A review of teenagers' perceived needs and access to primary health care: implications for health services

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The government has stated its commitment to provide equality of access to health care for all and has emphasized the need to take account of users' views. The aim of this review was to search for evidence of adolescents' perceived needs for and access to primary health care services and to evaluate and report on the evidence found. Methods used were systematic searching of data bases and direct contacting of health and related organizations. The main finding was that a substantial minority of teenagers has health-related problems which are not met by current services. The main barriers to accessing primary health care were a perceived lack of confidentiality, embarrassment and unsympathetic staff. Reported access to a school health nurse varied widely (between 5% and 83%). The conclusions were that the barriers to accessing services as identified by teenagers are amenable to staff training, and that taking account of users' views could act as a stimulus for such training.

Key words: adolescent health services; accessibility; drop-in services; primary health care services; teenagers

Introduction

The Government has stated its commitment to reducing inequality in health and to offering fair access to services according to need (Department of Health, 1998a; 1998b). Experience of the principal author in the field of school nursing was that many school aged children had health-related needs which were not met by current health service provision, for example, poorly controlled asthma (Gleeson, 1995). Significant gaps in service provision for children with emotional and/or physical difficulties were identified in a literature review of the school nursing service (Watters, 1998).

Unmet health needs have been highlighted from various other sources such as research on pupils with a chronic illness or disability in school (Lightfoot *et al.,* 1999), a study (Gleeson, 1999) of asthmatic children, and the children's charity helpline Child-

Line (1998). The Annual Report (ChildLine, 1998) indicated that 1% of the 102 816 calls during the previous year were about health, with many others being health-related such as bullying (17%), pregnancy (7%), facts of life (6%), bereavement, mental health and smoking (1% each). While it is possible that some calls could be to get a 'second opinion', it could also be that the caller feels that no other source of help is accessible.

The need for a literature review appeared to be confirmed by the fact that information on the health needs of school aged children is commonly reported to be weak (Hall, 1996; House of Commons Health Committee, 1997a; Lightfoot and Bines, 1997). Lastly, numerous reports and reviews relating to health services for children and young people have emphasized the need to take account of users' views (Children Act, 1989; Department of Health, 1996a; 1996b; 1998a; 1998b; Department of Health, Scottish Office, 1996; House of Commons Health Committee 1997a; 1997b; United Nations, 1989; Watters, 1998) but this does not appear to be happening.

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Aims and scope of review

The aim was to address the question: what evidence is there regarding teenagers access to, and barriers to primary health care services? The concept of primary health care used is that defined by the WHO Alma-Ata (as discussed in the Editorial in the first issue of this journal, Bryar, 2000). The definition encompasses a concept of broad service provision, including self-care, which could be accessed by any individual (WHO, 1988). It, therefore, includes the full range of services provided by the NHS, including general practice and primary care teams, school nursing services, community services such as family planning clinics, and A&E. Access and use of nonNHS services such as youth groups and patient support organizations could also be considered as part of self-care services.

It was acknowledged that evidence might come from many fields such as primary care, school health, public health and mental health. The target age range was 11–16 years but a degree of flexibility was essential in order to include evidence from sources covering a wider age range (the terms 'teenagers', 'children', 'young people' and 'adolescents' are used here, depending on the information source. The review is primarily focused in the UK, but where evidence is included from other countries, critical comments on the relevance to the review are made.

Method

A search of databases (MEDLINE, PSYCLIT, HMIC – health management information consortium, SOCIOFILE, British Nursing Index) was carried out using the keywords adolescent and health services and accessibility and (perceptions and/or attitudes). This identified 48 articles, of which 15 were selected on the basis of the title and reading the abstract. Some of these papers could not be included in the review as they lacked the key criteria for inclusion, i.e., that they contain teenagers' perceptions of their access to and/or use of primary health care services. Others were excluded because they were aimed at specific populations such as ethnic groups. Selected references from identified papers were also examined, resulting in a total of eight that met the inclusion criteria.

