



**TEENAGE PREGNANCY PREVENTATIVE  
SERVICES FUNDED BY THE LIVERPOOL  
TEENAGE PREGNANCY GRANT:  
A RAPID EVALUATION**

**PENNY A. COOK, LINDA MASON AND PENELOPE A. PHILLIPS-HOWARD**

## **EXECUTIVE SUMMARY**

### **Background**

Adolescent sexual health has become a public health priority in the UK. UK teenage pregnancy rates are the highest in Western Europe. Rates of teenage conceptions in Liverpool are particularly high compared to the UK average. Although the most recent year's data show a decline in teenage pregnancy in Liverpool, a longer view of the trends shows a mixed picture. Furthermore, a recent national study identifies Liverpool as having multiple hotspots for teenage pregnancy, sexually transmitted infections and alcohol harm in teenagers. As part of a strategy to combat Liverpool's high teenage pregnancy rate, the Teenage Pregnancy Partnership Board in Liverpool commissioned sex and relationships education (SRE) for young people in a variety of settings, alongside training for staff who deliver SRE. This report presents an evaluation of the preventative service provision of 2010/2011 in order to prioritise future commissioning of high quality services.

### **Aims and objectives**

To review current practice, identify gaps in provision and provide high quality, evidence-based recommendations that will assist the future commissioning of quality preventative services within the Teenage Pregnancy Strategy, by:

- synthesising literature on teenage pregnancy, SRE provision and training;
- benchmarking SRE provision and training against other local and national initiatives;
- evaluating the quality of SRE and accredited and non-accredited training, and performing gap analysis;
- making recommendations including a commissioning model for the provision of SRE and sexual health training.

### **Methods**

The RE-AIM framework to assess the preventative services by reach (how many of the target population received the intervention), effectiveness (does it work), adoption (how well is it accepted by target agencies), implementation (to what extent is the intervention carried out as intended) and maintenance (does the programme have a long term effect). Reach was assessed using service use data and 10 interviews with commissioners and providers (Liverpool PCT, Liverpool Local Authority, Healthy Schools, So To Speak and Brook). Information on perceived effectiveness of the SRE provision was collected from 6 focus groups of school children (who had received school-based SRE and Bitesize Brook sessions, x2), college students (SRE from a sexual health advisor, x2) and young people in other youth settings (small group support from So To Speak, x2). Adoption and implementation were assessed through service use data and provider interviews, as well as interviews (x10) with teachers and other professionals who had received training from So To Speak. Maintenance is harder to assess in a rapid evaluation, but providers' views were sought on this. The sexual health and wellbeing needs of young people were assessed using existing data from a survey of students at Liverpool Community College.

## Findings and recommendations

Recommendations are divided into those for commissioning of preventative services overall (C1 to C11), those stemming from the young people (YP1 to YP11), those arising from the college findings (LCC1 to LCC3), followed by those from recipients of training (T1 to T10).

### *Recommendations for commissioning*

**C1: In the ideal scenario, the existing funding would be maintained and the current broad provision would be maintained.**

Overall, the investment in SRE when assessed using the RE-AIM framework resulted in an intervention that was considered to have performed relatively well: i) there was good reach in terms of overall number of young people accessed (Healthy Schools reported work with all schools; the vast majority of which have Healthy Schools status, the achievement of which suggests SRE is prominent) and those most at risk in higher risk schools have been targeted by So To Speak; So To Speak have had moderate success in accessing young people's settings; ii) the intervention is thought to be effective (national guidance suggests good quality SRE is key to reducing TP rates; SRE described by Healthy Schools, So To Speak and Brook met these standards; young person feedback, particularly of small group sessions, and, to a lesser extent, Bitesize Brook, suggested young people modified their behaviour as a result; Brook report an influx of school students into clinical services after specific Bitesize events); iii) the intervention was adopted to some extent by all schools (at least some sort of contact with Healthy Schools; a substantial majority of the targeted schools had taken up further support), and So To Speak can demonstrate accessing a large number of other youth settings (although it is not possible to quantify how many vulnerable young people are not in contact with any schools or agencies); iv) the intervention was largely implemented successfully by partner agencies (i.e. So To Speak, Brook and Healthy Schools) but less so by the ultimate agents (schools/youth settings); where this did occur it was with significant support; v) agencies and schools (with support) showed evidence of changing ethos, enhancing the probability of long-term maintenance of the programme, and good quality SRE is thought to have lasting impacts on young people. There was some evidence that the intervention had reached a 'tipping point' whereby further funding at the same level would enable the providers to access the majority of settings (including those that were prioritised but not accessed in the year of the study).

**C2: We strongly recommend that the different agencies come together in a 'service providers' forum' to clarify their separate and unique roles and how their work inter-relates to prevent overlap and gaps. Create a multi-agency plan for outreach, SRE and training.**

This rapid review indicates that each of the partners does have unique contributions but often their roles merge. Communication is being improved with the tightening of monitoring, but gaps remain: for example Healthy Schools representatives thought that So To Speaks courses were accredited; commissioners were not aware of whole package of support; So To Speak were not aware of curriculum training provided by Healthy Schools.

**C3: Clarify the role of 'Healthy Schools Liverpool'**

Although nationally, the Healthy Schools scheme will no longer operate, the ongoing support for the local version 'Healthy Schools Liverpool' will still require schools to ensure good quality SRE. The exact nature of the support should be clarified.

**C4: Agencies should work jointly so that schools get a complete picture of the service offered and menu of choices.**

Healthy Schools may have this insight, but the other organisations do not. Healthy Schools Liverpool, currently the gatekeeper organisation, may be best placed to understand what is happening in each school and to offer schools the 'SRE package'.

**C5: Reconsider whether it is realistic or desirable to consider the cascade training model throughout schools and youth settings (as we found no evidence this happens on a formal basis), or whether an ongoing package of support is required for these organisations.**

So To Speak and Healthy Schools considered it was important to build relationships with organisations gradually, and it was unrealistic for staff within the organisations to i) take full training, and ii) pass it on. They also cited the high turnover of staff (especially the 'good ones' in agency settings) as a barrier to cascading.

**C6: A single commissioner should oversee the monitoring of all the contracts, meeting with providers separately and jointly on a quarterly basis.**

There appeared to be a conflict of interests, with Healthy Schools having a commissioning role as a member of the Teenage Pregnancy Partnership Board, and also a recipient of funds. The same funds were used to commission one provider, So To Speak, directly as well as via Healthy Schools.

**C7: Continue to support small group sessions provided by specialists.**

So To Speak demonstrate good access to young people. These young people overwhelmingly appreciate the SRE they receive from So To Speak.

**C8: Continue to provide universal coverage with larger groups.**

Brook's Bitesize sessions appear to be a useful addition to school-based SRE (but should be part of a wider package of SRE), and serve as useful outreach to attract young people into services.

**C9: Ensure that all provider agencies signpost and advertise all services.**

Young people gave an impression that Brook were advertising their services to those who were already having sex; So To Speak were acting more downstream. The College survey revealed that while knowledge of Brook services was high, few other services were mentioned.

**C10: Positive social norms should underpin all prevention work and should be included in the service specifications.**

Sessions should address the perception that all young people are having sex. Irrespective of age, participants perceived that 'everybody was having sex' and that those younger than themselves were even more likely to have sex early – 'kids these days...'. However, the college survey and other research show that before the age of 15 only around a quarter have had sex. Social marketing theory suggests that positive social norms should be emphasised. Service providers, by promoting clinical services, may (perhaps inadvertently) perpetuate the false norm that all young people are having sex. The positive social norm, that most young people use condoms when they first have sex, should be emphasised.

**C11: Revise all the monitoring tools to ensure they are capturing required information.**

Consider whether it is possible to obtain better residence data (postcode) from young people as a marker of reaching those most in need; some revision of the evaluation forms may improve the measurement of effectiveness.

*Recommendations from young people*

**YP1: Start SRE earlier, before young people begin to have sex.**

This was a common theme from the focus groups, based on a perception that SRE was ‘too late’ for many peers (but see also the recommendation about promoting social norms that many young people delay first sex until they are 16 years or older).

**YP2: Focus dedicated time to SRE to allow time for both an in depth treatment and broad perspective.**

The dedicated time for SRE and range of topics (‘something for everyone’) was valued by young people

**YP3: Ensure the right person is providing SRE – this can be a teacher, but it depends on the personality.**

There was a clear preference for an external ‘expert’ who ‘won’t be teaching me maths tomorrow’

**YP4: Staffing and timetabling should be flexible enough to teach males and females separately, with appropriate (same) gender of teacher.**

Although not universal, there was a view by a significant number of young people that SRE should be delivered in single gender sessions.

**YP5: If the ‘Bitesize’ format is retained, consider smaller groups in each ‘zone’ and single gender (and someone of the appropriate gender facilitating).**

Young people valued the small group sessions. They found it harder to get answers to their questions in the big groups.

**YP6: If the ‘Bitesize’ format is retained, consider refocusing towards SRE (retain the contraception and STI zones).**

These particular zones were appreciated by the young people, more so than the ‘drink think’ and alcohol/drugs awareness. Brook responded to the needs and requests of the school in this respect, but sufficient time needs to be given to young people to allow them to ask all their questions about sex and relationships.

**YP10: SRE studies should not solely focus on the sexual health, but retain the relationships, wellbeing, resilience aspects which are delivered to younger school aged children.**

We were surprised by the high rates of poor emotional wellbeing in all groups, but particularly among females – while there may be some ‘element of drama’ in these responses, it should be recognised that poor wellbeing is linked to poor sexual health.

**YP11: We would advocate the recent policy for integrating alcohol advice in sexual health sessions, (including when visiting services, with signposting to Young Addaction if necessary), and sexual health advice for young people seeking alcohol/addiction advice.**

Alcohol did not figure prominently in focus group findings, or as a risk factor for pregnancy in the college survey. We are unclear why this is the case, but data from other sources suggest a strong link.

### *Recommendations for the work in the college*

The college appears committed to maintaining its SRE but may need a little support to do so. The suggestions in these recommendations are estimated to cost less than one full time post.

**LCC1: Provide support for SRE training for ‘tutorial advisors’. Supply SRE training to update existing staff.**

The tutorial advisor is a relatively new role in the college that is dedicated to pastoral care and not curriculum. A significant proportion of the students see these tutorial advisors, thus investing in their skills to deliver SRE may be an effective method to reach a large number of students.

**LCC2: Use external specialist agencies or sessional workers to provide SRE lessons for those who are in tutorial groups that are not run by one of the tutorial advisors, or whose tutorial advisor is not comfortable or confident with dealing with SRE.**

A proportion of the students receive their tutorials from staff whose primary role is delivering the curriculum. These staff should have external support for their SRE tutorials, as should those tutorial advisors who are not confident to deliver SRE themselves.

**LCC3: A staff member with overall responsibility for student welfare within the college should observe occasional sessions run by tutorial advisors to make sure that quality is high and to get an impression of the level of need of the students.**

Such a system allowed useful insight about how the SRE was run under the sexual health advisor and the needs of the young people. If maintained, the college would be confident in the quality of the provision, and would have an ongoing insight into young people’s needs.

### *Recommendations for training of people working in young people settings*

**T1: continue to provide training for staff working in young people settings.**

The training received was universally very highly valued by participants, and participants demonstrated increased confidence in signposting services to young people as a result. Since the training provider also offers small group or one-to-one support for the young people that access the agencies, supplying the training was seen as a valuable way of raising awareness and gaining trust of staff. In many cases this enabled access to the organisations’ vulnerable young people to provide small group SRE.

**T2: Reconsider whether the ‘cascade model’ of training is the correct model.**

Providers considered that agencies required on-going support. Participants of training were happy to pass on literature, ‘tell their colleagues’ what they had been taught or learned, and

were very happy to endorse So To Speak's training; however there was little evidence to show that trained personnel had the capacity or the confidence to fully cascade the training themselves.

**T3: Consider whether work with staff should be enhanced by 'on the job training' e.g. by accompanying the young people on the sessions.**

Agency staff always accompany the So To Speak session. Could this be a training opportunity?

**T4: Consider accreditation of the longer (three day) courses, to improve quality, enhance uptake, and improve trainees' confidence to deliver SRE.**

Young people express a preference for a specialist – someone qualified to talk about SRE, whereas some staff working in youth settings see themselves as 'not qualified' to talk about sex. Obtaining a formal qualification could give the professional that confidence. Following the So To Speak 1 or 2 day course appeared to provide the confidence to speak with young people; this effect may be enhanced with an accredited 3 day course. Accreditation may not be appropriate for 1 or 2 day courses, but having a goal of a formal qualification could enhance uptake of the longer course.

**T5: Create a payment system to ensure that training provision is respected.**

The lack of a charge was perceived as a major incentive to doing the course, and it may be difficult to fill courses if they are not provided free of charge. However, the rate of cancellation at an agency- and individual-level is high. Consideration should be given to increasing the notice period (5 days) and charge (currently £25) for cancellation. In interpreting feedback, providers and commissioners should be aware that because they perceived the course to be free they may be reluctant to give a low evaluation mark – it is of course not free, but paid for by the teenage pregnancy grant rather than themselves.

**T6: Trainees should be warned in advance that lunch is not provided.**

Participants accepted that as the course was free it was reasonable to make their own arrangements, but would have appreciated notice of this so that they could have made their own arrangements. They regretted the lost networking time over the lunch period.

### *Recommendations for training of school teachers*

**T7: Ensure schools are aware of the wider package of support, and are fully aware of the particular aims of this training.**

Especially for shorter sessions, teachers should be made aware that they will not be getting actual materials to use in the classroom. The learning outcomes (improve confidence, skills in talking to young people) should be absolutely clear from outset.

**T8: Reconsider whether the 'cascade model' is the correct model.**

Those teachers that had valued the training were willing to cascade training, possibly because, as trained teachers, the prospect of teaching other colleagues was more natural (than for workers in other youth settings). Providers considered that schools required on-going support. Greater insight into the operation of SRE at a school level and the perceptions by schools of the menu of choice of support (C4) is required to fully evaluate the role of cascading.



