

Access to health care among NSW adolescents

Phase 1

Final Report

NSW Centre for the Advancement of Adolescent Health
The Children's Hospital at Westmead

Michael Booth
Diana Bernard
Susan Quine
Melissa Kang
Tim Usherwood
Garth Alperstein
Lisa Beasley
David Bennett

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Research Group

Investigators

Michael Booth MPH PhD FACSM (Principal Investigator)
Coordinator of Research and Development
NSW Centre for the Advancement of Adolescent Health
The Children's Hospital at Westmead

Clin A/Prof David Bennett AO MBBS FRACP
Director, NSW Centre for the Advancement of Adolescent Health
Head, Department of Adolescent Medicine
The Children's Hospital at Westmead

A/Prof Susan Quine, BSc(Hons) MSc MPH PhD
Associate Professor in Preventive and Social Medicine
Department of Public Health and Community Medicine A27
Faculty of Medicine
University of Sydney

Dr Melissa Kang MBBS MCH
Coordinator of Education and Training
NSW Centre for the Advancement of Adolescent Health
The Children's Hospital at Westmead

Prof Tim Usherwood BSc MD BS FRCGP FRCP DMS
Professor of General Practice
Department of General Practice
University of Sydney at Westmead Hospital

Dr Garth Alperstein MB ChB MPH FAFPHM FRACP
Area Community Paediatrician
Community Health Services
Central Sydney Area Health Service

Ms Lisa Beasley B AppSc MHSM
Coordinator, High St Youth Health Service
Westmead Hospital and
President, Australian Association for Adolescent Health (NSW) Inc.

Project Officer

Diana Bernard BSS Grad.Dip ECS MPH
NSW Centre for the Advancement of Adolescent Health
The Children's Hospital at Westmead

Schools

A list of the pilot and participating schools is included as Appendix 4.

Advisory Group

Dr Liz Barrett (NSW Rural Doctors)

Cindy Dargeville (Northern Sydney Area Health)

Simone Dilkara (Southern Area Health)

Georgie Ferrarri (NSW Association of Adolescent Health)

Michael Kakakios (NSW Health)

Helen Kerr-Roubicek (Department of Education and Training)

Sally Lambourne (South Eastern Sydney Area Health)

Cathy Richardson (Alliance of NSW Divisions of General Practice)

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Dr Michael Booth
Principal Investigator

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Executive Summary

Background

The NSW youth health policy *Young People's Health: Our Future* has four primary goals: To improve the health and well-being of young people; to improve access to health services by young people; to improve the quality of services provided to young people; and, to promote partnerships both within and outside the health system. The Access Study is relevant to all four of these goals and is focussed on improving access to quality health care services for young people in NSW.

Phase One of the 'Access study' was a needs analysis designed to discover from young people when they do and do not access health care services, and if they fail to do so, why they do not receive appropriate care. *Phase One* was also to develop an understanding of access to health care for young people from the perspective of health care providers. *Phase Two* will use the findings of *Phase One* and an extensive process of audit and consultation, to develop and evaluate new and existing approaches to providing health care to young people in NSW. *Phase Three* It is envisaged that beyond *Phase 2*, certain of these identified models of health care will be piloted and evaluated and recommendations for a coordinated approach to the delivery of sustainable health services to young people in NSW can be provided.

This report describes *Phase One* of the Access Study and summarises the findings.

Methods

Given the paucity of systematic research in this area, qualitative research methods were employed, particularly focus discussion groups. Both consumers (in-school and out-of-school young people) and health care providers (general practitioners, community health centre staff, youth health service staff, youth health workers and youth health co-ordinators) were approached to participate in the study. Ten of the 17 NSW Area Health Services (AHS) were selected to participate in the study, including a range of Sydney metropolitan AHS and regional, rural and remote AHS. Within these, metropolitan and rural community health centres (CHC), Divisions of General Practice and youth health services were invited to participate. Youth health workers based in metropolitan Sydney and youth health co-ordinators from metropolitan and rural areas were interviewed.

Two broad groups of adolescents were approached to participate in the study: those not engaged with mainstream education, many of whom were also homeless; and those who regularly attended private or state schools. Out-of-school young people were recruited through youth health services. In-school students were recruited through their school and the sample was stratified by:

- gender
- age; early (12-14 years), middle (14-16 years) and late (16-17 years) adolescence
- socio-economic status, and
- geographic location (urban and regional/rural).

Prompts for focus group discussions were developed on the basis of the published literature, pilot focus groups, and discussions with youth health service coordinators, a general practice academic, a GP practitioner/educator, an experienced community health worker and experienced youth health co-ordinators. The interviews were recorded, transcribed and analysed using NUD*IST 4.

Principal findings

Young people's definitions of health

Young people defined health primarily in terms of physical well-being although females and older students were somewhat more inclined to offer a slightly wider definition. Out-of-school young people readily defined health in broader terms, including mental, social and sexual health. There did not appear to be an association between socio-economic status or place of residence and the definition of health offered.

Young people's health issues

Despite an apparently narrow definition of health, young people identified a very broad range of situations, conditions or behaviours which they believed might impact on their health. These included: mental health issues, social issues (such as lack of recreational activities); sexual health issues; drug and alcohol issues; stress or pressure; diet and body image; bullying; safety (including on the street and at home); relationships; employment and educational opportunities; homelessness; poor self esteem; perceived teacher's sexism (ie. female teachers toward male students); income; and transport. The issues varied in their importance depending on the age, gender and urban/rural location of the respondents and whether they were in or out of school young people. Socio-economic status appeared to be unrelated to the issues identified except for a slightly higher concern about street safety amongst younger females in lower SES areas and out-of-school young people.

Young people's barriers to seeking help

By far the most significant of young people's barriers to seeking help were concerns about confidentiality and trust in terms of the patient/provider relationship and having to deal with embarrassment and shame in disclosing concerns. Also significant were young people's lack of knowledge of what services were available, what they provided, the competencies/ skills of the providers and how to access them. Socio-economic status appeared to be unrelated to the barriers identified except for cost of access in rural areas and the possibility of private access amongst private school young people.

Young people's preferred sources of help

Having identified the issues young people perceived as posing the greatest threat to their health, we then sought to discover where, or from whom, young people are most likely to seek help when confronted by one of these health concerns. The overwhelming answer to this question was that *if* they discussed these issues (and many simply did not), the majority discussed them with friends, family or relatives, in descending order of importance. The findings had two striking features. First, only a small number of young people considered seeking help from a service provider and, even then, had usually come to know a particular service provider by coincidence and had subsequently formed a positive relationship with them. Second, approximately half of all young people did not seek help from anyone at all, particularly males. Young people were generally unaware that GPs might be trained in other skills such as counselling and were dubious about the possibility of service providers having such skills.

