West Dunbartonshire Council

West Dunbartonshire
Community Health & Care Partnership

NHS
Greater Glasgow and Clyde

Delivering Best Practice on Sexual Health and Relationships for Staff Working with Children and Young People who are Looked After

A Policy Document

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Acknowledgements

This policy document was developed by a writing sub-group on behalf of West Dunbartonshire Sexual Health Strategy Group.

Membership of the Strategy Group includes:

West Dunbartonshire Council - Educational Services
West Dunbartonshire CHCP – Strategy, Planning and Health Improvement
NHS Greater Glasgow and Clyde – Sexual Health Team
NHS Greater Glasgow and Clyde – Sandyford Initiaitive

Significant contributions were made by :

West Dunbartonshire CHCP - Specialist Childrens Services – LAAC Nurse
West Dunbartonshire CHCP - Violence Against Women Partnership
West Dunbartonshire CHCP - Childcare Team

1. Introduction and Background

West Dunbartonshire Council and NHS Greater Glasgow and Clyde are committed to addressing the health and wellbeing of children and young people that are looked after either at home or away from home and in residential care or foster care[1, 2].

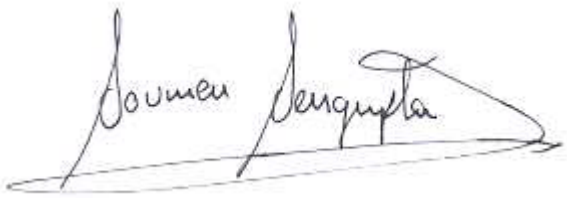
Compared to the wider population of children and young people, those who are looked after often experience poorer health and wellbeing outcomes. One of the areas where this can be most profoundly experienced is in their relationships, sexuality and sexual health. It is therefore crucial that the important adults in the lives of children and young people are able to respond and intervene appropriately to the evolving and changing needs that children and young people have.

It has been developed following consultation with staff both at formal engagement events in 2010 and through discussion with staff teams. A parallel process to consult with young people who are looked after or leaving care in West Dunbartonshire has also taken place.

This document has been developed with a view to it providing a basis for enhancing the practice of those most closely working with looked after children, to enable them to meet the very significant needs that looked after children and young people present with their sexual health and relationships.

It is intended that staff will be provided with training specifically on the issues raised by the policy to increase their confidence and skills in this important area of children and young people's lives.

By implementing this new policy, we are demonstrating our intention to support the delivery of continuous and consistent high level of best practice within West Dunbartonshire. Importantly this policy represents our commitment to promoting healthy relationships and positive sexual health and wellbeing to all children and young people.



Mr Soumen Sengupta
Head of Strategy, Planning & Health Improvement
West Dunbartonshire Community Health & Care Partnership
West Dunbartonshire Council and NHS Greater Glasgow & Clyde

1.1 Local Consultation

The process began with a series of consultation events with staff from Social Work and health services working across West Dunbartonshire to ascertain their views and experiences on practice in relation to these issues.

Staff reported that for young people:-

- There are very specific needs tied up in their often already distorted experience of relationships and in the experience of being looked after.
- This includes distorted boundaries in relationships, peer pressure to be sexually active, poor basic knowledge of sexual health, a lack of concern for their own wellbeing, becoming pregnant to feel loved and seek affection from others and uncertainty about confidentiality.
- That in the current climate of a highly sexualised media and culture and the widespread ease of availability and use of pornography boundaries including sexual boundaries for looked after young people can be especially damaged.
- There is a need for unambiguous appropriate guidance and information and positive role models of appropriate behaviour in the absence of their parents.
- There is a need to be able to access local sexual health services easily and with minimal barriers.

Therefore staff identified:-

- That they see a significant role for themselves in providing accurate information and guidance.
- That they would welcome a chance to receive training on sexual health and relationships to enhance their skills and confidence in this area.
- That clear well defined policy and practice guidance across council and health services would be very useful in taking this work forward.
- That the Sandyford Hub and satellite services at the Vale of Leven and Clydebank and the Looked After nurse offer an opportunity for looked after young people to have improved access to clinical services.

Following these consultation events, a writing group was established to review policies from other local authorities and develop guidance specific to West Dunbartonshire. In adapting this policy the writing group were mindful that the intention is make sure that staff and carers are provided with unambiguous guidance which fully enables them to fulfil their role as corporate parents of the children and young people in this important area of children and young people's lives.

This policy is therefore designed to foster a culture among staff that normalises discussion of relationships, puberty and sexual health, and helps staff to change young people's perceptions so that they have the knowledge, attitudes and practical skills to delay sexual relationships until they are physically and emotionally mature to handle the consequences of a sexual relationship.

Definitions

The term 'looked after' includes all children and young people who are subject to supervision requirements and live with parents, family members as well as looked after and accommodated children who live with foster carers, in residential schools, residential establishments or secure care. Reasons for supervision requirements include the child or young person experiencing a lack of parental care; where there is a risk of offences being committed against them. Children and young people can also become looked after if they commit an offence; out with parental control; non attendance at school; or 'falling into bad associations or exposed to moral danger'[3].

Most children and young people are looked after through a supervision requirement naming their parent and remain at home or with extended family members. Where a supervision requirement names a residential establishment or foster carer, children and young people are "looked after and accommodated". Where a supervision requirement has a condition of residence naming a relative, this is known as kinship care. Children and young people can move in and out of looked after status and, when they are looked after, can experience several different placements. However, it should be remembered that children and young people who are looked after and/or accommodated are a highly heterogeneous group – and require suitable, appropriate and accessible services that are responsive to their needs[3].

The term "corporate parenting" is the collective responsibility of local authorities, their elected members and their stakeholder partners for all children and young people in their care. It constitutes the formal and local partnerships needed between all departments and services and associated agencies, who are responsible for working together to meet the needs of looked after children and young people. The Regulations and Guidance on Services for Young People [ceasing to be looked after by local authorities] gives a simple, but very clear definition of Corporate Parenting as "this means that the local authority should look after these children as any other parents would look after their own children. The role of corporate parenting is not restricted to the social work department of the local authority but applies to all departments and agencies who should recognise their own responsibility to promote the welfare of looked after children and young people and ensure that their needs are adequately addressed by each department"[3].

2. Policy Aims

The overarching aim of this policy is to provide guidance and a best practice framework for staff and carers to encourage them to positively and proactively promote the sexual health and well-being of children and young people in their care. Specific pieces of work and action need to be undertaken in discussion with the young person's social worker and in the context of the young person's care plan.

This policy has been created in the context of the local authority's statutory responsibilities to act as a 'corporate parent' to those children and young people who require, for whatever reason, to be looked after and accommodated away from home. It should be followed by all staff and carers who care for children who are the responsibility of West Dunbartonshire Council.

This policy specifically recognises the needs and vulnerabilities of children who are looked after away from home and actively seeks to challenge any barriers to their health and well being. It is worth reiterating that the emphasis within this work is to create an environment in which young people themselves, as they reach adolescence, learn to make confident and respectful choices in their lives. For this to be achieved, learning needs to take place throughout childhood, to be age and stage appropriate and to take into account the evolving capacities of each individual child. In this respect, the policy seeks to 'normalise' the varied discussions on sexual health and relationships that need to take place for a child or young person to understand themselves and how they relate to others.

It is recognised that by developing this policy, considerable challenges are raised for staff and carers, not least that it demands of them the need to look at their own values and attitudes towards sexual health and relationships and how these are communicated to children in their care. This communication can take place through a variety of methods e.g. what and how a topic is talked about, what is not talked about and role-modelling. For this policy to be effective, staff and carers will be helped to think through these issues and to reflect on the vital role that they play in promoting positive sexual health messages and anti-discriminatory practice.

In line with the broader context of this work, the emphasis within this policy is for staff and carers to promote with young people in their care the idea of 'delay'. There is a tendency in society when speaking about sexual health and young people to focus solely on the negative aspects of sexuality, in the hope that this will dissuade and scare young people from engaging in such activity. Whatever the rights and wrongs of such an approach, it is clearly not effective, as growing numbers of young people become sexually active at an early age. This policy therefore seeks to promote a more balanced view of human sexuality by acknowledging that sexual experiences should be about mutual pleasure, intimacy and respect. Staff and carers should help young people to realise that these goals are best achieved when they are older, have the maturity to know 'who they are' and they have the skills and confidence to relate to others

This policy does not stand in isolation and should be read and implemented alongside the existing policies and staff guidance in West Dunbartonshire

3. Rationale

The sexual health of young people in Scotland remains among the poorest of all Western European countries[5] and West Dunbartonshire's young people are no exception[4].

In one survey of S4 pupils aged 15 conducted in 2002 across West Dunbartonshire, 33% of all pupils had previously had sexual intercourse. Of those who had, 40% of girls and 17% of boys had used no method of contraception[5]. From national research conducted with S3 pupils aged 13 – 14, 18% of boys and 15% of girls had had sexual intercourse and 17% of boys and 13% of girls had had oral sex[6].

3.1 Local and National Intelligence

The growing body of research into the factors that show why some young people become sexually active at such a young age indicates that many of the same factors that lead to early sexual activity are the same factors that lead to young people becoming looked after[7].

It is also known that the circumstances in which young people who have sex under the age of 16 are often very poor, usually involving some form of peer pressure from partners of friends, alcohol or drug use, and having had no or limited discussion with important adults in their life on relationships and sexual health. Many young people who have sexual experiences at such a young age subsequently regret their experience[8].

Against this backdrop young people are growing up in a media culture that has become increasingly sexualised and one which sexualises children and adolescence[9].

Therefore it is not surprising that Scotland, in line with the rest of the UK, has highest number of teenage pregnancies in Western Europe and the third highest rate in economically rich countries[10]. Additionally it is estimated that approximately 1 in 10 of all young people will have acquired a sexually transmitted infection (STI) by the age of 20[5].

In this context it is therefore important that adults provide the appropriate information, learning opportunities and guidance to children and young people as they are growing up.

Research in the UK and Scotland shows that for children and young people who are looked after it is known that

- Despite the fact that looked after and accommodated children are identified as having a range of complex and unmet health needs, they experience more disadvantage than their peers in accessing universal and specialist health services. [13, 14]

- Many looked after and accommodated children have histories of sexual, physical and emotional abuse, contributing to distorted views and understandings of personal relationships and sex. In addition they can sometimes view sexual activity as a way of receiving love and affection[15].

- Many looked after and accommodated children may lack the essential inter- personal skills and self-confidence to access services and information and manage healthy personal relationships.[15]
- Disrupted schooling is a particular feature of the lives of looked after and accommodated children and is likely to lead to significant gaps in schools-based sexual health and relationships education.[16]
- Looked after and accommodated children are less likely than their peers to acquire information, support and guidance from parents and carers.[17]
- Both young women and young men with experience of care are more likely to become parents earlier than their peers without a history of care.[18, 19, 20]
- Significant numbers of those involved in prostitution and /or victims of sexual exploitation have previously been looked after and accommodated children.[21]
- Looked after and accommodated children who are lesbian, gay or bisexual (LGB) are vulnerable to homophobic bullying by their peers whilst accommodated. [22, 23]
- A disproportionate number of young people who have been looked after and accommodated become parents in their teenage years when compared to their peers who were not accommodated. [24]

3.2 Existing Legal and Policy Framework

In developing this policy, cognisance has been taken of the various laws,regulations, standards and policies that already exist and within which local authorities and health are required to operate. Many of these relate to children in general e.g. the Children's (Scotland) Act 1995, the UN Convention on the Rights of the Child (ratified by the UK in 1991), the Age of Legal Capacity (Scotland) Act 1991, the Criminal Law Consolidation (Scotland) Act 1995, the Sexual Offences (Scotland) Act 2010, the Human Rights Act 1998 and Equality Act 2010.

Others are more specific to children in particular circumstances and include Child Protection Procedures, the Regulation of Care (Scotland) Act 2001, the Support and Assistance to Young People Leaving Care (Scotland) Regulations 2003 and the Arrangements to Look After Children (Scotland) Regulations 1996.

The law in Scotland specifies that young people under the age of 16 cannot consent to sexual activity and that having sex with a young person of either sex under the age of 16 is a criminal offence regardless of the age of the person being charged

Offences can range from rape, unlawful sexual intercourse, lewd and libidinous behaviour to indecent assault. It should also be noted that the Sexual Offences (Scotland) Act 2010, which makes it an offence for staff with a professional relationship with young people to commit a sexual abuse of a position of trust, is applicable to young people up to the age of 18 years.

The Scottish Government has issued guidance for staff working with young people on how to manage the issues presented by young people who are sexually active under the age of 16. This remains in draft form at present.

It should be highlighted that although personal relations are sometimes ambiguous and open to interpretation, there are two particular circumstances which offer no ambiguity and would require an automatic referral to social work services. These are:

Where a child of 12 years of age or under is involved in sexual activity with another person and/or where the other person is in a position of trust in relation to a child or young person.

Scottish Government policy provides direction for both local authorities and NHS Boards, as well as their community planning partners to provide sexual health and relationships education, guidance and support to looked after children and young people.

Looked After Children & Young People: we can and must do better (Scottish Executive 2007) states that "in partnership with NHS Scotland, Learning & Teaching Scotland will develop supports to ensure high quality sex and relationships education and drugs education".

Respect & Responsibility (Scottish Executive 2005) states that "The Scottish [Government] Education Department will work in partnership with Directors of Education and Social Work, NHS Health Scotland and other key stakeholders on how best high quality, consistent and appropriate sex and relationships education which is consistent with national guidance is delivered in school and other settings, to vulnerable young people such as looked after young people".

This commitment was further strengthened in **Respect & Responsibility Sexual Health Outcomes 2008-2011** (Scottish Government 2008) which states that "young people not in school, young offenders and those who are looked after or accommodated are prioritised for the provision of sex and relationships education and one to one support by those services engaging with these groups".

Count us in: Improving the education of our looked after children (HMIE 2008) has 'signposts for improvement' that are relevant for SRE. In particular: "providing access to health checks and sex education programmes which looked after children may have missed due to changes in placements and schools" and "ensuring the needs of kinship carers including grandparents, are not overlooked when providing training programmes".

Equally Well (The Scottish Government 2008) reiterates the action within **Better Health Better Care: Action Plan** (The Scottish Government 2007) that each NHS Board should assess the physical, mental and emotional health needs of looked after children and young people and act on these assessments, with local partner agencies. Boards should ensure that more accessible health services are available to looked after children and young people as well as to those in the transition from care to independence.

Extraordinary Lives (Social Work Inspection Agency 2006) highlights the need to "Recognise sexually harmful behaviour and provide the specialist support that may help the child or young person to stop and keep others safe".

Curriculum for Excellence, Experiences and Outcomes (Learning and Teaching Scotland 2009) describe the expectations for learning and progression in Relationships, Sexual Health and Parenthood: Learners develop an understanding of how to maintain positive relationships with a variety of people and are aware of how thoughts, feelings, attitudes, values and beliefs can influence decisions about relationships, and sexual health. They develop their understanding of the complex roles and responsibilities of being a parent or carer.

Scotland's Children - The Children (Scotland) Act 1995 Regulations and Guidance:
Volume 2 places a duty on social work departments to ensure that appropriate Sexual Health and Relationships Education (SHRE) has been provided for looked after children and young people and care leavers. It notes that: SHRE will need to cover practical issues such as pregnancy, contraception and the prevention of the spread of sexually transmitted infections. It should cover the emotional aspects of sexuality, such as the part that sexuality plays in the young person's sense of identity and the emotional implications of entering into a sexual relationship with another person. It should also cover the right to say "no" and the need to treat sexual partners with consideration. It should refer to the dangers of sexual exploitation. The emotional and practical implications of becoming a parent should be conveyed.

It should be stressed, that this policy is not about promoting young people's sexual activity. Rather, it is about 'normalising' human sexuality and allowing children and young people to discuss issues, suitable to their age and stage of development. By such means, young people will have been given guidance in a safe environment and will be helped to develop the necessary skills to make confident and safe judgements in their lives.

