

The contribution of interagency collaboration to the promotion of young people's sexual health

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Abstract

This paper employs a case study approach in order to examine the contribution of interagency working to the delivery of education and services in the difficult field of young people's sexual health. It reports on a collaborative UK initiative involving teachers, community health practitioners, health promotion staff, and youth and community workers. The provision included school-based sex education, drop-in advice and information facilities, 'detached' street work, and a young person's clinic. A qualitative study was completed involving detailed interviews with 25 staff from the different agencies involved. The findings suggest that interagency collaboration can enhance the work of each organization, and can achieve a comprehensive response to young people's sexual health needs by making positive use of the distinctive roles, skills, knowledge and approaches of the different agencies. The potential that such a collaboration will have a significant impact on young people's sexual health is discussed.

Introduction

The notion of collaboration between different professional groups in the planning and delivery of services has gained considerable credence over recent years (Casto, 1994; Delaney, 1994; Rawson, 1994; Mackay *et al.*, 1995), particularly in relation

to health care and health promotion (Butterfoss *et al.*, 1993). Leathard (1994) identifies over 50 terms, such as multi-disciplinary, healthy alliances and inter-sectoral, to describe the idea of people from different professional groups working together and learning together. For the purposes of this research, the term 'interagency' is defined as shared planning and/or delivery of work across different organizations, involving different professional traditions and skills.

The benefits of interagency work are considered to be numerous and include rationalization of resources, a reduction in duplication of effort and the provision of a 'a more effective, integrated and supportive service for both users and professionals' (Leathard, 1994, p. 7). Collaboration is also seen as a response to the increasing complexity of society (Casto), where focusing on the behaviour of individuals without attention to other factors in their environment is likely to have less impact (Butterfoss *et al.*, 1993). Interprofessional collaboration may also contribute to improved communication between professionals working with the same clients (Mackay *et al.*, 1994) and Nezlek and Galano (1993) point to the increased potential of 'coalitions' to influence policy making in a positive way. However, despite the general emphasis on interprofessional work, it is argued that reliable evidence regarding collaborative practice is limited (Butterfoss *et al.*, 1993; Nezlek and Galano, 1993; Delaney, 1994).

The researchers involved in this study work in a higher education institution involved in the training of staff across a range of education and health professions, and the team comprises staff with backgrounds in health promotion, teaching,

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youth and community work, and midwifery. The research was initiated in response to our mutual recognition that the issue of young people's sexual health was important in all our professional fields. Consequently, one aim of the research study was to examine the specific contribution of interagency collaboration to the field of young people's sexual health in order to inform the development of this field of practice and our training of the relevant professionals.

The research team identified an initiative in a district in the north of England which comprises a medium sized town (population 40 000 plus surrounding villages). The research focused on this particular initiative because it involved shared planning and delivery of sexual health activity involving four different professional fields: secondary school teachers, youth and community workers, health promotion officers, and staff working in community health services. Whilst there is a long history of health professionals working in schools and many documented examples in both the UK and the USA of collaborative health promotion work between health agencies and schools (Zabin *et al.*, 1988; Howard and McCabe 1990; Thomson and Scott, 1992; Burke 1994a,b; Dryfoos, 1994; Scriven, 1995; Tierney and Cohen, 1995), we have found no documented UK examples of a four-way collaboration incorporating these different professions with their distinctive approaches and traditions, and very few published reports of collaborative projects involving youth and community workers (Burke, 1994a,b; Coyle and Loveless, 1995). Undoubtedly, a great number of collaborative health promotion ventures are underway across the UK, and it is hoped that this paper will serve to inform and support such work.

Sexual health has become a major concern and current 'issue', particularly the sexual health of young people. It has been pitched into the limelight by various factors, e.g. the advent of HIV/AIDS, publicity regarding young, single mothers, *Health of the Nation* (Secretary of State for Health, 1992) targets for teenage pregnancies and the primacy of a 'moral' dimension in current educational debate

about sex education (Meredith, 1989; Health Education Authority, 1994; Lees, 1994).

Therefore, although *sexual health* means different things to different professional groups, there is widespread official concern to improve provision for young people, particularly in relation to sex education. This concern is echoed by both the current government (Secretary of State for Health, 1992; Department for Education, 1994) and parents (National Foundation for Educational Research, 1995).