**T9: Consider accreditation (as for workers in youth settings above).**

Although teachers are less likely to do the longer courses, a reported benefit of the accreditation approach is the increased focus on structure and measurable learning outcomes. This may help to answer some of the teachers' criticisms of lack of structure and materials.

**T10: Consider supporting training of teachers in primary schools.**

This evaluation focussed on secondary education. There is a strong argument that intervention should start in primary schools, and one significant advantage of this would be that it is easier to access teachers for training, thus enhancing the probability that the cascading model would be successful.

## **ACKNOWLEDGEMENTS**

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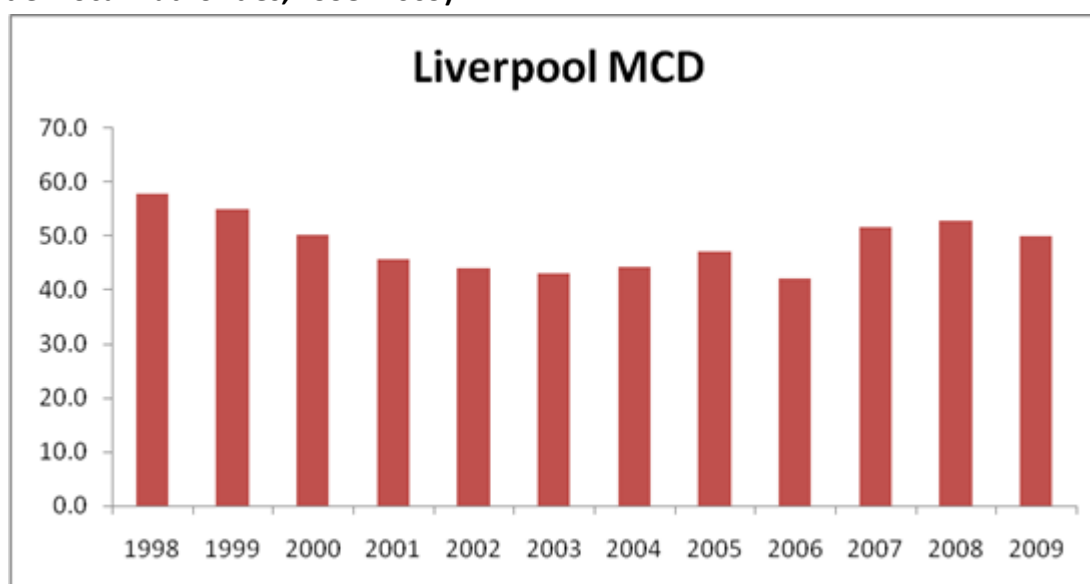
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## INTRODUCTION

Adolescent sexual health has become a public health priority in the UK. The United Kingdom has the highest teenage birth and abortion rates in Western Europe; teenage birth rates are five times those in the Netherlands, double those in France and more than twice those in Germany (United Nations Statistics Division 2010). Among the factors that contribute to these high rates are: low expectations of young people with no job prospects; ignorance about relationships, contraception and the realities of parenthood; and mixed sexual messages from adults.

Rates of teenage conceptions in Liverpool are particularly high compared to the UK average. Although the most recent year's data show a decline in teenage pregnancy in Liverpool, a longer view of the trends shows a mixed picture (figure 1).

**Figure 1: Rates of Conception among those aged under 18 years in Liverpool (data for top-tier Local Authorities, 1998- 2009)**



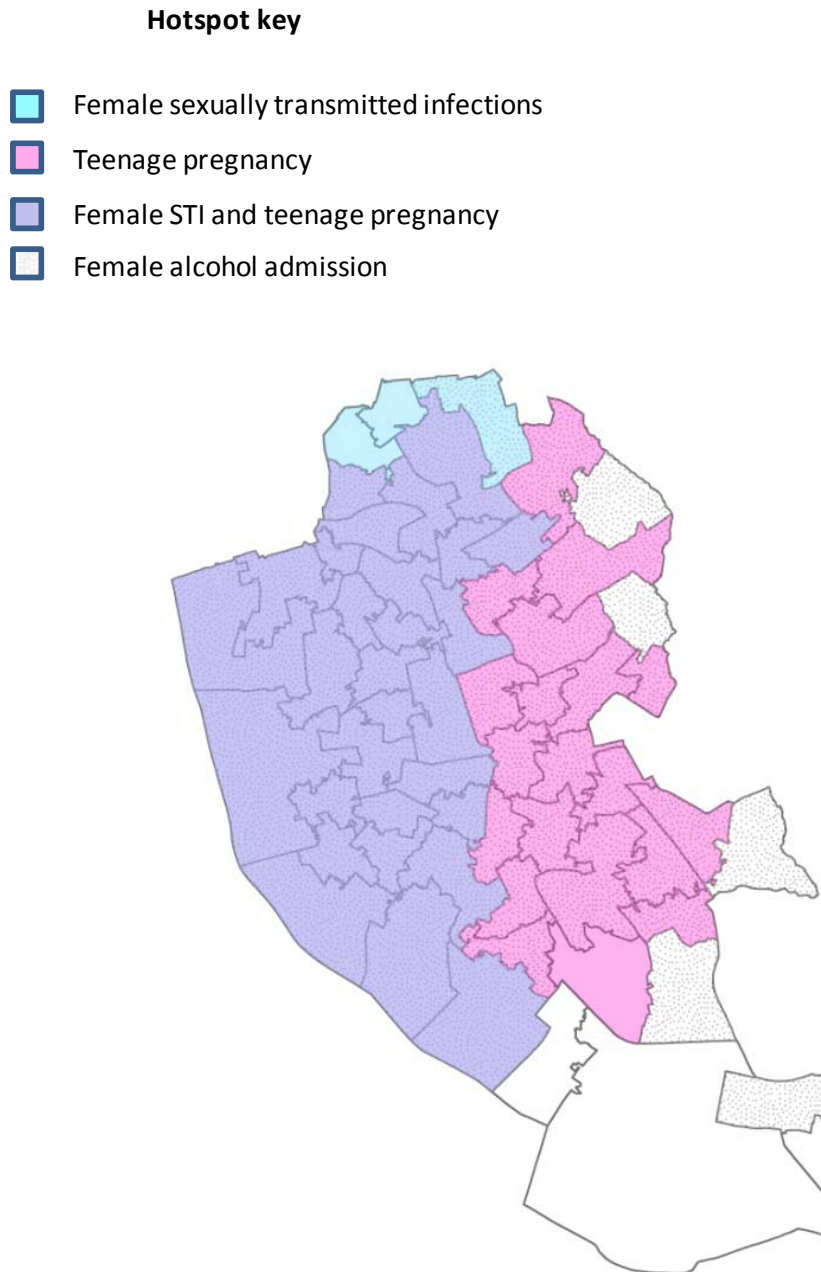
*Rates are per 1000 female population aged 15-17.*

*Sources: Office for National Statistics and Teenage Pregnancy Unit*

A recent national study identifies Liverpool as having multiple hotspots for teenage pregnancy, sexually transmitted infections and alcohol harm in teenagers (Cook et al. 2010). A hotspot is a group of areas that has a statistically higher rate than its surrounding areas. Figure 2 illustrates this at the Middle Super Output Area (MSOA) level for Liverpool. The teenage pregnancy hotspot (pink) and the joint teenage pregnancy and female STI hotspot (purple) covers all but seven southerly and easterly MSOAs. Three northerly MSOAs have a hotspot of female STIs (pale blue). The black stippling pattern represents female alcohol admissions, showing a hotspot that covers almost all of Liverpool. The male alcohol admissions hotspot covered the whole of Liverpool, and so is not illustrated. Interestingly,

there was no male STI hotspots (although these did occur in neighbouring areas, notably Wirral). The STI data are dominated by Chlamydia diagnoses, which are generally lower in males because screening is less prevalent in males.

**Figure 2: Teenage pregnancy, sexually transmitted infections and alcohol admissions hotspots in females aged 15-19years in Liverpool**



*NOTE: An alcohol admissions hotspot covered the whole of Liverpool. There were no male STI hotspots.*

*Source: Cook PA, Harkins C, Morleo M, Jarman I, Tiffany C, Bellis MA, Zhang X, Perkins C, Phillips-Howard PA (2010) Contributions of Alcohol Use to Teenage Pregnancy and Sexually Transmitted Infection Rates. Liverpool John Moores University. <http://www.cph.org.uk/showPublication.aspx?pubid=579>*

In 1999 the UK government launched the Teenage Pregnancy Strategy with the goal of reducing teenage birth rates (Social Exclusion Unit 1999), and, based on an evaluation those areas that appeared to be achieving this goal, the Department for Education and Skills published guidance on achieving reductions in the rates of teenage pregnancy (DFES 2006). The review found that strong delivery of SRE/PSHE by schools, targeted work with at risk groups of young people (in particular Looked After Children), and workforce training on sex and relationship issues within mainstream partner agencies was strongly evident in successful areas. The DFES review featured Liverpool's young people-friendly sexual health services, sexual health outreach and workforce training with partnership agencies as good practice.

International research evidence suggests that good quality sex and relationship education is effective at delaying onset of first sex, and when young people do have sex they are more likely to use condoms and contraception (Kirby 2007). A systematic review commissioned by the National Institute for Health and Clinical Excellence (NICE) to evaluate the effectiveness of sex and relationship education found that there was:

- Strong evidence from three systematic reviews to suggest that abstinence-only programmes have limited effects or are ineffective for preventing or reducing sexual risk behaviours.
- Moderate evidence from five systematic reviews to suggest that interventions incorporating information on safer sex and contraceptive use may have positive, but limited effects on preventing sexual risk behaviours. There is no evidence that such programmes increase the occurrence of sexual activity among young people.
- Moderate evidence from four systematic reviews to suggest that effective characteristics of sexual risk reduction interventions include: (1) a theoretical basis; (2) use of trained adult health educators as providers; and (3) provision of highly specific content focusing on sexual risk reduction.

*Source: A review of the effectiveness and cost-effectiveness of personal, social and health education in secondary schools focusing on sex and relationships and alcohol education for young people aged 11 to 19 years (Jones et al. 2009)*

Factors that contribute to good quality SRE have been summarised as:

- both school and home contribute to SRE
- trained educators are used
- a comprehensive range of topics is addressed, including contraception
- 'psychosocial' factors, which affect behaviour, including values, norms and self-efficacy, are addressed
- programmes begin before a young person first has sex
- participatory learning methods are used
- children and young people are taught using small group work.

*Source: Does sex and relationships education work? A Sex Education Forum evidence briefing (Emmerson 2010)*

As part of a strategy to combat Liverpool's high teenage pregnancy rate, the Teenage Pregnancy Partnership Board in Liverpool commissioned sex and relationships education (SRE) for young people in a variety of settings, alongside training for staff who deliver SRE. This report is an evaluation of the preventative service provision of 2010/2011, using the RE-AIM evaluation approach, in order to prioritise future commissioning of high quality services. RE-AIM facilitates translation of research to practice and provides standard methods of evaluating potential for public health impact and widespread application.

## **AIM & OBJECTIVES**

To review current practice, identify gaps in provision and provide high quality, evidence-based recommendations that will assist the future commissioning of quality preventative services within the Teenage Pregnancy Strategy, by:

- synthesising literature on teenage pregnancy, SRE provision and training;
- benchmarking SRE provision and training against other local and national initiatives;
- evaluating the quality of SRE and accredited and non-accredited training, and performing gap analysis;
- making recommendations including a commissioning model for the provision of SRE and sexual health training.

## METHODS

The provision of SRE in Liverpool was assessed using the five themes of the RE-AIM framework:

- **Reach the target population:** This is the number of people whose behaviour can be influenced by the intervention, and whether those are the people most in need. We attempted to assess the demographics of those attending programmes against those of the population using routinely collected data, as well as to assess the total number of staff and proportion who have received training.
- **Effectiveness or efficacy:** This theme relates to whether the intervention works, assuming it is carried out as envisaged. Taken what are considered to be the benchmarks of high quality SRE, based on national recommendations, we assessed the fit of Liverpool's programme against these standards. We assessed effect sizes using pre- and post testing (when such data had been routinely collected), and gathered information on perceived effectiveness through focus groups/interviews.
- **Adoption by target settings or institutions:** This is considered to be equivalent to 'reach' at an organisational level. Adoption was evaluated using interviews with key informants, comprising providers of services and commissioners, as well as teachers and recipients of SRE training.
- **Implementation, consistency of intervention delivery:** This is the extent to which the intervention is delivered in the way it was intended. This used perceptions of key interviewees (providers and recipients of training).
- **Maintenance of intervention effects in individuals and settings over time:** This theme concerns maintenance in individuals and institutions. Perceptions of long term effects on individuals was assessed through focus groups. Key informant interviews were used to assess extent to which interventions were embedded in the system.

### Liverpool Community College (LCC) Survey

As part of an ongoing CPH project, a survey was conducted in 22 tutor group classes at Liverpool Community College, between October and November 2010. In total, 254 questionnaires were completed. Ethical approval for this study was received from Liverpool John Moores Ethics Committee, and participants received information sheets about the study and completed signed consents before filling in the confidential questionnaires. Key sexual health/wellbeing/alcohol/drug use data were used to estimate the level of unmet need.

## **Interviews with stakeholders**

The project team selected (with agreement from Liverpool PCT) eleven key personnel for interviews. Interviews were conducted one to one, except for three representatives from Healthy Schools, who were interviewed as a group. Interviews were face to face except for one telephone interview to a provider in a neighbouring primary care trust. Interviews focused on professionals' views on the performance of the interventions, incorporating the RE-AIM evaluation tool (<http://www.re-aim.org/tools/self-rating-quiz.aspx>).

## **Interviews with recipients of training (staff)**

Staff recipients of SRE training were invited to take part in interviews. A total of 10 interviews covered staff trained by So To Speak in schools and youth settings. Interviews were short, semi-structured telephone interviews, and were carried out opportunistically, recognising the restrictions on teachers' time.