Almost no young people had ever heard of community health centres and did not consider them relevant to their needs, assuming they were for older people. In-school young people thought of youth centres as "*activity type places*" and did not distinguish these from youth health services or if they did saw the latter as places for "*losers*".

More females than males reported that they sought help. Younger adolescents (Year 7) were more inclined to seek help from their parents whereas older adolescents

(Years 10 and 11) and out-of-school young people were more inclined to seek help from their friends with some exceptions of older females who had trusting relationships with their mothers. There were no noticeable urban/rural or SES differentials in help-seeking behaviours.

Young people's use of service providers

When young people did seek help from a service provider, they approached the following, in descending order of importance: GPs they knew and trusted; school counsellors; GPs they did not know (on purpose); counsellors not based in schools; school year advisers and other trusted school staff; community telephone counselling services; women's health services; and, adolescent mental health services or, in relation to out-of-school young people, Juvenile Justice and Centrelink. Whereas most young people were aware of school counsellors and some young people sought help from them, there were significant barriers to using them, particularly issues of confidentiality and visibility.

Out-of-school young people also chose not to access services unless they were in crisis or had heard 'positive word on the street' about the service, although they knew of more services than in-school young people. Their barriers to accessing services were the same as those expressed by in-school young people with additional reasons including: self esteem; drug use; and being perceived by service providers as "*street rats*". Out-of-school young people had generally sought help from GPs or school counsellors to resolve difficulties they were experiencing while still at school, but their problems had often not been successfully resolved. After leaving school, many of them then sought assistance from youth health services after they had encountered further significant difficulties.

Knowledge of services and what they provided was limited among all young people across SES strata, gender, age and rural/urban settings with slightly greater knowledge among older adolescents, particularly females in regard to sexual health and out-of-school young people.

The only noticeable SES differences were that young people attending private schools suggested that their parents might access private counsellors if they saw a need. They were, however, no more inclined to attend than other young people.

Although young people knew little about services, they stated that they would not tend to use them even if they did know more about them. This critical finding was encapsulated by one young person with "*...you go to someone you know and trust and they know you*".

Young people's suggestions for 'ideal service provision'

These included a range of services in schools, group programs, more education and publicity, a youth web site, phone lines, videos, youth specific services, different opening hours, confidentiality and respect and a range of structural possibilities for a prospective "ideal centre". The physical aspects of such a centre were considered to be of less importance than the general atmosphere and the attitudes of the people who worked there.

Service providers' barriers to providing optimal care

There was a great deal of consistency between general practitioners and community health centre staff in terms of their perceived barriers to providing services to young people. Barriers to service provision appeared to cluster under five main factors: cost/time; communication with young people; having sufficient support and backup from other services; flexibility of service provision; and, having the requisite skills and confidence to meet the needs of young people. Issues of cost/time and communication

were more likely to be raised by providers working in urban areas than by rural service providers. Youth health workers' barriers were more structural although their difficulties in working with mental health issues were consistent with other service providers.

Service providers' support and training needs

As with barriers to the provision of services, the issues raised regarding support and training were quite similar for general practitioners and community health centre staff. Although providers identified some key areas in which they would like to improve their knowledge, they placed far greater emphasis on the need for enhanced professional support and networking. The key areas identified for further development were: feedback/links with other providers regarding effective approaches to working with young people; collaborative approaches with other disciplines; greater involvement with outreach programs, schools and participating in workshops with young people. Youth health workers and co-ordinators also concurred with these ideas. Some of these require additional funding for ideal service provision, but in many cases, significant improvements could be achieved without increased resources.

Service providers' suggestions for "ideal service provision"

These included shopfront models, outreach programs involving schools, flexible service provision in terms of opening hours and other structural components, more advertising/teaching, better linkages with other services, more training, different financing and more frequent inclusion of young people in the development of services. In summary, a multi-strategic approach with structural and policy changes.

Summary

Young people's understanding of "health" tends to be limited to physical well-being and to exclude social, psychological and other aspects of health. They do appreciate, however, that a very broad range of conditions, events and behaviours (e.g., unemployment) may have a detrimental impact on their health. Younger adolescents rely on their parents to arrange care when they are unwell, but middle and older adolescents frequently fail to access care when it may be of benefit to them, particularly males. By far the most significant barrier to young people seeking help was concern around confidentiality and trust and having to deal with feelings of embarrassment in disclosing health issues. The other major barrier to accessing health services was lack of knowledge of services available or what the service might provide and how to access them. Many young people do not regard GPs as being appropriate for treating anything other than physical ailments and turn to friends, family or other familiar and trusted adults for all other health concerns.

The key is *trust*. Given an opportunity to become familiar with or to develop a trusting relationship with a service provider, young people are far more willing to avail themselves of their services. Although we found distinct differences between males and females, by age and between urban and rural young people, socio-economic status appeared to be generally unassociated with adolescents' access to health care.

Service providers identified several barriers to offering improved services to young people including: the difficulties of making sufficient time available (which is necessary to develop a trusting relationship); the skills to communicate well with young people; insufficient support and backup from other health professionals; appropriate knowledge about issues which are more specific to young people; and, financial and service provision impediments which limit the possibilities of appropriate, innovative and outreach practices. There was an obvious mis-match between the main reasons young people gave for not accessing health care services and the understanding service providers have of why young people do not attend.

Some very significant challenges confront efforts to improve access to health care among young people, but we are encouraged by our discovery of some innovations which appear to be having very positive effects and by the number of service providers committed to improving the situation. The research has confirmed information that was previously anecdotal, thus encouraging us to look at more far-reaching approaches. This will facilitate identification of good practice models for service application and training.

Introduction

The Access Study: A research and development program

The Access study was envisaged to encompass several phases. *Phase 1:* Formative research involving needs assessments focussed on young people, general practitioners, community health centre staff, youth health service staff, youth health workers and youth health co-ordinators. *Phase 2:* The identification, description, collation and evaluation of initiatives of health care service providers for young people that seek to: be innovative, improve access, evaluate the effectiveness of their services and offer training. The description of the main innovative models of primary health care in NSW that target out of school/homeless young people. Finally, the identification of options for innovative and sustainable models of primary health care service provision that can be subjected to evaluation, collaborate with other sectors and optimise quality of care and health outcomes for young people. *Phase 3:* the pilot and evaluation of certain of these identified models of health care with subsequent recommendations for, a coordinated approach to the delivery of sustainable health services to young people in NSW, given that different young people have different needs and no 'one size fits all'.

