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Underage sex and the best interests of the child: how both excessive control and neglected needs could pose threats to the sexual autonomy and wellbeing of young people.

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Underage sex and the best interests of the child: how both excessive control and neglected needs could pose threats to the sexual autonomy and wellbeing of young people.

By Brigid Teevan

Abstract

This article discusses how both excessive control and neglected needs pose threats to adolescents' sexual autonomy and wellbeing. The debate explores the dilemma of under-age sex; the responsibilities of the State; parental responsibilities; and the best interests of the child. Using Ireland as a case study and using case vignettes, the article explores the tensions between autonomy and protection; capacity versus best interests. Difficulties resolving these tensions have an impact on young people in that they are often not given the support or information they need. The article concludes by suggesting a way forward that prioritises young people's right to comprehensive sexuality education, sexual wellbeing and development of self-efficacy.

Key words: Adolescents; Autonomy; Capacity; the State and Parents

The dilemma of underage sex

We live in a culture sensitive to protecting children from sexual abuse by adults and people in authority. There is, however, growing evidence of a worrying trend of adolescent relationship abuse (RCNI 2012, Hackett 2011, Barter 2011, McGee et al. 2002). In addition, adolescents who suffer peer sexual coercion are at risk of increased externalizing and internalizing symptoms such as anxiety, depression, and suicidal thoughts (Howard and Wang 2005, Ahrens 2006), as well as its negative impact on the health of future relationships (Young and Furman 2012). Moreover, there is a body of research evidence indicating a strong connection between adverse childhood experiences (ACE) and optimal health, wellness and opportunities over a life-time (Felitti et al. 1998, Anda et al. 2004, Liu et al. 2013, Ports et al. 2016). As discussed below, the Irish Government recently introduced new legislation via the Criminal Law (Sexual Offences) Bill 2017 to establish a 'proximity of age' defence. This essay reflects on the United Nations Convention on the Rights of the Child (UNCRC) and puts forward the argument that the 'proximity of age' defence, in isolation, is not in the best interests of the child (Article 3). Notably, a State has a duty to protect children from all forms of abuse (Article 19), as it does not factor in the significant evidence that children and adolescence can also present a risk to other children. In fact, there is growing evidence that over a third of all sexual abuse of children is committed by someone under the age of 18 (RCNI 2012, Hackett 2011, Barter 2011, McGee et al. 2002).

In the last few decades, Ireland's social norms about 'acceptable' versus 'unacceptable' sexual behaviour have altered dramatically. Until the 1960s the Catholic Church's social and moral teachings were the principle framework; concerns about sexual integrity were enforced to various degrees throughout Irish society (Inglis 1998). Sex was not openly discussed, and

when it was, the discourse was strongly influenced by the Church's ethos (Mayock and Byrne 2004). This resulted in a 'climate of repression' in sexual matters, which influenced the structure within which 'relationships and sex were experienced by the majority of Irish people' (Layte et al. 2006:9). The attitudes in Catholic Ireland were not unique: sexual prudery was part of the Victorian mentality that had spread through Protestant Britain and America. But Inglis states, the 'Victorian attitudes and practices penetrated into the Irish body and soul', with the Catholic Church developing a monopoly position in the areas of 'family life, health, education, and social welfare' (2005:17). Irish society generally frowned on co-habiting or childbirth outside of marriage. The late 1960s saw the gradual giving way to more openness, discussion and acceptance surrounding sex and sexuality (Inglis 1998, O'Connell 2001). Still, until 1985 contraception was only available on medical prescription; homosexuality remained illegal until 1993; and divorce was only legalised in February 1997.[i] Indeed, in recent decades there has been a dramatic shift in 'sexual practices, values, beliefs, and attitudes' in Irish society (Inglis 2005:2). The rules and 'ethical regime' on sexual morality are being rewritten; what was once hidden, silenced, and discouraged is now openly portrayed and discussed (Inglis 1998:26).

