

Developing and piloting a peer mentoring intervention to reduce teenage pregnancy in looked-after children and care leavers: an exploratory randomised controlled trial

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Scientific summary

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Background

Teenage pregnancy is associated with a range of adverse health and social outcomes and is recognised as a major public health issue. Looked-after children (LAC) who have been in care have the highest rates of teenage pregnancy (for ease of reference, throughout the text we use the term 'looked-after children' or LAC to refer to both children and young women who are, or who have been, in care). Interventions that have been introduced in the past decade to combat this problem, such as improved sex and relationships education in schools, have resulted in a fall in the rate of teenage pregnancy in the UK population generally but this fall has not been mirrored amongst LAC. Girls and young women within the care system have often experienced a range of adverse early life experiences that brought them into care and, for some of them, becoming a mother represents an opportunity to feel a sense of achievement and to combat feelings of worthlessness and low self-esteem. Having access to a mentor may help young women to develop a sense of emotional security, self-esteem and confidence, as well as providing an opportunity to deliver important messages around sexuality, relationships and early pregnancy. There is some evidence of mentoring programmes enabling young people to make positive decisions and choices in their lives, particularly around their education and personal development. Young people often report the need to talk to someone of a similar age and background, although there have been few evaluations of the effectiveness of peer mentoring interventions in young people and none that target pregnancy or sexual relationships using an experimental design in LAC.

Intervention

A peer mentoring intervention for children and young people who have been in care was developed and piloted (Phase I) followed by an exploratory randomised controlled trial (RCT) (Phase II), based on the Medical Research Council's original framework for evaluating complex interventions. The components of the peer mentoring intervention were informed by a scoping exercise and targeted literature review to identify existing examples of, and evidence for, the effectiveness of peer mentoring and other interventions to reduce teenage pregnancy and mentoring and peer mentoring in LAC and non-LAC, both to reduce pregnancy and in relation to other areas such as education. A behaviour–determinants–intervention (BDI) logic model was designed to describe and explain the intended causal mechanism of the intervention.

Study aim, objectives and research questions

The aim of the study was to develop a peer mentoring intervention to reduce teenage pregnancy in LAC and to undertake an exploratory RCT. This trial did not aim to (and therefore was not powered to) study intervention effects.

The objectives were to:

- develop a complex intervention to reduce teenage pregnancy in girls and young women who are 'looked after'
- conduct an exploratory RCT of the intervention in three local authorities (LAs) in England
- assess the feasibility of a Phase III trial based on the following criteria: availability of eligible participants; recruitment and retention of mentors and mentees; acceptability of consent and randomisation; evidence of harm to participants; appropriateness of proposed outcome measures; costs for a future full-scale Phase III trial; and ability to manualise the intervention

- determine the costs of the intervention and develop a model of the running costs suitable for estimating the costs of a larger trial
- embed a process evaluation within the exploratory trial to assess the acceptability and feasibility of the intervention and the trial procedures to LAC and those working as mentors.

Methods

The pilot (Phase I) was conducted in one LA with four mentor–mentee dyads. Phase II consisted of an exploratory RCT of the intervention in three LA areas. The target was to recruit 48 LAC mentees (young women aged 14–18 years) and 24 care leaver mentors (young women aged 19–25 years). The LAC mentees were individually randomised in the exploratory trial, stratified by LA, using blocking, with half receiving the peer mentor intervention and half receiving ‘usual support’.

A mentor training package was developed. Adjustments were made to recruitment methods and the training for the exploratory trial following feedback received from participants, trainers and LA professionals.

Data were obtained from the following sources: observation of the training programme; semistructured individual interviews with all mentors and mentees and the usual support group at baseline and 1 year; analysis of selected measures of psychological health and help seeking; information regarding sexual activity, pregnancy and relationships; interviews with mentors post training; interviews with project co-ordinators (PCs); focus groups with LA staff and social care professionals; and national surveys of young people in care, directors of children’s services and social workers regarding the acceptability of the intervention and the feasibility of a Phase III trial.

Project co-ordinators were asked to record the time that they spent managing the intervention and any costs incurred. Mentors were also asked to record the time spent on activities with their mentee and retain records of all expenses.

The process evaluation was informed by semistructured interviews with mentors, mentees and PCs and mentor diary data, focus groups, survey data and interviews with other professionals.

Results

The peer mentoring intervention for LAC was unsuccessful, largely because of the inappropriateness of this intervention within a LA context.

Difficulties were encountered in meeting the recruitment target for both the pilot and the exploratory trial, with only 54% (26 LAC) of target recruitment reached for the exploratory trial. Thirteen out of 20 mentors (65%) and 19 out of 30 participants aged 14–18 years (63%) (recruited during Phases I and II) were retained for the research. The training programme for mentors was acceptable to mentors and could be manualised and replicated.

Difficulties in recruiting the target number of mentors and mentees delayed the start of the intervention. LAs lacked the infrastructure or resources to be able to manage the intervention effectively, the PCs found it difficult to prioritise the demands of the research without additional resources and support from senior management and social workers tended to act as informal gatekeepers, which limited access to potential participants.

Randomisation was acceptable to the young people and mentees appeared to value the intervention. However, weekly meetings were not feasible and only one in four of the relationships continued for the full year. Mentees were irregular in their attendance at meetings. Mentors also found it difficult to set up meetings or to comply with all of the requirements of the role, including completion of contact diaries, keeping a record of expenses and ensuring that all contacts were safe and communicated to members of their professional network. Mentors and social workers considered that more individual and group support would need to be provided in any future trial. There was no evidence of harm to any of the participants.

The study did not aim to detect intervention effects and lacked both statistical power and intervention duration to be able to do so. However, analysis of qualitative data was indicative of improved self-esteem and decision-making in the intervention group, especially around social networks and education, as had been anticipated in the BDI logic model. Mentors also reported increased confidence and self-efficacy.

There was a sufficient pool of potential participants for a peer mentoring intervention in a future Phase III trial. However, various changes would be required for such a trial: peer mentoring should be delivered in an individual and a group format, with sex and relationship education best delivered within a group setting; the project would need to be managed internally by LAs although delivered in collaboration with an external agency such as a charity or the third sector; and LAs would need to receive research support costs to be able to ensure dedicated PC time to support recruitment and retention of mentees and mentors. In future, mentees should be recruited at a younger age, from around 12 years (instead of 14 years), based on the fact that many of them were already sexually active by the age of 14 years, and mentors would need to be older (21–28 years), based on the relative vulnerability and immaturity of this group. Formalised structures for recruiting and selecting mentors and ensuring that they have the capacity, as well as the willingness, to deliver the mentoring in a consistent and responsible way should be introduced.

The data do not allow us to be able to address whether a peer mentoring programme is effective in reducing rates of teenage pregnancy. The measures used were acceptable and appropriate although, given the size of the sample, we are unable to comment on the impact of the intervention on help seeking, attachment or other psychological measures related to general anxiety, self-esteem and locus of control. Young people were happy to answer questions related to sexuality and relationships.

Conclusions and recommendations

The intervention as it was implemented in this study was not appropriate in this setting and was unsuccessful. A Phase III trial of peer mentoring in the future would require more resources for participating LAs, better structure, both within the mentoring programme and the management of the project, and more individual and group support for mentors. A new development phase to adapt the intervention manual in line with the findings from this study followed by a small-scale exploratory intervention, incorporating the changes recommended by participants and based on our findings, would be necessary before proceeding to a Phase III trial.

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