

# **An Evaluation of Services for Young People in East Sussex**

**Provision of Nurse-led Sexual Health Service in Schools and Colleges, Pulse Innov8, and the Young Men's Health Worker Service**

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# An Evaluation of Services for Young People in East Sussex

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## Executive Summary

### 1. The Service Evaluations

- 1.1 This evaluation was commissioned by East Sussex Downs and Weald Primary Care Trust (PCT). The report sets out the findings of three discrete but inter-related evaluations of three services for young people in East Sussex: 1) Nurse-led sexual health provision in schools and colleges; 2) Pulse Innov8, and the; 3) Young Men's Health Worker Service.
- 1.2 The evaluation comprised two methodological aspects: qualitative primary research with staff and young service users of the three inter-related services, and; analyses of secondary monitoring data provided to the evaluators for inclusion by the commissioning PCT.
- 1.3 The findings and recommendations in this report are based on 1) in-depth qualitative interviews and focus groups with 32 young service users and 14 professionals and/or practitioners, and; 2) analysis of secondary monitoring data relating to each of the three services. Purposive sampling was used to recruit individuals to participate in the evaluation. All primary data collection took place between March and June 2011.
- 1.5 Ethical approval for the study was received from the University of Brighton's Faculty of Health and Social Science Research and Ethical Governance Committee (FREGC).

### 2. Main Findings

- 2.1 The findings of this evaluation clearly show that all three services (nurse-led sexual health provision, Pulse Innov8, and YMHWS) are highly valued by young people, and in many cases, appear to have had a considerable impact in terms of improved health and social outcomes with changes evident through young people's knowledge, attitudes and behaviours.
- 2.2 For many young people, the three services have increased confidence, esteem, skills, knowledge, and impacted positively on (health and social) behaviours, for example in relation to anger management, physical activity, diet, and substance misuse. For other young people, the impacts of the services have been no less than life-changing. Careful consideration therefore should be given to the potential impacts on young people of reductions in service provision (e.g. decommissioning of the YMHWS and nurse-led provision, and reduction of Pulse Innov8 staff and services), and where possible and/or appropriate, decommissioned services should be reinstated.

### 3. Overarching Recommendations

- 3.1 There is a need to improve the routine monitoring data recorded for each of the three services evaluated. More consistent, detailed, and prescriptive form of monitoring is required that is linked specifically to programme objectives. This will (amongst other things) facilitate better performance evaluation (process and outcome) over time, enable direct service comparisons, and make it easier to demonstrate whether (or not) targets for the particular services in question have been met. Any improvements in data monitoring also need to be contextualised within service-specific strategies as well as being located alongside forward planning of respective service evaluation(s), for example to ensure appropriate baseline data are generated. Across all three services,

it would be beneficial for staff delivering services to be involved in developing monitoring and evaluation systems to gain awareness around the impacts of their work.

- 3.2 Evaluation data show some differences across the three services in terms of the model of engagement with young people. It is proposed that any service provision for disadvantaged young people should adopt a 'youth-work' style approach to service development and delivery. This implies a needs-led approach that take the young person's agenda (e.g. acknowledging privacy concerns regarding service location for the nurse-led sexual health drop-ins), rather than imposing a definition of 'what works' at the outset, is likely to be more effective in addressing young people's needs. Participatory engagement with young people can be a useful mechanism to achieve this during service development, service delivery, and service evaluation.
- 3.3 Working with young people takes time for short-term impacts and longer term outcomes to be fully realised. Appropriate acknowledgement is required in terms of the time needed to market and promote the services available, as well as the considerable input needed to 'reach' and engage with disadvantaged young people. Sustainability is thus a key factor and sufficient investment needs to be made over a long period (allowing for consultation, piloting, and evaluation) in order for services to be able to demonstrate (potential) impact on reducing health inequalities in the short, medium and ultimately the longer-term.

#### **4. Recommendations for the nurse-led sexual health provision in schools and colleges**

- 4.1 The sexual health provision led by specialist nurses are particularly essential in rural areas where accessibility to alternative services is limited compared to more urban centres. This lack of accessibility is compounded in rural boarding colleges where the potential for sexual activity and sexual ill-health, is heightened. Future service provision should therefore consider the geographic location of any planned services and how this may be impacted on, as well as impacted by, existing services for young people in the locality.
- 4.2 Support from additional (e.g. pastoral) staff in colleges appears to be an important contributory factor in terms of increasing service uptake by young people. Such staff may include school tutors, governors, and additional staff (e.g. onsite Connexions workers) to sign-post young people to the service. Without this 'whole school' support, young people may be less likely to use the service.
- 4.3 Linking the college services to schools is an important 'added-value' of the nurse-led provision. This enables school-aged young people to become aware of the service before they are in need. Future service provision should therefore consider school sites as useful opportunities to normalise sexual health by engaging young people through early interventions.

#### **5 Recommendations for Pulse Innov8**

- 5.1 Strategic plans and their related outcomes (e.g. within the SLA) which affect the remit of Pulse Innov8 should be well-documented and communicated to the staff delivering services to young people. This will not only help to empower the team to plan their work programme more effectively (for example in terms of targeting and reaching young people most 'in need' of the services including those from diverse ethnic groups), but will also assist in the creation of relevant data collection mechanisms to monitor and evaluate the implementation of such strategies.

- 5.2 The marketing activities for Pulse Innov8 services are generally disjointed and ad-hoc with young people being unable to differentiate between Pulse Innov8 and other young persons' services (e.g. teenage pregnancy initiatives and the Youth Development Service). It would therefore be beneficial to develop a specific marketing and branding strategy in order to create a clear and recognisable service identity, and to raise the profile of Pulse Innov8 services to young people (and other service providers).
- 5.3 A reduction of Pulse Innov8 capacity through changes in staffing and the decommissioning of some services has meant that the Pulse Innov8 team have needed to be particularly creative in meeting the needs of young people, for example through the use of social networking media (i.e. Facebook) and developing new partnerships with other service providers to 'fill the gap' left by decommissioning. Such efforts are to be commended and should be continued.
- 5.4 Two aspects of Pulse Innov8 services appeared to have a considerable impact on young people in terms of both social (e.g. confidence and self-esteem) and health outcomes (e.g. weight management, diet). As such, it is recommended that the 'gym and swim' card scheme is considered for reinstatement (either fully to all young people or targeted to those most 'in need') and to explore the possibility of increasing capacity for outreach work via greater use of the Pulse bus. In terms of the latter, such resources can be particularly crucial in engaging those vulnerable young people whom may be invisible to services (e.g. those who are LGBT or those in rural locations).

## **6 Recommendations for the Young Men's Health Worker Service (YMHWS)**

- 6.1 Services specifically for young disadvantaged men are scarce locally, and nationally. Young men's needs are different to those of young people more generally meaning that specialist dedicated support is often required (see Gomes *et al.*, 2007; Sherriff, 2007). Consideration should be given to re-instating the YMHW service for disadvantaged young men or look to how other provision may be able to continue the work in a similar form, as the outcome of this evaluation shows that the service has had a considerable impact on young men's lives and their willingness to take up services in the future.
- 6.2 The needs-led and flexible outreach model of working adopted by the YMHW is very suitable to addressing young men's needs. Such approaches are crucial to engaging effectively with disadvantaged young men and should remain a central feature of any future service aimed at this target group.
- 6.3 Individual support is particularly important in working with disadvantaged young men who often present with multiple cross-cutting and complex needs which simply cannot be addressed through more 'traditional' group approaches. Instead, individual support should be a key and sustained part of any future service provision for young men.



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# Chapter One

## INTRODUCTION



## CHAPTER ONE: Introduction

This service evaluation was commissioned by East Sussex Downs and Weald Primary Care Trust (PCT). The report sets out the findings of three discrete but inter-related evaluations of three services for young people in East Sussex: 1) Nurse-led sexual health provision in schools and colleges; 2) Pulse Innov8, and the; 3) Young Men's Health Worker Service.

### 1.1 Background

In 2008 Hastings and Rother PCT commissioned East Sussex County Council Children's Services to deliver a range of targeted interventions aimed at disadvantaged young people in Hastings and Rother. The aim of the funding was to reduce health inequalities and provide early interventions to support young people through adolescence and early adulthood, with health outcomes to be aligned with the Choosing Health outcomes (DoH, 2004). Three of the targeted interventions implemented by East Sussex Children's Services included a nurse-led sexual health service within schools and further education (FE) settings, the provision of Pulse Innov8 services; and a young men's health worker service. These respective services are outlined briefly below:

#### *Nurse-led Sexual Health Provision*

In 2009 as part of East Sussex County Council and PCT's plan to reduce unintended teenage pregnancies, two nurses specialised in sexual health were commissioned to provide a level one sexual health service within school and FE (schools and colleges) settings. A level one service may provide services such as sexually transmitted infections (STI) testing for women as necessary and non-invasive testing for men, contraception advice and provision, for example. In addition, the specialist nurses were required to provide a range of contraceptive choices including long acting reversible contraception (LARC). Operational for two years until March 2011, the nurse-led provision was also intended to raise awareness of existing local community sexual health services alongside empowering young people to make informed decisions regarding their sexual health.

Whilst operational, the staff of the nurse-led provision worked in partnership with a variety of other agencies (such as Connexions, CAMHS [*Child and Adolescent Mental Health Services*], and youth services for example) in order to provide young people with a more holistic service that could address wide-ranging issues such as sexual health, emotional and psychological well-being, and career choices. Addressing such issues ensures a more comprehensive service addressing all the risk factors associated with teenage pregnancy. Local and national knowledge has highlighted that low self-esteem, low aspirations, and poor emotional health are risk factors for Teenage Conceptions and are all inter-dependant and linked.

The nurse-led sexual health service provided 14 drop-ins per week across eight schools and colleges (FE and sixth form) in East Sussex. These services were set up in consultation with young people, and the location of the drop-ins were targeted at sites corresponding to high teenage conception areas.

#### *Pulse Innov8*

The Pulse Project was established in 2009 to help young people to make healthier choices. Bringing together a wide range of voluntary and statutory partners, Pulse worked together to improve health outcomes for young people aged 16 to 25 in Hastings & St Leonards.

Pulse Innov8 is part of a joint commissioning arrangement between Hastings and Rother PCT and East Sussex County Council and sits within a youth service which engages with young



people in Hastings and Rother who are not currently aware of Pulse services. Pulse Innov8 deliver a broad range of information support and advice services to young people, particularly targeting those most 'at risk' of social disadvantage. Delivery models include innovative campaign and outreach work through schools, colleges, youth settings (as examples) on a range of issues which might affect young people (e.g. alcohol and substance misuse, safer sex, improving physical health etc.). In addition, Pulse Innov8 also offer one-to-one consultations, to support young people back into early intervention health services. More recently, Pulse Innov8 have used 'Facebook' to promote their services, as a discussion forum including for those young people whom may not wish to meet face-to-face

### *Young Men's Health Worker Service (YMHWS)*

The Young Men's Health Worker Service was established in April 2009 sitting within the East Sussex Crime Reduction Initiative (CRI) Young People's Service which is responsible for post-16 Connexions work across the county. Funded for two years until April 2011 by Hastings and Rother PCT, the YMHWS role developed due to a realisation by the local teenage pregnancy action group that young men (particularly those experiencing disadvantage) were not engaging with health services, leading to poor choices and lower aspirations.

Working collaboratively within Hastings and Rother as part of the Pulse partnership, the YMHWS thus aimed to engage with disadvantaged young men (aged between 16-25 years) with diverse needs including those experiencing social exclusion; were N.E.E.T. (Not in Education, Employment, or Training); young fathers; those in contact with the Youth Offending Team; those moving on from care, and; those with special educational needs. In doing so, the service aimed to improve health outcomes for vulnerable young men by supporting them in accessing education, employment and training, providing informal education relating to health issues (e.g. diet, substance misuse, physical activity, sexual health etc.), emotional well-being, parenting, and relationships, and any other issues that are related to promoting health awareness and healthier lifestyles.

Services were provided to young men by one male worker via one-to-one and group approaches utilising interventional methods that are 'young person friendly'. For example, techniques used when working with young men included structure planning techniques; exercise and fitness plans; anger management; sexual health education; motivational Interviewing; coaching techniques; resilience therapy, and; brief solution focused therapy. An additional service delivered by the YMHWS was to provide information, signposting and training for a range of agencies and professionals working with young people.

## **1.2 Evaluation objectives**

Three inter-related evaluations thus form the focus of this report, and address the following five objectives/questions:

1. To describe the number and characteristics of young people using the nurse-led sexual health provision, the YMHWS, and Pulse Innov8 services;
2. To describe the types and number of services being accessed;
3. To measure the number of young people who go on to access external services following a consultation with the nurse-led sexual health provision, young men's health worker and Pulse Innov8, and to describe the external services used;



4. To describe the impact of:
  - The nurse-led sexual health provision had on reducing unintended pregnancies and sexually transmitted infection (STIs) in young people aged 16-25 years across East Sussex;
  - The Young Men's Health Worker Service on increasing the uptake of health services amongst the most disadvantaged or at risk young men;
  - Pulse Innov8 on young people's health behaviours and earlier engagement with health services.
5. To describe any added value of the respective services over and above services already offered to young people in East Sussex.

### 1.3 Overview of the report

This report is divided into five chapters.

This first chapter provides an overview of the context within which the service evaluations were conducted, including details of the evaluation aims and objectives.

*Chapter Two* presents an overview of the methodology for the primary data collection including details of the design, sampling strategy, qualitative methods and procedures, as well as issues around data analysis and ethical considerations. Brief details are also provided regarding analysis of the secondary monitoring data.

*Chapter Three* presents the findings from the interviews with staff of the nurse-led sexual health provision in schools and colleges, and the focus group discussions with young service users. A secondary analysis of the monitoring data provided by the PCT is also provided.

*Chapter Four* presents the findings from the interviews with staff of the Pulse Innov8 service for young people, and from the focus group discussions (and one individual interview) with young people who used the Pulse Innov8 services. A secondary analysis of the monitoring data provided by the PCT is also provided.

*Chapter Five* presents the findings from the interview with the Young Men's Health Worker, and from the focus group discussion and individual interviews with young men who used the Young Men's Health Worker Service. A secondary analysis of the monitoring data provided by the PCT to the evaluators is also provided.

# Chapter Two

METHODS

AND ETHICAL APPROVAL



## CHAPTER TWO: Methods and Ethical Approval

This evaluation comprised two methodological aspects: 1) qualitative primary data collection with staff and users (young people) of the three inter-related services, and; 2) analyses of secondary monitoring data provided to the evaluators for inclusion by the commissioning PCT.

### 2.1 Design

This report presents the detailed findings of a summative evaluation of three inter-related services for young people within East Sussex. It focuses particularly on areas such as efficacy and programme impacts (short-term) and/or where possible (longer-term) outcomes; that is whether the respective services achieved what they were designed to do, for whom, and under what circumstances. However, in contrast to some interventions or actions which have a control or comparison group not receiving services, the evaluation of this initiative has been unable to comment directly on the degree of progress made by young people relative to what may have occurred in the absence of the three services. However, it does seek to triangulate experiences by comparing the young people's accounts of their experiences of service provision with the views of others including project workers, and secondary (monitoring) data.

#### *Qualitative primary data collection*

Focus groups can be particularly useful for eliciting the kinds of data that are valuable in the evaluation of services. For example, participating in a focus group for some young people can be less 'threatening' than taking part in an individual interview; this is in part due to the existence of other peers helping to lessen any power differential between the facilitator and the participants. Moreover, young people often report that they enjoy focus group discussions as they provide an opportunity to hear the voices of others and to confirm (or not) their own beliefs about a particular issue. However, in recognition that some young people may wish to participate in the evaluation process, but are not happy to take part in a focus group discussion, individual interviews (face-to-face or by telephone) were also offered to all young people as an alternative way of being involved in the evaluation.

#### *Quantitative secondary analysis*

In terms of the quantitative elements, no data generation was required to be conducted by the evaluators. Instead, quantitative data has been derived from questionnaires already completed (and administered by the services themselves), and quarterly routine monitoring and referral data collected by the respective services for analyses by the evaluators. This data enables a degree of corroboration between the quantitative data and the qualitative data from the individual and focus group interviews. In doing so, the combined data can provide a more elaborate analysis providing a greater degree of detail than a single method alone.

### 2.2 Participants and recruitment

Purposive sampling was used for the service evaluation; meaning that the evaluation team selected purposively people to participate in the study based on variables designed to be representative of the relevant population. In total, 32 young service users and 14 staff delivering the respective services participated in the evaluation through a series of focus group discussions and in-depth individual interviews (see summary Table 1 below).

Table 1. Summary of evaluation participants

| Service Evaluated                 | Young (16-25yrs)Service Users<br>(N=32) | Staff Delivering<br>Services<br>(N=14) | Totals    |
|-----------------------------------|---|--|-----------|
| Nurse-led Sexual Health Provision | 10                                      | 8                                      | 18        |
| Pulse Innov8                      | 11                                      | 5                                      | 16        |
| Young Men's Health Worker Service | 11                                      | 1                                      | 12        |
| <b>Totals (N)</b>                 | <b>32</b>                               | <b>14</b>                              | <b>46</b> |

Further details of participants and how they were recruited are provided below.

### 2.2.1 Individual interviews with staff

A total of 14 individual semi-structured interviews (face to face or telephone) were carried out between March and June 2011, with staff involved in the delivery of the nurse-led sexual health service from five college sites (n=8), Pulse Innov8 core staff (n=5), and the young men's health worker (n=1). All interviews lasted approximately 45-60 minutes.

#### *Nurse-led sexual health service*

Eight in-depth individual interviews were conducted with staff delivering the nurse-led sexual health service during March-May 2011. Each interview lasted between 45-60 minutes and was conducted in one of the five (of eight) sites where the service was delivered including Plumpton College, Lewes College, Ringmer College, Bexhill College, and Hailsham College. Participants represented a variety of roles including specialised sexual health and outreach nurses, student and residential services, Connexions, student welfare, extended services, and an Every Child Matters manager.

As the contact details of the nurse-led sexual health service staff were not publically available, in order not to breach data protection recruitment was assisted by the respective college administrator(s) in collaboration with the commissioning PCT. In terms of the former, administrators were asked to send emails on behalf of the evaluators to each of the potential (staff) participants asking whether they were interested to participate in the evaluation. If so, at this point further information about the evaluation was then sent to the relevant staff and the evaluators details provided. All potential interviewees were advised that they should contact the evaluators for more information about the evaluation and to register their interest in participating (i.e. in an interview by telephone or face to face). In some cases, snowballing was additionally used whereby participants recommended others to be interviewed (largely college based staff) and, on occasions, were instrumental in assisting the evaluators to make arrangements for times and venues. The interviews for staff of the nurse-led service sexual health service focused on a number of topics including the context within which the service was provided; actual services delivered; factors affecting uptake and impact; benefits and impacts of the service for young people; as well as the future impacts of the service closure.<sup>1</sup>

It should be noted that the context to the data collection for the nurse-led sexual health service was unusual. Following the commissioning of the evaluation and post-ethical approval for the work to commence in early March 2011, the nurse-led service was closed on 31<sup>st</sup> March 2011. As the closure was not known to the authors at time of commissioning, it was therefore not taken into consideration during the initial planning stages of the service evaluation. In practical terms, this meant that the data collection for the nurse-led provision had to be conducted much quicker than was originally planned. Moreover, all staff delivering the service were aware of

<sup>1</sup> For brevity, details of the interview and focus group schedules, recruitment posters, participant information sheets and consent forms are not included here but can be found in the interim report (see Sherriff, Hall, and Coleman, 2011) or by contacting the authors directly.



the planned closure at the time of their interview which may have shaped their discourses as they were talking about services they knew were being (or had been) cut.

#### *Pulse Innov8 staff and the Young Men's Health Worker (YMHW)*

A total of five in-depth individual interviews were conducted with the staff involved in delivering the Pulse Innov8 services during May and June 2011, and one in-depth individual interview with the (sole) YMHW. In terms of the former, three staff (at time of interview) were the core health promoters working within the Pulse Innov8 service. The remaining two staff members were the manager for Pulse Innov8, and the Pulse Innov8 administrator.

Each interview was face-to-face, lasted between 45-80 minutes, and was conducted at the Targeted Youth Support Hub in Hastings for Pulse Innov8 staff, and for the YMHW, at the offices of a charity based in Brighton. As Pulse Innov8 staff and the YMHW contact details were publically available, potential participants were emailed directly by the evaluators asking whether they were interested to participate in the service evaluation. At this point, further information about the evaluation was sent to each of them (PIS) and the evaluators details provided. Potential participants were advised that they should contact the evaluators for more information and to register their interest in participating.

Similarly to staff of the nurse-led provision, interviews for Pulse Innov8 staff and the young men's health worker focused primarily on areas such as the context within which the respective services were provided/located; actual services delivered; factors affecting uptake and impact; benefits and impacts of the service for young people; as well as the future impacts of the service closure.

### **2.2.2 Focus group discussions/individual interviews with young people**

A total of 32 young people participated in either focus groups (n=24) or individual interviews (face to face and/or by telephone; n=8) across the three services being evaluated between March and June 2011.

#### *Nurse-led sexual health provision*

Two focus group discussions (n=10; five per group with equal gender weighting) were conducted with young service users. All participants were White British and aged between 17-19 years old. Groups lasted approximately 45-60 minutes and were conducted at Plumpton and Lewes Colleges during March 2011. In the first instance, staff delivering the service provided young people whom had accessed the service previously with a PIS and a recruitment flyer/poster. Any interested participants were then advised that they should contact the evaluators for more information about the evaluation and to register their interest in participating. The overall aim of the focus groups was to explore young people's opinions and impact of the nurse-led sexual health provision on increasing the likelihood of safer sex, and thus reducing the potential for unintended pregnancy and STI.

It was originally hoped to conduct a total of three focus groups, however, despite numerous and varied attempts there was considerable difficulty in recruiting sufficient numbers of young people to form the focus groups. It had been suggested that school-age young people (under 16 years) could make a contribution to the evaluation within a focus group. However, this was not possible due to additional ethical considerations which apply to this age group. Inclusion of under 16s in the evaluation would have required a full ethical application re-submission; this was not possible given the already tight timescales of the work. However, a third group was arranged at Ringer Community College during April 2011, but unfortunately no young people attended on the day. Further attempts were made to re-arrange a group (this time at Bexhill College), but this was declined by the college due to pressing student exam arrangements.

Consequently, following consultation with the PCT, and given the depth and quality of data already generated through the previous two focus groups, it was decided not to pursue a third group any further.

As noted previously, knowledge about the imminent closure of the sexual health service may have impacted on service users narratives given all were aware of the closure at the time the focus groups were conducted (late March, 2011). It is also likely that knowledge of the closure contributed to the difficulties experienced by the evaluation team in recruiting young people to take part.

### *Pulse Innov8*

A total of two focus group discussions (n=10; five per group, eight female, two male) were conducted during May and June 2011, with young people who had accessed the Pulse Innov8 services. All participants were White British and aged between 18 and 25 years old. Both groups lasted approximately 45-60 minutes and were conducted at the Targeted Youth Support Hub in Hastings. One individual interview was conducted with a female service user immediately following the first focus group (May, 2011) and in the same venue.

Staff delivering the Pulse Innov8 services provided young people with PISs and recruitment flyer/posters. Interested participants were then advised that they should contact the evaluators for more information about the evaluation and to register their interest in participating (i.e. in an interview, by phone or face to face). The overall aim of these focus groups was to explore young people's perspectives and the impact of the range of Pulse Innov8 services (e.g. on knowledge, behaviour, self-reported confidence etc.). Similar to the nurse-led service, up to three groups were originally planned to be conducted but for one of the arranged focus groups, none of the young people whom had signed up to the focus group turned up on the day. A further focus group and/or individual interviews were sought but could not be arranged. One individual interview was carried out (see above) but, despite best efforts from Pulse Innov8 staff, no other interviews or focus groups could be arranged. This may be as a result of decreased levels of staffing and thus the staff's capacity to engage with more potential participants.

### *YMHWS*

One focus group discussion (n=4) was conducted during March 2011 with young men who had accessed the YMHWS. The group lasted approximately one hour and was conducted in the CRI offices in Hastings. In addition, one face-to-face individual interview was conducted with a service user immediately following the focus group in the same venue. Although it was originally hoped to conduct a total of three focus groups (circa n=15), in consultation with the YMHWS, it was agreed that telephone interviews for some young men may be more appropriate. Consequently, a further six individual interviews were conducted by telephone during April 2011. All individual interviews lasted approximately 30-40 minutes. All interviewees (focus group and interviews) were male, White British, and aged between 16-25 years.

In terms of recruitment, the YMHWS provided young men whom had accessed the service previously with a PIS and a recruitment flyer/poster. Any interested participants were then advised that they should contact the evaluators for more information about the evaluation and to register their interest in participating. The overall aim of the focus group and interviews were to explore young men's experiences of using the YMHWS as well as the impact of the service (e.g. on knowledge, behaviour, self-reported confidence and so on).

As with the nurse-led provision, the announcement of the closure of the YMHWS during mid-March 2011 was not known by the evaluators at the time of project planning. Consequently,

following ethical approval in early March 2011, data collection had to be conducted quickly before the end of service on the 21<sup>st</sup> April 2011. Young men were aware of the closure at the time of their participation in the evaluation; again meaning that their narratives may have been influenced as they were talking about a service that they knew was being cut. Furthermore, a number of young men agreed to participate in the telephone interviews but they unfortunately did not keep their appointments despite several follow-ups from the evaluators and the YMHW. Once the YMHW had formally left his post, further recruitment was not possible.

## 2.3 Data analysis

### *Qualitative data analysis*

All participants (young people and service staff) agreed to the digital recording of their discussions. Data from the interview and focus group discussions were transcribed verbatim by agencies external to the evaluation team. All data were analysed thematically by the evaluation team. Analysis of the qualitative data focused upon the generation and emergence of common themes and explanations derived from the transcripts. In the first instance, the interview data were inspected through iterative listening and reading to ensure that there had been accurate transfer of information between the digital audio tracks and transcription. This is a useful exercise as it facilitated familiarity with the data and allows the beginnings of an interpretative process. In doing so, a preliminary coding structure was devised as emerging themes are identified within and across the focus group discussions and interviews. Development of the final thematic categories were then informed and guided by the evaluation's key questions, and also grounded from the data itself i.e. whereby patterns, themes, and categories of analysis emerge out of the data (Patton, 1990; see also Dey, 1993). The following conventions were used for the transcription of the interview data: [ ], background information or any contextual note; "", direct quotation; ?? inaudible responses; [...], text extract from the same interview, or extract from a different interview to follow.

### *Quantitative data analysis*

Basic descriptive quantitative analysis was conducted on the data provided by the PCT for each of the services. Illustrative charts and graphs were used where this served to increase understanding of the analyses.