Equality Act (October 2010)

The Equality Act 2010 brings together a number of existing laws into one place so that it is easier to use. It sets out the personal characteristics that are protected by the law and the behaviour that is unlawful. Simplifying legislation and harmonising protection for all of the characteristics covered will help Britain become a fairer society, improve public services, and help business perform well. Further information on the new Act can be found on our website here: www.equalityhumanrights.com/ea2010. Legislation is around protected characteristics listed below:

Protected Characteristics

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex

- Sexual orientation

Unlawful Behaviour

Under the Act people are not allowed to discriminate, harass or victimise another person because they have any of the protected characteristics. There is also protection against discrimination where someone is perceived to have one of the protected characteristics or where they are associated with someone who has a protected characteristic.

Discrimination means treating one person worse than another because of a protected characteristic (known as direct discrimination) or putting in place a rule or policy or way of doing things that has a worse impact on someone with a protected characteristic than someone wihtout one, when this cannot be objectively justified (known as indirect discrimination)

Harassment includes unwanted conduct related to a protected characteristic which has the purpose or effect or violating someone's dignity or which creates a hostile, degrading, humiliating or offensive environment for someone with a protected characteristic.

Victimisation is treating someone unfavourably because they have taken (or might be taking) action under the Equality Act or supporting somebody who is doing so.

4. Organisation and Management

4.1 Training, Support and Supervision

For this policy to be effective, staff and carers need to have clarity and confidence in what they are doing. It is essential, therefore, that appropriate training, support and supervision is provided to ensure that the demanding task of caring for young people and the positive promotion of their sexual health and relationship needs are carried out. It is equally essential that staff and carers are open to and attend such training so that their practice meets the requirements of the local authority.

In order that staff and carers develop confidence in communicating with children and young people and others about sexual health and relationships, training will be provided. This will be designed to explore the value-base that staff and carers bring to the subject, to provide the opportunity to share good practice, knowledge and skills and will include information about the range of professionals and theirs roles and responsibilities. When staff and carers identify gaps in their own knowledge and skills, or require help from more specialist resources, they should be listened to by line managers or supervising social workers and helped to access training and support. Staff and carers also have a responsibility to highlight if training is not meeting their needs.

Support for staff should take place within formal supervision with their line manager. This should be planned and consistent. Good supervision should be proactive in considering the building blocks required by children and young people. It should provide opportunities to discuss and record the complexities of this work and the feelings associated with it. This provides an opportunity to evidence the agreed outcomes of discussions with management. It should address the training and development needs of staff and it should also ensure that planned sexual health work that meets the individual needs of young people is being carried out. Foster carers and their link workers should also ensure that a similar means of support and monitoring takes places.

Support can be gained from staff and carer networks and also from colleagues in health including the LAAC nurse.

4.2 Safe Practice and Professional Boundaries

Staff and carers need to be mindful of the fact that it is through the trusting relationships developed with children in their care that they are best placed to provide young people with opportunities to safely discuss and explore their emerging sexuality and sexual behaviour. These relationships and discussions must, at all times, be undertaken in a professional context and within existing guidelines and codes of practice.

Staff and carers must always ensure that their relationships with young people are safe, caring, respectful and sensitive, and are maintained within appropriate professional boundaries. Under no circumstances would it be acceptable for staff or carers to engage in a personal or sexual relationship with a young person.

Some young people have a limited knowledge of sexual health and relationships and a basic lack of understanding of how their body works. Many children and young people who are accommodated have experienced abuse, whilst some may become involved in high-risk behaviours. Both of these may distort their responses to work undertaken with them relating to sexual health and relationships. Staff and carers therefore should always bear in mind the young person's background when offering any advice or guidance on sexual health and relationships, whether responding to general questions or undertaking specific work on certain topics. Any planned work with young people should form part of their care plan.

It is inappropriate for staff and carers to share information relating to their own personal intimate relationships and sexuality as this could be misinterpreted by the young person. Inappropriate use of personal information has been used to prime and groom young people towards abusive and exploitative relationships. If staff or carers have any doubts then they should discuss them within their line manager or link worker.

When working with children and young people on sexual health and relationship issues, staff and carers should be mindful of existing practice-guidance on safeguarding issues e.g. codes of conduct, dress codes, children and young people's rights to privacy, whistle-blowing procedures etc. For residential staff and foster carers in provision directly provided by the local authority, reference should be made to existing guidance on safe caring.

4.3 Care Planning and Reviews

Local authorities have a range of statutory duties towards children and young people looked after by them and once they leave care. These duties can be found in various legislation that includes the Children (Scotland) Act 1995 Regulations and Guidance, the Arrangements to Look After Children (Scotland) Regulations 1996, the Regulation of Care (Scotland) Act 2001 and the Supporting Young People Leaving Care in Scotland Regulations 2004, We Can and Must Do Better (2007), These Are Our Bairns (2008), Looked After Children (Scotland) Regulation 2009 and the Adoption Act 2007. The most important duty the local authority has in respect of looked after and accommodated children is to safeguard and promote their welfare. In addition, it is required to formulate a written care plan, to formally review care plans and to prepare young people for when they are no longer looked after

The care plan (known as the 'pathway plan' for young people leaving care) should be drawn up with the child or young person, their parent(s) and other important individuals and agencies in their life and should reflect their views, even if they are contrary to that of the statutory agencies. Staff and carers will ensure that all children and young people are adequately prepared for reviews, including who will be present and what will be discussed. The minute of the review should also reflect their expressed views.

The health and education of children and young people are important issues that must be addressed throughout the care planning and review process. In planning and managing care plan reviews local authorities should balance the requirements of accountability and information-sharing with children and young people's rights to privacy and normality. Reviews should be managed so that children and young

people and their parent(s) are able to see a review as helpful rather than intrusive. Sexual health issues can be very private and sensitive topics and a review is not the best place to discuss these issues in depth. However general issues in relation to sexual health and education of young people should be included in the planning and review process.

Any proposed work in the care plan should be shaped by the expressed needs and concerns of children and young people, alongside their existing levels of knowledge and sources of information. The person responsible for ensuring the provision of advice, support and guidance will be identified. Children and young people should be encouraged to take an active role in choosing this person. Choices around the sex of the adult, ethnicity and sexual orientation should be accommodated as much as is practicable.

As young people approach adolescence, it would be good practice to ensure that they meet, or at least know of or how to contact, the Looked After Children's Nurse (See Appendix 2) This contact can be on any health related issue. Familiarity with staff from this team may assist young people to more easily raise issues with them and gives young people another alternative source of information and guidance.

Some young people place themselves in danger and present a risk to themselves or others because of their involvement in risk taking behaviour. In such cases the child protection will be applied, with a review of the action plan linked to the existing care plan reviews.

4.4 Confidentiality

Personal sexual health information, by its very nature, is a private matter whatever the age of the person involved. Its handling therefore requires the utmost sensitivity and respect and would come under the terms of human rights legislation (Article 8) and the Data Protection Act 1998. The existence of such legislation does not mean that information can never be shared but that particular care needs to be taken over the sharing of such information. The local authority as the 'corporate parent' needs to ensure that personal sexual health information is not shared with others (staff, carers or agencies) unless there is a clear and good reason to do otherwise[25].

It is well documented that one of the main obstacles deterring young people, whatever their background or living circumstances, from seeking early sexual health and relationships and/or pregnancy advice is their fear about who will have access to their personal and private information. Both legal judgments and professional codes of conduct recognise that without assurance and clarity about confidentiality, children and young people may be reluctant to give professionals the information they need in order to provide good care and protection [26].

For children and young people who are looked after and accommodated the issue of who has access to personal and private information is not as straightforward as for other young people. The sharing of information required by the care-planning process is necessary to ensure an integrated care approach is taken by all those involved. It is however acknowledged that this requirement can often leave young people feeling that they have few rights to privacy about any aspect of their lives. information needs to be shared and to help young people understand these distinctions.

Under the national guidance for working with young people who are sexually active, one of the key tasks that professionals are required to do is to make an assessment as to whether the young person is involved in behaviour or a relationship that is abusive or exploitative. To make such an assessment, the professional needs to be competent and be in a position of responsibility to carry out this duty. Such a responsibility would never lie with substitute carers nor would it be the lone responsibility for a residential worker. Young people therefore need to be made aware that information acquired by staff and carers about a young person's sexual activity would need to be shared with the young person's social worker and a line manager. This requirement does not negate the fact that information needs to be dealt with sensitively and respectfully. The assessment would then proceed as it would for any young person who is or is planning to be sexually active[27] .

Professionals need to ensure that young people who are looked after and accommodated are informed from the outset that confidentiality is not absolute and that information may be shared with other residential or social work staff. If confidentiality needs to be departed from, every reasonable attempt will be made to discuss this with the young person beforehand, and to seek their agreement. However, there may be occasions of a child protection nature when a discussion with the young person at the referral stage is not possible.

Alongside the law and professional obligations of confidentiality, there are strict rules under the Data Protection Act 1998 as to what professionals are allowed to do with personal information regarding children and young people. It is also important to note that for data protection purposes, under S66, the critical age is 12 – a child or young person aged 12 or above is presumed to have sufficient mental capacity to be able to exercise their rights and make decisions regarding their own information. This specifically includes matters such as the results of pregnancy or STI tests, as well as information supplied by the young person to the professional (or to which the professional has access) [26].

Both the Council and the Health Board have detailed guidance and procedures relating to data protection issues, and it is equally important to follow these when working with children or young people in a sensitive area such as this. The data protection rules create a framework within which professionals can determine whether they may disclose information to another person or not, and spell out what the child or young person themselves have to be told about how their information will be used, and by whom. For inter-agency work, professionals should also consult the Data Sharing Protocol between the Council and NHS Greater Glasgow and Clyde, which addresses many of these issues in more detail.

All professionals recording information or releasing information to other parties and persons have legal and professional duties to ensure that the information recorded is accurate, relevant and sufficient for its purpose, and that any disclosure is lawful – either through the consent of the young person concerned, or due to the presence of concern factors which outweigh lack of consent.

Staff and carers will ensure young people are aware of their right to access the complaints procedures where they feel their confidentiality has been infringed.

4.5. Working with Birth Parents and Extended Carers

It has long been recognised that children and young people who are accommodated have a more positive care experience when staff and carers are able to work in partnership with birth parents and the extended family to promote the best interests of the child. Whilst tension may exist as to the reasons behind the child's need to be accommodated, in general, parent's views and their co-operation should, where appropriate, be sought, as it is better for the child's well-being to work in a spirit of openness and through consensus. Therefore all parents, foster carers, kinship carers will be made aware of this policy through routine contact with staff.

Adults who have parental rights in relation to children who are looked after away from home have the right to have their views considered in the decision-making processes which affect their children. The Children (Scotland) Act 1995, S17 (3), also states, in so far as is reasonably practicable, that the views of parents without parental rights and responsibilities and other people who the local authority consider relevant e.g. a relative with whom the child is placed away from home, must also have their views considered. In addition, the Act places an obligation on the local authority to work in partnership with parents who have responsibilities, rights and duties to direct and guide their children in the exercise of their rights, consistent with their evolving capacities [28].

In general, parents should be informed and encouraged to take an active part in promoting the sexual health and well being of their children. Where it is possible, and particularly in those circumstances in which a return home is likely, it may benefit the long term welfare of children to include parents, in whatever way possible, in any planned pieces of work. This would help to improve child-parent communication and should avoid mixed messages being given to the child.

As young people mature and become more capable of making informed decisions about their lives there may be occasions when issues relating to sexual behaviour or its outcomes are not communicated to parents. Decision making on this matter should take into account the views of the young person, their evolving capacities to make decisions, the safety of the young person and their overall 'best interests'. In general, staff and carers should encourage and support young people to share information with their parent(s) where it is safe to do so. It should be noted that information should not be shared with parents of young people aged 16 -18 years against their wishes. This is due to the fact that the only responsibility that parents have to their 16 -18 year old children is that of guidance. Guidance is only advice and if the young person does not wish to take advice from his/her parent then confidentiality should be maintained [28].

It should also be noted that in Scot's Law a child under the age of 16 has the legal capacity to make decisions on health interventions provided they are in fact capable of understanding its nature and possible consequences. This is a matter of clinical judgement and will depend on the age, maturity of the child, the complexity of the proposed intervention, its likely outcome and the risks associated with it. This rule applies to all health interventions, including assessment, treatment and counselling. Under this Act, every effort should be made to encourage the child to involve their parents. However, intervention can take place if the child is opposed to parental involvement and is deemed to be competent. If there is a difference of opinion between and child and their parent, where the child has the capacity to make an

informed choice, the child's decision must be respected and given effect to, even if it differs from the parent's or professional's view [29].

4.6 Involving Young People

For this policy to be effective and a living document, young people need to be made aware of its existence, its contents and the implications for their care. From the outset, as this policy was being drafted, young people were consulted about its contents and how messages can effectively be delivered. This process will hopefully continue, particularly regarding the production of material for young people that is accessible and attractive to them and ensuring that their views are incorporated into training for staff and carers.

However, the most important means of getting information across to young people on an on-going basis will be through staff and carers themselves. In relation to ensuring that young people have access to practical information about services, help-lines etc., staff and carers need to develop methods of providing information for young people that are discreet, sensitive and accessible within their particular care setting. However, what are of more importance are the indirect messages that staff and carers provide. Attention therefore should be given within the care environment to setting an appropriate tone and normalising discussions about sexual health and relationships and appropriately using opportunities that occur in everyday life to explore issues.

5. Normalising Discussion of Relationships & Sexual Health Between Adults and Children & Young People

5.1 Early Messages

This document is focused on helping staff and carers to educate children and young people in a way that helps them to see sexual health and relationships as a normal part of 'growing up' and making that transition to adulthood. It acknowledges that children and young people are sexual beings and that they require guidance to help them understand the physical and emotional changes they will experience from puberty onwards. Learning about relationships and, in particular, gender roles, begins at an early age. In addition, good self-esteem, an internal focus of control and the skills that teenagers require are all learned in their formative years. It is important therefore that the 'building blocks', that are not explicitly sexual at all, are put in place in an age-appropriate manner throughout childhood.

Currently in society, many parents struggle with the idea of talking with their children about sexual health and well-being. When it comes to children and young people who are accommodated, staff and carers may have additional worries about raising such issues when children in their care are already vulnerable, may struggle to trust or communicate with adults or have a range of unmet emotional needs due to previous poor parenting. It can be tempting to delay talking about their emerging sexuality, particularly with children who are emotionally immature or who have special needs. However, this may make it more difficult to discuss such issues when they do arise. Children, particularly those who have difficulty forming relationships, who have attachment difficulties or who have experienced neglect, will benefit from staff and carers clearly showing concern for their safety and health before adolescence begins. How children will respond to puberty and to sexual health and

relationship education will largely depend on their early experiences and the quality of the parenting they have received [30].

With this in mind, staff and carers need to encourage and support children to identify their own and others peoples' emotions, to talk about and identify their feelings and encourage them to talk about relationships and friendships. In addition they should ensure that children know the proper names of parts of the body, including private body parts. Staff and carers should be familiar with the language individual children use for parts of their body.

Staff and carers should also be mindful of the fact that children learn as much from what adults do not say as from what they do say. They also learn from what they see around them in their daily lives. Staff and carers therefore need to role model problem solving, whether that is about dealing with relationships or difficult emotions.

Best Practice

- Staff and carers should try to answer all questions sensitively and honestly, in an age-appropriate manner. If more detailed information is required they should seek appropriate support or information.
- Staff should, where appropriate, ensure parental involvement in the same conversations.
- Children should be encouraged to take care of and respect their bodies and other peoples, with this being reinforced by rules e.g. "no-one is allowed to hurt anyone else here".
- Staff and carers should sensitively use issues in the media as an opportunity to open a discussion about particular topics.
- Staff and carers will ensure children know their safety and health are important.
- Staff and carers should seek advice and support for children with problematic sexualised behaviour.

5.2 Puberty

Puberty can be an exciting but also a confusing and embarrassing time for young people due to the physical and emotional changes they experience as their bodies develop into adulthood. It can be particularly stressful for young people who may have difficulty in trusting adults or who are less likely to enjoy positive relationships with their peer group. Puberty may also bring a range of emotions and reactions from children and young people and it can be a time when they develop unhealthy eating patterns and lifestyles.

