Barriers and facilitators in delivering a new model of sexual health service for young people who are looked after

Hannah Dale and Lorna Watson

Corresponding author:

Hannah Dale, Clinical Psychology Department, Stratheden Hospital, NHS Fife, Cupar, Fife.

Introduction

The health of young people who are looked after away from home is frequently documented as poorer than their non-looked after peers (Polit et al., 1989; Buchanan, 1995; Meltzer et al., 2004). This includes the area of sexual health where these young people suffer even poorer outcomes and lower knowledge levels than their peers (Fraser, 2005; Department for Education and Skills, 2006). This is particularly concerning since, Scotland - and Fife in particular – tends to fare worse than most of Western Europe (Kmietowicz, 2002; Information Services Division, 2007; NHS, 2008; WHO, 2008). Many factors contribute to the poorer health of looked-after young people, including abuse, neglect, frequent change in placements, and poor adult role-modelling, along with a frequent history of socio-economic deprivation (Grant et al., 2002; Social Care Institute for Excellence, 2004; Scottish Healthy Care Network, 2007). Due to their poorer outcomes, the need to intervene with and prioritise them has often been highlighted (Scottish Executive, 2005; Scott & Hill, 2006; NHS Fife, 2007; Scottish Government, 2007; Health Scotland, 2008).

Whilst it is clear that looked-after young people often have poor health outcomes, interventions or consultations with this group around sexual health are severely lacking, or remain unpublished. A desire for more input, along with the importance of confidentiality, has been highlighted previously (Meltzer et al., 2004; Eisley et al., 2007). However, there remains a lack of evidence which comes directly from this group about their experiences. This paper aims to document some of barriers and facilitators in delivering a service pilot on sexual health for looked-after young people, reflect on some of the reasons for this, and propose ways through which they might be circumnavigated.

Context

The observations which structure our commentary were made during the piloting of a specific health care project for looked-after young people. The pilot was informed by a

piece of research which aimed to assess their sexual health needs (Dale, 2009). The research was undertaken over 2008/09 in Fife, Scotland. The needs assessment aimed to explore from where looked-after young people receive their knowledge of sex and relationships, as well as their knowledge levels and broader views and concerns around these issues. Their preferences for learning about sexual health were also explored. In total, 10 semi-structured qualitative interviews were carried out with LAYP between the ages of 14 and 19 (seven females and three males) across Fife.

Following the completion of the data collection and analysis, a pilot service was developed, which drew heavily on the needs assessment but also Health Psychology theory and evidence (Dale, 2009). The ongoing pilot service offers one-to-one support to looked-after young people around sexual health, smoking, exercise and diet, with consultancy for staff or carers. This draws on a new model of health intervention and consultancy involving a partnership between Health Psychology and Public Health. To date, 24 young people have been referred or have self-referred from a range of settings. The one-to-one input is designed to support young people choosing healthier behaviours. It includes individual goal setting and may continue for a number of appointments, led by the young person's needs. The barriers and facilitators to delivering such a new service will be discussed below.

Gatekeeper barriers

Gatekeepers are those who control access to populations. In the research phase of this project, staff and carers of looked-after young people performed this gatekeeper function. While researching the need for this project, gatekeepers were sometimes reluctant to allow us access to gather information upon which to develop the service. We found, however, that gatekeeper barriers were reduced when it came to actually delivering the new pilot service, since the benefit is more tangible and there is more flexibility around approaching the young people and advertising services to them. In addition it was possible that a relationship had been built up from the research phase, giving more credibility to the researcher who was, subsequently, also the provider of the service. By actively disseminating research results to participants and staff, this generated positive interest. The researcher/provider also achieved some familiarity over time with the changing and complex organisational structures which may surround looked after young people.

Time is a barrier to gatekeepers when offering services. There can often be a lot of pressure on those working with this group of young people, particularly due to their accountability around child protection issues (Burton & van den Broek, 2008). Staff may also be forced to concentrate on the most vulnerable, who can often be very difficult to engage. Those, however, who are less vulnerable may also benefit from input around lifestyle issues. Other categories of staff, such as those in health, education, community services or the voluntary sector may also publicise the service to young people if they are known to be looked after. Thus far, the majority of referrals have been via social work foster carers, and health care professionals.