The definition of sexual health employed in this study draws from a number of sources (Doppenberg, 1993; Ingham, 1993; Jewitt, 1994) and involves providing the following elements for young people:

- Development of high self-esteem, self assertion and decision-making especially in the area of loving relationships and sex.
- Development of 'interactional competencies'—skills to handle sexual relationships.
- An opportunity to discuss their developing sexuality openly with adults and peers.
- An opportunity to discuss sexual behaviour and contraception.
- Easy access to information, advice, and contraception.
- Easy access to information, advice about and treatment of sexually transmitted infection

Method

The aim of the research study was to examine interagency collaboration in the field of young people's sexual health. This paper forms part of the results of this study and concentrates on the apparent *benefits*, at least in the early stages, of the collaboration. Limitations on space prohibit the inclusion of material exploring the *process* of collaboration. It is sketchily referred to here but is largely the subject of a further report (Bloxham, 1996).

A small group of staff from the different organizations involved participated with the research team in designing a research strategy. A qualitative,

interview-based method was selected as most likely to allow for the collection of material both because some of it, such as the personal relationships involved, may be sensitive, but also because of the narrative nature of respondents answers about the development of the collaboration.

The interviews were designed to elicit information and views regarding the nature and funding of any interagency collaboration in the field of young people's sexual health, the aims of the work, training available, how the collaboration was established and developed, constraints on the work, perceived difficulties in collaborating, contributing factors to effective collaboration, and future plans. The interviews took place during March to June 1995. Minor amendments to the question schedule were included after the first six interviews to improve the clarity and relevance of the questions. The interviews were carried out with 25 staff from the community health service ($n = 8$), health promotion ($n = 3 + 1$ joint appointment), the youth and community service ($n = 7 + 1$ joint appointment), and four secondary schools ($n = 6$), who were identified by senior staff in each organization. The interviewees included a combination of managers with some policy making authority (e.g. heads of school departments, the clinical services manager for the health authority, the HIV prevention co-ordinator) and those delivering the services (e.g. classroom teachers, the doctor and family planning nurses at the young person's clinic, school nurses, health visitors, and health promotion officers). In the case of youth and community workers, those interviewed were generally staff who both worked with young people themselves and managed the work of part-time staff.

As Dryfoos (1994) points out, 'Collaborative plans are difficult to achieve because of the differing characteristics of the agencies involved' (p. 145) and it is important to note some key differences in the agencies participating in this study. Community Health Services and Health Promotion fall within the remit of the local health services trust (HST), whereas the schools and the youth and community service are administered by the

local education authority (LEA). These organizations are not co-terminus in their geographical areas, and have different forms of democratic control, bureaucratic systems and professional traditions. For example, LEAs are an element of democratically elected local government whereas HSTs operate on a more commercial purchaser-provider basis. Furthermore, individual schools are increasingly achieving greater independence from local authority control although there has been a growth in central government directives, such as the National Curriculum, with which schools must comply. The different professions involved have a wide range of routes of entry and specific qualifications, including both degree and sub-degree level training. Whereas teachers are generally trained to work with children and young people in formal contexts, the training of youth and community workers emphasizes informal education and welfare services, particularly with disadvantaged and troubled young people. The nearest equivalent to youth and community work in the US context is the school or community counsellor. Staff working in health promotion were generally drawn from other professions, and had completed initial training in youth and community work and/or school teaching.

The interview material was analysed, firstly, by categorizing the different practical elements of the provision and identifying the respondents' views about the specific contribution of interagency working to that service. Secondly, the analysis focused on the perceived effectiveness of, and constraints on the provision.

Results

We identified the elements of the provision as, personal and social education (PSE) and 'drop-in' facilities in school, advice and information facilities in the community, youth groups, detached youth and community work, clinical provision, and support and training from a health promotion unit. Whilst many of these services, e.g. PSE courses, youth groups, family planning clinics and school nurse provision, are provided independently across

the UK, we focused on provision where significant collaboration between the different agencies was taking place. This was not a centrally planned initiative but a series of projects developed by the different agencies concerned, involving shared delivery and, increasingly, shared planning. The different elements of the provision are discussed below.

Sexual health education was offered in school as part of a broad curriculum of PSE. This was largely group based, and although mostly delivered by school staff, respondents reported that it is also used as an opportunity for pupils to get to know other key professionals such as the school nurse, local youth workers and health promotion personnel.

These external staff were seen to bring a specific range of knowledge and skills which is used to enhance the teaching in the sensitive area of sexual health. The PSE teachers interviewed listed a number of benefits of using other professionals in this way. These include the bringing in of up-to-date information; pupils being more likely to open up to strangers; youth and community workers working in an informal way in class creating a better atmosphere for discussion; the absence of authority and health and youth work staff being more comfortable working with a subject which was difficult or embarrassing for some teachers.

