WHO ARE THE YOUNG ADOLESCENTS ATTENDING SEXUAL HEALTH SERVICES IN SOUTH WESTERN SYDNEY? – Their clinical needs and socio-demographics.

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Introduction

South Western Sydney Local Health District (SWSLHD) is one of the most ethnically-diverse Local Health Districts in NSW. In 2012 there was an estimated 867,873 residents of whom 7% were very young adolescents (10-14 years). It is a relatively disadvantaged area and the health of young people is on average poorer than the rest of NSW. Research has shown there is a link between early sexual debut and adverse sexual and reproductive health. In an attempt to understand the needs of our local cohort of adolescents ≤14 years we wanted to investigate those attending the Liverpool and Campbelltown Sexual Health Services during 2010-2013. What were their clinical presentations, management, behavioural risk factors and socio-demographics? We also wanted to explore the prospect of developing a best practice model from which future clinical practice could be measured.

Method

We audited case notes on all clients 14 years and under during the 2010-2013 period and reviewed national and state guidelines relevant to young adolescents.

Results

Fifty one adolescents 14 years and under were seen; 17 males and 34 females. 22 (43%) identified as Aboriginal or Torres Strait Islander of whom 10 were boys attending an outreach public event. 28 (55%) lived in a suburb classified as most disadvantaged on the SEIFA index. 17 (33%) were smokers and 18 (35%) engaged in regular drug or alcohol use.

51 ≤ 14 year old attended during 2010-2013

<table>
<thead>
<tr>
<th>Male</th>
<th>17 (33%)</th>
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<tbody>
<tr>
<td>Female</td>
<td>34 (67%)</td>
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<tr>
<td>Aboriginal or Torres Strait Islander</td>
<td>22 (43%)</td>
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<tr>
<td>Disadvantages suburb (SEIFA 1 index)</td>
<td>28 (55%)</td>
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<tr>
<td>Cigarette use</td>
<td>17 (33%)</td>
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<tr>
<td>Drug and alcohol use</td>
<td>18 (35%)</td>
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Thirty one females and 2 males were sexually active. Of these, 27 (82%) requested a screen, 3 (9%) reported sexual assault, 7 (21%) sought contraception, 1 (3%) was pregnant, and 7 (21%) had anogenital symptoms. 11 (33%) reported no condom use at their last sex. 5 (15%) were pregnant, and 7 (21%) had anogenital symptoms. 11 (33%) were notified to the Department of Health.

Clinical assessment was comprehensive however mandatory reporting applies to young people up to the age of 14 years we wanted to investigate those attending a sexual health clinic. Mandatory reporting makes it compulsory for all healthcare workers to report any sexual assault, sexual health, community, educational and other services. Sexual Health clinics are based on an adult (18+) model of care and are not well placed to manage young adolescents. However given that we are a significant number of young people on such clinics to provide the best care possible. Best practice care for adolescents involves addressing identified sexual and reproductive health needs on the day of service, to improve the young person’s understanding of all presentations with the young person’s needs and to assist in care planning to provide positive health outcomes.

Overview of consent for medical treatment of under 14 years old

NSW Kids and Families (NSW Health, 2014) identifies under the common law, young people under 18 might be capable of giving informed consent – although consideration should be given to the nature of the treatment and the ability of the young person to understand the treatment.

Case study

Fiona was a 14 year old girl brought into the clinic by a DOCS case worker for an unplanned birth. She had been having sex with a male partner who was 26. Fiona immigrated to Australia with her family as a young child. She was sexually assaulted at 7 yrs of age and started having sex at 10 yrs of age but reported that she didn’t like using them. She was in trouble at school for her angry outbursts and was difficult during consults with a nurse and social worker. She was in contact with her family but living in out of home care. She had attended the emergency department on several occasions with suicidal ideation. A sexual health screen was performed at the clinic which was negative and was referred to the nearest family planning clinic for contraception. She was seen for counselling on a further 3 occasions where issues of consent to sex, safe sex, contraception and abusive relationships were discussed, and had a repeat sexual health screen after reporting sexual sex with 10 partners without condoms in the prior 5 days. Fiona eventually attended the family planning clinic 3 months after her first visit and was prescribed the pill. She continued to return only to have a repeat screen after again 9 months after her initial consult with an unplanned pregnancy. After counselling regarding her options she elected to continue the pregnancy, and had an uneventful pregnancy and normal vaginal delivery. However the baby was removed from her care at birth. She returned at 16 years of age and was still not using condoms or contraception.

What can we learn from Fiona’s case?

Very young adolescents seen in the context of a sexual health clinic often have a past history of sexual abuse and complex family and social circumstances. Their complex needs mean they may ‘fall through the cracks’ of hospital, mental health, drug and alcohol, sexual assault, sexual health, community, educational and other services. Sexual Health clinics are based on an adult (18+) and not on a child (11) based model of care and are not well placed to manage young adolescents. However in the clinic which was negative and was referred to the nearest family planning clinic for contraception. She was seen for counselling on a further 3 occasions where issues of consent to sex, safe sex, contraception and abusive relationships were discussed, and had a repeat sexual health screen after reporting sexual sex with 10 partners without condoms in the prior 5 days. Fiona eventually attended the family planning clinic 3 months after her first visit and was prescribed the pill. She continued to return only to have a repeat screen after again 9 months after her initial consult with an unplanned pregnancy. After counselling regarding her options she elected to continue the pregnancy, and had an uneventful pregnancy and normal vaginal delivery. However the baby was removed from her care at birth. She returned at 16 years of age and was still not using condoms or contraception.

Conclusion

The conversation around sexual health issues will vary enormously between individual young people, depending on their age, maturity and reason for presenting. Use of the HEEADSSS assessment with a young person presenting with a seemingly unrelated issue is beneficial. It is essential to provide an environment where the young person feels comfortable to discuss sexual health issues. That is, confidentiality is assured, they have permission to ask sensitive questions and there is an acknowledgement of feelings which is void of judgement and assumptions. Helping the young person to recognise that sexuality involves more than acquired infections but also issues of relationships, values, decision-making, and behaviour is also important. This can greatly be enhanced by the utilisation of a multidisciplinary team approach to identify the young person’s needs and to assist in care planning to provide positive health outcomes.

The young adolescents seen through the Liverpool and Campbelltown Sexual Health Service were at high risk of adverse health and social outcomes. We are currently developing a best practice model, including implementing HEEADSSS assessment, to improve our service provision in this high risk cohort. The discussion around our service providing on-site contraceptive management to young adolescents is an important future consideration.

References

2. NSW Health. Patient Information and consent to medical treatment. PDD2005_046

Acknowledgements: Rhiana George and Julius Parke 2013

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AVS 74980