

UK NATIONAL SURVEY

Standards for comprehensive sexual health services for young people under 25 years

K E Rogstad, I H Ahmed-Jushuf and A J Robinson

On behalf of the MSSVD Adolescent Sexual Health Group

Summary: This document is a first response to the need to develop sexual health services for young people on a single site whilst awaiting research from pilot studies of 'one stop shops' suggested in the Sexual Health and HIV strategy¹. It is a document which is intended to be a tool to use for those wishing to set up a service providing testing for sexually transmitted infections and provision of contraceptive services for those under 25 years. It is not intended that such a service would replace existing specialist or general practice care but complement it, allowing clients to choose the service most appropriate and acceptable to them, with close links and clear pathways of care for referral between services.

This paper should be used as a template when initiating and monitoring a clinic but some of the standards may not be achievable without significant financial input. However, economic limitations should not detract from striving to achieve the best possible care for those most at risk from sexually transmitted infections and unwanted pregnancies. For example, not all clinics will be able to provide the recommended tests for the diagnosis for gonorrhoea and chlamydia immediately, but should work towards achieving them. Although the upper age limit in this document is defined as 25 years, some providers may wish to limit clinics to those under 20 depending on local needs.

Detailed information on specific issues such as consent and confidentiality, provision of contraception, investigation of non-sexually transmitted vaginal infections and sexually transmitted infection management and diagnosis are referenced and we recommend these are accessed by the users of this document. Many of the references themselves are live documents available on the worldwide web, and are constantly updated.

The Sexual Health and HIV Strategy has now been published and these standards are aimed at those who wish to provide a level 2 sexual health service for young people wherever the setting e.g. genitourinary outreach clinic, contraceptive services, general practice. This document is a starting point to be reviewed and updated as new research becomes available, as the Sexual Health Strategy is implemented and with further input from providers of care (family planning, general practice, genitourinary medicine, gynaecology and paediatrics) and service users. All service providers must maintain a high quality of care and have networks both with those who provide more specialized services (Level 3) and Level 1 services. This document is an initial attempt to ensure that there is equity of clinical provision wherever a Level 2 sexual health service is provided and should be a useful tool for those setting up or monitoring services.

OVERVIEW

The 'sexual health' of adolescents in the UK is amongst the worst in Europe². There is a high prevalence of sexually transmitted infections (STIs) which is increasing. Between 1995 and 1999

gonorrhoea increased by 58% and genital Chlamydia by 76%³, with the major increase in those under 25 years of age. Additionally, England and Wales have the highest rate of teenage pregnancy in Western Europe, with 62.9 in 1000 girls aged 15–19 and 8.3 in 1000 girls aged 13–15 becoming pregnant in 1999⁴. Reducing teenage pregnancies is a priority area of the government, with a goal of halving teenage pregnancies by 2010. This will require many different approaches including more openness between parents and children⁵, school-based

Correspondence to: Dr K E Rogstad, Department of GU Medicine, Royal Hallamshire Hospital, Glossop Road, Sheffield S10 2JF, UK
E-mail: Karen.Rogstad@sth.nhs.uk

general and specific education^{6,7} and easy access to contraception. Publicity campaigns promoting access to contraceptive and sexual health services have been associated with declining pregnancy rates in other European countries⁸ and are essential in tackling the rise in unwanted pregnancies and sexually transmitted infections.

In order to achieve this young people must have services appropriate to their needs and acceptable to them. Young people have highlighted various factors relating to acceptability, which include confidentiality, informal and friendly service convenient location and times, availability of telephone advice and gender of staff^{9,10}. Access to a general practitioner (GP) alone may not be sufficient to reduce conception rates. One study found that 93% of pregnant teenagers had discussed contraception with their GP in the preceding year¹¹. Those at risk of pregnancy are also at risk of STIs and it would be logical to provide testing for STIs wherever contraceptive services are available, and to provide contraceptive services wherever testing for STDs occurs. Indeed opportunistic screening for *Chlamydia trachomatis* was recommended for all under 25 year-olds by the Chief Medical Officer's Expert Advisory Group¹² and some screening initiatives are to be instigated according to the Strategy¹.