### *Limitations of the secondary data*

As stated in the interim report of this evaluation (Sherriff *et al.*, 2011), it is important to note the limitations in terms of the quantitative data provided with respect to answering fully the original evaluation questions. For example, in terms of the nurse-led provision, Objective 4 was: "To describe the impact of the nurse-led sexual health provision on reducing unintended pregnancies and sexually transmitted infection (STIs) in young people aged 16-25 years across East Sussex". However, in order to address this question fully, appropriate baseline data would needed to have been collected at the start of the provision, with comparable data collected at the end of the provision. Without this data, it is impossible to ascertain the actual impact of the service on reducing unintended pregnancies and STIs in young people. Local or county-wide data from these two time points would not be sufficient to answer this question either as it would not be possible to trace any particular intervention as causal pathways are complex and any link found is likely to be spurious. In addition, there were inconsistent reporting measures of service uptake across the services in terms of referral and impact and no allowances were made for controlling other influences (including services) on service uptake for example. Despite this, it has still been possible to draw tentative conclusions about the *likely* impact of this service provision on reducing unintended pregnancies and STIs in young people aged 16-25 across east Sussex. This has been possible by triangulating the

data with the views of service users and staff to provide useful insights into what appears to be working, why and under what circumstances.

A further limitation of the data set provided concerned Objective 3 “To measure the number of young people who go on to access external services following a consultation with the nurse-led sexual health provision, young men’s health worker and Pulse Innov8, and to describe the external services used”. Across all three services evaluated, no data are collected systematically that records the uptake of external services following consultations, beyond patchy informal feedback to practitioners on an ad-hoc basis. Consequently, it has *not* been possible in this evaluation to address this objective fully. In some cases (e.g. the YMHWS), it has been possible to report the numbers of referrals and to which external services (see Table 6), but it has not been possible to determine the actual uptake of these services by young people due to no data being available.

## 2.4 Ethical approval

Ethical approval for the evaluation was received from the University of Brighton’s Faculty of Health and Social Science Research and Ethical Governance Committee (FREGC). Further details of this procedure can be found in the interim report (see Sherriff *et al.*, 2011).



# Chapter Three

NURSE-LED

SEXUAL HEALTH PROVISION

IN SCHOOLS AND COLLEGES



## CHAPTER THREE: Nurse-led Sexual Health Provision in Schools and Colleges

### 3.1 Introduction

This chapter presents findings from the evaluation of the nurse-led sexual health provision. These findings are based on: 1) in-depth interviews with specialised sexual health nurses and other professionals (n=8) who were either providing, or referring, students to the sexual health services in schools/colleges; 2) focus group discussions with young people who had all used the drop-in service in their respective schools/colleges (n=10), and; 3) secondary analysis of monitoring data provided by the PCT to the evaluators.

### 3.2 Nurses and other professionals with knowledge and experience of the drop-in sexual health services in schools and colleges

The aim of the interviews with professionals<sup>2</sup> was to explore the impact of the nurse-led provision on reducing unintended pregnancies and STIs in young people aged 16-25 years across East Sussex (Objectives 2 and 4). In assessing the impact, any added value of the service over and above sexual health services already offered to young people in East Sussex, was also explored (Objective 5). The findings are structured into five themes:

1. Service context
2. Services provided
3. Factors affecting uptake and extent of potential impact
4. Service benefits
5. Service impact on young people

#### 1) Theme One - Service context

Across East Sussex, sexual health drop-in services for young people were provided at eight separate colleges including Sussex Downs College Eastbourne Vocational College (EVoC), Park College (Eastbourne and Lewes), Plumpton Agricultural College, Ringmer Community College and Sixth Form, Causeway School, Uckfield Community Technology College, and Hailsham Community College. The majority of services in these institutions were set-up from new, and created within the last two years. However, professionals reported that the actual start-up of provision to young people had been delayed due to staff training needs, and that there was a real sense that the drop-ins had been closed before achieving their true potential:

*“When [a colleague] and I came into post we weren’t qualified... so we weren’t able to do quite a lot of the work... slowing up the initial start of the service.” (Nurse 1)*

*“We were told two weeks ago [about service closure] which has come as a massive shock, particularly because we haven’t had the opportunity to set them up properly.” (Nurse 1)*

Once the services had become established, the process of engaging young people was slow followed by increased demand although, by the very nature of a drop-in, this demand was unpredictable:

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<sup>2</sup> The term ‘professionals’ includes all those interviewed. The term ‘nurses’ refers specifically to the two professionals who worked exclusively in the colleges, and ‘additional professionals’ refers to the remaining six people interviewed who were largely college-based staff.

*“There was a clear need from the young people and a clear need to have it in school time - it’s started off very very slow and then poor [a nurse] became inundated...”  
(Professional 5)*

## **2) Theme Two - Services provided (Objective 2)**

As the nursing staff were often working in tandem with college support staff in providing sexual health services, it is important to note the differences in their capabilities to deliver such services. In general, the additional professionals (not the nurses) were able to provide condoms and pregnancy testing, occasional Chlamydia postage testing, but were not qualified to prescribe pills or provide specialist advice. However, they viewed their roles as complementary with the nurses. For instance, professionals saw themselves as being influential in encouraging people to see the nurses for specialist advice, while also allowing themselves to focus on their remaining part of their job role (not sexual health):

*“Nurses provide a medical based service that only they can deliver. The rest of the week I provide condom distribution and pregnancy testing, Chlamydia self-screening packs. We’ve complemented the service by ensuring that the nurses are used for what they need to be used for - the medical stuff.” (Professional 4)*

In addition to specialist support, the primary activity of the drop-ins was reported as providing condoms to young people to a fairly even mixture of boys and girls (see Section 3.4 on quantitative data). However, condoms and other contraception were provided in the context of further information and discussion, which the nurses viewed as an important ‘added-value’ (Objective 5) to the service:

*“A lot is... talking about sexual health as a ‘you’ve come here because you want to go on the pill to stop you being pregnant’. But we have to talk about STIs too. Some are having sex with lots of different people... so it’s not just about not getting pregnant, but not getting STIs, self-esteem, and needing support.” (Nurse 2)*

Finally, the drop-ins also made occasional referrals (Objective 3) to other services when required, although the actual number was reported as not being recorded:

*“We provided referrals for other long term contraception, implants, coils, emergency coils. Pregnancy testing and subsequent decision support if necessary or referrals or GP or midwife referrals.” (Professional 6)*

## **3) Theme Three - Factors affecting uptake and extent of potential impact (Objectives 2, 4-5)**

A key feature of the interviews were reflections on the unique nature of the drop-in services (Objective 2). On the one hand this supports the ‘added-value’ (Objective 5) of the service although, on the other can also identify factors that may potentially have limited the impact (Objective 4). Either way, these factors are likely to be of interest if sexual health services in the future were to be established in similar settings.

### Service room location

Within a college setting, the room location was viewed as critically important. However, this was one of the rare examples of where inconsistent views arose both here with the professionals and also, as to be seen, with the young people (see Section 3.3). Some professionals viewed the best location as an accessible room with a ‘visible’ presence:



*"We were put into a room that was right by the main reception, so being in the right location is key. We moved about six months ago... to a room next to their common room which is perfect because they're always in there... sitting right in the room next to them. So it's a reminder, just nip in and have a pregnancy test or whatever, so that was great." (Nurse 1)*

However, others felt that a more private room where attendance was not so obvious may be more attractive to young people:

*"Having it [the service] based where you can come into a room and there is nothing else there - they don't have to walk through somewhere else to go to the service, has been really good because it will mean that nobody knows particularly that they've actually used that service, which is how young people want it to be." (Professional 4)*

More specific benefits of the room included the ease at taking further tests, such as for STIs:

*"It's handy [at] Plumpton because there's another door in the room so the girls can nip to the toilet if they want to do a wee test. It's a different door so they don't have to go back down. It's set up quite nicely." (Nurse 1)*

Also, in relation to the quote earlier regarding complementary roles of staff, a service location close to other services in the school was seen as beneficial:

*"From this September I've had a room in the library. There's a mezzanine in there - but the counsellor's up there, the school nurse is up there, the Connexions worker goes up there so there are other professionals up there at the same time that I'm there." (Nurse 2)*

### Marketing the service

One of the major factors affecting the service uptake was the time available to market the service to students. With colleges bringing a new cohort of students every year, the continual marketing of the services was viewed as essential:

*"There's no point in sitting in a room and expecting people to come to you. The trouble with the age group we're working with, is it's a rolling programme, you can't sit back on your laurels... we haven't had time to do [marketing] this year." (Nurse 2)*

The extent of marketing the service was acknowledged as one of the primary factors affecting service uptake and ultimately its impact. For instance, professionals reported that a reduction in staffing (nurses) had restricted the time for marketing. This was viewed as being instrumental in affecting service uptake in a number of sites:

*"Because [a colleague] left, we picked up Plumpton, Ringmer and Lewes off her... It's not increased our hours it's increased the amount of clinics that we do. It's had an impact on the amount we can market which has had a massive impact on the numbers." (Nurse 1)*

Reductions in staffing also impacted on the time available to discuss issues (marketing and other) with the complementary staff which was particularly missed by one professional:

*"She [former nurse] could go over to the sixth form because she had more flexibility in that time. I have found recently with the nurses it's been very much they come in, run the drop-in and leave. I've missed the contact with that person because it*



*makes it easier to share responsibility, but it's also meant that we've not had the opportunity to discuss things..." (Professional 4)*

### Pastoral staff and whole school support

Professionals reported that the pastoral role of some staff in the colleges (Plumpton, Lewis and Ringmer) was a further factor in affecting the service uptake in that they were able to direct young people to the drop-in services. To illustrate, one nurse provided two contrasting examples of where this support had been influential (in a positive and negative way)

*[Positive] "We put a few posters up but it's not been that important at Plumpton because the pastoral lady is there all day so she's developed a long reaching role over the years. She gives out condoms and will often say, 'you need to go and see the guys' and she'll remind them. So she's a key figure for us there." (Nurse 1)*

*[Negative] "We don't have that key person there. There are about three thousand students on both those sites so you would think just by numbers alone that we would attract enough... I've had meetings with personal tutors. So they lead young people in sometimes, bring them in, but because that key person isn't there, they don't come." (Nurse 1)*

Similarly to pastoral staff, having 'whole school support' was also seen as critical in terms of service uptake, for example with senior staff acknowledging and normalising the provision and use of services:

*"... You've got to have a Head who supports sexual health services. A lot of that groundwork was done before we came into post because that takes years." (Nurse 1)*

*"It is about young people feeling that there's no stigma attached here... it comes from the Principal all the way down, it's like, no this is really important to the well-being and health of our young people." (Professional 5)*

Having 'whole school support' was also seen to affect the service delivery to younger students which is a particular benefit (Objective 5) of the service:

*"... The school are very pro having the service in right from the beginning. A lot of schools put barriers down, saying 'I only want Year 11', whereas Hailsham was, no, 'I want the whole school to know that you're in', so we went into the assembly, we talked to whole school assemblies right from Year 7." (Nurse 2)*

### Consistency of seeing the same nurse

Viewing the same nurse every week was a feature that was considered important by professional staff in terms of impacting on service uptake. However, influenced by the reduction in staffing, such consistency was reported as being difficult to achieve and for some, was viewed as having a negative effect on uptake. The following examples show the difference that seeing the same or different nurse can make:

*[Same Nurse] "... If young people are going to confide in very private things, they want to know that that person isn't just going to go away and they're never going to see them again... Those young people built up a good relationship with [the nurse] and would pop in and see her and just say hello... It's about the person as much as the service" (Professional 5)*

*[Different Nurse] “Consistency is crucial - [Nurse] and [Nurse] are fantastic... However, due to circumstances it’s been inconsistent who’s been coming and young people are turning up not knowing who they’re seeing... that has had an impact on people returning or people choosing to use the service...” (Professional 4)*

#### **4) Theme Four - Service benefits (Objectives 4-5)**

The benefits of the drop-in service start to illustrate the potential ‘impact’ and ‘added-value’ of the services provided (Objectives 4-5). In some instances attention is drawn to the difference between the college drop-in services and other forms of sexual health provision.

##### Importance of early intervention

Both professionals and nurses reported that the sexual health services delivered in schools tended to be better in terms of uptake, compared to those exclusively provided in colleges:

*“The best places are the schools. The school drop-ins do more pill give-outs than anywhere else... I think it’s because we’re starting them on the pill, so they haven’t established themselves anywhere else.” (Nurse 1)*

Such early intervention was perceived as an ‘added-value’ of the service as it presented an opportunity to raise awareness of the existence of the service before young people might need to use it. Moreover, early intervention was reported as allowing for discussions around readiness for sex including correct condom use. Such opportunities are particularly important given the link between early age at first sexual intercourse and future sexual health (Wellings, Nanchahal, Macdowall, McManus, Erens, *et al.*, 2001):

*“Occasionally I get quite young people coming in just to find out what I’m there for... so they get a feel for the fact that a sexual health nurse is in the school, without using the services, but knowing that when they get older they can come.” (Nurse 2)*

*“... even though they weren’t always sexually active they’d still be able to take the condoms away and the lube and the leaflets - and have a chat about what was safe, what was normal, whether or not people were actually having sex, when would be the right time to have sex, what their relationship was like and where they wanted to take it, if they had any issues or felt vulnerable in any way. It was an opportunity to raise all of those issues.” (Professional 6)*

##### More time for the appointment

A perceived benefit of the service was the flexible time allowed for young people to talk freely to the nurses and for the nurses to impart crucial information beyond simply distributing contraception. For example, adequate time allowed for detailed discussions around condom negotiation rather than purely condom provision, as well as discussions around personal responsibility. Again, evidence from the literature suggests that having condoms does not automatically lead to condom use without these additional skills in place (Coleman, 2001; Coleman and Testa, 2007; Sheeran, Abraham, and Orbell, 1999):

*“I wouldn’t issue a condom until I was confident she could put one on herself and we talk about her taking responsibility for that and how to negotiate condom use if she’s got a boy that isn’t keen and why it’s important.” (Nurse 1)*

A further benefit of extra time for appointments was that issues such as anal sex and misconceptions via pornography were also able to be picked up on by the nurses and both discussed and challenged:

*“Sometimes with boys particularly, if it’s the right moment and they’ve said something jokey about porn or anal sex, I’ll often explore that... it’s important to talk to them about condom use but also about negotiation and not to assume girls want to have anal sex... that’s stuff they don’t talk to anybody else about, and that they won’t have thought too much about...” (Nurse 1)*

### More accessible and immediate services

For colleges that were geographically isolated, having a college-based sexual health service was perceived as particularly beneficial given the difficulties young people often face in accessing other (external) services compared to their more urban counterparts (e.g. Sherriff, Hamilton, Wigmore, and Giambrone, in press):

*“Most students live-in [at Plumpton] and there’s not much to do so they drink and have sex - it’s a perfect breeding ground for something like Chlamydia... GP services are quite far away, so there wasn’t any sort of sexual health service near so the college took it [the service] up willingly.” (Nurse 1)*

Linked to accessibility, the immediacy and convenience that drop-in services can provide also emerged as a related benefit of the service. This was perceived as particularly pertinent for younger people (and those in rural areas), particularly given the limited transport facilities open to them. This reinforces the early intervention benefits outlined earlier to school-aged students:

*“They don’t have to think too far ahead to go in... If there’s a journey or they have to wait it’s not going to happen. Whereas this here on the doorstep, it’s now and it’s happening and they can go to it.” (Professional 3)*

These findings regarding the importance of service accessibility resonate with the wider literature around young people and service provision (e.g. Pope and Sherriff, 2008; Sherriff, *et al.*, in press A). Although at the time of writing the nurse-led provision has closed, consideration should still be given to alternative flexible support options for young people particularly for those schools and colleges in more rural areas (e.g. virtual support, access to support on-line, confidential phone service etc.). Having services in the more isolated areas is a clear ‘added-value’ of the services over alternative sexual health provisions (Objective 5).

### Confidentiality

Although confidentiality is well acknowledged as a barrier in the uptake of sexual health services (e.g. Mullinar and Martinez, 2007), in college settings this was perceived as being overcome by the drop-in services. In doing so, this highlights an important ‘added-value’ of the drop-ins in direct relation to other services available (Objective 5). In their interviews, professionals felt that confidentiality had been established through the college-based services by providing a ‘safe’ environment that was less formal than other services (e.g. GP) and facilitated young people to ‘not being seen by others’, and by building up personal relationships with young people:

*“A lot of it is around the relationships that we build up with the young people... it’s a face that they recognise. It’s a much more casual set up... it’s not clinical... which I think that reduces some of the barriers to uptake of services.” (Nurse 2)*

*“... This is where they see the college counsellor, the police officer, the school counsellor, the Connexions IPA, Connexions career, because they’re all here I suppose it’s about feeling safe and trusting and having that confidence.” (Professional 5)*

## 5) Theme Five - Service impacts on young people (Objectives 4)

Interviewees reported that the drop-in services had raised young people's awareness around sexual health through information giving and the opportunity for discussion. However, whilst the nurses and fellow professionals were convinced that the services had impacted on young people in various ways (for example, awareness raising, reductions in unintended pregnancies and STIs; Objective 4), they were also aware of the difficulties in evidencing such claims. Nonetheless, the examples below (although anecdotal) illustrate the likely impact of the service in these areas:

Reduced STIs:

*"We test every three months at Plumpton... and they can pop in and test, so there's an awareness there that definitely wasn't there before [when earlier testing showed higher rates of Chlamydia]." (Nurse 1)*

Reduced unintended pregnancy:

*"For the one pregnancy test, for the one contact that you connect with that gets the advice they need then that's potentially a pregnancy reduced isn't it." (Professional 6)*

Reduced STIs and pregnancy:

*"It is difficult, as every person we saw for a pregnancy test we would also talk about STIs, we'd talk about the reality of pregnancy and discuss contraception. All this is beyond what you would get from buying a pregnancy test in a shop. I'm sure there are many cases where people have come here for pregnancy tests and therefore not become pregnant - but we can't count those people unfortunately." (Professional 6)*

Interviewees' narratives also revealed evidence on impact through case examples. The first example refers to providing people with information to delay their first sexual experience (which has been shown to link to future sexual health):

*"Sometimes you're... having serious conversations with quite young people about readiness for sex. I've had a couple of young people have come in and said, 'I've got a girlfriend or a boyfriend, and we're talking about having sex'. So the conversation there is 'you are very young, there are other things you can do, you don't have to have sex, and why do you feel that it's important for you to have sex?'... and hopefully they're going away thinking, 'actually I'm not ready'." (Nurse 2)*

More specifically in relation to pregnancy, there were a number of cases where professionals felt that the service had helped to prevent pregnancy, for instance through the provision of oral contraception and condoms, and the provision of emergency contraception with a clear illustration of how, without the service, the outcome may have been left to 'chance':

*"We're allowed to give emergency contraception up to 72 hours after unprotected sex - but there is another method of contraception that can be given up to five days. I've had a least two young people that I've referred to for this... which they wouldn't have known about otherwise and would have just been, 'let's just cross our fingers and hope for the best'." (Nurse 2)*



Aside from contraception, professionals also recalled discussions about the future aspirations of young people which is a leading factor in reducing the appeal of becoming pregnant (e.g. Gutman and Akerman, 2008). By recognising the opportunities that people may 'lose' by becoming pregnant can be considered an equally powerful contraception to more traditional methods:

*"I had a young girl with issues around her relationship. The conversation was all around, 'what do you want for your future? Where does this relationship tie in with that? So yes the service is encompassing all of those things" (Nurse 2)*

### 3.3 Young people's experiences of using the sexual health drop-in service in schools and colleges

This section outlines findings from two focus group discussions with young people (N=10) who had all used the drop-in service in their respective school or college. The overall aim of these focus groups was to explore young people's opinions and impact of the nurse-led provision on increasing the likelihood of safer sex, and thus reducing the potential for unintended pregnancy and STIs. This impact (Objective 4) is derived from the perspectives from the young people who used the services. The findings are structured into the following five themes:

1. The service
2. Service benefits
3. General impacts
4. Behavioural impacts
5. Future impact of service closure

#### 1) Theme One – The service

Young people had (perhaps understandably) a good understanding of what the service offered. The main provisions were understood as supplying contraception and related advice and information (around pregnancy, relationships and STIs), as well as referrals to external services:

*"It's everything to do with sexual health isn't it? If you've got any questions just go down... It's information... You can get things like contraception there and pregnancy tests..." (FG2)*

In terms of how they first heard about, or used, the service, most people were referred through the school support staff (supporting the professionals perspective of this role) or by 'word of mouth'. However, it is important to note that not all students were aware of the sexual health services available to them which reinforces the important role of marketing the service as outlined earlier by the sexual health nurses:

*"We spread the word because I'm not particularly embarrassed about it so you just go and tell your mates and it just gets round... Yes people have come to me and said, oh where can I get this, there's a drop in service on a Tuesday, you just drop in any time." (FG2)*

*"One of my friends had to tell them where to go to a clinic and they went with their friend and they had two STIs, but she wouldn't go - and her friend made her and she didn't realise there was one [a clinic] at college either." (FG2)*

As in the previous section, service location was perceived to be important with young people viewing the privacy of the location as critical. Being situated alongside other student-related services made it less obvious what specific service they were using:

*“There’s quite a few things down there so you could be doing anything, there’s the EMA [Educational Maintenance Allowance] thing, and that’s in the same corridor.” (FG2)*

Such comments from young people are particularly interesting because they contrast to the professionals’ perspective that the ‘common room’ location was a preferred option. Whilst such positioning may indeed raise students’ awareness of the service, for young people central locations had implications regarding preferences for privacy. Of all the findings, this one reflected the greatest discrepancy in views from the professionals and young people:

*“The fact that it’s near the common room, the door’s shut, no-one can hear... It’s fine that part, it’s just the going there... It’s like the walk of shame... You come out and it’s like so ‘what are you going in there for?’ and I hold my pills so people know.” (FG1)*

This contradiction in views between young people and professionals delivering the service is important as it arguably has considerable implications both for service uptake and likely impact. For example, in relation to engaging with young fathers, Sherriff (2007) argues that is necessary to consult with young people (e.g. through interviews, discussion groups, or participation) given that many young people tend not to respond readily to services that impose a particular content and/or style of delivery; rather services need to ‘identify the needs of their clients at the outset, and then regularly review them to improve and develop the service’ (Mordaunt, 2005). In other words, adopting youth-work style approaches to service delivery (and service development) that take into account the young person’s agenda (in this case, acknowledging privacy concerns regarding service location), rather than imposing a definition of ‘what works’ at the outset, is likely to be more effective.

## 2) Theme Two - Service benefits (Objectives 1, 4, 5)

The benefits of the drop-in service start to illustrate the potential ‘impact’ and ‘added-value’ of the services provided for young people (Objectives 4-5), and in doing so also link to descriptions of the services (Objective 1).

### Accessible and confidential

When asked about obtaining contraception and advice, several young people cited the benefit of accessibility (the recurring finding of ‘accessibility’ in rural areas was again apparent) as being easy to use, convenient, and confidential:

*“This college [Plumpton – rural location] is different having a sexual drop in compared to other colleges... it’s nice to know they’ve got that service here so that if we went for our contraception you could get it easily or if we did think we had a problem we’d be able to sort it out quicker rather than waiting for a doctor’s appointment.” (FG1)*

*“Because you have to sign this confidential thing that it’s just between you and her, it makes you feel more comfortable talking to her about things.” (FG1)*

### Relaxed atmosphere

A further benefit according to young people was the friendly and relaxed atmosphere of the service. The creation of such an atmosphere should not be underestimated as it appeared to be a key factor in getting young people 'through the door' for their first visit. For example, the quotes below show how fears or nervousness were allayed on their first visit which also demonstrates the importance of the marketing and other factors outlined in the previous sections regarding increasing uptake:

*"It's friendly, it's a relaxed atmosphere and there's no stigma attached to being in there... you're just in college anyway. And people have changed a lot with their perception of it because when you get to come to college you're like it's fine, it's nothing, it's part of the routine really." (FG2)*

*"She's a really nice person as well... you can talk to her about stuff... At first [I felt nervous] but as soon as you get in there and she starts talking, it goes fine because she seems really nice." (FG1)*

### A 'holistic' service

In their narratives, young people reported that the 'holistic' nature of the service was a perceived benefit as they valued information that was often imparted alongside obtaining contraception:

*"They give you leaflets about contraception. I remember when I was going to have my implant we discussed why it was a good choice for me to have that, and different things and why I preferred that, what we thought the pros and cons over all the other different types of contraception were." (FG1)*

Young people also appreciated the general advice about young people's issues alongside information:

*"...if you go to her about something like you want contraception, she'll ask you whether you've got a partner or whether you're just sleeping around that you want it [contraception] just in case." (FG1)*

### Comparisons to GP

Finally young people often made direct comparisons with the nurse-led service to that offered by GPs (Objective 5). For example, convenience of the nurse-led service in terms of being easy and quick to access compared to having to make appointments to see a GP. Moreover, further comparisons were made in reference to the more specialist advice compared to the GPs:

*"I would find going to the GP more embarrassing because the doctor is more for all your life problems, your family - and I don't want to go to him for contraception or a test... With my doctors, it's always a different person every week so you won't get the same person. We've got two nurses [at my GP] and I remember going in there to get my jab and that was the first one, I went to the second one and I thought it was the same person, but it wasn't and she knew everything about me because the other nurse told her which I didn't feel very comfortable about, the fact that she knew I was sleeping with someone... [here] you've got one person knowing and it's only that person." (FG1)*

### 3) Theme Three - General impacts

In terms of the general impacts (Objective 4) of the service, young people frequently mentioned how the service had helped them learn more about sexual health matters. In supporting any behavioural impacts (outlined in Theme Four), participants often spoke about how they learnt new information from the specialist nurses:

*“I didn’t realise you can get Chlamydia in the throat which she told me... I learnt about a wider range of contraception than I knew about before, just going in there and asking for condoms and there’s this way of doing things and this sort of thing that you can get as well, have you thought about this? I didn’t know that existed.” (FG2)*

Further comparisons with the school sex education provision were made to illustrate the learning:

*“It’s really not good for kids to learn about sex education [in school], not because of the age thing, because the things that they give them to learn about is nothing compared to the real world. In Year 6 we had this video and it was these two lovers in bed and they’re having sex and a love heart starts popping out, so you think the first time I have sex there’ll be love hearts popping all over the place! - If you want children to respect sex you want to get in the real world.” (FG1)*

As a result of the increased learning and awareness, this young person noted how she was now more confident about talking about, and dealing with, contraceptive issues:

*“... It’s so much easier because I can talk to my parents now - but that’s because of the nurse’s help because she’s made me feel a bit more confident about the contraception about all of the contraception so it makes life easier for me.” (FG1)*

### 4) Theme Four – Behavioural impacts (Objectives 4-5)

This theme is potentially the most important of all findings given instances of behavioural change were reported and attributed to use of the service (Objectives 4-5). Although some were young people talking quite generally, some also spoke about their personal behaviours:

*I: “Do you think it’s [the nurse-led service] increased people’s use of contraception?  
P: Yes, definitely.” (FG1)*

*“I think it’s [the nurse-led service] made me a bit safer. If you’re worried that you’ve Chlamydia and you’re panicking, then if you get a negative result, then you use some condoms and you’ll be a lot safer after that because you don’t want to go through that all again.” (FG2)*

*I: Do you think it has affected your use of contraception?*

*P: Yes.*

*P: Yes, definitely yes.*

*I: Have you been in situations before where you’ve been a bit more risky?*

*P: Yes.*

*I: Do you think on a personal level that’s affected you in a positive way?*

*P: Yes.*

*P: Knowing that she’s there to help us, it puts your mind at ease. You can go and tell her what happened, it’s not too late, you can still do something about it, and it just kind of goes, ok that’s fine, and then you can relax a bit.” (FG1)*



To illustrate more detailed impacts of behaviour change, there were three case examples in relation to pregnancy reduction. The case for pregnancy prevention is quite clear, presuming effective contraception was prescribed following their visit to the nurse:

*“There’s a couple of girls that I know go in there thinking they might be pregnant, then they’ve gone in there to get advice and they’ve come out, had a pregnancy test, realised they weren’t pregnant, so carry on as normal, but they were, before they went in there they were panicking and they came out and they were happy as Larry.” (FG2)*

*“She went in for some advice, did a pregnancy test, and obviously stressed about her exams... so she went in there and she was pregnant and it was early enough to sort it out with the doctors. If she’d not gone there I don’t know if she would have bothered because it was too late.” (FG2)*

## 5) Theme Five - Future impact of service closure

Young people’s reflections on the planned service closure are speculative and there is no guarantee that the impacts they elicit may arise. Nonetheless, they do illustrate the value that young people attach to the service and are thus presented here. Issues connected to access difficulties were the most immediate response made by participants:

*“If you need them [condoms], you’re going to have to buy them [if the service closes] and it’s £3 quid a box... There’s more stigma going into a shop to buy condoms than there is going into a free drop-in because you have to ask for them over the counter.” (FG2)*

The inability or difficulties to access the sexual health support services were also thought to be integral in reducing the likelihood of obtaining contraception in the future:

*“Everyone knows how dangerous unprotected sex is but at the end of the day if everyone went to Lewes town to go all the way to get some condoms, even if there is one, and they’ve not got a break at the time, it’s not going to happen.” (FG2)*

Thoughts about difficulties accessing contraception led some people to foresee a greater risk of unintended pregnancy and STIs in the future. The first quote illustrates a lowered awareness of the risks:

*“I think less [contraception] would be used... You’d feel less conscious, like ‘oh my God he’s going to make me pregnant’, or ‘oh my God I’m going to get a disease out of this’... We wouldn’t be as aware of contraception protects you.” (FG1)*

*“[If the service closed] A lot more of trouble to get contraception... difficulty to get advice if you had done something wrong... our college used to have a high rate of Chlamydia and I just think it will go back up if we didn’t have the contraception available.” (FG1)*

The final quote illustrates the strength of feeling participants had about the service closure, and how they saw it as an essential component of student support:

*“If there was anything the college could do, is keep that [the nurse-led service] because you’ve got a place where there’s people from lots of different areas, all mixing, it’s that typical college environment, something like sexual health you cannot cut...” (FG2)*

### 3.4 Analysis of monitoring data provided by the PCT

This section outlines findings from secondary monitoring data provided by the PCT to the evaluators. The data are largely quantitative and present detail on how many people used the nurse-led service, some indication of their demographic profile, what they attended for, and what specific services they were offered. In doing so, this data address Objectives 1 and 2 in relation to the nurse-led provision. As noted previously, due to (*inter alia*) no data being available it has not been possible to address Objective 3 (see p.18).