Lists of teachers and staff working in youth settings who have recently participated in So To Speak sexual health training were provided to Liverpool John Moores University. Nine persons from these lists were randomly selected for telephone interviews. Telephone interviews were conducted during March 2011, by the researcher using a semi-structured open questionnaire. Questions concerned the participant's experience of the So To Speak course, including content, the methods used, and materials available. Participants were encouraged to give their own personal opinion of the training, and its usefulness and relevance for interacting or teaching young people, and their ability to provide information on sexual health and teen pregnancy prevention.

## **Focus groups with young people**

School groups took place in lesson time. College groups took place in SRE lesson time or free periods. The number of focus groups planned (six) was designed to be sufficient to represent the range of experiences and views of young people, and the number was also a pragmatic one, based on the timeframe for this study and the need to finish focus groups before schools finished for the Easter break. Groups took place in March 2011. Incentives were provided for young people who participate in their own time (£10 high street shopping voucher per participant). Young people provided informed consent.

Six focus groups were carried out in three different settings (table 1). A total of 47 participants took part with ages ranging from 15 to 17 years. Each focus group was conducted by a facilitator with a second person in attendance to make notes and ask any additional questions. The lengths of session ranged from 26 minutes to 54 minutes. The main topics covered were:

- Overall view of the SRE session,
- Content and format of the session,
- What was good about the session,
- what was not so good about the session,



- would the session have any impact on behaviour,
- what can be done to change behaviour in young people,
- suggestions for improving the SRE sessions.

Each group was recorded with prior permission from the participants and ground rules were set prior to commencing the session. Following the session the recordings were transcribed verbatim. Analysis was undertaken using thematic analysis framework, which is a method for analysing, interpreting and reporting patterns within data. Whilst specifically searching for information pertaining to the above topics, we also looked to the data to see if additional predominant themes were occurring which would be indicative of the young person’s own SRE agenda. Due to time limitations, the transcripts were read once over in order to familiarise with the data, then a set of themes using the above topics were listed with other additional emergent themes. Each transcript was then revisited and appropriate sections were coded under the appropriate heading. The coded sections were merged to obtain a full body of data pertaining to the coded themes. Each cluster of data was then examined to identify the underlying ideas, assumptions, meanings, strength of feeling as well as language used. These threads were then written as a narrative with quotes incorporated to illustrate the text. The separate sections were then merged to provide an overview of the findings from the focus groups.

**Table 1. Participants**

Setting	Group 1	Group 2
<b>School</b>	Year 11 Mixed gender 3 had SRE session (+ 3 additional group members) Teacher present	Year 11 Girls 12 participants Teacher not present
<b>Liverpool Community College (LCC)</b>	Final year Girls 12 participants	First year Mixed 5 participants
<b>Non school setting (NSS)</b>	16 year olds Mixed 4 participants	16-17 year olds Mixed 8 participants

### Service use data

Where available, data on young people accessing SRE and staff accessing training programmes were evaluated for use in assessing the RE-AIM themes (reach, effectiveness and implementation). These included: number of sessions, number of attendees per session, total potential pool of attendees, number of events carried out, number planned. Service use data and assumptions were validated by key informants during their interviews.

## RESULTS

### Liverpool Community College Survey

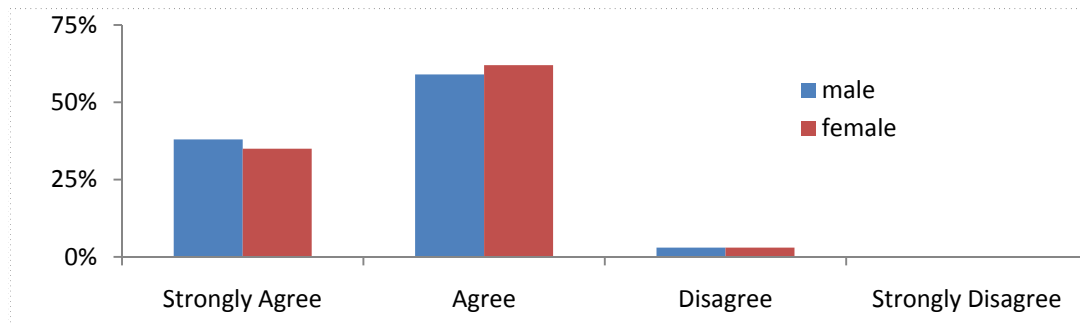
#### Demographics

In total, 254 questionnaires were completed. Data was requested from tutors on attendances for each class to identify response rates. Of the tutor groups able to provide information on participation, 86% students agreed to participate and 14% withdrew, with a slightly higher proportion of males (125; 51%) participating than females (119; 49%). The ages of students contributing were spread across the years; 28% were 16, 28% were 17, 29% were 18, and the 16% remaining were 19-20 years. Of 90% of students who reported their ethnicity, the majority (84%) reported being White British, the remaining reported themselves to be either Asian or Black 12% and 6% each reported being Asian/Asian British, About half (126) of the students who participated were in their first college year. Of 246, 19 (8%) recorded they had special needs.

#### Students' wellbeing and college life

*Attitudes towards college life:* Students were asked about their college life to determine their connectedness with the college. Students responses are scaled on the Likert scale of strongly disagree, disagree, agree, and strongly agree (figure 3).

**Figure 3: Our college is socially a nice place to be**

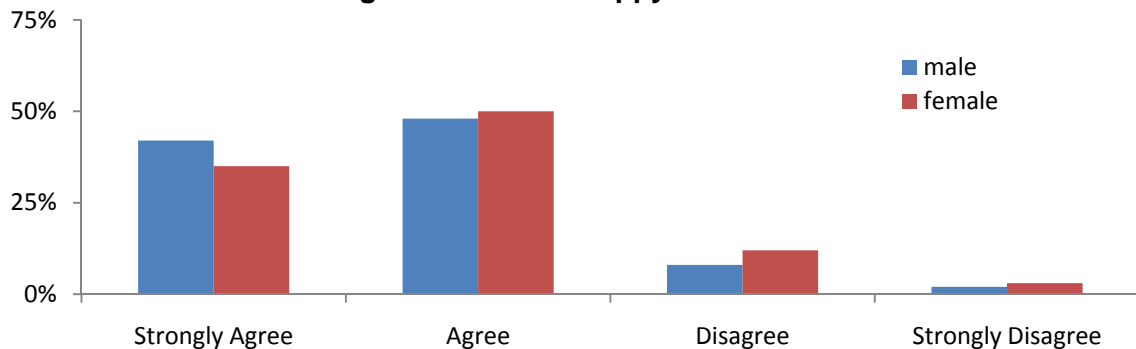


The students clearly showed connectedness with the college in terms of social enjoyment, with none indicating they strongly disagreed, and 4% per gender disagreeing. A quarter agreed their tutors expected too much from them, but over 60%, both genders, disagreed. Younger students were less likely to consider tutors expected too much. Less than 5% of students disagreed or strongly disagreed that their tutors treated the students fairly.

*Students' perceptions of their personal wellbeing:* Students were asked to respond to a number of statements, to assess their perception of their own wellbeing. The majority of students (88%) agreed or strongly agreed that they have a happy home life (figure 4), with 10% of males and 15% of females disagreeing. Males responded more positively to a statement on whether they had confidence in themselves, compared with females. Over a

third of females (38%) disagreed compared with 20% of males. The highest proportion with no confidence was 16 year old girls and the highest proportion reporting confidence was among the males 18 years and older. Questions were asked on students' ability to make their own decisions, as this potentially influences risky behaviour. The below responses to three statements suggest students struggle to be assertive. Two thirds (65%) of students disagreed or strongly disagreed with the statement that they 'I have a hard time saying no'. Males were more likely to agree (44% compared with 27% of females); the highest proportion were in older males. Responses to statements on asserting views with friends and girl/boyfriends indicate most students, regardless of gender, consider they can do this. Fewer females, compared with males, felt they could state their own views to their boyfriend, and 16 year olds more frequently reported disagreeing compared with older ages.

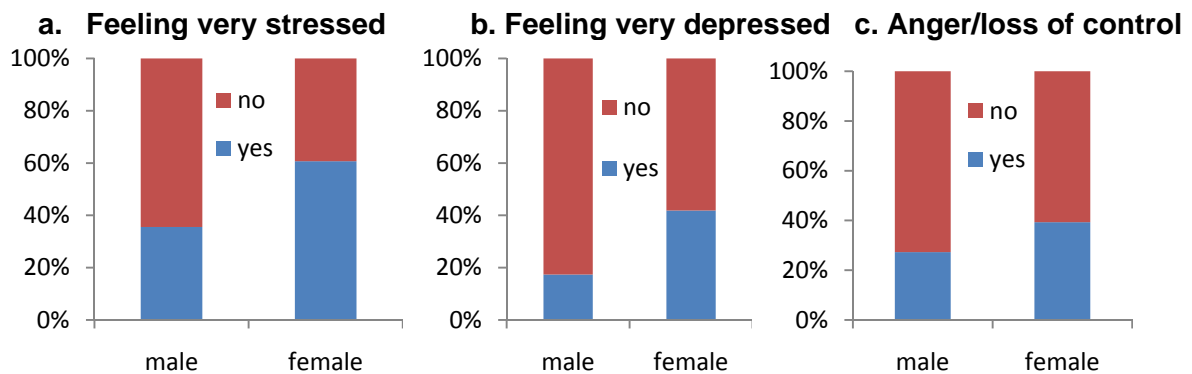
**Figure 4: I have a happy home life**



*Bullying:* Students were asked if they were bullied or had bullied others in the past 3 months. Few reported bullying – either as a bullier (6% males, 5% females), or having been bullied (7% males, 3% females). The spreading of rumours/lies was more frequent with 29% of males and 18% of females saying this occurred to them in the past 3 months, while 26% of males and 20% of females were recipients of sexual jokes. Bullying, rumours and sexual joking occurred more frequently in the youngest age group.

*Students' perceptions of their emotional health:* Students were asked if they suffered a number of emotional health related feelings in the previous 3 months, which covered their first college term of the year. Over a third (38%) recorded no emotional health concerns, and were 'just fine'. This strongly differed by gender, with 50% of males and 26% of females reporting this, indicating a high proportion of concerns among female students.

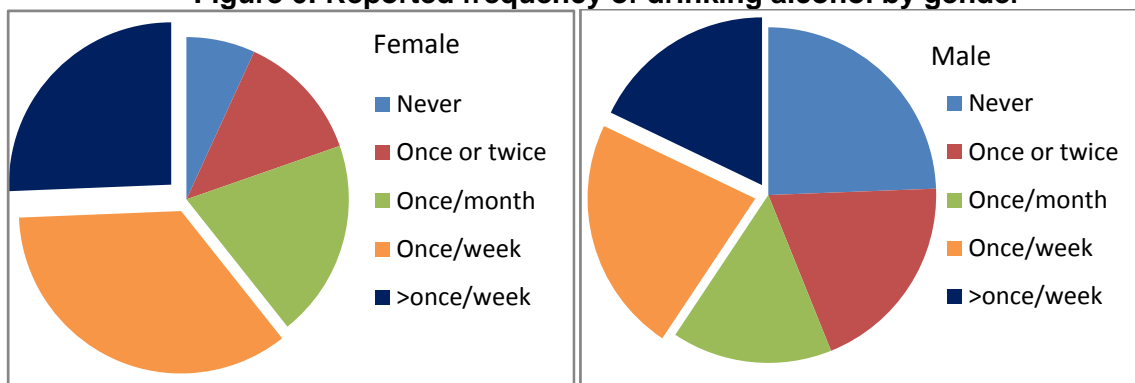
**Figure 5:**



The most commonly cited problem was ‘feeling very stressed’ reported by 48% (figure 5a), followed by experiencing anger or loss of control (33%, figure 5c) , and ‘feeling very depressed’ (29%, figure 5b). Such feelings were significantly higher in females, with 60% reporting they were very stressed, 42% very depressed, and 39% displaying anger or loss of control. This also translated into more serious emotional feelings, with 9% of students reporting they had felt suicidal (6% males, 12% female), and 8% reported they had self-harmed (6% males, 9% female).

*Reported Alcohol Use:* Drinking is a frequent activity of students, with a high proportion indicating that they drank once a week or more (figure 6). Just over a quarter (26%) of females indicated they drank more than once a week, a higher proportion than males (18%). Once weekly drinking was highest in 16 year olds, with more frequent drinking highest in the oldest age group. Among drinkers, a quarter reported being drunk 12 or more times in the past three months, e.g. at least drunk once a week, of whom just over half were females. A further quarter of the students reported getting drunk between 6-11 times (e.g. at least fortnightly), and among these, two thirds were females.

**Figure 6: Reported frequency of drinking alcohol by gender**



Students were asked if they got drunk and could not remember what had happened – 33% of males and 46% responded this had occurred to them in the past 3 months, while 60% of females and 38% of males said they had felt ill or hung over the next day. Further, 12% of males and 19% of females admitted getting into a fight or were injured; and overall 6% had

been in trouble with police after drinking. They were asked if they had sex with someone they did not want to after drinking in the past 3 months, 10% of males and 8% of females indicated they had. Similarly, 11% of males and 12% of females stated they did not use protection or a condom when having sex after drinking during this time.

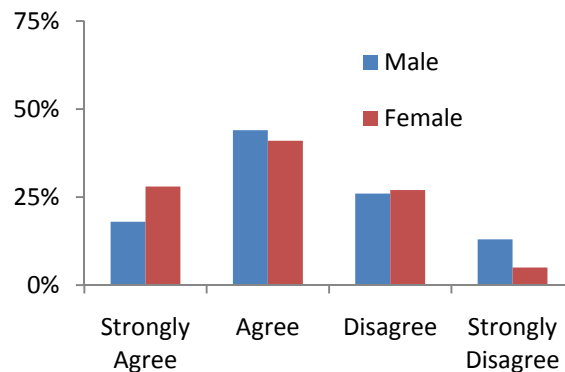
*Smoking and drugs:* 52% of females and 26% of males have smoked, 30% of females and 26% of males had taken cannabis, 17% of females and 5% of males had tried cocaine. Fewer had tried ecstasy (9% females and 3% males), ketamine (9% and 2%) and MDMA (Meow: 2% females). While 12% of females stated drugs had made them feel so ill/hung over the next day (compared with 60% for alcohol), few drug-related harms were experienced in the past 3 months with 1%-3% reporting having sex with someone or not using protection after drug taking.