Some staff members may feel that they should not be involved in health issues and even those who feel they ought to be are not always actively involved (Kendrick et al., 2005). Furthermore, staff do not always feel equipped to deal with health issues, especially around emotional and behavioural difficulties, leaving them overwhelmed and stressed; further training may assist in addressing this problem (Furnivall et al., 2007). Staff may also recognise that their young people are often resistant to additional services since there are already many people involved in their care. This may result in fewer referrals or avoidance of informing young people about what is available. Research has found that when leaving care, unhealthy lifestyle behaviours among this group can be very high, with young people even stating that they lacked encouragement to be healthy (Ridley & McCluskey, 2003), thus suggesting there have been missed opportunities for preventative health care.

Barriers relating to young people

One pertinent barrier is that motivation to engage in discussions around health may be lacking. Like adults, adolescents probably underestimate the potentially negative consequences of their personal behaviour (Millstein, 1994). When young people are interested in discussing health issues, they sometimes lose interest on subsequent appointments or change their mind about working on improving their health. Another issue may be changes in placement, as engagement may be more likely when there is some stability in the young person's life. In addition, more serious concurrent health or behaviour problems such as addiction or a mental health diagnosis may preclude some young people from being suitable for the project at a specific point in time.

Facilitators to engaging young people in health issues

The new service pilot did not require full NHS ethical review, and therefore it could be flexible. Flexibility was important in the view of participants in the original research for the pilot. Looked-after young people were involved in designing the publicity cards for the project and are able to self-refer via phone or text, or be referred by a worker. Being flexible in the location and times to meet young people has been critical. Most young people so far have been met in their home or residential placement, though school has been preferred by a minority. This has helped with engagement, since some have forgotten about appointments but have been happy to engage since they have been at their home. Texting appointment reminders has also assisted with engagement and has helped to reduce non-attendance. Patience has been required, since young people are sometimes reluctant to engage at the time of appointments. Simply letting them know they can take their time may have assisted some young people to engage, and whilst they may have attended an appointment 15 minutes late, they have been more ready and receptive. Keeping a non-judgemental attitude about time-keeping is important in order to establish rapport and a therapeutic alliance.

Ensuring that the interactions are as informal as possible has assisted in engagement. Often the first appointment is short and merely consists of introductions, informal chat and informing them of the service offered. A staff member or carer may also be present. These factors have often put young people at ease and led to them being more open to

discuss health issues. The option of meeting in pairs or small groups has further increased uptake, particularly in residential settings, where some young people were unwilling to engage on an individual basis. In the residential settings also, it is feasible to offer dropins. This has had a large uptake and allows young people to find out about the service in a less-daunting way and has often had a high return rate.

In engaging looked after young people in sexual health issues, one key factor has been finding what is salient to them, whether it be particular health goals, their body image or other factors, and promoting or marketing potential benefits. Highlighting the more salient short-term, rather than long-term, health benefits may also assist behaviour change (Prokhorov et al., 2003).

Building on previous links with social work has assisted in gaining support for the project and encouraged staff and carers to inform young people about it. More generally, it has helped raise the profile of important health issues among those working with looked after young people and perhaps assisted uptake of the pilot service. What may further assist the engagement of young people is timely referral by staff and carers and/ or passing on advertisements to them. If engagement with young people occurs prior to them reaching 'crisis' or engaging in many risky behaviours, engagement may be higher and they may also be more receptive to change. This may be achieved through further informal training for staff and methods to raise awareness of health issues and services available.

Conclusions

Looked-after young people are a difficult group with which to conduct health research and deliver targeted services but should be seen as a priority if meaningful improvements in health are to be achieved. The challenge is to achieve partnership working both at strategic and operational level, which facilitates working with both the staff/ carers and the young people, and this may be true of other vulnerable or hard-to-reach populations. This paper has made comment on some of the barriers and facilitators to providing new health services for looked after young people. Our findings suggested that gatekeepers are more likely to encourage young people to use a new service if there are obvious tangible benefits for the young people. The paper also highlighted some important issues which should be taken into account if the take-up of health services by this group of young people is to be encouraged.

This paper is one of two articles produced by the authors. The second paper, which will be published in the next edition of this journal, will look at our experiences of the barriers and facilitators to research with this group of young people.

Acknowledgements

References

Buchanan, A. (1995). Young people's views on being looked after in out-of-home- care under The Children Act 1989. *Children and Youth Services Review, 17,* 681-696.

Burton,J. & van den Broek, D. (2008). Accountable and countable: Information management systems and the bureaucratization of social work. *British Journal of Social Work, 39,* 1326-1342.