It is also important to note that the quality of data (relating to Objectives 1 and 2) varied considerably without a uniform set of monitoring statistics across the eight sites. This appeared to be because it was left to the particular nurse leading provision at a specific site to decide what data to collect. Moreover, it is also important to note that no data were available from Bexhill and Hastings Colleges, whereas most data were available from Lewes, Ringmer and Plumpton colleges.

For those colleges that did provide data, some (but not all) generated data from the Spring Term 2010 to January 2011 meaning that it is possible to track their levels of service use and provision through a reasonable length of time. Given that the drop-in services in these settings were relatively new, it could be argued that this level of use and provision is broadly representative of their use since set-up.

However, such variability in quality and availability of secondary data impacts on how the data are presented in this section (compared to equivalent sections in Chapters Four and Five) as it was not possible to combine data from all eight colleges and draw conclusions from comparing their levels and types of provision. Consequently, in view of the data available, the findings are presented as follows.

- Combined Spring and Summer Terms (2010) use and provision data for Lewes, Plumpton and Ringmer services;
- Quarter 3 comparable use and provision data across all colleges;

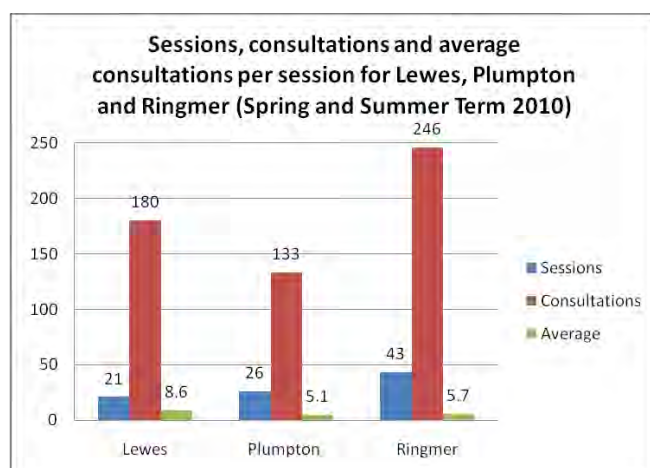
#### 3.4.1 Combined Spring and Summer Terms (2010) use and provision data for Lewes, Plumpton and Ringmer services

Given the largely consistent data provided by these three colleges, it was decided to combine the data for each drop-in across the Spring and Summer Terms (2010). This combined data, per college, can then be compared across the remaining colleges. This comparison must not be assumed to indicate 'demand' or 'success' as the frequency of service provision (as to be seen) varied across the colleges.

##### Sessions and consultations

The three drop-ins in question provided a different number of sessions across this time period (Figure 1). Ringmer provided 43 sessions and a total of 246 consultations. However, the number of sessions was not always positively correlated to the number of consultations – with the number of sessions at Plumpton resulting in fewer consultations, compared to Lewes who had the least number of sessions (but a higher number of consultations). This is reflected in the average number of consultations per session (one possible indication of demand), shown to be greatest among the Lewes service (8.6 people per session).

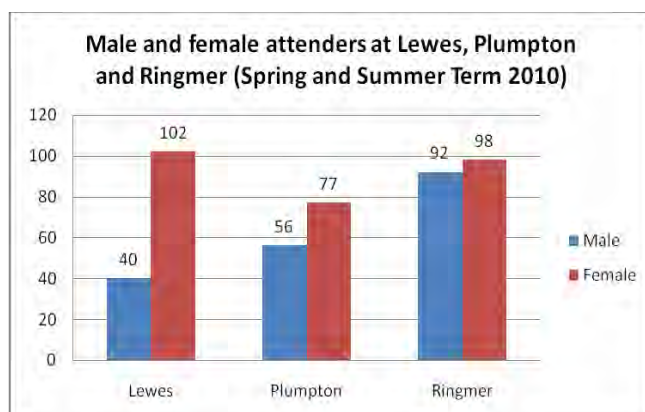
Figure1 - Sessions, consultations and average consultations per session for Lewes, Plumpton and Ringmer (Spring and Summer Term 2010)<sup>3</sup>



### Demographic profile of users

For all three services, a higher proportion of young women attended (Figure 2). This difference was most notable in the Lewes service, and least notable in Ringmer. Such findings link to the broader evidence base which demonstrates that women commonly have higher rates of use of health services than men (e.g. Gomes Nascimento, and Araújo 2007; Wilensky and Cafferata, 1983).

Figure 2 - Male and female attenders at Lewes, Plumpton and Ringmer (Spring and Summer Term 2010)



The services also provided data on the age of service users, although this was only available for the Summer Term 2010. With reference to Figures 4-6 below, Ringmer was attracting a slightly younger age group which was not surprising given that the service was allied to a secondary school (unlike Lewes and Plumpton). Using this data to provide an average age, the respective ages were 17.2 years for both Lewes and Plumpton and 15.7 years for Ringmer. Although this age profile does not provide detail on sexual activity, age alone suggests that a significant proportion of these service users are receiving advice and support at a younger age.

<sup>3</sup> Unless stated, all Figures report numbers or average numbers rather than percentage values.

Figure 3 - Age profile for Lewes (Summer Term, 2010)

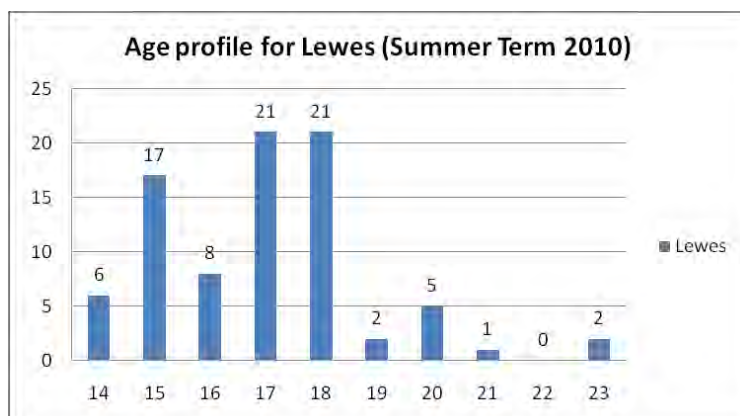


Figure 4 - Age profile for Plumpton (Summer Term, 2010)

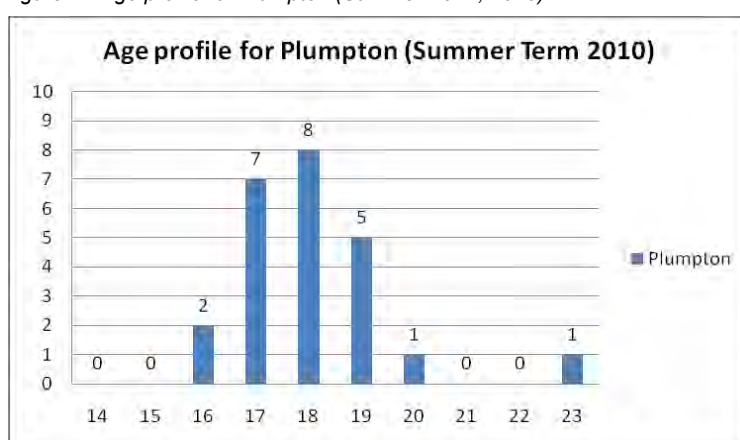
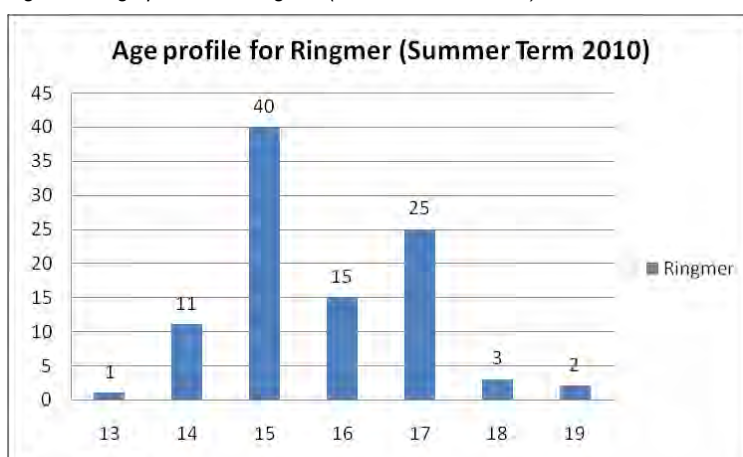


Figure 5 - Age profile for Ringmer (Summer Term, 2010)



### Service provision

Some of the terms used in the service provision monitoring data were inconsistent across the two reporting dates (within the same colleges). For example, there were variations in 'Chlamydia treatments' and 'Chlamydia results', and some made reference to 'referrals' and 'advice/referrals' across the two time points. Nonetheless, Table 2 presents the main types of services provided through the drop-in clinics.



Table 2 – Services (number) provided by Lewes, Plumpton and Ringmer (Spring and Summer Terms 2010)

| Provision                  | (Colleges) |            |                 |
|----------------------------|------------|------------|-----------------|
|                            | Lewes      | Plumpton   | Ringmer         |
| Condoms                    | 121        | 38         | 125             |
| First pill                 | 10         | 6          | 12              |
| Repeat pill                | 17         | 7          | 9               |
| Chlamydia tests            | 49         | 37         | 35              |
| Chlamydia treatment        | 3          | No data    | No data         |
| Pregnancy testing          | 29         | 5          | 12              |
| Emergency contraception    | 6          | 1          | 8               |
| Referrals (LARC, GU, etc.) | 12         | 14         | 39 <sup>4</sup> |
| <b>Totals</b>              | <b>247</b> | <b>108</b> | <b>240</b>      |

This table reflects the findings in the earlier sections in that condom provision was clearly the main reason people attended (or was the service they were most frequently offered). Encouragingly (from a prevention perspective), Chlamydia testing was frequent, as was pregnancy testing and emergency contraception (an indicator of reducing unplanned pregnancy). Importantly, when comparing Table 2 to the earlier data on consultations (Figure 1), it is evident that many of these consultations involve more than one issue (for example, condom and pill provision). To illustrate, from the reported 180 consultations at the Lewes service during the Spring and Summer Terms (Figure 1 [earlier]), 247 services were offered (see Table 2).

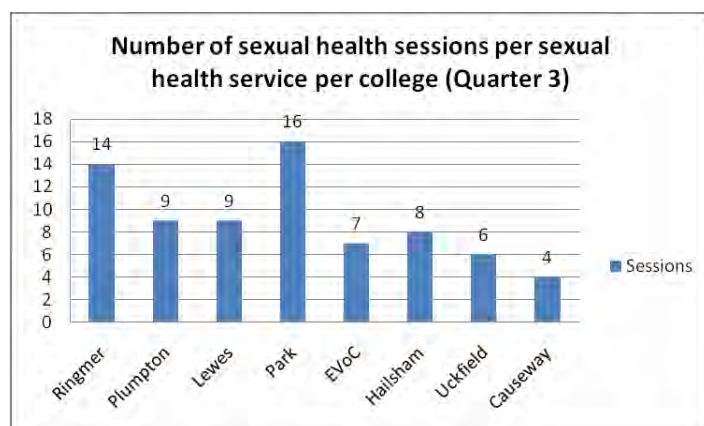
### 3.4.2 Quarter 3 comparable use and provision data across all colleges

Quarter 3 reporting (October-December 2010, and reported on 5th January 2011) was the closest indication of a more efficient and accurate reporting system. Compiled by one person, data for eight different sites were reported thus permitting a more broad comparison across the services. This section reports these variations according to the criteria used above: sessions and consultations, demographic profile of users, and service provision.

#### Sessions and consultations

The greatest number of sessions (Figure 6) for this third quarter was in Park College (16) followed closely by Ringmer (14). For other services, there were between four and nine sessions run.

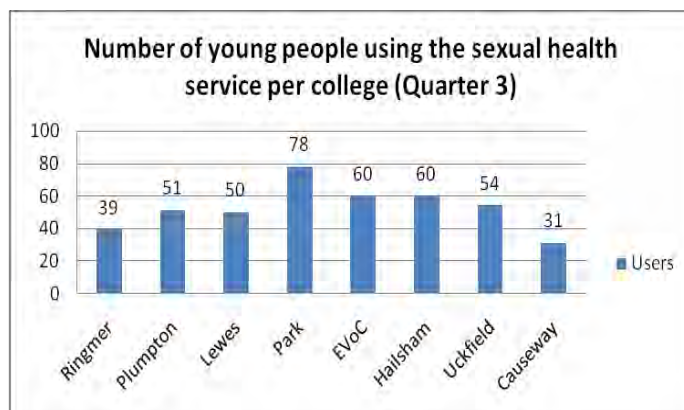
Figure 6 - Number of sexual health sessions per sexual health service per college (Quarter 3)



<sup>4</sup> Advice and referrals were grouped together for Ringmer.

With Park College having the most sessions, it was not surprising to see this college having the greatest number of consultations (78; see Figure 7 below). However, of real interest was the relatively even spread of participants using the other services which did not match the pattern of sessions provided.

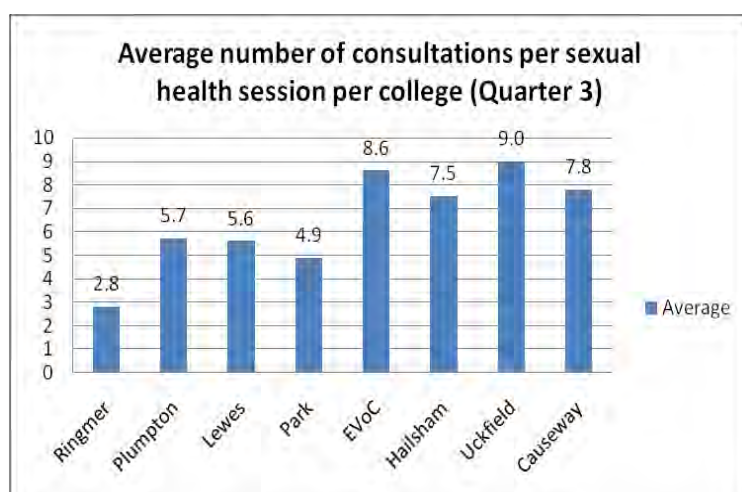
Figure 7 - Number of young people using the sexual health service per college (Quarter 3)



Of additional interest, the data do not permit a comparison with total student numbers per college, which may be a more accurate measure of 'reach'. This is presumably why, although EVoC and Park Colleges show a relatively high number of consultations, the person compiling the Quarter 3 data wrote: *"We would like to see a greater uptake of service at the Sussex Downs Eastbourne campuses but feel that more marketing needs to be done to achieve this. Unfortunately this is not possible currently."* This statement presumably reflects the higher number of students at both these sites.

This disparity of sessions and participants is more clearly evident when presenting the average number of consultation per session (Figure 8). There was quite a range in average numbers, from 2.8 in Ringmer to 9 in Uckfield. Note how these data are not totally consistent with the earlier data for Lewes, Plumpton and Ringmer – this suggests different reporting systems and/or different demand according to time of year. Note also how this average is consistent with the concerns for Park College noted above (4.9 consultations per session).

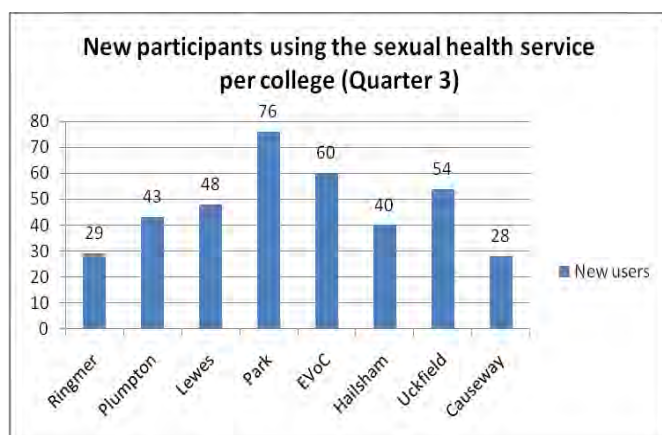
Figure 8 - Average number of consultations per sexual health session per college (Quarter 3)



A further interesting insight to the services is the number of *new* participants (presumably first time users across this third Quarter). This is a good indication of service reach and effectiveness in attracting young people to the service. The following Figure 9 shows all

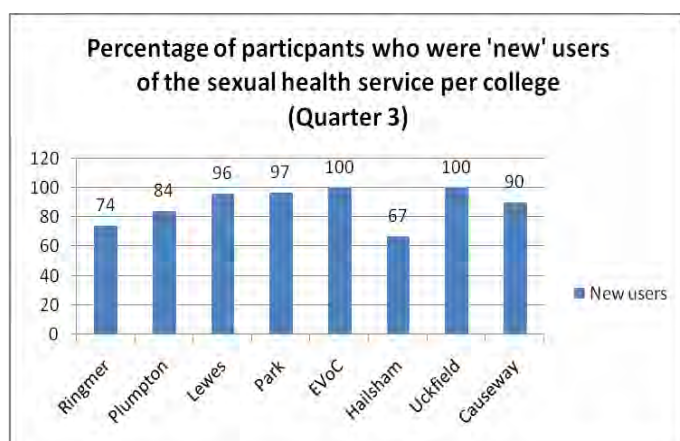
services were attracting a sizeable number of new users, ranging from 28 in Causeway to 76 in Park College.

Figure 9 - New participants using the sexual health service per college (Quarter 3)



Perhaps more significantly, the following Figure 10 shows the proportion of total users for this third quarter who were first time users. Note that Lewes (97%), Park (97%) and EVoC (100%) had attracted exceedingly high proportions of new users to their services.

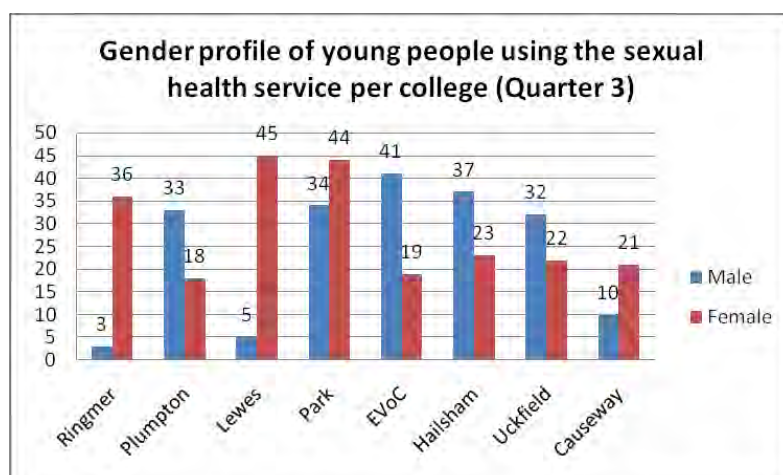
Figure 10 – Percentage of participants who were 'new' users of the sexual health service per college (Quarter 3)



### Demographic profile of users

The gender profile (Figure 11) shows a relatively even pattern of young people using the services although there were considerable variations from college to college. For example, whereas Lewes was attended almost entirely by young women, EVoC showed the highest proportion of male participants. Given that condoms were the main provision sourced, it is clear that these were being obtained by both young men and women.

Figure 11 - Gender profile of young people using the sexual health service per college (Quarter 3)

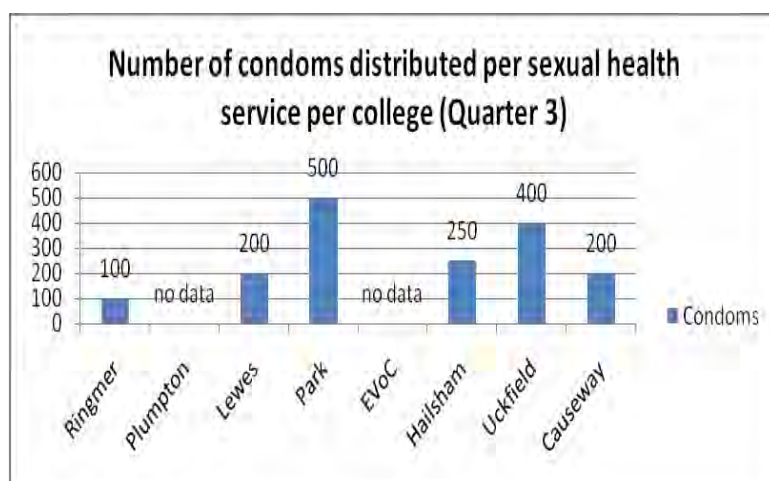


Across the colleges, the main age group was aged 16 to 18 years inclusive (68% of users were of this age). There were some variations, with Ringmer, Hailsham and Causeway the only service reaching those aged 11 to 15 years (given the presence of school pupils). For these three sites, the numbers attending aged 11 to 15 years exceeded those aged 16 and over.

### Service provision

Condom provision dominated the services offered by the drop-in clinics. Although there were areas of missing data, Figure 12 shows the numbers of condoms distributed during this third quarter. Note the high numbers in Park and Uckfield in particular.

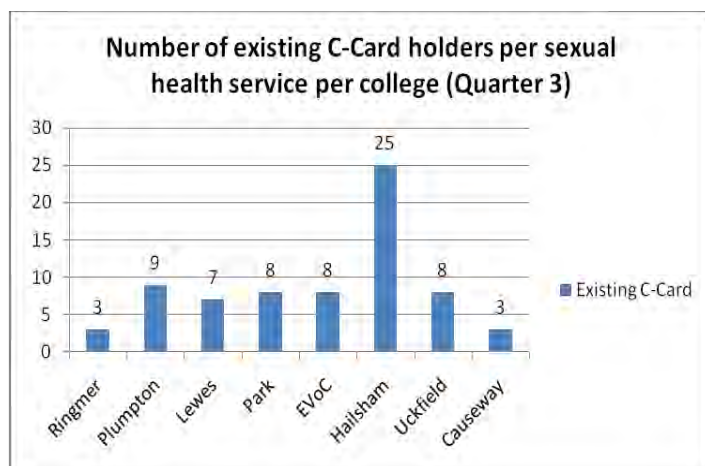
Figure 12 – Number of condoms distributed per sexual health service per college (Quarter 3)



A proportion of these condoms were obtained through the C-Card scheme, which was particularly prominent in Hailsham College especially (Figure 13).

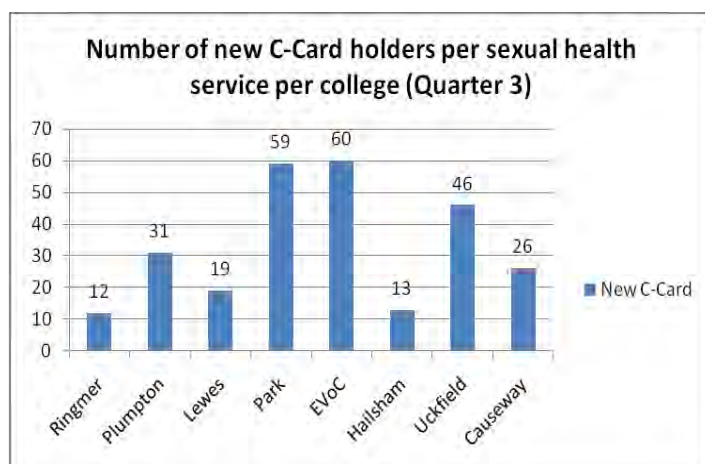


Figure 13 - Number of existing C-Card holders per sexual health service per college (Quarter 3)



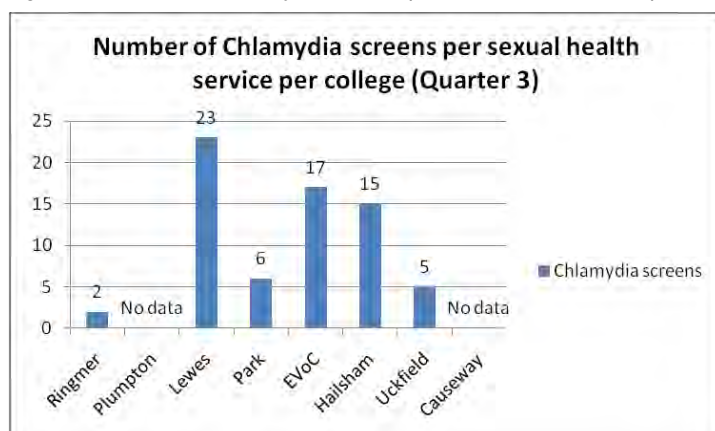
Of interest, Figure 14 shows the development of this scheme across the college network. The numbers of *new* C-Card holders generally exceeded those of existing holders. This was particularly the case in Park, EVoC and Uckfield Colleges.