**Students reported sexual experiences**

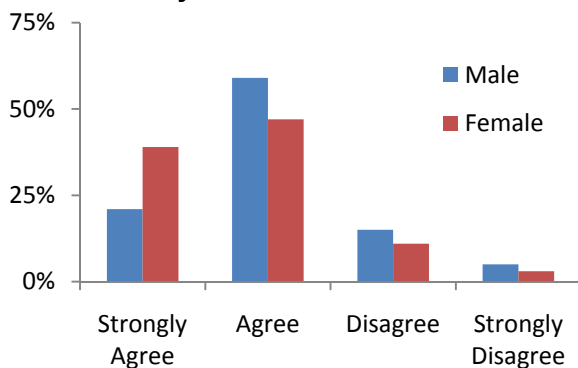
*Students' thoughts on sex and relationships:* Students were asked if they ever had sex and relationships education 'at school', 79% stated yes, both among males and females. No question was asked on SRE while in college. Students were asked a series of questions regarding what they think about sex and relationships.

**Figure 7:**

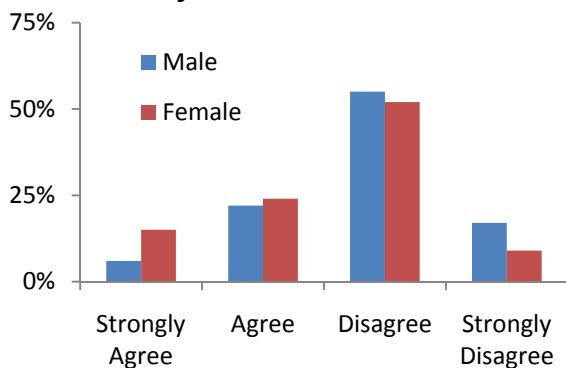
**a. I learnt more about sex from my friends than from anyone else**



**b. Talking to my partner about sex is or would be easy**

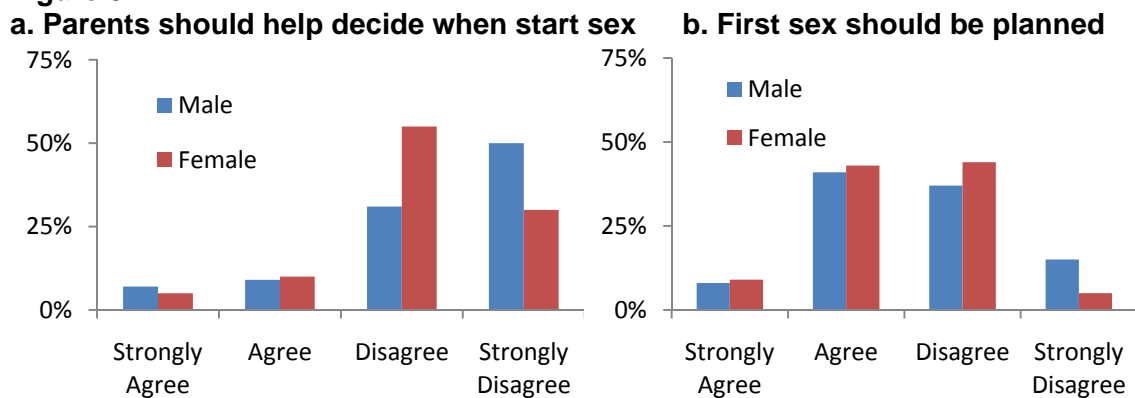


**c. Girls find it easier to talk about sex than boys do**



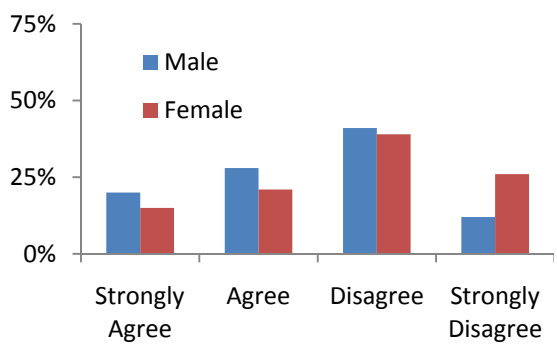
The majority of students agreed that they had learnt more about sex from their friends than from anyone else (figure 7a). More females than males strongly agreed with this statement (25% and 18% respectively). Over 80% of males and females agreed they could talk to their partner about sex (figure 7b), with a higher proportion of females strongly agreeing. Most students disagreed that 'girls find it easier to talk about sex', although more females than males strongly agreed (figure 7c). Students do not agree that parents should be involved in the decision of when to start having sex (figure 8a). Only 15% indicated they agreed or strongly agreed, and males particularly strongly disagreed. Students' opinions on whether first sex should be planned showed half of all students agreed, with very few females compared with males strongly disagreeing (figure 8b).

**Figure 8:**

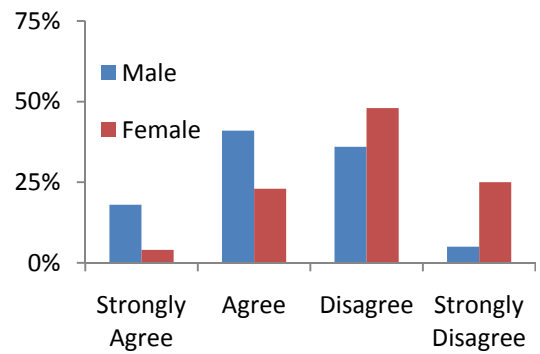


Responses to the statement 'condoms spoil sex' was diverse (figure 9a), with a higher proportion of males agreeing, while a quarter of females strongly disagreed. No significant difference was found between the age groups. However, the difference of opinion regarding the statement 'men should take the lead in relationships' (figure 9b) was strongly associated with gender, across all age groups, with males generally agreeing and females disagreeing. Surprisingly, more females than males agreed that 'girls sometimes mean yes when they say no' (figure 9c). In general the response approximated half agreeing and half disagreeing. A larger proportion of students disagreed that their friends were more sexually experienced than they were (figure 9d), with a higher percentage of females agreeing or strongly agreeing compared to males. There was no significant difference between age groups.

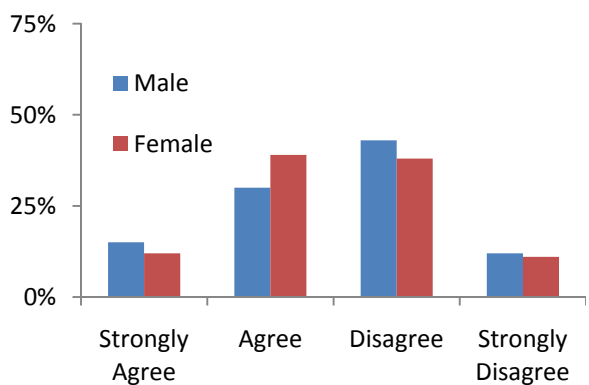
**Figure 9:**  
**a. Condoms spoil sex relationships**



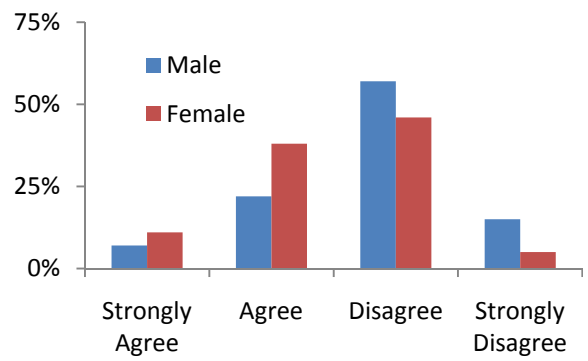
**b. Males should take the lead in**



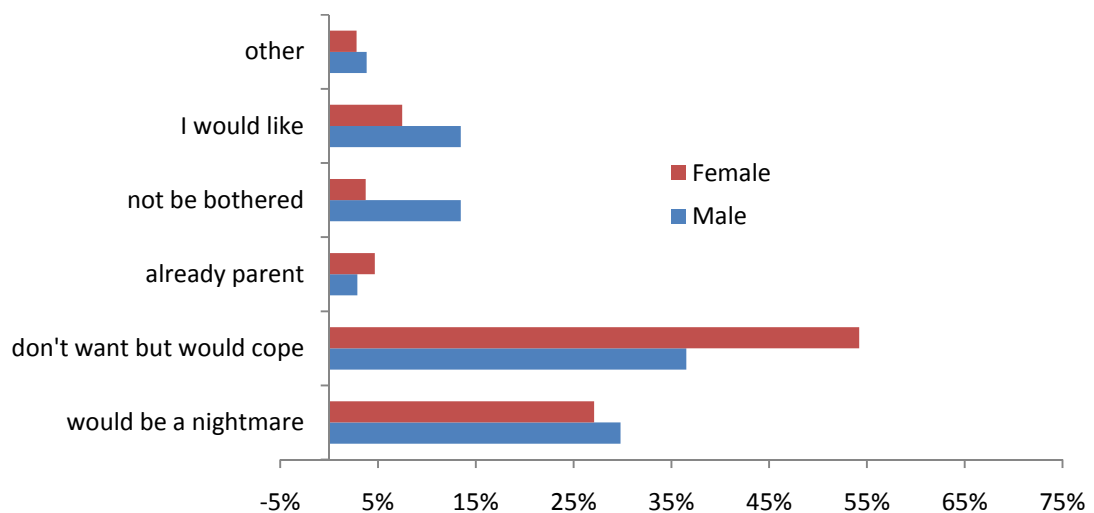
**c. Girls sometimes mean yes when they say no**



**d. My friends are more sexually experienced than me**



**Figure 10: What would your reaction be if you became a parent before the age of 20 years?**



*Attitudes to Pregnancy:* Students were asked to indicate what they thought would be the ideal age for them to become parents. Of 207 respondents, 84% indicated that the ideal age would be between 20 and 29 (91% females; 78% males). None said under 16 years but 3% of females and 5% of males recorded 16-19 years was the ideal age. When asked their

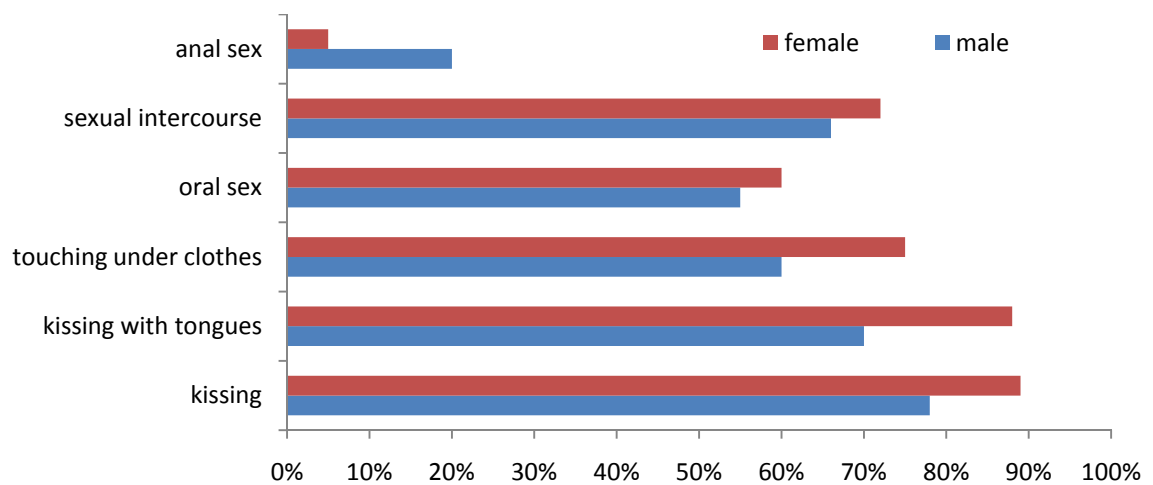


response if they found themselves becoming a father or a mother before the age of 20 years (figure 10), students responded from the list below, showing less than a third would consider it a 'nightmare', with 37% of males and 54% of females saying they would not want it to happen but if it did they would cope well. It was notable that more males stated 'they would not be bothered'. Students were asked if it worth having a baby for the extra benefits. They overwhelmingly disapproved, with 82% of males and 92% of females saying no.

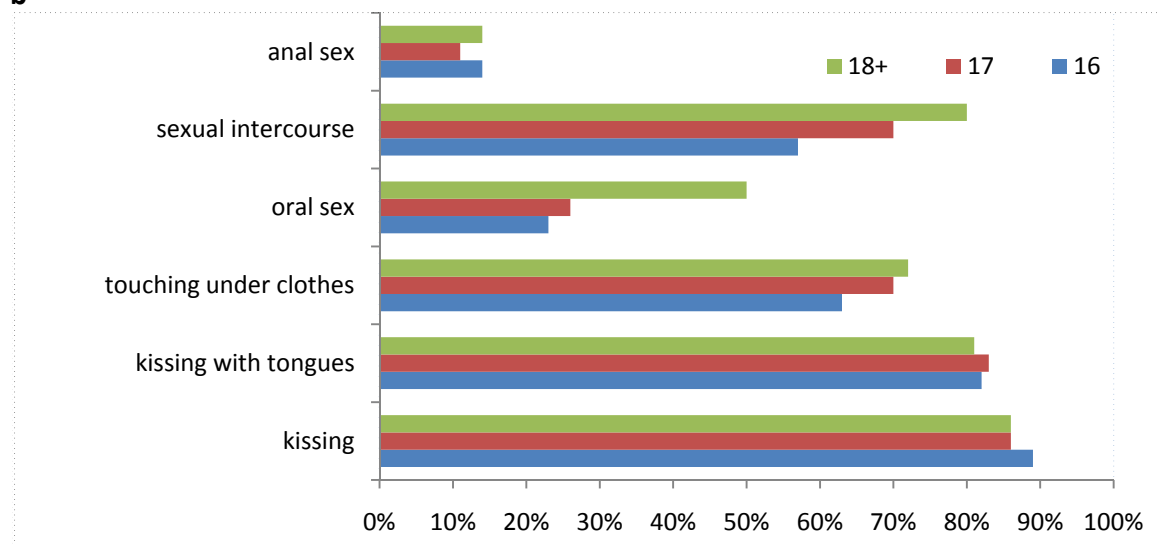
*Sexual experiences:* Students were asked to record what sexual experiences they had had. A higher proportion of females reported sexual experience than males, except for anal sex (figure 11a).