However, sexual development and sexual autonomy is complex and dynamic. As a child gets older, they gain a greater awareness of their sexual self, enhanced by interplay of biological, and social changes (Ybarra and Mitchell, 2005). The onset of adolescence is a time of significant changes in motivation cognition, behaviour, and social relationships (Tolman and McClelland 2011). One of the main tasks for adolescents is gaining knowledge and experiences that will allow them to engage in romantic and sexual relationships (Suleiman et al. 2017), hence their quest for information on sex and sexuality. The Internet and modern

media are prioritized in the lives of young people and have become important sources of information. Owen et al. (2012:99) maintains the 'proliferation and mainstreaming of online pornography has influenced youth culture and adolescent development in unprecedented and diverse ways' (Lofgeren-Martenson 2010, Peter and Valkenburg 2007, Paul 2005). While the World Health Organization and German Federal Office for Health Education (WHO/BZgA) warn a lot of the information, especially around sexuality, is 'distorted, unbalanced, unrealistic, and often degrading (online-pornography)', particularly for women (2010:21). Furthermore, Rush & Le Nauze (2006a, 2006b) argue that through sexualization,[ii] a young girl's sexual autonomy is compromised, shaping their attitudes, expectations, and behaviours related to gender roles, sexual roles, and sexual expectations. These patterns may also culminate in distortions of young people's understanding of consent (Powell 2010).

In Ireland under the Child Care Act 1991, the Children Act 2001, and the United Nations Convention on the Rights of the Child (1989), a child is defined as anyone under the age of 18. However, Hayes (1995) asserts that children have, in the past, been frequently characterised more by what they cannot do than what they can do and are being portrayed as immature and dependent on adults, usually their parents. Hayes states that childhood is both a biological reality and a social construct, that childhood is not just defined by physical maturation, but also by a 'particular society at a particular time, in a particular way' (2002:22). Likewise, Walsh (2004)[iii] supports Hayes view, claiming our concept of the 'child' and 'childhood' is transient and evolutionary, that it is both context-linked and time-specific. In effect, children are now understood to be active agents in the developmental process (Haydon and Scraton 2002) and actively contribute to the construction of their own lives and of those around them (Leonard 2015, Stoecklin and Bonvin 2014), hence the recent

movement towards the self-directed child (Syse cited in, Irish College of General Practitioners 2005).

Evolving into a sexually healthy adult is a fundamental and complex task for adolescents and an important determinant of their wellbeing (Layte et al. 2006). The World Health Organisation (WHO) defines sexual health not just in terms of the absence of disease or dysfunction but within the broad definition of health:

> *'The integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are enriching and that enhance personality, communication and love' (2006:10)*

All children are born sexual beings and need to develop their sexual potential (WHO/BZgA 2010). An individual's capacity is developed through education, whether formal (schooling) or informal (experience). It is within the 'capacity' of each individual to realize their own 'autonomy' (Formosa 2013). However, autonomy is a broad concept with numerous definitions, for instance, Holec considers autonomy to be 'the ability to take charge of one's own learning' (1981:3), compared with Little's view that 'autonomy is a capacity for detachment, critical reflection, decision making, and independent action' (1991:4). Similarly, Dworkin's (1988) concept of autonomy is 'reflection upon preferences, wishes and desires'. Whereas, Noom et al. (2001) counsels that adolescent autonomy ought to be considered across three dimensions: attitudinal, emotional, and functional autonomy.[iv] Archard on the other hand argues autonomy comprises of 'rationality, maturity, and independence' (cited in, Nakata 2016:16). These examples illustrate the tensions between (sexual) autonomy and protectionism modes of thinking with regard to children's rights**.**

Until recently, any consensual sexual activity between 16-year-olds or younger, was, by Irish law, criminalised, regardless of consent, thereby making it incumbent on all service providers, such as social workers, doctors, and psychologists, to report the incidents to the legal authorities (Irish Garda). The author has constructed a vignette to examine the complexities of the topic under question. It is not intended to cover every possible circumstance, but designed to broaden discussions, outline some key concerns, while attempting to identify, and assess ethical problems (Gould, 1996, Flaskerud, 1979).