Figure 14 - Number of new C-Card holders per sexual health service per college (Quarter 3)



Only six colleges provided data on Chlamydia screens, and the numbers were highest for Lewes, EVoC and Hailsham (Figure 15).

Figure 15 - Number of Chlamydia screens per sexual health service per college (Quarter 3)



There was some limited data on pill prescriptions, pregnancy tests and referrals – for Quarter 3, the numbers of all did not exceed 10 for any college.

# Chapter Four

PULSE INNOV8





## CHAPTER FOUR: Pulse Innov8

### 4.1 Introduction

This chapter presents findings from the evaluation of the Pulse Innov8 service. These findings are based on: 1) five face-to-face in-depth interviews with staff delivering Pulse services; 2) focus group discussions with young service users (n=10), and; 3) secondary analysis of monitoring data provided by the PCT to the evaluators.

### 4.2 Perspectives of Pulse Innov8 staff

The aims of the interviews with Pulse Innov8 staff were to explore their perspectives in terms of the impact of the services on young people (Objective 4). In assessing impact, types of services were explored (Objective 2) as well as any added value of the service over and above services already offered to young people in East Sussex (Objective 5). The interviews also enabled some insight into the external services to whom the young people were referred (Objective 3), although lack of available follow up data meant that conclusions could not be drawn as to whether these services were then used by the young people. The findings are structured into the following five themes:

1. Service context
2. Services provided
3. Factors affecting uptake and extent of potential impact
4. Service benefits
5. Service impacts on young people

#### 1) Theme One - Service context (Objective 1)

Pulse Innov8 delivers a broad range of health (promotion) services to young people using a partnership model of working. In doing so, they are able to develop and deliver campaigns and workshops on a variety of issues of relevance to young people, as well as referring and signposting young people to (external) related services where necessary. Innov8 services adopt primarily a young person led outreach model of service delivery in settings frequented by young people (e.g. schools, youth clubs, in the town centre etc.). More recently, social networking media (i.e. Facebook) has additionally been used to complement the delivery of existing services. In their interviews, when asked to reflect on the nature and purpose of their roles with respect to Innov8, staff were clear in that they perceived their roles primarily as that of a health promoter, promoting healthy lifestyles to young people:

*“The idea behind it was that they [Commissioners] wanted to get a team of young people to promote healthy lifestyles to young people... so we were brought in to do campaigns and ideas to promote health to young people in a fun and creative way.” (S1)*

In terms of the service users, Innov8 has been mostly aimed at young people between 16-25 years old. However with recent growth in interest concerning the health campaigns and workshops delivered by the Pulse Innov8 team (e.g. from schools), 15 year old young people have also become a key target group for Pulse Innov8's work:

*“The 15 year olds, they're a lot more who we're coming in contact with now. Instead of having to cut them off, saying 'you'll have to wait 'til you're 16', we decided to go down that route.” (S1)*

In delivering age-appropriate campaigns, Pulse Innov8 staff reported that adopting an outreach approach by taking the service to where young people were rather than expecting young people to attend the service had helped to ensure service accessibility for young people in the older age bracket too:

*“We wanted to hit the higher age bracket of our young people, so we decided to do a pub quiz in a local pub that’s popular with young people. We decided to go where the young people were instead of asking them to come to us.” (S1)*

One of the key target groups for Innov8 services was reported as being ‘vulnerable’ young people or those most ‘at risk’ of disadvantage. However, staff acknowledged that in practice, the service has been made available to young people from a broader range of backgrounds that may benefit from the kind of services offered by Pulse Innov8 (i.e. including those who might not be seen as being ‘disadvantaged’). The difficulty of targeting more vulnerable groups within particular contexts was raised by staff in their interviews, particularly in terms of delivering workshops to schools. For instance, staff reported that although it is possible to target more vulnerable young people, this may be undesirable in terms of potentially stigmatising those individuals:

*“There’s a reluctance to stigmatise children. If they’re all in a room and they recognise their colleagues that are in their remedial classes, they’re gonna cotton on real quick that they’ve been singled out and that’s something that teachers are conscious of avoiding.” (S5)*

Consequently, some staff felt that the remit of the service should and indeed does apply to all young people whether they are perceived as being ‘vulnerable’ or not:

*“Anyone that we see needs the service... the fact that they’ve spoken to us or the fact that they’ve gained a little bit of knowledge shows that they did need that... if they’ve learned something... then in my eyes, that’s classed as needing the service.” (S2)*

## 2) Theme Two - Services provided (Objective 2)

In terms of services provided to young people, primary areas were reported as including sexual health provision (including contraception, pregnancy prevention and testing), alcohol and substance misuse advice and awareness, smoking cessation, mental and emotional well-being, and physical health (e.g. physical activity and healthy eating; see also Section 4.4). As examples, these were delivered via a number of young person friendly means including creative and innovate campaigns and workshops, one-to-one consultations, a breakfast club, outreach activities (including use of the mobile Pulse Bus), referrals and signposting, and the provision of specific support cards offering free and/or discounted services such as the ‘gym and swim’ card.

Staff reported that given that they would often be the first point of contact for young people wanting or needing information and advice, a crucial part of the service they provided therefore was the ability to refer and signpost young people to appropriate and relevant (external) related services when needed:

*“It’s a first line of promotion... letting young people know where to go.” (S1)*

Although referrals and signposting activities were reported as having reduced as a result of some services being decommissioned (e.g. the Young Men’s Health Worker Service [YMHWS]), Innov8 staff reported working to resolve the drop in capacity by starting to build up



new relevant contacts with alternative service providers to whom the young people can be referred or signposted:

*“As a small team, we still signpost young people as much and as often as we can if it’s something that we can’t support them on ourselves.” (S3)*

*“We’re in that transitional period - we’re trying to figure out how to deliver those services that we used to commission in the past.” (S5)*

*“We’re working closely with other services and trying to find new contacts to refer young people to... so we’re adapting to it.” (S2)*

### **3) Theme Three - Factors affecting uptake and extent of potential impact (Objectives 2, 4-5)**

A key feature of the interviews with Innov8 staff were their reflections on the unique nature of the services they provided (Objective 2). Not only can such views start to lend support to the ‘added-value’ of the services (Objective 5), but they can also start to identify factors that may potentially limit their impact (Objective 4). Three factors were particularly evident in the data including: marketing and branding; changes to the service, and; partnership working.

#### Marketing and branding

Pulse Innov8 have made considerable efforts to market and brand their services to young people through a variety of means including the use of more traditional methods such as flyers, posters, website, and campaign resources and ‘freebies’ as well as more unusual and arguably innovative methods such as flash mobs<sup>5</sup>, and social networking media including Facebook. In their interviews, staff were confident that the reputation and profile of the Pulse Innov8 team had been raised as a direct consequence of such actions, thereby increasing the likelihood of young people accessing the Innov8 services:

*“Our reputation has snowballed and it’s built up because the young people know who we are... Our freebies... our campaigns, all those sort of things help teach young people who we are and they recognise us... we’ve got a strong presence... word of mouth as well.” (S2)*

However, this was one of the few examples of where inconsistent views arose between Pulse Innov8 staff and young service users (see Section 4.3). For example, through the focus group discussions, it became apparent that there was a lack of clarity and considerable confusion amongst young people over identifying which were (or not) Pulse Innov8 services (as opposed to other service providers such as the teenage pregnancy team), suggesting a lack of effective marketing and/or branding.

Inconsistent views were also apparent between Innov8 staff regarding the value of the erstwhile Pulse Innov8 website versus the use of more ostensibly trendy social media network Facebook. For instance, in terms of the Pulse website (closed down earlier in 2011 when the domain name came up for renewal and aspects of the Innov8 services had already been decommissioned), some staff supported its reinstatement arguing that the profiles showing ‘the faces’ of the team had been valuable along with providing a referral point for young people to access:

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<sup>5</sup> A flash mob is a group of people who assemble suddenly in a public place, to perform an unusual act for a brief time, then disperse, often for the purposes of entertainment, satire, artistic expression or in this case, health promotion.

*"It was good to have somewhere to promote young people to go to... young people used it... it wasn't just all information, it was like fun stuff as well." (S1)*

In contrast, other staff felt that the social networking site Facebook provided a positive marketing tool not only to engage with a range of young people (e.g. including those who might be classed as 'hard to reach'), but also allowing the distribution of information, resources, and updates relevant to young people's needs:

*"Facebook's one of the biggest tools we have now our website's down... it's the best way to contact them and to provide them with the information that they need." (S2)*

Facebook was also seen by this particular staff member as being a useful tool for engaging with young people whom may not necessarily wish to meet face-to-face to discuss their individual needs, thus potentially engaging with young people whom may not have otherwise accessed the service:

*"... A lot of young people whom we may see at a campaign or workshop and then they go on to Facebook and they'll e-mail us - they're more confident to talk to us as they don't have to actually speak to us in person. So we're trying to reach various different characters and different personalities." (S2)*

### Changes to the service

Two key factors thought to potentially affect both service uptake and the extent of its impact, were reported to be 1) a reduction of Innov8 core staff numbers from four to two, and; 2) a number of related services being recently been decommissioned (e.g. the Young Men's Health Worker, and the alcohol and substance misuse worker). In terms of the former, reductions in staffing were viewed by participants in both positive and negative terms. For instance, in terms of positive impacts, a change in personnel was thought to be refreshing for Pulse Innov8's work as the newer staff brought with them new, creative and fresh ideas for the development and delivery of new campaigns, workshops and so on:

*"That was good 'cos obviously they're both very different types of people... so that's good and they come up with fresh ideas... having two people it's not your biggest group, but it's worked quite well." (S1)*

In terms of negative impacts of these changes, reductions in staffing were reported to have led to a decrease in capacity to deliver services and interventions to young people. For example, staff felt that the number and scope of the campaigns and/or workshops that could be delivered was limited:

*"There's not as much money so you can't do as many, like, promotions than we used to... when you come up with a really good campaign or idea... I s'pose it restricts us on that." (S1)*

*"When there were four of us, it was a lot easier to do the campaigns. It was easier to deliver more than one thing on the same day... But now there are only two of us... it is tough... having a third or fourth person... would be really beneficial." (S2)*

*It was really good that we had such a variety of services... The variety... was really beneficial to young people and it's a detriment now that those services aren't all available..." (S5)*

Moreover, changes in staffing were also felt to impact on young people directly in the sense of them having to re-build relationships with (different) workers:

*“Particularly young people... if they’ve got a relationship with a particular worker and that worker’s moved on, generally all young people get on with the workers, but it’s having that trust and building that positive relationship up again as well, so it can have a negative effect.” (S3)*

Nevertheless, although faced with the changes outlined above, Pulse Innov8 staff have clearly demonstrated resilience, adaptability and responsiveness in how they have dealt with difficult changes to the service (e.g. decommissioning). As reflected on by one of the (non-frontline) staff members:

*“They [Pulse Innov8 staff] had to fend for themselves in a lot of ways and development strategies in a more independent way. But they have handled that challenge really well.” (S5)*

### Partnership working

Pulse Innov8 adopt a partnership working model by engaging with related (external) services to develop and deliver campaign and workshop materials and/or to signpost or refer young people to. Such partnership working was perceived by staff as being important with regards service uptake and impact on young people because it allowed the possibility of ‘joining-up’ with external providers. This allowed Innov8 to deliver services, share knowledge, and draw upon the expertise of related professionals to increase capacity and improve the quality of service delivered to young people:

*“All the partnerships we’ve got are good like schools, colleges... we’ve always got close relationships. It’s important to have that as the different services we signpost to – they signpost to us and us to them...” (S2)*

*“Linking in and using everybody’s skills and expertise and experience... it’s sort of sharing the workload in a sense.” (S3)*

## **4) Theme Four - Service benefits (Objective 4-5)**

The benefits of the Pulse Innov8 service(s) start to illustrate the potential ‘impact’ and ‘added-value’ of the services provided to young people (Objectives 4-5). A number of benefits to the Pulse Innov8 service were reported, namely the Pulse Innov8 staff and their perceived qualities; innovative campaigns and workshops, and; outreach work.

### Pulse Innov8 Staff

The Pulse Innov8 staff were perceived to be a crucial benefit in delivering services and maximising the possibilities for engaging young people. The characteristics and qualities which staff perceived as being important included their own social distance<sup>6</sup> and approachability to young people:

*“All the health workers at Pulse are young. They’re the same sort of age range as the young people... we know what they’re going through. We know what works and what doesn’t.” (S2)*

*“We’re kind of ‘on the level’ and therefore they [young people] can be more open with us and have a laugh with us. It kind of makes us more approachable.” (S4)*

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<sup>6</sup> Social distance refers to the extent to which someone is perceived to be socially similar to someone else, in terms of culture, age, experience and so on.

*“By having young people in the positions of the Innov8 crew, it definitely adds value because young people see them as equals.” (S5)*

In their interviews, the staff also perceived themselves as being adept at empathising with young people, and responding to young people’s individualistic needs and abilities, and adapting accordingly:

*“Each feedback form we get, we see if there’s any... positive feedback or negative comments... they don’t like this, they don’t like that. So we take on-board what they’re saying... It is a constant review [process] and we are constantly changing to adapt with the young people.” (S2)*

The characteristics and qualities of staff, combined with the range of services and ‘young person friendly’ modes of delivery offered by Pulse Innov8, were also reported as contributing towards the removal of barriers to young people in accessing services. For instance, by the use of local knowledge combined with innovative and interactive methods help staff to engage with young people with whom they may not have otherwise been able to reach:

*“We use creative and quirky ideas that other services might not. We use the language in a sense of a young person... use innovative and creative ways of engaging. We use the team’s knowledge of the local area and the latest trends to attract young people.” (S1)*

*“We’re breaking down the barriers that young people may have about either contacting a service or even just talking about it.” (S1)*

### Campaigns and Workshops

Pulse Innov8 staff reported developing and delivering numerous campaigns and workshops for young people, on a variety of different topics taking guidance from national and local policy agendas (e.g. *Choosing Health*; Department of Health [DoH], 2004). Campaigns and workshops were reported as being delivered in a range of different venues and settings including schools, colleges, youth centres, alternative education provision (e.g. Learning and Behavioural Units attached to schools), and in any other locations across the area that are frequented by young people (e.g. town centre, shopping malls, higher and further education college fresher’s fairs etc.).

A key strength of Innov8’s campaigns and workshops was reported by staff as being due to their creative and innovative approach which appeals to young people and may well be different to the more traditional information-conveying routes which young people often encounter (e.g. at school). Staff felt therefore, that they offered a unique service in this respect which no other young person’s service offered:

*“The workshops are designed to be light-hearted... we deliver in a way that conveys we’re not there to preach... we use words and answer questions that their teachers wouldn’t necessarily answer... we tell ‘them things that they wouldn’t learn in school and it’s just a completely different style... so they’re more engaged and it’s interactive.” (S2)*

*“We’re different... as we offer a service that’s nothing like anything else that they’ve [young people] got.” (S2)*

Staff reported that their workshops and campaigns were well received by young people and deemed to be successful in terms of engaging with large numbers of young people and



conveying knowledge and information that is likely to impact on their knowledge, behaviour and attitudes:

*“If it’s Alcohol Week or Young Men’s Health Week and there are things going on... we’ll see hundreds of young people... when we do our campaigns that’s when we engage with a lot of young people.” (S4)*

### Outreach work

Pulse staff reported providing a variety of outreach services to young people in the community by visiting areas specifically chosen for the high number of young people in the area (e.g. supported housing centres, hostels, youth centres, etc.). Staff felt that such outreach modes of delivery were invaluable in engaging with young people whom may not otherwise access services, and provided an important opportunity to deliver services directly (e.g. condoms) to young people or make referrals to external health-related services:

*“We go to supported houses and hostels – places where there’s gonna be lots of young people there that need help. We bring various different things with us... C-Cards [condom card] and free condoms... we give out information and we talk to them... we work to address the problem and to point the young person in the right direction...” (S2)*

However, staff reported that their outreach work had been impacted considerably by the loss of the Pulse (outreach) Bus. Not only can such mobile resources facilitate working in rural or isolated areas, but it can also help to provide an important (and mobile) ‘safe-space’ in which to work with young people privately, as well as being able to physically carry sufficient health promotion materials:

*“We used to have the Pulse bus... now (on the street) they haven’t got anywhere to talk to in private when they come and find us... they might be embarrassed and not want to talk about it... it’s tough sometimes if you don’t have the privacy so having the Pulse bus back would really improve our service.” (S2)*

Buses are commonly used in outreach work with young people as they can help service providers (amongst other things) to establish positive relationships with young people particularly those who are often described as being ‘hard to reach’ (e.g. see Edgecombe and O’Rourke, 2002). Such mobile services are important because they can allow outreach working where traditional services are unable to access or are unavailable; for instance with groups of young people who roam the streets at night who may not necessarily breaking the law, but are excluding themselves from opportunities open to other young people. Moreover, outreach buses can provide a confidential and relaxing environment for young people leading to greater engagement with services than they might in a more traditional settings. Evidence shows that mobile outreach services also attract as many young men as young women which is unusual with ‘mainstream’ public services (Edgecombe and O’Rourke, 2002; see also Gomes *et al.*, 2007).

## **5) Theme Five – Service impacts on young people (Objective 4)**

Interviewees felt that the Pulse Innov8 services had impacted on young people’s knowledge, attitudes, and behaviours in a number of ways, for example by learning about specific topics (e.g. sexual health, substance misuse, and healthy eating) as well as raising awareness and confidence of knowing where to go to access other health related services (through signposting and referral). However, whilst the staff convinced that the services had impacted on young people, they were also aware of the difficulties in evidencing such claims.

Most of the Pulse Innov8 staff felt that through gaining knowledge, the service had impacted on young people's attitudes and behaviours.

*"... there are lots of positive stories of young people that have made major turnarounds from really being in trouble... those addicted to a variety of substances, no ambition, see themselves on a downward spiral of killing themselves slowly... abusing drugs, self-harming, practicing unsafe sex. And they've [Pulse Innov8] have enabled them to turn their lives around." (S2)*

Similarly in relation to the workshops focusing on alcohol awareness, staff reported that young people were often surprised to learn about the calories associated with alcohol units and that in some cases (see Section 4.3), this had led to young people changing their drinking behaviours:

*"With drinking, the calorie intake – that's a big thing that we do in our workshops. There's a lot of shocked faces when they realise how much their calorie intake is." (S4)*

Interventions designed to increase young people's levels of physical activity and healthy eating, were also reported by staff to have impacted on young people:

*"We did boxing lessons and we did a thing called Jog-On where we meet at Xtrax and take them jogging and the breakfast club, offering smoothies... healthy wraps and things like that... getting young people active." (S4)*

Innov8 services were also thought to impact on young people by contributing to increasing levels of confidence and raising self-esteem, which in turn, may contribute to increasing the ambitions and future aspirations of young people including progression into training schemes and/or further education:

*"Well, I think just confidence... in the sense that a young person might not have accessed a service for help. But if talk to them and say that there's this place or whatever, giving them the confidence to do that... building their future aspirations... to know that it is possible to achieve those goals." (S4)*

*"A lot of them have progressed on to college – some of them have gone down the employment route." (S3)*

Linked to both impacts in terms of increased physical activity and mental and/or psychological well-being, the 'gym and swim' card was reported by staff as being an exceptionally popular service offered by Pulse Innov8 in partnership with local health and leisure clubs. The card was made available to all young people on accessing Pulse Innov8 which entitled them to free access to local gyms and swimming pools. This scheme was one of the tangible ways in which Pulse Innov8 staff were able to promote physical activity and healthier lifestyles. The main impacts of the card were perceived by staff as providing young people with an affordable way to increase physical activity levels, which in turn was reported as having other beneficial effects on mental health and well-being (e.g. improved self-esteem, increased confidence and so on):

*"... That [using the gym and swim' card] boosts up their self-esteem – especially, particularly young women." (S3)*

*"... It [the effects of using the gym and swim' card] gives them confidence and that can lead on to other things in their life." (S4)*

However, at the time of writing (September 2011), the 'gym and swim' scheme has been withdrawn. This was viewed by Pulse Innov8 staff as a considerable loss to young people with potential impacts to their health (physical and mental) as a result of its withdrawal:

*"It's going to have a big impact on fitness, wellbeing, self-esteem, their aspirations... socialisation. A lot of these young people are from deprived areas, and they live very insular lives. This gave them a really good opportunity to interact with people from all walks of life." (S5)*

This view was also expressed by young service users themselves (Section 4.3) as well as by young men attending the Young Men's Health Worker Service who also had been able to receive the card (see Chapter Five; Section 5.3).

Finally, although difficult to evidence, perhaps one of the most important impacts of the service as reported by Innov8 staff (in line with the underpinning aims of the service), was that it has engaged with young people who were not previously known to services:

*"I: Do you think you're reaching people who may otherwise not access mainstream health services?"*

*P: Yeah - 'cos you're breaking down that barrier, I s'pose to use the service and they might either think I'm not going there because I don't wanna be seen there... people have that idea about services a bit differently to – actually, they're not scary places that are gonna judge you when you go in and stuff like that." (S1)*

*"I: D'you think people attending Innov8 and the things that you do, d'you think they're using these types of service for the first time?"*

*P: A lot of 'em do yes.*

*P: D'you think you're reaching people who may otherwise not access mainstream health services, health and wellbeing services?"*

*P: Definitely." (S4)*

### 4.3 Young People's Experiences of Using Pulse Innov8

This section presents the findings from two focus groups and one individual interview with young people who had used the Pulse Innov8 services (N=11). The aim of this aspect of the evaluation was to explore young people's experiences and perspectives of the service in order to elicit the potential impact of the service including any potential behaviour change (Objectives 4-5). This impact is derived from the perspectives of the young people who used the services. The findings are structured into the following four themes:

1. The service
2. Benefits of the service
3. Impact of the service
4. Future of the service

#### 1) Theme One – The service (Objectives 1 and 2)

As Pulse Innov8 offer a broad range of health promotion services to young people, in the first instance participants were asked to describe Pulse Innov8 in order to understand better what they perceived the service to consist of. As noted later, although young people were often unclear about which services were provided by Pulse Innov8 and which were delivered by other service providers, in general they nevertheless recalled sexual health advice (including condom provision, unwanted pregnancy prevention, and pregnancy testing), 'gym and swim

cards' as well as alcohol and substance misuse advice, as being the most common health areas associated with Pulse Innov8:

*"Condoms and protection - making you more aware of stuff." (FG2, YP1)*

*"We learned a lot from Pulse Innov8 about alcohol." (FG1, YP1)*

*"P: It [Innov8] gives you those cards where you can go swimming and you can go to the gym. (FG1, YP1)*

*P: They give you advice on safe sex and contraception and stuff. (FG1, YP2)*

*P: Yeah, they have a bus. You can get condoms. (FG1, YP1)*

*P: And they give pregnancy tests. (FG1, YP2)*

*P: It's telling you about sexual diseases. What they look like and what you should be doing about it. (FG1, YP1)*

*P: Condoms and protection, that stuff, just making you more aware of stuff." (FG1, YP2)*

Rather than necessarily recalling specifics about the nature of the service, young people often recalled more easily the innovative and creative delivery modes of the services such as campaigns and workshops, which were reported as being 'fun' and engaging with 'freebies' and other incentives distributed as part of these:

*"P: They come up with new and inventive ways of getting the information across so that you actually remember it. (FG2, YP1)*

*P: Fun. It's always just a laugh. (FG2, YP2)*

*P: It wasn't all serious and 'you must be here you must take part.' (FG2, YP1)*

*P: 'Cos you'd learn as well, didn't you (FG2, YP3)*

*P: 'Cos she had a presentation at the beginning, didn't she? (FG2, YP2)*

*P: About what infections look like. It was quite interesting." (FG2, YP1)*

*"P: They give away free stuff 'cos everyone likes free stuff. (FG1, YP1)*

*I: What makes them stand out [Pulse Innov8]?*

*P: Freebies." (FG1, YP2)*

When asked whether they were aware of the target groups for Innov8's work, some service users expressed the view that although the remit was for young people aged 16-25 years, they felt it would also be useful to a younger (than 15 years old) school-based audience. Such views are congruent with those of the Pulse staff and also resonate with the findings from the nurse-led sexual health provision and YMHWS (Chapters Three and Five respectively) i.e. that early intervention can present an opportunity to raise awareness of the existence of the service before young people might necessarily need (or want) to use it.

*"If they went into schools more, it would be handy for the kids. If they are having sex at a young age, to protect themselves to show 'em properly... They could have done it in a school with teenagers, say 13 year olds... Then it probably would have had more of an impact." (FG2, YP1)*

Participants in the above focus group went on to explain that they felt the Pulse Innov8 service was a more effective way to deliver sexual health education in the school environment (as opposed to the more usual route of PSHE (Personal Social Health and Economic education) lessons) due to a combination of the perceived limitations of school staff and the perceived positive qualities and characteristics of the Innov8 staff:

*"P: When we had PSHE – when it's the teachers doing it, they just saw it as a bunk lesson – like, you wasn't doing your actual subjects. (FG2, YP2)*



*P: Most people didn't turn up to them. (FG2, YP3)*  
*P: You just didn't take it seriously. (FG2, YP2)*  
*P: You then had that awkward sort of, 'oh I can't say anything because then they're gonna know every single day I'm at school'. They [Pulse Innov8] are more our age and completely different people, it's easier to talk. (FG2, YP1)*  
*P: [They] make it fun and more enjoyable." (FG2, YP2)*

## 2) Theme Two – Benefits of the service (Objective 5)

### Pulse Innov8 staff

The most prominent, frequent, and positive response amongst young people regarding service benefits overwhelmingly related to the Pulse Innov8 staff. Staff were seen by young people as being friendly, relaxed, non-judgemental, approachable, and easy to talk to. Supporting the views of the staff themselves, young people felt that this was due partly as a consequence of the relatively small social distance between staff and themselves.

*"I like the atmosphere of the staff, just like really friendly and you can talk to them... Most of the Pulse Innov8 workers are our age, or just a little bit older, which I like." (SU1)*

*"P: They're good to talk to... they're there most of the time. So you can just pop in. (FG1, YP1)*

*P: Have a chat. (FG1, YP5)*

*P: Most of 'em are young so it's easier for us to talk to. (FG1, Y41)*

*P: They're friendly – and they're really, really friendly... they're laid back. (FG1, YP1)*

*P: Chilled out kind of people. (FG1, YP4)*

*P: They have a joke with you. (FG1, YP2)*

*P: They don't judge you." (FG1, YP5)*

By providing a service which young people find very accessible and as a consequence of the staff being approachable, young people reported that they felt comfortable and more confident in engaging with the service about health matters, probably at a much earlier stage than they might otherwise have done. For instance, in the extract below, the young person describes an incidence where a friend had been able to approach Pulse staff before a problem had become more serious:

*"My friend – well, she was pregnant and she obviously wanted advice on how to stop drinking and obviously that worked." (SU1)*

Interestingly a number of participants reported that they would rather go to a Pulse Innov8 worker than to their doctors for advice. Linked to the earlier concept of social distance, Pulse Innov8 staff were seen to be on the 'same level' as the service users, whereas doctors were commonly seen as being judgemental and unapproachable:

*"P: If I had the choice of where I went, I'd go to a Pulse worker rather than to the doctor's. (FG2, YP1)*

*P: Mmmm. (FG2, YP2)*

*P: The same. (FG2, YP3)*

*I: OK - is that the same for all of you?*

*P: It's a lot easier to talk to 'em about stuff. 'Cos they know you as a person, and they don't judge you." (FG1, YP1)*

The approachability of staff was also reported by young people as being important in terms of referrals and signposting as they were confident that if Innov8 staff couldn't meet their needs, then the staff would still be able to refer or signpost them to other services that could.