**Figure 11: Reported sexual experiences by (a) gender and (b) age of students**

**a**



**b**

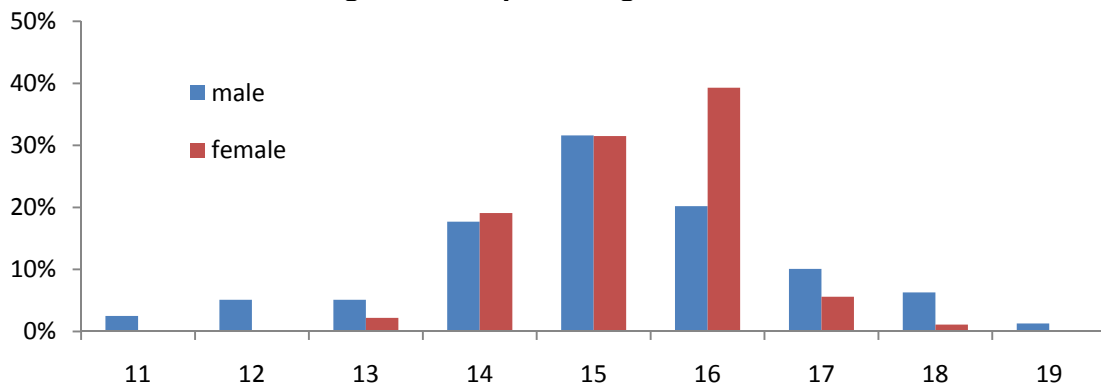


Around 80% of students had kissed, including 'kissing with tongues', and two-thirds reported touching through and under clothes. Oral sex was reported by 56% (55% of males and 60% of females) and sexual intercourse by 69% (66% of males, 72% females). Anal intercourse was recorded by 13%, most of whom were males. Sexual intercourse and oral

sex was significantly associated with older age, sex increased from 60% to 80% between 16 years and 18+ years, and oral sex frequency doubled (figure 11b). Students were asked how many sexual partners they had had: two-thirds indicated between one and three partners, and a quarter indicated between 4 and 10 partners. When asked if they had ever gone further sexually than they had planned; three in ten stated yes, with slightly more females than males reporting this (31% compared to 27% respectively). There was no clear difference by age. Asked if they had ever been pressured to have sex, one in ten stated they had (12% males, 8% females). Students were also invited to say if they ever received gifts or favours in exchange – 5% stated yes, these were predominantly males.

*Characteristics of first sex:* The age students reported that they first had sex was predominantly (62%) between 15 and 16 years, with 25% reporting below 15 years, and 12% reporting 17 years or older (figure 12). Most females (71%) recorded being aged 15-16 years, while males reported a wider age range, both earlier and later.

**Figure 12: Reported age at first sex**

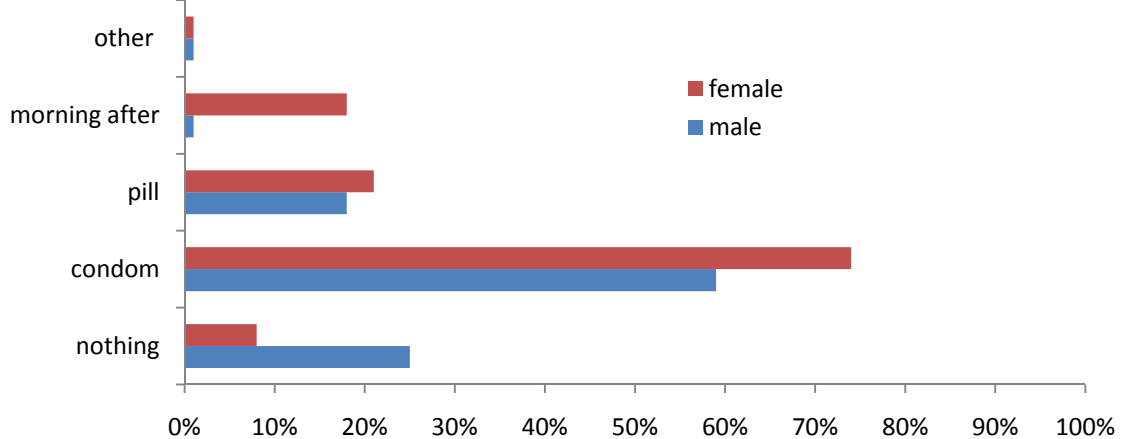


Students were asked if their first sex was planned. Three quarters reported that the first time they had sex ‘it just happened’, while a quarter reported it was planned ahead of time. There was no statistically significant difference between genders, though slightly more females reported planning ahead of time (26% to 22% of males). A slightly higher proportion of older, compared with younger, aged students reported it was planned.

Respondents were asked where were they the first time they had sex. Most reported it had happened at a girl or boyfriend’s house (47%), followed by their own home (29%). A small proportion (10%) reported outside (street, park etc), and 9% reported at a party, with 5% reporting elsewhere. When looking at gender, there was a significant difference in the place of first sex. Females predominantly (63%) reported first having sex in their boyfriends house, compared with 28% of males, suggesting a tendency for couples to feel more freedom opting for the boy’s home over the girl’s, or that girls are more vulnerable to coercion. Males also more frequently had sex the first time outside (17%) or at a party (15%) compared with <5% reported by females. Nearly three-quarters (71%) reported that their parents/carers did not know about them having sex for the first time, with 75% of females and 67% of males reporting this. Around 20% said that their parents knew and were supportive, with no difference by gender.

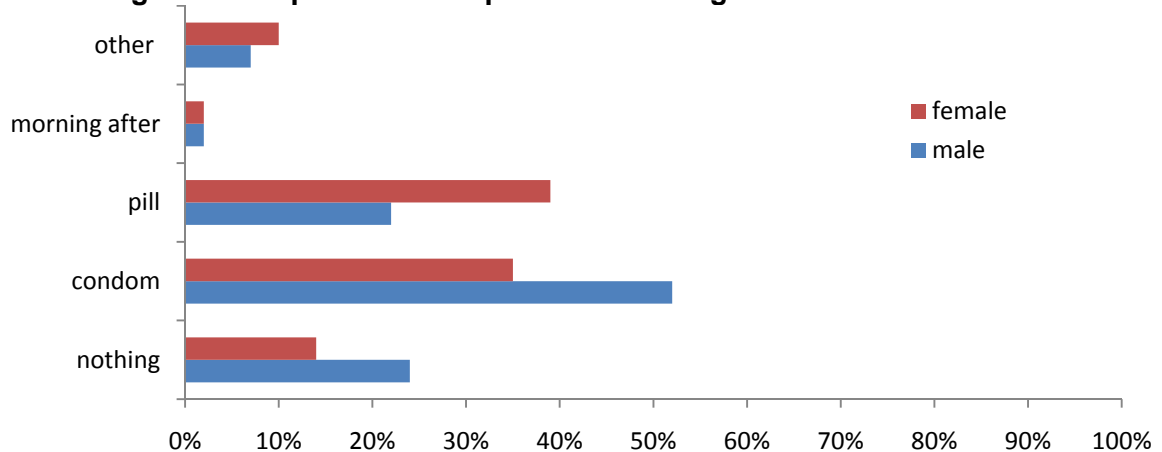
*Protection during first and most recent sex:* Over half of males (59%) and three-quarters of females (74%) reported using a condom the first time they had sex, and around a fifth reportedly used the pill (figure 13). While 17% recorded not using any protection at first sex, this was mainly due to males, 25% of whom reported using nothing compared with only 8% of females. One in 5 females stated they used emergency contraception (the morning after pill). Use of the pill increased from 11% in 16 year olds to 23% in 18 years and older, while use of the morning after pill was 14% in the youngest and 10% in the oldest age group.

**Figure 13: Reported use of protection during first sex**



Reported protection differed between first sex and most recent sex. While the proportion of males stating nothing was used for most recent sex was similar to first sex (~25%), the proportion among females increased from 8% first sex to 14% most recent sex (figure 14). A substantially smaller proportion of females indicated they used a condom in their most recent sex (35%) compared with first sex (75%). This partly reflects an increased proportion using the pill (39% most recent compared with 21% first sex), and 10% of females reported ‘implants’/‘the needle’ for long acting contraception.

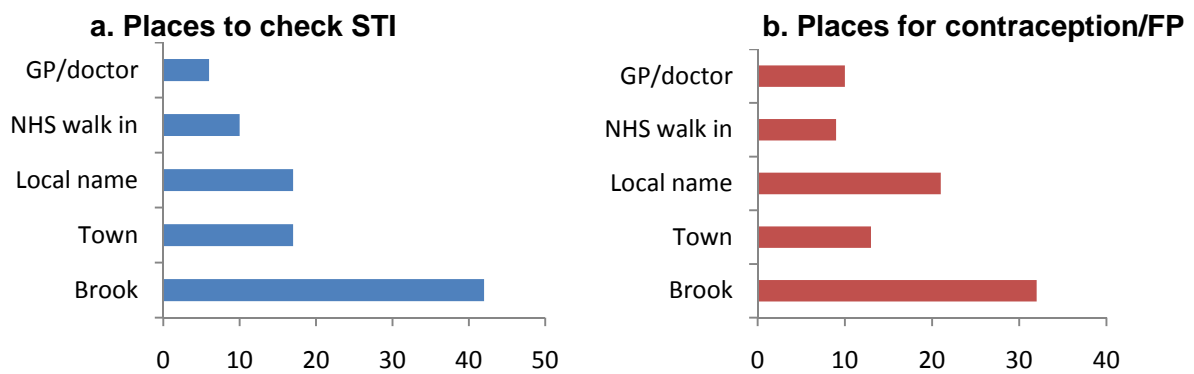
**Figure 14: Reported use of protection during most recent sex**



*Sexual health seeking:* Students were asked if they knew where sexual infection testing was in their area - 66% (73% of females, 55% of males) indicated they knew, but only 43% (59% of females, 28% of males) named a place or service (figure 15). Brook was the main named

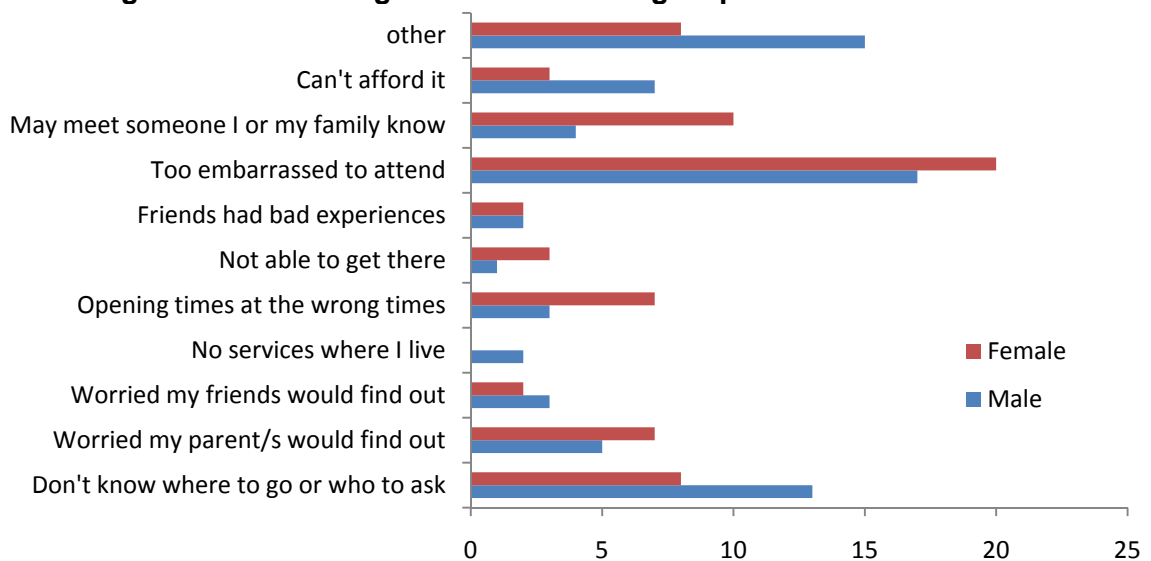
place; another 17 gave a specific other local name, and 17 simply stated 'town' or 'city centre'. Similarly, while 61% (70% of females 52% of males) reported knowing where the contraception/family planning service was, only 41% (60% of females and 22% of males) could name a place, with Brook again the best known, with 21 other local names given. When provided with a list of sexual and reproductive health needs, the students were asked an open question on where they would go for seeking advice/help for each. While these were not fully completed, (average of 50% answered), of those that did, there was for each health need, a preponderance of answers stating 'Brook' showing this place appears to be best known and appreciated by students for care.

**Figure 15:**



*Reasons for not seeking advice:* Students were asked if they wanted advice about sex but have not sought it. While only 15% (31 students) stated yes to this, a larger number gave reasons for not seeking advice. By far the strongest reason for not seeking advice was embarrassment (figure 16). 'Other' mainly related to 'could not be bothered' or did not need it.

