

# *In Brief*

## An Evaluation of **Brook Sexual Health Outreach** in Schools



Centre for  
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## Overview

The Brook Sexual Health Outreach Service was funded by Neighbourhood Renewal in 2006-08 with the aim of reducing the impact of teenage pregnancy and sexual ill-health amongst young people within the Neighbourhood Renewal Areas in Bristol. The service was commissioned by Bristol Teenage Pregnancy Partnerships (BTTP) and managed by Brook Bristol. BTTP also commissioned the evaluation.

The service was delivered in sixteen secondary school settings including three pupil referral units. All schools were in areas of high social deprivation. Historically, services provided in schools have been limited to advice and condom distribution. This service was innovative in that it provided a much wider range of contraception including oral and emergency contraception STI testing, pregnancy testing and signposting for other health related issues. Appropriate staffing meant staff had the skills and capacity to work with large numbers of younger pupils and groups who have traditionally been defined as 'hard to reach'. This included boys and those involved in early sexual activity, staff were able to encourage contraceptive take-up prior to sexual activity or where appropriate delay sex.

## The Evaluation

The evaluation sought to assess the implementation of the Brook Outreach School Drop-in Service and the consequences for young people living in areas of high deprivation. Key objectives were to identify the patterns, reasons and outcomes of young people's attendance and to explore young people's views of the service including any perceived barriers to attendance. Views of professionals working within the service were also sought to highlight their experiences of service development and their views on sustainability.

The evaluation methods included analysis of neighbourhood renewal data of clinic attendance, comprehensive database completion for nurse consultations, a survey of young people's views of the service, data on attendances collected by youth workers and qualitative interviews with young people focusing on reasons for non-attendance. In addition, semi-structured interviews were undertaken with key staff. The young people included were those attending all 16 schools receiving the service during a 15 month period from September 2006 to November 2007. The staff sample included eight front line professionals and managers working within the service.

## Findings

The Brook Outreach School Drop-in Service was successful in that large numbers of vulnerable and 'hard to reach' groups of young people who had not previously accessed sexual health provision within mainstream services accessed this service. It is important to appreciate the ambitious nature of this service development in its aim to engage with young people from sixteen deprived communities.

Although having sex was often a trigger for young people to attend for a nurse consultation to discuss contraception and relationships, the youth work staff in particular had the capacity to work with younger age groups. This allowed for sexual

health promotion that included discussions about delaying sex and encouraging young people's consideration of contraception and safer sex prior to engaging in sexual activity. The accessibility of the service, youth work input focussing on the health promotion aspects of sexual health and the availability of free condoms appeared to encourage higher levels of attendance by young men. 48% of those seeing youth workers were boys.

Young women accessed a wide range of contraceptive services including pregnancy testing, oral contraception, emergency contraception and when appropriate were referred to specialist services. Regular attendance at the clinics and on going relationships with staff had a positive impact on sexual health outcomes most importantly preventing pregnancy and early identification of STIs.

Over two-thirds of young people rated the clinic environment highly, describing it as 'very relaxed', 'very cheerful' and 'very comfortable'. While there was recognition that the locations and quality of rooms in some schools could be improved, the staff were seen by young people as key to providing an excellent school service. They felt that the staff were friendly, helpful, approachable, trustworthy and discrete. In fact young people identified that the best thing about the clinic were the staff who were easy to talk to, non-judgemental and offered an unique opportunity to talk about sex and relationships.



There will inevitably be a number of young people who will choose not to use the service, but with careful consideration to the development of community based services the school service can offer an important point of contact for sign posting to other services. A significant aspect of the service was the integrated approach developed through the contribution of staff to delivering SRE sessions, where young people had the opportunity to ask questions, understand the service and build on-going relationships.

Staff interviewed, were pleased and enthusiastic about what had been achieved and hoped that progress to date would result in further funding. Access to young people who had not previously attended sexual health services was perceived as indication that the service had 'really made a difference'. However, areas for further development were identified around inclusion of minority groups; extension of youth work and health promotion activities; developing stronger links with existing provision for young people.

Improving communication with school communities to establish the role of the Brook Outreach, particularly in relation to PSHE was also identified.

## Conclusions and Recommendations

- We recommend that the service should continue based on the findings of improved access to sexual health provision and positive outcomes for young people in relation to sexual health and preventing pregnancy.
- Medium to long-term outcome data should be collected to assess the impact of sexual health outreach drop-in clinics in schools on young people and their sexual health.
- Young people should continue to be involved in on-going assessments to include their perspective on the acceptability of the service, including identification of areas for improvement.

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- In the busy schools, young people would like the service to be extended to an additional lunch time or some after-school provision.
  - The findings from this study need to be made widely available to support the work in schools. This is particularly where PCTs, Local Authorities and the Voluntary Sector are considering extending their services to make a full range of contraception available to young people. The key to reaching 'hard to reach groups' and those most at risk is to prioritise service development in schools in deprived communities.
  - Routine methods to raise awareness of the service to young people, parents, staff and governors should be developed. The service also needs to establish its medium to long term objectives around the role of drop-in staff in PSHE delivery.
  - Clinical staff within the service should continue to develop efficient links and relationships with primary care, CASH and young peoples' services. This will enable young people with established sexual health needs to move from the school based drop-in service to mainstream services as part of an integrated approach.
  - Youth workers should continue and extend their development work to encourage new young people to attend the service prior to engagement in sexual activity.
  - Continued work with boys is needed to increase the numbers of boys attending, which may be supported by the recruitment of a male youth worker. Similarly, any staff recruitment needs to consider the lack of professionals from black and minority ethnic groups and the positive impact such staff would have on work with minority groups of young people.
  - For those young people not wishing to use the drop-in service, clear signposting and service development should take account of their needs and wishes.
  - Service level agreements with schools need to specify what the Brook outreach provides, including levels of PSHE. In addition, the requirement by schools to provide appropriate locations, on going support and identified channels of communication need to be explicit.

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