Youth and community workers and health professionals considered that input into the school curriculum was important for other areas of their work (discussed below) because the pupils would become familiar with them, it gave them an opportunity for structured group work that young people would be less likely to tolerate in community settings and it enabled them to inform pupils about other services available to them outside school. Youth and community workers considered that their particular approach enabled them to establish different kinds of relationships with pupils compared with teachers. They also felt able to involve young people with all levels of ability.

In general, all parties to this involvement of non-school staff in the delivery of the sexual health curriculum were in agreement about the

complementary nature of their roles and the joint benefit that was gained by both pupils and professionals.

A second element of the provision has been the establishment of drop-in facilities for young people in their secondary schools. All four of the schools involved in the research provided a drop-in advice and information facility for pupils. These sessions were usually provided by school nurses but two schools provided a weekly lunchtime drop-in staffed by youth and community workers, to which access was limited to older children in one of the schools.

This provision is seen by the staff concerned, as an important addition to the educational programme for several reasons. Firstly, it allows young people to gain one-to-one information and advice. Secondly, it reflects the fact that the development of young people's sexuality and sexual activity takes place at different rates and therefore it is impossible to neatly match all pupils individual needs with the age-related school curriculum. Thirdly, it provides the confidentiality required by young people and, lastly, it enables staff to suggest specific clinical and advice facilities outside school. However, the research also indicated a 'grey area' in relation to school nurses making clinical appointments for pupils for such things as emergency contraception, although they felt that they would receive the backing of their managers if such a course of action was later challenged by parents.

Drop-ins were also seen to provide a referral point for teaching staff when pupils bring up questions or problems that are beyond their expertise or outside their area of responsibility. Respondents considered that the broad remit of drop-in facilities acts to protect young people's confidentiality as they are not specifically linked to sexual health. For example, pupils call on the school nurse for a range of reasons, e.g. to obtain sanitary towels, and therefore making use of the service would not attract the attention of other pupils or staff.

One respondent indicated that they were trying to establish an extension of their school-based drop-in facility to include youth and community

workers mixing with young people in school recreation areas during their break times in order to help them become aware of what services are available both in and out of school. A further advantage of this informal 'detached' work is seen to be the opportunity it gives pupils to develop a vocabulary regarding sexual health issues that will assist them in discussions with health professionals and others. The freedom youth and community workers enjoy to use young people's colloquial expressions, and explicit language in discussion of sex is considered a key feature in helping them bridge the gap between their existing knowledge and formal language they are likely to meet in sex education and health settings.

Outside school, the youth and community service operate a range of advice and information projects for young people which are seen to play an important role in the overall access to sexual health services by young people. One organization that featured in our research data offered both general drop-in sessions and specific advice sessions on subjects such as health, contraception and parentcraft. Staff from the community health service and the health promotion unit work alongside youth and community workers in this facility, and where appropriate, young people are referred to other services.

Our research identified a number of different groups for young people in the district for which all or part of their brief was related to young people's sexual health in the broadest sense. These included young women's groups, young men's groups, young (and very young) mothers' groups, youth clubs/groups based on housing estates, junior youth clubs and drama/arts-based groups. These groups are largely run by youth and community workers but in a number of instances, they are jointly run with staff from health promotion or the community health services, such as a parentcraft sister.

Such groups were seen to provide a unique opportunity to offer young people informal education, away from the constraints of the school curriculum, and centred on the young people's specific needs and experiences. Youth and com-

munity staff felt that activities, discussion topics and explicit language may be used in such groups which may not be tolerated in the school setting and the voluntary nature of attendance by young people is likely to enhance their interest in and commitment to the group, particularly for those young people who have a generally disaffected experience of school. However, staff expressed concern that the voluntary nature of such projects (and the limited resourcing of youth and community work) means that this work reaches a very small proportion of the age range and therefore it can only be seen as an important complementary programme to the general provision offered in school. There is a continuing dilemma for youth and community staff in reconciling the competition between choosing to focus on high quality work with small numbers of young people or the alternative of a much more superficial approach spread across larger numbers.

Detached youth and community work has a long history of provision designed to make contact with and offer support and services to young people on the street and in other places where they gather. A strong feature of the local youth and community service strategy emerging from this research is the emphasis on detached work. Respondents felt that detached workers can gradually gain the confidence of young people and encourage them to discuss issues such as sexual health. They have also provided young people with condoms and helped them to access other relevant provision such as family planning and Genito-Urinary Medicine (GUM) clinics, an information/advice shop, a young person's clinic, and various specialist youth groups. The research suggests that the existence of detached workers is considered very important by health professionals in helping young people to become aware of, and access, clinical and other services related to sexual health.

