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An Evaluation of Brook Sexual Health Outreach in Schools

Final Report

Debra Salmon
Jenny Ingram

March 2008

Centre for Public Health Research

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Executive Summary

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 (BTPP) and managed by Brook Bristol. BTPP 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. It provided advice and support to young people in schools around a range of issues including information about puberty, relationships and sexual health. Advice and treatment were also available in relation to a range of methods of contraception, including oral contraception and condom provision. Associated services included testing and treatment for sexually transmitted infection (STI), pregnancy testing, confidential advice and signposting for other health related issues.

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.
- 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.

Chapter 1 **Introduction**

The Brook Sexual Health Outreach in Schools Service

This initiative 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 Neighbourhood Renewal Areas in Bristol. The service was commissioned by Bristol Teenage Pregnancy Partnership (BTPP) and managed by Brook Bristol, BTPP also commissioned the evaluation. The service was delivered across sixteen secondary schools including three pupil referral units. The Brook Outreach School Drop-in Service provided advice and support to young people in schools around a range of issues including information about puberty, relationships and sexual health. Advice and treatment were also available in relation to a range of methods of contraception, including oral contraception and condom provision. Associated services include testing and treatment for sexually transmitted infection (STI), pregnancy testing, confidential advice and signposting for other health issues.

The evaluation

The purpose of the project was to evaluate this school-based sexual health service for young people living in areas of high deprivation in Bristol. This evaluation will inform future practice and sexual health service development for young people. The key objectives were to identify young people's patterns of and reasons for attendance, explore the views and experiences of young people attending the service and identify potential barriers to access. Views of professionals working within the service were also sought to highlight their experiences and comment on areas of service development and issues of sustainability.

Content of the report

This report presents the findings of the fieldwork conducted with young people attending the drop-in service and professionals involved in delivering it. Chapter Two outlines the national policy context of the evaluation and gives details of the development and delivery of the service. The methods used to carry out the evaluation are described in Chapter Three. Chapter Four focuses on capturing the views, experiences and health outcomes of young people using the service. The views of professionals, developing, managing and delivering the service particularly in relation to issues of service development and sustainability are explored in Chapter Five. Chapter Six describes the involvement of staff with PSHE lessons in the schools and a discussion of the findings, conclusions and recommendations are presented in Chapter Seven.

Chapter 2 **Background**

The UK Sexual Health Strategy aims to reduce conception rates and the incidence of sexually transmitted infections among those under 18 years, by developing sexual health services specifically for young people (Department of Health 2001). Sexual experimentation is a key aspect of young people's development. The median age of first heterosexual intercourse in the UK has dropped from 17 years in 1990 to 16 years in 2000. However, 26% of girls and 30% of boys will have had sexual intercourse before the age of 16 (Wellings et al. 2001). It is generally accepted that early sex is often associated with unprotected sex and Tripp et al (2005) have found that a third to a half of both boys and girls under the age of 16 reported engaging in unsafe sex. Consequences associated with unprotected sex include sexually transmitted infections (STIs) and early pregnancy. Diagnosis of sexually transmitted infections has risen dramatically in the last ten years, particularly among young people (Horton 2005) but, unwanted pregnancy continues to be the main health risk associated with teenage sex. Conception rates for those under 16 fell from 9.3 per thousand in 1991 to 7.9 per thousand in 2002 and to 7.7 per thousand in 2006 (Office for National Statistics and Teenage Pregnancy Unit 2006). However, recent figures raise questions about whether these trends confirm a genuinely sustained long term decrease (Coleman and Schofield 2003).

Barriers to young people accessing sexual health services

Young people often access services after they have become sexually active and are sometimes inconsistent and erratic in their uptake (Stone & Ingham 2003). They may experience services as off putting if they feel staff look down on them or are unfriendly or intimidating (Counterpoint, 2001, Ingram et al 2005). Accessing services via a GP practice may also be a less favoured option because of concerns about confidentiality and the perception that medical practitioners do not have time to listen to young people's concerns (Burack 2000, Thistle 2003). However, for most young people the GP surgery is likely to be the closest service geographically and potentially the most accessible. The Faculty of Family Planning & Reproductive Care (2006) has suggested in their Service Standards for Sexual Health Services that dedicated young people's services should be staffed by those who have an understanding of adolescent development and experience of working with young people. Although there has been increasing pressure on primary care services to deliver appropriate sexual health services to young people (DH, 2001; Free 2005) evidence of their impact remains scarce. Randomised controlled trials examining GP consultations around sexual health interventions have highlighted success in increasing knowledge about contraception and improved condom distribution. However, studies have not explored behavioural change or focused on adolescents in particular (Free 2005, Little et al 1998, Oakeshott et al 2000).

Between 1991 and 2001 the number of new episodes of sexual ill-health rose by 143% and reached 1.3 million in 2001 (Office for National Statistics 2001). Factors identified as contributing to the rise in STIs in young people include lower age of first intercourse, higher acquisition rates of new partners, increased likelihood of being involved in two or more sexual relationships simultaneously and inconsistent condom use (Wellings et al 2001). Lack of service provision combined with embarrassment, stigma, and sometimes poor communication skills can lead to a failure to seek treatment, which has a negative impact on young people's ability to access services (Munro et al 2004, Djuretic et al 2001).

Evidence of provision and effectiveness of services

The Health Development Agency (2003) has identified gaps in the evidence base including a dearth of interventions aimed specifically at vulnerable groups, such as young people who are looked after, excluded from school or leaving care the care system. Oakley et al (1994) undertook an international comparative analysis of the effectiveness of sexual health services concluding that young people had improved sexual health and were more likely to avoid teenage pregnancy when they had good sexual health information. This view was confirmed by a systematic review from the NHS Centre for Reviews and Dissemination (1997) which argued that access to good school sexual and relationships education and to contraceptive services can be effective in reducing teenage pregnancy without leading to an increase in sexual activity. Studies at the Centre for Sexual Health Research (Clements et al.1998) modelling the spatial distribution of teenage conception rates found a significant

relationship between ease of access to a young people's service and local teenage conception rates, indicating the important impact that such services can have.

Service innovation

The TPU has compared areas with differing teenage pregnancy rates to identify the initiatives that contributed most in areas with declining rates. Findings showed that best practice incorporated the existence of a discrete but highly visible young-people friendly sexual health/contraceptive advice service, with a focus on health promotion as well as reactive services; strong delivery of SRE/PSHE by schools; targeted work with at risk groups of young people (in particular Looked After Children); workforce training on sex and relationship issues within mainstream partner agencies and a well resourced Youth Service, with a clear remit to tackle young people's sexual health. Other factors included a focus on the specific needs of young men, on sexual health promotion through outreach work in schools, and work with professionals to improve their ability to engage with young people on sexual health issues.

The school drop-in service evaluated in this report incorporated these elements, combined with lessons from service innovation developed in the South West. This included "No Worries!" a nurse-led drop-in sexual health service for young people in North Somerset (Ingram & Salmon 2007). These dedicated sexual health services for young people have been developed to complement more traditional provision delivered in CASH clinics and GP surgeries. They are nurse-led and provided by experienced staff, including nurse practitioners and youth workers, who have received training in support and advice on a wide range of teenage health issues. These include sexual health and contraception, drugs, alcohol, stress and relationships. Significant emphasis is placed on respecting young people's confidentiality in line with the latest Department of Health guidance (DH 2004). The Department of Health (2005) has also published 'You're Welcome' criteria to encourage health service providers to develop young-people friendly services. This guidance emphasises a need for services that are 'accessible, well publicised, joined up, effective and open to all'.

The Teenage Pregnancy Strategy Evaluation (2005) suggests that young people are increasingly using school-based services, help lines and websites to access contraceptive help. Nurse-led, school based provision is therefore increasingly seen as a way of delivering confidential, accessible and comprehensive health services to young people, although evaluation of these initiatives remains relatively under-developed (Chase et al 2006). School based evaluations that have been carried out suggest there are clear benefits from this kind of provision for young people (Osborne 2000, Nelson and Quinney 1997) and that they are particularly effective in providing sexual health services and information (Thistle 2003).