Phase 1 was funded by NSW Health and conducted over the period February 2001 to April 2002. The project officer, Diana Bernard: recruited and liaised with schools, divisions of general practice, community health centres, youth health services, youth health workers and youth health co-ordinators; collected, entered, collated and analysed the data; and, contributed substantially to the preparation of this report, working most directly with Dr Michael Booth, A/Prof Susan Quine and Dr Melissa Kang. The study was guided and informed by regular meetings of the chief investigators.

An Advisory Group was also formed and included: Helen Kerr-Roubicek (NSW Department of Education and Training), Michael Kakakios (NSW Health), Cindy Dargeville (Northern Sydney AHS), Liz Barrett (Rural Doctors Association), Simone Dilkara (Southern AHS), Sally Lambourne (SESAHS), Georgie Ferrari (NSW Association for Adolescent Health), Cathy Richardson (NSW Alliance of General Practitioners). The purpose of the Advisory Group was to inform the study of activities and initiatives in other sectors relevant to the study, to inform colleagues in their sectors/agencies of the study and its implications, to provide advice on the conduct of the study and to become engaged with the whole program of research and development so they might most usefully contribute to the development and dissemination of more effective models of health care delivery.

Policy context

Direct access to low or zero cost, high-quality health care is arguably the most critical aspect of Australia's health care system. Failure to receive timely treatment for common health problems may result in substantial threats to health from otherwise benign conditions. Health care providers also have a key role to play in the detection of asymptomatic conditions, in disease prevention and health promotion and as a first point of contact for a broad range of allied health services. Finally, the role of health care providers extends well beyond the treatment of somatic conditions to providing assistance to those experiencing psychological or social distress. This project was not limited to the treatment of medical problems, but also attempted to identify the social and psychological needs of young people. The central rubric by which our health care system should be judged, is that all groups within the population have immediate access to primary health care at low or no cost whenever they have a significant health concern and the right to receive appropriate advice and opportunities to maximise their health when they are well.

The NSW youth health policy, *Young People's Health: Our Future*, was launched by the Minister for Health in December 1998. The youth health policy has four primary goals: To improve the health and well-being of young people; to improve access to health services by young people; to improve the quality of services provided to young people; and, to promote partnerships both within and outside the health system. This project attempted to cover all of these aspects of health care.

Literature review

There are few published studies, which address all of the aspects of this study. Most of the published studies are from overseas, predominantly the USA and the United Kingdom and address only one aspect, generally health issues and health service provision rather than access. It is doubtful if the results of those studies would translate to the Australian health care context. Published studies in Australia have tended to be focused on localised communities. With regard to the reasons young people do not seek help when they have a health concern, there appear to be only three Australian reports.

The Youth Policy Development Council (YPDC, 1987) consulted with 3,000 young people about their health concerns and identified hours of operation of mainstream health services, lack of transport, cost (lack of bulk billing), inappropriate waiting rooms and treatment by receptionists, concerns about confidentiality and lack of knowledge of available services. The authors had not been able to retrieve a copy of this report at the time of writing so are unable to critically evaluate the methods of the study and interpretation of the data.

The Victorian Youth Advocacy Network Inc. (VYAN) conducted a study in the early 1990's (Victorian Youth Advocacy Network, 1993) to explore the barriers to access to community health centres (CHCs) by young people aged 12-25 years and to develop models of change of service delivery for CHCs. Using an action research framework, the study examined the views of young people (mostly recruited through surrounding local schools) and of community health centre staff (including workers and board of management staff separately). Via questionnaire surveys and interviews, the researchers performed health needs analyses and service evaluations of five pilot CHCs within five geographically and demographically different areas of Melbourne. The study found a range of barriers that prevented the use of CHCs by young people and made comprehensive recommendations directed at young people, community based young people's services, CHCs and the Victorian Department of Health and Community Services. Because this study had the specific intention of improving the capacity of community health centres to deliver accessible and acceptable services to young people, all of its recommendations consisted of strategies directed towards that end. The study also did not tease out any potential gender, age or socio-economic differences with regard to barriers to access.

Winefield (1995) reported a small study of 15 transcripts of consultations between an adolescent and a medical practitioner, aimed at better understanding ways of improving doctor/patient communication. The report did not come to any firm conclusions.

Veit, Sancic, Young and Bowes (1993) and Veit, Sancic, Coffey, Young and Bowes (1996) conducted surveys of general practitioners in Victoria to ascertain doctors' perspectives on adolescent health care. They found that most GPs felt that: having to access the family Medicare card; concerns about charging for the longer consultations that many adolescents require; and concerns about availability of advice for complex mental health problems were key issues that had to be addressed. Although the sample of GPs was stratified by geographic location (rural/urban), it was not stratified by socio-economic status.

A recent study (Reed, Adamson, Pinter, Stennett and Bennett, 1999), conducted under the auspices of the NSW Centre for the Advancement of Adolescent Health into access to mental health services by young people in the Blacktown LGA in Western Sydney found that: the stigma of mental illness; lack of awareness of mental health services; inadequately trained staff; negative attitudes of staff toward young people; and poor collaboration between services were all important barriers to accessing mental health services.

Aims of the study

The purpose of Phase 1 of this study was to conduct comprehensive and systematic research by collecting data from stratified groups of young people, general practitioners, community health centres, dedicated youth health services, youth health workers and youth health co-ordinators.

More specifically, the study had three main aims:

- 1 To better understand the conditions or concerns for which adolescents resident in NSW do not seek or seek, but do not receive, appropriate, good quality health care and support. Good quality health care refers to health being defined and addressed in its broadest sense. The conditions may include significant health concerns (somatic, psychological or behavioural), unrecognised symptoms of poor health, mental health problems such as depression or anxiety, abuse, neglect or homelessness.
- 2 To better understand the factors associated with failure to receive appropriate health care in terms of intra-personal, social, service and structural factors. Particular emphasis is given to understanding how these factors may vary across population groups (on the basis of gender, age, geographic location and socio-economic status) so responses may be delivered equitably.
- 3 To better understand the factors which enhance or inhibit the provision of health care to adolescents from the perspective of service providers.

This report presents the findings of Phase 1.

Methods of the study

Design

Because so little is known about health care and young Australians, it was necessary to develop an understanding of the experiences of young people with health care and its providers and of the experiences of health care providers with regard to young people. Under these circumstances, qualitative research methods were the most appropriate as they provide a range of opinions on a topic without a view to consensus. Given the breadth of the study and the large numbers required, focus group interviews were the qualitative method of choice.

Ethics

This study was approved by the Children's Hospital at Westmead, Human Research Ethics Committee, the NSW Department of Education and Training and the Human Research Ethics Committees for each of the Area Health Services in which health service staff were interviewed.