*"P: I went to 'em last week 'cos I thought I had a Chlamydia and they showed me where to go so it was really helpful. (FG1, YP2)*

*P: I remember a while ago when one of the Pulse Innov8 workers signposted things like Active for Change. (FG1, YP4)*

*I: Did you use that? Did you go?*

*P: Yeah." (FG1, YP4)*

*"P: It was just like finding out about it and feeling more confident that where they've told you to go to. (SU1)*

*I: What you might not have found it on your own, you mean?*

*P: Yeah. (SU1)*

*I: Or you might not have had the confidence to go, is that right?*

*P: Yeah." (SU1)*

### 'Gym and Swim' and 'Know Where To Go' Cards

In line with staff views, the 'gym and swim' card was also viewed positively by young people as an important benefit of accessing Pulse Innov8. Indeed, several participants expressed disappointment at the closure of the scheme and described the benefits they felt they had received previously from having the card.

*"I lost half a stone using that. A lot of people benefitted from the 'gym and swim' cards, 'cos where – for example, I live on my own and obviously so I can't pay to go to the gym, but with that 'gym and swim card' it was really useful." (SU1)*

*"If you had no money, it was the point that you could still go out and get exercise and you could go and do it and just not sit there and go, oh – where's the money gonna come from for that? 'Cos it costs a lot. (FG2, YP1)*

*"I couldn't believe it stopped... I've stopped going because obviously I can't afford to pay for it." (SU1)*

Again supporting the views of Innov8 staff, the 'Know Where to Go Card' was perceived by participants as being a good idea in principle, but in practice they reported some problems with it. For instance, a lack of clarity over where to use the card, a perception that the percentage discount was too low, and that the physical nature of the card itself could be improved:

*"I've got it in my purse, but I've never used it. I don't know where to use it – I have to look it up... I think it it'd be better if the cards were plastic." (SU1)*

### Outreach and the Pulse Bus

Young people were aware of Pulse outreach activities with many young people referring to the Pulse (outreach) Bus as a useful benefit of the service, as it was perceived as a convenient, and confidential place to access contraception, pregnancy test and other youth 'freebies' such as condoms. Young people reported examples of where the Pulse Bus service had been beneficial in terms of helping them stay safe (e.g. with regards alcohol use) and unwanted pregnancy prevention (e.g. contraception advice and condom provision):

*"They had this little bag they were giving out – it said 'what would you prefer, carry a condom or a baby?' " (SU1)*

*P: If you saw me on a Friday night, it wouldn't just be about drinking." (FG1, YP2)*  
*P: ...'Cos they can advise you not to get too drunk." (FG1, YP3)*

*"P: They have a bus. (FG1, YP4)*  
*P: You can go and get condoms (FG1, YP4)*  
*P: And they give pregnancy tests. (FG1, YP1)*  
*P: And you get those cool little. (FG1, YP2)*  
*P: And you get a little sperm key ring." (FG1, YP1)*

### Facebook

As noted previously, following the loss of the Pulse Innov8 website, a new 'face' of the service had been created by using the social networking site Facebook. The style and tone of the Pulse Innov8 Facebook page is in keeping with their broader style or 'look' in the sense of being informal, interactive, and engaging. Through Facebook, young people reported that they were able to get in touch directly with Pulse Innov8 staff, without having to physically attend the service and meet with the workers:

*"A lot of people use Facebook. If they're too scared to come into town, they can access it [Pulse Innov8] through Facebook." (SU1)*

Most young people agreed that Facebook provided an effective medium through which to access a high number of young people:

*"P: Facebook's probably one of the best places to advertise. (FG1, YP5)*  
*P: Everybody's on Facebook. (FG1, YP1)*  
*P: It'll encourage more people to use it [Pulse Innov8]." (FG1, YP1)*

### **3) Theme Three - Impact of service (Objective 4)**

Young people frequently mentioned how the service had helped them increase their awareness, understanding or knowledge of relevant health-related issues as a direct result of accessing the Pulse Innov8 service. For example, in relation to alcohol and safer sex young people in both focus groups (and the one individual interview) remembered with amusement the 'Saturday Night Challenge' in which participants wore 'beer goggles' and then searched for a condom under a duvet to illustrate the issue of safe sex and excessive alcohol consumption. Such innovative methods appeared to provide a highly effective way of engaging, and impacting on, young people.

*"P: ...I always remember the Saturday night challenge. (FG1, YP1)*  
*P: The beer goggles. (FG1, YP2)*  
*P: Oh, yeah. (FG1, YP3)*  
*P: And then you had to like, do it in the fastest time, to get like, a condom on properly." (FG1, YP2)*  
*P: It was so funny – I always remember that." (FG1, YP1)*

*"That [beer goggles] was really fun...we had to find, like, this condom and put it on the right way, without breaking it or anything – it obviously showed us how unsafe it can be when we are drunk." (SU1)*

*"When you've had a drink and you see that 'cos you don't really realise what's happening anyway. So when you're actually in a sober state and you see what it's like being drunk, it's – yeah – you realise vulnerable you could put yourself in." (YP1, FG2)*

For some young people, increased knowledge and understanding about and alcohol and drug misuse via Pulse Innov8 had reportedly led to direct behavioural changes, for instance in terms of reducing alcohol consumption and stopping the use of ‘recreational’ drugs:

*“I’ve cut down on drinking.” (FG1, YP3)*

*“A couple of my friends have cut down their drinking... Obviously after you find out how many calories it is.” (SU1)*

*“P: They’ve [Innov8] changed my behaviour of drugs. I used to use a lot of drugs before and now ever since I’ve been going [to Pulse Innov8], I don’t use now. (FG1, YP4)*

Despite such positive examples however, some young people reported that although they felt equipped with new knowledge, they would not necessarily change their behaviour:

*“P: I’m still the same as I used to be. (FG1, YP3)*

*P: The only difference is that I know more now. (FG1, YP2)*

*P: Just because you know more, doesn’t mean you’re gonna change. (FG1, YP1)*

*P: I know more but it don’t mean I’ve changed. (FG1, YP3)*

*P: I’m still being unsafe when it comes to sex.” (FG1, YP1)*

Discrepancies between knowledge (attitude) and behaviour is well documented in the academic literature and amongst health promoters (e.g. Bettinghaus, 1986). Moreover, it is possible that the focus group setting may also have influenced young people’s willingness to discuss attitudinal and/or behavioural change. However, young people did report being more confident to talk to their peers around subjects like sexual health as a direct impact of gaining greater knowledge through Pulse Innov8:

*“I: Do you think your attitudes have changed as a result of accessing Innov8?*

*P: We just talk about everything easier, don’t we? ‘Cos everyone knows the same thing you know and stuff. I said if people are talking more about stuff like – you know – sexual health and crap – ‘cos everyone knows everything – if you get what I mean?” (FG1, YP1)*

### Marketing and branding

This final subsection is included here because of its relevance in terms of potentially *limiting* the impact of Pulse Innov8’s services on young people. In-line with the perceptions of Pulse staff, some young people felt that Innov8’s marketing techniques were particularly age-appropriate and friendly to young people:

*“It’s really young people friendly. ‘Cos like, the staff obviously when they advertise it, it’s all young person advertised – like the graffiti and the writing and just stuff like that, really.” (SU1)*

However, despite such positive views (and as noted previously in Section 4.2) through the focus group discussions it became apparent that there was a lack of clarity and considerable confusion amongst young people over identifying which were (or not) Pulse Innov8 services (as opposed to other service providers such as the teenage pregnancy team), suggesting a lack of effective marketing and/or branding. For example, when participants were asked how they heard about Pulse Innov8, responses were unclear and muddled:

*“P: I went on a bus, but I don’t know if it was that one. (FG1, YP1)*

*P: I went on this fun bus – I don’t know what it. (FG1, YP2)*

*P: I think it was through the YDS [Youth Development Service]. (FG1, YP1)*  
*P: No, that is not the Pulse bus – that seems to be the special needs bus.” (FG1, YP3)*

One young person expressed the view that with better advertising (and branding), young people may have a clearer understanding of Pulse Innov8, and thus get more out of the services on offer:

*“If they were just better known and people knew more about them that they’d probably get more use out of the service.” (FG1, YP2)*

A review of working practices and procedures as part of this evaluation, did indeed highlight that the marketing activities for Pulse Innov8 services are generally quite disjointed and ad-hoc. These findings suggest that it would therefore be beneficial for Pulse Innov8 to develop a specific marketing and branding strategy in order to create a clear and recognisable service identity, and to raise the profile of Pulse Innov8 services to young people (and other service providers).

#### **4) Theme Four – Future of service (Objective 4)**

With related services been decommissioned/discontinued (e.g. the YMHWS, ‘gym and swim’ card, smoking cessation worker etc.), there was a general feeling of uncertainty from young people about the future of Pulse Innov8 provision and how it might affect them. To help to capture young people’s views on service closures, they were asked how they would feel if the Pulse Innov8 service was closed.

In an individual interview, one young person felt that loss of the Pulse Innov8 service would impact on young people because they had managed to succeed in engaging with young people where other services have failed; for example, in delivering sexual health education in schools where PSHE lessons were reported as being ineffective by service users:

*“It’d affect quite a lot of young people [service closure] because their workshops are so engaging you learn a lot from ‘em. Some places like, say for example, school – you sit there, the teacher talks to you and it’s in one ear, out the other.” (SU1)*

Similarly, other young people in the focus groups felt that without Pulse Innov8 services, there would be an impact on the behaviour of young people in relation to (amongst other things) increased use of alcohol, drugs, more crime and a lack of access to contraception:

*“P: There’d be a lot more kids hanging around on the streets... (FG1, YP1)*  
*P: I’d be hanging around on the streets. (FG1, YP2)*  
*I: What d’you think the kids hanging round on the streets would be doing?*  
*P: Crime. (FG1, YP4)*  
*P: Drinking. (FG1, YP5)*  
*P: Drinking. (FG1, YP2)*  
*P: And drugs. (FG1, YP3)*  
*P: Drugs.” (FG1, YP2)*

*“We wouldn’t know where to go contraception. ‘Cos I don’t think a lot of people actually know where the clinics are where you can get stuff like that from. ‘Cos I didn’t, before I came here.” (FG1, YP1)*

Participants in this same focus group also discussed the importance of knowing professionals were available for to talk to them, for information and support and implied an expectation of



distress if the service were to close. This final extract perhaps conveys the value that young people place on the Pulse Innov8 service.

*"P: I'd miss talking to 'them. (FG1, YP1)*

*P: Yeah – but if they ever actually shut down... (FG1, YP3)*

*P: You'd cry. (FG1, YP3)*

*P: I would actually! And they know – they know who we are. (FG1, YP1)*

*P: No-one knows us really that well – but when we come to Pulse Innov8, they know us. (FG1, YP3)*

*P: ...and they're just, like if you've got no-one to talk to, they're there." (FG1, YP3)*

## 4.4 Analysis of monitoring data provided by the PCT

This section outlines the findings from analyses of the secondary monitoring data provided by the PCT to the evaluators. The data is part quantitative and part qualitative. The quantitative components of data provide an indication of how many people attended the services, their demographic profile, and numbers of new existing young people to the service. The qualitative components of the data provide some information about the kinds of activities that were offered during each of the reporting periods, including achieving outcomes, problems and actions to engage with hard to reach groups. Combined, these data contribute to addressing evaluation Objectives 1 and 2.

### Derivation of Service-led Targets and Related Strategy

The document which details 'the activities being funded by Hastings and Rother PCT to children's services for the delivery of the Pulse project' SLA (April 2008-November 2009) was provided by the PCT for use within this evaluation on the understanding that this document is still the key written reference point for assessing whether beneficiaries have been reached/targets have been met. The SLA outlines expected activities, impacts to be achieved and planned measures and timescales for achieving outcomes. The SLA states that the overall Pulse project aim is: 'To develop targeted services for young people aged 16-18 as a preventative measure, in addition to ensuring that support services are in place for young people aged 18-25 who experience disadvantage.

However, in considering the detail of the SLA, and on seeking clarification of expected targets and accountability to measurable outcomes, it became apparent (in particular through dialogue with Claire Blake (Pulse Innov8 Project Manager, June 29<sup>th</sup>, 2011) that a number of details within the SLA were no longer relevant. Despite this, an updated version of the SLA has not been written. Amendments have apparently been made in response to changing agendas at national and local level, which were subsequently fed into Pulse Innov8 team meetings and incorporated into their work plan. The specific activities and respective targets affected (for which data does not exist and which therefore cannot be analysed within this evaluation) were noted as being:

- 'Monitor and evaluate SLA with Hastings Voluntary Action (HVA) to deliver Pulse Youth Programme across Hastings and Rother, with 150 young people pre quarter stated as the target to meet, with the planned activities being a mystery shopper evaluation of sexual health services delivered as well as a needs assessment carried out with young people and report produced.'

Given explanation: Neither of the latter activities took place. This evaluation could not therefore comment upon these activities nor the respective expected target of 150 young people to be reached per quarter.

- 'Pulse to develop a Pulse Youth mentors programme to provide young people with the opportunity to be supported by trained young people when accessing local services. Again there was a target to meet of 150 young people per quarter, with the outcome being a pulse youth mentors programme developed and mentors in place within local services.'

Given explanation: The youth mentors programme was not developed. The target figures could not therefore be incorporated into this evaluation.

Another activity reported as not being carried out was the following:

- 'Monitor and evaluate existing SLA with HVA to provide Youth Participation Worker (YPW), promoting services and developing interventions for young people across Hastings and Rother. 150 young people per quarter were stated as the target number for accessing campaigns which the YPW and Pulse Innov8 would jointly develop and implement.'

Given explanation: The YPW resigned from his post approximately 18 months ago. Nevertheless the Pulse Innov8 team continued to develop and deliver campaigns without his support (see types and number of services being accessed below).

One further point to note is that Pulse Innov8 staff reported that they were not aware of the targets set out in the SLA for reaching certain numbers (and/or demographic profile) of young people. This is somewhat surprising given that Innov8 staff are required to record the numbers of young people accessing the service, and to then feed this into quarterly reports. In future, it would be beneficial for the SLA (and any changes) to be well-documented and communicated to the staff delivering services, to allow them to monitor and evaluate progress more effectively.

#### **4.4.1 Describe the number and characteristics of young people using the Pulse Innov8 services (Objective 1)**

The total number of young people who engaged with Pulse Innov8 services between 2009-2011 was 5442 (52% female; 48% male) with a mean of 680 young people accessing Pulse Innov8 services per quarter. This clearly exceeds the SLA target which states that 500 young people a quarter should access Pulse Innov8 interventions, through delivery of three campaigns per year targeting young people at most at risk of poor health outcomes. 3589 young people accessed Pulse Innov8 services in 2009-2010 compared to 1853 in the period 2010-2011. The reduction in numbers (in particular in quarters 3 and 4) may have been partly due to the loss of one member of staff (currently on maternity leave), due to poor weather in December 2010 which meant one of the key campaigns could not go ahead as planned, and also as a result of decommissioning the 'referral' services which used to sit alongside Pulse Innov8's work including the young men's health worker, sexual health worker and alcohol and substance misuse worker. Highest numbers were achieved when running campaigns at 'fresher's fairs' as demonstrated in quarter two (2009-2010) when 1600 students visited Pulse Innov8's stall for information on safer sex and alcohol misuse at Hastings College.

Of the 5442 accessing Pulse Innov8's services, 81% were new participants, 13% were repeat participants and 18% were recorded as using other Pulse Services. This demonstrates that Pulse Innov8 have been successful in reaching large numbers of young people across Hastings and the surrounding area. No data however were available regarding which specific Pulse services were accessed and in addition, no data was collected for quarter 4 (2010-2011) regarding numbers of new and repeat participants, nor numbers using other Pulse services.

Table 3 Numbers of young people using the Pulse Innov8 Service

| Young people (service users)      | April 09 to April 10 | April 10 to April 11 | Totals      |
|-----------------------------------|----------------------|----------------------|-------------|
| Number using the service          | 3589                 | 1853                 | <b>5442</b> |
| New participants                  | 3045                 | 1375*                | <b>4420</b> |
| Repeat participants               | 505                  | 204*                 | <b>709</b>  |
| Number using other Pulse services | 822                  | 191*                 | <b>1013</b> |

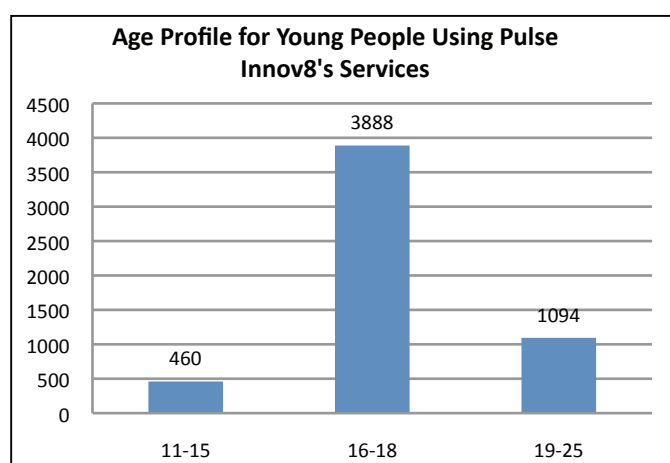
\*No information was available for Quarter 4, 2010-2011.

### Socio demographic profile of users

In terms of the socio-demographic profile of young people using the Pulse Innov8 services:

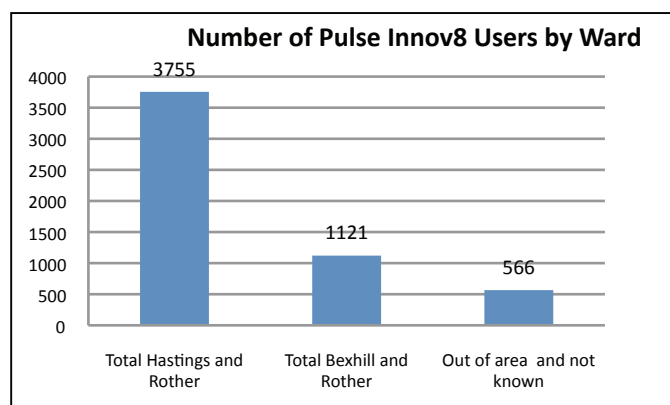
The majority of young people accessing Innov8's services were between 16-18 years old (n=3888 or 71%), followed by those between 19-25 years old (n=1094 or 20%). 9% (n=460) of young people accessing the service were aged between 11-15 years (see Figure 16).

Figure 16 Age Profile for Young People Using Pulse Innov8's Services



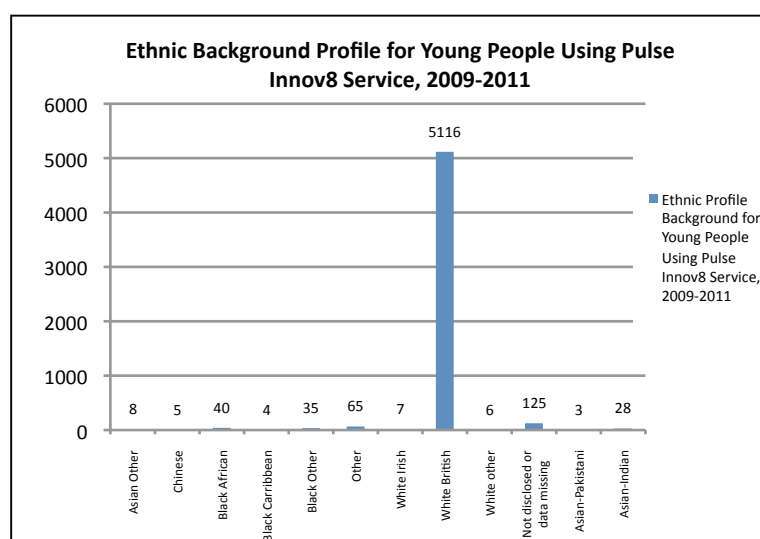
Of the data available (n=5442), the majority of young people (n=3755 or 69%) were reported as living in Wards comprising the Hastings and St Leonards district (including Baird, Castle, Hollington, Central St Leonards and Ore/Downs Farm/Red Lake). 21% (n=1121) reported living in Bexhill and Rother, and 10% (n=566) were reported as living out of the area or not known (see Figure 17).

Figure 17 Number of Pulse innov8 users by ward



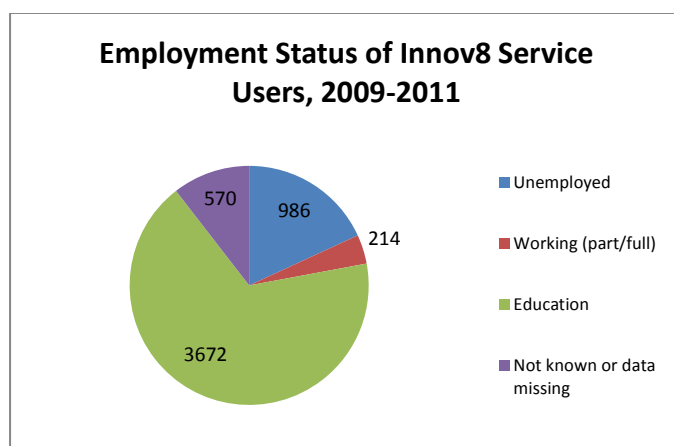
With reference to Figure 18 (below), the majority of young people accessing Innov8's services were from White British backgrounds (n=5116 or 94%). Just 2% (n=125) preferred not to disclose their ethnicity. The remaining 6% of young people (n=201) were reported as being from a variety of other ethnic backgrounds. The proportion of people from an ethnic group is 5.9% in Hastings and 4.7% in Rother (Race for Health, 2011). Although this figure is lower than the national (13%) and regional (8.7%) averages, there are some areas within these local authorities that the figure is higher, with the BME communities concentrated in some of the most deprived wards. Hastings and Rother Health Profile data suggest that in Hastings there are more people from BME communities in routine and manual employment. People in these types of occupations are likely to be in poorer health and are more likely to smoke than those in professional occupations. Efforts therefore need to be made to ensure that young people from BME communities, who may go on to work in these sectors of work, have equal opportunity of access to health services and concentrated efforts should be made to ensure differing needs around health status of these groups are met. Hastings and Rother PCT already work in tackling inequalities in relation to health outcomes within the BME community, for example through partnership working with organisations such as Hastings Voluntary Action, LINKS (a service for asylum seekers refugees and newly arrived communities from Europe) and Hastings Intercultural Organisation. Pulse Innov8 have an opportunity to increase their work with BME communities and to help to improve health outcomes within a population group which so far, have not routinely accessed Innov8's services.

Figure 18. Ethnic background profile for young people using the Pulse Innov8 service (2009-2011)



In terms of employment status, 67.5% of young people accessing Pulse Innov8's services were in education. This perhaps undermine with meeting the needs of one of Pulse Innov8's main target groups i.e. those who are N.E.E.T. However, this high figure can be explained by the campaign which took place at Hastings College fresher's fair, which attracted large numbers of young people and which subsequently represent the high proportion of overall numbers. The second largest category was unemployed young people (n=986 or 18%), with over 10% (n=570) of data missing for this category, and the remaining 4% of young people being in employment of some kind (Figure 19).

Figure 19 Employment status of Pulse Innov8 service users



#### 4.4.2 Types and number of services being accessed (Objective 2)

Data monitoring indicates that the Pulse Innov8 team provide young people with a diverse range of services including campaigns, workshops, outreach work and health-related events. The core work of the Pulse Innov8 team aligns itself with relevant government strategy documents, which broadly speaking, aim to improve health outcomes. The two key strategy documents senior managers use to guide work 'on the ground' are the Choosing Health White Paper (DoH, 2004) and 'Every Child Matters: Change for Children' (DoH, 2003).

'Choosing Health' – Key Priority areas for action included:

- improving sexual health,
- tackling obesity,
- reducing harm and encouraging sensible drinking,
- tackling health inequalities,
- improving mental health and wellbeing.

'Every Child Matters: Change for Children' - Key priority areas for action included:

- being healthy: enjoying good physical and mental health and enjoying a healthy lifestyle;
- economic well-being: overcoming social disadvantage to achieve their full potential in life;
- staying safe: being protected from harm and neglect and growing up able to look after themselves;
- enjoying and achieving: getting the most out of life and developing broad skills for adulthood
- making a positive contribution: to the community and to society and not engaging in anti-social or offending behaviour.

The SLA states that the Pulse Innov8 team were to 'champion' for young people on a minimum of three 'Choosing Health' issues a year. Analysis of the quarterly reports documents a variety of campaigns and workshops which by far exceed the target figure of tackling three issues per year stated in the SLA. This is despite the loss of the HVA Youth Participation Worker, with whom the campaigns were originally envisaged (within the SLA) to be developed and implemented alongside the Innov8 workers. Credit for maintaining numbers of campaigns developed and delivered should therefore go to Innov8 staff during this time.



Examples of Pulse Innov8's work are outlined below which demonstrate coverage of some of the key strategy themes outlined above.

#### Quarter 2, 2009-2010

- Stall at 'Fresher's Fair' at Hastings College: awareness raising activities around alcohol, safer sex and unplanned pregnancies. 1600 young people participated. This kind of event shows great potential for accessing large numbers of young people whom are at a prime age for engaging in risky behaviours in order to achieve positive health outcomes for young people.
- Key strategy themes covered within this campaign include **improving sexual health, enjoying and achieving; reducing harm and encouraging sensible drinking,**

#### Quarter4, 2009-2010

- Non-Smoking Day (working in partnership with the smoking cessation services): Pulse Innov8's remit is to respond to national awareness raising events as well as local and national health and wellbeing-related strategy. 120 young people participated, 25% of whom continued to work with the smoking cessation services after the event.
- Key strategy themes covered within this campaign include: **being healthy; reducing harm.**

#### Quarter 4, 2009-2010

- School Workshops (working alongside Hastings and Rother Teen Pregnancy agencies): delivered in Rye College and Bexhill High about sexual health and alcohol awareness, over the two schools and three days, 16 workshops were carried out and 420 students participated. A similar programme of workshops was carried out in Claverham School (Quarter 4 2010-2011) as part of the PSE lesson. An average of one class a week has been seen with an average of 25 students per class over 3 months. Interview data reinforces the popularity of this workshop, which is likely to be continued in the next academic year.
- Key strategy themes covered within this campaign include: **improving sexual health; being healthy; reducing harm and encouraging sensible drinking.**

#### Quarter 4, 2009-2010, Quarters 1 and 2, 2010-2011

- Outreach work at different agencies including Sanctuary Housing (which houses homeless and vulnerable young people), the Hazel Lodge children's home and Pathways (which houses young people with mental health issues), 'Enterprise 1' (offering alternative training for young people) and 'Finding Futures'. This partnership work has continued over a period of more than 1 year. The outreach work at the community agencies specified continues. This work is one of the key ways on which Pulse Innov8 attempt to engage with hard to reach groups. The catchment group also covers a key target group (i.e. those who are N.E.E.T). Additional activities include: visiting rural areas and engaging with young people through distribution of health promotion information for example, during Quarter 1, 2010-2011 in Rye.
- Key strategy themes covered within this outreach work include: **improving mental health and wellbeing, making a positive contribution to society; staying safe;**

**economic wellbeing; enjoying and achieving; staying safe; tackling obesity; being healthy; tackling inequalities.**

#### Quarter 1, 2010-2011

- Men's health week (in partnership with the YMHWS): engagement with young people through a number of activities and information distribution, related to sexual health, substance misuse, diet and fitness. This included condom distribution and promotion of 'gym and 'swim' cards'.
- Key strategy themes covered within this campaign include **improving sexual health, tackling obesity and being healthy.**

#### Quarter 4, 2010-2011

- On-going regular Innov8 work, for which there are no specific numbers of young people accessing them available include: Breakfast club: coordinated by a member of the Innov8 staff on three days a week, the club enables young people access to healthy food as well as information and advice about a range of issues including how to access other health and wellbeing services. Unfortunately, since a number of related referral services were closed, new services have had to be sought to refer young people to, for example around sexual health, young parenting, men's health.
- Key strategy themes covered within this work: this work reflects a broad range of advice and information-giving scenarios, it virtually covers all strategy themes outlined in 'Choosing Health' and 'Every Child Matters'. This is supported by the provision of healthy food which links to the theme around **tackling obesity.**

#### **Facebook**

- Pulse Innov8 began to report on a new way of engaging with young people through accessing their Facebook page during Quarter 3 (2009-2010). At this point, Pulse Innov8's page had 116 users and featured information about local health services, latest initiatives and a monthly prize draw for 'new fans' (i.e. new users). By quarter 4 (2009-2010) there were over 200 members reported to be signed up to Pulse Innov8's Facebook page and by Quarter 1 (2010-2011), nearly 300 members. No further data about use of Pulse Innov8's Facebook page was recorded after this time through the Quarterly reports. However, interview data reinforced Facebook's ever-growing popularity with young people and effectiveness at engaging with new service users.