It was noted that relevant published reports (e.g., from charities such as ChildLine) did not appear in the databases, so additional information was sought from organizations with an interest in child health. These were identified using a directory of voluntary agencies (NCVO Publications, 1998). Letters were sent to these bodies asking whether they had any published work on teenagers' perceptions of access to primary health care services, 'teenage clinics' or 'drop-in services'. Organizations contacted included professional bodies for health staff, key health organizations and voluntary bodies. Four additional reports meeting the inclusion criteria were identified in this way. A further seven were found by hand searching of nursing journals, from conference presentations and personal communication. A full list of organizations contacted, and the response, is given in the main report (Gleeson, 2000).

Results

Overview of results

Nineteen papers fulfilled the criteria, none of which had set out solely to seek views of access to primary health care. However, teenagers' views were included as a contributory aspect to other evaluations with broader aims. Findings from these papers are presented under three headings, between which there is a degree of overlap:

- prevalence surveys and other questionnaire-based studies indicating perceived unmet needs and use of services;
- barriers to using services and attributes which facilitate use;
- evaluation of specific initiatives.

Prevalence surveys: questionnaire-based

Balding's health-related behaviour (HRB) questionnaire has been completed annually by children in schools in England and Scotland since 1986 and provides evidence of perceived unmet health needs (Balding, 1998). The surveys show that although the vast majority of teenagers thinks that they are healthy and visit their family doctor once a year, a substantial minority (up to 30% depending on the problem) identify areas of unmet need, as summarized in Table 1. The survey includes a question on sources of help with health problems, specifically:

Table 1   Perceived levels of unmet health-related need

Author/Year	Sample size, age range	Visit health provider	Unmet need, drug alcohol	Unmet need, sexual health	Unmet need, mental health
Balding 1998	37 538 9–16 yrs	90%	7–18% worried	6–17% worried; over half do not know where to get free condoms	15–30% worried about family 8–25% keep it to selves
Zimmer-Gembeck *et al.*, 1997	14 000 14–18 yrs	80%	2.3%	3%	6.3%
Klein *et al.*, 1998	259 14–19 yrs	90%	16%	10%	18%
Epstein *et al.*, 1989	485 12–17 yrs	73% seen GP since 12th birthday	5% concerned	41% contraception; 18% (of 221 girls) menstruation	Various concerns up to 15%: death, family conflict, homosexuality

'if you wanted to share health problems, to whom would you probably turn?' A list of possible responses included various family members, teacher, school nurse or friend. Results consistently show that 5% or less would consult a school nurse if they had a health problem, and worryingly, over 10% of secondary school aged pupils said they would 'keep it to myself'.

In the USA the Standard Youth Risk Behavior Surveillance Survey (YRBSS) (Centres for Disease Control and Prevention, 1997) has been used over the past decade to provide local and national data on young people aged 14–18 years. Zimmer-Gembeck *et al.* (1997) added questions to the YRBSS regarding health care needs and access which revealed that school-based health centres (SBHC) were available to 32% of participants, and use of their SBHC in the past year was reported by 61% of students. Areas of perceived unmet needs were of a similar nature (emotional problems, birth control and drug/alcohol problems) to those in Balding's surveys, but were identified by a lower percentage of students.

Two other studies were found which sought to quantify adolescents' perceived health problems and access to help for these. Epstein *et al.* (1989) assessed pupils' health concerns in nine comprehensive schools in London. Topics which pupils would have liked to discuss with a health professional but had not been able to, included contraception (41%), menstruation (18%), acne (19%), illness in the family (12%) and arguments with parents (11%). A lack of confidentiality and embarrassment were perceived barriers. A study in

New York (Klein *et al.,* 1998) showed a similar perceived lack of access to help for mental health problems (18%), drug and alcohol problems (16%) and various sexual health matters (10%).

