

School-linked sexual health services for young people (SSHYP): a survey and systematic review concerning current models, effectiveness, cost-effectiveness and research opportunities

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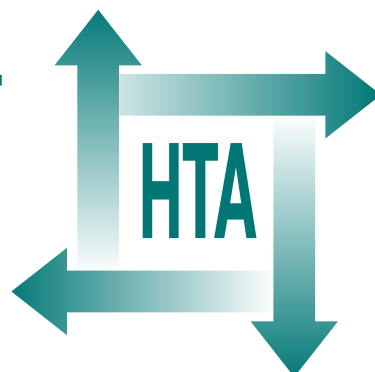
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Executive summary

Health Technology Assessment 2010; Vol. 14: No. 30
DOI: 10.3310/hta14300

Health Technology Assessment
NIHR HTA programme
www.hta.ac.uk





Executive summary

Objectives

The aims of this study were, first, to identify current forms of school-based sexual health services (SBSHS) and school-linked sexual health services (SLSHS) in the UK; second, to review and synthesise existing evidence from qualitative and quantitative studies concerning the effectiveness, acceptability and cost-effectiveness of these types of service, and third, to identify potential areas for further research.

Methods

The study had two components. The first, the service mapping component, was based on a postal questionnaire circulated to school nurses in all parts of the UK (gaining a response rate of 14.6%), and on semistructured telephone interviews with 51 service coordinators in NHS and local authority (LA) roles. Quantitative data from the questionnaire were analysed with the use of SPSS, primarily to produce descriptive statistics relating to staffing and facilities offered. Qualitative data from questionnaire free text sections and from interviews were subject to thematic analyses. The second component was an evidence synthesis, based on a three-part systematic review: a review of quantitative evidence about service effectiveness; a review of qualitative evidence about user and professional views; and a mixed-methods synthesis. Electronic databases were searched from 1985 onwards, and all literature searches were performed in January 2008. Cost-effectiveness modelling was not carried out because insufficient data were available to support it.

Results

The findings from the mapping study and from the evidence synthesis emphasise the wide diversity in SLSHS and SBSHS for young people. UK national policy has encouraged local initiatives in service development, but there have been no templates, no consistent sources of sustainable funding and no systematic approach to evaluation. This context has facilitated local innovation, but has also produced an uneven distribution of services and resources.

Analyses of mapping study data revealed a spectrum of five levels of service provision, ranging from 'no sexual health service', to 'minimal', 'basic', 'intermediate' and 'comprehensive'. Overall, three broad types of UK service provision were identified. First, SBSHS staffed by school nurses: these included both drop-in sessions and individual appointments, and typically offered 'minimal' or 'basic' levels of service. Second, SBSHS and SLSHS staffed by multiprofessional teams, including school nurses, youth workers and other professionals, but not medical practitioners. These could include appointments systems, drop-in sessions and outreach services; they typically offered 'basic' or 'intermediate' levels of service. Third, SBSHS and SLSHS staffed by multiprofessional teams, including medical practitioners. These too could include appointments systems, drop-in sessions outreach services, and typically offered 'intermediate' or 'comprehensive' levels of service.

Importantly, findings from the systematic review provide evidence that SLSHS and SBSHS are not associated with higher rates of sexual activity among young people, nor with an earlier age of first intercourse. There is some evidence of positive effects in terms of reductions in births to teenage mothers, and in chlamydia rates among young men. However, this evidence comes from the USA; the findings need to be tested in relation to UK-based services.

Both the mapping study and the evidence synthesis provide some converging messages about the service features that matter to young people. There is some evidence from the systematic review to suggest that broad-based, holistic service models, not restricted to sexual health, offer the strongest basis for protecting young people's privacy and confidentiality, countering perceived stigmatisation, offering the most comprehensive range of products and services, and maximising service uptake. Findings from the mapping study also indicate that broad-based services, which include medical practitioner input within a multiprofessional team, meet the stated preferences of staff and of young people most clearly. Partnership-based developments of this kind also conform to the broad policy principles embodied in the Every Child Matters framework in the UK

and allied policy initiatives. However, neither these service models nor narrower ones have been rigorously evaluated in terms of their impact on the key outcomes of conception rates and sexually transmitted infection (STI) rates, either in the UK or in other countries.

Conclusions

There is no single, dominant service model in the UK. Respondents to the mapping study expressed concern about gaps in service provision across the UK, while recognising innovative aspects too. The systematic review demonstrated that the evidence base for these services remains limited and uneven, and draws largely on US studies. There is no evidence to suggest that these services contribute to earlier or higher levels of sexual activity; there is some evidence of positive effects on teenage conceptions and (among boys) STI rates. But there is an absence of methodologically rigorous studies of impacts on STIs and on conceptions. For this reason, analyses of cost-effectiveness would require further research.

Implications and recommendations

Implications for policy and practice

Evidence from the mapping study reinforces findings from the recent Sex Education Forum (SEF) survey in England, showing that SLSHS and SBSHS are unevenly distributed, both between UK countries and regions, and within them. Developing services, for young people in rural areas and in Northern Ireland, is an important priority. More generally, it is important for commissioning bodies [primary care trusts (PCTs) and LAs] to review the provision in their areas, and to consider how to address gaps in provision.