# Chapter Five

YOUNG MEN'S

HEALTH WORKER SERVICE (YMHWS)





## CHAPTER FIVE: Young Men's Health Worker Service

### 5.1 Introduction

This chapter presents the findings from the evaluation of the Young Men's Health Worker Service (YMHWS). These findings are based on: 1) one face-to-face in-depth interview with the Young Men's Health Worker (YMHW; n=1); 2) a focus group discussion with young men who had all used the service (n=5) and individual in-depth interviews with young men (n=7), and; 3) secondary analysis of monitoring data provided by the PCT to the evaluators.

### 5.2 Perspectives from the Young Men's Health Worker

The aim of the interview with the YMHW was to explore the impact of the Young Men's Health Worker Service (YMHWS) on vulnerable and disadvantaged young men's health outcomes (Objective 4). In assessing impact, types and number of services provided were also explored (Objective 2) as well as the potential added value of the service over and above services already offered to young people in East Sussex (Objective 5). The findings are structured into the five following themes:

1. Service context
2. Services provided
3. Factors affecting uptake and extent of potential impact
4. Service benefits
5. Service impacts on young men

#### 1) Theme One – Service context (Objective 1)

The overarching aim of the YMWH service was to improve health outcomes for vulnerable and disadvantaged young men. In the YMHW's narrative, disadvantage was perceived (and intended) to apply in its broadest sense, for example including those young men whom might be experiencing difficulties at home, at school or college, or relating to (un)employment:

*"Disadvantaged could mean... poverty, self-esteem, confidence issues, and that may be at home or at school or at college, or in a workplace. If they are (un)employed, if there's health issues, if there's issues around sexuality, being a parent, or if they're from a BME background and so on - so anybody that may be experiencing disadvantage even those whose personal background may not define them as being traditionally disadvantaged."*

Although the service was set up originally for young men aged between 16-25yrs, the worker reported that it had been necessary to negotiate with the service Commissioner to facilitate working with slightly younger men (11-15 years) due to demand from young men themselves.

*"Over the last year, after we had discussions with the commissioner to ask if it was possible to bring the age down to under 16 partly but certainly not exclusively, to help that transition from being in school to suddenly not being and having no one to guide you or tell you what to do or where to go."*

Indeed, findings from the focus group with young men support the notion that such a service may be required for men younger than 16yrs (Section 5.3).

An important contextual element to the YMHWS was the relationship with Pulse Innov8. The YMHW reported that he worked closely with the Pulse Innov8 team meaning that services for young men could be 'joined-up' more easily with other services for young people such as



smoking cessation, sexual health, and Action for Change (a service that provides help, advice and support to people who are being affected by their own or somebody else's drinking of alcohol). Working in such a way meant young people could be exposed to a more holistic and 'seamless' service pathway:

*"I have close contact with the Pulse Innov8 team, Action for Change, smoking cessation etc. – so if there's an event... we all do it together... we all join up in that way... A [Pulse Innov8 worker] worked with a young man and he was coming to the end of his programme with her, so she said that he needs to build up his confidence, his self-esteem, he's been misusing substances - so she would refer him to me. I was then able to refer him to the opticians down the road, and into counselling to talk about anger management - so it was a real easy pathway into my service and other services."*

## 2) Theme Two - Services provided (Objective 2)

The provision of services to young men was reported to be unpinned by an approach that was needs-led, person-centred, and one that drew on principles of resilience therapy or resilience frameworks<sup>7</sup>. As the YMHW explains:

*"It's [the YMHW] needs led... I work in a resilience based way, person centred... sometimes if you're working in a group... young men become very reliant on the worker and not having the ability or enabling them to be able to do it [change] themselves - resilient therapy has enabled them to take the skills away from that session and be able to do it themselves."*

At the start of the service, the YMHW viewed his mode of service delivery primarily as adopting an outreach model of working, for example visiting young men in their homes, attending youth clubs, cafes, and so on. However, he reported that although outreach was still an important component, young men tended to come to the service in the CRI offices for their individual one-to-one appointments (intensive or signposting), group sessions, and drop-in sessions:

*"The service was set up so that I would go to people's houses, but now most people come to the service, if they are able. What I can then offer them is that I can go on a home visit for the first time and we then encourage them to come down to the service."*

In addition, training during the YMWH role to be a Life Coach meant that the YMHW could extend the range of flexibility in terms of supporting young men by offering coaching via telephone appointments:

*"...Although most people can attend... through the year I started training to be a Life Coach... So I used those skills within the [YMHW] service to be able to offer telephone sessions. If somebody couldn't get in because of child care, or disability, then I could offer a coaching session over the phone which worked really well - as long as that person sets that time aside, an hour and a half or hour for the session."*

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<sup>7</sup> Resilience is generating intense interest as a concept to guide intervention with children and young people who have experienced adversity or who are identified as vulnerable to poor developmental outcomes. It is a relatively new methodology that is designed to help young people find ways to keep positive when living amidst persistent disadvantage (Hart, Blincow, and Thomas, 2007)

In terms of the actual services provided and/or techniques adopted to deliver services the YMHWS reported that these were wide ranging (led by the young man's needs). Triangulating the qualitative data from the interview with the worker with the quantitative data (outlined in Section 5.4.2; see also Table 5) as well as additional qualitative data outlined in the quarterly monitoring reports, services provided to young men were extensive and included (but were not limited to): provision of a series of support cards that offer free goods or access to services and facilities (namely, gym and swim; know where to go cards; C-Cards; 'After party' drop-in sessions delivered jointly with other Pulse services; Chlamydia screening; one to one intensive support (for example, utilising anger management techniques; fitness and diet plans; structured planning exercises; coaching; resilience therapy; sexual health education; and brief solution focused therapy); referrals to other services; day events (e.g. Inside out-day; Fresher's Fair Hastings College; Men Christmas Campaign; Lads to Dads day), and; group sessions and/or support (e.g. sexual health focus group; boys talking sex group; fathers and fathers-to-be group etc.).

In delivering services, the YMHWS reported the use of specific techniques to help build resilience in young men via interactive activities and toolkits that can facilitate young men to work through their problems to identify solutions themselves:

*"We base the work on a resilience framework... if there's a situation that someone's talking about, something they feel uncomfortable with such as around anger management, then we look at what would enable them to get through that situation... I worked with a young man... who wanted to disclose to his partner that he'd been in prison and why. We used this tool kit for him to work through what he would need to get him through that situation. He took it [the tool kit] away with him, brought it back into the session and said, 'I realise what I need, I've already got it' and it enabled him to then disclose to his girlfriend why he'd been in prison."*

The YMHWS also reported engaging young men in similar resilience based activities including 'resilience jenga' which aimed to assist young men in talking about pertinent issues in an empowering way:

*"...I developed a tool kit called 'resilience jenga'. You play it like a game of jenga in that they make choices over what to do – so they pick up the words that they want to talk about. As a practitioner, you then talk to them about what that means to them, how they can build up positive relationships, what they do to enlist the help of others and so on. So it's a fun way of doing it, at the same time the young man has control over the situation as well."*

### **3) Theme Three - Factors affecting uptake and extent of potential impact (Objectives 4-5)**

An important feature of the interview with the YMHWS, were reflections on the unique features of the service. This on the one hand supports the 'added value' of the service (Objective 5) although, on the other, can identify factors that limited potential impact (Objective 4). Either way, these factors may be of interest if a young men's health service were to be established in similar settings and contexts in the future.

#### **Communication between the YMHWS and Pulse Innov8**

One important factor that appeared to facilitate young men's uptake of the YMHWS was the productive and positive relationship between the YMHWS and the Pulse Innov8 team. In his interview, the worker highlighted the benefits of setting up of an informal Pulse service providers' worker's meeting to aid communication and thus facilitate young people's progress or pathways through the various services:

*“Me [the YMHW], the smoking cessation worker, and the Pulse Innov8 team have got a friendship as well as a working relationship. So that’s why we all meet up and have e-mail contact, phone contact - e-mail is impersonal so we tend to just phone up somebody and say, can you do this, can you do that, and we have that contact all the time. This was partly in response because there’s been a lot of changes in [Pulse] managers... at one point it didn’t feel like there even was a manager - so we all got together and said, ‘let’s carry on our meetings’. And so we set up as Pulse service providers’ worker’s meeting. That was our own initiative because we wanted to keep that communication going.”*

### Relationship building

From the YMHW’s perspective, a further factor potentially impacting on service uptake was the focus on relationship building with young men prior to and during service provision. This was felt to be particularly important depending on the route taken by the young man into the service. For example, young men referred in from another service are perhaps likely to have already established some form of relationship with the service provider (positive or otherwise) compared to those who may have self-referred or been referred by someone else (e.g. a parent). Indeed, cross-referencing to the focus group and interviews with service users, young men reported that their relationship with the YMHW was one of the key benefits of the service and main reason for taking up the service offer. In his interview, the YMHW felt that meeting young men who had been referred to the service before their first appointment was a useful opportunity in order to start building a positive relationship with the young man. The quote below illustrates this point in relation to a referral from the local Youth Offending Team (YoT):

*“If they’ve been referred through another service, then unless they’ve got a relationship that’s built... what they [the referrer] would [usually] do is ask me to meet somebody and then do a session with that young person. But that never works as the young person may not turn up. So we would go in as part of their existing work with the YoT. They would have a session for an hour, half way through they would introduce me - they would have introduced me the week before saying, ‘[the YMHW] is going to come in on that session and tell you a bit about his role’. I would then speak to him about what my role is and what support I can offer them and whether that fitted in with what they wanted - so they met me through a relationship with somebody else. Working in this way helps them overcome that initial worry of ‘I’m going to have to meet somebody new’ – it feels like it worked because it would then produce people turning up for the first [YMHWS] session.”*

### Marketing and promotion

An important part of the YMHW role (as set out in the GM02 targets for the role as set by the Pulse manager) was to work closely with the Pulse Innov8 team to promote the engagement of some of the most difficult to reach young people. In his interview, the worker reported a variety of activities in relation to this target. One strategy adopted was building on previous relationships (and creating new ones) with other agencies and organisations to raise awareness of the YMHW role and capacity:

*“I have built up partnerships with people over the years in work that I’d done before [substance misuse, sexual health]. It then enabled me to go into and say, I’m doing a different job now, but those relationships were already there, so... The first year of my current post was spent going round to different services, going to their meetings and saying, ‘this is my role, this is how I can enhance the service that you’ve already got there and I can do that specific work with that young man’.”*

A related activity included using marketing materials such as posters in prominent public spaces in collaboration with Pulse Innov8 to raise awareness of the services available for young people:

*"I: In your file [YMHW file of activities completed] you've got posters, do you put those up where you can or are they given out via partners?"*

*P: Partners, doctor's surgeries, anywhere that you can think a poster could be put where young people go, health services, around town. We had a great big six foot poster that we put in a shop window in the town centre so young people who don't access services would see it when they went past. We also had the events such as dancers who... would do flash mobs in the town centre - and then give out a load of leaflets as well, so they'd attract young people to it, see what they were doing and then give them the leaflet."*

In addition to the YMHW interview, analysis of the qualitative data from the quarterly reports also confirms a variety of marketing and promotion activities were conducted during the time the service was operational. For example, the GM02 target for the YMHW role stated that the 'the worker will provide regular presentations and training workshops to... agencies working with this [young men] client group to raise awareness, share information and to promote the services and activities available.' This target was to be achieved monthly by attending (and presenting) at a variety of local groups, meetings, and conferences to raise the profile of the YMHWS to external agencies, third sector organisations, and statutory services and so on as well as to young people themselves. Examples from the quarterly monitoring reports for the service show this target was met and included attending: local events in Hastings and Rother; relevant conferences (e.g. Working With Men's conference in Brighton; Young People in Focus conference in London focusing on young fathers); the local Lesbian Gay and Bi-sexual forum (which involve the local police and council services); young fathers steering group; adult sexual health meeting; Hastings and Rother Teenage Pregnancy action group; self-harm group terms of reference meeting; Reach meeting (a volunteering agency); London Action Trust (LAT; a crime reduction initiative) meeting; Pathways residential service; media/campaign meetings for East Sussex (e.g. a radio advert on Arrow FM); and the local University Fresher's Fair.

Unfortunately, it was not possible to determine whether such marketing and promotion activities directly influenced the number of referrals into the service (from young men themselves or via referrals from other services and agencies) as no data are available to draw such conclusions. However, given the high numbers of young men using the YMHWS, it is likely that such activities were instrumental in translating to actual service uptake.

### Lack of role clarity

The YMHW also outlined some of the challenges experienced during the early stages of the project's operations, namely relating to a lack of role clarity for the post.

*"It was difficult for me in the beginning, because was it [the YMHW role] to focus on teenage pregnancy and working with young fathers and reducing teenage pregnancies, or was it to engage young men into health services? I found it quite unclear in the first place."*

In his narrative, the worker went on to explain that the origins of the post developed out of a realisation by the local teenage pregnancy action group that young men (particularly those experiencing disadvantage) were not engaging with health services, leading to poor choices and lower aspirations. Although the role was managed by the Pulse Partnership (not teenage pregnancy partnership), he reported that its origins still seemed to impact on other professional's perception of the role and its value:



*"I was part of the development of this role following a conversation with the teenage pregnancy team... But I don't think, my role was directed at young fathers because it was a health initiative to support young men into looking after their health, but...there is still a focus on teenage pregnancy... forgetting all the other health issues that may come into working with young men, about confidence, about self-esteem, about anger management - it is just about reducing the teenage pregnancy numbers. That's what it has been about and I think it was difficult to get people to grasp what was the point of the young men's health role?"*

...

*I: What do you think your role is?*

*P: It's a health role. It's a health initiative but I think what it is also around confidence, making positive choices, self-esteem, so that is all part of their [young men's] health."*

#### **4) Theme Four - Service benefits (Objectives 4-5)**

Viewing the benefits of the YMHWS service, albeit from the professional's perspective, moves the findings beyond discussions surrounding context and delivery towards impacts. The following benefits of the service are presented as sub-themes, and clearly illustrate the apparent 'added-value' of the YMHWS.

##### Male worker

One of the key benefits of the service as reported by the YMHW, related to gender of the worker himself. Although in general some young women often express clear preferences in terms of the gender of workers (e.g. in health settings such as GP surgeries or GUM clinics), this preference is often not quite as clear cut in relation to young men (Lloyd, 2001; Sherriff, 2007; Sherriff *et al.*, in press B). However, in his interview, the YMHW felt that offering young men the opportunity to see a male worker was an important benefit and added-value of the service particularly given the sensitive nature of topics they may want to explore such as sexual health and sexual practices:

*"It's not just about engaging them [young men] into services, it's about the ability for that young man to have a choice that he sees a male worker - because it will enable him to talk about sexual health because some young men feel uncomfortable speaking to young women about sexual health... but it's not only about sexual health, young men have talked about sexual practices too... young men can feel inadequate about sexual performance and things like that and there's no service [other than the YMHWS] that offers somewhere to talk about that in a 'safe' space."*

##### Individual approach vs. group approaches

A clear benefit of the YMHWS from the perspective of the worker was that it was able to provide young men with one-to-one (and if required, intensive) support in addition to the more usual group based support. This intensive support was flexible in terms of delivery (including in the client's own home, by telephone, in the CRI offices or other services' offices, as well as in other public locations of the client's choice) and was based on time-limited sessions adopting a resilience framework with goal setting and structured action plans.

Projects and agencies providing services for young men have commonly been criticised for becoming too fixated on working in groups (e.g. Lowe, 2006; Sherriff 2007; Sherriff *et al.*, in press B). Although group work can be extremely valuable and have many advantages in delivering services for young people, it is not universally appealing and can exclude and alienate some young men (Sherriff, 2007). Indeed, although resource-intensive, one-to-one work is often the *only* way some harder to reach young men will engage with services, at least

at first. It can be particularly difficult for some young men to 'open-up' in group settings. Being able to tailor sessions therefore to individual needs and set personalised targets means that effective work can be done relatively quickly (Sherriff *et al.*, in press B). Such views were reflected by the YMHW in relation to anger management which he reports as one of the most common reasons young men access the service:

*"I: What is the main reason young men come to the YMHWS for?*

*P: Anger management... [young men] don't want to do it in a group... a lot of young men have witnessed domestic abuse at home. Not experienced it themselves necessarily but because they've witnessed it, not spoken to anybody about it and then they don't want to go to a group - they have anguishes themselves, and they need individual support."*

Similarly in terms of one-to-one support by telephone, the YMHW outlined the benefits in terms of facilitating some young men engage and 'open-up':

*"Initially the person said that he didn't think he would be able to do it on the phone but he actually opened up more. There was emotion in his voice and what I learnt through coaching is that young men don't want to make eye contact in the session - they don't want to show emotion so if no-one's in the room with them and they're on the end of a phone, it may help them open-up and not feel that uncomfortable - they feel safer, because it's only them there in the room."*

However, the YMHW worker reported a caveat in that he felt the freedom to conduct needs-led one-to-one intensive work with young men had become more restricted due to the GMO2 targets for the service being updated during November 2010.

*"It's [the YMHWS] become more prescriptive in the last six months... we've changed to having six one-to-one sessions at which point they're reviewed and moved on. If at the review they still need further sessions, then that's fine, but before it wasn't that prescriptive, we were able to work with them over three, four months as long as they needed. And that's why I think it worked so well because it wasn't prescriptive. A lot of young men don't turn up for their appointments one week but they might next week. So if you say, 'you've got six sessions and you're out', that doesn't allow for that drop-in kind of service and that's the reason I think it worked for so long."*

### Offering choice and streamlined pathways

A key benefit of YMHWS perceived by the worker, and added value of the service, over and above other existing services, was that of offering young men choices which was possible partly through the nature of the role allowing intensive work with young men on an individual one-to-one basis:

*"I: What do you think your service offers over existing services?*

*P: It offers a choice to a young man - a choice of a male worker, a choice of other services, helping them to make healthier choices in what they do. For example, I was able to take young men to the sexual health clinic, talking them through the process... I can tell you what this person's going to do when you go in for a sexual health check and sit with them through the session and talk them through the process of what happened... and having that ability and time in my role to be able to do that."*

Furthermore, the YMHW added that a further benefit of the service was to be able to offer young men a more streamlined pathway into other services:

*“A lot of young people get lost in between one service and another, so to be able to physically take them up to that service is great... it [the YMHS] also streamlines services into Connexions because I’m in the office, straight into family services downstairs, intensive services that we’ve got in CRI, parenting support and so on.”*

To support the above statement, the YMHS reported the case of a young man who was N.E.E.T (Not in Employment Education or Training) whom had accessed the service via a drop-in session:

*“He had no job, he was sofa surfing [homeless but sleeping on friends/acquaintances sofas]... I referred him to Youth Accommodation Support Service, referred him to Connexions. He then got into supported accommodation and into education as well. That was something really simple but it was so smooth because he’d been referred and attended the drop-in, and I’d then been able to refer him on... So it was an easy pathway from one service to another.”*

### **5) Theme Five - Service impacts on young men (Objective 4)**

The YMHS reported impacts in that he felt the service had facilitated young men to be able to challenge their own attitudes regarding diversity issues particularly sexuality and attitudes to homophobia. In the extract below, the YMHS goes on to reflect upon a session with one young man along with how changes to the existing referrals form to include details of an individual’s sexuality, can provide a useful opportunity to raise discussions and challenge heteronormative (and often homophobic) perceptions and comments:

*“A young man sat in the session and said ‘I won’t go to the gym because there’s lots of gays up there’. I’m sitting there thinking ‘do you not understand that I’m a gay man and you just said that?’ But then I challenge that... part of their referral form is monitoring people’s sexuality because you’re covering a lot of the groundwork - you’re opening up the conversation that they may not feel comfortable opening up the conversation with you. With that in mind, if I said to somebody what sexuality are you and they go ‘normal’ then I challenge that. I can spend that whole session saying, ‘what is it about normal why do you think that’s normal?’... I love those sessions because that’s part of my role is to challenge people’s perceptions.”*

Similarly, the worker felt that the YMHS had also been able to challenge homophobic and/or heteronormative attitudes and comments in relation to staff and other professionals as well as young men:

*“I run a youth group... there’s four young men that go that always use the word ‘gay’, or ‘poof’. But I challenge them and other people have started challenging them too. They got warnings for racism but the staff wouldn’t challenge them if they said ‘that’s gay’. But when I said the reasons why you should challenge it, that’s when they kind of changed their perception and agreed that even though it’s not always intentionally homophobic it needs to be challenged.”*

Moving from awareness and attitude change towards behaviour change, the YMHS was convinced that the service had had an impact in this respect. In his interview he outlined examples in the form of case studies of young men he had worked with. In this first example (also referred to briefly earlier in the chapter), he described the case of a young man referred to the YMHS from the probation service following recent incarceration for domestic abuse:

*“.... He had issues round self-esteem, confidence, anger management... He was in prison because he had beaten his girlfriend until she was in hospital. It was the only incident he’d ever had of domestic abuse, and he says that there were never any*

*issues around it before. He engaged with the prison service around domestic abuse and did a lot of work, had a glowing report when he came out. They wanted him to continue that work in the community and he has turned up at every session with me. Half-way through the sessions he was able to disclose to his new girlfriend that he was in prison for domestic abuse. So through working on confidence issues, talking about his relationship with his parents, and learning to recognise the signs that led up to that domestic abuse issue, through talking about how to develop positive relationships, what that would mean to him about honesty, about how to manage jealousy, all those issues. Half-way through he sent me a text saying 'I've never felt this happy in my life, I never realised that I had choices'."*

The YMHW also reported that the young man had continued to engage with the YMHWS after finishing with the probation service, and with support, had managed to gain part-time employment and access education and training. Moreover, the YMHW felt that attitude and behaviour change with this particular young man had taken place:

*"That's why I love my job... it's when you see young men like that - he challenged my own perceptions around domestic abuse... that somebody still has that ability to change and can change if they want to."*

The second case example concerned a young man with multiple presenting issues including substance misuse, a difficult relationship with parents, homelessness, and becoming a father for the first time. The YMHW explains the considerable impact the service had on the young man's circumstances and behaviours including reducing his substance misuse, finding accommodation in supported housing and learning to become a positive parent:

*"...He had a poor relationship with his father, his mum had left years ago, and he started to drink. He accessed the [YMHWS] service because his friend had been in the year before for a gym and swim card. He has been working on anger management issues, on being a positive parent through me... we were able to buy him a book on being a father and to talk about those experiences about what the feelings might come up for him, and what he thinks is going to be a positive parent. He's now... cut down on his drinking and stopped smoking marijuana. He was 'sofa-surfing' when he first came to me. Within two weeks I'd referred him into the Youth Accommodation Support Service and he's now been in supported accommodation."*

The third and final case example demonstrates a less acute impact than the previous two but nonetheless still highlights important outcomes for the young service user as a result of accessing the YMHWS. Interestingly and of relevance to this evaluation, is that he also draws attention to the difficulty in monitoring and measuring sustained impacts and/or outcomes of the service:

*"A young man I worked with was referred through the youth offending team - we talked about anger management, confidence issues, self-esteem, his relationship with his parents and he was getting into trouble and drinking a lot... every now and again I'd e-mail him from work and say, how are you getting on, what's up, what are you doing, how's that anger management carrying on, and he would always respond... his behaviour changed over a period of time... but his attitude has taken longer... it's the same with substance misuse, what you do initially might not have an effect for them because they might go and lapse the next week - so it might be a year down the line actually they take on board what you say where there's a behaviour change then."*

## 5.3 Young men's experiences of using the Young Men's Health Worker Service

The findings in this section reflect the data collected from seven individual in-depth interviews and one focus group (n=5) conducted with young male clients of the YMHWS. The aim of this aspect of the evaluation was to explore young men's experiences and perspectives of the YMHWS in order to elicit the potential impact and added-value of the service including any potential behaviour change (Objectives 4-5). This impact is derived from the perspectives from the young men who used the services. Findings are structured into the following five themes:

1. The service
2. Service benefits
3. Service impacts
4. Recommendations for service improvement
5. Future impact of service closure

### 1) Theme One – The Service

To understand how young men first came to receive services from the YMHWS, two main sub-themes were identified through the analyses of young men's narratives: (1) nature of referral to the service (self vs. other-initiated); and (2) reasons for the first visit.