Sample selection

An important feature of this study was that we sought to develop an understanding of the issues related to access to health care based on the perceptions and experiences of both health care consumers and providers. We felt that this could best be achieved if the data were collected simultaneously in the same geographic areas, allowing clearer identification of the matches and mis-matches between the perceptions and felt needs of providers and consumers. Consequently, schools, general practitioners, youth health services and youth health workers located in the vicinity of the selected CHCs were approached to participate in the study. Due to refusals, however, not all data were collected as proposed.

Area Health Services

NSW is comprised of 17 Area Health Services (AHS). Of these, the following AHSs were selected in consultation with NSW Health: five metropolitan AHSs (Western Sydney, South Western Sydney, South-eastern Sydney, Central Sydney and Northern Sydney); one regional AHS (Illawarra); one rural AHS with a long stretch of coast line (Southern); two inland rural AHSs (Macquarie and Mid-western) and one remote rural AHS (Far West). These AHSs were selected primarily because they represented most aspects of the Sydney metropolitan area and rural/regional NSW, including the spectrum of socio-economic status, but consideration was also given to the characteristics of their populations and the nature of the existing adolescent health-related activities. Some AHSs were selected because there were few adolescent health initiatives under way and others were chosen because a great deal of innovative activity was being undertaken.

Community Health Centres

Every AHS in NSW had previously nominated at least one community health centre (CHC) on the basis of its history in being or interest in becoming a youth-friendly service. The CHCs in the selected Area Health Services were approached to participate in the study.

Divisions of General Practice

Divisions of General Practice (DGP) which, to a greater or lesser extent, overlapped with the selected AHSs constituted the sampling frame. From these, two metropolitan and two rural DGP were selected because of their strong interest in improving access to quality health care services to young people. The four selected Divisions all agreed to participate. General practitioners were paid Division rates for their participation. Representatives from two other Divisions, which were undertaking innovative work in

this field were also interviewed after it became apparent that students within the areas covered by those Divisions had been offered a service model not in existence in most other areas.

Youth Health Services

All Youth Health Services located in the participating AHSs were approached to participate in the study. Interviews were conducted with service coordinators and/or service staff individually or in small groups, depending on the preferences of service coordinators. Some youth health workers are not based within a particular service, but work across agencies or on the streets and often have contact with the most alienated and vulnerable young people. Several youth health workers were identified for the investigators by youth health service staff and were interviewed for their perspective on hard-to-reach young people.

Youth health co-ordinators

Three Area Health Service youth health co-ordinators (two urban and one rural) who had been working vigorously to improve access to health care among adolescents in their areas were brought to the attention of the investigators by NSW Health and were subsequently interviewed.

Schools

The Australian Bureau of Statistics has calculated an index of socio-economic status for each postcode area in NSW which were rank ordered and classified into tertiles. Each of the selected CHCs were located on a street map of metropolitan Sydney and all of the high schools within a radius of approximately 2-3 kilometres were identified and their postcode noted. The details of each school were tabulated by the gender of the school's students (boys, girls or both) and socio-economic status (Table 2). The schools were then approached, sequentially, to participate in the study until enough schools and students had been recruited to allow us to conduct three focus group discussions for each cell represented in Table 1.

Young people

"Young people" do not represent a homogenous population group: their needs and concerns are likely to vary with age and gender, cultural background, socio-economic status, family circumstances and geographic location. Consequently, two broad groups of adolescents were approached to participate in the study: those not engaged with mainstream education and those who regularly attended private or state schools. Out-of-school adolescents were those who did not attend school, attended sporadically or who had left mainstream education and attended alternative education programs. In-school students regularly attended either government or private schools in NSW.

In-school adolescents were stratified by:

- gender
- age; early (12-14 years), middle (14-16 years) and late (16-17 years) adolescence
- socio-economic status, and
- geographic location (urban and regional/rural).

Table 1 illustrates the cells which resulted from stratification of the sample of in-school adolescents. Note that stratification based on socio-economic status was applied to urban areas only. Although it would have been desirable to include strata on cultural background and family circumstances, the number of strata needed to understand the impact of cultural background would become unwieldy. It would also have been difficult, possibly unethical, to attempt to form focus groups on the basis on family circumstances (single-parent families, neglectful parenting).

Table 1 Stratification of the sample of in-school adolescents

	Boys			Girls		
	12-14	14-16	16-17	12-14	14-16	16-17
Socio-economic status						
Lower	X	X	X	X	X	X
Middle	X	X	X	X	X	X
Higher	X	X	X	X	X	X
Geographic location						
Regional	X		X		X	
Rural	X	X	X	X	X	X

Recruitment**Community health centres**

The information sheet and consent form, under a covering letter, were sent to the selected CHCs and follow-up contact made by telephone. The project officer negotiated a time for the focus group with those CHCs which agreed to participate, requesting a broad cross-section of CHC staff (each of the health disciplines, managers and receptionists) attend the focus group discussion.

General practitioners

Selected Divisions of General Practice were contacted and asked for assistance in identifying general practitioners with a particular interest or experience in providing services to adolescents. The project officer then sent the information sheet and consent form, under a covering letter, to the identified Divisions and negotiated with the Divisions who agreed to participate in the study to identify a suitable date for the focus group discussions. General practitioners were paid Divisional rates for their participation.

Youth health services

The information sheet and consent form, under a covering letter, were sent to the selected youth health services and follow-up contact made by telephone. The project officer described the study and the desire to conduct focus group discussions with out-of-school young people and negotiated how they might be formed and when and how they might be conducted. The manner of conducting interviews (focus group or individual) was also negotiated with the service coordinator.

Youth health workers/ youth health co-ordinators

Youth health workers with extensive experience and expertise were identified by the youth worker representative on the Chief Investigators group and an interview with them was requested in order that the study might gain their perspective and the perspective of those homeless young people who were not in touch with youth health services and therefore not likely to attend focus groups. Youth health co-ordinators who were particularly active in developing services for young people were identified by NSW Health and the chief investigators.

School students

In each of the participating schools, the liaison teacher was asked to select an "average" group of 10 boys or an "average" group of 10 girls from Year 7 or Year 8 (12-14 year olds), Year 9 or Year 10 (14-16 year olds) and Year 11 (16-17 year olds). The liaison teachers were asked to avoid selecting the most articulate or outspoken students, but to identify students who were, by and large, typical of their school year/age peers. Liaison teachers were also asked to select a group of students who

were not too disruptive and reasonably comfortable in a group situation so that they would feel more inclined to openly discuss some potentially intimate matters. The selected students were given the information sheet, consent form and parental consent form and invited to participate in the study.