The method used for the above surveys was confidential questionnaire, with the exception of Klein's study (1998) which was by telephone interview. A comparison of the level of perceived unmet health needs is shown in Table 1. The studies did not use identical questionnaires, but the levels of unmet needs were identified from responses to similar kinds of questions. For example, Balding's questionnaire asks: 'How much do you worry about these problems?' (A list of 15 items, including health, HIV/AIDS, smoking, drinking, drugs, to be marked on a five point scale of 'never' to 'a lot' is given). Epstein *et al.* (1989) asked 'Are you concerned about . . . .' (multiple choice response options were: not at all/a little/quite a lot/very concerned).

Barriers and factors which facilitate use

Teenagers' individual experiences were expressed in a diverse range of studies such as: general practice patient surveys (Kari *et al.,* 1997; Oppong-Odiseng and Heycock 1997); school and teenage magazine survey (Jones *et al.,* 1997); analysis of calls to a charity helpline (Cross, 1998); evaluations of health education and promotion interventions (Aten *et al.,* 1996; Donovan *et al.,* 1997; Gleeson and Robinson, 2000 unpublished paper) public consultation on services (Eliott *et al.,* 1996; Brook Advisory Centres, 1998); and as part of a survey of children's rights in school (Participation Education Group, 1997).

Young peoples' attitudes to a general practice in London were assessed by Kari *et al.,* (1997) who identified problems of access, particularly for sexual matters. Problems in seeing their GP were reported by 40%, with reasons given as embarrassment (59%), difficulty in getting a quick appointment (50%), unsympathetic doctor (34%) and a belief that parents will find out (29%). Only 33% knew they were entitled to ask their GP for emergency contraception. Factors which they reported would make it easier to see their GP were quicker appointments (58%), a more sympathetic doctor (46%) and a friendlier receptionist (47%). Preference for a doctor of the same sex was expressed by 39%.

Oppong-Odiseng and Heycock (1997) in a survey in eight secondary schools in Stoke-on-Trent found that the young people preferred different service provision, depending on the problem. Many had poor knowledge of local services available. Aten *et al.* (1996) examined access and use of health care as part of an evaluation of a health education/skills acquisition project in New York. Eighteen percent were not aware of their local teenage clinic. Younger males had the least knowledge and use of health care sources. Those not receiving care were less knowledgeable about available sources of care.

Donovan *et al.* (1997), as part of an evaluation of a sex education programme in 30 schools in England, examined young people's views of consultations with their GP. Concerns expressed, and ways in which consultations could be made easier were very similar to those found by Kari *et al.* (1997) and are summarized in Table 2. A survey of adolescents in four schools and via a teenage magazine (Jones *et al.,* 1997) also showed that sexual health matters, mental health issues and general health worries were areas they would like to discuss. Preference for a drop-in health facility was expressed by the majority. Focus groups with young people, carried out by the Brook Advisory Centres (1998) also showed preference for drop-in services for their sex advice centres. Participants identified the main barriers to using services as a perceived lack of confidentiality, embarrassment and judgemental staff.

Children's views were obtained from group interviews in schools, as part of a wider public consultation on children's services in Salford and Trafford (Eliott *et al.,* 1996). Although mainly focusing on hospitals, some opinions on primary health care

services were gained which revealed the main concerns to be a lack of confidentiality and accessibility. Many children said nurses were more approachable than doctors, and some felt 'it takes guts' to go to the GP. A preference for female doctors was expressed by all ages. Waiting was hated, and older boys felt that receptionists were unhelpful and did not respect privacy.

An analysis of 305 records of health-related calls to ChildLine (Cross, 1998) revealed that a large proportion felt isolated from adults around them. School absenteeism was a problem which increased their isolation and stress about missing work. Enuresis accounted for around 12%, and some of the children had not seen their doctor about this. Of those who did, many felt they received an unsympathetic hearing. Barriers to accessing their GP were a lack of confidentiality and embarrassment. Callers said they wanted to be taken seriously, listened to and treated courteously. School nurses were seen as a reliable source of help by some callers.