Dale, H (2009). *The sexual health needs of looked after young people.* NHS Fife. Accessed on 18th September, 2009 at http:/ /www.dwfchp.scot.nhs.uk/ article/ uploaded/TheSexualHealthNeedsofLookedAfterYoungPeople-FinalReportMay091_1.pdf

Department for Education and Skills (2006). *Teenage pregnancy: Accelerating the strategy to 2010.* DfES Publications: Nottingham.

Elsley, S., Backett-Milburn, K. & Jamieson, L. (2007). *Review of research on vulnerable young people and their transitions to independent living.* Edinburgh: The Stationery Office.

Fraser, S. (2005). Briefing Paper 2. *Promoting a healthy respect: What does the evidence support.* Glasgow: NHS Health Scotland.

Furnivall, J., Wilson, P., Barbour, W, S., Connelly, G., Bryce, G. & Phin, L. (2007). 'Hard to know what to do': How residential child care workers experience the mental health needs of young people. *Scottish Journal of Residential Child Care, 6*(1), 1-13.

Grant, A., Ennis, J. & Stuart, F. (2002). Looking after health: A joint working approach to improving the health outcomes of looked after and accommodated children and young people. *Scottish Journal of Residential Child Care, 1*(1), 23-29.

Health Scotland (2008). *Respect and responsibility: Delivering improvements in sexual health outcomes 2008-2011.* Accessed on 18th February, 2009 at http://www.healthscotland.com/ uploads/ documents/ 8411 R&Routcomes200820011_final.pdf

Information Services Division (2007). *Teenage pregnancies by board of residence, age of mother at conception and outcome.* Accessed on 28th July, 2009 at www.isdscotland. org/isd/2071.html

Kendrick, A., Milligan, I., & Avan, G. (2005). 'Nae too bad': Job satisfaction and staff morale in Scottish residential child care. *Scottish Journal of Residential Child Care, 4*(1), 22-32.

Kmietowicz, Z. (2002). US and UK are top in teenage pregnancy rates. *British Medical Journal, 324*, 1354.

Meltzer, H., Lader, D., Corbin, T., Goodman, R., & Ford. (2004). *The mental health of young people looked after by local authorities in Scotland.* London: The Stationery Office.

Millstein, S. G. (1994). A view of health from the adolescent's perspective. Chapter in S. G. Millstein, A. C. Peterson and E. 0. Nightingale (Eds.), *Promoting the health of adolescents: New directions for the twenty-first century.* New York: Oxford University Press.

NHS (2008). *Scotland's sexual health information.* Edinburgh: IDS Scotland Publications.

NHS Fife (2007). *Director of Public Health Annual Report 2005/2007.* Fife: NHS Fife.

Polit, D., F., Morton, T., D., & White, C., M. (1989). Sex, contraception and pregnancy among adolescents in foster care. *Family Planning Perspectives 21*, 203-208.

Prokhorov, A. V, Hudmon, K. S., & Stancic, N. (2003). Adolescent smoking: Epidemiology and approaches for achieving cessation. *Pediatric Drugs, 5*, 1-10.

Ridley, J. & McCluskey, S. (2003). Exploring the perceptions of young people in care and care leavers of their health needs. *Scottish Journal of Residential Child Care, 2*(1), 55-65.

Scott, J. & Hill, M. (2006). *The health of looked after and accommodated children and young people in Scotland - messages from research.* Social Work Inspection Agency. Accessed on 15th April, 2009 at http:/ /www.scotland.gov.uk/Resource/ Doc/128931/0030711.pdf

Scottish Executive (2005). *Respect and responsibility. Strategy and action plan for improving sexual health.* Edinburgh: The Stationery Office.

Scottish Government (2007). *Better health, better care: Action plan.* Edinburgh: The Stationery Office.

Scottish Healthy Care Network (2007). *The health & well-being of children and young people in and leaving care in Scotland.* Accessed on 30th October, 2009 at http:/ /www.shcn.org.uk/ docs/ Oct07 /SHCN%20Briefing%20Paper%20-%20Health%20-%20LAC.pdf

Social Care Institute for Excellence (2004). *Research Briefing 9: Preventing teenage pregnancy in looked after children.* Accessed on 30th October, 2009 at http:// www.scie.org. uk/ publications / briefings/ files /briefing09. pdf

WHO (World Health Organisation) (2008).*Inequalities in young people's health. Health behaviour in school-aged children. International report from the 2005 / 2006 survey.* Copenhagen: WHO.