Drop-ins that provide sexual health services - advice, emergency contraception, condoms and pregnancy testing - are popular with young people.

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Drop-in clinics in secondary schools: the perceptions and experiences of school nurses

A popular service that can leave the nurses feeling overwhelmed and unprepared for the workload - recommendations include ongoing training, a name change and confidential locations.

Recent government health policy directives have called for greater accessibility and acceptability of health services for young people.[1] School-based drop-in clinics (known simply as "drop-ins") can play a considerable part in delivering such services and this study explores the experience and perspective of nurses running them.

The research used a qualitative approach,[2] ensuring that the actual experience of the school nurse participants could be preserved. Two localities were chosen: one urban, the other with both rural and urban aspects. The data were generated from four focus groups followed by six individual interviews. Ethical approval was obtained from the relevant committees.

Focus groups yield a rich body of data, expressed in the participants' own words, and give concentrated insight into their experience and perspective on a subject.[3]

An opportunistic sample of all school nurses working within the study areas who run drop-in clinics was obtained by writing and inviting them to participate in focus groups. Nursing grades E, F, G and H were represented in four groups, totalling 28 participants

Some participants were then selected for subsequent individual interviews by purposeful sampling. The data were analysed according to the principles of grounded theory, an approach in which emerging theories are "grounded" in the data, offering insight, enhancing understanding and providing a meaningful guide to action.[4]

Key themes were initially identified and defined following analysis of the first two focus groups. The formation of concepts and categories, the data collection, and analysis were carried out within a framework of "alternating sequences".[5] This is an iterative process in which data collection and analysis alternate, such that each modifies and shapes the other.

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Results

Why Young People Attend Drop-Ins

The majority of young people attending the drop-in clinics in this study come with concerns about emotional well-being and mental health: relationships, stress, depression, self harm or eating disorders. A few attend for medical reasons, e.g. skin conditions or asthma. Very few attend to discuss substance misuse or smoking.

Sexual health services

Where specific sexual health services are provided, between one third and one half of consultations are for sexual health advice, condoms, pregnancy tests and emergency contraception. Often young people coming for emergency contraception have complex needs

and there may be child protection concerns, which highlights the importance of the conversation with the young person when giving out emergency contraception as highlighted by the following experiences from a school nurse:

> "We can give general sexual health education about contraception and STI's, counselling, talking about whether they're happy with their relationship, whether they really wanted to have sex; so much about themselves goes into that consultation."

Nurses' dilemma

However, the provision of sexual health services may involve an uncomfortable mismatch between what is actually happening in school and the expectations of parents:

> "...giving a 14 year old emergency contraception in school, in school uniform feels different from giving it to them at the family planning clinic. It feels a different responsibility.... In school, parents expect them to be in school receiving an education, but they're in here accessing sexual health advice. I have no problem with the fact I can do that, under medical confidentiality, but am more aware of them as a very young person."

There is also the dilemma of being a nurse bound by confidentiality and so often unable to discuss a pupil's health with their parents, and being a parent themselves:

> "I can feel in two minds about working confidentially with children without parents' knowledge. There is a great deal of conflict and feeling of dilemma within you as a professional. And it can feel dangerous, very uncomfortable. There's a moral feeling that I should speak to parents about this, that they should be involved..."

These dilemmas feed into a more general experience of often feeling overwhelmed, unprepared for the work and anxious about what a young person might say and how they deal with it. Some issues brought by students can result in the nurse finding it difficult to leave the work behind at the end of the day, or week:

> "It's Friday afternoon - you think about it over the weekend. I don't think any of us should have a job where you go home worrying about a child to the extent to which I'm sure most of us have."

The distress of the students can give rise to feelings of inadequacy in the nurse, sometimes resulting in:

> "a personal recognition that I don't really want them to spill the beans to me because how can I deal with that."

There is a danger of going down:

> "a blind alley with more and more children becoming dependent on us. How do you get closure? How do you struggle out? How do you help them move on, move forward. There's a danger of being over involved..."

The question of 'closure' relates to the time pressure many drop-ins are subject to, particularly lunchtime drop-ins, since:

> "Children come out with things that are quite devastating. How do you allow closure to happen when time is so limited and there are other children waiting?"

Relevant training

Such matters raise the issue of relevant training, but:

> "What are the training needs? Well, I think we need to work backwards, starting with what is safe and what we're trained to do and then look forward. And we need to see what young people think about the service."

Along with training comes the issue of clear guidelines and policies, along with the value of supervision, although:

> "it needs to be by someone who really understands the issues, preferably by another school nurse who does drop-ins."