Staff and carers should prepare children and young people in advance for both the physical and emotional changes they will experience during puberty and reassure them that puberty is a normal experience. Young people need a basic understanding about their bodies and how they work before puberty starts. Whilst the onset of puberty varies, it can begin as early as 9 years of age. Age appropriate reading material can help prepare young people for the changes they will experience and provide a focus for discussions with staff and carers. Young women need to be

prepared for menstruation, vaginal discharge and breasts starting to enlarge. Young men need to be aware of voice breaks or deepening, penis enlargement, erections, muscle growth, 'wet dreams' and Adam's apple growth. Hormonal and emotional changes, mood swings, growth of body hair, tiredness, awareness of sexuality and masturbation are likely to affect all young people.

It is really important that girls are fully prepared for the physical and emotional changes that can occur when they start to menstruate. Some girls can start their periods at the age of 9 so it is important not to delay learning about this important part of girls' development. Some young women may require additional support including health care to manage the physical and emotional impacts of menstruation. This might include accessing a GP or other health practitioner. Young women that have experienced sexual abuse may require more intensive support to manage menstruation.

Unfortunately menstruation can be referred to in negative terms, as something to be ashamed of and not to be discussed openly. Because of this some young women can view menstruation with anxiety and some young men can use it as a source of inappropriate humour. It is therefore important that staff and carers discuss menstruation in general terms openly and positively with all young people and always challenge negative remarks, inappropriate jokes and ridiculing behaviour especially involving sanitary products. A similarly level of openness should occur in respect of changes experienced by young males.

Best Practice

- Young people should be encouraged to take responsibility for their personal care and hygiene and should have easy access to toiletries, skin care products, sanitary materials and disposal. They should ensure that girls are aware of the range of sanitary products available and how to fit them before their bodies reach puberty.
- Staff and carers should be aware that emotional difficulties e.g. those arising from low self-esteem and/or sexual abuse can affect how young people experience puberty and manage their own self-care.
- Any emerging unhealthy eating patterns and lifestyles should be discussed with the young person's social worker and the carer's link worker.
- Staff and carers need to be familiar with different cultural and minority ethnic practices in relation to puberty.
- Staff and carers will also be available to discuss any issues relating to puberty sensitively and discreetly on a one-to-one basis with both young women and young men.
- Staff and carers will ensure that young women know that GPs (See Appendix 2) and other health services can provide additional support in relation to pre menstrual stress etc.
- Staff and carers should be aware of any gender sensitive issues e.g. allowing a young person to choose between a male or female worker.

5.3 Masturbation

Masturbation is a part of normal sexual behaviour, for both boys and girls who are exploring their sexuality. There is ample medical evidence stating that masturbation does no harm. However, many religions and cultures teach that people should not masturbate and this can cause feelings of guilt and embarrassment. It is important to acknowledge their differing beliefs and ensure young people understand the social conventions associated with sexual behaviour in general and masturbation in particular

In all situations, staff and carers need to give clear and consistent messages that while masturbation is normal there are times and places when it is not appropriate. Staff and carers should be aware of the importance of language used when talking about masturbation. Young people should be encouraged to use safe and private places and they need to be sensitively made aware of inappropriate touching and how this may cause embarrassment and offence to others.

Staff and carers should be aware that overtly sexualised behaviour or inappropriate sexualised behaviour might be a sign of underlying issues e.g. abuse. In such instances they should raise this with their line manager or supervising social worker to seek advice

Best Practice

- Staff and carers should have an awareness of their own values and beliefs and discuss any issues in supervision.
- Staff and carers will actively challenge myths about masturbation being harmful, e.g. it will make you go blind.
- Staff and carers will know how and where to obtain and provide appropriate information for young people about masturbation along with all sexual health issues (See Appendix 2)

5.4 Sexual Health & Relationships Education in School

All local authority schools, both primary and secondary, are expected to provide age-appropriate sexual health and relationships education. Children and young people who are looked after and accommodated can often miss out on this important part of their education either through placement moves or periods of exclusion or through non-attendance of a local authority school. School based education offers an opportunity for staff and carers to open up discussion on sexual health and relationships and, by being informed of what is being taught in school, staff and carers can positively reinforce the learning for the child and young person.

Schools have a legal responsibility to consult with parents and carers on the content and delivery of sexual health and relationships education. Staff and carers will ensure that schools attended are aware that they are expected to consult on this matter.

Efforts should be made by staff and carers to work with the school to consult with birth families on the curriculum. Practically all parents support the provision of school based sexual health and relationships education and many recognise the need to work jointly with schools. Staff and carers must also play a role in supporting this education. Birth families may object to aspects of the curriculum and may also ask that their child be removed from certain classes. Often some reassurance from the school on the content will overcome this. Staff and carers will make every effort to reassure parents on the need for this class so their child does not miss out, however families may still proceed to ask for their child not to attend. Young people have the right to have their views taken into account and if they wish to attend, staff and carers are expected to work with the school staff on trying to resolve this matter.

If, for any reason, young people do not have access to school-based sexual health and relationships education this must be addressed in their care plan.

Best Practice

- Staff and carers should be familiar with the content of the curriculum of a school attended by a child or young person in their care and can use this to support learning.

- Birth families should be informed on the schools based education programme as appropriate to the young persons care plan. Any parental objection to sexual health and relationships education should discussed at the young person's review meeting.

- Every school has a designated LAC senior member of staff and West Dunbartonshire Education Department has a LAC Education Team which is part of the Flexible Resource Centre. (See Appendix 2) that can provide staff and carers with advice and guidance if required.

6. Addressing Equalities

"Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled"[31].

6.1 Anti-Discriminatory Practice

The UN Convention on the Rights of the Child states that all the rights in the Convention must apply to all children "without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religious or other opinion, national, ethnic or social origin, property, disability, birth or other status" [Article2:1] [32].

In addition, public bodies are required to work within various laws and have specific public duties to ensure that their practice is non-discriminatory. The European Convention on Human Rights, which the Human Rights Act 1998 gives effect to, is

directly binding on the Local Authority. As a result of these, both West Dunbartonshire Council and NHS Greater Glasgow & Clyde have specific policies on these matters.

It is now well established that people from communities that experience any form of discrimination are more likely to experience ill health. If people grow up only hearing negative messages about themselves then they are likely to experience low self esteem, have less of a sense of their own rights, less likely to feel the need to look after themselves and more likely to seek approval and affection from any source. In a sexual health and relationships context this often means agreeing to unwanted sex or entering into unequal and unfulfilling relationships to try to numb the feelings of damage caused by discrimination[33].

All young people have the right to grow up with a positive self-identity and be free from discrimination of any kind. No young person should be disadvantaged or discriminated against because of his or her race, culture, religion, age, gender, disability, sexual orientation or because of their "looked after " status [32].

Best Practice

- It is essential that staff and carers have opportunities via training and supervision to discuss their own values and beliefs and how these impact on their work with children and young people. It is important that staff and carers respond positively to 'difference' and that they do not impose their values and beliefs on those in their care.

- Anti-discriminatory practice will be addressed as an integral part of supervision.

- Discriminatory attitudes, behaviours, comments and stereotypes about sex and sexuality will be challenged by staff and carers, whether they are from carers, children and young people or staff.

- It is essential that information is provided to children and young people in ways and formats that best meet their individual and specific needs. In terms of access to information, it is important to use accredited translators, interpreters, sign language interpreters and to provide information in formats which enable young people to fully understand the information provided. Where this information does not exist, this should be raised through line management structures.

6.2 Working with Young People in a Gender-Sensitive Manner

This policy proposes that to achieve effective intervention with children and young people on sexual health and relationships issues, an understanding of gender is vital. A gendered approach challenges the view that traits and behaviours, often described as 'masculine' or 'feminine', are biologically determined and inherent in all males or females. A gendered approach sees traits and behaviours as being socially prescribed, thus forcing males and females into pre-determined, narrow roles. What is also created is a gender-imbalance in which, as a result of masculinity, male's traits are often associated with power, knowledge, analytical thinking and physical prowess etc. whilst feminine traits are associated with weakness, nurturing, intuition and passiveness. In practice, what this creates is a set of assumptions and negative

and restrictive stereotypes that ultimately affect young people's well-being and safety.

All young people have the right to a positive body image and a healthy and confident attitude to relationships, feelings and sexuality. It is important therefore that staff and carers do not actively promote negative stereotypes. Through training and supervision they will be helped to look at their own values and attitudes and how these translate to children and young people in their care. In addition, staff and carers need to explore issues about gender-imbalance and its impact on behaviour and so challenge negative stereotypes within the care environment.

When working with young men, this means not assuming that they are knowledgeable and confident about sexual matters and do not want to talk about emotions. Staff and carers need to be mindful that many young men may have experienced past abuse which has affected their confidence and abilities to form relationships. Young men should therefore feel respected and listened to by staff, believe that anything they raise will be sensitively dealt with and that they will be given appropriate information. All young men need advice about safer sex, about negotiating skills and their responsibilities towards sexual partners. In particular, issues around consent and commitment should be discussed.

Some heterosexual boys and young men, in an attempt to mask low self-esteem or possibly as a result of what they may have witnessed or experienced as children, demonstrate and verbalise very negative attitudes to females that can be carried into their own relationships. In addition, homophobic language and bullying can be used to distance themselves from what they perceive to be feminine traits. These behaviours can become more apparent during adolescence when young men are trying to conform to a sense of 'masculinity' and establish what 'maleness' means for them. Staff and carers, both through what they say and through role-modelling, need to challenge negative perceptions and provide these young men with an alternative way of seeing the world. In particular, the use of violence, whether actual, threatened or verbal, needs to be countered.

In recognition of the different power relationships in society, the approach to working with young women needs to be framed differently. From an early age, young girls need to be given a positive view of their bodies and, as they get older, a positive view of their sexuality and the right to make choices. This approach should promote acceptance and pride of their bodies to counter constant messages that lead to a sense of shame and anxiety. Staff and carers should not assume that young women understand their bodies or how they function. Clear and accurate information is vital.

Young women also need to be taught a range of assertiveness and negotiating skills that emphasises their rights to make choices and to have those choices respected. Again, due to past abuse or what they may have witnessed and experienced in childhood, many girls and young women who are accommodated may have distorted ideas about relationships, in particular the use of violence. Staff and carers need to help young women move away from such distorted thinking, to learn how to value themselves and to see their own safety as paramount. Staff and carers will support young women to get out of abusive or exploitative relationships, if these occur.

Best Practice

- Discussions with young men and young women need to contain clear factual information about sexuality that take a gendered approach and is delivered in a manner chosen by them and with which they feel most comfortable. Options should include who talks to them, the sex of the person and preferences for a group or individual setting or jointly with a partner.
- For all young people, but particularly when working with young women, staff and carers should emphasise that they should not be defined solely by whether they are in a relationship or not.
- Staff and carers will understand and explore with young men different power relationships in society, particularly exploitative relationships, and encourage them to make safe choices for themselves and their partners. Staff will challenge any sexually discriminatory or abusive practice and support young women to get out of any abusive relationship.
- Staff and carers will provide positive role models and will not exhibit any negative, discriminatory or homophobic attitude.

6.3 Working with Young People with Disabilities

Young people with a disability have the same rights, feelings, interests and concerns associated with their personal care, sexual health and relationships and sexuality as all other young people. This should not be ignored but needs to be discussed with the young person to explore their wishes and feelings.

Young people with a disability may be at greater risk of abuse, exploitation and coercion than their non-disabled peers. Staff and carers can appear over protective in their attitudes and need to respect the young person's rights to express their sexuality in a safe and appropriate manner [34].

For some young people the major impact on personal relationships and sexual activity is social and emotional rather than as a direct result of their disability. Young people with a disability may experience less independence in their lives that may limit their opportunities to experiment with or experience intimate personal relationships. All young people have a right to respect and privacy.

As part of a young person's care plan, alternative ways of expressing intimacy may require some explicit and detailed information giving on the part of staff and carers. They will need support and additional training that includes exploring their own attitudes and assumptions about the sexuality of young people with a disability.

Young people with a disability who need information, advice and support with issues of sex and sexuality have the right to the same level of confidentiality as other young people. This can be a particular issue for young people with a learning disability. In the past sexual health and personal relationships education for these young people has been about protecting them from abuse and understanding appropriate behaviour. It is equally important to include knowledge, the use of skills and exploration of attitude to help young people make positive decisions in their lives.

Best Practice

- Staff and carers should negotiate clear boundaries around physical contact and personal care with the young person at a level appropriate to their understanding.

- Staff and carers will need training and access to support and advice from specialist agencies. They may also need access to specific material geared to the variety of abilities and needs of young people who have a disability.

- The care plans for all young people who have a disability should incorporate sexual development and the young person's views taken into account.

6.4 Sexual Orientation

It is thought that around 10% of the population do not identify as completely heterosexual i.e. are attracted only to the opposite sex [35]. People who are lesbian, gay or bisexual (LGB) are present in all classes, creeds, cultures and races of the world. People who are LGB experience high levels of prejudice which can take various forms. These range from overt comments, threats and physical violence to more subtle behaviour that leads to exclusion. Many young people experience homophobic bullying, particularly at school, whether a young person identifies as LGB or not. It is known that young people who are LGB are more likely to have poorer mental health than other young people [36]. Those who are looked after away from home may experience greater emotional distress and therefore will require comprehensive support.

All young people who are LGB have the same right to explore and express their feelings and pursue happy and fulfilling relationships as everyone else and therefore staff and carers are expected to provide an environment that is welcoming and supportive.

Young people who are LGB go through a process known as "coming out" whereby they acknowledge their sexual orientation first to themselves and then, if they feel safe enough, to others. Whether it is to parents, staff, carers, friends etc, telling others can be stressful. It is therefore important that staff and carers explore their own beliefs and values from the outset so that they are able to deal with situations sensitively and ensure that the young person is supported throughout these events.

Young people who are LGB may have additional knowledge gaps around their sexual health therefore staff and carers should offer guidance and help source appropriate information and support. A referral to another agency should not be the only means of supporting a young person.

Like all young people who are sexually active, those who are LGB should be encouraged to look after their health and have regular health checks. Sandyford (See Appendix 2) are able to offer a range of advice and information to staff, carers and young people if required.

Some young people who are LGB explore their sexuality in secret due to concern about other people's prejudices. This can mean that specific child protection issues

might arise, especially for young gay men who may use cruising areas or internet chat rooms.

Best Practice

- As part of their day-to-day practice, staff and carers should acknowledge sexual diversity and should promote, with other staff, carers and children and young people in their care, anti-discriminatory practice. They should avoid the use of, and challenge, discriminatory jokes, language, and behaviour. They should not assume that everyone is heterosexual.
- If a young person 'comes out' to a member of staff or a carer it is helpful to acknowledge their bravery, to offer reassurance and to listen. In addition, their feelings can be further validated by staff and carers involving them in the same conversations about relationships that occur with heterosexual young people. It is not helpful to make statements about a young person's sexual orientation being a passing phase. Whilst, this can be true for some young people, it implies that it would be better if they weren't LGB.
- Staff and carers should deal with the issue of sexual orientation with the utmost sensitivity. They should not directly ask a young people their sexual orientation; however staff should finds ways to open discussion on sexual identity in an affirming manner. Staff should not share information about a person's sexual orientation with others unless not to do so would put the young person at risk of significant harm.
- In relation to violence or harassment, staff and carers will encourage young people to explore the implications of pursuing police action, either in person or through the third party reporting system and support them to do this should this be required.
- If a young person has been subjected to homophobic bullying in school, with the young person's agreement, staff and carers should inform the school and ensure the school takes steps to address this. If the young person does not wish to have the incident taken up directly with the school, the issue should be raised anonymously with the Education Service.

6.5 Transgender Issues

Transgender or 'Trans' is an umbrella term used to describe the whole range of gender identity and expression. People who cross dress only, belong to a slightly different category. People who cross dress are happy in the main with the gender into which they are born and do not wish to transition. For example, a male would wear female clothing but is happy to take off the female clothing and remain male. This is quite different from an individual with gender dysphoria or transsexualism, who has a persistent and ongoing desire to remain in the converse gender, and identifies as trans. It is important not to confuse gender identity issues with sexual orientation.