It was seen as important for young people's confidence in using services that they can meet the same faces in school, on the street, in the information/advice shop and at the young person's clinic's. This is a *specific and unique* role that youth and community workers can play in a way

that is not generally available to other professional groups.

As mentioned above, a young person's clinic has been established one afternoon a week after school. The clinic provides a one-stop facility for contraception, diagnosis and treatment of sexually transmitted diseases and advice on sexual health. It is the fairly unique combination of GUM and family planning services which has been particularly successful with an unexpected emphasis on sexually transmitted disease diagnosis and treatment amongst those attending.

The clinic operates a no-appointment system and attempts a strongly 'non-judgemental' approach in order to encourage young people's use. Although predominantly clinical staff, the team includes a male youth worker. This interagency element is seen as vitally important by the clinic staff interviewed because the youth worker can encourage young people he meets in his other work in schools, on the streets and in an information/advice shop, to make use of the clinic knowing that there will be a familiar face there. This also applies to some of the clinical staff who can refer young people to the clinic from their work in school drop-in sessions. Furthermore, the youth worker is valued for the 'non-medical' dimension that he brings to the clinic, e.g. stage-managing the reception space with pop videos, drinks and leaflets to create a young-people-friendly atmosphere. Use of the clinic was averaging 9.4 young people per session in June 1995 and is increasing at a steady rate. A high proportion of the users are male. A further family planning clinic operates a young person's session for an hour after the main clinic once a week. However, a doctor is not available for this hour, so 'desperate' young people are referred to the young person's clinic which operates later the same day.

Health care and community health services are also available to young people through their GPs and in five family planning and two GUM clinics operating in other parts of the district. Contraceptive advice, pregnancy testing and supply of condoms are also offered at the information/advice shop.

The research identified that the development of sexual health education and services for young people in the district has been supported at most stages by the work of the local health promotion unit. In co-operation with schools, youth and community workers, and the community health service, the unit appears to have had an important impact in encouraging the overall programme of work, particularly a number of innovative initiatives such as the appointment of a young people's health information worker. Health promotion specialists see themselves as operating at the level of policy and strategy development, researching needs assessment, and purchasing appropriate services. Rather than face-to-face work with groups, such as young people, they see their role increasingly as one of the training and development of professionals in order that they can have an effective health dimension to their work (in whatever field). They also provide resources for health promotion.

The research at this stage was largely concerned with the nature of the initiative and the perceived benefits of collaboration. However, we did ask the respondents how they viewed the effectiveness of the work described above. The data suggests limited agreement over effectiveness. Whereas all staff interviewed demonstrated a commitment and belief in the work, health service staff were more confident about effectiveness, based on the numbers of young people using facilities such as the young persons' clinic and returning for follow up visits. Respondents considered that contraceptive and family planning services had become more accessible to young people than in the past. Youth and community staff and teachers were more circumspect, indicating that young people's behaviour was difficult to change and the results of the work hard to measure. They were more likely to 'hope' that they were being effective. However, a number of teachers felt that young people were becoming less self conscious, more confident and asking questions that suggested 'something is happening'. Youth and community staff were pleased with the increased use of services and their information giving function, but less confident that young people were putting their

knowledge and assertiveness into practice at the crucial moments during their personal relationships. Various constraints to effectiveness were also identified by the research, as discussed in the following sections.

Accommodation

The data indicates that a major perceived constraint was that of suitable accommodation. Teachers were the only group who tended not to mention it although this differed between schools, with one strongly complaining about lack of space and equipment. Other professionals were more likely than not to feel that their work was limited by accommodation. For example, the young persons' clinic may have to use the same space for both reception and waiting rooms, which limits confidentiality. The desire to offer clinical services in less medical surroundings was limited by the lack of suitable space in community buildings. Some non-teaching staff stated that there were insufficient suitable spaces in schools for activities such as drop-in although other school nurses had their own dedicated room.