First consultation with GP

Jane (15 years old)[v] consults with her GP and requests contraception. The age of sexual consent in Ireland is 17 years, and 16 years for consenting to medical treatment, e.g. contraception. Irish legislation does not recognize the capacity of a minor under the age of 16 to consent to sexual health treatment. Jane informs her GP that she is in a relationship and has recently started (and will continue) having consensual intercourse with her boyfriend (17 years). To the best of his knowledge, she has a stable background and no history of physical or psychological abnormalities. She is firm in her resolve that the consultation is kept confidential and her parents are not informed. Following National Consent Policy (HSE, 2013), which supports the Medical Council's (2009) guidelines,[vi] which state, if the patient understands the treatment she is 'competent'[vii] to make an informed decision. He believes that Jane will continue to have sex with her boyfriend (17-years) and therefore is at risk of an unwanted pregnancy.[viii]

On the matter of underage sex, and as part of interdepartmental discussions that would inform the later changes[ix] made to the Irish age of consent laws, Dr O'Keeffe (2012), Director

of HSE Crisis Pregnancy Programme[x], provided the Department of Children and Youth Affairs and HSE Children and Family services, with a briefing paper, to 'Inform Developments in Relation to Mandatory Reporting of Underage Sexual Behaviour'. The report made the case that while a significant minority of adolescents engage in underage sexual behaviour, 'mandatory reporting' could be a barrier to young people attending sexual health services. It added that the law states that, 'any consensual sexual activity between 16-year-olds is presumed to be abuse and must be reported', even though stated Dr O'Keeffe, the majority of underage sexual activity in Ireland is among peers who are 'equally willing with a partner of a similar age' (2012:2).

However, Dr O'Keefe continued, reporting many services feel 'vulnerable' when providing crisis pregnancy counselling and contraceptive services to 'sexually active' underage adolescents (2012:8). This issue was further complicated if the girl requiring contraception was under 16-years, as the legal age to consent to medical treatment in Ireland. Consequently, the health professional is faced with the dilemma of balancing their responsibility to act in the best interest of the child (young person); and to act within the law regarding the medical treatment and fulfil their obligations regarding child protection guidelines. Nonetheless, the report went on to state, the Programme had knowledge of, and supported, at least 15,500 underaged youths per year, with many on an 'ad hoc basis' (2012:8). A second vignette is provided as an example of some complexities health professionals may face in circumstance such as Jane's follow-up visit to her GP.

Second consultation with GP

Ten months later, Jane again presents herself to her GP. On this occasion she requests the morning-after pill[xi]. During this consultation the GP learns that Jane broke up with her boyfriend after a couple of months and she had a brief relationship with another boy of a similar age. But she was not in a steady relationship and had not bothered renewing her contraception. Last night she had unprotected sex with a boy she had been seeing for a few weeks; they had both been drinking. There is some evidence that alcohol can confuse a young person's understanding of what was, or was not, consensual sex (Kennedy et al. 2014; MacNeela et al. 2014). Jane again requests their consultation is kept confidential. However, Jane (a minor) has conflicting rights, she has the right to have her decision-making powers respected, while also the right to be protected from harm (Fortin 2003).

In the Irish College of General Practitioners (ICGP 2005) guidelines, they referred to the UK law, the Gillick competence and the Frazer Guidelines[xii] and Article 12 (UNCRC), affirming the importance of focusing on a 'child's maturity rather than simply concentrating on the child's age'. The ICGP (2005) guidelines, advised practitioners to use the Frazer guidelines if they decide to provide contraceptive treatment to under 16s without parental consent. However, Daly (2013) later warned that this practice could be legally challenged, due to parental interests and rights under the Irish constitution. In fact, Lundy (2007) maintains, that Article 12 became one of the most controversial provisions of the UNCRC during the drafting process. Some perceived it to undermine adult authority (parents) and it was central to the reasoning for the United States refusal to ratify the Convention (Kilbourne, 1998).