Relationship with Schools

Drop-ins offer a point of contact for the school community and a clear way of accessing the school nursing service, raising the profile of the nurse within the school. There is a higher uptake at drop-ins which are actively promoted by the school. The active support and promotion by schools can involve: meetings with school staff, governors meetings, parent consultation, nurse-led assemblies, promotion of the service in tutor group time and during PSHE sessions, posters, cards with drop-in details issued to all students, drop-ins advertising on the daily bulletin. In one participant's experience:

> "The idea came from school. Advertising was done by the PCT and myself. We set up a steering group of a parent, a school governor, a deputy head, a PCT project worker and myself. We designed posters and little laminated cards for all students. The drop-in is advertised on the screen in the entrance hall that gives daily notices and there are posters in every tutor room about drop-in and about confidentiality. It's been a co-operative venture."

The importance was acknowledged of regular and consistent communication with key members of the school staff, such as a deputy head or year head, who can support and promote the service, but this means that:

> "We need to be knowledgeable about how schools work and to speak their language."

However, it can take time to find a key person, particularly if a nurse is able to visit a given school only once or twice a week:

Trust

Trust is, unsurprisingly, frequently alluded to as a necessary aspect of both the professional relationship between health and education staff, where there are different professional boundaries and guidelines about confidentiality, and between young people and the adults working with them:

> "When I first went into the school and we were working out the drop-in, I explained to the deputy head that it was a confidential service, and she said, 'yes, but you'll tell us,' and I said, 'No...' Initially it was a bit sticky, but as she's seen me working there that's settled down and now there's a trust between us. She knows that if there's anything I'm very concerned about I will seek permission of the child to discuss it with her or an appropriate member of staff. Usually the children are fine with that because they trust her. It's all about trust."

However, the trust that school staff and young people feel in the school nurse takes time to build up - when a drop-in first starts, young people come with relatively minor issues such as friendship problems, but as time goes by and a more trusting relationship develops with the nurse, they come with more serious or personal issues. But trust can be eroded by organisational and political changes:

> "Health authorities have let (schools) down in the past and it takes a long time to prove 'yes, we can be there for you.' It's been hard work."

Location of the Drop-in

One indicator of the relationship with the school is the rooms offered to

school nurses for drop-ins. These vary considerably. Some schools provide a safe, confidential, comfortable space, but other locations make confidential work with teenagers difficult, such as a room behind the secretary's office, a room on a corridor where Year 11 congregate at lunchtimes (deterring younger pupils from coming), and a very small room known as 'the cupboard'. The location is a non-verbal message, since:

> "unless you supply suitable or congenial surroundings both for the nurse and the pupil, you're not putting a value on the service."

Drop-ins situated in community education or family centre premises offer a different environment, allowing young people to have coffee, sit and chat or play pool, while a small 'consulting room' provides a quiet, confidential space for the nurse or co-worker. Such drop-ins appear to have more attendances from boys than other drop-ins.

A third environment is that of cyberspace: one participant, as well as a lunchtime drop-in, also runs a 'virtual' drop-in with an e-mail advice and support service.

Working with other agencies

School nurses who run drop-ins with a co-worker (e.g. a youth worker or a health visitor) all spoke positively about the experience:

> "Often the young people who need our services most are those with quite complex needs. A service where you've got different people with particular specialisms and personalities working together would seem the most efficient."

It also provides opportunities to debrief with a colleague immediately after a session.

Most participants considered it to be a key role of school nurses to facilitate young people's access to other primary care services and to give them confidence in their ability to use these in the future. These services were mainly GPs, Contraceptive Services and the Walk-In service (nurse led drop-in health centres, usually in town centres):

> "I want to be able to help them to use health services throughout their lives. So I've got to help them to learn where the services are in the community... I want to empower them to use services when there's no-one here."

Perceived and actual difficulties for young people in accessing GP services were noted, in particular fears about confidentiality, the timing of GP surgeries (especially in rural areas), and GPs who will see young people under 16 only if a parent is present. In contrast, however, one participant spoke of two GP practices willing to see any students from the school, unaccompanied, whether registered with them or not.

There are often difficulties with referring to the mental health services or to Social Services, possibly because these services are resourced to respond quickly only to a crisis, such as concerns about suicide, or a child protection disclosure. When the young person's need was less acute, there were few referral pathways that did not entail a long wait.