In a joint venture between education and health professionals in Tyne and Wear, focus group discussions were carried out with 187 young people (91% in the 11–18 years age range) to gain their views of health within the school context (Participation Education Group, 1997). Results indicated that when they are ill young people would like to be believed, and to have confidentiality and privacy respected. Many (41%) had difficulty seeing the nurse, 94% felt that most adults in school would not consider stress or depression an illness and none felt they could talk to someone about their health concerns.

Asthmatic children's perception of their access to educational resources in both hospital and primary health care settings was documented in an evaluation of a computer-assisted learning programme (Gleeson and Robinson, 2000 unpublished paper). This showed that around one-third had not accessed commonly available resources, such as leaflets or consultation with their practice nurse. In the ChildLine study (Cross, 1998) the lack of access to a sympathetic and knowledgeable professional to discuss asthma (and other chronic conditions) was also highlighted.

Evaluation of specific initiatives

Five initiatives are reviewed here in which the systematic collection of teenagers' views formed

Table 2   Sources of evidence in the review

Study number (source)	Author/Year	Study type	Sample size, age range
1 (db)	Aten *et al.*, 1996	Evaluation of health education/skills acquisition programme	3677 12–19 yrs
2 (db)	Balding, 1998	Survey of health-related behaviour	37 538 9–16 yrs
3 (og)	Brook Advisory Centres, 1998	Consultation to assess what young people want from sex advice centres	Five focus groups age 13–18 yrs
4 (og)	Cross, 1998	Review of calls to helpline	305
5 (db)	Donovan *et al.*, 1997	Evaluation of sex education programme	4481 15–16 yrs
6 (og)	Eliott *et al.*, 1996	Public consultation on services	21 groups 4–16 yrs
7 (db)	Epstein *et al.*, 1989	Survey of health concerns and behaviours	485 12–17 yrs
8 (p)	Gleeson and Robinson, 2000	Evaluation of computer-assisted learning for asthmatic children	110 8–16 yrs
9 (og)	Jones *et al.*, 1997	Survey of health concerns and service preferences	525 11–19 yrs
10 (db)	Kari *et al.*, 1997	GP survey of attitudes	347 12–18 yrs
11 (db)	Klein *et al.*, 1998	Random digit-dialled survey of adolescents' access to care	259 14–19 yrs
12 (p)	Lewthwaite, 1990	Consultation prior to setting up advice service	265 14–25 yrs
13 (p)	Murphy, 1998	Evaluation of school drop-in service	242 11–16 yrs
14 (p)	Nelson and Quinney, 1997	Evaluation of lunchtime school drop-in service	593 11–17 yrs
15 (db)	Oppong-Odiseng and Heycock, 1997	Survey in 8 schools	253 14–15 yr olds
16 (p)	Paignton Community College, 1999	Annual report of teenage information and advice centre	592 individual consultations age 12–16 yrs
17 (p)	Participation Education Group, 1997	Consultation about health within the school context	187 5–25 yrs
18 (p)	Smart, 1996	Evaluation of drop-in clinic	16–18 yr olds in a high school and clinic attendees
19 (db)	Zimmer-Gembeck *et al.*, 1997	Survey of needs and use of health care	14 999 14–18 yrs

Source of article/report: db (database search and/or references from these); og (organization contacted); p (personal contact, conference presentation or hand search).

part of the evaluations (Lewthwaite 1990; Murphy, 1998; Nelson and Quinney, 1997; Paignton Community College, 1999; Smart, 1996). There were numerous anecdotal accounts (mainly verbal reporting) of initiatives specifically directed towards teenagers, such as drop-in services in schools, youth centres, health clinics or general practice surgeries. Fourteen had some form of written report but are not referenced here (references available in full report, Gleeson, 2000) as they lacked relevant information such as how views were obtained, details of sample sizes, service specification and reliability of the service or some lacked user views. Even the five reviewed here report only service use rather than health outcomes.