The Bristol picture

Reducing the rate of teenage pregnancy by 50% by 2010 is part of a broader strategy to improve sexual health has been set as a performance indicator for Primary Care Trusts and a target for Neighbourhood Renewal. In 1998 teenage conception rates in Bristol were 51.0 per 1000 girls aged 15-17; in 2003 the rate was 52.8, indicating a 3.5% rise; in 2006 it had dropped to 49.7, a 2.6% reduction. Over the same period, Bristol was also experiencing increasing rates of sexually transmitted infections particularly in young people.

Services for young people

At the time of the evaluation sexual health services in Bristol were available through General Practionners (GPs), specialist contraception services (CASH) and Brook. Although there were a range of services, some areas of Bristol were poorly served (South East and North West of Bristol). Where sexual health services did exist, they varied greatly in their ability to attract young people. In 2003-2004 only 15% of those attending CASH young people's services were under 16 and only 2% were boys. At inception of the schools based service there were six young people's clinics located in venues accessible to young people, either in or near to schools. Young people from a range of backgrounds (including those from BME groups) evaluated these services positively and highlighted a desire for locally based services that were young people friendly and confidential. Difficulties in establishing young people's services within local communities or general practice combined with concerns over local teenage pregnancy and STI rates provided the impetus for the development of a school based service.

The development of the Bristol school based service

Teenage Pregnancy funding enabled a basic school based service to be piloted in two schools over a two-year period. This led to a successful bid for Neighbourhood Renewal funding to develop the service. The Director of Children's Services wrote to all schools to endorse and encourage the schools involvement in the drop-in provision and to explain the importance of sexual health provision for young people across the City. This was based in a belief that schools were a key setting in enabling young people to attain high levels of health. access to health services and information. This work is in accord with other important policy agendas particularly 'Every Child Matters' and the Full Extended School development programme.

All schools in the targeted areas had a visit from the Teenage Pregnancy Coordinator to explore current provision and the steps needed for each school to be able to establish a sexual health service. As part of this process an information pack was developed, which included the aims of the service, introductory information and expectations of schools wanting to become involved. Additional information focused on confidentiality, guidelines for the welfare of under 16s, and an information sharing flow chart. The pack also included an agreement to undertake work, the service level agreement and monitoring forms. For a full pack or for further information please contact the Brook Bristol Senior Project Administrator.

The Brook Outreach School Drop-in Service was established at 16 school venues across Bristol including three pupil referral units. The total number of pupils registered in the 16 schools was 11,805. All schools were serving young people living in areas of high social deprivation based on the Index of Multiple Deprivation (APHO website 2006) and with high rates of teenage pregnancy. As previously indicated the service provided advice and support to young people in each school around a range of issues including information about puberty, relationships and sexual health. The Brook Outreach Drop-in Team also gave support in the delivery of Sex and Relationships Education (SRE) within the schools and linked community settings. Brook Outreach staff also worked with other school health professionals including drug and alcohol workers, counsellors and school nurses to provide a comprehensive health advice service for young people. The service was also supported by local youth workers, who were already known to many young people and encouraged them to attend the clinics.

The sessions were run weekly at lunchtimes, and delivered by a nurse and youth worker. In most of the schools a full contraceptive service was delivered and where this was not possible, because of staff shortages, comprehensive support, advice and information was offered to enable young people to access local services, although condoms, STI and pregnancy testing were also available. A team of part-time female staff (six sexual health nurses, two youth workers and two managers (job-share)) ran these sessions on a rota basis. The venues used ranged from music rooms and empty classrooms to new counselling rooms created as part of recently built schools.

Chapter 3 **Aims and methodology**

Evaluation aims

As previously stated the aim of the research was to evaluate the school-based sexual health drop-in service for young people living in areas of high deprivation in Bristol. The key objectives were to identify young people's patterns of and reasons for attendance, to explore the views of young people attending the service provided, to describe the reasons for non-attendance and to explore staff perspectives. Particular focus was placed on 'hard to reach groups' including boys and young people with low educational attainment. In addition, findings from non-attendees were fed back as part of an iterative service development process to support future action planning. Data were collected in two main phases. The first phase included the establishment of a comprehensive nursing database which detailed biographical information on attendees, reasons for attendance, treatments, advice and where possible health outcomes. Semi-structured focus groups were also carried out with young people to establish their perceptions of any potential barriers to accessing the service. The final phase included a survey of young people's views and experiences of the service. Focus group interviews were again carried out with groups of young people who had not attended because they felt that the service was not appropriate to their specific needs. Interviews with staff explored their perceptions of working in the clinics and the sustainability of the service.

Research methodology

Analysis of neighbourhood renewal data of clinic attendance

Routinely collected data were stored by the outreach team on an Excel database and plotted over time to explore the patterns of attendance at the 16 venues.

Comprehensive database completion for nurse consultations

Details of the young people who attended the clinic to see one of the nurses were collected on a standard clinic form and entered onto an Access database. In addition to collecting background demographics, sexual behaviour and previous attendance at clinics, the nurses recorded treatment, advice given and referrals made to other services. In order to track attendance at the drop-in clinic, attendees were allocated a unique number. Data were restructured using STATA v7 to present each young person's data as a single entry and analysed for frequencies and associations using SPSS v12. This database has enabled us to identify how many individuals were attending the clinics and the reasons for attendance, rather than just counting attendances.

Survey of young people's views of the service

The questionnaire used for the survey was a shortened version of one specifically designed for use with young people aged 13 to 21 to explore their knowledge about sex, relationships and contraception (London School of Hygiene and Tropical Medicine, 2000). It assessed the ease of access to advice and information on a variety of issues presented and the responsiveness and acceptability of the service to the client group. Demographic information was also included as well as questions about their opinions of the service. Youth workers initially gave out the questionnaires at five schools and then extended it to another five to increase the range of opinions. The questionnaires were anonymous and completed forms were posted into a sealed and labelled box to maintain confidentiality. Data were entered onto an Excel spreadsheet and analysed using SPSS v12 to produce frequencies and means.

Data on attendances collected by youth workers

This routinely collected information described the numbers of condoms given and types of health promotion advice that youth workers were giving, often to groups of young people or to those who were waiting to see the nurses. Data were entered onto an Excel spreadsheet and analysed using SPSS v12 to produce frequencies and means.

Qualitative interviews with young people focusing on the reasons for non- attendance

In three schools, young people who potentially had not attended the service were asked to participate in small focus group discussions during PSHE lessons or one to one interviews during lunchtime sessions. Particular attention was paid

to involving boys, hard to reach groups and those who may be involved in early sexual activity. The focus groups and interviews offered the opportunity to explore barriers to attendance and strategies that from the young people's perspective would support future engagement. For ethical reasons it was inappropriate to single out those not using the service. The focus groups therefore included both those who had and had not attended the service.

Interviews with key staff exploring issues of sustainability and future service development

Semi-structured interviews were undertaken with service managers, nurses and youth workers. Interviews were conducted by a single researcher, mostly face-to- face though one participant was interviewed by telephone. All interviews were audio taped and transcribed verbatim. Questions focused on experiences of working within the service, reflections on service progression, areas of service improvement and the degree to which young people who were most vulnerable to sexual health threat were using the service. This question included prompts about the potential barriers to service access. Participants were also asked to raise any policy or practice issues relating to school as a setting for sexual health for young people, and whether there were any additional benefits of this model of service delivery over others. Finally, participants were asked to focus on issues of service development and sustainability and to raise any additional aspects relevant to the evaluation.

Qualitative data analysis

During data analysis interview transcripts were analysed using the recognised qualitative data analysis approach of sorting quotations from the transcripts into data units or themes and sub-themes. This was done using the more traditional 'cut and paste' approach whereby the researcher reads and re-reads the transcripts drawing out themes. In negotiation with schools over ethical considerations, it was felt inappropriate to audiotape focus groups or informal one to one conversations with young people. An experienced researcher took detailed field notes and these were summarised around a number of key themes which emerged as part of the discussions. In particular, they focused on the barriers and reasons young people may have for not accessing the service.

Respondent validation (Silverman 2000), whereby interview scripts or aspects of the analysis are returned to study respondents to be verified, modified, or rejected is a technique often used by qualitative researchers. While it was possible to do this for the professional interviews, it was not practical or appropriate in relation to the focus groups or one to one conversations with the young people taking part. However, in line with NCB Guidelines for Research (NCB 2003), young people involved in the evaluation process were valued for the perspectives they contributed to the evaluation and service development.