The Social Exclusion Unit has advocated a young-people friendly approach, and a one-stop service with the aim of achieving both reduction in STIs and pregnancy rates in teenagers as likely to be the best way forward¹³. There are several such clinics in the UK already but these are exceptional.

Although a combined service may not be able to provide as comprehensive care as separate ones, the quality of the service that is offered should be equal to that provided elsewhere. When additional expertise or services are required there should be prompt referral to those who can provide it through a planned care pathway. Management of the young person should be in line with national guidelines set by specialists in that field and there must be regular audit to ensure that there is compliance with national guidelines. Outcomes must also be audited and meet the defined standards as set by the speciality. The service provider needs to liaise closely with those providing more specialized services in order to ensure that guidelines are up-to-date, care-pathways developed and that joint audit can be performed. The combined service should be complementary to traditional specialized services and not seen as a replacement, unless it meets all those requirements needed for a specialist service (including facilities, accredited consultant staff etc.). Units should be encouraged to work together and not in competition.

Further information on services for young people has been produced by the Teenage Pregnancy Unit¹⁴.

PRINCIPLES OF SETTING UP A SERVICE

The key areas that should be addressed when setting up a service for young people are:

1. Consent and competence

Guidance on the issues involved in assessing children and young people, including consent to and refusal of treatment by those aged less than 18 and the concept of 'Gillick competence' have been recently published^{15,16}.

2. Confidentiality

Advice on confidentiality for those young people aged under 16 who request contraceptive services is provided in the Teenage Pregnancy Unit's guidance on best practice for contraception¹⁴ and the Health Circular on Family Planning Services¹⁷. For those requesting STI services, there are standards laid down in statute for services diagnosing and managing STIs¹⁸ and advice is provided in the National Guidelines on the Management of Suspected Sexually Transmitted Infections in Young People¹⁹.

Other guidance and standards on confidentiality issues are available and deal with young people seen in general practice and family planning clinics²⁰ and those involved in prostitution/commercial sex work²¹. The Royal College of General Practitioners has developed a toolkit to use²². Consideration must be given to the Children's Act²³ and the Sexual Offences Reform Act if this becomes law²⁴.

The service should have a written policy on the management of children under 16 who are sexually active. This should be based on a national policy designed to address the sexual health care needs of these children and their right to confidentiality, balanced with child protection issues (e.g. national guidelines on the management of suspected STIs in children and young people)¹⁹. All young people accessing the service must have individualization of their care, based on the policy.

3. Accessibility

On bus/train route.
Close to areas utilized by young people e.g. school, town centre, sports facilities.
Adolescent friendly.
Open access.
Self-referral.
At user-friendly times e.g. after-school, Saturday sessions.

4. Acceptability

Non-judgemental staff.
Young-person-friendly environment.
Choice of gender of staff where possible.

5. Clinical care and treatment

STI treatment provided on site and free.

Quality of care and treatment according to national guidelines.

Audited against national standards.

6. Liaison

There should be clearly defined routes of liaison with specialist genitourinary medicine (GUM) and family planning clinic (FPC) services as appropriate, child protection services, child and adolescent mental health services, adult psychiatry, paediatrics, drugs services, voluntary agencies, youth services, police and social services.

7. Patient records

Notes and computer systems are separate from the main hospital Patient Administration System (PAS) and meet the requirements of the Data Protection Act.

8. Data collection

Data on STIs diagnosed must be communicated to a nominated local GUM consultant for surveillance purposes. It is likely that there will be an enhanced data collection in the national surveillance programme for STIs which currently only covers GUM clinics (KH09 and KC60) and the service would be expected to participate. Similarly data applicable to contraceptive services should be shared with a designated family planning consultant and be included in KT31 returns.

9. User-input

The service should be developed in consultation with those who would access the service or are potential service users¹¹. Their views should be used to continually improve the service.

There should be broad based consultation with males and females to include under-16 as well as over 16 year olds, those from different ethnic groups, children in care, and vulnerable young people.

10. Staff

The service should normally be consultant led with close collaboration with a nominated GP, if appropriate. There should be close collaboration with a nominated consultant in GUM if testing for STIs is undertaken and with a nominated consultant in Family Planning if contraception other than condoms, injectables and oral contraception including emergency contraception is provided.

Nurses should have training in GUM and family planning.

