client with female partner, encourage female partner to attend Brook to arrange contraception and access support.		
Has the client reached puberty?		
Does she or he have a regular partner?		
If yes, first partner?		
Age of partner?		
Is the sexual activity consensual for both partners?		
Is client the first partner of partner or has partner had previous partners?		
Number of previous sexual partners?		
Further information relating to previous sexual partners – ages, consensual etc?		
When did she or he first become sexually active?		
Are there any other risk factors (see p.30 of Protecting Young People policy)		
Does client have a social worker?		
Does client have any other professional support (for example key worker)?		
Explain that to ensure client is safe we encourage them to talk with children's social care who are better able to make an assessment of support needs. If the client refuses explain we will need to make a decision about whether we will make a referral to children's social care without their permission but that we will let them know if we do.		

Case study C	12-year-old boy
F is a 12-year-old boy who visits the Centre for condoms. He claims to be sexually active and that his girlfriend is 15, but when you ask him questions about his girlfriend and the nature of their sexual relationship you doubt whether he actually does have a girlfriend at all and believe he is just testing the service.	
Q: Is client or other young person at risk of harm?	No – you do not believe he is sexually active. Discuss assessment with designated member of staff as he is under 13.

Example file note

[Date] Client claims to be having sex with 15-year-old girl. Talked to him about the relationship and after discussion do not believe he is sexually active. Did not present any other cause for concern. Explained legal situation and gave two condoms for educational purposes. Encouraged to return if necessary.

Discussed on anonymous basis with designated member of staff who concurred with assessment.

Case study D

14-year-old girl requesting contraceptive implant

This is a fictitious case study to illustrate good practice in working with young people to establish autonomy. It has been prepared by Dr Alison Swain, the senior doctor at Brook in Birmingham.

Cassie is 14. She has come to the clinic requesting 'the three-month contraceptive implant'. The nurse who sees her notes the following information as she picks up the records to call her in:

- she is under 16
- from the information given she does not seem to have a good understanding of her contraceptive choices (does she mean the three-month injection or the three-year implant or neither of these?)

As she comes in the nurse notices that she looks young for her age and that she is accompanied by another girl. The nurse introduces herself, asks Cassie to confirm her name and date of birth, and turning to the girl with her asks if she is a friend. The accompanying girl says that she is her sister and she's brought Cassie along today.

The nurse turns to Cassie and asks what she can do for her. Her sister immediately says, "*She needs contraception. We were thinking about something that lasts a long time because she won't be able to remember pills or patches.*" Turning to Cassie again the nurse asks if this is right. Her sister again intervenes and answers for Cassie.

Realizing that she will be unable to assess Cassie's capacity to consent to treatment or find out what Cassie herself really wants while her sister is present, the nurse asks her sister if she would take a seat in the waiting room while she sees Cassie on her own. She explains to her sister that she will invite her back into the consultation if Cassie would like that – Cassie nods and her sister leaves.

Cassie is much more able to talk freely and answers the nurse's questions clearly now she is alone. She appears much more mature away from her sister's influence. It becomes clear that Cassie does have a boyfriend of three months. They have not had sex yet (and she has never had sex previously) but have talked about it. She thinks they will soon decide to have sex. She knows her sister is worried she will have sex and get pregnant without sorting out contraception first.

Although she has told her sister that she is not having sex, her sister still thought it best to sort things out now. The nurse discussed all the methods of contraception that were available to Cassie. Although Cassie was initially a bit confused about how some of the methods worked, and how long they lasted, this was easily put right with further explanation. Cassie also volunteered that she knew she must start contraception before they have sex and that she needed to use condoms to prevent Chlamydia (further information about sexually transmitted infections was given).

The nurse then asked Cassie whether there was anyone else she could talk to about her relationship and whether Cassie and her sister lived together with their mum and/or dad? Cassie said, "*Not really, just my sister*" but that, yes, they did live at home, just with mum and a younger brother. The nurse asked whether she was able to talk to her mum or any other adult about relationships, contraception etc. Cassie said that she might tell her mum at some point, but that she couldn't talk to her at the moment because she felt she would be really upset that she was going to have sex because she's so young. The nurse explained that having the support of an adult can be very helpful and encouraged her to talk to her mum when she felt the time was 'right'.

Because Cassie is under 16 the nurse then explained that she just needed to ask a few more questions to ensure that Cassie was safe in her relationship. She asked how old her boyfriend was and whether he was putting any pressure on her to start having sex. As she did so she explained that no one should ever feel they are being made to have sex against their will. Cassie said her boyfriend was 15 and that, no, there was no pressure.

Finally Cassie agreed to take some information about the contraceptive injection and implant. She said she would consider both and book an appointment to return next week so she could start her preferred contraceptive choice before they start having sex. She asked if the nurse would ask her sister to come in again and explain to her what they have decided.

Good practice points

1 Nurse notes important details BEFORE calling client in.

2 Nurse notices that client appears 'young'.

3 Nurse is aware of problems/difficulties that can arise when young people are accompanied and the importance of seeing young people alone.

4 Nurse takes time to explain contraceptive methods. Through doing this she assesses the young person's understanding both by the way they respond and the questions they ask, and by asking them questions back at the end to check understanding.

5 Nurse ascertains who Cassie lives with and encourages her to talk to her mum when she feels able to.

6 Nurse asks relevant questions to assess whether there are any safe-guarding/child protection issues and therefore whether a more detailed assessment needs to be made.

7 Nurse talks to sister again at the end with Cassie's consent and uses the opportunity to acknowledge the support that she has given Cassie.

Cassie was Fraser competent

She understood the information given, did not want to talk to her parents but was encouraged to do so, stated that she was likely to start having sex soon and therefore her health would be likely to suffer if she did not have contraceptive treatment, and contraception was in her best interests.

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This Right to Decide series of papers was initiated by IPPF to learn more about young people, autonomy and sexual rights from experts working on these topics in various fields. We wanted to understand the theory behind the laws, policies and practices that both facilitate and restrict young people's autonomy as well as the key factors contributing to the development of young people as autonomous decision-makers.