Ethical considerations

Research participants who attended the service were invited to complete a questionnaire by the youth worker at the drop-in service. Information sheets were available outlining the evaluation and young people's role within it. Completion of the anonymous questionnaire was taken as consent. Two groups of young people recruited through the schools were invited to take part in a focus group to discuss barriers that may deter young people from using the service. These schools plus an additional school also agreed young people could be approached at lunchtimes to illicit their views of the barriers to using the service. Schools took overall responsibility for the process, organising young people to attend on a voluntary basis, proving a classroom and giving out information sheets. Teaching staff and drop-in staff were also available, so that any problems identified by the researchers during the interviews could be appropriately referred. As previously indicated through negotiation with schools it was decided not to audio tape and therefore written field notes were recorded and not direct quotes. Young people were told at the beginning of the sessions that their involvement was voluntary, their identity would be anonymised, that they could withdraw at anytime during the process and information sheets were provided. Consent to attend was given by senior staff on behalf of schools.

This evaluation did not involve research methods or techniques that can harm participants. Research adhered to the NCB statement of Values and Principles, the NCB Equal opportunity policy statement, NCB Child Protection Policy and in accordance with the British Sociological Association's Code of Professional Conduct and the Statement of Ethical Practice and the British Psychological Society Code of Conduct. The

guidance cited in the British Educational Research Association's Revised Ethical Guidelines for Educational Research (2004) was addressed throughout the research process, including: informed consent, voluntary participation, confidentiality and anonymity. Approval was obtained from the UWE Bristol Research Ethics Committee. This was rather than an NHS committee because the drop-in service was delivered by staff working for Brook (a registered charity) within a school setting. Particular attention was paid to child protection and both researchers involved were required to provide a current copy of an Enhanced Criminal Record Certificate issued by the Criminal Records Bureau.

Chapter 4 **Findings from young people**

Overall clinic attendances from Neighbourhood Renewal reporting

The numbers attending the clinics rapidly increased to around 1500 attendances per quarter over the 15-month period of the evaluation as shown in Figure 1. Initially eight clinics were established and by April 2007 there were 15, with the final one being added in September 2007. The ratio of attendances between boys and girls was 38% boys to 62% girls, which was promising given the consistent difficulties that have previously been highlighted in encouraging young men to access sexual health services within the UK. Young people from Black and Minority Ethnic groups have also attended the drop-ins and attendance levels were in similar proportions to the numbers of young people from BME within the whole school population. From September 2006 to November 2007 12 gay, lesbian or transgender young people have attended the service.

Young people attending school clinics for nurse consultation

Details of each young person who attended the clinic to see one of the nurses was collected on a standard clinic form. In order to track attendance at the drop-in clinic, attendees were allocated a unique number and data stored on an Access database. This has enabled us to identify how many individual young people are attending the clinics and the reasons, rather than just counting attendances. Table 1 summarises the advice and treatment given by sexual health nurses from 1303 visits by 515 young people, between September 2006 and November 2007. Figure 2 shows the numbers of visits made by young people (girls and boys) over the period, with an average of 2.6 visits each (range 1 to 14).

The young people reported a significant number of factors that highlighted their vulnerability, not

Figure 1 **Attendances at school sexual health clinics over the first year of operation**

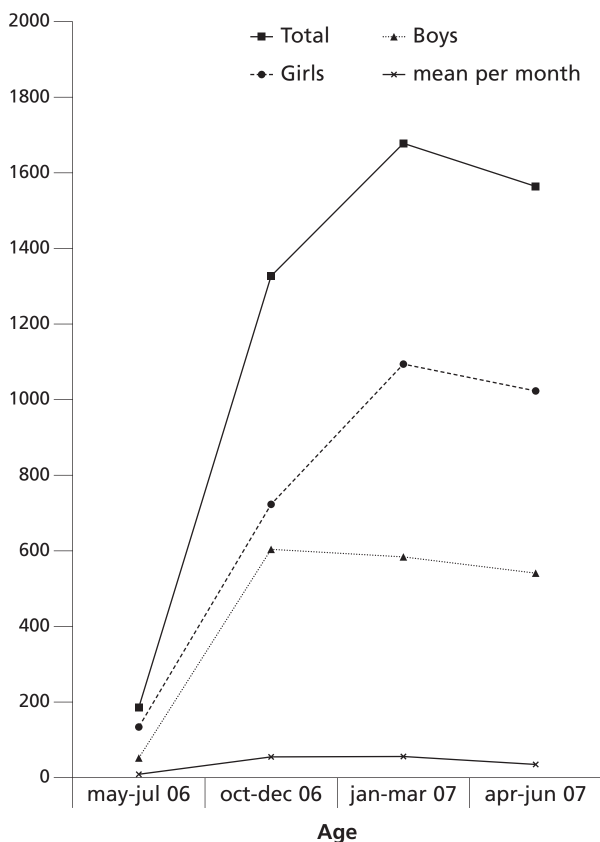

Figure 2 **Number of visits made by young people to the sexual health clinics**

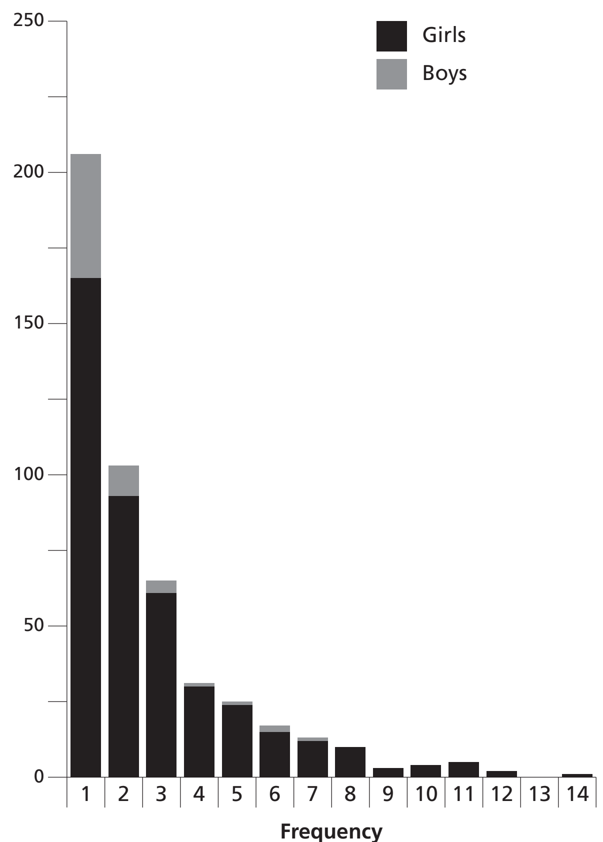

Figure 3 **Age range of young people attending nurse consultations**

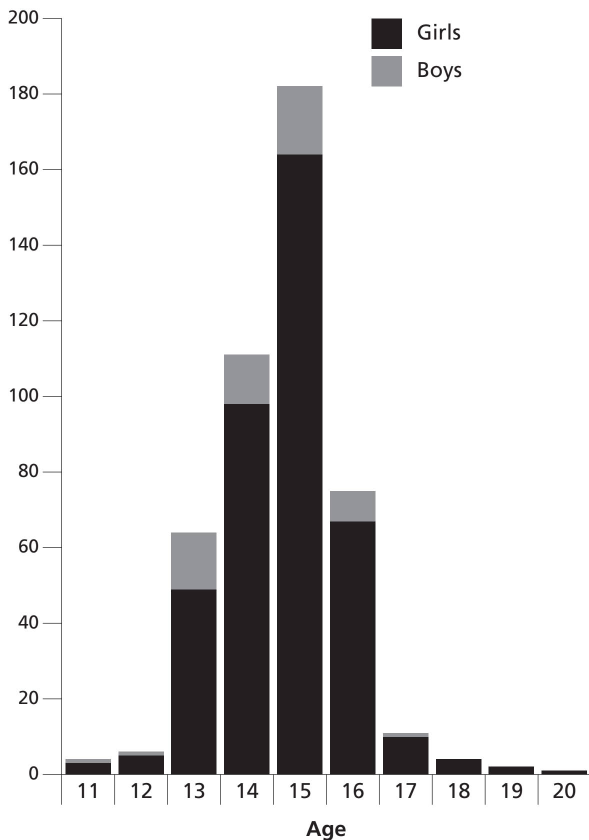

Table 1 **Advice and treatment given by sexual health nurses to individual young people**

Observation	Advice given to individual	Treatment given
Condom	404 (78%)	372 (72%)
Contraception	389 (76%)	COC 109 (21%) POP 37 (7%) Injection 10 (2%)
Emergency contraception	195 (38%)	55 (11%)
STI	373 (72%)	NAAT test 135 (26%) Chlamydia treatment 11 (2%)
Pregnancy test		137 (27%) 9 positive results
Relationships	230 (45%)	
Delay Sex	136 (26%)	
Referral made	169 (33%)	

only in relation to sexual health in terms of unplanned pregnancy and STIs, but also poor educational outcome. As an indication of educational attainment, young people were asked which Mathematics set they were in at school. The proportions of young people in high middle and lower Maths sets was normally distributed with 29% in top sets, 53% in middle sets and 18% in low ability sets.