#### Nature of referral to the service

Most of the young men interviewed reported that they had first been referred to the YMHWS either by another individual or through an agency or other organisation. For example, some participants said they had been referred by family members or friends who had accessed the service themselves, whereas others reported being referred by professionals (such as key workers, the Police, Connexions, the probation service, Pulse Innov8, and so on). The extracts below reflect the referral process as experienced by some of the participants:

*"...I'd been in contact with [the YMHWS] through [the probation service] 'cos I've got a key worker and basically when I came out of prison – I came out with nothing. I was in a new area and... and she explained them [the YMHWS] as a sort of mental health worker..." (P2)*

*"I: How did you find out about [the YMHWS]?"*

*P: The police ended up coming round to my mum's house... they gave me this leaflet – there was a load of numbers on to get in touch... I spoke to someone and she put me through to [the YMHWS]." (P5)*

Three young men indicated that they had self-initiated contact with the service. Two of these had met the YMHWS at community-based workshops and had then gone on to contact him at a later date when experiencing adverse life events. A further participant was referred by his worker at Connexions upon expressing interest in wanting to be healthier:

*"I met [the YMHWS] through a course I was doing. I was part of the peer education group in Bexhill and he [the YMHWS] came and delivered a six week course [Speakeasy] - I met the YMHWS there and I actually went through a really, really rough patch at one point where I felt I needed to talk to someone. So I just rang him up and that's the first time I had used the service" (P3)*

*"I: So you heard about the YMHWS through Anything But [a local LGBTU youth group]?"*



*P: Yes I was in the group and [the YMHW]...took it over... I needed to talk to someone so I went to see him.” (P6)*

*“I was talking to [my Connexions worker] about how I wanted to be much healthier... cos I was really obese... She advised me if I wanted to talk to [the YMHW] and that’s basically how I got to know him and what he was – a health worker for young men.” (P4)*

### Reasons for first visit

While each of the young men shared their individual reasons for accessing the support of the YMHWS, there were a few common reasons noted among the responses. Specifically, anger management, challenges around preparation for school or college, job (in)security, personal relationships (both with parents and sexual partners) as well as a general desire to get ‘things sorted out’ were most frequently cited as motivations for seeking support:

*“It was in preparation for college when I first come here... and [the YMHW] would help a lot. I was in the army but I had to come out because I had family problems. All got in the way and he’s just helped me to sort my life out really.” (P1)*

*“I was working... and my eczema got really, really bad and... was impacting on my life – I was having trouble at work and I just needed to talk to him through it and other personal issues.” (P6)*

*“I came here because of things at home. I can’t really talk to people at home, if I do there’s loads of arguments break out, stuff like that, and I did self-harm in the past as well and that’s not good - and it’s just all issues from my past that I’ve come to talk to [the YMHW] about and he’s been able to sort them out.” (FG, M2)*

Other specific reasons for seeking help were also identified. For example, one participant reported accessing the service because he had been experiencing multiple issues including recent incarceration, substance misuse, and homelessness:

*“It [accessing the YMHWS] was because I was homeless and I’d just come out of prison and then I had drink problems... my whole life was just turned upside down at that point, so yeah, there was a lot to talk about!” (P2)*

Anger management was cited by two young men (one in an individual interview and one in the focus group) as being the central reason for seeking, or being referred for, help to the YMHWS:

*“I just wasn’t getting on with my parents and... I was struggling to hold down a job and... just like everything in my head sort of, went pear-shaped. I just couldn’t keep anything together and kept flipping out and things, so I had to seek help” (P5)*

*“...Because of anger - pretty much like I’ll get angry sometimes and I approached my Connexions worker and told her about it and she forwarded me to him.” (FG, M3)*

Although in the primary data anger management was only reflected twice, in his interview the YMHW reported confirmed that anger management was the most common reason young men accessed the service.

## 2) Theme Two - Service benefits (Objectives 4-5)

To understand the potential impacts of the YMHSWS sexual health provision, this section outlines how the young men perceived the benefits of the service. There were a number of sub-themes evident in young men's narratives including accessibility; one-to-one sessions; qualities of the worker; referrals to other services, and; a one-stop shop.

### Accessibility

When discussing the YMHSWS, most young men reported that accessibility was an important benefit of the service. In particular, two focus group participants cited the provision of bus tickets and/or reimbursement of travel expenses as an important means used by the service to increase financial and geographic accessibility to the service:

*"You get here and if you keep your ticket, you get your money back, so you're not actually spending anything" (FG, M4)*

*"What I do if I haven't got the money [for the bus] I get my Connexions worker or the YMHSW or whatever will buy the tickets for me and send them to me in the post" (FG, M2)*

Two other participants also discussed service accessibility, this time in terms of readily available and flexible appointment times with the worker:

*"It's good, you can call him up and if he is free or if he can squeeze you in, he does, and it is very good because he will talk to you over the phone if he's not available in person." (FG, M3)*

### One-to-one sessions

As noted in the interview with the YMHSW (see Section 5.2), one aspect of the service provided to young men included one-to-one work either via rapid signposting sessions or longer intensive sessions over a six week period. The opportunity to engage with the worker on a one-to-one basis was perceived by most participants as a valued opportunity to speak openly, and informally, about anything they wanted to disclose:

*"It doesn't feel like you're going to a service... 'with [the YMHSW] we go out for a walk somewhere and talk or we go for a coffee or something. That's brilliant 'cos I don't like sitting in an office 'cos it feels too formal, doesn't it?' (P2)*

Such one-to-one sessions were also valued because it enabled young men to build a relationship with the worker facilitating dealing with multiple issues:

*"... The more he can do with one person its better because then you're not having to see different people... If it's always just one person, that way he knows... you more and he can help more 'cos he knows what you're like..." (FG, M3)*

Some participants also referred to the YMHSW's use of activities during the sessions such as structured time planning, cost-benefit analyses, skills-building, as well as advice about healthy eating:

*"...I needed to plan things... It [structured time planning] was like, how much time I spent sleeping, working, time with the family, other activities, work, what do I enjoy doing most... another activity he did was to draw... what I liked about it [a job] and what I disliked and the pros and cons of the job... I was about to blow up if I didn't*

*leave that place, but I needed money, so I felt trapped... but because I weighed up the pros and cons and, if [the YMHW] hadn't of done this thing with me, I wouldn't be where I am today." (P3)*

*"When I saw [the YMHW], he actually took me shopping for healthy food and gave me information on how to be a little bit more healthy." (P4)*

*"[He] helped me get in college and stuff like that. When I was going in the forces he helped me over a load of paperwork as well. It's just the place for you to come and help with anything really." (P1)*

### Qualities of the worker

Inextricably linked with the benefits of the one-to-one work above, many reported benefits of the YMHS as identified by participants, were related directly to their experiences with the worker himself; in other words his personal and professional characteristics. In terms of their first encounter with the YMHW, several young men reported that although they felt nervous before their appointment, during appointments they felt relaxed, comfortable, and able to talk freely:

*"I: What did you think when you first met the YMHW? Were you nervous about going?*

*P: Yeah... 'cos I didn't know what he was gonna be like or anything like that. But then it was really really comfortable and made everything nice and that – I felt I could talk to him." (P7)*

Trust, accountability, and objectivity were repeatedly identified as qualities highly valued in the worker. For instance, several participants referred to the worker as a friend, someone they trusted, and/or someone they felt comfortable disclosing personal information to:

*"As if I was his friend, more than somebody just doing a job." (P1)*

*"He's kind of relaxed... he's somebody you can sit down and talk to about all your issues. Whatever the issue he'll come up with some solution, and try and make your life better." (FG, M2)*

*"He's completely professional, but at the same time he's got such a polite laid back attitude. He's really approachable like a friend, but... he's got professionalism within it too." (FG, M3)*

Feelings of support, reliability and accountability were also frequently alluded to by participants as positive qualities in the worker. For instance, one young man who had experienced significant disadvantage, felt that his experience with the YMHW had been very different to his previous experiences with other services for young people. In the extract below, he goes on to explain that the YMHW followed through with what he said he would set-out to do, and that this was an unusual experience for the young man when engaging with other services:

*"P: I can talk to him about anything because he actually followed through on what he said he was gonna do, which is a first – for me, anyway! All these other services that promise to do this, that and the other but normally nothing comes of it, but everything [the YMHW] said that he was gonna do, he's done.*

*I: Can you give me a couple of examples?*

*P: Seven months ago, I literally had nothing – I had one set of clothes, no coat, no jumper and – you know – it was cold back then... The next day he [the YMHW] brought up a bag of clothes for me... he'd gone to some charity organisation and picked up a*

*load of, brand new clothes and toothbrush and all this sort of stuff, all within 24 hours of meeting me. He got me a doctor, dentist – he sorted out my CV which I'd been trying to do for months. The Job Centre keep saying 'oh yeah we'll do it then' but he done it all within a week of me asking." (P2)*

Finally, perceptions of the worker as a non-judgemental and an objective third party were commonly identified as a key benefit of the service:

*"I'm the kind of person that's not too open, but I can talk to [the YMHW] like I wouldn't talk to my other mates..." (P1)*

*"...I couldn't talk to a friend of mine because they wouldn't understand and I'd feel they judge me. Whereas [with the YMHW]... I felt like he wasn't gonna judge me at all." (P3)*

### Referrals to other services

In their interviews (and supported by the findings from the interview with the YMHW; see Section 5.2), young men reported being commonly referred by the worker to supplementary services on a case-by-case basis. Indeed, as set out in Section 5.4, the GM02 targets for the YMHWS service state that the service should, per quarter, signpost 100 young men to relevant (external) services (e.g. doctors, dentist, parenting groups, connexions, sexual health clinic etc.). Some examples of these referrals are provided below:

*"I: You've been to see the [YMHW] quite a few times, has he signposted you or sent you to other services?*

*P: He sent me to XTrax [A multi-agency one-stop shop for young people] and other places like that." (P1)*

*"Got me in contact with Action for Change." (P2)*

*"I: Does [The YMHW] refer you to other stuff [services] as well?*

*P: I didn't have a dentist and [the YMHW] helped me find a dentist and sign up to him and he helped me in my application to get a grant for a course I'm going to do. So he'll help you find what you want to find, and what you want to do..." (FG, M3)*

### A one-stop shop

Although only one young man actually reported this benefit to the YMHWS, it is nonetheless valid and important in that it not only highlights the person-centred nature of the service but also goes some way in highlighting what young men require from service provision. As such, it is likely to be of interest if a service for young men is created in the future:

*"... the way I look at it [the YMHWS] is its several services but all in one. It's a bit like probation where they can help... you think for your future. And then there's a bit like sort of Action for Change because there's somebody to sit there and talk to and get a bit of advice. So I think it's like a mixture of a lot of different services, but all in one place which is good because you don't wanna have to keep repeating yourself to different people all the time." (P2)*

## **3) Theme Three – Service impacts (Objectives 4-5)**

The possible impact of the YMHWS on the young men was explored according to changes identified in attitudes, knowledge, behaviours, and future aspirations. Participants were readily able to detect changes they had experienced in these areas since attending the YMHWS and

were further able to attribute these changes to the service itself. The service impacts noted were broad, albeit common themes were evident, and appeared to have an overwhelmingly positive effect on participants. No negative impacts of the service were reported.

### Attitudes

The most commonly identified change in attitude was that of increased self-confidence. Perceptions of an increase in self-confidence were noted by six of the seven individual interview participants as well as amongst several of the focus group participants. The quotes below are representative of this service impact:

*"I: Has your confidence changed?"*

*P: Yes, because [the YMHW] boosts you up a little bit every time you go. You then feel more able to go and meet new people and you feel able to start coming out of your shell." (P1)*

*"... it's not just that he helped me lose weight, it's that he helped me, sort of – 'cos losing weight – I said even if it's losing a little bit of weight it will boost my confidence and that's what he was helping me to achieve and that's what I have achieved..." (P4)*

Other perceived changes in attitude were noted to be closely associated with increased self-confidence. For example, many participants reported that they felt happier and more enthusiastic about life in general. Presumably these more positive life perspectives were precipitated by increased feelings of self-worth and control over one's life. The quotes below further illustrate the (for some) life-changing impact of the YMHWS:

*"Yeah it [the YMHWS] actually changed me – the actual person that I am – I've never felt so happy in my all my [laughs] life. And I know that sounds really dramatic but it's true – I've never been this happy." (P3)*

*"On a day to day basis – I think I'm a lot more confident in myself and a lot more positive." (P6)*

A more positive attitude towards seeking the help of services in the future was also commonly noted among participants. In their narratives, young men tended to draw upon their positive experience with the YMHWS as a means to deduce that other services may be similarly valuable and relevant. The quotes below reflect notions of increased willingness to access other services and/or ask for help in the future:

*"I: ...Following your experiences and confidence gained from accessing the YMHWS do you think you are now more likely to also access other services?"*

*P: Yeah – I would now – I'd do it any day. But before... it wouldn't have even crossed my mind." (P3)*

*"I: Do you feel now that you can ask for help more easily? Not just about [the YMHWS], but perhaps other people or other services too?"*

*P: He [the YMHW] helped me a lot. I feel that I can let other people help me as well now." (P7)*

### Knowledge

In addition to attitude change, young men were asked about how (or if) the YMHWS had impacted on their learning, for example in terms of new knowledge about sexual health or other matters such as anger management, diet, physical activity and so on. One young man in



particular reported that the YMHWS had increased his understanding and knowledge around healthier eating and more active living:

*"I: ... have you learned anything new since seeing the young men's health worker... and has anything surprised you?"*

*P: It surprised me how through my life I haven't been able to tell me mum the truth apart from when I saw [the YMHWS] – something else that surprised me is learning what sort of foods I can eat and what sort of exercise I can do." (P4).*

Knowledge gained around coping mechanisms was also commonly reported by young men. Examples of such coping mechanisms included that of general stress management as well as more specific anger management skills. For instance, two young men reported learning how to more effectively manage feelings of anger and how to apply conflict resolution skills to mitigate situations that may instigate feelings of anger:

*"P: I've learned to think things through now and let people help me. I know how to deal... with anger and how to remove yourself from the situation so that the problem you're having doesn't actually happen.*

*I: Have you found that's working?"*

*P: Yeah... it's really helped and it prevented me from getting as angry as I was – I've learned how to deal with it... I'm not as angry a person now." (P7)*

*"I: Do you feel you've learnt anything new since seeing him [the YMHWS]?"*

*P: Absolutely. He touches on so many things that you wouldn't realise about yourself... what I thought my anger when I came here I would have said I can just snap and that, but it's not the fact that you are an angry person - you are snappy, it's a build-up of things. For everyone it's different things, things could be happening at home or with your parents or a partner or a life problem or money, and he's just so good at helping you not only find it but then try to find a solution round it that." (FGP, M1)*

## **Behaviours**

In the narratives of young men, there appeared to be some evidence of tangible behaviour change attributable to the YMHWS. Adoption of healthier lifestyles was one type of behaviour change identified. For example, one young man reported that he had managed to increase his levels of physical activity levels in addition to adopting healthier eating practices. Furthermore, another participant who had previously misused alcohol reported that he had now stopped drinking alcohol and felt that his health (not just physical but social and emotional health) had improved as a direct impact of attending the YMHWS:

*"My health is so much better now... I'm not drinking at all any more, I'm more confident. The worker helped me get in contact with a solicitor as well, for access [to my child] and all that." (P2)*

Another common area of behaviour change was increased positive social interactions. This was evident in reports of increased ease in approaching others as well as through the application of skills learned in YMHWS sessions to real-life situations. More positive social experiences are likely to be associated with increased self-confidence, suggesting important relationships between service impacts. The quotes below reflect such changes:

*"I learned about talking to people... most of the time I'd rather keep to myself – read a book, play a game or do something that involves just me. It's a lack of confidence to go up to someone, say hello and then get involved – the physical walking up and saying hello. I now feel a lot more confident and more comfortable with myself, just*

*to go up to someone to say hello and meet and greet and see if you can hit it off.”*  
(P6)

*“I: Do you think what you’ve learnt here has helped change your behaviour?”*

*P: Yes it has helped with my personal issues and I was able to go away from the sessions and be able to practise what he told me to do and sometimes it worked and sometimes it didn’t. I used to go back to him and say what had worked and thank you for that and sometimes if it didn’t work I’d say ‘can you give me any other solutions and ideas?’”(FG,M3)*

### Future Aspirations

The YMHWS appears to have impacted positively on young men’s future aspirations. For example, since accessing the YMHWS, young men reported a variety of plans for the future including gaining employment, training, and starting college. Moreover, young men reported increased motivation to realise their future goals and aspirations, as a direct result of attending the service:

*“I: Thinking about what you went to see him first to where you are now and starting a new job in May, which is brilliant, is that getting to where you want to go?”*

*P: Yes, I’m looking for a permanent job, that’s the thing.” (P1)*

*“I: ...Thinking about long term now, have – has it helped you think about your future plans and aspirations – whether that’s work or college or family relationships?”*

*P: It’s [the YMHWS] helped me wanna go to college more...” (P4)*

Finally, one young man in particular, reported that he felt more positive and enthusiastic about their future prospects after attending the YMHWS:

*“I: ...do you think going to see the Young Men’s Health Worker has had any impact or effect on your future aspirations, your hopes for the future – for example, as a father – your hopes for work – your hopes for education – that sort of thing?”*

*P: Definitely. I’m looking forward to the future now, whereas before I just didn’t even think I had one.” (P2)*

### **4) Theme Four – Recommendations for service improvement**

In both the individual interviews and focus group, young men were given the opportunity to suggest ways in which the YMHWS could be improved. No negative feedback was reported; instead young men talked about wanting to see the service continued and expanded, for instance, whether through additional staff, establishing more locations, or offering more sessions.

*“Expand it... and let everyone else know about it because you can guarantee there are a lot of people out there that don’t know about it [the YMHWS- that don’t know it even exists.” (FG, M1)*

Two young men spoke directly to a need for increased staff capacity within the YMHWS:

*“I: Is there anything about the service that you don’t like or would like to see change?”*

*P: There is not enough staff. There should be more people like him [the YMHWS].” (P1)*

*"I: Thinking about the service, are there things you'd like that aren't there at the moment?"*

*P: More staff probably for other kids, more staff for other people." (FG, M2)*

One participant stated the need for the YMHWS to establish more locations in an effort to reduce travel distance and related barriers for service-users. Specifically, he recommended a service branch be opened in Brighton:

*"I would like to see someone in my area like the YMHWS. Although Hastings isn't far, it's quite far if you've got a family and on a low budget. I'd like something in my area because there's nothing like [the YMHWS] in Brighton." (P3)*

Another young man suggested that the YMHWS could increase the range of services offered, for example, by offering larger group sessions to service-users. The participant elaborated upon his recommendation by highlighting the value in giving service-users the opportunity to both participate and listen as they so choose in group sessions, while protecting anonymity. This is reflected in the quote below:

*"P: I'd like larger groups of people – if somebody comes with any problems... when there is about 10 or more people [in a group] I'd feel a lot more confident talking about it if there's somebody else going through it as well. You'd have people to share it with.*

*I: Is that easier in a larger group?*

*P: Yeah if it was in a larger group, you'd feel more comfortable. A smaller group makes me very nervous, uncomfortable." (P6)*

One young man highlighted that he had already recommended the YMHWS to his friends but that they didn't fall with the age remit of the service:

*"I've tried to get some people here already but some of my friends aren't old enough to come... I wish they did a service where they could come and see someone who's under 16. [I: Because this service is for 16 and over?]. Yes. One mate who is 14... It would be really good for someone like him to see someone like [the YMHWS]." (P1)*

From young men's narratives it was very clear that they valued the YMHWS service. This was reflected time and again in the dataset. Indeed, in these final extracts, several young men felt there was nothing that could be changed about the service:

*"I: Is there anything that you would like to see in the service that isn't there?"*

*P: [um] No it's outstanding, to be honest. So, no nothing." (P5)*

*"I: Is there anything that you would like to have seen in the service that hasn't been available?"*

*P: Being with [the YMHWS]... it wasn't perfect, but it was really, really, really good. I mean, I couldn't really think of what else could have been involved... he helped me as much he can and he helped me beyond what I thought he could." (P4)*

Finally, young men were asked whether they would recommend the YMHWS to others. Unsurprisingly given the very positive feedback from young men about the service, most young men reported that they would indeed recommend the YMHWS to others, and on occasion already had:

*"Definitely..." (P7)*

*"I'd tell 'em my experiences... I'd tell 'em exactly how it helped me... most of my friends knew the patch I went through, so they can see what it's done for me." (P3)*

*"It's completely turned my life around, so yeah I would [recommend the YMHWS]" (P2)*

## 5) Theme Five – Future impact of service closure (Objective 4)

At the time of interview in March 2011, the YMHWS was still operational although young men had been informed that the service would close a month later. Consequently, the perspectives of young men in this section are necessarily speculative and thus some caution should be applied in their reading. Nonetheless, they do illustrate the value that young people attach to the YMHWS. Several other participants felt that they would not have made the same progress, or experienced the same positive life changes, had the YMHWS not been available to them:

*"I: ... if the [YMHWS] service wasn't here, what d'you think you would do? Where would you go?"*

*P: ... Considering my circumstances, probably just living on the street." (P5)*

One young man raised a concern that should the service not continue, access to necessary services may be restricted due to financial constraints:

*"I: ... If the service wasn't here anymore, what d'you think you'd do if that goes? Who would you go to instead?"*

*P: I dunno really, 'cos I think you'd have to find someone who'd do, like, private counselling but then not everyone can afford that." (P7)*

The final extract reflects the strength of young men's feelings about the service closure:

*"I don't know... you're probably letting down a lot of other people because people depend on this." (P1)*

## 5.4 Analysis of the monitoring data provided by the PCT

This section outlines findings from an analysis of secondary data provided by the PCT to the evaluators. The data are largely quantitative and present detail on how many people used various the YMHWS, some indication of their demographic profile, what they attended for, what services they received, and an indication of the numbers of referrals to external services following a consultation with the Young Men's Health Worker. In doing so, these data address Objectives 1-3 although as noted previously; it has not been possible to address Objective 3 fully due to a lack of data being available (see Chapter Two).

### 5.4.1 The number and characteristics of young people using the YMHWS (Objective 1)

GMO2 targets for the YMHWS state that the service should engage with at least 400 young people a year, 120 of whom should be new to services each year. Analysis of the quarterly monitoring data shows on average this target was achieved with a total of 840 young men having accessed the YMHWS between April 2009 and April 2011 or a mean of 420 per quarter (see Table 4 below for break downs). During the latter part of the eighth quarter (Jan 11 to April 11), the YMHWS was informed that funding would be withdrawn at the end of April 2011 hence the relatively lower figures compared to previous quarters represents this gradual and necessary reduction of referrals into the service.

Of the 840 young men accessing the YMHWS, 97% were recorded as being new participants to the services which is a considerable achievement given the well documented difficulty in 'reaching' and engaging young men into both mainstream and specialist services (e.g. see Sherriff, 2007; Sherriff *et al.*, in press B). Indeed, qualitative findings from the focus groups and interviews with young men (and YMHWS) support the notion that the YMHWS has been particularly successful in meeting its targets and expected outcomes (see Section 5.2 and 5.3). During quarters one and two of 2009, a total of 111 young men were recorded as also accessing other Pulse services. However, no data are available regarding which specific Pulse services. Moreover, no data were collected regarding accessing other Pulse services for the remaining quarters of 2009 or at all for 2010/11.

*Table 4. Numbers of young men using the YMHWS*

| Young men (service users)         | April 09 to April 10 | April 10 to April 11 | Totals     |
|-----------------------------------|----------------------|----------------------|------------|
| Number using the service          | 473                  | 367                  | <b>840</b> |
| New participants                  | 464                  | 353                  | <b>817</b> |
| Repeat participants               | 0                    | 14                   | <b>14</b>  |
| Number using other Pulse services | <b>111</b>           | <b>N/A*</b>          | <b>111</b> |

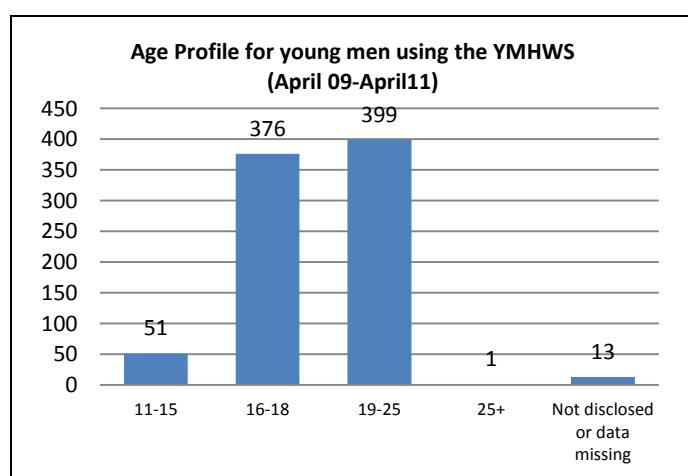
\*Data not available

In terms of the socio-demographic profile of young people using the YMHWS:

From the reported data available (N=795), the majority of young men accessing the YMHWS reported living in Wards comprising the Hastings and St Leonards district (75% or n=594). 19% or (n=154) reported living in Bexhill and Rother, and 47 cases (6%) were reported as either being out of the area or not known.

In terms of reported data available (N=827; excluding n=13 missing cases from the analysis), the majority of young men accessing the YMHWS fell within the target age group (16-25 years) for the service (93.7% or n=775; see Figure 20 below). More specifically, 45.5% (n=376) of young men were aged 16-18 years and 48.2% (n=399) were aged 19-25 years. 6.2% of young men being aged 11-15 years (n=51). In terms of the latter, data were only collected from the third quarter of 2009 (October 2009 to December 2009) i.e. only five quarters vs. seven quarters for the 16-18 and 19-25 age brackets. One young man reported as being aged 25 years or over.

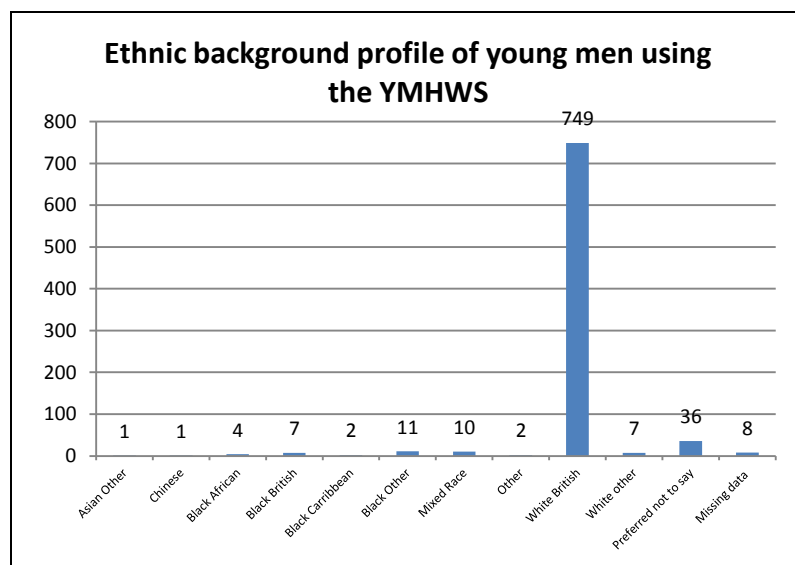
*Figure 20 Age profile for young men using the YMHWS*





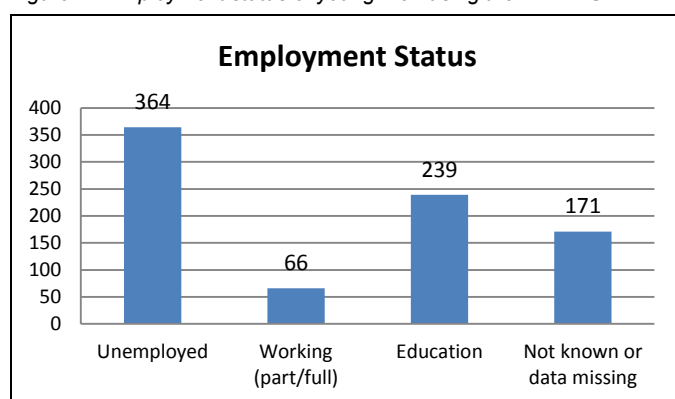
Of the data available (N=830; excluding n=8 missing cases from the analysis), the majority of young men accessing the YMHWS service reported being from White British backgrounds (90.2% or n=749) with a small number of young men preferring not to answer (4.3%; n=36). The remaining 45 young men (5.4%) reported being from a range of other ethnic backgrounds (see Figure 21 below). However, as noted earlier with regards to Pulse Innov8, although the proportion of people in BME groups is lower in Hastings and Rother compared to the national average (see Race for Health, 2011), efforts still need to be made to ensure that young people from BME communities have equal opportunity of access to health services. Thus, concentrated efforts still need to be made to ensure differing needs around health status of these groups are met.