Transsexuals often feel like they were born in the wrong body. This can be extremely distressing and many can undergo a long period of psychiatric or psychological assessment, social and emotional support and eventually may undergo hormone treatment and surgery. This is so that their body will match what

they consider to be their true gender identity. This process is known as transitioning. The Gender Recognition Act 2004 now enables people to be legally recognized and accepted in their new gender role and the Sex Discrimination Act 1975 offers legal protection against discrimination.

Trans people often become aware of these feelings at a very young age (often by the age of 4 years). Parents, staff and carers can become upset, confused and anxious when children and young people express themselves with a different gender identity and may also be worried about the consequences for their physical safety.

When young transsexuals become aware of the changes at puberty, this can crystallise their feelings and cause the onset of extreme distress. This often leads young transsexuals to experience depression, self harm or problematic alcohol or drug use. Only consultant psychiatrists specialised in gender identity are able to offer diagnosis and treatment. An early referral to an appropriate Child and Adolescent Mental Health Service (See Appendix 2), or the adolescent psychiatrist within services offered at Sandyford, (via the young person's GP), is crucial in order to access clinical support.

When young transsexuals approach puberty it may be possible for them to be prescribed hormone blockers which can delay the onset of puberty indefinitely until such time as the young person is able to make a more informed choice about the level of transitioning they wish to pursue. This is becoming a more recognised treatment but one that would require a very sensitive and expert assessment beforehand. It can be particularly important for biological girls that identify as male as this can prevent the need for a mastectomy later in life. While some young people may be taking hormone therapy it is unlikely that many will have undergone gender reassignment surgery.

Best Practice

- Staff and carers will ensure that their behaviour and that of others around young transsexuals is respectful and that all discriminatory jokes, language and behaviours are challenged. It is helpful to explain trans issues to all young people so they understand that young transsexuals have a right to be treated with respect.

- Staff and carers should consult with the allocated care manager about young people who appear to be trans and together they should ensure a referral for psychiatric assessment (see above).

- Staff and carers can offer a range of support including listening and talking with the young person about their feelings, ensuring they are consulted at every stage of the process and by assisting the young person with any medical treatment they are prescribed. Staff and carers should also consider how they might be able to sensitively support the young person to cross dress, if this should arise. This can raise challenges within a residential setting. Appropriate support for staff and carers will be made available.

- Staff and carers will discuss with young people their feelings in relation to telling parents, carers, staff or other young people about their gender identity and respect and support their decisions.

- Staff and carers will use the young person's choice of pronoun "he" or "she" and use the name chosen by them. If unsure, staff and carers will ask the young person how they wish to be addressed or referred to and support this by asking other staff and young people to agree to this. In some cases the young person may not identify with either gender.

6.6 Working with Young Parents

Young people, and especially young women, have babies at an early age for a variety of complex reasons. From evidence gathered as part of the English teenage pregnancy strategy, about three-quarters of conceptions are unplanned. Young women from more deprived areas are more likely to continue with the pregnancy whereas young women from more affluent areas are more likely to seek a termination. A significant minority of young women plan their pregnancies. The majority of these tend to come from areas of high deprivation. For many this decision can be influenced by emotional gaps in their own upbringing, an attempt to gain control in their lives or a perception that motherhood offers them a positive and fulfilling role in society, particularly when educational and employment opportunities are perceived as being poor[37].

Young parents face considerable discrimination. In general, society's approach to teenage parenthood is extremely negative, a view that is heightened the younger the teenager is. Whilst there is a genuine concern and sadness about the loss of childhood and the responsibility that early parenthood brings, there is a very judgmental tone to much of the comment, with the brunt of criticism being shouldered by young women, who are used to personify a range of perceived societal ills. Young women who become pregnant may internalise these negative perceptions and this can have a major bearing on how they deal with their pregnancy and when and how they approach services. With this as a backdrop, it is incumbent upon staff and carers not to promote but to challenge such views.

Once a young woman or couple choose to proceed with a pregnancy, the emphasis for staff and carers should be about supporting the young person to make a smooth and confident transition to parenthood. Whilst it should be acknowledged that some young people's previous life experiences may leave them ill equipped to deal with the responsibilities of early parenthood, it is important to avoid assumptions and to assess individual's needs and capabilities. In particular, young people's requests for support should be viewed positively. Staff and carers should not automatically assume that such requests mean the young person is not coping. Recognition should also be given to the needs and responsibilities of young fathers and the positive contribution they can make. Where there are clearly identified difficulties, staff have a duty to consider child protection measures.

Staff and carers should help to alleviate the many structural inequalities that early parenthood can bring. In particular care planning should address young women's educational needs and help her to plan for the future. It should also address financial and accommodation issues, accessing health services and relationship difficulties, should they arise. Staff and carers should understand the young woman's need for stability at this time and ensure they are involved in the decision making around potential placement moves and choices.

Best Practice

- The young person's care plan will identify an appropriate package of support which is reflective of the young person's individual views and needs and those of their baby. This should include contact with the Special Needs in Pregnancy Team.
- Staff and carers will ensure young mothers and fathers are aware of their individual legal rights and responsibilities in respect of their child.
- Staff and carers will continue to remind young parents of their ongoing sexual health needs including post natal checks and contraception /protection. They should also encourage and support young people to access community health services.
- Staff and carers should help young parents link into community resources that help counter feelings of isolation.
- Staff and carers should not make assumptions about the sexual orientation of young parents.

6.7 Unaccompanied Minors

Young people who are unaccompanied and seeking asylum may present particular challenges to staff and carers in that there may be a lack of clarity about their histories or indeed their age. They may be unable to divulge information regarding their background or how or with whom they travelled to the United Kingdom. In addition the uncertainty regarding the achievement of refugee status, the right to remain and fear of deportation does not assist this process.

It is known that many young people in this position have experienced major physical, psychological trauma and sexual assault as a result of war or during their journey to this country. Some of these young people may have been smuggled or trafficked and placed under great pressure not to disclose the circumstances of this. Such experiences can have a profound impact on young people's physical and mental well being. Whatever their individual circumstances, it is likely that these young people will be traumatised by the loss and/or separation from their families and friends, some of whom may be left behind.

Young people in this position may have specific sexual health issues e.g. pregnancy, abortion, female genital mutilation, HIV, sexual transmitted infections etc that may either be historical or may require to be addressed promptly. Whilst mindful of confidentiality and the need for sensitivity, some of these issues maybe pertinent to their asylum claim.

Safe care issues for unaccompanied young people encompass all those identified for the indigenous population; however there are additional aspects that may expose them to exploitation by individuals or groups who may be able to put them under pressure. Young unaccompanied minors may find support from members of their community but can also be placed under undue pressure regarding cultural or religious practices they may not now wish to follow. Staff and carers should therefore not make assumptions regarding their thoughts and wishes.

Best Practice

- Staff and carers should ensure, as far as possible, that they understand and are sensitive to the particular circumstances of individual young people. This includes offering a gender and culturally sensitive approach as a matter of course.

- Staff and carers will ensure that young people are supported to clarify their legal position.

- Staff and carers will support young people to access appropriate health care and specialist health services.

- Staff and carers will access appropriate training and support.

- Staff and carers should ensure that young people have access to interpreting services as the need arises.

6.8 Religion and Culture

It is recognised that in our society individuals and groups can be discriminated against on the basis of their religious beliefs and cultural values. Staff and carers can play a vital role in challenging such behaviour by ensuring that a young person's cultural or religious beliefs are taken into account in all aspects of their care. Local authorities are required to take into account issues of culture and religion when identifying a placement.

Cultures and religions have differing sexual norms. It is important to remember that in all religions and cultures there are a range of views and values held by families and young people, carers and staff. Whilst different cultures and religions may have an impact on how and at what age sexual health and relationship issues are discussed, young people should not be denied the benefits of information and support on sexual health and personal relationships education because of religious and cultural values. The content and timing of information and support should be carried out sensitively and take into account the needs and level of understanding of each individual young person.

Research has shown that within this context, the anxieties of staff and carers providing information about sexual health and relationships have hindered discussions. As many parents from all religious and cultural backgrounds feel ill equipped and sometimes unwilling to educate their own children in an area where they themselves may have received little formal education, assumptions about parental responses need to be discussed.

Best Practice

- In general, staff and carers should inform themselves about the religious and cultural beliefs of all young people in their care. They should not however, make assumptions based on that information. It is important that the interpretation of the information is checked out with the young person and their parents, where possible and appropriate.

- Staff and carers should actively challenge discriminatory jokes, language, assumptions and behaviour that oppress and discriminate against any group whether from young people, carers or staff. It is not appropriate for communal spaces or offices to be decorated with material that could cause offence to others. In the West of Scotland context it is important that the issues of sectarianism are taken into account.

- Staff and carers need to be aware of the influence of prejudice, stereotyping and generalisations in relation to different cultures and sexual practices. Staff and carers are encouraged to increase their understanding of different religious and cultural approaches to sexual health and relationships through, for example, accessing professional development and through working in partnership with religious/cultural communities.

- Written information should be culturally and linguistically appropriate and should be translated or interpreted into the young person's language.

- It may be appropriate to provide some information in single gender or same faith groups. Young people's preferences should be sought on these matters.

6.9 Domestic Abuse

When working with children and young people who are looked after or accommodated it is essential to acknowledge that they may have current or historic experience of domestic abuse. Domestic abuse can have a profound impact on those experiencing it directly but also on children and other family members. The Scottish Government recognises domestic abuse as a form of violence against women and defines it as: Gender based abuse which can be perpetrated by partners or ex partners and can include a range of behaviours such as **physical abuse** (assault and physical attacks), **sexual abuse** (acts which degrade and humiliate women and are perpetrated against their will, including rape) and **mental and emotional abuse** (threats, verbal abuse, withholding money and other types of controlling behaviour such as isolation from family and friends).

It is estimated that 100,000 children in Scotland are living with domestic abuse, and in 90% of incidents of domestic abuse children are in the same or the next room [38].

Children or young people may be affected by domestic abuse in a variety of ways. They may be psychologically affected by witnessing their mothers being assaulted many times, as a woman is assaulted on average 35 times before the police are involved[38]. They may have been injured trying to defend their mother from an abusive partner, or may have been abused during contact visits after the relationship has ended. They may have actually been abused directly as in approximately half of families where there is domestic abuse there is also child abuse[39].

Domestic abuse may not be presented as the main reason for a child or young person being looked after or accommodated outside their family, but it is important to understand how domestic abuse may have contributed to the situation. It can impact

them in a variety of ways, and Women's Aid workers have come up with some of the impacts by talking to children and young people in refuges.

'the effects of violence can be influenced by the type, composition and quality of children and young people's relationships with friends and family members and to the frequency, form and length of exposure to violence in the home' (A Donaldson 2005)

The following list examples ways in which children or young people **may** be affected by domestic abuse:

- Being withdrawn, isolated from their peer group, having poor concentration,persistent absences or being reluctant to go home.
- Some children who are high achievers at school may find their studies are a means of escape which attracts positive and welcome attention from teachers.
- Difficulties in managing anger may be the result of feeling powerless to control what is happening at home. Such negative behaviour may have been learned by those who have been living with domestic abuse from a young age.
- Children and young people affected by domestic abuse often are very aware that they should not talk to anyone about it, and it becomes a huge secret in their lives.
- Self-harming behaviour such as eating disorders, cutting or alcohol and drug abuse maybe an issue for some young people seeking to find ways to cope with the trauma they are experiencing at home or in their own relationship.

Research shows that abuse in teenager's relationships mirrors adult domestic abuse in that it happens more to girls than to boys, and that it is a common occurrence [40]. Staff should be aware that young people they are working with could be involved in abuse in their personal relationships.

Recommendations:

- There are services in West Dunbartonshire which offer specific support services to children and young people affected by domestic abuse and will carry out this support in an environment identified as suitable by staff and the child or young person. Details of these services are in Appendix 2. Staff can refer to these services or encourage self referral.
- In order not to collude with the silence and 'secret' nature of domestic abuse, staff should encourage the child or young person to talk about their feelings and experiences
- Training on domestic abuse and its impact on children and young people is available in West Dunbartonshire. Contact the Violence Against Women Partnership for details.

7. Managing Sexual Health Issues in a Care Setting

7.1 Introduction

It is important that staff and carers create an atmosphere of openness and honesty within the care setting so that children will feel able to seek advice and guidance at any time and on any subject. If staff and carers have 'normalised' sexual health and

relationships as a topic for discussion, they will be better able to offer guidance to those in their care, particularly around the issue of 'delay' i.e. encouraging young people in general, but especially those under the age of 16, not to engage in sexual activity until they are emotionally and physically able to deal with its potential consequences.

7.2 Supporting Young People to Delay Sexual Experience

It is natural for all young people during adolescence to form attachments, develop crushes and form romantic relationships. It is also natural for adolescents to be curious about sex. It is likely that some young people will embark on sexual behaviour before the lawful age of 16. Evidence shows that young people who are looked after are more likely to have sex before the age of 16 and for the circumstances of their early sexual experiences to be poor, have adverse outcomes and later be regretted[41].

It is therefore important that routine conversations between staff, carers and young people, and planned learning for young people do not reinforce the assumption that having sex is inevitable and always presents the view that it is possible to delay having sex until the young person is physically and emotionally ready to handle the consequences of a sexual relationship, and that such a relationship is genuinely understood as a positive choice.

It is also important that such an approach is taken whereby young people that have already had sexual relationships understand that they can choose to stop doing so.

Staff and carers should be aware that promoting the idea of delay is not an approach that means being negative about sexuality or sexual relationships. Rather it requires being positive about sexual relationships and framing the positive aspects of sexual relationships in ways that make it clear that sexual relationships are best left until adulthood. This means being clear that if the positive aspects of sexual relationships such as mutuality, a shared sense of intimacy, respect, love or closeness are not present, then the young person is not ready for sexual relationship and that as a staff members or carer, you would want better for the young person.

Staff and carers should understand that this is not the same as an "abstinence" or "just say no" approach which evidence has shown does not work and in some cases brings about poorer outcomes for young people [42].

Staff and carers should consider the role that building strong non sexual friendships between young people can help to meet their social and emotional needs which can mean some young people therefore do not feel the need to have sex which they may perceive as meeting these wider needs.

Staff and carers should be mindful that young people will be most likely to delay sex when they have their information needs met and have a chance to learn and practice assertiveness skills.

Staff may find the following prompt questions and lines helpful to use in discussing relationships with young people. These are not offered a substitute for child

protection assessments, but staff and carers should be mindful that discussion with young people on these matters can highlight areas of concern.

- Do you feel you could say no if you wanted to?
- Can you have fun together without anything sexual involved?
- Are you sure you each want it for yourself, not for the other person or to fit in with friends or others' expectations of you?
- Are you sure nobody's forcing you, pressuring you or making you?
- Have you discussed using condoms and contraception, and agreed what happens next and whether or not to tell your friends and family afterwards as well as talking about the implications if you become pregnant?

Unless a young person can answer yes to all of these questions then the young person is probably not ready for a sexual relationship. It is important that this if framed for young people in a sensitive manner and the following lines may be helpful in doing so. Even if a young person is ready staff and carers should emphasis that this does not mean that they have to have a sexual relationship. Staff and carers should acknowledge with young people the role of pleasure in sexual relationships and note its absence if young people have had sexual relationships they did not enjoy.

"If you're not sure then you're probably not ready"

"Putting off sex for a while can help you feel more in control"

"Just because you're saying 'No' now doesn't mean you always will"

"If they'd dump you if you won't – do you really want them?"

"How do you feel about it?"

"You do have the right to say 'no' you know"

"I'm not happy with that – I want something better for you"

"It's not unusual for someone your age not to be having sex"

"Most people aren't having sex yet - even though they say they are!"

"Whenever you say 'no' to one thing, you're saying yes to something else"

"Most people don't have sex till after they're 16, you know"

"What kind of relationship do you want?"

" You can take some time out from having sex to think about what you want for yourself"

"I'm wondering where *you* are in all of this?"

Best Practice

- Staff and carers will be offered training on using a delay approach

- Staff and carers should recognise that if a young person wants to talk about the place of sex in their relationships, this is usually because the young person is not sure that this is what they want and so staff and carers should use these opportunities to have a full discussion with young people about their relationship.

