

“A drop-in secondary school health service”.

A draft working paper by Professor Philip Graham, National
Children’s Bureau

Note: This paper was written by Professor Graham, previously Director of the Institute of Child Health in London and Professor of Child Psychiatry. Professor Graham now leads the National Children’s Bureau. He has kindly agreed to make this paper available to inform those interested in teen health. The paper does not claim to offer a comprehensive literature review but aims to set out the evidence base telling us that we do know what young people want and therefore what is likely to work.

David Hall, 11.6.01.

A drop-in Secondary School Health Service

One of the most widely expressed demands of secondary school students is for a service they can attend without fear of breach of confidentiality. In the government's own consultation with young people, in which 500 young people were surveyed and many others were interviewed, four needs were expressed relating to health. They were for a) accessible, confidential health services, b) greater involvement of young people in planning services, c) health education that reflects their experiences, especially about drugs and alcohol and d) specialised advice centres for those with drug problems (Home Office 2000). Young people would like advice on family and emotional problems, various aspects of sexual health especially contraception, a variety of physical complaints such as menstrual symptoms, acne, obesity, and migraine, as well as drug and alcohol problems. Although the number of adolescents who consult their general practitioners each year is not greatly different from that of older age groups, many students would prefer a more age-specific, accessible service.

A model for this type of service is that described by Jepson et al (1998). A general health service based in an American High School attracted 4,852 attendances over a period of one year from a population of approximately 2,000 students. 20% of the largely self-referred students came for mental health problems. The remainder came for issues around pregnancy, sexuality, drug problems and a range of physical symptoms. The advantages of the clinic lie in the fact that it is not perceived to be primarily a mental health service, and consequently attendance does not attract stigma. The easy access is a major advantage for those students who need rapid advice, such as those contemplating suicide or at risk of pregnancy and wishing to use emergency contraception.

There have also been descriptions of similar, but much more limited services in the UK. Nelson and Quinney (1997) described an evaluation of a weekly lunch-time drop-in health clinic (Time 4U). The clinic was staffed by a youth adviser, a doctor and a school nurse. Over a six month period there were 190 pupil contacts during 27 clinic sessions in a school with approximately 620 students on roll. Contraception (63 contacts), other health issues (65 contacts) and family problems (41 contacts) were by far the most common reasons for attendance. 14-15 year olds were the most frequent attenders. A school-wide questionnaire asking for comments on the service from both users and non-users elicited largely positive responses especially from users.

A build-up of a more limited drop-in service in a secondary school in Cornwall was described recently by Osborne (2000). Family issues, general health and immunisation were the most common reasons for attendance. In both these services girls were much more frequent users than boys.

I have made a number of informal enquiries from contacts helpfully suggested by Pat Jackson, Professional Officer for School Health and Public Health at the CPHVA. Useful information was provided by Babs Young, who manages the school health service in east Kent. There a number of school nurses do provide a drop-in consultation service for secondary school pupils, very occasionally every day, but more commonly once a month. This may not seem much, but the area is covered by eight school nurses who are responsible for a school population of 95,000 pupils, with 95 secondary schools. Recruitment of new staff presents 'dire' problems.

A more encouraging account was given by Hilary Mosley, a public health nurse specialist in Huddersfield. For some years now, all 14 year old pupils in Huddersfield have been given a wide ranging questionnaire concerning, amongst other matters, their health, lifestyle and worries. These are completed confidentially, and each questionnaire is given a code number. All pupils are then interviewed by a nurse who has the

questionnaire information available and can counsel appropriately. In addition to this universal screening process, there are two facilities available to students. Within all secondary schools there is an 'Open Door' facility, enabling pupils who wish to use the service to see a nurse and talk confidentially about a health or personal problem at lunchtime. In addition, there are a number of Teenage Advice Centres linked to large general practices and seeing young people of school age after school hours. Again staffed by school nurses, these are mainly used for sexual health issues, especially contraceptive advice. The Huddersfield service has various other positive elements. The school nursing staff appears generally well trained in a variety of counselling approaches. It is well supported by Tier 2 CAMHS staff, who have helped, for example, in the design of the questionnaire and provide consultation on difficult cases. Recruitment is not a problem and morale in the school nursing service is high. The service provides a 'pack' for services in other parts of the country interested in using its materials such as the questionnaire.

There is a more limited number of initiatives led by primary health care professionals. Examples are those run by Dr. Marian Davies in a town in the Welsh Borders and the TicTac project in Paignton, Devon.

Both the published material and the informal contacts I made suggest a number of key issues in the provision of drop-in clinics for secondary school age young people in the UK.

1. Such services do exist but are very patchily distributed and inadequately staffed. They are usually led by the school nursing service, but there are a few examples of such services led by primary care teams.
2. It is essential that there are good working relationships and excellent communication between the staff of school clinics and the primary care health service that will remain primarily responsible for the health care of young people. It is particularly important that prescribing issues are clearly agreed between the school nursing and the primary care services.
3. For a clinic to be successful various conditions need to be met: a) the existence of the service needs to be well publicised at regular intervals within the school. b) the clinic needs to be sited away from teaching areas and in some cases may be situated in a neighbouring building. c) confidentiality needs to be completely assured within agreed limits. d) there need to be clear service agreements between the education and health authorities and the school. e) the views of young people regarding the service need to be regularly ascertained. f) the possibility of consultation with a child and adolescent mental health service, such as that described by Richardson and Partridge (2000) might be desirable.
4. There is an evidence base for the value of drop-in clinics but it is very limited and needs to be expanded.

There is a further important issue. This proposal needs to be considered in relation to other government initiatives. The aims of the Healthy Schools initiative would seem fully consistent with the proposal put forward here. The initiative with the most significant overlap is probably the proposed Connexions service. The details of this service are not clear, but it would seem to involve a universally available personal counselling service. The service is most unlikely to be health orientated and indeed its existence is likely to increase rather than reduce the need for accessible school health services.

It can reasonably be concluded that an accessible drop-in health service should be universally available to students either within or close to all secondary schools. The Huddersfield service functions well on one full-time school nurse for 2000 students, usually in two secondary schools. However it is possible to provide only a 'very superficial' service and it would seem more realistic, and still below resources available for schoolchildren in at least some areas in the United States, for there to be one full time

school nurse for 1500 students. The total cost of such a service would be in the region of £66m. (based on a full annual cost of a full-time school nurse of £27,000 and a total secondary school population of 3.2m.). The existing cost of the school nursing service is around £40m, based on a figure of 2,500 school nurses, equivalent to around 1,500 whole time equivalents. Of these, about half work in primary schools, so the cost of the existing school nursing service in secondary is around £20m. It would therefore be necessary to recruit approximately 1500 additional school nurses and find approximately £46m. Could such a number be recruited and could an extra £46m. be found to meet the cost of such a service?

There is strong support from the Community Practitioners and Health Visitors Association (CPHVA) and the Royal College of Nursing (RCN) for a significant increase in the numbers of school nurses (CPHVA 2000). However action is unlikely to occur unless considerable political and professional pressure is brought to bear. It should be noted however that much larger sums have been made available for the SureStart programme.

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