Durham Health Authority (Lewthwaite, 1990) used group discussions to gather young people's views on services for health advice and information, prior to establishing a health advice service. Participants expressed a need for advice on appearance, mental health, sexual matters, alcohol and smoking. The main barriers to access were fears about breaching confidentiality, and unsympathetic, uncaring staff. Boys and girls felt that female health professionals were easier to talk to than males.

A school-based weekly lunchtime drop-in clinic (Nelson and Quinney, 1997) staffed by a school nurse, youth advisor and a doctor was used by 18% of pupils during the first 6 months, and a further 8% felt they would have liked to use it but did not. A similar weekly lunchtime drop-in service, this one at a community centre, was initiated in a rural area (Smart, 1996), triggered by a rise in local teenage pregnancy rates. Staffing was similar to

Nelson and Quinney's (1997) service, with a strong multidisciplinary team base, co-ordinated by the school nurse. The service was based upon the views of teenagers, obtained by questionnaire and discussion groups in schools and youth clubs. Common areas where teenagers wanted advice were sexual matters, relationships and general health. Only one-third knew the location of their local family planning clinic.

Personal communication has identified two other projects. A school-based daily lunchtime information and advice service was set up in Devon (Paignton Community College, 1999) with the approval of all the GP practices in the area, and with initial funding from the health authority. The service offers individual consultations for pupils and is staffed on a rota basis by GPs, practice nurses, health visitors and school nurses. There is also the opportunity for pupils to drop-in informally for information leaflets on a range of health and related matters, or to chat with staff. A part-time co-ordinator with a youth work background provides continuity across the sessions, thus giving pupils the chance to 'check out' the service before deciding to consult with a health professional. Ongoing evaluation is built-in by using a confidential pupil questionnaire, and by the participation of the pupil representative group. The 1998/9 annual report showed that around 40% of pupils (average of three per day) had attended for consultations with a health professional, and an additional 2209 visits were made on a drop-in basis.

A project led by a public health consultant, funded as part of a broader 5-year single regeneration budget initiative, provides lunchtime drop-in sessions in a secondary school (Murphy, 1998). Systematic recording showed various reasons for attending including sexual health, drugs/alcohol problems, general health, family problems and bullying. Three sessions per week were provided by the Youth Service, with the other two by the school nurse. On average, three to four pupils attended per school nurse session, one third of whom received some form of follow-up care from the school nurse or other agencies such as GP or Youth Service. Over a 1 year period there were also 36 pupils referred to the school nurse by teachers, parents, educational welfare officers and the A&E department. Over half of these were for support with mental health problems.

Table 3 Perceived barriers indicated in studies

Perceived barrier	Study
Embarrassment	3, 4, 5, 6, 7, 10, 12, 14, 17
Lack of confidentiality	3, 4, 5, 6, 7, 10, 12, 17
Unsympathetic doctor	3, 4, 5, 6, 10, 12
Inconvenient appointments	3, 5, 10
Unfriendly receptionist	6, 12, 16
Poor knowledge of local services	1, 2, 10, 15, 18

Summary of results

Results from the evidence review (see Table 2) showed a high level of consistency regarding the reported health-related concerns of teenagers, visits to their doctor, perceived barriers to accessing services and suggestions of how access could be improved. The teenagers reported level of contact with their GP is similar to the level of actual contacts reported in the National Morbidity Survey (OPCS, 1995: 27). The barriers and suggested facilitating factors from the evidence sources listed are summarized in Tables 3 and 4.

The only major variation in the evidence was in reported use of school nurse services (i.e., use of school-based and school-linked services, or visits to the school nurse). In two schools in England which had evaluated their lunchtime drop-in clinics the service was used by 40% of pupils during the year (Paignton Community College, 1999), and by 18% in 6 months (Nelson and Quinney, 1997). This contrasts with the findings of Balding's annual surveys (e.g., Balding, 1998), which have shown that 5% or less would turn to the school nurse for a health problem. Two American studies of school-based health centres have shown students to have much higher usage of this service, by 44% (Kisker and Brown, 1996) and 61% (Zimmer-Gembeck *et al.,* 1997).