- Staff and carers will be mindful in their discussions of the need to also assess the relationship situation in terms of child protection.

- Staff and carers should not present sexual relationships in general as negative but make sure they are framed as best left to adulthood.

- Staff and carers should reinforce the legal age for sexual relationships.

7.3 Managing Sexual Relationships

However, the reality is that during the period of adolescence, young people, whether accommodated or not, often engage in behaviours against the wishes of their carers and which place them at varying degrees of risk. In the context of sexual health and relationships, the main priority is to ensure that young people are safe and protected. The most effective method of achieving this aim is to improve the knowledge, skills and confidence of the young person themselves so that they learn how to make healthy choices that are respectful of themselves and others. Given that it is known that young people who may have experienced rejection, loss, and/or abuse may struggle to appreciate the consequences of their actions and be lacking in self-esteem and self-care skills, it is especially incumbent on all staff and carers to discuss with young people issues around emotions, relationships, commitment, consent etc.

In addition to the emotional and attitudinal aspects of relationships, young people need to be made aware of the physical risks involved in sexual activity and how these can be minimised. Staff and carers, within their capabilities, need to provide unbiased basic information on contraception and protection, where and how services can be accessed and choices and services available to young people. At a minimum, there is a responsibility to either signpost or refer a young person, with their permission, to appropriate local services. It is within the law, without parental consent or even knowledge, to provide information, to make an appointment and/or to accompany a young person to an agency which is able to meet their immediate health needs. Such action should be taken in consultation with the young person's social worker.

Staff and carers are reminded that, alongside the responsibility to meet the young person's immediate health needs, there is an additional responsibility on the local authority to assess the nature of the sexual relationship that the young person is engaged in, to determine whether it involves abuse or exploitation [27].

The young person's social worker has the responsibility for ensuring that this assessment is carried out in a sensitive manner. Given their direct relationship with

young people, staff and carers will be asked to contribute to this process. In all cases staff and carers will follow the Child Protection Procedures for West Dunbartonshire.

Best Practice

- Young people should be prepared for the emotional and physical consequences of sexual activity and encouraged to delay such behaviour until they are ready. In particular staff and carers should challenge common myths around pregnancy and sexually transmitted infections.
- Young people should be made aware of what the law is around sexual activity. This not only relates to the age of lawful sexual intercourse, but also should include issues of consent, assault etc.
- Young people should either be given information, assisted to access information or signposted to appropriate services, to help them appreciate that sex is not just about intercourse but can involve other ways of expressing closeness and intimacy in a relationship.

7.4 Accessing Services

All young people who are, or who are planning to be, sexually active have a right to access information and services to meet their immediate health needs. Staff and carers should particularly be aware of the need for those who are accommodated by the local authority to have equal access to health provision as other young people living in the community. Young people who are sexually active should be made aware of the importance of having a sexual health check up to ensure good sexual health. Some young people who have not yet engaged in sexual activity may also wish to access a sexual health service for advice or support.

Young people should be made aware that a visit to a clinical practitioner in a health setting and the results of such a visit will remain confidential, unless the young person chooses to divulge information themselves or they give their permission for information to be passed on to someone else. In addition, young people should be made aware that the clinical practitioner will need to satisfy themselves that the young person is competent to understand what is being discussed and that the sexual activity does not appear to involve issues of abuse and/or exploitation.

Young people should be given information about a range of options about where they can seek help and advice if, and when, they need it. It should be made clear to them that they do not need to seek permission to access such services but that support is available if they require it. They should be made aware of both general and specialist services and those that are particularly geared towards young people's health, whether they are based within local youth services or health clinics. Both young people and staff and carers can seek advice and information from the Looked After and Accommodated (LAAC) Nurse (See Appendix 2) on a range of issues. Depending on the knowledge base, the level of confidence and the relationship with the young person, general health advice may be given by staff and carers themselves.

Best Practice

- Staff and carers will provide young people with information about sexual health services, how to access them, opening times etc. (See Appendix 2).
- Staff and carers will reassure young people about concerns they may have about accessing services. This might include how they will be treated, confidentiality and if required, they will offer to accompany the young person to an appropriate service.
- Staff and carers will provide young people with the telephone numbers for *confidential help lines* See Appendix 2) (and ensure there are opportunities and private spaces for young people to make such calls.

7.5 Contraception and Protection

All young people need to be advised that proper use of contraception/protection can dramatically reduce their chances of pregnancy or acquiring a sexually transmitted infection (STI). They should be made aware that there are a number of different methods available which offer variable degrees of protection. Depending on the type of contraception/protection used, the young person may require to see a nurse, doctor or other specialist adviser. It is also important to highlight that no method is 100% guaranteed to prevent either conception or the transmission of an infection and that not having sex is the only way to avoid these things completely.

Whilst a member of staff or a carer may feel disappointed or uneasy about a young person being sexually active or their choice of contraception/protection they are required to put their personal views aside and ensure that the young person receives advice and information about safe practices and protection.

If a heterosexual young person (whether male or female) is sexually active, staff and carers need to speak with them about the importance of contraception and protection. It is important to stress both the need to avoid an unplanned pregnancy and to protect against STIs. Discussions should therefore include information that hormonal methods of contraception, by themselves, are not sufficient.

Staff and carers are reminded that whilst pregnancy is not an issue for same-sex sexual activity, other forms of protection e.g. condoms and dental dams should be used.

Condoms and femidoms are the most easily available, non-prescribed form of protection and when correctly used, can protect against unintended pregnancy, HIV and other STIs. Dental dams protect against oral transmission of STIs. Negotiating their use, knowing how to use them and where to get them are essential for maintaining young people's sexual health and are issues that should be addressed with all young people.

Recent consultations with young people in Glasgow have highlighted crucial gender-specific attitudes around condom use that need to be addressed. Male attitudes about condoms affecting their enjoyment of sex, only using them if they 'think' the female might have an infection or only considering them if the female raises the issue, all need to be challenged. It is also clear that young women's perceptions of condoms being the responsibility of the male and the age-old problem of young

women's knowledge or possession of condoms casting aspersions on her 'reputation', all mitigate against the safe use of condoms [43]. It is important therefore, that staff and carers discuss issues of responsibility and respect with all young people, whether they are sexually active or not. In addition, they should ensure that young men are aware of equal responsibilities for contraception/protection.

For other types of contraception/protection, young people will require to seek specialist advice from a health professional. Young people under the age of 16 years have a right to access health services for contraception/protection. This contact will remain confidential providing that the young person is not thought to be involved in activity that is abusive or exploitative. Young people do not need to seek permission from their parents or carers as long as they are deemed competent by the medical person to understand the nature and possible consequences, benefits and risks of the treatment under the Age of Legal Capacity (Scotland) Act 1991.

All young people should be made aware of the two types of emergency contraception that is available. They should be given information about how the two methods work (that oral contraception can be taken up to 72 hours (3 days) and that a coil can be fitted up to five days after having unprotected intercourse) and that emergency contraception is more effective the sooner it is used. If a young woman has had unprotected sexual intercourse or if the method used has not worked (e.g. condom splits), staff and carers should advise them about emergency contraception and support them to access this if requested to do so. Two points to note are that emergency contraception does not protect against sexually transmitted infections and so additional checks may be required, and, emergency contraception is not the same as a medical termination.

Staff and carers should know how to access emergency contraception or where they can get this information from. If they become aware that unprotected sexual intercourse has taken place, they should act quickly, reassuringly and support the young woman to obtain emergency contraception if requested to do so. In addition, they should prioritise accompanying a young person to a clinic or chemists (See Appendix 2) to obtain emergency contraception, if the young person has requested this or appears to need this level of support.

Best Practice

- As a matter of course, staff and carers should ensure that all young people are aware in general of contraception/protection at an age appropriate to their individual maturity, understanding and need, including young people with learning disabilities. If it is appropriate and they feel confident enough, they should discuss safer sex with young people in an open and non-judgemental way. At a minimum, they should 'signpost' young people to services where this advice can be obtained.

- Staff and carers need to ensure that they have up-to-date and accurate knowledge on the various issues relating to contraception/protection. It is not expected that each individual member of staff or a carer should know the details of all methods available. What they should have is a basic working knowledge of the most common forms and what can reduce their effectiveness. Staff and carers can do much to educate themselves through easily available booklets and

leaflets (See Appendix 2). They should also seek information, advice and guidance through training and supervision.

- In residential settings, a list of local chemists all of which provide free emergency contraception, with their opening hours should be easily accessible for young people to consult. In particular, they should know how to access emergency contraception 'out-of-hours'. This information is available on the Sandyford website (See Appendix 2).

- If the need for emergency contraception has arisen, staff and carers should use this as an opportunity to talk about sexual activity and delay, emotions and relationships, planned methods of contraception/protection etc. Whilst other agencies may have been involved in this particular episode, it should not be assumed that all of these topics were discussed with the young person.

- As a matter of course, regular information sessions for young people who are accommodated should be organised. The LAAC health nurse (See Appendix 2), a trained youth worker or a member of staff from the local clinic could help staff deliver these sessions.

- Staff and carers should never withdraw contraception/protection as a means of sanction.

- Staff and carers should know where to obtain free condoms and other forms of contraception/protection locally. They should familiarise themselves with the local *condom distribution service* and how young people can access this. Staff and carers should be aware that some GP's may not prescribe emergency contraception or other forms of contraception to under 16's. They should also remind young people to check the sell-by date.

8. Possible Outcomes of Sexual Activity

8.1 Sexually Transmitted Infections

Sexually Transmitted Infections (STIs) are infections that can be passed through having unprotected penetrative vaginal, oral or anal sex. Common STI among young people are genital warts, chlamydia, gonorrhoea and herpes. Their prevalence in the under 25 population is rapidly growing. Some STI, if left untreated, can seriously damage a person's health or may affect their fertility. It is vitally important therefore, that all young people who are accommodated, at an age appropriate to their individual maturity, understanding and need, are given accurate information and advice about prevention, treatment and support. Whilst staff and carers should have a basic knowledge about STI, they should ensure that they are aware of local services and how these are accessed (See Appendix 2).

It is important for staff and carers to be aware that some STI do not have signs and symptoms and so a person may not to be aware that they are infected. This message needs to be clearly imparted to young people and emphasises the need to encourage sexually active young people to attend for regular health checks. Some common signs can be unusual or smelly discharge from the penis or vagina, rashes, sores, blisters, bumps or itchiness around the genitals, pain in the genital area, a

burning sensation when urinating or having sex or urinating more than usual. However, a person can have each of the above symptoms, but not necessarily an STI.

If a young person thinks they may have an STI, staff and carers should deal with this in a non-judgemental and supportive manner and either signpost or accompany them to an appropriate medical service. If the young person attends a Sandyford clinic (See Appendix 2) their GP will not be advised of this visit.

If the possibility of an infection has arisen, staff and carers should use this as an opportunity to talk about sexual activity and delay, emotions and relationships, the safest methods to protect against future infection i.e. the use of condoms, femidoms or dental dams etc. Whilst other agencies may have been involved, it should not be assumed that all of these topics were discussed with the young person.

8.2 HIV

Particular mention has to be made of Human Immunodeficiency Virus (HIV). Although not exclusively an STI (it can also be passed though sharing injecting equipment or being born to a mother with HIV), it is a serious infection which can weaken the body's natural defence system and affect its ability to fight off common infections. It is mostly the result of having unprotected penetrative vaginal or anal sex, although there is a very small risk associated with oral sex. Again in its early stages symptoms may not be obvious. The only way for anyone to find out whether or not they have HIV is to have a specific blood test. In Scotland in recent years, the highest rate of increase in new cases is amongst the heterosexual population that have arrived from countries with high HIV prevalence, and through sex between men [44].

As with other forms of STI, it is vital that all young people are made aware of HIV and how it transmitted and prevented. Staff and carers will ensure that young people are informed that condoms and femidoms used properly considerably reduce the possibility of getting HIV as well as preventing STI and pregnancy. Staff and carers should be particularly mindful of the importance of this with young people from countries with high rates of HIV and sexually active young gay or bisexual men, ensuring that information is provided in culturally appropriate ways. This must be balanced with a need to avoid stigmatising them in relation to HIV. Staff and carers should discuss the importance of HIV testing with young people where current or past experiences have made them vulnerable to infection.

If a young person is considering or requires an HIV test, staff and carers should be mindful of the extra support that will be required, particularly during any wait for results or managing the test result whether negative or positive. Tests can be carried out at a Sandyford clinic, at the Brownlee Centre (see Appendix 2) or by the young person's GP. Staff and carers should always discuss with the young person whether or not they wish anyone else to know about their HIV test or HIV result.

If a young person in placement has HIV and does not want other staff to know their HIV status they have a right for that information not be shared. However in a residential setting, due to the nature of shift work, this will require more than one member of staff being aware of the young person's status to ensure appropriate level of care in administration of medication and attending appointments. Any member of

staff not involved in these tasks should not be informed of the young person's status. Staff will ensure the young person is aware of which members of staff are aware of the young person's HIV status. Staff and carers may therefore need to find ways of sensitively administering medication that requires to be taken regularly in a way that protects confidentiality. They should also ensure that the young person is enabled to access appropriate emotional support regarding their condition (See Appendix 2). Young people living with HIV need to be made aware of the implications on their health of not keeping medical appointments.

If a young person continues to have unprotected sex, staff and carers have a duty to work with the young person to help them manage their behaviour responsibly. The young person should be advised that it is potentially a criminal offence for someone with known HIV positive status to engage in unsafe sexual practices. In those rare circumstances where it comes to the attention of staff and carers that a young person's behaviour may present a risk of harm to themselves or others, a discussion should take place with a line manager to determine what action, if any, is required. Whilst staff and carers need to recognise that young people have the right to take risks and to have sensitive information treated confidentially, there is also a responsibility on staff to take necessary steps to minimise the risks of young people from doing actual or potential harm to themselves or others. Where the balance lies in individual cases will be a matter for professional judgement.

8.3 Conception and Options

In many situations, conception can be the first time that staff and carers become aware that a young person in their care has been sexually active. Whilst most of what follows is more pertinent to the care of young women, it should also be remembered that young men who are accommodated will also have feelings and views on conception.

The most common sign of conception is usually a missed period, but can also include nausea and vomiting, soreness or enlargement of the breasts, weight gain etc. It should be noted however, that some women may not have many symptoms and may continue to have periods. Staff and carers will be aware that some young women will be at greater risk of conception, i.e., those with irregular periods, having unprotected sex or those who have expressed a wish to have a baby. The only way for a young woman to be sure that she has conceived is by having a pregnancy test, which are available in chemists or supermarkets or can be done, free of charge, through local sexual health clinics (See Appendix 2) or by the young woman's GP. Results are normally immediate.

It is important that a young person receives support throughout this process. If a test is negative, the young person should also be encouraged to be screened for STI. Staff and carers should use this as an opportunity to talk with them about their sexual activity and delay, emotions and relationships, the safest methods to protect against future unplanned conceptions and STI etc. Whilst other agencies may have been involved, it should not be assumed that all of these topics have been discussed.

If conception has occurred, staff and carers should not make assumptions about the conception e.g. it being planned or unplanned, consensual or the result of abuse or exploitation etc. The young person's social worker should be informed.

At this stage, the young woman should be offered advice, guidance and support to enable her to make an informed choice about what she wants to do. She needs to be given unbiased information, time and space to think through her options. The Looked After and Accommodated Children's Nurse can assist the young woman to think through her options. Staff and carers need to be mindful that they should not impose their own values and attitudes on the young woman at this particularly sensitive time. They may have a view, substantiated or not, about the young woman's abilities to deal with early parenthood. However, this should not get in the way of the decision that the young woman herself needs to make. It should also be noted that the young woman has the right, at any point, to change her mind.

For young people who have a learning disability, it is important to acknowledge that although they may have been unable to make decisions in one area of their life, it does not automatically mean that they are unable to make informed decisions about intimate relationships. The emphasis needs to be on support, encouragement and the development of skills and knowledge.