Although, Holt (2013:183) argues that all people, including children and young people should have the right to control their own 'private sex lives and acts'. Similarly, Archard (2014)

contends that self-determination, in the case of sex, should be a child's right to choose when, with whom and in what manner. Holt and Archard's opinions relate to Article 12 (UNCRC 1989) which states the views of the child must be 'given due weight in accordance with the age and maturity of the child'. The expectation is that a child's concerns, perspectives and/or ideas inform decisions that impact on the child's life (Lansdown 2011). However, the GP must now consider that Jane potentially could have been sexual abused, or at risk of future abuse, therefore has her parents a right to be informed? Albeit, that confidentiality is a fundamental principal in medical ethics and key to patient and doctor relationship (Pavilsnis 1989), in exceptional circumstances, if the health professional felt the young person was at risk of significant harm, disclosure may be necessary (Daly 2013; Medical Council 2009). Furthermore, if on a future date, Jane discloses she was actually sexually abused, and as a result her mental and/or physical health was significantly affected, the GP and/or his employer, for example, the State, could be held accountable.

With regard to sexual abuse in childhood, the public focus has, to date, has mainly been directed towards adults or people in authority whereas, Quadara cautions, violence which is taking place in 'social scenarios such as parties, in dating relationships, or between students, is often still not acknowledged' (2008:1). In fact, research statistics suggest that anywhere from one-fifth to two-thirds of sexual abuse is committed by other children and young people (Hackett et al. 2016). Notably, research in Ireland show an increase in child perpetrators. The Sexual Abuse and Violence in Ireland (SAVI) (McGee et al. 2002) report found one in five females under 17-years, experience some form of sexual abuse; with 7.2% of all girls experiencing penetrative sex[xiii] and 27% of perpetrators were under 18s. Yet, in 2012, the

RCNI the figures were higher: out of 1562 cases 12% were minors; 64% of child victims were between 13-17 years; 37% of perpetrators were under 18-years; with 75% experienced rape. Yet, Ahrens (2006) and Quadara (2008) warn that adolescent victims of sexual abuse may not have the abilities or means to recognise or report occurrences of sexual abuse, therefore there is a likelihood of under-reporting. Thereupon, while all professionals have a duty to respect the maturing adolescent's right to autonomy, however, paternalism in the upbringing of children, states Feinberg, is to some degree, unavoidable. Consequently, even an older child, at times, need protecting from their 'own immature and uniformed judgment' for their future autonomy (2007:118).

Similarly, Cowley advises of dangers in medical ethics and that the use of autonomy and confidentiality[xiv] may encourage a culture of back covering: 'doctors can pass too much responsibility onto the competent patient, muttering *caveat emptor* (2005:742). This is further supported by O'Neill who claims that informed consent is often used by institutions and professionals against 'accusation, litigation, and compensation claims' (2003:4). Competence[xv], says Freeman is one of those concepts 'so easily grasped, or apparently so, that it had tended to be treated as if it were unproblematic' (2007:12). Hence, O'Neill (2003) maintains we must also consider the nature, moral values and the limitations of the health professional involved.

An adolescent may be competent to consent for the immediate issue at hand (wants to avoid pregnancy) but how can a health professional know, especially on an 'ad hoc bases' (O'Keeffe 2012), if they have the social skills to negotiate consent to, or refusal of, sexual intimacies, or their understanding of what constitutes abusive sex. In addition, an adolescent could have

personal traits, unknown to the health professional, such as being a high-functioning autistic,[xvi] which can cause difficulties in negotiating romantic and peer relationships, being bullied, higher risk of sexual exploitation or abuse (Baker 2002, Cridland et al, 2014); lower self-esteem, depression and anxiety disorders (Noom et al. 2001). In reality, there are often time restraints[xvii] on health professionals, and disclosure is often a piecemeal affair (Quadara 2010, Ogden et al. 2004). Also, another consideration to take into account, the RCNI (2012) reported only 11% of first time disclosures of abuse were made to professionals.

Turning to Meier's (2007:1835) research finding on '*Adolescent first sex and subsequent mental health',* she states that even though many teenagers engaging in early sex do not suffer mental health consequences, approximately 15 percent did. Consequently, calculating the HSE Crisis Pregnancy Programmes (O'Keefe 2012) figures of at 'least 15,500 per year', (under age youths engaging in sexual intercourse) these would suggest a worrying 2,325 adolescents could be experiencing some mental health problems as an outcome. This argument is supported by Mendle et al.'s (2012) study, which compared the emotional and psychological well-being of more than 1,500 pairs of siblings ranging in age from 13 to 18-years. They measured siblings who were romantically involved with another person, engaging in sexual activity with that person, or when they were sexually active with non-romantic partners. They found the teens who participated in casual or non-commitment relationships had significantly higher levels of emotional distress and depression. This was especially pronounced in adolescents under 15-year-olds.