Figure 21 Ethnic background profile of young men using the YMHWS



Of the reported data available (N=669), in terms of employment status, over half of young men accessing the YMHWS service reported being unemployed (54% or n=364), with 36% (n=239) in education, and 10% (n=66) working either full or part time. See Figure 22.

Figure 22 Employment status of young men using the YMHWS



A total of N=13 young men who accessed the YMHWS reported having a disability.

## 5.4.2 Types and number of services being accessed (Objective 2)

In general, data monitoring indicates the YMHWS provided young men with access to a high number and diverse range of support services (see Table 5) which is supported by the narratives of the YMHWS and young male service users; see Sections 5.2 and 5.3). However, it

is important to note that the data (and quality) are varied in places due to inconsistent and unclear reporting in some instances. Whilst in such cases the evaluators have consulted with the PCT to try and determine and verify the accuracy of the data, caution should nonetheless be applied in interpreting the findings that follow.

*Table 5 Services and interventions accessed by young men through the YMHWS*

| Services / Interventions accessed      | April 09 to April 10 | April 10 to April 11 | Totals      |
|--|----------------------|----------------------|-------------|
| Gym and Swim issued                    | 296                  | 367                  | 663         |
| (After party) drop-in sessions         | 108                  | 10                   | 118         |
| Chlamydia screening                    | 47                   | 22                   | 69          |
| Condom cards (C-Card)                  | 25                   | 4                    | 29          |
| Inside out-day                         | 51                   | 0                    | 51          |
| One to one (intensive 6 week sessions) | 41                   | 47                   | 88          |
| Fresher's Fair Hastings College        | 400                  | 0                    | 400         |
| Men Christmas Campaign                 | 75                   | 0                    | 75          |
| Lads to Dads day                       | 25                   | 0                    | 25          |
| Sexual health focus group              | 0                    | 10                   | 10          |
| Boys talking sex group                 | 0                    | 46                   | 46          |
| Speakeasy                              | 6                    | 0                    | 6           |
| Young Parents to be                    | 2                    | 0                    | 2           |
| Parents with Prospects                 | 0                    | 0                    | 0           |
| Substance misuse group                 | 4                    | 0                    | 4           |
| know where to go cards issued          | 0                    | 10                   | 10          |
| Referrals to other services            | 30                   | 31                   | 61          |
| <b>Totals</b>                          | <b>1098</b>          | <b>547</b>           | <b>1645</b> |

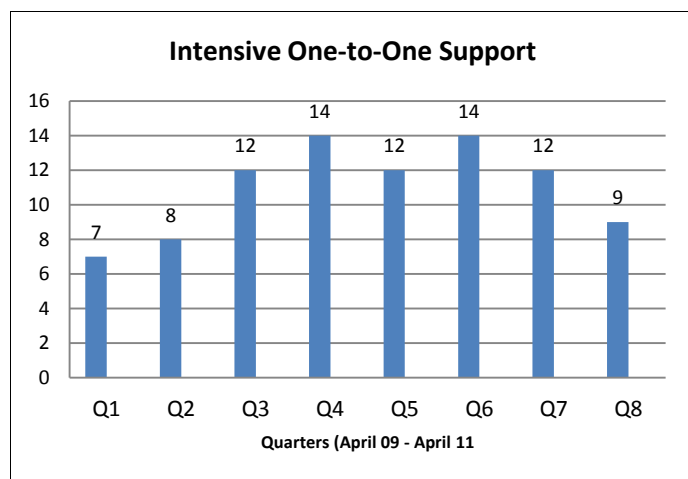
The table above reflects the findings earlier in the report in that the gym and swim cards were particularly valued by young men. Moreover, drop-in sessions were also popular along with intensive one-to-one sessions.

GM02 targets for the YMHWS service state that the service should, each year, work with 160 young men on a one to one basis. However, it is difficult to determine precisely whether this target has actually been met as there appears to be no dedicated data collection system associated with the indicator nor is there a clear descriptor defining what counts as one to one work. Recording of monitoring data regarding one-to-one work through the quarterly reports is therefore in some cases inconsistent and unclear, meaning that there is often no differentiation between intensive one-to-one support (comprising six one-hour sessions) as opposed to one-to-one 'rapid' contact such as five minute signposting sessions where young men may just 'drop-in' for a one off 'consultation' with the worker (see Section 5.4.3).

However, despite this, it is possible to use proxy indicators (i.e. an indirect measure in the absence of a direct measure); in this case the numbers of young men receiving intensive one-to-one sessions (i.e. six week programme of one hour sessions), and the services and interventions recorded as being provided to young men which are *not* group settings (e.g. issuing of cards such as the 'condom card', 'gym and swim', and the 'know where to go' card as well as Chlamydia screens, and (after party) drop-in sessions. Combined, these figures would suggest that it is very likely that the YMHWS not only met but well exceeded this target through the delivery of a range of diverse services to young men (see Table 5 above).

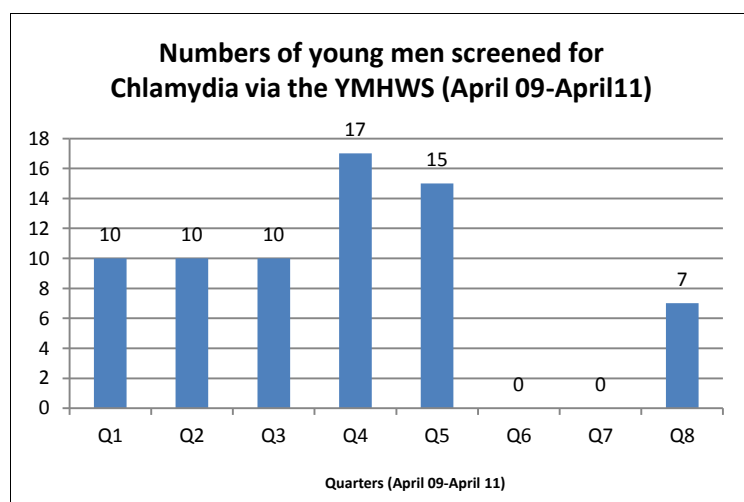
As part of the above target, GM02 also states that for each quarter the service should work with 10 young men through intensive one to one support consisting of six one hour sessions that utilise techniques such as review and action planning, resilience therapy and coaching. This target appears to have been met with a total of 88 young men receiving intensive one-to-one sessions between April 09-April 11. Thus, on average 11 young men, received intensive one-to-one sessions per quarter (M=10.25 for April 09-April 10; M=11.75 for April 10-April 11; see Table 5 above, and Figure 23 below). However, caution should be applied here as it is not possible from the data recorded to distinguish between new cases per quarter and existing cases where a young man's support has continued over into the next quarter (and thus may be counted a second time).

Figure 23 Intensive one to one support received by young men



GM02 targets also state that for each quarter, 35 young men should receive Chlamydia testing. Using the data available, this target has *not* been met. On average, only 8.6 young men received Chlamydia testing per quarter over the two years the service was operational (M= 11.75 for April 09-April 10; M=5.5 for April 10-April 11; see Figure 24). However, the data recorded here only represent the actual tests conducted by the YMHWS directly. They do not reflect the numbers of young men the YMHW reported as having referred for testing, for example at events for young people run by Pulse Innov8. Thus, although the data suggest that the target for the YMHWS has not been met; this should be viewed cautiously as it is likely that far more young men did receive Chlamydia testing through other (related or external) services as a direct result of their contact with the YHMWS.

Figure 24 Numbers of young men screened for Chlamydia via the YMHWS



## Presentations, Training, and Dissemination

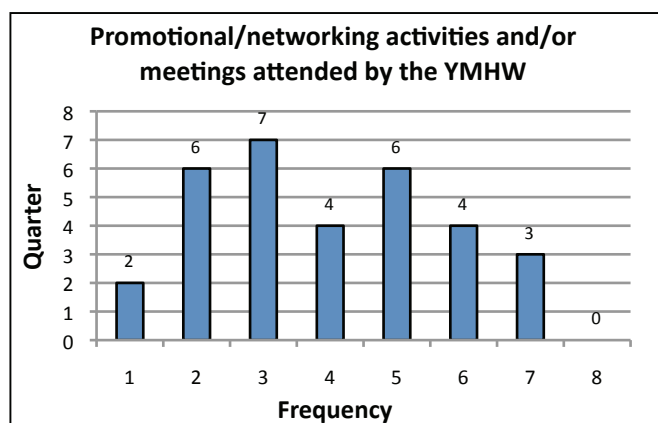
In addition to delivering services to young men, the YMHW was also required to provide regular presentations and training workshops to groups of young men and to agencies working with this client group to raise awareness, share information and to promote the services and activities available. In this respect, GM02 expected targets/outcomes were:

- To provide information for staff about local health services (to attend two network meetings per quarter);
- To deliver four training sessions to professionals each year (e.g. working with LGBTU young people, working with young men and boys etc.);
- To research and establish a young men's group to meet the demands of local priorities (e.g. boys talking sex; me and my baby, and/or any other appropriate programme).

### To provide information for staff about local health services (to attend two network meetings per quarter)

As noted previously, the YMHS was operational for eight quarters between April 2009 and April 2011 meaning that that YMHW was required to attend 16 networking meetings. From the data available, it appears that the GM02 target for this aspect of the role *has* been met. A total of 32 identifiable meetings were attended or four per quarter on average (see Figure 25).

Figure 25 Promotional/networking activities and/or meetings attended by the YMHW



As noted in Section 5.2, monitoring data indicate that a variety of networking meetings were attended including (but not limited to): local events in Hastings and Rother; relevant conferences (e.g. Working With Men's conference in Brighton; Young People in Focus conference in London focusing on young fathers); the local Lesbian Gay and Bi-sexual forum (which involve the local police and council services); a young fathers steering group; adult sexual health meetings; Hastings and Rother Teenage Pregnancy action group; self-harm group terms of reference meeting; Reach (a volunteering agency) meetings; London Action Trust (LAT; a crime reduction initiative) meetings; Pathways residential service; media/campaign meetings for East Sussex (e.g. a radio advert on Arrow FM); and attendance at the local University Fresher's Fair.

However, caution needs to be applied in that monitoring data for this target are incomplete and inconsistent in how they are reported. For instance, in Q6 (June 10 to Sept 10) data relating to this target are unclear as they do not record specifically how many meetings (and where/when and with whom) were actually held instead stating: *"I [the YMHW] have raised the profile of my role... by attending... local events in Hastings and Rother... Positive Steps' meetings..."* Thus in such circumstances, only the minimum identifiable networking meetings have been utilised in

such circumstances, only the minimum identifiable networking meetings have been utilised in Figure 25 above (e.g. taking 'local events in Hastings And Rother' as only one meeting, and 'Positive steps meetings' as only one meeting). Consequently, it is very likely that the actual number of networking meetings attended by the YMHWS was much higher than Figure 25 suggests. Although the criticism of the recording mechanism used in the reporting may seem relatively minor, it does demonstrate the need for more careful and accurate reporting of project activities as any conclusions drawn from analysis of such data can only ever be tentative and must be viewed with caution.

### **To deliver at least four training sessions to professionals each year (or one per quarter)**

A total of eight training sessions were required to be delivered over the two years the YMHWS was operational. From the data available, it appears that the GM02 target for this aspect of the role *has not* been met. Six actual sessions (via five different types of training) were delivered by the YMHWS out of the eight training sessions required by these targets (see Table 6).

However, unfortunately again the monitoring data for this activity is incomplete and inconsistent. For instance, concerning the attendance of professionals at the 'working with LGBTU young people' training, data is reported inconsistently in Q6 (June 10 to Sept 10) and Q7 (Sept 10 to Dec 10) compared to the final CRI Young Men's Health Worker Project Report produced in Q8 (Jan 09 to April 11). The Q6 and Q7 quarterly data state that 17 and 14 professionals were in attendance respectively vs. 40 in the final CRI report document. Moreover with reference to Table 6, two training events delivered ('Resilience Therapy' and 'Sexuality') were not mentioned at all in the quarterly reports but were reported verbally by the YMHWS to the evaluators. Although arguably these are again relatively minor discrepancies, it highlights the need for more careful and accurate reporting of project activities.

*Table 6 Training delivered to professionals by the YMHWS*

| Training Delivered  | Target Group/Purpose  | Attendance (Quarter conducted) | Frequency of delivery |
|---|---|--------------------------------|-----------------------|
| Working with LGBTU young people' (in collaboration with the Youth Development Service; YDS) | For professionals to build up confidence around working with young people and sexuality, to raise the awareness of issues and challenge some professional attitudes when working with LGBT & U young people | 17** (Q6)<br>14** (Q7)         | 2                     |
| Risk Assessment and Management training (in collaboration with CRI)                         | To assist professionals to identify and manage the risks associated with a chaotic and challenging client group.  | N/A* (Q3)                      | 1                     |
| Student Police Officer  | To discuss the YMHWS role and demonstrate partnership working local agencies to support young men   | 1 (Q3)                         | 1                     |
| Resilience Therapy  | N/A*  | 20** (N/A)*                    | 1**                   |
| Sexuality (in collaboration with a Teenage Pregnancy Coordinator)                           | Targeted to foster carers. No other data available*   | 10** (N/A)*                    | 1**                   |

\* Data not available

\*\* Data incomplete, missing or inconsistent in the quarterly monitoring

### **To research and establish a young men's group to meet the demands of local priorities**

For this GM02 target, the YMHWS was required to deliver two young men's group sessions per quarter (e.g. boys talking sex, me and my baby, or any other appropriate programme). Over the operational life of the YMHWS, this therefore equates to 16 group sessions. This target was also *not* met with only eight group sessions being delivered to young men during the eight quarters the service was operational (see Table 7).



Table 7 Group sessions delivered to young men by the YMHW

| Group Session Delivered  | Target Group/Purpose   | Attendance (Quarter conducted) | Frequency of delivery |
|--|--|--------------------------------|-----------------------|
| Speakeasy (in collaboration with a sexual health nurse)            | An accredited training session for parents to learn new skills in terms of talking to their children about growing up and sexual health.     | 6 (Q4)                         | 1                     |
| Boys talking sex   | Developed by Brookes Sexual Health Services for 14-25 year olds to be able to talk more openly about issues relating to sexual health.       | 14 (Q5)<br>22 (Q6)<br>10 (Q7)  | 3                     |
| A sexual health focus group  | For young men to provide feedback to the PCT on relevant issues.   | 10 (Q5)                        | 1                     |
| Young Parents to Be (in collaboration with Excellence Cluster)     | Aimed at young mothers and young fathers to enable them to become positive parents.  | 2(Q4)                          | 1                     |
| Parents with Prospects   | An NCLP Parenting training programme provided nationally to centres working to support parents and their children from birth to 3 years old. | N/A*                           | 1                     |
| Substance misuse (in collaboration with Youth Development service) | A workshop delivered to young people at the Anything But group.  | 4 (Q2)                         | 1                     |

\*Data not available

\*\* Data incomplete, missing or inconsistent in the quarterly monitoring

However, similar caveats also apply to this target as monitoring data relating to this target are not reported consistently. Clearer reporting mechanisms (perhaps using more prescriptive data reporting templates) are required to increase the accuracy of the data and thus validity of any evaluative conclusions that are drawn.

#### 5.4.3 The number of young people who go on to access external services following a consultation with the YMHW and to describe the external services used (Objective 3)

The GM02 targets and indicators for the YMHWS service state that the service should, per quarter, signpost 100 young men to relevant (external) services (e.g. doctors, dentist, parenting groups, connexions, sexual health clinic etc.). Analysis of the data show that this target was *not* met by the YMHWS with, a total of only 61 referrals over 8 quarters. Thus, on average, 8 referrals were made per quarter (see Table 8).

Table 8 Number of referrals and/or signposting of young men to other services

| Services Referred to                    | April 09 to April 10 | April 10 to April 11 | Total Young Men Referred |
|---|----------------------|----------------------|--------------------------|
| Anything But                            | 2                    | 0                    | 2                        |
| Community Dietician                     | 2                    | 2                    | 4                        |
| Finding Futures                         | 8                    | 0                    | 8                        |
| Hastings and Rother Counselling Service | 2                    | 0                    | 2                        |
| Sexual Health Clinic                    | 6                    | 0                    | 6                        |
| ALLSORTS                                | 1                    | 0                    | 1                        |
| Opticians                               | 2                    | 0                    | 2                        |
| Doctors                                 | 2                    | 9                    | 11                       |
| Dentist                                 | 5                    | 10                   | 15                       |
| Solicitors                              | 0                    | 5                    | 5                        |
| Local parenting group                   | 0                    | 4                    | 4                        |
| Teenage pregnancy coordinator           | 0                    | 1                    | 1                        |
| <b>Totals</b>                           | <b>30</b>            | <b>31</b>            | <b>61</b>                |

However, the YMHW reported that data from the eighth quarter (January 11-April 11) were particularly low given the service was informed that funding would be withdrawn at the end of the quarter. Thus, few onward referrals were made by the worker as fewer young men were referred in to access the YMHW service. Moreover, and as noted previously, the data passed to the evaluators is limited in that there has been no recording of data depicting actual use of external services (through referrals and other means). So whilst it is possible to report the numbers of referrals and to which services (as above), it is not possible to determine the actual uptake of these services by young men.

# Chapter Six

## RECOMMENDATIONS



## CHAPTER SIX: Recommendations

### 6.1 Overarching recommendations

- The findings of this three-part evaluation (nurse-led sexual health provision, Pulse Innov8, and YMHWS) clearly show that the services are highly valued by young people, and in many cases, appear to have had a considerable impact in terms of improved health and social outcomes with changes evident through young people's knowledge, attitudes and behaviours. For many young people, the services have increased confidence, esteem, skills, knowledge, and impacted positively on (health and social) behaviours, for example in relation to anger management, physical activity, diet, and substance misuse. For other young people, the impacts of the services have been no less than life-changing. Careful consideration therefore should be given to the potential impacts on young people of reductions in service provision (e.g. decommissioning of the YMHWS and nurse-led provision, and reduction of Pulse Innov8 staff and services), and where possible and/or appropriate, decommissioned services should be reinstated.
- There is a need to improve the routine monitoring data recorded for each of the three services evaluated. More consistent, detailed, and prescriptive form of monitoring is required that is linked specifically to programme objectives. This will (amongst other things) facilitate better performance evaluation (process and outcome) over time, enable direct service comparisons, and make it easier to demonstrate whether (or not) targets for the particular services in question have been met. Any improvements in data monitoring also need to be contextualised within service-specific strategies as well as being located alongside forward planning of respective service evaluation(s), for example to ensure appropriate baseline data are generated. Across all three services, it would be beneficial for staff delivering services to be involved in developing monitoring and evaluation systems to gain awareness around the impacts of their work.
- Evaluation data show some differences across the three services in terms of the model of engagement with young people. It is proposed that any service provision for disadvantaged young people should adopt a 'youth-work' style approach to service development and delivery. This implies a needs-led approach that take the young person's agenda (e.g. acknowledging privacy concerns regarding service location for the nurse-led sexual health drop-ins), rather than imposing a definition of 'what works' at the outset, is likely to be more effective in addressing young people's needs. Participatory engagement with young people can be a useful mechanism to achieve this during service development, service delivery, and service evaluation.
- Working with young people takes time for short-term impacts and longer term outcomes to be fully realised. Appropriate acknowledgement is required in terms of the time needed to market and promote the services available, as well as the considerable input needed to 'reach' and engage with disadvantaged young people. Sustainability is thus a key factor and sufficient investment needs to be made over a long period (allowing for consultation, piloting, and evaluation) in order for services to be able to demonstrate (potential) impact on reducing health inequalities in the short, medium and ultimately the longer-term.

### 6.2 Recommendations for the nurse-led sexual health provision in schools and colleges

- The sexual health provision led by specialist nurses are particularly essential in rural areas where accessibility to alternative services is limited compared to more urban centres. This lack of accessibility is compounded in rural boarding colleges where the



potential for sexual activity and sexual ill-health, is heightened. Future service provision should therefore consider the geographic location of any planned services and how this may be impacted on, as well as impacted by, existing services for young people in the locality.

- Support from additional (e.g. pastoral) staff in colleges appears to be an important contributory factor in terms of increasing service uptake by young people. Such staff may include school tutors, governors, and additional staff (e.g. onsite Connexions workers) to sign-post young people to the service. Without this 'whole school' support, young people may be less likely to use the service.
- Linking the college services to schools is an important 'added-value' of the nurse-led provision. This enables school-aged young people to become aware of the service before they are in need. Future service provision should therefore consider school sites as useful opportunities to normalise sexual health by engaging young people through early interventions.

### 6.3 Recommendations for Pulse Innov8

- Strategic plans and their related outcomes (e.g. within the SLA) which affect the remit of Pulse Innov8 should be well-documented and communicated to the staff delivering services to young people. This will not only help to empower the team to plan their work programme more effectively (for example in terms of targeting and reaching young people most 'in need' of the services including those from diverse ethnic groups), but will also assist in the creation of relevant data collection mechanisms to monitor and evaluate the implementation of such strategies.
- The marketing activities for Pulse Innov8 services are generally disjointed and ad-hoc with young people being unable to differentiate between Pulse Innov8 and other young persons' services (e.g. teenage pregnancy initiatives and the Youth Development Service). It would therefore be beneficial to develop a specific marketing and branding strategy in order to create a clear and recognisable service identity, and to raise the profile of Pulse Innov8 services to young people (and other service providers).
- A reduction of Pulse Innov8 capacity through changes in staffing and the decommissioning of some services have meant the Pulse Innov8 team have needed to be particularly creative in meeting the needs of young people, for example through the use of social networking media (i.e. Facebook) and developing new partnerships with other service providers to 'fill the gap' left by decommissioning. Such efforts are to be commended and should be continued.
- Two aspects of Pulse Innov8 services appeared to have a considerable impact on young people in terms of both social (e.g. confidence and self-esteem) and health outcomes (e.g. weight management, diet). As such, it is recommended that the 'gym and swim' card scheme is considered for reinstatement (either fully to all young people or targeted to those most 'in need') and to explore the possibility of increasing capacity for outreach work via greater use of the Pulse bus. In terms of the latter, such resources can be particularly crucial in engaging those vulnerable young people whom may be invisible to services (e.g. those who are LGBT or those in rural locations).



## 6.4 Recommendations for the Young Men's Health Worker Service (YMHWS)

- Services specifically for young disadvantaged men are scarce locally, and nationally. Young men's needs are different to those of young people more generally meaning that specialist dedicated support is often required (see Gomes *et al.*, 2007; Sherriff, 2007). Consideration should be given to re-instating the YMHWS service for disadvantaged young men or look to how other provision may be able to continue the work in a similar form, as the outcome of this evaluation shows that the service has had a considerable impact on young men's lives and their willingness to take up services in the future.
- The needs-led and flexible outreach model of working adopted by the YMHWS is very suitable to addressing young men's needs. Such approaches are crucial to engaging effectively with disadvantaged young men and should remain a central feature of any future service aimed at this target group.
- Individual support is particularly important in working with disadvantaged young men who often present with multiple cross-cutting and complex needs which simply cannot be addressed through more 'traditional' group approaches. Instead, individual support should be a key and sustained part of any future service provision for young men.

## References

- Bettinghaus, E.P. (1986). Health promotion and the knowledge-attitude-behaviour continuum, *Preventative Medicine*, 15(5), 475-491.
- Coleman, L.M. (2001). Young people's intentions and use of condoms: qualitative findings from a longitudinal study, *Health Education Journal*, 60, 205-220.
- Coleman, L.M. and Testa, A. (2007). Sexual health knowledge, attitudes and behaviours among an ethnically diverse sample of young people in the UK, *Health Education Journal*, 66 (1), 68-81.
- Dey, I. (1993). *Qualitative data analysis: A user-friendly guide for social scientists*. London, Routledge.
- Department of Health (2003) *Every Child Matters*, London: The Stationary Office.
- Department of Health (2004). *Choosing Health: Making Healthy Choices Easier*. London: The Stationary Office.
- Edgecombe, J. and O'Rourke, B. (2002). Mobile outreach services for young people, *International Journal of Adolescent Medicine and Health*, 14(2), 111–116.
- Gomes, R., Nascimento, E.F., and Araújo, F.C. (2007). Why do men use health services less than women? Explanations by men with low versus higher education, *Cad Saude Publica*, 23(3), 565-74.
- Gutman, L. and Akerman, R. (2008). *Determinants of aspirations: Research Report 27*. London: Institute of Education.
- Hart, A., Blincow, D., and Thomas, H. (2007). *Resilient therapy: working with children and families*. Hove: Routledge.
- Lloyd, T. (2001). *What Works with Fathers?* London: Working With Men.
- Lowe, K. (2006). Young Fathers, *Working With Young Men*, 5(2), 18-20.
- Mordaunt, E. (2005). *Young Fathers Project Evaluation Report*, Brighton, TSA.
- Mullinar, G. and Martinez, A. (2007). *Confidentiality: Promoting young people's sexual health and well-being in secondary schools*. London: National Children's Bureau for the Sex Education Forum.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods*. (2nd Ed.) Newbury Park, CA, Sage.
- Pope, R., and Sherriff, N.S. (2008). *West Sussex Lesbian, Gay, Bisexual, Trans, and Unsure (LGBTU) Youth Project*, Final report to the West Sussex Youth Service and West Sussex PCT: Brighton, University of Brighton.
- Race for Health (2011). [http://www.raceforhealth.org/members/pcts/hastings\\_and\\_rother](http://www.raceforhealth.org/members/pcts/hastings_and_rother) accessed 28th September

Sheeran, P., Abraham, C. and Orbell, S. (1999). Psychosocial correlates of heterosexual condom use: a meta-analysis. *Psychological Bulletin*, 125, 90-132.

Sherriff, N.S. (2007). *Supporting young fathers: examples of promising practice*, Brighton, TSA. ISBN: 978 1871504 81 1

Sherriff, N.S., Hall, C., and Coleman, L. (2011). *An Evaluation of Services for Young People in East Sussex: Nurse-led Sexual Health Provision in Schools and Colleges, Pulse Innov8, and the Young Men's Health Worker Service*. Interim report to East Sussex Downs and Weald Primary Care Trust, April 2011.

Sherriff, N.S. Hamilton, W., Wigmore, S., and Giambrone, B. (in press A) Addressing the needs of Lesbian, Gay, Bi-Sexual, Trans, and Unsure Young People: The Sussex LGBTU Training and Development Research Partnership. *Journal of Community Psychology*.

Sherriff, N.S. Lowe, K., and McDonnell, E. (in press B). Engaging Young Fathers, In Olley, R. and Potter, C. A. (Eds.) *Engaging Fathers in the Early Years*. London: Continuum.

Wellings, K., Nanchahal, K., Macdowall, W., McManus, S., Erens, B., Mercer, C.H., Johnson, A.M., Copas, A.J., Korovessis, C., Fenton, K.A., and Field, J. (2001). Sexual behaviour in Britain: early heterosexual experience, *The Lancet*, 358, 1843-1850.

Wilensky, G.R., and Cafferata, G.L. (1983). Women and the use of Health Services, *The American Economic Review*, 73(2), 128-133.



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