8.4 Termination of Pregnancy

One option open to the young woman at this time is to seek a termination. Within the UK a termination of pregnancy is legal and safe, and access to it is the same for all women irrespective of age. Doctors will use the Age of Legal Capacity (Scotland) Act 1991 to assess a young woman's competence to come to a decision in her own right and termination will only be carried out if two doctors confirm legal grounds are satisfied. A termination on social grounds can normally be carried out up to the 24th week of a pregnancy, although in Glasgow, terminations are generally only carried out up until 16 weeks. After this time, terminations can still be accessed through the British Pregnancy Advisory Service (See Appendix 2) but this would involve travelling to England for the procedure.

It is acknowledged that within society the issue of terminating a pregnancy raises strong feelings. However, staff and carers should not allow their own values and beliefs to impinge on the information and choices available to young women in their care. If a conflict of interest exists, this should be raised at the earliest opportunity so that alternative advice and support can be offered. Neither should assumptions be made about what a young woman may choose to do. For a variety of reasons, women from all cultures, religions and backgrounds have terminations. Staff and carers' role is to enable a young woman to make an informed choice that is in accordance with her own values and beliefs. It should also be noted that the earlier a procedure is carried out, the less invasive the procedure is for the young woman.

It is expected that staff will discuss with the young woman who she wishes to know about the termination. If the young woman has advised that she does not wish her parent(s) to be informed of the termination, and it is deemed in her best interests, there is no obligation for staff or carers to do so.

Young men have no legal say in a young woman's decision whether or not to continue with a pregnancy. It is acknowledged however, that they may have strong feelings about a conception. In these circumstances, staff and carers should discuss with young men their thoughts and feelings and encourage them to offer support to their partner, if appropriate.

8.5 Adoption

Another option open to young women is to proceed with the pregnancy but place the child for adoption. Young women need to be helped to think through this option and how it might be put into practice. They should receive formal support and counselling from practitioners specifically trained in these matters. Whilst voluntary adoption may be the young woman's chosen path, the adoption process is not completed until it has been formally approved by the Court.

Once the baby is born, young men who have legal rights and responsibilities in relation to the baby would have to have their views heard if adoption was being considered.

8.6 Caring for the Baby

If the young woman has decided to continue with the pregnancy and to raise the baby, she should be offered every support and assistance to have a happy and healthy pregnancy and to make a smooth and confident transition to parenthood. Options for her future should take place within the usual care planning process. The care plan should pay particular attention to her additional support needs. Any proposed changes should be planned well in advance and the timing of their implementation should be dealt with sensitively and take into account the amount of 'change' that the young woman has already experienced and will experience with the birth of her baby. Where there is significant, identified vulnerability, child protection procedures may be considered.

Best Practice

- Staff and carers should explore their own values and attitudes that may affect the care, support and advice that they are able to give to a young woman who conceives. They may hold particular views on early parenthood, termination and/or adoption. However they are required to separate their personal views from the needs and best interests of the young woman in their care. Staff and carers who feel that they would be unable to separate the 'personal' from the 'professional' should raise this in supervision with their line manager or their link worker.
- In addition, staff and carers should either have, or know how to obtain information and resources which may help young people reach decisions at this time. As a useful starting point to decision making there is a free, introductory booklet called *"Worried about pregnancy? A guide for young women and young men"* (See Appendix 2) which provides information about all pregnancy choices. Sandyford would also be able to offer advice and counselling.
- It would be helpful if staff and carers were aware of whether the GP with whom the young woman' is registered may object to providing information on, or making referral for, a termination. Should such a situation arise, staff and carers need to be familiar with local services e.g. Sandyford (See Appendix2), and support the young woman to access the alternative.

9. Sexual Relationships in Placement

Caring for young people in either residential or foster care during their sexual development can present particular challenges. It is recognised that relationships which develop between young people in the same placement may be of a sexual nature. These may be opposite or same sex relationships. While staff and carers will be sensitive and non-judgemental about these issues, sexual relationships between young people living in the same placement are not manageable, even when legal, and cannot be permitted.

If a sexual relationship develops between young people in the same placement appropriate information needs to be shared with the young peoples' social workers. Young people should be informed prior to the sharing of this information about the necessity to do so. The young person's social worker has the responsibility to carry out a sensitive assessment to ensure that the relationship is not abusive or exploitative in nature.

It is important to remember that adolescence is a period when young people begin to experiment and make choices. It is essential that staff and carers are able to help a young person understand the possible consequences for themselves and others of a sexual relationship within their placement.

If a serious, ongoing relationship develops between two young people in a placement then finding a local alternative placement for one of them may be an option. This would enable the young people to continue their relationship within appropriate boundarie

10. Managing Sexual Health Issues in a Care Setting

10.1 Pornography and Male Prostitution

As a general definition, pornography is sexually explicit imagery that is not used for the purposes of education. Such imagery is now common within society and what would have once been considered 'top-shelf' explicit material is now part of the mainstream, and prevalent in many men's magazines. Whilst recognising young people's sexual curiosity, in general, staff and carers should discourage young people from possessing or buying any kind of pornographic material. They should ensure that young people and their carers understand the legal implications of possessing and sharing pornographic material. They should help young people to consider the detrimental effects of pornographic imagery and to understand that it portrays negative gender stereotypes, distorted and exploitative views of sex, relationships and women, in particular, which can cause offence. If staff or carers discover young people in possession of such pornographic imagery the young person should be asked to remove it.

In relation to legally-defined pornographic material (which includes magazines, multi-media imagery and live acts), it is illegal for anyone under the age of 18 years to purchase such material. It is a serious criminal offence to pass or share pornographic material to any young person under the age of 16 years, regardless of the age of the person who is sharing it. Therefore irrespective of the setting young people should not be permitted to possess such material. Depending on the age and understanding of the young person and/or if the images involve the abuse of

children, the information regarding its possession should be passed on to the child's social worker. The material should be removed and preserved for possible further investigation by social work and the police.

Staff, parents and carers should be alert to the potential to access pornography through the Internet, mobile phones, DVDs and videos. Staff in residential settings will have clear guidelines and checks on the use of computers in care settings and will check the contents of DVDs and videos. Advice will be given to parents and foster carers to do the same.

Staff and carers will be alert to any attempts to involve young people in the production of pornographic materials. They will actively discourage this and will seek appropriate counselling and support for any young person who has been involved. Any attempts to involve young people who are under 18 years should be reported immediately to the young person's social worker. Child protection measures will be considered.

Best Practice

- Staff and carers will be supported to examine their own attitudes to pornography and have a clear understanding of the negative stereotypical, exploitative and distorted view of sexuality it offers. They will be assisted to understand the poor role model it offers young people and be able to provide them with positive alternatives.

- Staff and carers will be provided with training and ongoing support and supervision around this issue.

- Young people should be helped to understand the distortion and exploitation that is involved in pornography. They should be assisted to be sensitive and confident in how they respond to such materials.

- In cases where staff consider it in the young persons best interests to view any communication devices that may have pornographic material, they should do this with another member of staff present and inform the young person about the need to do this.

10.2 Internet Safety

Internet access can be a very useful and user-friendly source of information for young people, with a range of information easily and quickly accessible from the web. Staff and carers should encourage the young people to use the internet sensibly and to gain information that will benefit their development. However, staff and carers need to be alert to the potential for young people to be groomed for sexual exploitation via the internet.

Monitoring young people's use of the internet is difficult. However, staff and carers should ensure that software is installed to limits access to adult sites. Any concerns about what is being viewed by young people on the Internet should be discussed with the young person in the first instance to ascertain their reasons for visiting certain sites. Staff and carers need to be particularly alert to young people's use of chat rooms, both in terms of the information and pictures uploaded by young people

and the possibility of meeting people through these sites. Issues around personal safety, self respect and the potential dangers involved should be discussed with young people. They should be strongly discouraged from pursuing any meeting via the internet.

Staff or carers who discover pornographic materials should report this to their line manager immediately; a discussion needs to take place with the young person's social worker and Police. The young person could be a victim but may also be accessing child pornography so this needs to be fully assessed. An incident of this nature should never be ignored.

Best Practice

- Staff and carers need to be aware and keep pace with new technology to keep young people safe. They should also regularly check the history on the computer and monitor the internet use.

- Internet safety guidelines should be displayed and/or discussed with young people so they are aware of appropriate use and their own personal safety. It should be noted that there are legal limitations on staff and carers accessing emails sent and/or received by young people. Firewalls installed to the same level of protection as that of the libraries and schools in West Dunbartonshire.

- If staff believe it is in the best interests of the young person to restrict their access to communication devices then this should be discussed as part of their care plan.

- Staff and carers will be aware of web sites that offer support or information to young people on issues of sex, sexuality and sexual health. Young people will be provided with opportunities to view such information in privacy if they wish.

- Staff and carers will be provided with training and on-going support and supervision on these issues. They also have a responsibility to request assistance when required.

10.3 Working with those who have been Abused and/or Sexually Assaulted

Despite the progress that has been made in recent years in acknowledging the extent and nature of childhood sexual abuse, rape and other sexual assaults, circumstances are such that victims are frequently not believed when they disclose incidents of abuse and attitudes still persist in society that the victim was somehow complicit in the abuse. It is vitally important therefore that staff and carers ensure that, in the general messages that they give to children and young people in their care, victims of abuse or sexual assaults are never made responsible for the crimes committed against them. This would also include talking with young men about what 'consent' means and challenging attitudes that women who have been raped or sexually assaulted somehow 'asked for it' or provoked the incident in some way.

It is known that a proportion of children and young people who are looked after and accommodated have experienced childhood abuse, whether physical, sexual or emotional. It is also known that children and young people in these circumstances can develop distorted thinking about themselves, where responsibility lies for such abusive behaviour and the nature of relationships and roles within them.

Where it is known that a young person has experienced historical abuse, it is important that general sexual health and relationships work does take place but is sensitive to this fact and takes place within the young person's care plan. Young people have much to lose in terms of their privacy and self-esteem when talking about sexual health issues in the light of their previous abuse. Staff and carers carrying out this work with the young person need to be respectful and encouraging and enable the young person to negotiate what will be discussed. From the outset, staff and carers should ensure that the child or young person is aware of confidentiality and its boundaries.

It is also recognised that by encouraging staff and carers to talk with children and young people about sexual health and relationships in age and stage appropriate ways throughout their childhood, this may lead to children and young people disclosing both historical and/or current abuse. Staff and carers need to be aware of this possibility and deal with such a situation calmly should it arise. If a young person makes a disclosure of abuse, staff and carers should listen, without prompting or probing, and reassure the young person that it was a positive step for them to talk about such abuse.

If the abuse is historical in nature, staff and carers should discuss with the young person how the matter should be dealt with. This information should be immediately passed on to the young person's social worker. Although the young person may not be at immediate risk the information may have implications for other children.

If the young person has been recently abused or assaulted, staff and carers should immediately contact the young person's social worker, the duty social worker or standby-by social work services. In such circumstances speedy action is crucial both in terms of gathering potential evidence and for obtaining emergency contraception, if required (See Appendix 2). Depending on the nature of the information, social work services will then make a decision has to how the matter will be progressed.

Irrespective of whether the abuse or assault is historical or current, it is vital that the young person is offered appropriate support and counselling. It should be acknowledged that the young person needs to dictate the timing of such intervention. Information and contact help lines should be given to them so that they can choose how and when they seek support.

Best Practice

- Staff and carers will need to address their own feelings, views and attitudes about sexual abuse, rape and sexual assault and should have access to appropriate support and agencies when dealing with this complex issue.

- Supporting a young person who has disclosed abuse should be a planned piece of work undertaken by those who have experience in this work and must always

be supported by supervision, training, information and advice. More specialised or additional support must also be incorporated into the young persons care plan.

- Staff and carers should familiarise themselves or at least know where to get information about the range of services that can offer support. If a young person aged 13 or over has been assaulted within the last week immediate support and forensic evidence is now gathered through the Archway service. (Appendix 2).

- Staff and carers will ensure that if a young person discloses rape or sexual assault that they communicate to the young person that the matter will be taken seriously and what action requires to be taken.

- Staff and carers will ensure that the young person's information is kept confidential from other young people and supported to understand the importance of sharing information in a way that protects them.

10.4 Sexual Exploitation

Sexual exploitation can take many forms. It can include participating in a range of sexual activity for material or emotional rewards e.g. money, gifts, drugs, accommodation or even affection. Often associated with it, is the threat (direct or implied) of violence or coercion. Young people can become involved in street prostitution which is visible [45].

However, it is important to note that the majority of exploitative behaviour takes place out of the public view, in flats/houses belonging to adult perpetrators. Equally, it should be remembered that all young people, irrespective of their sex or sexual orientation are vulnerable to sexual exploitation.

Young people who are sexually exploited do not usually become involved by choice, but often for a variety of complex reasons. Young people who are looked after and accommodated are particularly vulnerable to sexual exploitation due to their care backgrounds [46].

Some may have experienced childhood sexual abuse whilst others have such a poor sense of self and self confidence that they are unable to understand or safely negotiate personal relationships. Young people living in children's units are particularly vulnerable. It is known that residential units can be targeted by perpetrators and that young people themselves can encourage others to become involved in behaviour that is sexually exploitative [46].

Young people involved in prostitution are regarded as 'children in need'. They must be cared for as victims of abuse and in need of protection.

Given the particular vulnerabilities of looked after and accommodated young people to sexual exploitation, it is vital that, as a preventative measure, work takes place with all young people who are looked after and accommodated around sexual health and relationship issues. This need is even more pressing for the most vulnerable young people. Their vulnerability or past abuse should not be used as a reason as to why this work should not be carried out.

Staff and carers need to be aware of what young people are doing in their spare time and who they are associating with. They also need to be alert to a young person being particularly secretive about their whereabouts, any changes in their demeanour or in the appearance of unexplained monies, clothing etc.

For those young people who are, or may be, being exploited, staff and carers need to create safe, supportive and non-judgemental environments to encourage trust and enable young people to speak openly about their experiences. Support and advice around health and personal risks should also be offered.

Recent research indicates that male use of prostitution is not as uncommon as might have previously been suspected [47]. It is important therefore that sexual health and relationships education work, with young men particularly, focuses on the harm caused by prostitution and challenges the notion that sex is a legitimate commodity.

Best Practice

- Through training, support and supervision, staff and carers need to be able to address their own feelings, views and attitudes about sexually exploitative behaviour. They should be able to access specialist support and advice services as required.

- Staff and carers will raise young people's awareness of the need to keep themselves safe from abuse and exploitation and to assist them with developing strategies to keep themselves safe. Young people need to develop an understanding that relationships should be caring, respectful and sensitive with appropriate boundaries.

- For those young people who have been exploited staff and carers will offer understanding and support, to help them explore and deal with their experiences. Young people may benefit from a range of services including advice and counselling for harm minimisation, health promotion and advice on sexually transmitted infections, including HIV.

- If a member of staff or a carer is concerned about the behaviour of a young person, they should discuss matters with the young person's social worker at the earliest opportunity.

10.5 Female Genital Mutilation

Female genital mutilation (FGM) sometimes known as female circumcision is a harmful custom involving injury to the female genital organs or partial or total removal of the external female genitalia. This is usually done as a cultural practice within certain communities and countries. FGM is usually carried out on girls aged between 4 and 13 years of age, but may be carried out from birth to first pregnancy. Within the communities where FGM is practiced, most women believe that such a procedure is necessary to be accepted within their community.

FGM is a criminal offence in the UK. The Prohibition of FGM (Scotland) Act 2005 (45) also makes it illegal to try to (or attempt to try to) take a girl out of the country for the purposes of FGM. FGM is therefore a serious child protection issue and a form of gender based violence. Staff and carers should be alert to any arrangements of

holidays abroad involving young women from countries where FGM is conducted and treat any suspicions around possible FGM as a child protection matter. Staff and carers will be aware that where there are sisters from the same family placed together and one of them has undergone FGM, the other girl will automatically be considered at risk in terms of child protection.

FGM can cause significant physical and psychological distress for girls and young women especially during pregnancy and birth. Staff and carers are most likely to be in a position of caring for a child dealing with the physical and emotional after effects rather than the actual procedure. Women can experience pain during sexual intercourse, infection of the genitals, urine retention, disruption of menstruation, as well as psychological distress such as depression or flashbacks.