All nurses providing contraception other than emergency hormonal contraception should have obtained a specific qualification in family planning.

All staff should have training in child protection (Appendix 1) and appropriate on-going support in order that they can fulfil their roles in respect of the Children Act 1989 and child abuse.

All medical staff to attend Foundation Course for Sexually Transmitted Infections (STIF) (unless they possess the Diploma in Genitourinary Medicine or are Consultants in GUM) and a recognized course in Contraception/obtain Diploma of Faculty of Family Planning. Further advice on training requirements is expected in the near future from the MSSVD.

CORE PROVISION

The service provided will vary depending on the setting. Care pathways must be established before screening for sexually transmitted diseases or undertaking pregnancy testing.

All services should provide the following (or have referral mechanisms in place to a service which does provide them) for those young people who require them.

1. Contraceptive services

- Advice on contraception offered to all.
- Pregnancy testing.
- Provision of hormonal contraception to include.
 - combined oral contraceptive pill.
 - progesterone-only pill.
 - emergency hormonal contraception.
 - injectable contraceptive.
- Information on other forms of contraception.
- Provision of condoms in a range of shapes and sizes.
- Ongoing supervision for those using contraception or referral to other services that will provide it e.g. primary care, FPC by letter/provision of appointment, whenever possible whilst client attending.
- Referral to specialist service for intrauterine device insertion (including for emergency contraception), implants, or for those with complex contraceptive problems.
- Referrals to termination of pregnancy service or ante-natal clinic by providing appointment whilst client is present or on the next working day.

2. Sexually transmitted disease service (GUM)

- Opportunity for immediate diagnosis of *Neisseria gonorrhoeae* would normally be expected by having access to direct microscopy, with plating for culture as confirmation. Screening for *N. gonorrhoeae* by DNA amplification methods is acceptable with referral to GUM services for confirmation and antibiotic sensitivity testing.
- Screening for *C. trachomatis* normally by DNA amplification methods.

- Non-invasive tests for *N. gonorrhoeae* and *C. trachomatis* to encourage screening and for those declining genital examination.
- Hepatitis B screening and vaccination for risk groups.
- HIV testing.
- Advice on safer sex practices.
- Treatment of *C. trachomatis* according to national protocols, with onward referral to GUM for treatment, identification of other STIs, follow-up and partner notification if not performed on site according to national standards and protocols.
- Referral to GUM of all those with gonorrhoea diagnosed by DNA amplification methods, herpes, hepatitis B positive serology, syphilis, Trichomonas or HIV.
- Referral to GUM of those who are symptomatic, by providing appointment whilst client is present or on next working day.
- Referral to GUM for those requiring full STD screen, unless available on site.

Drug abuse service

- Assessment of drug or substance abuse.
- Screening for hepatitis B and C and HIV offered to all at risk.
- Hepatitis B vaccination offered to all at risk.
- Referral to drug abuse agencies.
- Needle-exchange scheme—on site or referral.

4. Psychology service

Access to clinical psychologist, psychosexual services.

5. Cervical cytology service

According to national guidelines.

Referral to colposcopy service if abnormal cervix.

6. Social/youth workers

Either provision on site or with clear referral pathways, preferably to designated link worker.

Membership of Medical Society for the Study of Venereal Diseases Adolescent Sexual Health Group

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Additional reading

Child Abuse—Clinical Factors in the assessment and management of concern. A Clinical Practice Guideline commissioned by the

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APPENDIX 1

Suggested Training Objectives in Adolescent Sexual Health and Child Abuse

Induction of new staff

- Introduction of proformas for children under 16 years.
- Introduction of local policies, procedures and guidelines for child protection.
- Introduction to the main themes of the training objectives.

Training objectives

Knowledge of:

Children Act
 Consent & confidentiality
 Medical responsibilities in child protection
 Writing reports

Local Service organization for children

Identification of children who most at risk

Drug use

Prostitution/commercial sex work

Children living away from home

Adolescent sexual health education

Child and adolescent psychiatry

Adolescent contraception

Attendance at

Local Area Child Protection Committee child protection basic training courses

Child abuse clinic, adolescent family planning clinic

Adolescent protection conference

Continuing medical education/continuing professional development on adolescent sexual health issues