Demographic data indicated that 14% of those seeing the nurses were boys, 17% were from minority ethnic groups, and the overall mean age was 14.7 years (range 11 to 20 years as shown in Figure 3). 65% said they had a partner and the mean age of their partners was 16.1 years (range 11 to 35 years). There were several young women aged 18 to 20 who attended a drop-in clinic held at a school for young mothers, and some of them had older partners.

Seven percent of the young people attending said they had a disability, including ADHD, epilepsy, dyslexia and hearing problems. 42.5% had been excluded from school at some point and 68% (351) reported having had sex before registering with the clinic. Of these, 70% said first sex was protected (safe sex), the age at which they reported first having sex ranged from 10 to 16 years (mean age 13.8 years). In addition, 10% of the group (51 young women) said they had been pregnant before and two had been pregnant three times. Thirty-four per cent of the total group said they had previously attended a sexual health service (at their GP surgery or other young people's clinic) and 61% said that they attended the outreach service because it was at school and easily accessible.

Referrals

Details of the referral agencies and problems that the clinic nurses referred the young people for are shown in Tables 2a and 2b. Referrals to GPs were made for long acting contraceptive implants, mental health, physical health, social problems and child protection issues. Referrals to the school nurse were for mental health, physical health and social problems, child protection and bullying. Young people with social, mental health and physical health problems, for child protection issues and bullying were referred to the teacher mentor. Young people's clinics were mainly referred to for contraceptive implants and physical or social health problems.

Table 2a **Number of referrals made to agencies**

Agency	Numbers (% of 515)
GP	43 (8%)
Brook	41 (8%)
School nurse	30 (6%)
CASH	26 (5%)
Young People's clinic	26 (5%)
Counsellor	21 (4%)
Teacher mentor	12 (2%)
Pregnancy Advisory Service	10 (2%)
Substance abuse service	7
Secondary care GUM clinic	4

Table 2b **Type of referral made**

	Numbers (%)
Physical health	38 (7%)
Implant	29 (6%)
Social problems	20 (4%)
Mental health	20 (4%)
Child protection	15 (3%)
Emergency contraception	6
Bullying	2

Young people with disabilities

Young people with ongoing medical conditions and those using medication were carefully assessed by Brook outreach nurses and were only given hormonal contraception if permitted under the relevant Patient Group Direction. Some young people needed to be assessed by a doctor before they could start contraception and if so Brook Outreach nurses made appointments at GP Surgeries or local Young People's Clinics according to their preferences.

Tracking young people and their clinic treatments

Detailed illustrations of the young people seen and subsequent outcomes are described in Case illustration 1.

Contraception

Over 100 girls were given combined oral contraception pills (COC) and the database shows that 35 were given contraception on more than one visit (up to 5 for some) indicating prevention of pregnancy for over several months. Similarly for those given POP (37 girls), 13 came for repeat medication, and for the 10 on Depo-Provera injections, 3 had had more than one injection providing protection for longer periods. 88% of those on oral contraception were given advice about STIs and 34% were tested for Chlamydia.

Pregnancy tests

Nurses undertook 213 pregnancy tests for 137 girls; two girls had 5 tests and 7 had 4 tests. Overall 11 (5%) of the tests had positive results (9 girls), but three of these were for one girl. 18 of the girls had been given emergency contraception at previous clinics visits; 55 (48%) had chlamydia tests and 3 were treated for Chlamydia; 23 were prescribed COC pills, 15 POP pills, 4 had DEPO injections; and 96 (84%) were given advice about STIs. 50 were given advice about relationships, 21 advised about delaying sex, 62 had been referred to other services including 4 to PAS and 24 to their GP. All the girls who had positive pregnancy test results were in middle or lower Maths sets. Further examples are shown in Case illustration 2.

Emergency hormonal contraception (EHC)

55 girls were prescribed EHC; 47 on one occasion, 7 twice and one 3 times. All were subsequently given contraception advice, some of them were tested for STIs (23), 24 were given COC pills, 11 POP pills and 45 given condoms.

STI tests

Of the 135 young people who had tests for STIs, 24 were boys, one girl had 4 tests and four had 3 tests. Eleven young people were treated for Chlamydia (9 girls, 2 boys) and one girl was treated on three occasions.

Implants

Twenty-nine young women were referred for contraceptive implants, follow-up information was available for 26 and of these 13 (50%) had sub-dermal Implanon fitted and 13 (50%) did not. Two of those who after discussion decided not to have an implant, went on to use oral contraception instead.

Case illustration 1

Young people having tests, treatment or advice at the clinic	Illustrative case studies	Headline outcomes
143 girls on oral contraception	13yr old girl, lives with parents, and first had sex at 13; made 6 visits to clinic. Given COC at each visit for 3 months; given condoms; had one Chlamydia test. Advice given about STIs, relationships, and delaying sex.	35% repeat prescriptions to provide longer protection; 88% given advice about STIs; 34% tested for Chlamydia.
114 girls for pregnancy tests	14yr old girl, lives with Mum; first sex at 11; and made 4 visits to clinic. Positive pregnancy test at 1st visit so referred to PAS. At 2nd visit referred for sub-dermal Implanon and she had this fitted at a young people's sexual health clinic. Advice given on contaception, STIs, relationships, and delaying sex.	48% given Chlamydia tests; 37% given contraceptive pills or injections; 54% referred to other services.
55 girls given emergency hormonal contraception	15yr old girl, lives with parents; made 2 visits to clinic. She was given condoms at 1st visit and EHC on 2nd visit	82% given condoms; 64% given oral contraceptive pills; 42% given Chlamydia tests.
10 girls given Depo-Provera injections	16yr old girl, lives with Mum, and her partner is 17. Made 7 visits to clinic over a 6-month period. 1 DEPO injection at 1st visit, then 3 months and 6 months later given COC. 1 NAAT test. Advice given on EHC, contraception and STIs.	90% given advice about STIs; 70% given condoms.
135 young people tested for Chlamydia	15yr old boy, lives with Mum. 4 visits to clinic over a 9-month period. He had 2 Chlamydia tests and was treated after 2nd test. Given Condoms and advice on STIs and relationships.	89% given STI advice; 44% of girls given oral contraception; 43% referred to other services.
230 young people given advice about relationships	14yr old girl lives with parents, first sex at 14 and regretted it. At clinic offered pregnancy test, STI testing and advice about future contraception. She was reassured that sexual relationships could improve with the right partner and offered support in delaying sex until she felt ready.	Mean age 14.4 years; 11% were boys; 90% given condom advice; 78% STI advice; 55% delaying sex advice.
136 young people given advice about delaying sex	15yr old boy came to get condoms, unsure about being ready for sex. Nurse and youth worker gave him the 'respect card' and encouraged him to talk to his girlfriend about delaying sex until they both felt ready. Several visits to the drop-in clinic and they waited 6 months before having sex; before then girlfriend came for oral contraception and condom teaching session.	Mean age 14.2 years; 12.5% boys; 94% given condom advice; 93% advised about relationships; 77% advice about STIs; 85% given condoms.
169 young people referred to other professionals	14yr old girl came for contraception; she was vague about her sexual history, repoted seeing several young men, one sometimes violent.. Relationship advice given and child protection aspects considered. She was referred to Barnardos Against Sexual Exploitation (BASE), and they worked with her to support makng good relationship choices and protection from unplanned pregnancy and STIs.	25% of referrals to GPs; 18% to school nurses; 7% to teacher mentors.

Young people's self-report survey

Young people and their relationships

Young people in 10 of the schools completed 222 anonymous questionnaires.