Table 4 Facilitating factors to improving access

Factor facilitating use	Study
Sympathetic staff	3, 5, 6, 8, 10, 17
Confidentiality assured	3, 4, 6, 17
Preference for doctor of same sex	5, 10
Preference for female doctor	6, 12
Preference for drop-in service	3, 9, 18
Quicker appointments	5, 10

Discussion

Methodological issues

As stated in the Results section, data were included from all types of studies and reports which sought to gain teenagers' perceptions of their access to primary health care. In this review it has been assumed, rightly or wrongly, that teenagers' concerns about health are an indication of unmet needs for these to be addressed. The high level of consistency found across the data sources regarding perceived access, use and barriers, supports this assumption.

It is possible that additional evidence may be available but was not found owing to the fragmented way in which teenage health is documented. It is of note that two of the specific initiatives were not identified from the systematic search of data bases or contacting organizations, but from the national media (Paignton Community College, 1999) and personal contact (Murphy, 1998).

Since completion of the review a compendium of family planning services for young people within each NHS Region (Health Education Authority, 1996) was found by chance in a GP surgery. At the time of contacting national organizations the HEA was closing down, which could account for a lack of response to the letter requesting information on teenage services. The report summarizes the following aspects: setting, aims, services offered and staffing, appropriateness, accessibility and evaluation and contact details. There were between six and 12 services per region and evaluations used a variety of methods including service use, feedback questionnaires, suggestion boxes, user surveys and audits. All services were multidisciplinary, and the contact person was most commonly a doctor (consultant in family planning, senior clinical medical officer, GP). Others were nurses (nurse managers, practice nurses, health visitors), health promotion staff and youth workers.

Broadening the search to include 'grey' literature, contacting charities and organizations, and personal communication has resulted in an added benefit of setting the teenage health agenda within a wider context of education and social policy. For example, within education research (Balding, 1998) bullying is identified as a problem for some children, and health research has shown the impact that this can have on health, such as avoidance strategies (not wearing glasses, not wearing splints, or staying away from school) (Lightfoot *et al.*, 1999),

or attempted suicide (Davies and Cunningham, 1999). Similarly, data on children's perceptions of their civil rights in schools (Alderson, 1999) has many parallels with access to health care, as typified in the Participation Education Group (1997) study reviewed. Solutions to improving access to and use of health care involve similar strategies to education and social policies that have the aim of increasing empowerment of young people to cope with life.

Young people's access to primary health care services

The Patient's Charter (Department of Health, 1996b) states that young people can expect to be able to get: 'individual advice and information from your school nurse, school doctor and GP about any health aspect causing concern, including matters about growing up'. The barriers identified by teenagers in this review mean that access to the GP is difficult for many, in spite of encouragement by some doctors (Donovan *et al.*, 1997; Epstein *et al.*, 1989; Jacobson and Wilkinson, 1994) and children's charities (Hogg, 1998) to make general practice more friendly. In contrast, it is reported anecdotally that some surgeries display notices stating that children under 16 years will not be seen without a parent.

The fact that only 5% or less (Balding, 1998) of UK children would turn to a school nurse if they had a health problem could be due to various reasons such as lack of availability, inconsistent or unreliable service, perception that the role does not include self-referral or the same barriers generally identified. The wide variation in perceived access to this service suggests an inequality of provision which is against current government policy of reducing inequality in health care (Department of Health, 1998b).

Fragmentation or diversity?

A lack of knowledge of locally available services was a common finding, echoing the concerns of the Health Committee Reports (1997a; 1997b) which were highly critical of the fragmented nature of health services for children and young people. It was disappointing that so few of the so-called 'innovative' services had been systematically evaluated. Unless initiatives are co-ordinated with mainstream NHS services there is a risk of conflict and/or loss of information and a lack of overall

accountability to the young people at the receiving end of health services. A report by the National Children's Bureau (Jones and Bilton, 1994) points out the need for real collaboration between various agencies. The authors state that a clear vision should be articulated, and that: 'vague mission statements, strong on superlatives but weak on critical analysis are unhelpful'.