**Figure 16: Reasons given for not seeking help or advice on sex**



*Students that have experienced pregnancy:* Of 109 females answering questions on pregnancy, 15 (14%) reported either having been pregnant in the past or being currently pregnant, with a further 2% waiting to find out. Of those pregnant (or waiting result), 29% indicated that they have or would have the baby, 24% indicated they had already had a miscarriage, and 35% had/would have an abortion. Two-thirds were aged 18 or over, 20% were 16 and 13% were 17. All indicated they have only been pregnant once. The majority (88%) did not mean to get pregnant. All females had at least one friend they knew who have been pregnant. They were asked if alcohol was consumed at the time of pregnancy – 29% had been drinking, 18% said they had drunk a lot – the majority of these were 16 year olds; over a third reported the male had drunk alcohol, 29% had drunk a lot. Male students were also asked about pregnancy. A very small proportion (3%) responded they had partnered a pregnancy, and so further analyses on this information was not possible.

### **Service use data**

Brook had accessed a total of 18 of the 30 high schools in Liverpool, prioritising those most in need.

So To Speak were given a target of 15 schools to participate in the project, which was achieved. They delivered sessions to vulnerable groups and trained teachers in 8 schools, as per their targets.

The reach of So To Speak's work in accessing other vulnerable young people was harder to quantify, because the total number of such people is unknown. The target was to carry out 504 sessions with an average of 8 young people, resulting in a total of 4032 young people receiving the intervention. By the end of quarter 3 of 2010/2011, So To Speak had seen 2738 young people (90% of the target by quarter 3), and were therefore not on line to achieve the annual target. The rationale for the selection of targets was unclear to the commissioners interviewed in this rapid evaluation. Targets and monitoring was finalised after December 2010 – well into the financial year that the targets related to.

It appeared that every effort had been made to access as full a list as possible of all agencies. Agencies were prioritised by need. Monitoring data supplied by So To Speak included first part postcodes of young people receiving interventions. The largest number (279) resided in L12, a postcode corresponding to the West Derby ward, an area that is relatively affluent compared to Liverpool's average. This apparent anomaly may be explained by the use of the agency (rather than young person's) postcode, West Derby's close proximity to more deprived wards (Clubmore, Norris Green and Croxteth), and the fact that agencies in a specific area often serve a large catchment area. The next highest number of young people (200) came from L8, corresponding with the Riverside ward, where 31% of the area is in the most deprived 1% nationally. They saw 100 young people from L4 (Anfield, a ward where 32% of the area is in the most deprived 1%). Thus, other than the large number from L12, the deprivation profile indicates that in general the poorer areas were targeted by So To Speak. For example, there were no interventions given to young people in L70: a relatively affluent

part of Liverpool. Young people attending So To Speak sessions complete evaluation forms, reporting high levels of satisfaction and increases in knowledge.

In terms of training received by staff working in youth settings, So To Speak were set a target of sessions booked (rather than sessions received). The target was 76 with an average of 8 attendees. By the end of quarter 3, 49 sessions were booked of which 8 were cancelled. Only 303 of the total 608 aimed for were trained. So To Speak report (and commissioners accept) difficulty in working with third sector organisations facing financial uncertainty, resulting in difficulty in committing to training, and high rates of cancellations. Evaluation forms completed by trainees on the day showed high levels of satisfaction, and improvements in confidence and knowledge scores.

The college had delivered interventions to around 1,500 young people, most of level 1, which was the highest need as defined by educational attainment. Young people complete an evaluation form at the end of the session, and these indicated satisfaction with the course and planned changes in behaviour as a result of the session, e.g. reporting an increased level of intention to use condoms.

### **Focus groups with young people**

One of the strongest themes to emerge from the focus groups were that whilst most were very positive in their opinion of the SRE session they had received, the consensus was that it had come too late, and would be far more useful at an earlier age. The one group who refuted this was a group of schoolchildren aged around 15 years.

*'Fifteen is a good age'* (School 1)

*'When you're 13 you're more like an arrogant age, if you want to do something you'll do it anyway, regardless of what you get told so, I think it's better to teach people like our age, make them aware of what can actually happen'* (School 1)

A couple of individuals from other groups also felt they were the right age. In contrast, participants from School 2, who were of similar age, were vehement in their agreement that it should have been provided at an earlier age.

*'don't wait until year 11 to tell us about sex when in reality a lot of people are gonna...so probably should have done it in year 9 to have stressed the importance of, rather than doing it too late'* (School 2)

There were two reasons frequently given for reducing the age of SRE provision. First, there was a strong consensus that 13 was the right age for receiving a full SRE programme because it needed to be given before people started having sex. Any later than this would miss out a substantial proportion of young people who were thought to be sexually active.

*'Could have done with it a few years ago like'* (NSS2)

*'By the time they get taught it, they've already done it...there's no point going to 16 year olds' (LCC1)*

*'Well kids are having sex at like 13 now so I think they need to start on it then' (NSS2)*

*'I think like young people these days do not have like the morals we had at 13' (LCC1)*

The second reason for reducing the target age for the SRE session was that, particularly for the college students, most of the information provided in the recent session was already known to them.

*'because we're mature, we've heard most of it, but for someone who's younger it would be like, it would be good for them, if it was like the way she taught, I mean I found the session useful, but because I'm 18 like, I already know what most is being taught to me' (LCC2)*

*'Like the woman who came in the other day, she was good and everything, but it's a bit late, now we're all like 18 do you know like' (LCC1)*

*'It might have been because we already knew what she was saying, that's why she wasn't that good, she wasn't telling us anything that we didn't already know, so it was a bit boring' (LCC1)*

As stated most of the groups/participants were generally positive about the SRE they had received in spite of the timing, participants in the non school settings who had a So-to Speak session particularly - *'I'd have the session again'* (NSS2). Feedback on the positive aspects of each SRE session fell into three main categories: the wealth of information given, the interactive format, and the role / personality of the instructor.

Whilst many of the participants reported they had received SRE prior to the session in question, the session itself was felt to be detailed or *'thorough'* enough to provide some extra information for everyone. They covered *'everything'*. Predominantly, the additional information was around STIs: some participants were not aware of specific STIs, although mainly the additional information was around the symptoms and how checks can be made. Some forms of contraception were also new to a few of the participants, for example the coil and Femidom (although the Femidom was ridiculed as a method of contraception in those groups who mentioned it). Some of the information such as the different side effects was also new to some participants, as was the implant *'and where it goes'* (School 2). For those participants who had attended a Brook Bitesize session the *'tables'* (that Brook refer to as *'zones'*) on STIs and contraception were well thought of, being thorough, useful and applicable. Another feature of all SRE sessions that most participants had not been provided with before the session in question was that around relationships and peer pressure, but which was, on the whole, felt to be useful.

*'well it's been touched on, but she went like through dead thoroughly so we got more information' (NSS2)*



*'so she was telling us more about like what is a healthy relationship and what does it mean like you have a boyfriend and girlfriend and like she was saying stuff about consent' (NSS2)*

As well as new information some participants thought it was useful to be reminded of information they had already been taught but may have forgotten.

*'Sometimes, sometimes when you get told something it can just go out your brain, so it's good to really be told again every now and again, 'cause sometimes you remember about a session and you remember everything about contraception and down the line you totally forget, like forget certain things about it I think anyway' (LCC2)*

As stated, the interactive format was praised by many participants, who enjoyed the SRE session,

*'More vocal and more discussion which I think is better because sometimes when someone goes just like speaking to you, lecturing you about something, sometimes it can tend to just go through one ear and out the other. Whereas when she'd done the session she like included the pupils, like our views on whether the contraception will work, or whether we agree with this, or we disagree with that, so I think when its more vocal and more of a discussion instead of like too much information' (LCC1)*

*But they made it like funny, so like you're not bothered to ask them questions either.... In school you just get a basic information about sex and that's it. Here is completely different. I never had an understanding of information in me life so it was beneficial' (NSS2)*

The 'vagina in a box', was mentioned a number of times specifically by groups who had received a So-to Speak session. The novelty of this added impact whilst the teaching around it imparted some new knowledge.

Comparison with school format SRE was often made, with the recent SRE session being deemed far more interesting and beneficial.

*'I felt I learnt more with [name] than in school, because they just don't explain it to you.'* (NSS1)

Partly this was felt to be related to the fact that teachers were not seen as the best people to impart information around sex. However participants from both school groups demonstrated mixed views on this. In the case of School 1 this view may have been influenced by the fact that the teacher remained present in the room during this particular focus group. However this was not the case at School 2. It appeared that some teachers were well thought of in terms of having *'built up our trust to be able to have that conversation'* (School 2) although when other teachers were mentioned by name, it was clear that not all would be suitable to engage pupils in sex education.

Two main reasons were put forward for general preference for an outside agent rather than a teacher. The first being that staff from a SRE service were deemed far more knowledgeable in this field, and had the confidence and self assurance to discuss issues which may be sensitive or embarrassing. The second reason related to the positionality of the teacher – who was in authority and someone they had a long standing relationship with. This meant that a number of participants felt they couldn't ask personal questions.

*'She didn't come like a teacher, she just said whatever you want to know about sex, just ask me now, and everybody just asked and then she was here for ages wasn't she'* (NSS2)

*'they only learn so much to tell us, so if we wanted to know more and ask them questions they might not be able to answer us, whereas there's more chance of someone else who's come in, they can answer more of our questions – and you won't feel ashamed to ask questions cause they're a teacher'* (LCC1)

*'She knew what she was talking about and she was proper qualified and you know what I mean? We trusted her like, you know, whatever she was saying' 'you knew she wouldn't judge'* (both NSS2)

The two Non school setting groups who had received SRE from So-to speak were, on the whole, very complimentary about the person who delivered the session which appeared to impact positively on how useful or enjoyable they found the session. (Although one individual from NSS1 felt that

*'She used to treat you like a little kid. She was too in your face'* (NSS1).)

The majority made comments such as:

*'Interesting, enthusiastic, very talkative'* and *'I thought she was funny'* (both NSS1)

*'You could ask questions, she wasn't embarrassed'* (NSS2)

The two school groups who had received sessions from Bitesize Brook were less complimentary about the instructors for a few reasons, one of which was a reluctance to answer questions that pupils had asked. (This was also echoed in one of the College sessions as well, suggesting this issue is important to redress.)

*'They didn't answer any of the questions'* (School 2)

*'It wasn't a bad session, I just think she might have been quite nervous or something cause she like just stood there and just spoke to us and like couldn't really answer the questions and stuff. I don't know if that's just the way she teaches or...' 'She needs more experience maybe'* (both LCC2)

There were some other areas which participants felt could be improved. However, whilst on balance they felt it had been useful, both school based focus groups had more negative

feedback about aspects of Bitesize Brook in comparison to feedback from the other groups, (although there were clearly positive aspects of the session as well). Criticism was made of the content and applicability of some of the 'tables' ('zones'), (though as stated above, those on contraception and STI's produced very positive responses)

*'Sexuality table – what's going on!?'*

And

*'Gender / stereotyping – useless'*

*'Some tables should have been scrapped to make more time for questions and answers cause they were the vital things that, the things you wanted to know personally and they didn't answer them'* (School 2)

Both focus groups carried out in the schools expressed preference for the session to have been provided to them in smaller groups. The Bitesize Brook session was described as a *'big assembly thing'* where they were split into groups around a number of different tables pertaining to various topics, the general perception of being educated in a mass, coupled with being in what they perceived as 'large' non friendship groups – they estimated around 25 or so per group, was perceived in a negative way.

Furthermore, according to a number of participants in School 2, they felt the message received from Brook was not quite the message they wanted to hear, as it was perceived to be very negative.

*'I think that the message they kind of gave to us was – come to the Brook when you've got yourself in the problem, when you're pregnant come to the Brook, when you've got your STI come to the Brook and we can fix it'* (School 2)

Other general criticisms of the SRE session, irrespective of provider, included for some, showing pictures of STIs that illustrated very graphic worst case scenarios. Preference was expressed for showing the mild end of the symptoms spectrum which would enable people to assess if they had an STI earlier on, rather than waiting until symptoms were full-blown.

*'Because they don't show you the first signs of getting warts, they show you like full extended warts, when like your bits have crusted and gone, they don't show you like the first starts of when you get it so you know what it looks like'* (NSS2)

Other participants did however feel that the graphic images had a purpose and in fact were effective in their message to have safe sex.

*'The full contents of what will happen if you don't get it treated, they work'* (NSS2)

Another criticism expressed was that whilst in each group there were some members who had no preference for single sex SRE sessions, all groups had members who found this

difficult. Similarly, the majority opinion was for preference of an instructor of their own sex – or at least both male and female for a mixed group.

*'because I'm the only boy in the class I didn't really like the demonstration of putting a condom on, I found that uncomfortable being around so many women, I think it should be sectioned into a boys session and a girls session, with males taking males and females taking females'* (LCC2)

*'I don't think girls would speak up if boys were there', 'I don't think boys would speak up if girls were there'* and *'and they'd probably mess around as well'* (all School 1)

Participants were not sure if these SRE sessions would change behaviours. Two reasons were put forward for this. The older participants felt that they were already established in their pattern of behaviour.

*'We're more mature, we've already made our minds up and we already know what we're doing sort of thing'* (LCC1)

Whilst the other view was that it was very much down to the individual themselves, and whether they were *'ready to take that information on board, or if they're not'* (NSS2).

## **Training provided by So To Speak**

The content of the So to Speak course covered all aspects required for interaction with young people, as well as updates on factual aspects of sexual health, including STIs and contraception.

*'It was quite detailed training over two days... enlightened discussions on sex and the law, able to talk freely about things to the other trainees... did also do factual talks on contraception, STI etc.'*

*'Talked about words young people use, sexual health, diseases, pregnancy and how to prevent, new methods (contraception), where to go, legalities, website/signposting; shared photos of STIs and percent'*

*'They provided everything that was needed – all the contraception information and literature'*

*'Very detailed and full... really good I learned so much'*

Half the teachers and all the community staff liked the content and discussion on words used by young people, as this enabled them to be able to talk directly to young people and know what they are talking about. For example, one teacher reported *'I feel more comfortable talking to young people... nothing would faze me'*, and further explained that sometimes teachers worry young people will ask questions the teacher does not know the answer to, or slang they don't understand. However another teacher was strongly against this content:

*' words kids use - slang words - I don't want to use these as their teacher – we try to teach kids the correct words! They talked and read out all the names, which I found disturbing'*

The legalities section was particularly well received, as it was thought provoking and helped differentiate legal and illegal statements.