Training

It was clear from the research that relevant training for the work was widespread amongst the health professionals, the youth and community staff, and teaching staff in charge of PSE programmes. However, a number of the teachers raised concerns that many school staff who find themselves with responsibility for PSE, and therefore elements of sex education, have not been given appropriate training. This mirrors the findings of the Sex Education Forum's enquiry (Thomson and Scott, 1992) into the support and monitoring of school sex education which recommends that all teachers of sex education should have appropriate training. It is clear that school sex education is probably the only feature of the overall programme described above that virtually *all* young people will come into contact with. Therefore it is significant that this is the *one* area where staff training is lacking. One head of PSE felt that the programme was constrained by not having a dedicated team of

specialist trained teachers in the way you would for other areas of the curriculum.

A further training issue raised by the research is the growing importance of family planning training for school nurses. In general, the school nurses in this enquiry had completed such training although it is not a pre-requisite for the job, but those interviewed considered that it would be difficult to satisfactorily complete their current school responsibilities without having completed such training.

Counselling

Counselling was offered as part of the service by many of the respondents across all four professional groups, but often it was seen as not a routine facility but as an occasional provision and only as first stage counselling. Community health service staff were more likely to see it as clearly part of their role in drop-in and clinical settings but even they referred to the *ad hoc* nature of what was on offer, with a long waits for referrals to the clinical psychologists. Consequently a number of the respondents recommend that a young persons' counselling service is needed to complement the educational and clinical services offered. Such a service would provide an important referral point for all the professionals involved in this study who find that their sexual health service is throwing up other problems and concerns amongst individual young people which they are neither equipped, nor have the time, to deal with. The need for adolescent counselling services to handle the high proportion of mental health issues raised by those attending young people's clinics has been identified in previous research (Dryfoos, 1994).

Publicity

Very little of the publicity provided by the different agencies indicated exactly who a young person would see when they visited a service which may militate against some of the efforts to have familiar faces in different settings. Respondents from all the different professional backgrounds indicated that young people are more likely to use a service if they know who they will see when they get there.

Other constraints on practice

Individual respondents raised many different features that they felt constrained their practice in the area of sexual health and these included unnecessary fear of legislation such as section 28 of the Local Government Act 1988 and the promotion of homosexuality, the political climate and society's general ambivalence towards sexual health. Not surprisingly, lack of resources, including staff time, was also seen as a constraint, particularly the lack of stable funding for specific elements of the work and short-term posts. Additionally, the traditional separation between family planning and GUM services was identified as a limiting factor. Collaboration, itself has been shown to have many inbuilt constraints, although the participants in this study expressed a remarkably positive response to it. The analysis of the 'process' of collaboration is the focus of a separate article (Bloxham, 1996).

Discussion

The research findings discussed above indicate that interagency collaboration can offer a fairly comprehensive response to young people's sexual health needs, making positive use of the distinctive roles, skills, knowledge and approaches of different agencies to provide a coherent and developmental programme of education and services for young people. Basic personal and social education is at the start of it, and adolescent-friendly community health services provide an important culmination. Supporting the process, making important links between education and services, and offering an outreach programme, occur through the work of a number of key agencies and individuals, particularly the youth and community service, the health promotion unit, and school nurses. There is little doubt that such a level of service, with so little duplication of effort, could not be provided without interagency co-operation and joint delivery.

It is interesting to note the distinctive role of youth and community workers that emerges from the research. Personnel across all the other profes-

sions were very clear that the particular informal style, language and relationships offered by youth and community workers provided a vital link in enhancing the work of other agencies in the difficult area of sexual health. Their specific role in meeting young people 'where they are', through detached work, provided access to those young people most likely to have missed schooling and least likely to feel confident accessing formal services such as clinics.

A further aspect of contemporary youth and community work which this research suggests is important to the development of sexual health services for young people is the provision of community-based advice and information facilities—information shops. Their strength is that they can offer an approachable, central, access point for young people, unsure of what specific service they need. Staff can provide first-line information and advice, using appropriate personnel (e.g. health visitors) where necessary to carry out services such as pregnancy tests, but the strongest feature is the link they offer to other agencies. In the case of sexual health, this may be referring users to a young person's clinic, a family planning clinic or a GUM clinic. This link may involve taking a young person to the appropriate service in order to provide support and advocacy. The research indicated that other services considered this 'link' function to be very important in helping users access their facilities.

Furthermore, appropriate clinical services appear to be important. It is of little use providing young people with an excellent education regarding their sexual health if they cannot easily access services to put into practice their learning regarding, for example, sexually transmitted diseases and contraception. Our research indicated that the establishment of a young person's clinic one after-school session a week in a local health centre is an important development in encouraging young people to use sexual health services. This supports the work of Williams *et al.* (1992) whose study of a teenagers' clinic indicated that such provision can significantly improve young people's, particularly young men's, access to reproductive health care.