Challenges of getting young people's views

Teenagers' perceptions in this review have come mainly from studies aimed at quantifying patterns of health-related behaviour. Users' views as part of routine health care as recommended in the many documents listed in the introduction were rarely available. The particular difficulties of getting young people's views have previously been highlighted, for example, by Cunliffe and English (1997) in their Kids Count project, and Clarke *et al.* (1997) as part of a health needs assessment in relation to child and adolescent mental health services (CAMHS).

Getting consumer views about health services is relatively new. A survey of general practices in three health authority areas (Jordan *et al.,* 1996) on health needs assessment, indicated that few practices had an interest in consulting local people. However, those that had done so were more likely to make changes in practice, and to have future plans for local consultation. Information on ways of increasing the voice of users of NHS services is available (Department of Health, 1996c), and the requirement to include users' views in service use and development is integral to the NHS Plan (Department of Health, 2000).

The specific initiatives reviewed here are promising in that teenagers' views were an integral part of the service evaluation. A similar strategic approach (Goudie and Redman, 1996) starting with a two day consultation exercise with teenagers and multi-professional staff would appear to be a realistic way of initiating a whole-systems approach to mainstream services.

Conclusions and recommendations

Recurrent themes of what young people would like from services were that they would like access to a sympathetic health professional, with confidentiality protected and to be treated in a friendly manner by receptionists. Quicker appointments and a preference for a doctor of the same sex (and some overall preference for talking with a female health professional) were also expressed. Minor organizational changes (e.g., to enable quicker appointments), staff training (to ensure a friendly reception by all staff), and an explicit commitment to offering a confidential service (e.g., a large poster displayed in the waiting area) could address these within general practice at minimal cost.

Failure to empower young people to cope with growing up has potentially expensive consequences for the NHS, for example, in unwanted teenage pregnancies and mental health problems. The true cost of failure to help young people to address their problems as they arise is likely to be far greater than 'nipping them in the bud', but is difficult to demonstrate. Other benefits of helping teenagers to access health care also include less embarrassment and increased likelihood of consulting alone (Donovan *et al.,* 1997; Klein *et al.,* 1998). Balding (1998), in summarizing other survey data recommends specific coaching in use of health services. Similar conclusions were reached (Fullerton *et al.,* 1997) following a systematic review of evidence on approaches to preventing teenage pregnancy.

Given the seeming lack of evidence of effectiveness of specific initiatives, a conclusion is that research is needed to establish the accessibility, effectiveness, outcomes and cost effectiveness of such initiatives. There is a need for controlled evaluations in which outcomes are measured. The developments in information technology in general practice will facilitate the ability routinely to monitor service use, aspects of quality of services and outcomes. The integration of school nursing work within general practice information systems is still at an early stage but is likely to increase in the future.

The Paignton Community College (1999) service would appear to offer a promising model as it has all the desired attributes commonly identified by young people. It was started in partnership between all the local general practices, the health authority and the school, and is therefore more likely to be fully informed of the range of locally available services, in comparison with initiatives of a uni-professional group.

The services described in the Health Education

Authority compendium (1996) are similarly characterized by their multidisciplinary staffing.

The Department of Health (1994) document *Negotiating School Health Services* provides a useful model for school nurses and other primary health care staff on which to base service agreements with schools. Guidance is also available for auditing confidentiality in general practice teenage contraceptive services (National Co-ordinating Unit for Clinical Audit in Family Planning, 1997). The guidance provided in this audit tool is highly applicable to all health-related concerns (not just contraceptive services) and could readily be used in any health setting available to teenagers.

A paper based upon the findings of this review suggests practical ways in which school health nurses can make themselves more accessible to school children (Gleeson, 2001). A report on communication with teenagers in general practice was also recently published (Jacobson *et al.,* 2001) which supports the findings of this review and suggests the encouragement of more partnership working between general practice teams, education departments, health promotion agencies and school health nurses.

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