Out-of-school young people

Different approaches were taken to recruiting out-of-school young people, at the discretion of the youth health service coordinator. Some were directly invited to participate by service staff and others were recruited through in-house advertising. Out-of-school young people were paid for their time.

Some out-of-school young people have little contact with health services, making it difficult, by definition, to discuss their issues with them. Experienced youth health workers were interviewed as a proxy to conducting the interviews with the young people themselves.

Identification of issues for focus group discussions

The discussion group prompts are attached in Appendix 3. The prompts were only for guidance, the convenor was at liberty (as is appropriate with focus group discussions) to follow particular themes or lines of thought that students felt were of importance.

Community health centre staff

Very little is available in the literature on the capacity and interest of community health centres to provide services for young people. However, youth health services in NSW have some considerable experience of working with community health services on providing services relevant to young people. These experiences were used to formulate the prompts for community health centre focus groups which included, but were not limited to:

- what do young people want from a health service?
- with what health concerns do young people present?
- confidence in treating adolescent health concerns?
- how are adolescent sexuality, lifestyle, risk taking behaviours and mental health issues dealt with in your service?
- perceived personal barriers to treating adolescents and retaining their confidence
- perceived structural barriers to treating adolescents (e.g., costs, length of consultation available, opening hours, lack of privacy)
- perceived social barriers to treating adolescents (e.g., lack of support from or inappropriate involvement of parents/carers)
- does management support innovative approaches and staff development?
- contact with other youth-related services in your community?
- do you have a directory of services to assist in making referrals?
- is there an opportunity for participation of young people in your service?

General practitioners

Although some good data are available on Victorian GP experiences of and feelings toward providing services for young people, this study provided an opportunity to extend and build upon those findings, considering issues related to the social environment and cooperation and communication between service providers.

The prompts for the focus groups were based on previous research involving general practitioners and young people's access to health services and on the extensive experience of several of the chief investigators and the project officer. The issues included, but were not limited to:

- proportion of patients who are adolescent

- confidence in treating adolescent health concerns
- perceived personal barriers to treating adolescents and retaining their confidence
- perceived structural barriers to treating adolescents (e.g., costs, length of consultation available, opening hours, lack of privacy)
- perceived social barriers to treating adolescents (e.g., lack of support from or inappropriate involvement of parents/carers)
- most appropriate settings for contact with young people (e.g., school clinic, practice rooms, community health centres)
- types of professional support which would facilitate more satisfactory contact with and treatment of adolescents.

Youth health service staff/ youth health workers

The discussion prompts were developed on the basis of discussions with experienced youth health service coordinators and the Executive Officer of the NSW Association for Adolescent Health and included, but were not limited to:

- do young people seek help for their health concerns and, if so, from where?
- how accessible / attractive is your service for young people?
- describe a model youth-friendly service?
- what do you see as the barriers for young people attending a health service?
- relationships with other services?
- confidence in treating adolescent health concerns?
- promotion of service to young people?
- does management support innovative approaches and staff development?
- do you have a directory of services to assist in making referrals?
- is there an opportunity for participation of young people in your service?

Youth health co-ordinators

The discussion prompts were developed from the literature and discussions with youth health co-ordinators and the Executive Officer of the NSW Association for Adolescent Health and included, but were not limited to:

- how would you describe your local community and what youth health services does it have?
- do you think that young people use any of those services?
- what do you think are some of the barriers for young people in accessing those services?
- how would you define youth-friendly services?
- what does your brief entail and how does it seek to overcome any service gaps?
- what sort of support and training is needed for staff?
- are there any systemic problems in service provision?
- are there better ways to reach young people if you are trying to disseminate information?

Young people

Issues for discussion with young people were identified in four ways: 1) issues identified in previous research; 2) issues identified by the chief investigators and members of the Advisory Group based on their experiences of working with young people; 3) the results of pilot focus group discussions; and 4) issues not identified prior to the commencement of the study, but which arose during the course of the focus group discussions and interviews.

The four key issues were:

- the health concerns (e.g., sexual health/contraception, mental health, substance use, relationships) for which young people do and do not access a health care provider
- the reasons for not accessing a health care provider (unavailability of service; hours of operation; lack of transport; cost; waiting time; waiting room/receptionist; provider characteristics (gender, age, manner); confidentiality concerns; privacy concerns; discomfort with raising some health issues; concerns about reaction of parent/carer; lack of support from parent/carer; provider fails to provide sufficient consultation time; lack of awareness of services; uncertainty of when symptoms should be treated
- positive experiences or perceptions of health care services
- desirable characteristics of services (the “ideal” service).

For the issue “identifying reasons for not accessing a health care provider”, the list of reasons was not provided directly, but was elicited from participants in the first instance to establish their self-reported concerns. Reasons on the list which were not reported by participants were then raised by the moderator. In addition to the predetermined issues, the focus groups provided the opportunity for the moderator to pursue any emergent issues.

Data analysis

The research in Phase One focussed particularly on young people. Given the range of socio-demographic characteristics (age, gender, socio-economic status, urban/rural location) amongst young people it was necessary to conduct a large number of focus groups in order to obtain sufficient numbers for analysis within each cell (see Table 1). Eighty-one focus groups were conducted in 28 schools across the state. There were 35 groups of boys and 46 of girls selected across the three socio-economic strata and three age groupings. While the majority of focus groups were conducted in urban area (56 groups), there was strong representation of rural areas (22 groups) and some representation of regional groups (3 groups).

All focus group sessions were tape-recorded and transcribed. Given the very large number of groups (81) only 51 were entered into the NUD*IST software program, as more than this would prove time consuming and unnecessary given that ‘Theoretical Saturation Point’ had been reached. Theme groupings (nodes) were constructed which included the overall impressions so that data could be selected into those theme groupings. A command file was set up to look for words associated with those themes. The transcripts were then formatted so the information could be analysed in conjunction with NUD*IST 4. Tables with demographic data were added to the program so that the analysis could look for connections across groups, e.g., “what all Year 9 girls said about contraception” and which demographics this included or “what all service providers said about barriers”.

The transcripts of the 30 focus groups not included in the primary analysis were searched manually for any further relevant information. NUD*IST was also used to analyse the data from the focus groups conducted with GPs, CHC staff, youth health workers and out-of-school young people. For these groups, all data were analysed as the number of groups in each category was smaller. The findings are presented in text form with “*verbatim quotations*” for illustration. Qualitative data are not subject to statistical analyses, however, where an issue is repeatedly emphasised this is noted in the text as a general theme.