Few aspects were missing from the longer course. However normative values and helping young people to realise sexual activities were a part of a healthy relationship appeared (according to one teacher) to be under-represented. *'Not enough about relationships, how to talk to young people about their relationships or getting values across'*

*'provided information best for more able students (not so good for students with learning disabilities, special education needs)'*

*'The main content was lots of talking about sex and values'*

The half day course was not as well received by teachers as the one or two day course, predominantly because content was limited, and teachers found it unhelpful for their needs.

*'Difficult for a non specialist staff as they needed ideas on how or what to do in the lessons – start with this..., then do that..., key skills needed are..., A toolkit is needed for non-specialist – what can you cover with children in 40 minutes – cover this., using these strategies...'*

The staff from agencies working with young people, and some teachers, liked the open forum when anything could be discussed. Small group work helped this open dialogue:

*'Felt very comfortable talking about issues despite some having no experience of sexual health - everyone from different area of work but all inclusive so all felt could talk together. One of the questions was how would you assess the need of a young person and how would you signpost --- things to look for'*

One teacher considered this a waste of time.

*'But there was lots of digression, talking about anecdotes which wasted time'*

### **Materials**

The materials used to train were adequate for the community staff, but teachers wanted more structured materials that could be used in the classroom. Visual as well as verbal tools, such as laminated cards were used, and an anatomical structure showing how to put in a coil, but no demonstration piece of how to put on condoms.

*'Couldn't do much with the presentation and materials – will have to translate for the kids. two of the activities will be useful. Rest were not'*

*'We would have liked more on resources, where to get information once finished the course'*

For the last activity they had dominoes – *'large size laminated for an STI game – interesting idea of a compliant match for STI, could use in classroom'*

Materials for distribution appeared limited to leaflet packs that participants could make up to bring home to work on STIs, sexual health and signposting. This was considered useful so that other work colleagues could look through and use.

The staff from young people settings and some teachers did not find the limited materials a problem. One teacher stated *'Had a good display – sitting on the table to give us ideas on what is available – we can then resource ourselves, cards etc for lessons'*

The teachers recommended the programme used for youth workers should be adapted specifically for teachers, who already know how to talk to children and young people, so that the information is better translated into what is needed for classroom teaching.

*'You could tell the So To Speak trainers were not teachers, as they could not translate their youth work to teaching children in the classroom'*

One problem for teachers is that they have very busy schedules, so having to go back to the class and find their own materials is too time consuming, particularly if they have taken time out already to attend an outside training session.

Another teacher felt it did not help them to deal with a classroom full of students, and So To Speak misjudged what teachers require for actual classroom work with children *'we need tools, we cant just have a lesson where we go round the class and ask children one by one...*

*...we have to engage children for up to an hour'*

There was *'no knowledge base...no activities, ideas, .... we need structure and a formula. More on specifics details on HIV-AIDS, more on STIs: what are most important infections, risks, information to teach children.'* In this half day session the teacher confided *'I found myself having to drag it out of the trainer'* to get some facts.

One teacher suggested a Toolkit be made which could be used in the classroom.

### **Usefulness**

Half of the teachers and all the staff from youth settings felt the So To Speak course was extremely helpful and useful, both in terms of content, updates, as well as helping them know how to talk to young people. In comparison, the teachers were less happy with the programme; they felt they could talk with young people already and appeared much more stressed about needing factual content and materials, thus the lack of structure and open format for discussions were irritating to some teachers, while the majority of others found this the most relevant.

Even the teacher who did not enjoy the course acknowledged the trainer was *'Good at opening up people, get people to talk'*. One teacher was very shy and the trainer helped to open up and discuss sex.

Two other teachers found the training sessions very helpful for school based programmes.

*'Quite detailed training over two days... provided information best for more able students (not so good for students with learning disabilities, special education needs). Enlightened discussions on sex and the law, able to talk freely about things to the other trainees. The course showed how not to inflict views on students – it was very good. I felt prepared to do SRE after the course – at least some aspects, particularly on views, knowledge, it was thought provoking'*

One teacher considered the one day course was the right level for professionals, not patronising, and would recommend to all schools. The generalist course (half day) was not enough, whereas the longer course... *'provided everything that was needed – all the contraception information and literature'*

*'Now I can teach and train others. I have all the information now and know where to find resources'*

*'They should do more of this – every school should have one or two teachers fully trained with this course, and that would be enough for them to cascade training to other teachers'*

*'This was really helpful, I have not had this before so I learnt a lot, especially the importance of awareness of words young people use. Since I had not done this before it was a good way of catching up on sexual health issues'*

The link worker felt better prepared to talk to young people and reported the next day she was able to use her new skills: *'The next day a young teen mum came in asking advice and I was able to use the training... talk to her, give her leaflets, discuss where she needed to go to get protection, as she did not want to get pregnant again. It was very helpful to have had training'*

The staff from youth settings would recommend the course to their colleagues and other organisations, as they considered it really helped them to better understand young people.

*'Great. Everyone would benefit from it'*

*'Really good for people who work at children's centres and young peoples centres, really helps them learn how to talk to young people about sexual health'*

Most thought the training was excellent with a broad content and a lot of interactive group work. They also were grateful for the materials/leaflets they could take away that they could share with their colleagues.

One case worker does not deal with sexual health but attended in case she needs to fulfil this role in the future.

*'Each time training comes up whoever is free is chosen to attend – first come first serve'*

For such a person, with no previous training, the course *'filled all the gaps for me... gave me confidence to talk to young people'*.

Enjoyment of the course also included the personality of the trainers.

*'the way the trainer actually delivered the information – it was the trainer – as the group were not comfortable with sexual health so he took the fear away and it was OK to talk about sex with young people'*

### **Final thoughts**

The one and two day courses by So To Speak are well received, useful courses both for community staff and for teachers. They were so valued that they all recommended them for their colleagues. Following the course the person could pass on information to colleagues but not train *'I can tell them what I learned but not all the depth, best they do the course to help feel comfortable about sexual health.'*

However the short half day course got limited feedback, including teachers who enjoyed the longer course.

*'I needed more than the (school-based) generalist course; that one crammed too much in so needed one day to go through properly and have time to talk. This one (full course) was excellent'*

*'Felt very comfortable talking about issues despite some having no experience of sexual health'*

*'everyone was from different areas of work but all inclusive so we all felt we could talk together'*

The absence of lunch was frequently mentioned as the only negative component, as everyone had to leave then return, preventing the chance to network with fellow participants over lunch, and discuss different views with the trainers. Most felt it was 'free' so they had no complaints.

Better vetting of attendees may be required. Teachers do not benefit from exactly the same course as community staff and require a slightly different orientation. From this limited review it appears male community staff and teachers are under-represented in training on So To Speak courses. One male youth worker noted he was the only man being trained. Further, the 'first come first serve' approach to choosing participants to attend may mean that less able or interested persons may be missing, who are those most in need of training.



There is a clear need to enhance materials provided, particularly for the teachers – the idea of a toolbox or toolkit to help teachers was brought up and is very appealing.

It was not possible to fully understand whether persons attending the course could then themselves train others. Participants were asked whether they could cascade training, but generally they considered their colleagues themselves should attend the training programme.

*'I would be able to talk with other colleagues, but have just booked [facilitator's name] for training of new staff in the school'*

This in part reflects the availability of the programme, and partly showed that talking about sex to young people requires professional trainers – thus, they had the confidence to then talk to young people, but not the confidence to teach others how to do this. Some thus stated they would be 'happy to pass on the information'.

*'I can tell them what I learned but not all the depth, best they go on the course to help feel comfortable about sexual health'*

For school teachers, however, who are more confident talking to children, those that benefitted from the course would be happy to cascade training...

*'I can teach and train others – have all the information now and where to resource'*

### **Providers' assessments using RE-AIM tool**

*Reach:* Providers perceived the reach to young people to be high once access to the group (e.g. school or youth service) had been obtained. Evidence of this was cited as from the range of settings that are targeted. In the case of the youth services, most of these, by definition, encompass those young people of greater need (e.g. youth clubs in deprived areas, youth offending services, looked after children). In the case of schools, firstly schools are targeted on the basis of socioeconomic characteristics and TP rates in the catchment area, and secondly, vulnerable groups within schools are targeted for small group sessions by So To Speak.

Concern was expressed that there were significant barriers to accessing groups defined by their faith. In the case of schools, Healthy Schools, So To Speak and Brook have made progress with this and adapted the programme to be suitable for faith schools. Brook was confident that now these initial barriers had been overcome with two faith schools, more would follow suit. So To Speak reported having accessed all the schools on their prioritised list, regardless of faith, but acknowledged that the materials had been modified in order to do so. Less progress appeared to have been made for youth settings defined by a faith group.

In the case of the college students, confidence was expressed that the majority of students had received SRE delivered by the sexual health advisor, and that this had been prioritised to the most vulnerable (as defined by educational attainment).

*Effectiveness:* Providers were highly confident that the interventions were effective. They cited their own evaluations, and reported having modified content according to evaluation feedback. Brook cited the fact that after a Bitesize day there would tend to be an influx of young people from that particular school attending the service. Young people also cited school as the source of their information about Brook. Evaluations carried out by the organisations themselves all showed that SRE delivered by Brook, So To Speak and the college sexual health advisor was well received and perceived by the young people to be effective. Because of the interactive nature of the sessions, providers are able to get a feel for the needs of the young people from the questions that they ask. Providers report the satisfaction of witnessing a 'light bulb moment' as a young person becomes aware of a previously unrecognised sexual health issue. Examples of these included: a young woman realising that a boy in a normal relationship would not obsessively check his girlfriend's mobile phone for text messages; that STIs can be transmitted via oral sex; it is not respectful (or legal) to have pornographic images of a girlfriend on a mobile phone. Daily experience of this made the providers passionate about the effectiveness of their intervention:

*'... just that realisation, during a session, when you're talking about healthy relationships, that actually, someone checking your mobile phone for messages, and wanting to know where you are all the time, isn't that healthy... it happens all the time. ... it's that self confidence within a relationship'*

*... and with young men, about having pornographic images of young people on their phone is illegal and maybe a little bit disrespectful to them... and the realisation that that's you know ... you see the penny dropping and the colour draining from their face... they have never even thought about that being damaging to that young person or themselves'*

Providers used a teaching model that had been developed historically, and felt that it built on best practice. They were less able to articulate how this linked to theoretical models of behaviour change theory; however, key elements that link to these were present, e.g. the emphasis on empowerment/self efficacy. Providers showed more awareness of national recommendations (e.g. DFES 2006). Teaching methods for young people (both for So To Speak and Brook Bitesize) followed accepted best practice from pedagogic theory: were suitable for a range of learning styles, were interactive, broken down into short activities that fit the attention span.

A member of the college staff who had observed the SRE provided by the sexual health advisor in tutorial sessions was also highly confident that there was a need for SRE in this older age group because the nature of questions asked by young people revealed large gaps in their knowledge. It was felt highly effective because the approachability and honesty of

the facilitator ensured questions were answered and that positive social norms were emphasised (i.e. that many people of college age do not yet have sex). Evaluation forms also indicated that young people had positive future behavioural intentions.

Providers of training for teachers/staff working in youth settings were highly confident that the intervention influenced trainee's attitudes and skills around talking to young people about sexual health (as evidenced by feedback forms), but were slightly less confident about the intervention's effect on the final target group, because they were unable to measure this directly. It was felt that schools and youth services would still require a lot of support in this area, particularly as the vast majority would only attend a half or one day course, which at best could only provide an introductory session.

*Adoption:* These questions related to whether the training was adopted by partner agencies. High confidence was expressed about including all settings. In terms of Healthy Schools this was evidenced by progress with all the high schools; So To Speak reported having accessed all the schools on the priority list; Brook cited their success in accessing schools (18 out of 31 to date, with expectation that the majority would be included if the programme extended); So To Speak gave the example of access to groups such as NEETs to demonstrate their confidence they were able to access to all those with most need. The consensus was that all young peoples' settings and schools should have young peoples' wellbeing as a central organisational mission, and as such, the aims of the SRE programme fitted well and were more likely to be adopted.

As discussed under Reach, Faith based youth organisations were the only obvious gap in provision.

The main barrier with schools and the college adopting the intervention without support (i.e. making use of the teacher/tutor training) was the small amount of timetabling devoted to SRE and the disproportionate amount of training required to deliver it effectively. In terms of the college, one efficient way to increase adoption may be to make use of the staff that are employed in the relatively new role of 'tutorial advisor', a role that is dedicated to pastoral care (and not curriculum). A significant proportion of the students see these tutorial advisors, thus an investment in their skills to deliver SRE may be an effective method to reach a large number of students. A proportion of the students receive their tutorials from staff whose primary role is delivering the curriculum. Although such staff have been offered (and taken) training in SRE, there is a high turnover of those providing this secondary tutorial role; they are also less able to devote significant time to SRE development.

*Implementation:* Healthy Schools were confident that package offered to schools (support from Healthy Schools, So To Speak and sessions from Brook) had all the right components and that implementation was therefore carried out as intended. They continue (in partnership with So To Speak) to support schools to embed the programme so that the skills

and knowledge is cascaded in schools among a team of teachers responsible for SRE. So To Speak, when commenting on the training of teachers, felt that ongoing work in the school required further support, and whether the intervention would be rolled out in individual schools in the absence of ongoing support depended a lot on individual teachers. They expressed concern that the limited amount of teaching that had been negotiated with the school would not be enough to fully equip a teacher with the expertise to deliver SRE. So To Speak was not aware of the full package of support provided by Healthy Schools (namely the curriculum training). With respect to settings other than schools, So To Speak was confident that their training participants had been given more awareness and skills to talk to young people, and were better equipped to signpost to services. Again, with the limited uptake of training offers (most only doing one day courses), this was all that So To Speak considered reasonable to expect as an outcome.