Drop-Ins: Resources and Planning

Participants generally considered the school nursing service is inadequately resourced to offer a comprehensive, strategically planned, well supported system of lunchtime drop-in clinics in schools. In one area, for example, there are the equivalent to only seven full-time F and G grade school nurses for 29 secondary schools and 95 primary schools, compared with twenty qualified full-time school nurses ten years ago. This lack of resources means there is no protected funding for the planning and evaluation of drop-ins, and the nurses have:

> "...to make do. We try our best, but there's no money. It's frustrating because there's money out there, it just doesn't seem to come our way."

Moreover, although the role of the school nurse had changed dramatically over recent years, this is frequently not understood outside the profession:

> "Because our service is confidential you don't go round saying to staff, 'I've had six students in counselling sessions today; these were the issues, this is what I spent all day sorting out.' I've had students all day who've been too distressed to go to class. I've taken them home, spoke to their parents with them...it's a huge quantity of work going on. You can't get anyone to understand that this is part of the school nurses' job; we've moved on from being nit nurses."

Discussion

Resources

In the UK, the ratio of (full-time) school nurse to student varies between one to 3,000 and 1 to 8,000[6] compared with the one to 1,500 ratio necessary to provide a comprehensive school nurse led drop-in service. "The school nursing service is inadequately funded to provide enough nurses to staff a comprehensive service of school based clinics….Drop-in clinics are patchily distributed and inadequately staffed…. (with the current level of funding) it is only possible to provide a very superficial service."[7] When there is specific funding for drop-ins and they are given a high priority, more students attend, "increased accessibility and availability of drop-ins results in their increased use"[8]. The author also remarks on the lack of data about staffing levels and the systematic recording levels of school nurse work, commenting that these are likely to increase the fragmented nature of young peoples' services. DeBell and Everett[9] note that there is no effective measure in place to record (and therefore to evaluate) the service, and that it is likely that the hidden nature of school health services is due primarily to lack of information technology to manage and report on service.

Nurse-school relationship

The nurse-school relationship is of particular significance, since "the success of drop-ins is affected by the level of encouragement given by the school …..School nurses are supporting a school most effectively where they find a member of staff with whom they can work"[10]. However, the same authors discovered, by means of a questionnaire sent to over 500 schools in Norfolk, that most teaching staff were unclear about what the school nurse does: "in every perspective there was confusion about what her role is" This is echoed in the present study by a number of participants who felt they were still looked upon as simply being the 'nit nurses'.

The concerns expressed by participants in this present study about lack of understanding of the role of the school nurse, confidentiality boundaries, feeling unsupported and the dilemmas of the work, may be attributable to the fact that school nurses do work at the interface of

two organisations (the Health Authority and the Education Authority) with different agendas and philosophies. But given the account that participants gave of consultations and conversations with young people who were able to confide in them and demonstrate high levels of trust, it may be that the very independence school nurses have within the school setting which can cause misunderstanding and ambiguity, may also mean that she is particularly trusted by students. As has been observed by others, school nurses occupy the unique position of being independent observers and befrienders of children and young people in school.[11]

The location for a drop-in that appeared to work well for school nurses and for students was when the drop-in was in a separate building which was set up in an informal, young people-friendly style.

This difference in perspective between health and education services and the degree of (mis)understanding of the role of the school nurse by school staff would seem to be a strong factor in determining the viability and success of a drop-in. But why should there be such a misunderstanding of the work? It may be that the title "school nurse" is misleading. Generally, the expectation of nurses is that they are available to deal with illness or accident, but these are not part of the current school nurse remit, whose work focuses on the public health agenda, health promotion, immunisations and support of the vulnerable child. Because she may be able to visit a school only once a week or even less, and because much of school nurse work is confidential, an accurate understanding of the current role does not develop, a situation exacerbated by the lack of protected funding to publicise the service and, in general, the absence of any formal contract with schools to define areas of work, set targets and evaluate the work.

This relationship with the school and understanding of the role by school staff is epitomised by the accommodation given to school nurses for their work. A quiet, comfortable space? Or 'the cupboard'?

The location for a drop-in that appeared to work well for school nurses and for students was when the drop-in was in a separate building which was set up in an informal, young people-friendly style. These drop-ins also had the advantage for the nurse of working with a co-worker with whom she could share ideas and discuss problems. The young people had the benefit of two different people who are concerned about their well-being but who are from different backgrounds and can offer complementary services. But the Norfolk study cited found that facilities were "generally inadequate in location, size, privacy and security"[12] , whereas "Research evidence suggests that 'joined-up, multifaceted services' are more likely to be effective than isolated service specialisms".[13]

Supervision and Training

There are no national guidelines, protocols, stated competencies or training and assessment standards in this specific area, although individual PCT areas have developed some guidelines for nurses running drop-ins, and many of the guidelines and competencies for general school nurse work are relevant for drop-ins, e.g. for child protection, knowledge and understanding of the law, confidentiality and accountability, along with other competencies such as knowledge and experience of communicating with other agencies and making decisions and judgements about the safety of a particular drop-in location.