In addition, both the mapping study and the synthesis of evidence have identified a number of criteria that young people and staff see as characterising high-quality services. This evidence suggests that the following principles should inform the development of new services, and the evaluation of established services:

- Robust procedures to safeguard confidentiality, agreed between all agencies and professions contributing to the service.

- Consultation in advance with potential user groups of young people, and engagement of young people in the design and implementation of routine monitoring and evaluation processes.
- Consultation in advance with school headteachers, governors, staff and parents' groups, to secure informed leadership and support.
- Close liaison and (where possible) joint work with teaching staff who deliver personal, social, health and economic education (PSHE).
- Design of locations and session times to protect privacy of service users.
- Establishment of a multiprofessional staff team, including both male and female members, and including school nurses, youth workers, medical practitioners and other specialist staff where appropriate (e.g. drug and alcohol workers).
- Clear incorporation of local and national child protection guidelines and requirements, along with liaison with relevant local agencies.
- Provision of comprehensive sexual health services, i.e. including relationships advice, prescriptions for oral and emergency contraception, other forms of contraception, STI screening and pregnancy testing, signposting and referrals for specialist services that are not offered on site.
- Access to continuing professional development for staff, including specialist sexual health training.
- Marketing of the service as broad based, rather than restricted to sexual health.
- A secure funding basis.

Recommendations for future research

This report has demonstrated that there are significant gaps in available research about SLSHS and SBSHS. First, there is a lack of robust research from the UK. Messages from the available US research need to be interpreted with caution; some long predate current UK policy and service developments and some are characterised by significant methodological weaknesses; there are also substantial differences in health and education systems in the two countries, as well as differing political priorities with respect to contested issues such as abortion and sex before/outside marriage. These inter-related factors are all likely to shape young people's views, their opportunities to access specific services and their responses to those

services. Second, there is a lack of robust research focused on the impact of school-linked and school-based services on the key outcomes of unintended pregnancy rates and STI rates. Third, there is a lack of research addressing the specific components of interventions that this study has shown to be important to young people themselves.

The research gaps noted here include some aspects that are amenable to investigation through experimental or quasi-experimental study designs and others that would require alternative methods. The current context in the UK, with its diversity of SBSHS and SLSHS initiatives, offers opportunities for both. In particular, there is scope to make comparisons between different forms and levels of intervention and their components, in terms of young people's responses, staff perspectives and health outcomes. The following are priority topics for future research:

- Qualitative research with young people and with staff from health, youth work and education, to develop valid and reliable process and outcome measures related to UK SBSHS and SLSHS. These should include, but not be confined to, measures of the impact of services on rates of unplanned pregnancy and STIs, and measures of service costs. In this respect, there may be opportunities to build on research already completed about health promotion in schools, following the 1999 Health Technology Assessment (HTA)-funded systematic reviews on this topic. For example, the themes of school ethos and social and emotional well-being may be particularly relevant. The output of this research could be used both to inform the commissioning of largescale primary research, and to inform initiatives in local evaluation.

- Substantial, primary research with the scope to address specific measures developed through the above process, and to compare the distinct models identified in this report: school-based services staffed by school nurses; school-based and school-linked services staffed by multiprofessional teams without medical practitioners; and school-based and school-linked services staffed by multiprofessional teams with medical practitioners. This research should include a longitudinal element in order to examine themes such as sexual decision-making and use of contraception by young people, over a sustained period of time. It should also include an examination of interprofessional and interagency relationships and communications, for example, in terms of perspectives on confidentiality and of perceptions about sexual decision-making among young people. Lastly, it should include analyses of cost-effectiveness, drawing on evidence of service impact.
- Primary research to examine the views and experiences of particular groups of young people who have not been included explicitly in the studies discussed in this report, in relation to SBSHS and SLSHS. These include young people with disabilities, minority ethnic young people and lesbian, gay, bisexual and transgender (LGBT) young people.

Publication

Owen J, Carroll C, Cooke J, Formby E, Hayter M, Hirst J, *et al.* School-linked sexual health services for young people (SSHYP): a survey and systematic review concerning current models, effectiveness, cost-effectiveness and research opportunities. *Health Technol Assess* 2010;**14**(30).



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The research reported in this issue of the journal was commissioned by the HTA programme as project number 06/69/03. The contractual start date was in November 2007. The draft report began editorial review in July 2009 and was accepted for publication in November 2009. As the funder, by devising a commissioning brief, the HTA programme specified the research question and study design. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HTA editors and publisher have tried to ensure the accuracy of the authors' report and would like to thank the referees for their constructive comments on the draft document. However, they do not accept liability for damages or losses arising from material published in this report.

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ISSN 1366-5278

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Published by Prepress Projects Ltd, Perth, Scotland (www.prepress-projects.co.uk), on behalf of NETSCC, HTA.

Printed on acid-free paper in the UK by Henry Ling Ltd, The Dorset Press, Dorchester.