Of these 27% were completed by boys, 40% were 14 years old or younger, 5% were from Pupil Referral Units, 13% were from Black and Minority Ethnic groups and 98% stated that they were heterosexual (2% lesbian, gay or bisexual). Those who completed the survey reported that 53% were in a steady relationship and 64% had had sexual intercourse. The mean age at which they first had intercourse was 14 years. However,

Table 3 **How young people described the clinic staff** (n=200)

Staff described as	Nurses (%)	Youth Workers (%)
Very friendly	94%	91%
Very helpful	92%	93%
Very welcoming	87%	91%
Very approachable	81%	83%
Very discrete	83%	78%
To be trusted with private information	90%	91%

Case illustration 2

The case studies below illustrate the complexity of the issues facing some young women who were seen at the clinics, the range of services offered and the level of reinforcement that some needed to be able to establish and manage better sexual health. The nurses involved in the management paid carefull attention to the guidance set out in DH (2004) based on Fraser guidelines

These case studies do not attempt to generalise young people's experiences, detail the in-depth nature of individual consultations, or the degree of care and concern shown. Rather they illustrate the intensity and depth of the intervention needed to maintain their ongoing engagement with the service. They also give an indication of some of the outcomes seen.

Three case studies of 15 year old girls who had pregnancy tests at the school sexual health drop-in clinics
Is white and lives with her mother and mother's partner, said that she first had sex at age 11 and made 11 visits to the clinic over a period of 9 months. She is in low ability groups at school and has previously been to a young people's clinic at a health centre. She has had five pregnancy tests at the drop-in clinic, all of which were negative, and has frequently been given advice about contraception, emergency contraception, sexually transmitted infections (STIs) and relationships. Nurses considered all aspects of child protection. She has been given condoms on 7 occasions and COC pills three times. She was referred to a young people's clinic at the health centre for a contraceptive implant (at her last visit) and also to the school nurse.
Is white, lives with her parents, has a partner who is 15 and first had sex when she was 14. She is in middle ability groups at school and has made four visits to the clinic. Each time sha came for a pregnancy test and on the last occasion this was positive. At her first two visits she was given advice about contraception, STIs, relationships and given condoms. She was referred to th e Pregnancy Advisory Service after the positive test, to her GP and to a community young people's sexual health clinic.
Is mixed race, lives with her mother, has a 17 year old partner and first had sex at 14 years old. She is in low ability groups and has been to a young people's sexual health clinic in the past. She has made eight visits to the drop-in clinic and had four pregnancy tests, three of which have been positive. At the first few visits she was given contracetion and STI information and advice, and tested for Chlamydia. She has been referred to th e PAS after each positive pregnancy test result, and also to the young people's clinic, youth worker, social care and the teacher-mentor. The referrals were for social problems several times and for child protection issues twice.

importantly 36% said that they had come to the clinic before having sex. In the past, trends have suggested that over 70% of young people first access sexual health care after initial intercourse.

The clinic

For 33% of young people who completed the survey it was their first visit; 34% had been to other clinics, mainly at their GP surgery. The clinic environment was scored highly by over two-thirds of young people: 72% said it was 'very relaxed', 63% 'very cheerful' and 67% 'very comfortable'. Just under half of respondents (49%) thought that the room it was held in was 'nice', 75% scored it highly for privacy. Young people were very positive in their descriptions of how they felt the staff made them feel as shown in Table 3. When asked what the best things about the clinic were, young people identified that the staff were friendly, helpful and welcoming as well as being easy to talk to and non-judgemental, and that the clinic felt confidential, private, comfortable and relaxed.

Reasons for attendance

Young people said they came to the clinic for free condoms, information and advice as shown in Table 4, and in addition to support for their presenting reason they were offered a range of other advice as shown in Table 5. They reported that the advice and information given to them was all they wanted (91%), clear (93%) and that it was easy to ask questions (86%). 11% felt that they would change something about the clinic and this was mainly a better room to hold the clinic (45%) and to open the clinic more than once a week (18%).

Those completing the survey who had had intercourse (n=132 responded) reported their median age at first intercourse as being 14 years (mean14.12 years). 32% (n=42) came to the clinic

Table 4 **Reasons that young people gave for attending clinics** (top 7)

Reason	Number	%
Free condoms	67	42
Information and advice	36	36
To talk about a problem	18	11
Pill/contraception	13	8
Pregnancy test	11	7
Came with a friend	11	7
STI/swab test	8	5

before having sex; on average 6 months before having sex (median 2 months) and those who came after first sex, the mean time was 8 months (median 4 months).

Those who had not had sex (n=79) mainly attended the clinic for free condoms (41%), information and advice (32%), to talk about a problem (11%), or they came with a friend (11%). They were younger than the overall attendees, 60% being 14 or under. They were also given a similar range of advice as the other attendees (Table 5) and reported that they liked the attitudes of the staff (friendly, easy to talk to, non-judgemental), that information was easily available and that the clinic felt comfortable and relaxed.

Youth worker advice

Youth workers also undertook a large proportion of the health promotion work within the clinics. Areas covered by youth workers were similar to nurses and included condom and STI advice; relationship advice including delaying sex; health advice and referral to other services (Table 6). In almost 60% of attendances, youth workers distributed condoms to young people using the C card scheme, which gave them the opportunity for health promotion work around STIs. A higher proportion of attendances by boys (48%) seeing youth workers was recorded compared to those seeing the nurses, which emphasises their important role in giving advice to those who often do not attend sexual health clinics and encouraging boys to take responsibility for contraception.

From April to November 07 (7 months) youth workers gave advice on 1826 occasions (955 girl attendances (52%), 871 boys (48%)). Five young people considered that they had a disability and six were gay.

Forty percent of those seen by the youth workers had not had sex before coming to the clinic and the range of advice given is shown in Table 7; 67% said that it was their first visit to the clinic.

The age range of the young people attending to see the youth workers is shown in Figure 4, for all visits and for those who had not had sex. It shows that youth workers saw a slightly younger age group than the nurses (mean age 14.1 years) and gave advice to many younger people who had not yet become sexually active (mean age 13.6 years).

Qualitative interviews with young people

Focus groups and one to one informal discussions were undertaken with groups of young people to highlight potential reasons for or barriers to using the service. In total 44 young people were contacted and asked to express an opinion, the profile of these students is shown in Table 8.

Table 5 **Other advice offered to young people by sexual health nurses** (n=191)

Advice	Number	%
Contraception	146	76
STIs	83	43.5
Emergency contraception	71	37
Pregnancy test	53	28
Personal relationships	43	22.5
Abortion	20	10.5

Figure 4 **Age range of those attending to see youth workers**

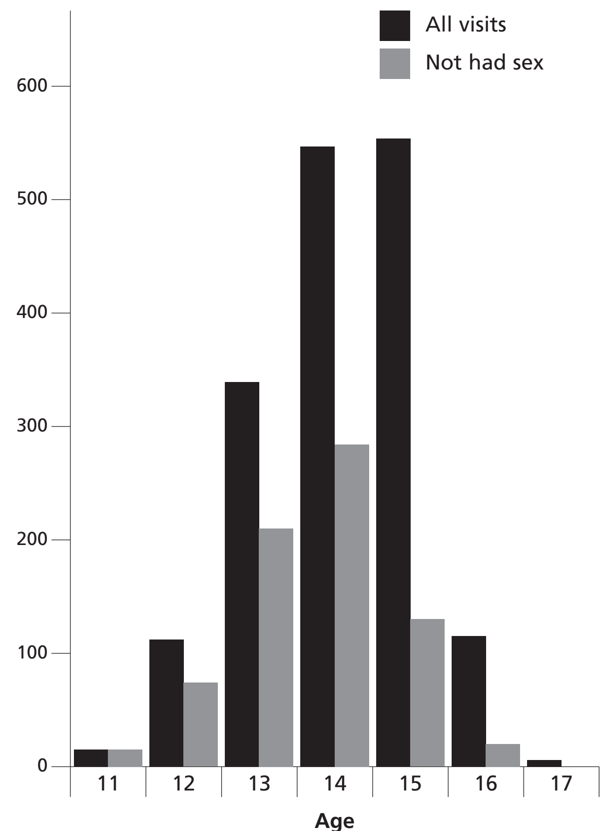

Table 6 **Advice given by youth workers from April to November 2007** (1826 young people visits)