*Maintenance:* Providers were confident that interventions had lasting effects on young people, but did acknowledge the inevitable difficulty of evidencing this without long term follow-up. Brook cited examples of some young people accessing services months after initial school contact, citing a Bitesize event at school as the source of their information. Providers cited international evidence and national guidelines suggesting that high quality SRE has lasting effects on young people. At an organisation-level (i.e. schools and youth settings), providers reported success in building relationships, and felt that once access had been granted to an organisation, their services were valued and they had begun to influence the ethos of those organisations; they felt this could be built on in future years.

### **Commissioners' perspectives**

Compared to the providers, there was less confidence among commissioners about the evidence base around the effectiveness of SRE, and that SRE did not produce unintended adverse consequences (i.e. encouraging young people to have sex).

Commissioners were more confident that SRE is effective if it is of the highest quality; however, they raised questions about how to ensure such quality, in particular raising the question of accredited training courses as a mechanism to ensure quality.

*Training:* The question of accreditation was explored further by interview with a provider of training from a neighbouring primary care trust. This provider reported that accreditation through the Open College Network was flexible as it allowed the provider to create bespoke programmes. They considered that accreditation had improved the quality of their training by making them more focussed on structure and outcomes. It had increased the attractiveness of the course, since trainees would get a qualification and made commissioners more confident to commission training. However, it was not considered appropriate for shorter (one or two day) courses. The provider acknowledged that there was a lengthy paperwork process, and some cost, but felt the benefits outweighed this.

Commissioners raised the question of Healthy Schools' role in training, and whether this duplicated provision by So To Speak.

*Funding:* The total funds for the programme in 2010/2011 were in the region of £352,000, of which £200,000 was allocated to So To Speak for youth settings work, £27,000 (via Healthy Schools) also to So To Speak was allocated for schools work. This £27,000 came from a total of £36,000 allocated to Healthy Schools. Brook was given £1,000 per school; they have reported visiting 18 schools, so this would equate to £18,000. However, not all of this came from the Teenage Pregnancy fund. £33,000 was allocated to the college.

Thus the total spend is £289,000, with the expenditure weighted towards the youth settings rather than schools. The remaining sum (more than £63,000, depending on what the Brook Bitesize allocation was) contributed towards the salaries of the teenage pregnancy coordinator and administrative support.

The total funds for the financial year 2011/2012 are likely to be around £176,000, of which £50,000 is already allocated to So To Speak to honour the contractual agreement of 90 days notice of termination (So To Speak services will be provided until 30 June 2011). Salaries of the teenage pregnancy coordinator and administration support will be required, leaving funds worth approximately £70,000-£80,000 to allocate.

## DISCUSSION

The provision of SRE support in Liverpool, as funded by the Teenage Pregnancy Partnership, has been built on best practice (DFES 2006) and has reached a substantial number of young people in Liverpool, and this is to be celebrated.

Overall, the investment in SRE when assessed using the RE-AIM framework resulted in an intervention that was considered to have performed relatively well.

- i) **R:** there was good **reach** in terms of overall number of young people accessed. Healthy Schools reported work with all schools and the vast majority of schools have Healthy Schools status (the achievement of which suggests SRE is prominent). The most vulnerable have been targeted: those most at risk in higher risk schools have been targeted by So To Speak. So To Speak have had moderate success in accessing young people's settings.
- ii) **E:** the intervention is thought to be **effective**. National guidance suggests good quality SRE is key to reducing TP rates (DFES 2006). The SRE described by Healthy Schools, So To Speak and Brook met the standards set out by such national guidance. Young person feedback, particularly from So To Speak's small group sessions, and, to a lesser extent, Bitesize Brook, suggested young people modified their behaviour as a result.
- iii) **A:** the intervention was **adopted** to some extent by all schools. All schools showed at least some sort of engagement with Healthy Schools, and a substantial majority of the targeted schools had taken up further support. However although So To Speak can demonstrate accessing a large number of other youth settings, absolute numbers of these were not available.
- iv) **I:** the intervention was largely **implemented** successfully by partner agencies (i.e. So To Speak, Brook and Healthy Schools) but less so by the ultimate agents (schools/youth settings) – where this did occur it was with significant support from Healthy Schools and/or So To Speak;
- v) **M:** there was some evidence that agencies and schools (with support from So To Speak and Healthy Schools) showed evidence of changing ethos, enhancing the probability of long-term **maintenance** of the programme, and good quality SRE is thought to have lasting impacts on young people. There was some evidence that the intervention had reached a 'tipping point' whereby further funding at the same level would enable the providers to access the majority of settings (including those that were prioritised but not accessed in the year of the study).

In the assessment of the total expenditure (£352,000), the balance of the funds towards enhancing SRE in schools was relatively modest (in the region of £50,000 across three providers) and appeared to be giving good returns (in terms of the number of schools supported). There was evidence that the benefit would be yet greater with a further year's investment, since many barriers had been removed. In particular, there was significant

progress in accessing young people attending faith schools. This was a big achievement that should be celebrated. We suggest that Healthy Schools and external providers should be allowed to capitalise on the investment that has already been made in building the trust with schools.

However, despite progress with schools, gaps remain, most notably in communication between agencies and coordination of services. The existence of two external providers (So To Speak and Brook) and two sets of training (So To Speak's course with its focus on confidence building and 'talking skills' and Healthy School's course on curriculum and policy training) present the potential for confusion for PSHE leads and staff within schools. Our findings suggested that school staff were not necessarily aware of the full range of services available to them. Some comments from teachers on the training they had received from So To Speak suggested that there were no materials available for use in the classroom. This suggests: i) the objectives of the course had not been made clear, and ii) Healthy School's offer of curriculum-based SRE resources and training, available free of charge to all schools that had apparently been promoted to all schools, had not been taken up or that the teachers accessing the So To Speak training were different to those accessing Healthy School's training. Moreover, So To Speak seemed unaware of the training offered by Healthy Schools, and considered such curriculum training to be part of their remit, provided they had access to participants on a longer course.

Future funding restrictions may mean that it is not possible to provide focussed SRE support from external providers. One aim of the package of SRE support commissioned in 2010/2011 was to leave a legacy of trained individuals, already working in schools and young people settings, who could provide SRE themselves and train other members of staff to provide SRE. Not only would this represent value for money, but also young people have greater access to teachers and other workers in youth settings. Thus, skilled, confident staff in schools and other settings would be a valuable resource for young people. While there is evidence that, by working with the providers, schools and other settings have begun to embrace the importance of providing high quality SRE, there was less evidence that confidence among staff was high enough to trigger a cascading of learning. Moreover, there are tensions between this aim and the obvious preference of young people for SRE provided by external providers. From a young person's perspective, the external providers were

deemed more knowledgeable, and had the confidence and self assurance to discuss issues that may be sensitive or embarrassing. Feelings towards teachers delivering SRE were influenced by that teacher being an authority figure and someone they had a long standing relationship with. This meant that a number of participants felt they couldn't

*'She knew what she was talking about and she was proper qualified and you know what I mean? We trusted her like, you know, whatever she was saying'*

Participant from a young people's setting commenting on a So To Speak session

ask personal questions. This was not universal though, and some teachers were perceived to be able to engage pupils in sex education.

Trainees from young people and children's services appear to be happy to go along and enjoy the training provided by So To Speak, and were less likely to have preconceived needs. In contrast the teachers went as part of timetabled event, and had a preconceived agenda, focussed on the need to 'translate' the So To Speak training into 40 minute teaching lessons. Interviews revealed teachers' stress with their workload, and the tension of having to catch up with lessons and work missed, making their investment in the time taken to train valuable. Thus, although by no means universal, teachers were more likely to be disappointed with lack of structure, formulations and practical tasks to do. In contrast, the staff from other young people's settings, perhaps because they did not have to teach, were universally very satisfied with the training; they were happy to learn about language and how to talk to young people, and get some feel for background sexual health problems.

The emphasis declared by So To Speak (and confirmed by recipients of training) on the development of interpersonal skills and confidence, and self-reflection on attitudes, is in line with the criteria outlined in the Department of Health's recommended quality standards for sexual health training (Department of Health 2005). The quality standards document does not specify a need for providers to offer accredited courses, and currently So To Speak do not offer accredited training. While accreditation is probably not practical or feasible for shorter courses (those under three days), it is an option worth exploring for longer courses that appears to have worked well in a neighbouring borough. One reason for this is that young people express a preference for a specialist (someone qualified to talk about SRE), yet some staff working in youth services see themselves as 'not qualified' to talk about sex. Obtaining a formal qualification could give the professional that confidence. Professionals taking part in the So To Speak one or two day course appeared to gain in confidence to speak with young people; this effect may be enhanced with an accredited three day course. It is also possible that offering an accredited three day course would increase the uptake of the longer course: low uptake has meant that So To Speak has carried out very little training of more than two days, a limitation that has been acknowledged by So To Speak and commissioners.

The survey of young people at Liverpool Community College revealed areas of need, particularly in relation to young women's emotional health, and alcohol use in both sexes. Wellbeing, alcohol and sexual risk are known to be strongly linked in young people in the North West (Phillips-Howard et al. 2010), and alcohol harm, sexually transmitted infections and teenage pregnancy hotspots overlap in Liverpool (Cook et al. 2010). However, in the college survey, of the 14% who declared having been pregnant, alcohol was not cited as an important factor.



The survey finding that the majority used a condom at first sexual experience should be highlighted as a 'norm', since evidence suggests that promotion of such positive norms is more effective than highlighting the risks taken by young people (Martens et al. 2006; Schaalma et al. 1993). Another norm that should be highlighted is the fact that the majority of young people do not start to have sex until the age of 15 years or older. Young people in focus groups were of the opinion that most of their peers were having sex. There was also a tendency to perceive that those younger than themselves were even more likely to be doing so. Young people at the college perceived that college-based SRE was useful, but should have been much earlier. The professional view from the college, based on having observed SRE tutorials, that the questions asked by college-aged students demonstrated a high level of need. It is hard to determine what the need of the future cohorts of college students, who would have benefited from the investment in school-based SRE, will be. However, education and services in the college have developed significantly over the past seven years and services are reported to be popular. The college's positive attitude and commitment towards SRE should enable this provision to remain largely intact; we judge that this would be made more secure with a relatively modest level of support.

*'I think like young people these days do not have like the morals we had at 13'*

College student

By far the most well received SRE by young people was the small group sessions delivered by So To Speak, praised for the wealth of information given, the interactive format, and the skills of the instructor. Providers of this service also get a unique perspective of the needs and vulnerabilities expressed by young people, and cited 'light bulb moments' as a young

*'...that realisation, during a session, when you're talking about healthy relationships, that actually someone checking your mobile phone for messages, and wanting to know where you are all the time, isn't that healthy...'*

Provider, talking about a 'light bulb' moment

person becomes aware of a previously unrecognised sexual health issue. Bitesize Brook sessions were perceived as beneficial (particularly the STI and contraceptives 'zones'), but young people had more reservations about the larger groups. Brook observes an influx of young people from specific schools after a Bitesize session in that school, suggesting that it is an effective outreach activity. Young people overwhelmingly name Brook as a service for young people's sexual health needs,

highlighted both in focus groups and in the college survey. This awareness of this young person-specific service is to be celebrated as a success. However, there was also an indication that the Bitesize Brook sessions were perceived as being used to advertise services at the expense of focussing on questions and answers that the young people really wanted. External providers of SRE that also provide clinical services should demonstrate

that they prioritise the primary prevention message (that a young person should not feel pressured to have sex before they are ready), and need to ensure that they do not (perhaps inadvertently) perpetuate the (false) norm that ‘all young people are having sex’. We also recommend that young people in each school should be provided information on specific nearby services, in the form of a leaflet, to ensure that these are promoted alongside Brook’s services.

## **Limitations**

There are many caveats to the findings in a rapid evaluation such as this. We rely on the premise that good quality SRE is effective, as evidenced from the best practice guidance, and here we assess the extent SRE provided by the services commissioned by Liverpool Teenage Pregnancy Partnership Board fitted the criteria of high quality SRE, and the extent to which it reached all intended recipients. The measurement of true effectiveness would require long-term follow-up of participants. Recent reductions in the rates of teenage pregnancy are encouraging and may be partly attributable to improved SRE. However it is not possible to separately assess the impact of SRE versus other measures (such as investment in clinical services) on teenage pregnancy rates. Importantly, in this limited time we were only able to obtain the views of a relatively small number of trainees and young people. In the case of the staff working in youth settings, this may not have limited the results because opinion was universally positive. However, teacher responses were very diverse; it would have been preferable to poll a greater number to ascertain majority opinion. Similarly, it was not possible to capture all the combinations of services that young people may have received (e.g. So To Speak support with or without a Brook Bitesize event, with or without SRE provided by a teacher trained by So To Speak).

## **Conclusions**

This rapid evaluation found causes for celebration: the high level of knowledge of young people about their local youth-specific service; progress with schools (even faith schools) and other youth settings with accepting support for SRE; high levels of satisfaction from participants of externally facilitated small group SRE sessions; and high satisfaction from staff working in youth-specific settings who received 1 or 2 day SRE training. Areas for improvement included: better communication between commissioners, the providers and schools about the nature of support on offer from each organisation; clearer advertising of the expectations from the shorter SRE training courses for teachers; ensuring that all providers prioritise the primary prevention message. Areas for consideration included: whether the model of cascading training in schools and youth settings is feasible; whether accreditation would improve the attractiveness (and therefore take up) of the longer SRE course, and whether accreditation *per se* might improve confidence of participants to deliver SRE; and whether SRE should be supported in younger age groups, including in primary schools. These findings have therefore led to a number of recommendations, detailed in full, with the rationale, at the beginning of this document.

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**Centre for Public Health**

Faculty of Applied Social Sciences  
Liverpool John Moores University  
Henry Cotton Campus  
15-21 Webster Street  
Liverpool L3 2ET, UK

Tel: +44 (0)151 231 4517

Fax: +44(0)151 231 4417

Email: [p.a.cook@ljmu.ac.uk](mailto:p.a.cook@ljmu.ac.uk)

Web: [www.cph.org.uk](http://www.cph.org.uk)

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