There may be a mismatch between young peoples' expressed health needs, for support with mental and emotional health concerns, and the training and experience of practitioners running drop-ins.

Clinical supervision is seen as central to the learning process and the development of knowledge and competence. It also provides a framework for the safety of care in complex situations and encourages self-assessment.[14] Participants generally took part in clinical supervision every four to six weeks, although these covered the whole range of school nurse work, not specifically drop-ins. Generally, it would seem that the school nursing service has responded to the government directive and need for this supervision work, although there may need to be other sessions particularly looking at the issues raised in drop-ins.

This is a new and evolving way of working for school nurses and training and assessment needs are yet to be defined. These would need to be developed by analysing the work so far and by asking young people what they would like of the service. DeBell and Everett[15] have commented that an important aim of any training should be to have a sound base in counselling techniques, and in view of young peoples' emotional health needs, this would seem entirely appropriate. They believe that the present training for school nurses is biased towards individual lifestyle change, personal physical health and health interventions to support individual good health. There may consequently be a mismatch between young peoples' expressed health needs, for support with mental and emotional health concerns, and the training and experience of practitioners running these drop-ins.

A combination of a careful analysis of the work in drop-ins, asking students what they would like of the service and a health needs assessment of young people would inform practice guidelines, and define training needs. This is however a huge challenge because of the wide range of issues that young people present at drop-ins. Assessment tools may need to be developed as part of a training package.

Conclusion

This study supports the findings of other studies showing is valuable work done in drop-in clinics for teenagers in schools, with school nurses responding to young peoples' health needs with professionalism, care and commitment. The nature of some of these issues, for example disclosures of abuse, can be challenging and stressful. There are some ethical issues for school nurses

working with under sixteens, particularly in the area of sexual health. Some support systems are in place, for example clinical supervision, but participants still felt overwhelmed at times and under considerable time pressure. They may feel unsupported in their working environment.

The financial constraints that are on the school nursing service mean that it is not possible to offer a comprehensive drop-in service. School nurses' unusual position of being health workers working within an Education environment can give independence and the possibility of greater confidentiality for their client group, which young people ask for as part of health services that are directed towards them. It can however lead to a lack of understanding from Education and Health organisations and a sense of isolation and role ambiguity for school nurses. The lack of adequate record keeping, evaluation and communication systems may perpetuate this lack of clarity of school nurse practice.

Partnership Agreements

There should be annual partnership agreements, individually negotiated with schools, which state the school's expectations for the school health service and the nurse's healthcare plan for her work for the coming year. These could include the setting of realistic targets and could be evaluated towards the end of the academic year. These agreements would give the nurse an opportunity to explain her role and differing practices with school staff e.g. confidentiality, to senior members of the school community.

These would also give school nurses' employing authority a greater understanding of the work that may be included in wider health reports and policies.

Name change

The title "school nurse" does not accurately reflect the nature of this work in schools and leads to misunderstanding. There has been some debate about this amongst school nurses, and an acceptable title has yet to be found. The title "health advisor", "school nurse practitioner" or "youth health nurse" are possible alternatives to the present title.

Ongoing Training and Support

Although these are time consuming, the concerns expressed by participants of feeling overwhelmed, anxious about the consequences of disclosure and unprepared for the work indicate that this is a priority area of work. There should be, say, at least one monthly supervision session with a supervisor who understands the work, and an on-call system of support from a senior nurse. Counselling training is important, as most of the issues that young people come to drop-ins are concerned with mental or sexual health and emotional well-being.

Location of Drop-ins

There should be drop-ins in schools where there is appropriate accommodation i.e. a comfortable room of adequate size that offers a confidential, safe space and access to a phone. There also needs to be a good working relationship between key members of the school staff and school nurses. They seem to work particularly well if they are situated in youth service premises or family centres, if these are easily accessible during lunchtimes by students.

School nurses would be able to provide a more comprehensive service of lunchtime drop-ins if the levels of staffing and funding were increased to those recommended by Graham[16] i.e. one full-time nurse to every 1,500 secondary school pupils. More resources and smaller caseloads in addition to appropriate supervision, training and assessment systems would mean that there would be less pressure on staff. Greater funding would also enable there to be appropriate, accessible IT systems for data collection, communication and evaluation.

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