Findings of the study

Description of the sample

The community health centres, Divisions of General Practice, schools and youth health services which participated in the study, stratified by Area Health Service, are shown in Table 3. Six focus groups were conducted with CHC staff (four urban, two rural) and one regional worker was interviewed in depth. Four groups were conducted with Divisions of General Practice (two urban, two rural) and the principals of two further Divisions were interviewed in depth (one urban, one rural). Five focus groups (three urban, two rural) were conducted with out-of-school young people, most of whom were homeless. Nine youth health workers in seven centres (5 urban, 2 rural) were interviewed.

Among in-school adolescents, a total of 81 focus groups were conducted in 28 schools: 35 groups of boys and 46 groups of girls. Of the 81 groups, 22 were conducted in rural high schools, three were conducted in regional high schools and 56 were conducted in urban high schools. Table 4 shows which schools were in which socio-demographic strata (that is, which groups were conducted in which schools). Data saturation was reached before all focus group discussions were completed so only 52 of the groups were included in the NUD*IST analysis (Table 4). However, the remaining groups were scanned for any extra information.

Conditions for which adolescents seek, or do not seek, health care

The first section presents the findings related to the first aim of the study: *To better understand the conditions or concerns for which adolescents resident in NSW do not seek or seek, but do not receive, appropriate, good quality health care and support.* Before this issue is specifically addressed, we report young people's understanding of "health" and the kinds of events or experiences which they felt were likely to impact on their health.

Definitions of health

Most young people initially defined health in purely physical terms. Definitions included *"fitness, food, your physical state, hygiene, keeping your body in good condition..."* In response to probing, some young people accepted the relevance of sexual and mental health being included, but would not include them in a definition in the first instance. Those who included aspects of health other than physical well-being were all in Year 11 (with one exception in Year 10). Of these, females (9/11 groups) were also more inclined to have a broader definition than males (2/9 groups), including mental, sexual and social aspects of health in their definitions. Age and gender were therefore relevant factors in defining health more broadly.

Definitions of health did not vary with socio-economic status or with urban/rural place of residence. Out-of-school young people (who tended to be in the 15-17 year age group) tended to have broader definitions of health, including physical, emotional, social and psychological aspects of health.

Table 3 Community health centres, schools, Divisions of General Practice and youth health services which participated in the study, stratified by Area Health Service

Area Health Service	Community Health Centre	Schools	Division of Gen. Practice	Youth Health Service
Western Sydney	Blacktown CHC	Blacktown HS Belmore BHS Merrylands HS Chester Hill HS Sefton HS	Western Sydney	High St, Harris Park ⁺ Traxside, Campbelltown [#]
Sth. Western Sydney	Merrylands CHC/Peers	Bossley Park HS St Johns Park HS Bonnyrigg HS Holroyd HS	Western Sydney	Flyght Youth Health Service ⁺
Central Sydney		Kingsgrove Nth HS Canterbury GHS Belmore North BHS Cranbrook School (Eastern Sydney)		Cellblock Youth Health Service ⁺
South-eastern Sydney	Child, Youth & Family Team, Sylvania	Picnic Point HS Menai HS	St George/ Sutherland	AHS Youth Co-ordinator [*]
Northern Sydney		Mackellar GHS Manly HS Balgowlah BHS Queenwood School SCECGS Redlands	Hornsby [*]	AHS Youth Co-ordinator [*]
Southern				AHS Youth Co-ordinator [*]
Mid-west	Orange CHC	Orange HS Canobolas HS		
Macquarie		Dubbo South HS Dubbo HS	Dubbo Plains	
Illawarra	Bulli CHC* Nowra CHC	Bomaderry HS Shoalhaven HS Nowra Tech. HS	Shoalhaven*	Shoalhaven Youth Service ^{+#*}
Far West	Broken Hill Primary Health Service (CHC)	Willyama HS	Barrier Division	AHS Youth Coordinator /OSYP ^{++*}

+ Out-of-school young people focus groups conducted

* Interview with principal only

Interviews/focus groups conducted with youth health service staff

Table 4 Schools in each stratum of socio-economic status and rural/regional areas

Strata	Boys			Girls		
	Year 7/8	Year 9/10	Year 11	Year 7/8	Year 9/10	Year 11
Low SES	Belmore Bonnyrigg	Belmore Chester Hill Merrylands Sefton	Belmore Bonnyrigg Merrylands Holroyd	Chester Hill Holyroyd Merrylands Sefton	Bonnyrigg Holroyd	Chester Hill Merrylands Sefton
Medium SES	Bossley Park Kingsgrove Picnic Point	Kingsgrove	Bossley Park Picnic Point St Johns Pk	Blacktown Canterbury St Johns Pk	Blacktown Bossley Park Canterbury Picnic Point St Johns Pk	Blacktown Canterbury Kingsgrove
High SES	Balgowlah Cranbrook SCECGS	Balgowlah Cranbrook Manly	Cranbrook Menai	Mackellar Manly Menai Queenwood	Mackellar Menai Queenwood SCECGS	Mackellar Queenwood SCECGS
Rural	Broken Hill Nowra	Dubbo Snr Dubbo Sth Orange	Bomaderry Canobolas Shoalhaven	Bomaderry Canobolas Dubbo Sth Orange	Bomaderry Broken Hill Canobolas Nowra Orange Shoalhaven	Broken Hill Dubbo Sth Dubbo Snr Nowra
Regional	Bulli		Bulli		Bulli	

Health issues

Despite their narrow definition of health, young people identified a broad range of events, situations, conditions or behaviours which they believed might impact on their health. The two issues young people identified as by far the most difficult to seek help for were sexual assault and mental health. The health issues include:

- mental health issues (such as suicide and depression)
- sexual issues (such as sexually transmitted infections, contraception, teen pregnancy and date rape/sexual assault)
- drug and alcohol issues (including cigarette smoking, marijuana use and the use of other illicit substances)
- social issues (such as lack of recreational activities leading, at times, to risky behaviours)
- stress or pressure (including from school, family and/or peers)
- diet and body image
- bullying
- safety (including on the street and at home)
- relationships
- employment and educational opportunities

and some less frequently mentioned issues including:

- female teachers perceived sexism towards male students
- transport.
- poor self esteem
- money

- homelessness

Initial analysis of these issues showed that expression of issues is not associated with socio-economic status. However, some issues were mentioned more frequently or were of greater importance at certain ages, for a particular gender or for out-of-school young people. Out-of-school young people (the majority of those we interviewed were homeless); were more focused on issues pertinent to them such as: drug and alcohol use; accommodation; staying safe; trying to finish school and getting a job. Their views are encompassed by the following quote *"health is a low priority if you don't feel good about yourself. You only think about it, if the other stuff is OK. I guess what you think about are food, hygiene, where you can get showers and how to stay safe on the street"*). The analysis also suggested that certain issues are more prominent in rural areas. Young people's views in regional areas involved in the study were more similar to those of young people living in rural areas compared with those living in urban areas. The following differences were most notable:

- Street safety was the only issue mentioned more frequently in lower SES areas as well as in a particular rural community where it was a significant issue. It was of greater concern to the younger groups (up to and including Year 10) and to girls and to out-of-school young people living on the streets.
- Tobacco use was frequently mentioned, but was not of great concern to young people. Young people discussed the fact that peer pressure created early smoking behaviour with many stopping in the older (Year 11) school years, if not addicted. The exception was a small number of girls who took up smoking to control their weight. Smoking is most prominent in Years 9 and 10 and there was a consensus that more girls than boys smoke.
- Alcohol use was also more prominent among Year 9 and 10 students with more boys than girls being heavy drinkers. It was widely perceived that certain ethnic groups were less likely to drink, particularly girls. Again, there were no noticeable SES differences. In one rural setting, there was also a high prevalence of drinking in the adult community which was thought to contribute to young people's heavier drinking.
- Suicide was seen as more of a male issue (although females were also concerned about it) and was of greater concern in rural areas. Depression was of concern to both genders and a more prominent issue for the Year 11 groups and for out-of-school young people.
- Bullying was a widespread concern, although concern was more prevalent amongst younger boys as they were most likely to be victimised. The bullies were in older year groups. Females also discussed bullying to a lesser degree, focussing more on verbal bullying. There were no noticeable SES or rural/urban associations.
- Discussions around drugs canvassed young people's knowledge of themselves/peers using and which drugs were available. Marijuana was the most widely used drug across all SES strata and among the older students. There was some indication that drugs such as cocaine, speed and ecstasy were more available amongst higher SES groups. Drug use appeared to be as widespread in rural communities as in urban and tended to more of an issue for older students, beginning around Year 8 or 9. Drugs were discussed more widely by girls than boys, although differences between genders in drug taking were not indicated. Drug use was a prominent issue for out-of-school young people who were living on the street.
- Family stress included issues such as divorce and was mentioned more frequently by boys and by out-of-school young people. School stress was widespread, particularly among the older age students, across all SES strata and urban/rural

settings. Recently immigrated students appeared to experience greater stress as a result of parental pressure to achieve.

- Lack of social or recreational activities was discussed at length by girls living in rural areas whereas males often occupied themselves with sporting activities. This issue was rarely mentioned (two groups) by students living in urban areas, but was mentioned by out-of-school young people.
- Discussions around financial issues/cost related to the pressures of juggling part-time work and school work and the need for a part-time income. This issue was slightly more prominent amongst females, lower SES groups, older students and in certain rural areas.
- Limited employment and educational opportunities were issues for those living in rural areas where there were limited apprenticeships, opportunities for vocational training and a need to leave town for further studies. This was an issue for both genders and for out-of-school young people in particular.
- Teen pregnancy was also a prominent issue in rural settings (with one exception in a lower SES urban setting). This issue was primarily of concern to girls, particularly Years 9/10.
- Sexual health, contraception, the morning-after-pill and date rape were also of high concern to females in all age groups, but predominantly those in Years 10 and 11. It was of roughly equal concern across all SES strata, but was of greater concern among rural students as a result of the extra difficulties associated with gaining access to contraception and issues of confidentiality.
- Body image/diet was predominantly a female issue across all ages although less so among Year 7 girls. A few older male groups also discussed being conscious of body image, but to a far lesser degree. Body image was particularly of concern in urban and rural settings where there was a predominant 'beach culture'. No associations with SES were indicated.

Young people's preferred sources of help

Having identified the issues young people perceived as posing the greatest threat to their health, we then sought to discover where, or from whom, young people are most likely to seek help when confronted by one of these health concerns. The overwhelming answer to this question was that *if* they discussed these issues (and many simply did not), the majority discussed them with friends, family or relatives, in descending order of importance. Two-thirds of females and 1/3 of males identified the following people as sources of advice or support when they had a health concern, in descending order of importance:

- Friends
- Parents (especially mothers)
- Siblings
- Friends of the opposite sex (mostly males approaching females)
- "*People you really trust*"
- Other family members (e.g., cousins)
- No-one (1/3 females, 2/3 males)
- Priest
- Responsible community elder (certain ethnic groups)
- Youth leader

The two most striking features of this list are that: 1) only a small number of young people considered seeking help from a service provider and, even then, had usually come to know a particular service provider by coincidence and had formed a positive relationship with them, and, 2) approximately half of all young people, particularly males, did not seek help from anyone at all. Because young people viewed health primarily in physical terms (particularly males) they accepted GPs, medical centres and

A&E departments of local hospitals as appropriate for attending to these concerns. A small number of older girls (members of 6 groups) also attended GPs, medical centres or women's health centres for access to contraception and related sexual health information. However, young people were generally unaware that GPs might be trained in other skills such as counselling, and, when prompted, were dubious about the possibility of service providers having such skills.

Almost no young people had ever heard of community health centres (except where there was a pilot program run by the local CHC in one rural area) and thought they were places where "*old ladies go to knit*". Further barriers to young people accessing health service providers are discussed in the next section.

Females sought help more than males and age was relevant in that younger adolescents (Year 7) were more inclined to seek help from their parents whereas older adolescents (Years 10 and 11) were more inclined seek help from their friends. A small proportion of older females (Year 11) had good relationships with and sought help from their mothers, but there were clear exceptions to the rule. There were no noticeable urban/rural or SES differentials in help-seeking behaviours. Out-of-school young people were just as reticent in seeking help as other young people and gave the same reasons as other young people with some additional ones specific to their circumstances.

Young people's use of service providers

When young people did seek help from a service provider, they approached the following, in descending order of importance:

- GPs they knew and trusted
- School counsellors (also out-of-school young people before leaving school)
- Youth health/youth services (out-of-school young people)
- Centrelink (out-of-school young people)
- GPs that they did not know (on purpose) (and out-of-school young people before they became homeless)
- Counsellors not based in schools
- School year advisers
- Other school staff (e.g., a trusted teacher)
- Community telephone counselling services
- Women's health service
- Adolescent mental health service

It should be noted that this issue of barriers to accessing a school counsellor was only discussed in five of the 51 focus groups conducted with females and three of the 51 focus groups conducted with males. However, a number of out-of-school young people mentioned having spoken to school counsellors before things "*fell apart*".