They emphasized the need for an after-school slot, no lower age range but an upper limit of 18, an accessible, quiet location, and committed, trained and welcoming staff. An additional aspect of the clinic in our study was the use of a youth and community worker to enhance the young-people-friendly atmosphere of the clinic, and to draw in young people contacted in other locations.

This research has focused on the system and the providers' views on the contribution of collaborative working to improving sexual health services for young people. How confident can we be that the provision of such collaborative services will have an impact on young people's sexual health and behaviour? In the USA, young people's clinics have been developed over the last 20 years, initially in an attempt to reduce the burgeoning teenage birth rates and more recently, to improve access for poor and minority young people to health care (Kirby *et al.* 1991; Dryfoos, 1994). They have been very successful in terms of accessibility to general health services (Dryfoos, 1994) but their effectiveness in relation to sexual health is less clear. Research has proved inconclusive or contradictory in terms of links between clinic attendance, use of contraceptives, sexual activity and pregnancy rates (Edwards *et al.*, 1980; Kirby *et al.*, 1993). For example, one study of high-risk youth reported clinic attendance associated with reduced use of condoms (Stiffman *et al.*, 1994). Studies of young people's clinics in schools suggest that the greater their emphasis on pregnancy and AIDS prevention, sexual health education, and on-site distribution of contraceptives, the more likely they are to improve young people's use of contraceptives (Kirby *et al.*, 1991; Brooks-Gunn and Paikoff 1993; Dryfoos, 1994). Kirby *et al.* (1991) also stressed the importance of follow-up and outreach activities in school, and the targeting of sexually active students. Unfortunately, political pressure has largely prevented such clinics from issuing contraceptives on school premises (Dryfoos, 1994) and such pressure would almost certainly be replicated in the UK should a young person's clinic become school rather than community-based.

This American experience is significant in evalu-

ating the initiative reported above because it provides support for the model being used. That is the linking of education to advice and clinical services, including distribution of contraceptives and outreach work with young people. If anything, the US research suggests a greater focus on the delivery *at school* of services by other agencies. Dryfoos points to evidence that young people's clinics enjoy significantly higher rates of attendance if they are on school property and not nearby in the community. However, the political climate and 'the current provisions of primary care in Britain would prevent the establishment of such clinics, and it is unlikely for them to receive much approval from anyone other than the teenagers' (Mellanby *et al.*, 1992, p. 456). Furthermore, compared with the UK, a very high proportion of young Americans remain in high school until they are eighteen. Consequently locating advice centres and clinical services in further education colleges (see, e.g. Page, 1995) and community settings may be the best solution in the UK. Brooks-Gunn and Paikoff (1993), in a depressing review of interventions and analysis of the failure of most programmes to promote the 'sexual well-being' of adolescents, argue that 'a joint school-community effort...will prove to be a better model' (p. 210).

The controversy regarding contraceptive advice in schools is unfortunate because the research studies consistently show no link between sexual health services and increased sexual activity amongst young people (Kornfield, 1985; Mellanby *et al.*, 1992; Sellars *et al.*, 1994) with some evidence that countries with greater access for young people to sex education and birth control also enjoy the lowest rates of teenage pregnancy, birth and abortion (Ray, 1994). Sex education may also lead to a delay in the onset of sexual activity (Baldo *et al.*, 1993). Indeed surveys of parents in the US (Dryfoos, 1994) indicate widespread support for clinical facilities and contraceptive distribution in school, and Dryfoos also points out that school-based clinics have little difficulty obtaining parental permission.

Oakley *et al.* (1995) reported on the paucity of rigorous evaluation studies which demonstrate a

positive impact for sex education projects and Dryfoos points to the enormous cost of effective studies. There is general agreement that it is an extremely difficult area of work to measure effectively, but, to date, there appears to be sufficient evidence to support initiatives which combine a range of services. Therefore, although school-based sex education remains vitally important, this research supports the view of Mellanby *et al.* that 'more is not enough' and a model of good practice for young people's sexual health needs a range of other services which can be most effectively provided by interagency collaboration and appropriate community services. Indeed school-based work itself appears to be enhanced by the collaborative process. The constraints identified by our respondents do not weaken that argument but point to areas, such as teacher training, publicity and improved accommodation, which can improve the practice. Therefore, although at this stage only the intentions and practice of this collaboration have been studied, such an innovative link between education and multiple services would clearly benefit from a systematic evaluation regarding the outcomes for participating young people.

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