Best Practice

- Staff and carers need to be aware that young women from countries where FGM is practiced may have had FGM performed on them in their country of origin or that their birth families may wish to arrange FGM.
- Staff and carers will be alert to signs of FGM such as discomfort or longer than usual time spent passing urine. Where FGM has occurred staff and carers will arrange appropriate medical and emotional health care (see Appendix 2).
- Staff will work sensitively with families to explain the legal position around FGM. If a child protection intervention has occurred the young person may be isolated from their communities and families if they refuse to undergo FGM. Staff and carers will work with families to ensure young women do not become estranged.

10.6 Young People who Demonstrate Sexually Problematic Behaviour

Some young people may display problematic sexual behaviour towards other young people and adults. Sexually problematic behaviour can be considered on a continuum of behaviour ranging from masturbating in public, sexually aggressive language through to inappropriate touching and at the extreme end of the continuum sexual offending. Such behaviours require to be identified early, properly assessed and appropriate interventions identified.

A young person with problematic sexual behaviours should not immediately be labelled as a perpetrator, but rather the problematic behaviours require to be fully assessed within a context of the young person's experiences and environment.

Some young people may themselves have been the victim of sexual abuse and require appropriate supports and interventions that acknowledge their own abuse experiences.

Young people with problematic sexual behaviours should be encouraged towards healthier sexual attitudes and practices and should receive the same sexual health and relationship education as other young people. Such support should form an integral part of the young person's care plan, within which staff and carers have a specific role in supporting the young person. Much can be achieved within an understanding and supportive environment.

Staff and carers need to ensure that their own feelings and practices do not prevent young people who display problematic sexual behaviour getting support around sex, relationships and sexual health issues.

Best Practice

- All problematic sexual behaviour will be challenged.
- Staff and carers have a responsibility to ensure that young people who exhibit problematic sexual behaviour access appropriate support.
- Any need for specialised or additional support must be incorporated into the young person's care plan.
- Where specialised work is required, staff and carers must receive support and training in working with the young person to implement the care plan.
- Whilst problematic sexual behaviour is not acceptable and requires to be addressed, staff and carers will work within the principles of rejecting the behaviour and not the young person.

10.7 Sexual Offences Act: (October 2010)

Part One of the Sexual Offences (Scotland) Act 2009 creates new statutory offences of rape, sexual assault by penetration, sexual assault, sexual coercion, coercing a person to be present during sexual activity, coercing a person to look at an image of sexual activity, communicating indecently, sexual exposure, voyeurism and administering a substance for a sexual purpose. These offences are committed when a person engages in any such conduct without the other person's consent, and without any reasonable belief that the other person consented.

Part Two of the Act provides for a statutory definition of consent as "free agreement", supplemented with a non-exhaustive list of circumstances in which consent can never be present. It further provides that consent to conduct does not in and of itself constitute consent to any other conduct, and that consent may be withdrawn at any time. Part Three of the Act makes provision regarding the capacity of persons with a mental disorder to consent to conduct.

Part Four of the Act provides for "protective offences" which address predatory sexual behaviour towards children. The Bill maintains the age of consent at 16. It provides that sexual activity of any kind between adults and children under the age of 16 is unlawful. Separate 'protective' offences are provided for in respect of sexual activity with young children (under the age of 13) and older children (from age 13 to age 15). It further provides that sexual intercourse and oral sex between under-16s remains unlawful.

Part Five of the Act provides for offences concerning sexual abuse of trust. The Act provides that it shall be an offence for a person in a position of trust over a child

under the age of 18 or a person with a mental disorder to engage in sexual activity with that child or person.

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Appendix 2 – Specialist Services and Resources

Looked After and Accommodated Children's Nurse

Child Health Department
Vale of Leven Hospital
Alexandria
G83 0UA
01389 817 339

Sandyford and Sandyford Hubs

All of these services are available to women, men and young people, of all sexual orientations, for example heterosexual, or gay. They offer information, advice and services relating to a number of sexual, reproductive and emotional issues including:

- HIV Testing
- Pregnancy
- Testing and treatment of sexually transmitted infections
- Counselling
- Hepatitis testing and vaccination
- Free condoms
- Contraception (birth control) including male sterilisation (vasectomy)
- Women's health problems including gynaecology and menopause
- Termination of pregnancy (abortion)
- Rape and Sexual Assault Support

At these services you can either make an appointment by phoning or visiting the service. There are also times of the day when you can drop in (go without an appointment) and wait to be seen.

Sandyford West Dunbartonshire

Ground Floor
Old Maternity Block
Vale of Leven Hospital
Alexandria G83 0UA
01389 818 511

Sandyford Clydebank

Clydebank Health Centre
Kilbowie Road
Clydebank G81 2TQ

Sandyford Central

2-6 Sandyford Place
Glasgow
G3 7NB
0141 211 8130

Sandyford Drumchapel
Drumchapel Health Centre
80-90 Kinfauns Drive
Glasgow G15

The Place @ Sandyford
Dedicated sexual health service for young people at all Sandyford services.
Visit www.sandyford.org for details and times of clinics

Emergency Contraception
Emergency contraception is available free over the counter at every pharmacist in West Dunbartonshire. It is also available within Sandyford during opening hours. You can make an appointment or drop in on weekdays and Saturday mornings. Young people under 18 can access the main young person's clinic 'the place' @ Sandyford and at Sandyford Hubs.

Sandyford Counselling and Support Services
Counselling is available to both men and women for a range of different issues. Counselling and support services are provided by a team of counsellors and support staff. All services can be accessed by phoning 0141-211-6700, or through the Sandyford main switchboard on 0141-211-8600. Open Monday – Thursday 9.00am-8.30pm and Friday 9.00am-3.30pm

Sandyford Transgender Services (Gender Identity Services)
A range of clinical, counselling and support services for individuals who have gender identity issues. Patients can self refer or be referred by their GP or hospital doctor. All visits are by appointment only. For further information phone: 0141 211 8137.

Steve Retson Project @ Sandyford
A sexual health service for gay men in Glasgow. The Project is based in both the Sandyford Centre every Tuesday Wednesday and Thursday. Same day
HIV testing at the Sandyford Centre each Tuesday morning, 9-11am
0141-211-8628

Sandyford Library and Information Services
Borrow or browse the large selection of books, DVDs and other resources on all aspects of health and well-being. (Even if you don't live or work in Glasgow you can still join Sandyford Library). The full range of Sandyford stock and the complete resources of Glasgow's libraries can be explored using the online catalogue at: www.libcat.glasgow.gov.uk

Child and Adolescent Mental Health Services (CAMHS)
based at the Acorn Centre, Vale of Leven Hospital, Alexandria, G83 0UA.
01389 754121

NHS Greater Glasgow & Clyde GP Services
To find a GP surgery and/or health centre in your area go to:
http://www.nhsggc.org.uk/content/

NHS 24
Confidential telephone health advice and information service. Out of hours service to provide patients with health advice and help when GP practices are closed. Also

access the NHS 24 website to obtain up to date details of pharmacies in your area for standard opening times and other relevant information.
08454 24 24 24. www.nhs24.com/

GEMS NHS
GEMS NHS provides out of hours medical advice and care for primary care emergencies, for everyone in Greater Glasgow, that cannot wait until patients own practices are open during normal working hours. Callers will, be offered either a face to face consultation with a doctor at one of the 6 Primary Care Emergency Centres around the city, or skilled professional telephone advice, or a home visit, as clinically necessary. www.gemsgp.co.uk/

LAC Education Team, part of the **Flexible Resource Centre** based at Aitkenbar Primary School. Whiteford Avenue, Dumbarton, G83 3JL
01389 763931

ChildLine Scotland – 'The Line' 0800 884444.
Free, helplines for children in trouble or danger.
'The Line' is a special childline helpline for children living away from home. The service operates 3.30pm - 9.30pm Monday to Friday and 2pm - 8pm at the weekend. Main Childline helpline also available 24 hours, 365 days a year - 0800 1111. Minicom service for children who are deaf or have impaired hearing is available on 0800 400 222. This service operates 9.30am - 9.30pm Monday to Friday and 9.30am - 8pm at the weekend. www.childline.org.uk/

FRANK helpline - 0800 776600
Available 365 days a year, 24 hours a day.
Helpline provides information, advice about drugs and local services. Can take calls in over 120 languages via a three way call with a translator. Also a website providing information and an email service for users to send in questions. www.talktofrank.com/

Women's Aid

Clydebank - 0141 952 8118
Dumbarton District - 01389 751036
Both Women's Aid groups have an outreach service which offers support to any child or young person affected by domestic abuse. The workers can meet with CYP in school or other agreed venues in the community. There are also opportunities to attend support group for CYP.
Dumbarton District Women's Aid has a counselling service for women over the age of 16 who have experiences childhood sexual abuse.

CARA (Challenging And Responding to Abuse) - 01389 768664
The CARA Service has a counsellor for children and young people who are affected by domestic abuse, and also young people who are experiencing abuse in their own personal relationships. The counsellor can meet with CYP in school or an agreed venue in the community and is mainly for children up to the age of 16yrs. The age limit is flexible and negotiable depending on the issue for the young person.
CARA also provides a support and counselling service for women over 16 who are affected by domestic abuse and childhood sexual abuse.

The Reduce Abuse Project - 01389 772214
The Reduce Abuse Project carries out prevention work in schools and informal youth settings with children and young people. The staff are also available to carry out training on domestic abuse and wider gender based violence issues affecting young people.

LGBT Youthline – 0845 113 0005
lesbian, gay, bi-sexual, transgender or just not sure? Information, advice, support for young people. www.lgbtyouth.org.uk/

National AIDS & Sexual Health Line - 0800 567 123 (calls may be charged if made from mobile phones). 7 days a week, 24 hours a day. A 24-hour, free and confidential telephone service with advice about HIV/AIDS, sexual health, STDs, local services, clinics and support services. Translation services available for speakers of UK ethnic minority languages.

Parentline Scotland – 0808 800 2222
Free, confidential helpline for parents is open 9am-5pm (Monday, Wednesday & Friday) and 9am-9pm (Tuesday & Thursday). www.children1st.org.uk/parentline/

SupportLine - **(020) 8554 9004 or info@supportline.org.uk**
Confidential emotional support to children, young adults and adults by telephone and email. Working with callers to develop healthy, positive coping strategies, an inner feeling of strength and increased self esteem to encourage healing, recovery and moving forward with life. Also keep details of counsellors, agencies and support groups throughout the UK.

Pharmacies
Call NHS 24 or access the website 'search engine', to obtain up to date details of pharmacies in your area for standard opening times, contact details and other relevant information.
08454 24 24 24 Textphone: 18001 08454 24 24 24 (can't find this on website but assume still correct if you found before
www.nhs24.com/

NHS Greater Glasgow & Clyde, Public Education and Resource Library (PERL)
West House, Gartnavel Hospital, 1055 Great Western Road, Glasgow G12 0XH.
0141-201-4915 PERL@ggc.scot.nhs.uk

Condom Distribution Service
The CDS offers access to a range of free condoms with minimum embarrassment. There are different venues across West Dunbartonshire. If you wish to be able to provide a supply of condoms to young people please contact the CDS team.
0141 232 8444
www.sandyford.org/freecondoms

Brownlee Centre
Confidential Testing and treatment for HIV and other Blood Borne Viruses
Gartnavel General Hospital, 1053 Great Western Road, G12 0YN
0141-211-1089

British Pregnancy Advisory Service
To book an appointment, call the national Action line on: 08457 30 40 30 (calls will be charged at a local rate) 8am to 9pm Monday – Friday; 8.30am to 6pm on Saturday; 9.30am to 2.30pm on Sunday.www.bpas.org/

The Archway
The Archway Glasgow is a service which brings together forensic examiners, counsellors and health advisers to assist those who have recently experienced rape and sexual assault. Young people (male and female) who have been assaulted in the last week and are 13 and over can be offered support here. If the assault took place more than a week ago young people will be offered support through Sandyford. Children who are 12 years or under will continue to be dealt with through Yorkhill Hospital. It is based at the Sandyford Initiative, 2-6 Sandyford Place, Sauchiehall Street, G3 7NB 0141-211- 8175 www.archwayglasgow.com. Appointment only

NHS Open Road
A service for males of all ages who are commercially sexually exploited through prostitution. The project provides direct support and care management for individuals involved, plus support for other health and care professionals who are supporting males involved in prostitution within generic services. The project also drives policy and protocol development regarding males involved in prostitution. For more information go to: www.openroadproject.com or call 0141 420 7284

Special Needs in Pregnancy Service (SNIPS)
This service is jointly run by health and social work to provide intensive support to any expectant mother who may have additional needs.
Based at the Community Midwives, Vale of Leven Hospital, Alexandria, G83 0UA.
Contact Number 01389 754121.

Y Sortit
Youth information and support network for 12 – 25 year olds. This service is provided across all West Dunbartonshire through the use of a cyberbus and information points in all secondary schools.
24 Kilbowie Road, Clydebank, G81 1TH.
Contact number 0141 941 3308.

Appendix 3 Further Reading, Resources and Services

FURTHER READING

Becker, M.,G. and Barth, R.,P. (2000). *Power Through Choices: The Development of a Sexuality Education Curriculum for Youths in Out-of-Home Care.* Child Welfare. 79:3, pp. 269-282.

Corlyon, J. and McGuire, C. (1997). *Young Parents in Public Care: Pregnancy and Parenthood Among Young People Looked After by Local Authorities: Report of Component 1 of Preparation and Support for Parenthood.* London: National Children's Bureau.

Corlyon, J. and McGuire, C. (1997). *Pregnancy & Parenthood: The Views and Experiences of Young People in Public Care.* London: National Children's Bureau.

Corlyon, J. and McGuire, C. (1997). *Young Parents in Public Care.* London: National Children's Bureau.

Mason, J. and Lewis, H. (1999). *Time to Decide: A Guide to Support Young People in Public Care When Making Decisions about Pregnancy.* London: National Children's Bureau.

McCluskey, S. (2002). *Sexual Health Consultation: Young People Looked After Away from Home, for the Scottish Sexual Health Strategy Group (unpublished).* Glasgow: The Big Step.

National Children's Bureau (2005). *Healthy Care Briefing: Sexual Health.* London: National Children's Bureau.

NHS Health Scotland (2010) Supporting Sex and Relationships Education for Looked After Children and Young People: A briefing paper

Patel-Kanwal, H. and Lenderyou, G., F. (1998). *Let's Talk About Sex and Relationships: A Policy and Practice Framework for Working with Children and Young People in Public Care.* London: National Children's Bureau.

Patel-Kanwal, H. and Mackie, S. (2003). *Let's Make it Happen: Training on Sex, Relationships, Pregnancy and Parenthood for Those Working with Looked After Children and Young People.* London: National Children's Bureau / family planning association.

Teenage Pregnancy Unit and Quality Protects (2003). *Guidance for Field Social Workers, Residential Workers & Foster Carers on Providing Information & Referring Young People to Contraceptive and Sexual Health Services.* London: Teenage Pregnancy Unit / Quality Protects.

Teenage Pregnancy Unit (2003). Teenage Pregnancy and Looked After Children / Care Leavers: Examples of Innovative Practice. London: Teenage Pregnancy Unit.

Teenage Pregnancy Unit (2003). *Teenage Pregnancy and Looked After Children / Care Leavers: Resource For Teenage Pregnancy Co-ordinators.* London: Teenage Pregnancy Unit.

The Scottish Executive (2005). *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health.* Edinburgh: The Stationery Office.

Many of the above publications may be available from:

NHS Greater Glasgow & Clyde, Public Education and Resource Library (PERL)
Dalian House, 350 St Vincent Street, G3 8YY.
0141-201-4915 PERL@ggc.scot.nhs.uk

Scottish Institute for Residential Childcare – Library Service.
National Office, 5th Floor, Sir Henry Wood Building, 76 Southbrae Drive, Glasgow G13 1PP
Search online at: www.sircc.strath.ac.uk/
0141-950-3683.