Finkelhor and Browne report contributes to the debate, stating sexual abuse can have a profound impact on a young person's mental and physical wellbeing; future relationships;

feeling of self-worth; and sense of powerlessness (1985). Typically Barter (2011) informs us, boys externalise blame whereas girls tend to internalise their responses, self-blaming, feeling guilty they had 'given in' to sexual pressure from their partners. Indeed, it is this aspect of sexual trauma and not the act itself, that negatively affects girls the most over time (Barter et al. 2009). While, Arnon Bentovim (1993) suggests that the way young people are socialised may play a role in how they respond to abusive experiences. In fact, numerous studies (Allnock 2010, McHugh 2014) show that many incidents of child sexual abuse go unreported, and delayed disclosure is common (Quandara 2008). Equally important, Quadara explains that disclosure is about support seeking and should be seen as 'distinct from making a report or allegation' (2008:3).

The Irish Constitution underpins the interaction between the State and its citizens, including children. The Constitution states that family is the 'primary and natural educator of the child' with Article 42[xviii] guaranteeing that the State will respect the 'inalienable right and duty of parents to provide (…), physical and social education of their children'. Recently, however, children's rights were re-enforced in the Constitution in the Thirty-First Amendment[xix], which added that the 'views of the child shall be ascertained and given due weight having regard to the age and maturity of the child (Article 42a.2). However, it could be argued that some health professionals, following the Medical Councils (2009) guidelines, were already giving 'due weight' to adolescent requests for contraception or the morning-after pill without parental knowledge. In fact, the Irish College of General Practitioners (cited in Syse 2000) claims that international thinking has moved away from the paternalistic ethic, governed by the health professional, to the individuals involved. Hence, the latter state that the law has moved away from classifying by age and now emphasises and examines the individual's (the child's)

capacity to consent (cited in Mills 2002). However, in 2013, Dr Daly, writing for the Irish College of General Practitioners, questioned the possible legal culpability of treating a minor under 16 without parental consent, due to the strong protection of parental rights under the Irish constitution. Therefore, it could be argued the State found itself compromised and motives questionable, in their pursuit of the lowering the age of consent. Indeed, Thomas argues that one must question the wisdom and motives of the State when it intervenes in or takes over 'the parent's responsibility' for the care and protection of a child (2002:49).

The Irish Government's Policy on Underage Sex

So, despite the growing evidence of sexual violence/abuse in teenage relations (Barter, 2009, McGee et al. 2002, RCNI, 2012), plus the difficulty young people have in recognising and disclosing sexual abuse (RCNI 2012, Quadara 2008), the Irish Government has taken steps to reduce the accountability for professionals to report their knowledge of underage sex. Notably, the Children First Act 2015 was signed into law in December 2015 and the new Criminal Law (Sexual Offences) Act 2017[xx] was enacted into legislation on 27th March 2017. These changes in legislation no longer requires a 'mandated person' to make a report to the appropriate Agency[xxi] when they have knowledge of, or believe, that the 'child who is aged 15 years or more, but less than 17 years, is engaged in sexual activity' with a person who is not more than two years older than the young person and the relationship is not 'intimidator or exploitative'. This appears to reduce the burden of responsibility and risk legal culpability of mandated people and/or their employers (the State). Interestingly, with this in mind it should be noted the Charter for Fundamental Rights of the European Union (2012) has warned that States can be held accountable for harms occurred:

> *Every person has the right to have the Union make good any damage caused by its institutions or by its servants in the performance of their duties (Article 41)*