Advice given	All visits	%
Condom advice	846	46
Condom given	1086	59
STI advice	669	37
Other health issues	456	25
Contraception advice	541	30
Relationship advice	505	28
Delaying sex advice	518	28
Referral to other services	112	6

Table 7 **Advice given by youth workers to young people who had not had sex** (n=379)

Advice given	Not had sex	%
Condom advice	247	65
Condom given	183	48
STI advice	203	53.6
Other health issues	136	36
Contraception advice	146	38.5
Relationship advice	188	50
Delaying sex advice	221	58.3
Referral to other services	38	10

Awareness and accessibility of the drop-in service

Most of the students were aware of the service and knew where and when it ran. They had heard about it from their tutors, year assemblies, some had seen posters and others had heard their friends chat about it. Several girls said that there were posters about sexual health issues on the back of the toilet doors. The service was generally available to any student who wished to access it with the exception of deaf students in one school. Here staff and students highlighted the inequity of services, as there was no interpreter provision. Teaching staff felt this left these young people vulnerable to a lack of information and advice. In addition, they raised ethical concerns about students being excluded from a service available to their hearing counterparts within the same school. Interestingly although students across all the age ranges could potentially access the service, students in years 7 and 8 expressed more concerns about being potentially teased or bullied by older students in their attempts to access the service. Similarly, several Muslim students said that while they had heard of the service, they were not sure what happened there.

Location and provision of the service within school

Locations were not always seen as ideal, for example in one school, the clinic was run in a room that could be seen from the staff room and participants found this off putting. In another school, access was compromised when the floor that the drop-in clinic was housed on had to be cleared and policed by teachers at lunchtimes. Young people could only access the clinic by explaining why they needed to be there. The situation was subsequently resolved through a senior management meeting. Other issues included young people reporting locations where students hung around outside the clinic and others saying that there was gossip about who went to the clinic. There were also issues about the availability of rooms so that in one school young people had to wait longer to be seen because staff were competing for space to ensure students' privacy.

Views of the service

Those who were either using or prepared to use the service were very positive about its role, emphasising the location, ease of access, approachability and friendliness of the staff as key to its success. Young people also liked the fact they could attend with the support of their friends, without which some would not have felt confident to attend. Many young people expressed the view that if young people did not have access to the school based drop-in they

Table 8 **Young people involved in interviews**

	Girls	Boys	BME	Age
School A focus group	10	3	none	Year 10
School B focus group	6	3	4	Years 10 and 11
School A one to one and group discussions	8	1	none	Year 11
	none	5	2	Year 10
	none	5	3	Year 8
	3	none	none	Year 7

would not attend alternative provision. Young people felt that lots of people were using the service, a minority felt that some were being turned away because it was so busy, but that clinic staff were prepared to stay on after school, so that they could return after lessons if necessary. One group of girls said they thought there were some boys using the service just to get free condoms, which gave them status and enabled them to show off. This view was echoed by a teacher, although she thought that this had been more of a problem when the service first started and was now largely resolved.

Why young people were not using the service

Approximately half of one of the groups interviewed thought that it would be less embarrassing to use the school-based service than an outside provider (eg GP, health clinic). They said that they would be more comfortable with the nurses at the school and thought that, because it was at school, their parents wouldn't find out (some were worried that their GP might know their parents). One boy from a BME group said that he would not mind going to the drop-in for STI testing, but a group of white British girls said that they would prefer to go to their GP. Nevertheless, half of the second group thought that it would be more embarrassing to use the school based service than an outside provider, because people would see you going in there and would know why you were attending (as it is only for sexual health). Whereas, if they saw you at the doctors, they couldn't be sure why you were there. A group of girls indicated that they were worried that they might be called a 'slag' if people saw them using the service.

Others were worried that people would make fun of them and said that they would prefer to go to the doctors instead, probably with a friend. When asked whether the worry of rumours being spread would put them off using the service, those who had indicated that they would prefer to use the school-based service felt that it wouldn't put them off; those who preferred to use alternative provision said it would. This appeared to be dependent on the student's own confidence. This was illustrated by a mixed race young woman who said that if she had a sexual health concern she would probably go to a teacher she trusted or the learning support mentor first and wouldn't go straight to the clinic on her own.

A group of Asian students felt that Muslim students would not use a drop-in service in school in case someone saw them, highlighting the consequences if their family or community found out. This did not mean they believed young Muslim people were necessarily not having sex, just that they would keep it quiet and not ask for help. A key theme of those interviewed about the barriers to service use was confidentiality. Those prepared to use the service were confident that their consultations would remain private but those not wanting to use the service, were worried about information being shared with school staff and their parents. There was a contradictory element to these discussions as young people (particularly young women) often said they would only attend if their friends could attend consultations with them, with little regard for the consequences of their friends sharing information about them.

Chapter 5 **Professionals views of the schools outreach service**

Semi-structured interviews were conducted with two service managers, two nurses and three youth workers all of whom had direct experience of the service. A number of issues were raised through these interviews concerning the lessons learnt in the initial development period of the Brook Outreach School Drop-in Service and the implications for future development.

General perceptions of the service

Managers in particular felt that the service had progressed well, particularly given their ambitious target of developing sixteen new drop-in sessions over a short time period. Staff felt that they were pleased they had met the outcomes required by Neighbourhood Renewal and hoped that this would support the case for mainstreaming the service. Posts within the service were mostly filled. However there were three schools where it was only possible to run sign-posting provision due to a lack of qualified nurses able to run a full contraceptive service. Staff involved in front-line delivery focused particularly on the development of positive relationships between themselves and those young people who had not previously accessed sexual health services.

In addition, the service had been successful in liaising with a range of statutory agencies such as education, social services and the voluntary sector. These collaborations had led to some 'fine tuning' of service delivery and the harnessing of additional specialist support when required. In particular, participants highlighted the development of multi-disciplinary practice in three main areas:

- Collaborative responses to child protection issues
- SRE delivery in collaboration with PSHE co-ordinators in schools
- Development of close links with voluntary agencies such as Freedom Youth to provide young people with more specialist support

Comments were also made about the excellent links between the Pregnancy Advisory Service and the Brook Outreach School Drop-in Service that had developed. This had been consolidated through employment of a specialist outreach nurse who worked with young women who had experienced termination and enabled them to seek subsequent contraception and where appropriate follow up at the school drop-in.

Staff experience

It was clear that those interviewed enjoyed working within the service and were highly motivated to improve sexual health service provision for young people within Bristol. Staff commented on feeling that 'the school service had really made a difference' and that this had led to high levels of job satisfaction. Nurses and youth workers were excited about meeting the challenges and opportunities facing them in working in school settings. Youth workers in particular highlighted how the school setting offered the possibility of working with young people who had never previously accessed sexual health services or were fearful of seeking advice. There was mutual recognition between participants of the roles and contributions that the different professional groups played in both service development and delivery.

> *I think it's having that combination of roles for a start, the youth worker and the nurse, and also having that kind of local link-in with the youth service as well … that's all really helpful and I think having that time to sort of chat to young people and really give them a chance to explore their kind of sexual health choices. (Youth worker)*

Nurses in particular commented on the contribution that youth workers made to the service both in terms of encouraging young men or 'hard to reach' groups to attend and developing a culture where young people felt safe to talk about personal issues. Several staff commented that the service had provided them with professional development opportunities and had stimulated their career interests. It was felt that this enthusiasm could be built on once staff were more certain of their future in relation to the continued funding of the service.

Barriers and opportunities

All those interviewed felt that the drop-in clinics acted as a platform to engage young people and empower them to have healthier lives. It gave them an opportunity to challenge young people's beliefs about sex and relationships and positively influence attitude and behaviour change. Locating the service within the school setting was seen as key to its success since school plays an important and central part of young peoples' lives. Relationships with school staff were seen as

both potential barriers and opportunities to the development of the service Where collaboration was effective, participants felt school staff respected the confidential aspect of the service and encouraged young people to attend. Examples were also given of drop-in staff supporting young people to share information with members of school staff, school nurses and parents.