NHS Health Scotland- Library Service.
Health Scotland Library, The Priory, Canaan Lane, Edinburgh, EH10 4SG
Search online at: www.healthscotland.com/
0845 912 5442. library@health.scot.nhs.uk

RESOURCES

Many of the above resources, and other similar resources, including a range of information for children and young people and for carers is available from:

NHS Greater Glasgow & Clyde, Public Education and Resource Library (PERL)
West House, Gartnavel Royal Hospital, 1053 Great Western Road, G12 0YN
0141-201-4915 PERL@ggc.scot.nhs.uk

OTHER SERVICES & WEBSITES

For staff and carers……..

Avert
HIV/AIDS site offering personal stories, history section, young and gay section, statistics and lots more. www.avert.org.uk

Family Planning Association
Offers information on contraception and sexual health, including news, campaigns, help and advice. www.fpa.org.uk

(Glasgow) Child and Adolescent Mental Health Services (CAMHS): Service Directory for Referrers. Mental health services for children and adolescents are not only provided by the health service but also by social work services, education, criminal justice, and the voluntary sector. This directory aims to provide key information on CAMHS for potential referrers. This Directory can be downloaded from: www.nhsggc.org.uk/content/default.asp?page=s19

LGBT Youth Scotland
Provide a range of services and opportunities for young people, families and professionals who aim to increase awareness and confidence; as well as reducing isolation and intolerance. www.lgbtyouth.org.uk/

Parents Enquiry Scotland
Information for parents if your child is gay, bisexual, lesbian or transgender.
www.parentsenquiryscotland.org

For young people……..

BBC Kids Health
BBC Body and mind matters for young people.
www.bbc.co.uk/health/index.shtml

Be Books
www.bebooksonline.co.uk

Children First for Health
The Children First interactive guide to life and health information for families and young people of a
www.childrenfirst.nhs.uk/

Don't Give Up Giving Up
Information and advice for young people who want to give up smoking.
www.givingupsmoking.co.uk/Youngpeoplesmoking/

Galaxy H (now seems to be directgovkids
Fasten your seat belts and take the interactive voyage on the Galaxy H space station to access information
for children and young people. http://www.directgovkids.co.uk/

Get Connected
Free confidential helpline giving young people in difficult situations emotional support and access looking for.
www.getconnected.org.uk/

It's not Your Fault
Information for young people whose parents have or may be splitting up.
www.itsnotyourfault.org/

Kidscape
Advice on keeping safe from abuse for young people.
www.kidscape.org.uk/

need2know
Whatever young people need to know, it's all here.
www.need2know.co.uk/

Condom essential wear
Young people site offering straight talking questions, answers, advice and information.
http://www.condomessentialwear.co.uk/

Teenage Health Freak
Informative and interesting health information for teenagers.
www.teenagehealthfreak.org/homepage/index.asp

Talk to Frank
Free confidential drugs information and advice 24 hours a day.
www.talktofrank.com/

Appendix 4 - Sexual Offences (Scotland) Act 2009

Background

There has been widespread public, professional and academic concern that Scots law on rape and other sexual offences is out-dated and derives from a time when sexual attitudes were very different from those of contemporary society.

In June 2004**,** Scottish Ministers asked the Scottish Law Commission (SLC) to "examine the law relating to such offences and the evidential requirements for proving such offences and to make recommendations for reform."

The Scottish Law Commission's "Report on Rape and Other Sexual Offences" was published in December 2007.

The report concluded that the existing law is a fragmented mixture of common law and statute law and is far from clear to ordinary members of the public. The Commission felt that codification would be a significant improvement. Codification in this context means enshrining the law in writing.

The 2009 Act creates a whole new set of statutory sexual offences which are intended to cover the majority of our existing offences both at common law and in statutory form.

The Act rectifies a number of inconsistencies which exist in our current law. e.g. As it stands, it is an offence for an adult male to have sexual intercourse with a 14 year old female whereas there is no offence if an adult female engages in sexual intercourse with a 14 year old boy

Another example is that offences against boys and girls are dependant on the age of puberty i.e. 12 years of age for girls and 14 years of age for boys.

These are only two examples of inconsistencies which the new Act addresses.

The issue of whether a person consents to sexual activity is central to all our existing offences (with the exception of a female child under 12 years of age and a male child under the age of 14 years). However, the term “lack of consent” has never been specifically defined by the courts. The Act sets down a definition of “consent” in an attempt to provide clarity to everyone involved in the judicial system including members of the public.

There are a number of situations in which we libel charges as a breach of the peace where the conduct in question is of a sexual nature. The Scottish Law Commission wanted the public to know that these offences will now be categorised as a sexual offence and the Act accommodates the Commission’s view to a large extent.

1.1.1 When the Act comes into force on the 1 October 2010, it will abolish the common law offences of Rape, Sodomy and Lewd libidinous practices or behaviours together with a number of statutory offences.

The Act, however, does not abolish the common law offence of indecent assault. This means that if we have conduct which does not fall within the scope of the Act, we can, if appropriate, still libel indecent assault

The Act classifies certain conduct as a **“type of wrong”**.

Having done so, the Act thereafter, **in general,** applies these wrongs to victims who are:
- adults of full capacity
- young children
- older children
- persons suffering from mental disorder and
- those in respect of whom the accused holds a position of trust.

This however, does create considerable repetition.

Note-It is important to note **that they are not identical** and care should be taken to ensure that any applicable section is fully understood.

The Act uses the letter “A” to denote the offender and “B” to denote the victim. It also introduces a third party “C” at some points. For consistency, this course adopts the same position.

Rape (s.1)

This offence is committed when A

- penetrates
- the vagina, anus or mouth of B
- with A's penis
- without B’s consent
- *and* without any reasonable belief that B was consenting

Note: This is wider than our existing common law where the offence of rape can only be committed by penile penetration of B's vagina.

Lack of Consent

Consent is now defined as “free agreement” (s.12) and is central to the offence. The Act does not provide a definition of “free agreement”.

However, the Act lists a number of situations where free agreement is absent.

The list is not exhaustive- there can be other situations which are not listed whereby there is no “free agreement”. The existing case law will still be of assistance in proving the lack of consent.

Statutory list of situations where there is no free agreement (s13)

- B is incapable of consenting because of the effect of alcohol or any other substance.
- B agrees because of violence used or threats of violence made to B or any other person.

- B agrees because B is unlawfully detained by A
- B agrees but is deceived by A as to the nature or purpose of the conduct
- A induces B to agree by impersonating someone known personally to B
- Where someone else agrees to B's participation

In addition, if B is either asleep or unconscious, then there is no "free agreement" to what took place and therefore no consent. (s.14).

Reasonable belief (s.16)

The term "reasonable belief" is not defined within the Act.

It will be for the court or jury to decide whether A had a belief that was reasonable and in reaching that decision, regard is to be had to what steps, **if any**, A had undertaken to ascertain whether the other party was consenting.

NOTE- the section does not say that belief will never be reasonable if A cannot point to any particular steps to ascertain whether there was consent.

Sexual Assault by Penetration (s.2)

This offence is committed when, without B's consent or any reasonable belief that B was consenting, A:-

- sexually penetrates
- B's vagina or anus (whether intentionally or recklessly),
- with anything at all

This includes A's penis, any other parts of A's body or any other object.

There is an obvious overlap here with the s.1 rape in that both of these offences can be committed by penetration with A's penis. This is designed to cover the situation whereby e.g. B was blindfolded and is not sure whether the penetration was by the penis or not

This type of conduct would be libelled as an indecent assault under our existing common law.

Note- the penetration must be of B's vagina or anus and does not include mouth.

Sexual Assault (s.3)

This section lists a number of acts which, if one or more of them are carried out by A (either intentionally or recklessly), will constitute the offence of sexual assault.

The offence is committed when A does any of the following to B without B's consent and without any reasonable belief that B was consenting:-

- Penetrates sexually by any means and to any extent, the vagina, anus or mouth of B.
- Touches B sexually.
- Engages in any form of sexual activity in which A has physical contact (whether bodily contact or contact by means of an implement and whether or not through clothing) with B.
- Ejaculates semen onto B.
- Emits urine or saliva onto B sexually

The section tries to capture those offences which do not fall within s.2, which are currently libelled as indecent assault under the existing common law.

Remember- the common law offence of indecent assault will not be abolished by this Act. Therefore, if the situation is **not** one of the ones listed, and it is appropriate to do so, you can still libel the common law offence of indecent assault

Coercion offences

Sexual Coercion (s.4)

This offence is committed when A causes B to take part in a sexual activity without B's consent and where A has no reasonable belief that B is consenting.

Whilst this section can apply to sexual activity between A and B, it is primarily intended to capture the situation whereby A compels B to have sex with a third party or to have sexual conduct with an animal, or an object. It also applies where A compels B to, for example, to masturbate him or herself.

Unlike the previous 3 offences, this offence cannot be committed recklessly. It can only be committed intentionally.

Coercing a person to be present during a sexual activity s.5

This offence can be committed in two ways:-

1. When A, for a specified purpose, intentionally engages in sexual activity and he causes B to be present during the activity.
2. Where a third person is engaging in a sexual activity and A causes B, again for a specified purpose, to be present during that activity.

In both cases, A must be acting without B's consent and with no reasonable belief that B is consenting.

The specified purpose referred to above can be either one or both of the following:-

For A's own sexual gratification

or

In order to humiliate, distress or alarm B

Coercing a person to look at a sexual image (s.6)

This offence is committed when A - again for A's own sexual gratification or to humiliate, distress or alarm B - causes B to look at a sexual image without B's consent and where A has no reasonable belief that B is consenting.

A sexual image is an image of one or more of the following:

- A engaging in a sexual activity
- A's genitals
- another person engaging in a sexual activity
- another person's genitals
- an imaginary person engaging in a sexual activity (e.g. a cartoon image, or computer generated characters etc)
- an imaginary person's genitals

Communicating indecently

This offence creates 2 offences and relates to unwanted sexual communication.

Subsection 1 offence- "communicating indecently"
and
Subsection 2 offence- "causing a person to see or hear an indecent communication"

We will look at each of these in turn.

Communicating indecently

This offence is committed when A intentionally sends a sexual written communication or directs a sexual verbal communication to B without B's consent and where A has no reasonable belief that B is consenting.

Once again, this offence only applies where A is doing it for A's own sexual gratification or to humiliate, distress or alarm B.

The sexual written communication can be in any form e.g. a book, a section of a magazine or a letter written by the accused.

The sexual verbal communication can be in any form. e.g. sounds of sexual activity or even sign language.

Causing a person to see or hear an indecent communication

This offence can only be committed when the circumstances in subsection 1 are not present.

Subsection 1 covers the sending or directing of a communication whereas this sub-section covers the situation where A hasn't sent or directed the communication to B, but has caused B to see or hear it.

Sexual exposure

This offence is committed when A, for A's own sexual gratification or to humiliate, distress or alarm B, intentionally exposes A's genitals in a sexual manner with the intention that B will see them.

Again, this offence only applies to exposure of the genitals to B without B's consent and where A has no reasonable belief that B is consenting.

Voyeurism (s.9)

This offence is committed when A does any of the following:-

- Observes B doing a private act
- Operates any equipment which would allow A or any other person to observe B doing a private act
- Records B doing a private act which would allow A or any other person to look at the recording of B doing the act

- Installs equipment, constructs or adapts a structure which would allow A or any other person to do any of the things mentioned in 1, 2 and 3 above.

This offence is designed to catch those persons (A), who spy on B when B is engaged in a private act. A does this without B's consent and with no reasonable belief that B is consenting. Again, the offence is only committed when A does this for A's own sexual gratification or to humiliate, distress or alarm B.

A "private act" includes situations where B is in what he or she believes to be a private place and B's genitals, buttocks or breasts are exposed or covered only with underwear. It also includes where B is using the lavatory or is engaged in a sexual activity which he or she would not normally do in a public place.

Administering a substance for sexual purposes (s.11)

This offence is committed when A gives a substance to B or causes B to take a substance which A hopes will overpower or stupefy B, therefore enabling A or any other person to engage in a sexual activity with B.

"Substance" is not defined but can mean drugs or alcohol.

Offences against young children (ss 18-26)

A young child is a child who has not yet reached the age of 13.

The previous offences contained in sections 1-9 can all be committed against a young child. However, a young child is incapable of consenting to any form of sexual activity. This means that the offences specifically relating to a young child do not make any reference to:-

B consenting, or
A acting without a reasonable belief that B was consenting.

Otherwise, all other elements of the offences listed in sections 1-9 are identical to the offences relating to young children contained in section 18-26 of the Act. The offences are:-

18 Rape of a young child
19. Sexual assault on a young child by penetration.
20. Sexual assault on a young child
21. Causing a young child to participate in a sexual activity
22. Causing a young child to be present during a sexual activity
23. Causing a young child to look at a sexual image
24. Communicating indecently with a young child
25. Sexual exposure to a young child
26. Voyeurism towards a young child

Offences against older children (ss 28-37)

An older child is a child (B) who has reached the age of 13 but is still under the age of 16.

Intercourse with an older child (s.28)

This section prohibits adults having any form of intercourse with children aged 13, 14 and 15.

The offence is committed when A, being a person who is 16 years of age and over, penetrates B's vagina, anus or mouth, when B is an older child.

An older child is incapable of consenting to intercourse with an adult. This means that this offence does not make any reference to:-

B consenting or
A acting without a reasonable belief that B was consenting.

The remaining sections involving sexual activity between an adult and an older child are contained with sections 29-36 and are:-

29. Engaging in penetrative sexual activity with or towards an older child
30. Engaging in sexual activity with or towards an older child
31. Causing an older child to participate in a sexual activity
32. Causing an older child to be present during a sexual activity
33. Causing an older child to look at a sexual image
34. Communicating indecently with an older child
35. Sexual exposure to an older child.
36. Voyeurism towards an older child.

An older child is incapable of consenting to any of the sexual conduct listed on the previous screen with an adult. This means that these offences do not make any reference to:-

B consenting or
A acting without a reasonable belief that B was consenting.

Otherwise, all other elements of the offences listed in sections 2-9 are identical to the corresponding offences relating to older children contained in sections 29-36 of the Act.

Sexual activity between older children (s.37).

The Act recognises that consensual touching, kissing and sexual conversations between older children are generally considered to be part of growing up. The Act does not seek to criminalise such conduct.

However, the Act prohibits certain types of sexual activity between older children.

The Act prohibits:

- Penile penetration of vagina, anus or mouth

  And

- Touching of the vagina, anus or penis with the mouth

In effect, the Act prohibits any form of intercourse or oral sex between older children. There are 2 offences:

1- If A penetrates B or touches B's vagina, anus or penis with his or her mouth, then A commits the offence of "engaging, while an older child, in sexual conduct with or towards another older child".

2- If B consents to the above activity, then B commits the offence of "engaging, while an older child, in **consensual** sexual conduct with or towards another older child".

Sexual abuse of trust involving children (s.42)

In addition to the all offences against children (young and old), this section makes it an offence for A, who is 18 years of age or over, to engage in any sexual activity with B where:-

- B is under 18 years of age
  and
- A is in a position of trust in relation to B

A in a position of trust in relation to B when:
B is in an institution by virtue of a court order and A looks after persons under 18 in that institution.

B is in a children's home provided by the local authority and A looks after persons who are under 18 at the home.

B is cared for in:

- a hospital
- accommodation provided by an independent health care service
- a residential establishment
- accommodation provided by a school care accommodation service or secure accomodation service.

B is receiving education at a school and A looks after persons who are under 18 at the school

B is receiving education at a further or higher education institution and A looks after B in that institution

(Note- “looks after” means where A regularly cares for, teaches, trains, supervises or is in sole charge of B).

A has or had any parental responsibilities/rights in respect of B.or A treats B as a child of A’s family, so long as at the time, B is a member of the same household as A

Sexual abuse of trust involving mentally disordered persons (s.42)

Like children, the Act makes it an offence for A to have sexual activity with B where B suffers from a mental disorder **and** where A holds a position of trust in respect of B.

A is in a position of trust where A

(a) is a person providing care services to B
(b) is a person who
(1) is an individual employed in or contracted to provide services in or to, or
(2) not being the Scottish Ministers, is a manager of,
a hospital, independent health care service or state hospital in which B is being given medical treatment