Therefore, one must consider carefully the motivations behind new legislation. For instance: Frances Fitzgerald TD, Minister for Justice and Equality, presented the Criminal Law (Sexual Offences) Bill 2015, which includes a wide range of legal reforms aimed at protecting children from sexual exploitation[xxii]. She professed that the Bill was in response to emerging threats, such as 'predatory activity which targets children via the internet'. However, the introduction of the new Sexual Offence Bill will lower the age of consent, albeit within 'proximity of age defence' (2 years). In wording her statement, Minister Fitzgerald 'confirmed' that the age of consent will remain at 17 years, whereas in reality, the Bill has lowered the age of consent, albeit between minors. The Minister stated the 'proximity of age' defence 'simply recognises the reality that young people can engage in consensual sex'. Yet young people can engage in underage drinking or driving a car, yet these are not accommodated by altering the law. Indeed, Saidlear advocated that the law;

> *is a pillar of our nation which functions in shaping, supporting and defining our culture and civilisation as we choose to define and live it (2006:2)*

Also, the announcement made no reference to concerns about sexual abuse on college campuses or the findings of the RCNI (2012) or SAVI (McGee 2002). The Irish State appears to be normalising early sexual activity and has chosen not to raise public awareness of the mounting concern of sexual relationship violence/abuse between peers or equally important, alert and support families to the need adolescent's capacity building in negotiating the various levels of sexual intimacies. Furthermore, Article 18 and 19 (UNCRC, 1989) stipulates the State

has an obligation to render appropriate assistance to parents in their performance of their child-rearing responsibilities and take appropriate measures to protect the child from all forms of abuse.

Adolescent males

However, in order to view the whole picture, one should consider the role of young adolescent males. Dr O'Keeffe (2012), stated in her response to the Children First Bill 2012 – Draft Heads and General Scheme, that the Crisis Pregnancy Programme was concerned that *any* consensual sexual activity between 16-year-olds or younger was presumed to be *abuse* and must be reported. Dr O'Keeffe's reported the 'system' (State services) could not cope with the workload. As discussed earlier, the HSE projections suggested there were at least 15,500 young people (aged 16 or below) were engaging in sexual intercourse each year, this would have resulted in 15,500 young males being held accountable for abuse. In contrast, the Beijing Rules (1985) stipulate that States should aim to promote juvenile welfare to the greatest possible extent in order to 'avoid' the juvenile justice system; before the changes to 'proximity of age' for sexual acts, 15,500 adolescent males' perpetrators would, in law, have been classed as sexual offenders. Obviously young people presenting with harmful sexual behaviours should be supported, wherever possible, ideally in their families or local communities (Hackett 2011). It is argued that young males may have few other scripts available to them, apart from seeing males as the macho predator (Wight 1994, Holland et al. 1998, Mayock et al. 2007), making it difficult for them to display and articulate their feelings (Aggleton et al. 1998). Intimacies move forward through the male's understanding of 'non-verbal cues, moves and body language' and penetrative sex is often not discussed in advance of casual relationships. Abbey (1987) suggests that males can misinterpret the friendly

behaviour of the female as sexual interest, which Young and colleagues (2009) argue has been used in understandings of adult sexual assault; as a result, good people can do bad things (Zilney and Zilney 2009). Still, it could be argued that the 'proximity of age' for sexual acts is a gendered issue (bias) protecting male adolescents' from being criminalised at the expense of female adolescents' victims of sexual abuse.

Parents and the family

It is normal that young people are curious about sex and experience sexual desire (Brady and Halpern-Felsher, 2008). Drobac (2006) does not suggest that teens should be sheltered from gradual learning experience in regard to sexuality and (romantic) relationships but makes the case that adolescents should be facilitated through their learning and maturation process under circumstances that safeguard their developmental vulnerabilities. However, if your fifteen-year-old son says he is ready to drive, he understands what driving a car means, he must first accomplish the amalgamation of the theory, practical skills and moral responsibility that is entailed. Therefore, society and the law expect him to respect the law with regard to the legal age for driving. In addition, for his safety and other road users, it is understood that he must first learn the theory and take a theory test. Then once that is accomplished, he needs to be guided through the practical by a professional and then successfully pass a practical test. It is clear young people are interested in sex and forming relationships but handing them a condom or providing contraception is not ensuring they are prepared. The GP is unlikely to be a position to ascertain Jane or her partner's level of knowledge or ability to negotiate safe and ethical sexual intimacies. Harmful sexual behaviour can impact on the young person's emotional health, and impact on their future wellbeing (Miere 2007, Hackett 2011).