Young people often attended the drop-in with their friendship group for support, as they felt this increased their confidence. From the staff's perspective, group attendance could be beneficial but also challenging. While staff felt strongly that young people should be able to attend with friends, it was also felt that at times it was more productive to see young people alone. They were more able to ask questions, which young people may have found embarrassing to answer in front of friends. The following extract from a youth worker highlights this view:

> *I think so yeah, I think even if they come in and they say they're best friends … I think particularly from young men's sort of experience they're not talking to each other about everything, this is probably the first time they've spoken about sex in front of each other, that kind of stuff … and being so open, I think there's a lot of bravado sort of in their conversations normally, sort of outside of the sexual health (Youth worker)*

Front line staff also raised the issue of confidentiality when seeing young people in friendship groups. Nurses and youth workers had to make careful and highly skilled judgements about consultations as some young people would only come to the drop-in if their friends could attend with them. However, the confidential nature of consultations was emphasised and opportunity made for young people to be seen alone. For example, practitioners sometimes asked young people to stay on after their friends had left at the end of consultations for a short discussion.

While most of the discussions focused on the positive aspects of setting up the service, there had been a number of challenges during the initial period. Without exception location and quality of space was highlighted. It was felt that schools should consider the quality of the space provided. Problems faced included inadequate space or inferior rooms in inaccessible or distant parts of the school. It was suggested that even in the newly built schools there were no suitable rooms available and that PFI schools in particular were often short of space. Regularly rooms were shared with other professionals such as the police, school nurses or drugs workers. On the whole, staff appeared to be accommodating of each other and did not experience this as too much of a problem.

Issues of inclusion

All staff interviewed felt that this service was definitely addressing the needs of young people who had not previously had access to sexual health services and particularly highlighted the large number of boys using the service. Boys' attendance was seen as an opportunity not only to give young men space to ask questions, but also challenge the traditional view that contraception is young women's responsibility. Similarly, staff felt that working with young people prior to sexual activity opened up health promotion opportunities which they had not experienced working within other sexual health services.

However, staff were not complacent and believed that there were still groups of young people who could be encouraged to access the service, including deaf students, those in special schools, gay, lesbian and transgender students and young people with English as an Additional Language (EAL). In the following extract a nurse raised concerns about EAL students in one school:

> *I think the only thing that worries me here is the fact, you know, I think it's something like one in three or one in five children here has English as a second language. There is a huge Somali group here … you get a few of these students come in but I'd imagine a lot of them probably would access the service if they felt able to, and would … if there was a translator available for them … … I mean, that is going to be a barrier for them isn't it? (Nurse)*

One manager highlighted that sometimes those young people considered the most vulnerable were often not attending school or the pupil referral units. Cultural or religious issues of being "found out" while attending drop-ins were also seen as important, since school was often perceived as a very public place. Muslim young people in particular expressed their fears about family repercussions if they were seen using the service. Collectively, these groups were considered to need additional resources and the recruitment of specialist staff, so that staff could be made available to work one-to-one with

young people. To improve attendance by BME young people, black or ethnic minority staff should be employed, since their absence within the service was thought to give out the "wrong message".

Child protection issues

All consultations were shaped by the DH (2004) 'Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People Under 16 on Contraception, Sexual and Reproductive Health' based on Fraser Guidelines. This highlighted all the ethical, professional and child protection aspects of treating those under sixteen. Throughout the interviews, staff highlighted the impact of child protection on their workload. During the evaluation period, staff recorded child protection concerns about 20 young people. These were discussed with the service manager, initially by phone, subsequently reviewed at the Brook office and recorded in the patient notes. Most of these cases were also discussed with the Clinical Director. Five concerns about young people were referred as emergencies to the Social Care Duty Team and the service manager followed them up with written referrals. Work connected to these referrals was time consuming and involved collaboration with a wide range of professionals, including community pediatricians, the Police, social work workers and school nurses. One manager attended regular multi-agency meetings, others with LEA child protection advisors, the Brook team and community based meetings with pediatricians, PCT nurse leads and school nurse managers to facilitate an integrated approach between agencies.

Referrals were made employing the Brook Child Protection procedure and the South West Child Protection procedures www.swcpp.org.uk. Most of the issues dealt with were with young people under 16 years old, including concealed pregnancy, allegations of sexual and physical abuse within family, threatened and suicide attempts, rape and sexual assault, young gay men meeting older men via internet contact, selling sex, Class A drug use and young women meeting groups of older men for sex.

Areas for service development and sustainability

All those interviewed felt there was no doubt that the service should continue and develop, as it was meeting the needs of those young people who previously had not attended sexual health services. Importantly, discussions were taking place with young people prior to their involvement in sexual relationships, allowing for preventative work and in some instances supporting the delaying of sex. One interviewee described it as 'a fantastic project' whose scope was wider than had first been envisaged.

However, there were also areas staff felt needed further development. This included liaison with General Practitioners, local health centre staff, CAaSH staff and school nurses. One manager suggested that she would have liked to see more collaboration between the services to provide a more integrated service for young people. Developing opportunities for local CAaSH and practice nurses to work alongside Brook staff would enable them to undertake follow up work with young people in the clinic or surgery. It was felt those students who had established their contraceptive and sexual health needs should be encouraged to take up and use mainstream services. This would enable Brook drop-in staff to see new young people from the younger year groups. Managers in particular highlighted that the service could only be sustained over time if external links were developed to enable easy referral, access and appropriate support for young people. There was concern about improving links particularly around the referral of young people for Long Acting Reversible Contraception, as it appeared that young people found it difficult to attend without support. Clinical development opportunities were also highlighted, such as providing implant insertion and treatments for Sexually Transmitted Infections other than Chlamydia.

It was also felt that the youth worker role could be used more effectively to develop the preventative aspects of the service by drawing on their existing skills and links within local communities. Two staff suggested that perhaps the service should become more generic to include other aspects of health promotion and counselling. This was seen as a way of de-stigmatising the service for those young people who felt anxious about attending because peers may gossip about their sexual behaviour. The following extract illustrates how this might work:

> *"For example the service so you don't have this stigma of it being just the contraception and sexual health, you know, if you do have the school nurse on board, if you do have a male link worker, you know, a drugs and alcohol worker, then you know*

there's no one reason why that person is accessing the clinic and you know if you've got that extended provision of services then it wouldn't be, you know, there wouldn't be that stigma of us being the sex clinic as it is, and then we probably wouldn't have the teasing so … but at the moment of course that's why they're accessing us, isn't it, because that's what we do." (Youth worker)

Staff recognised that work may need to take place within communities outside the school environment to enable access for young people who were not happy to use the school service. More detailed needs analysis was necessary to establish the needs of particular groups for example of young Muslim people. Community settings such as youth centres would need to be confidential, but could offer an alternative for those worried about using the school service.

There was a view expressed that the Brook Outreach School Drop-in service needed to be involved on a regular basis with teachers, governors and parents. As part of this process, there was a need to improve publicity and information about the service through a range of avenues including, school newsletters, web sites and school councils. This was emphasised as being important, since schools must sign up to service level agreements and that "there is transparency about what the service is and what it delivers" (service manager). Extending opportunities in relation to PSHE provision particularly for those organisations that were working with 'vulnerable and hard to reach groups', such as children in care or excluded from school was also seen as a priority. Staff suggested that more strategic management should be set up for PSHE delivery, to assess the workload implications, integrate delivery and maximise impact within schools.

Chapter 6 **Personal, Social and Health Education sessions (PSHE)**

During the first year of the Brook Outreach School Drop-in Service, 119 Sex and Relationships Education (SRE) sessions were delivered within Personal, Social and Health Education (PSHE) programmes to 2359 pupils. In the first term of Year 2, SRE sessions were delivered to 1780 young people in ten of the 15 schools, including two of the pupil referral units, with both nurses and youth workers involved. The outreach team provided support in delivering sessions on methods of contraception; sexually transmitted infections; emotional and physical changes during puberty; risk taking behaviours and sex and the law - including aspects of gay and lesbian sexuality. Motivation from the schools to involve Brook staff included perceptions of young people's sexual behaviour within the school setting or feeling that staff within the service were better placed to deliver such specialist knowledge. Alternatively, Brook staff proactively contacted schools to respond to issues raised by young people within the drop-in sessions. A benefit of involvement in SRE sessions was that drop-in staff were able to collaborate with teachers to provide information that is up to date and relevant, whilst supporting teachers' on going work with their pupils. The sessions had some didactic elements but tended to focus on more interactive methods including group discussions and debates, games and DVDs. Young people were encouraged to express their opinions, ask questions and share their views in a relatively safe environment, shaped by established ground rules. Any personal issues raised by young people in the sessions were dealt with confidentially at the end of the session through an appointment system.