The individual child has diverse needs, desires, problems, concerns, preferences and priorities. Hence, the World Health Regional Office for Europe and BZgA Standards for Sexuality Education in Europe (WHO/BZgA 2010) advices that children need both formal and informal sexuality education and that the two should complement one another. To this end, Hutchinson and Cooney (1998:185) make the case that families should be recognised as 'potentially important groups to be considered and incorporated into a multi-targeted prevention programme' for the reduction of adolescent' sexual risk taking. Furthermore, Hackett (2016:4) informs us that in many cases of abuse, children and young people are both perpetrators and victims. Hence, parents need preparing if they are to play a supportive role. Hackett maintains, that many parents whose children display harmful sexual behaviours are lonely and isolated. 'They often face considerable social stigma, rejection and hostility in response to their child's behaviour. Attention should be given to identifying and building upon family strengths'. With this in mind, appropriate training for parents is necessary, if they are to contribute effectively to 'high-quality sexuality education' (WHO/BZgA 2010:28).

However, Freeman draws are attention, that 'rights without remedies are of symbolic importance, no more. And remedies themselves require the injection of resources as commitment' (2007:8). It seems that the Irish Governments strategy, however well-meaning, is not working. The Beijing Rules proclaims that,

> *Sufficient attention shall be given to positive measures that involve the full mobilization of all possible resources including the family (…) with a view to reducing the need for intervention under the law (Article 1.3 1985)*

Conclusion

A major challenge presented by the UNCRC to the State and families, is the need to balance a child's right to adequate and appropriate protection, while at the same time safeguarding their rights to 'participate in and take responsibility for the exercise of those decisions and actions they are competent to take themselves'. The distinction between an adolescent and an adult is not demarcated by a 'single rite of passage'. Adolescents cannot always know what is in their own best interest and therefore must be protected from their own immature and uninformed judgment (Feinberg 2007:38). The transition from a child to a sexually active adult is not an instant occurrence. Furthermore, Douglas argues that adolescents' autonomy can be threatened in two ways: first when there is 'too much interference (excessive control) and secondly when we do not interfere enough (neglect). It is not an 'all or nothing' phenomenon and instead must happen by graduations. Therefore, legislators, health professionals and parents must navigate the 'fine line between respect for autonomy and abandonment' during the developing years of an adolescent's sexualisation (2001:40).

Recommendations

1. Promote adolescents' healthy, responsible, and positive exploration of their sexuality, promote relationships and sexual health. Improve knowledge and attitudes harmful sexual behaviour, preparedness for negotiating sexual boundaries and consent.
2. Cultivate a supportive climate and culture in the home, school and wider community with a collaborative and positive approach to all-inclusive relationships and sexuality education.
3. Develop innovated resources to tackle sexual sensitive issues that may arise, such as pornography, and co-ordinate rigorous multiple layer participatory research on the proposed resources with adolescents, parents, and teachers'.

4. Develop educational programmes that extend beyond the communication of biological and reproductive facts, this could be done within, or outside of, the school-based system.
5. Develop families' self-efficacy as a source of knowledge, support, and guidance in relational and sexual health.
6. Generate and support positive responses to disclosure of harmful sexual behaviour, and promote a multiple level response: peers, families, schools and wider community.
7. The development of resources for critical incidents of a sexual nature, that are effective, efficient, and supportive of the needs students, staff, families, and the greater community.
8. A co-ordinated programme of research into evaluating the effectiveness and/or appropriateness of the Fraser Guidelines in the context of societal changes and new information.
9. The development of a national sexual health certificate that informs the level of sexual knowledge and self-efficacy of the holder has acquired, with the dual principle, to provide a universal standard of relationships and sexuality education, which in turn supports health professionals in their role.

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[i] The Family Law [Divorce] Act, 1996

[ii] American Psychological Association (2007) define sexualisation when: a person's value comes only from their sexual appeal/behaviour, to the exclusion of other characteristics; or a person is held to a standard that equates physical attractiveness with being sexy; or sexuality is inappropriately imposed upon them; or a person is sexually objectifies.

[iii] See A Historical Overview Of Our Conceptualisation Of Childhood In Ireland In The Twentieth Century, Presentation by Thomas Walsh, Development Officer (CECDE) at The Human Development Conference, Voices and Images of Childhood and Adolescence: Rethinking Young People's Identities, 16/10/04 Retrieved from: http://www.cecde.ie/english/pdf/conference_papers/Our%20Conceptualisation%20Of%20Childhood%20In%20Ireland.pdf on 22 May 2016.

[iv] Examples: Attitudinal autonomy – Dworkin (1988), reflection upon preferences, wishes and desires. Emotional autonomy – Steinberg and Silverberg, (1986), the affective process of becoming emotionally independent from parents and peers. Functional autonomy – Dekovic et al. (1997), the regulatory process of developing a strategy to achieve one's aims.

[v]Section 23 of the Non-Fatal Offences against the Person Act 1997, a young person aged over 16 years can give their own consent to medical treatment such as contraception. However, sexual intercourse with a girl under 17 constitutes a criminal offence.

[vi] The Medical Council (2009:40) guidelines for children and minors: 43.5, 'In exceptional circumstances, a patient under 16 might seek to make a healthcare decision on their own without the knowledge or consent of their parents. In such cases you should encourage the patient to involve their parent in the decision, bearing in mind your paramount responsibility is to act in the patient's best interests.

[vii] Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 AII ER 402HI (For further reading see; Larcher, V. (2005) ABC of adolescence: Consent, competence, and confidentiality. British Medical Journal. 12 February Vol 330: 353-356.)

[viii] Further reading; Mayock and Byrne, 2004. A Study of Sexual Health Issues, Attitudes, and Behaviours: The Views of Early School Leavers, Crisis Pregnancy Agency. Dublin

[ix]

[x] The HSE Crisis Pregnancy Programme, with a yearly budget of €6,772,174, is tasked, to develop and implement strategies to reduce the number of crisis pregnancies by the provision of information, advice, and contraceptive services (Clayton and Illback 2013).

[xi] The morning after pill is more effective the sooner it is taken, therefore, to delay risks pregnancy.

[xii] Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. But

since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

[xiii] Women, experiencing penetrative sexual abuse in childhood was associated with a sixteen-fold increase in risk of adult penetrative sexual abuse, and with a five-fold increase in risk of adult contact sexual violence. (McGee, 2002).

[xiv] Confidentiality is generally seen as a fundamental right to a patient and a central concern for adolescents in regard to their sexual health treatment. 25% of adolescents' report that they would forgo health care if they had concerns about confidentiality (see; Carlisle, et al., 2006).

[xv] Competency is understood in terms of the patient's ability to understand the choices and their consequences, including the nature, purpose and possible risk of any treatment (Pavilanis 1989)

[xvi] Issues of particular relevance to adolescent girls on the autism spectrum, examples include, difficulties socialising with neurotypically developing girls, sex-specific puberty issues, and sexual vulnerabilities (Cridland et al. 2014).

[xvii] The average consultation with GP's is approximately 9 minutes which is hardly sufficient time to make an in-depth assessment concerning the possible sexual assault of a minor (For further reading see, Ogden et al., 2004).

[xviii] See; http://www.irishstatutebook.ie/eli/cons/en/html#article42

[xix] See, http://www.irishstatutebook.ie/eli/2012/ca/31/enacted/en/html

[xx] See, http://www.irishstatutebook.ie/eli/2017/act/2/section/17/enacted/en/html#sec17

[xxi] For example; Tusla; Garda Síochána

[xxii] Section 3(8) Where a defendant is charged with an offence under this section against a child who at the time of the alleged commission of the offence had attained the age of 15 years but was under the age of 17 years, it shall be a defence that the child consented to the sexual act of which the offence consisted where the defendant – (a) is younger or less than 2 years older than the child