Staff believed that sessions worked best when they were arranged in small groups within an established PSHE programme. Observations suggested that young people perceived drop-in staff as members of the school community and as such, offered a more consistent approach to providing support and education on an ongoing basis. This illustrated good practice in that it responded to historical criticism that one-off visitor sessions are problematic in terms of sustaining education, maintaining relationships and behaviour change for young people. However, an additional benefit was that young people met and developed relationships with drop-in staff that allowed them to feel more confident in their initial contact with the service. Anecdotal evidence suggested that where staff had delivered either SRE or 'awareness of the service' sessions, the numbers of new young people attending the drop-in rose for several weeks post delivery.

Chapter 7 **Discussion**

To what degree was the service inclusive?

This is an important question because a key problem has been the failure of traditional services to encourage uptake by young people, particularly those in vulnerable groups. There are also very few interventions aimed specifically at vulnerable groups, such as young people who are in care, excluded from school or leaving the care system (HDA 2003). A key finding of this evaluation is that by placing sexual health drop-in clinics in schools located in deprived communities difficulties of access are largely overcome. However, even within schools located within these communities, one can question the degree to which the 'hardest to reach' are accessing the service. Within the study, several indicators were employed to respond to these challenges. For example as an indication of educational attainment, young people were asked which Mathematics set they were in at school. The proportions of young people in high middle and lower Maths sets was normally distributed with 71% being in middle or low ability sets.

Given the evidence on the relationship between educational attainment, early sex and teenage pregnancy (SCIE 2004, Berthoud et al 2004, Fletcher et al 2007) this service managed to include less academically able young people to attend. Similarly, the vulnerability of those excluded from school has been highlighted and 42.5% of those attending for nurse consultations had been excluded from school at some point. The Teenage Pregnancy Strategy Evaluation (TPSE) (2005) suggests that young people having sex under 16 living in deprived communities are more likely to use specialist young people services than their affluent peers. This combined with the successes outlined in this project indicates the need to prioritise school based service development within deprived communities.

The mean age of first intercourse for the 515 young people seen by nurses was considerably younger (13.8 years) than the national average. Early sex is often associated with unprotected sex, teenage pregnancy, STIs, possible regret and multiple partners (Wellings et al 2001, Brook 2005). Wellings et al (2001) highlighted that in young people aged 16-24, 42% of young women and 20% of young men felt that they had sex too early. Similar to other studies the vast proportion of young people (68%) consulting the nurses reported having had sex before registering at the clinic. However, this was lower for those consulting with youth workers, where 40% contacted the service prior to sex, offering greater opportunity for health promotion including advice about delaying sex. In the UK approximately 10% of boys reported that they were drunk or stoned when they first had sex and 11% of girls said that they felt under pressure from their partner to have sex (Tripp and Viner, 2005). Age in itself can be a vulnerability factor, and as such a key developmental aim of the service was to communicate and encourage young people from year seven (11 years) onwards to access the service prior to sex, to ask questions and become familiar and comfortable within the clinic environment. This service was available to, and attended by, young people from year seven onwards, though the younger students were mainly given health promotion advice by the youth workers. As the service develops and embeds within schools it will offer young people an important opportunity to access advice prior to sexual activity.

Did boys attend the service?

As indicated previously although there has been increasing pressure on primary care services to deliver appropriate sexual health services to young people (DH, 2001, Free 2005) the evidence for their impact remains scarce. In addition, young men's use of general practice and family planning services is poor (ONS 2006, Brook 2007). The TPSE (2005) highlights not only how school based services are increasingly being used by young people but also that young men in particular are prepared to use them. Where young people do attend services, it tends be once they are already engaged in sexual activity. In fact, first sex seems to be the trigger to attend sexual health services, with some studies suggesting that only a third of young people (of either gender) use a service prior to having first sex (Stone and Ingram 2003). However, the importance of this service is the high proportion of male attendances (48%) to see the youth workers, and particularly the numbers of young people who had not had sex (40%), which offered an opportunity to provide contraception and relationship advice prior to young people embarking on sexual relationships. In particular, they were able to explore the possibility of delaying sex where appropriate and talk about the implications of having sex when young people felt scared or unsure.

Many boys in the study attended the clinics to obtain free condoms, particularly from youth workers (using the C-card scheme). Others have reported that obtaining free condoms from services seems to improve attitudes towards condoms, promotes greater condom self-efficacy and encourages their use (Parkes, Henderson and Wight 2005, Pearson 2003). Pearson (2003) also suggests that young men prefer quick and straightforward sexual health services with opportunities to ask questions, but no pressure to engage in more personal counselling. The schools drop-in service provided this type of service in a convenient and familiar location, which should encourage attendance by boys. Employing a male youth worker should also further increase attendance and engagement with boys in the future.

What were the health outcomes for young people?

Many more young people attended the service compared to their reported use of community or health centre based sexual health services. In most clinics, they could be prescribed a full range of contraception, checked for STIs and referred to other services.

Pregnancy testing picked up 11 positive results quickly and supported young women to tell others or attend PAS. Those with negative pregnancy tests were given advice and support, and treatment to prevent pregnancy and STI. Emergency contraception was given to 55 young women, which potentially prevented pregnancy; 29 were referred for longer-term contraception in the form of implants and 13 had them fitted, and another 10 had Depo-Provera injections. Eleven young people were tested and treated for Chlamydia and another four were referred for GUM follow up.

Young men were encouraged to take more responsibility for contraception, particularly around correct condom use. Young people were given advice about relationships and delaying sex, particularly for those who had not already had sex, when they came to the clinic. Young women having many partners or with complex social needs were supported over time, since they could access the service on a very regular basis. Helping to build up their confidence around sex has also allowed safer sex messages to be reinforced on a very regular basis.

Why did some young people not use the service?

There were groups who would not use the service, young Muslim women and specific groups of white British women talked about fear of being found out either by peer groups, families or their communities and the consequences. These included being labelled, ostracised or punished by families or just being talked about within their communities. For these groups alternatives need to be found, although confidentiality is a key aspect of the service it is unlikely these young people are ever going to feel safe attending a service that they feel is so public. There is a need for sign posting to other young people's clinics including those outside their own communities. However, other groups such as young lesbian, gay and transgender young people, those with English as an additional language (EAL) or with additional learning needs or disabilities may wish to the use the service. The staff involved saw the need to include these groups as a future aspect of service development including providing relevant training for staff.

How well was the service integrated into school and community life?

A successful element of this project included the relationship of the service to other voluntary and statutory agencies within children and young people's and sexual health services. More work needs to be done to enable young people with established sexual health needs to move into community and primary care based services that they feel confident to use. However, promising links were being developed around child protection, specialist provision within the voluntary sector and the Pregnancy Advisory Service. In addition, the collaboration with PSHE co-ordinators leading to delivery of SRE sessions by nurses has had an impact both on the quality of SRE provision and attendance at the clinics. Through meeting the young people, nurses and youth workers were able to advertise the service, and reassure young people about its' confidentiality prior to attendance. This undoubtedly played an important role in establishing and integrating the service into the culture of school life. OFSTED reported that the most successful delivery of PSHE areas was by specialist teachers, and external visitors should not replace these. Consequently, guidance has emphasised the importance of PSHE delivery by established members of the school team rather

than one off visits by expert professionals who have no on going relationships with pupils. Nevertheless, more attention needs to be given to the structure of delivery by the Brook Outreach School Drop-in Service team, as indications are that the demand may be unsustainable within the current staffing levels. This is especially the case, if the service to starts to reach out to community based groups who work specifically with to 'hard to reach' young people.

Conclusions

In conclusion this school based sexual health drop-in service is accessible to large numbers of vulnerable and 'hard to reach' groups of young people, many of whom have not previously accessed sexual health provision within mainstream services. Staff have the capacity to work with younger age groups of young people around sexual health promotion including delaying sex and encouraging young people's consideration of contraception and safer sex prior to engaging in sexual activity. The accessibility, health promotion aspects of the service and the availability of free condoms appeared to encourage young men's attendance. Young women on the other hand 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. There continues to 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. 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.

Recommendations for the future

- 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.
- 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.
- 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 continued acceptability of the service including identification of areas for improvement.
- In the busy schools, young people would like the service to be extended to an additional lunch time or some after-school provision.
- 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 School Drop-in Service 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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