Counsellors, not based in schools were located by parents. The list indicates the importance of "on site" contacts in schools and contacts with GPs. Again, females were slightly more likely to seek help and younger adolescents (especially Year 7 males) were more likely to seek help from school counsellors. Whereas most young people were aware of school counsellors and some young people sought help from them, there were significant barriers to using them which were discussed in most groups (see below). Other services young people were aware of included: the police, refuges, safety houses, Police Citizens Youth Centres (PCYC), youth centres (drop in), youth groups (usually church run), Reach Out, Juvenile Justice, Job Placement Education and Training Program(JPET), Centrelink, Salvation Army, Kids Helpline, Department of Family and Community Services, psychologists, Jenny Craig, local council and, rarely,

a community health centre. Knowledge of youth health services was largely restricted to out-of-school young people.

Out-of-school young people also chose not to access services unless they were in crisis or had heard "*positive word on the street*" about the service. Their barriers to accessing services were the same as those expressed by in-school young people with additional reasons including: self-esteem; drug use; and perceptions of being perceived by service providers as "*street rats*". Knowledge of services and what they provided was limited among all young people across SES strata, gender, age and rural/urban settings with slightly greater knowledge among older adolescents (Year 11), particularly in relation to contraception. Out-of-school young people were far more likely to be aware of available services. Younger adolescents (Year 7/8) generally had very limited knowledge of services and tended to assume that their parents would take them somewhere if they required help. There were substantial gender differences with regard to acknowledging and accessing services (more females). Access was generally accidental in the first instance. That is, young people attended a GP for a physical health issue and formed a good relationship and knowledge of what was provided, or because of active publicity by a service (e.g., GP/CHC services in schools or women's health centres across the road from the school). Older (Year 11) adolescents were more able to deal with appointment systems for service providers than younger adolescents. Out-of-school young people often used a service for the first time under duress, e.g., they were sent to a youth service by Juvenile Justice or Centrelink and then formed a positive relationship with the service provider. They valued the medical service provided in youth health services and by some GPs.

The only SES differences were that young people attending private schools suggested that their parents might access private counsellors if they saw a need. They were, however, no more inclined to attend than other young people. As one Year 9 girl at a private school commented "*I don't think anyone voluntarily goes...they would be ostracised*".

Although young people knew little about services, they stated that they would not tend to use them even if they did know more about them: "*...you go to someone you know and trust and they know you*".

Young people's barriers to accessing services

The following were mentioned by young people as barriers to accessing services, in descending order of importance:

- Confidentiality/trust (referred not just to service providers keeping issues confidential, but also in relation to being seen going to a service)
- Embarrassment
- Feeling vulnerable/scared/ashamed/stupid
- Don't know about service or what it offers
- Don't think I need to
- Find it difficult to talk about health concerns
- No one will be able to relate to the issue
- Service provider has a different background from out-of-school young people (they went to university and are perceived to have had a happy family life)
- Cost/waiting lists (GPs only)
- The service provider has not experienced the situation, so would not understand
- Services are not friendly
- Pride
- Don't feel good about self/self-esteem
- They would judge and criticise you

- Wrong gender (usually mentioned by females)
- It's not manly to seek help
- Inadequate transport
- They talk to my parents and ignore me
- They are not trained in ...
- Opening hours are inconvenient

Positive and negative experiences

Young people were invited to relate their positive and negative experiences of interactions with service providers. The negative experiences or failure to receive appropriate care included:

- *"I felt awkward"*
- *"They did not care"*

The positive experiences included:

- *"They help you think it through"*
- *"Someone listened to me"*
- The right gender (usually female)
- *"I think people come here (youth health service) and realise it's such a positive place, they feel comfortable and relaxed and that is a good start" (out-of-school young people)*
- *"It touches our hearts when you come to a place like this (youth health service) and they say 'how are you/what can I do for you'. It makes us feel a bit confident." (out-of-school young people)*

Most significant issues

By far the most significant issues were concerns about confidentiality and trust in the context of the patient/provider relationship and having to deal with feelings of embarrassment, fear and/or shame in disclosing health concerns. In order of significance, the next major barrier to accessing services was lack of knowledge of services among young people.

Confidentiality related to perceptions held by young people that: GPs had to inform parents, of the nature of the disclosures (especially if they were under 16 years of age); and, that school counsellors would tell the school principal or their parents about their disclosures and that they could gossip to other teachers. There was little understanding of the safeguards for young people around confidentiality, especially those related to self - referrals. The young people were also concerned that if they went to the school counsellor the other students would know, (as some schools call students out of class) or that they would be seen going into the counsellor's office. A Year 10 girl expressed these sentiments:

"...not many people trust the school counsellor because they think everything is not confidential and that there will be a report given to the principal".

Young people were also concerned that if they told their parents of their concerns, they would remind them of it constantly and that if they told their friends, they would gossip. One Year 11 girl encapsulated many views, especially those of young people in rural areas with:

"some people don't even know where to go to get the pill and they are too scared to go anywhere anyhow and even if they did, this is a small town and everyone knows everyone, so it's going to get around and that is not what young people want..."

The only young people who reported that they would willingly access a service were those who had had the opportunity to develop a positive and trusting relationship. For example, one rural CHC ran a clinic in the school, allowing the students to get to know and trust them. Another example was that some young people had formed a trusting relationship with a GP after attending for a physical ailment and subsequently felt more comfortable about raising other issues with them. Yet another group of young people had been exposed to an education program in school run by GPs and said that they were somewhat more likely to use their services or the other services that the GPs had informed them about.

Out-of-school young people stated that the greatest facilitation to their utilising a service was “*positive word on the street*” and young people at school also stated that if their friends recommended a service, they were more likely to consider using it.

Where do young people hear about services?

Young people were generally unaware about services in their local communities and elsewhere, other than GPs/medical centres or services that they happened to walk right past. Most had no idea what a community health centre was or what services it offered. The best known service was Kid’s Helpline which is advertised on all bus passes. Some schools handed out further service providers numbers (often drug and alcohol services) on wallet-sized cards, (although they were usually 1800 numbers rather than local, making them less user-friendly). Females were more likely than males to keep these cards. Males reported that they usually threw the cards away and did not listen to speakers in school assemblies because it was “*not cool*”. Speakers were more likely to be attended to by both genders if they had an angle, i.e., Had been in the situation themselves or were young. Older adolescents (Year 11), particularly females, were more interested in finding out about services, stating that they would have liked the information earlier (in Year 9 or 10). As one out-of-school young person said “*It takes time to get the message. The person has to want to get it. They have to want help*”. Out-of-school young people knew of a broader range of services because of their experiences which had often put them in touch with them (e.g., Juvenile Justice or Centrelink). However, they also said that they generally chose not to use services until they had to and that the most convincing information was word-of-mouth from other out-of-school/homeless young people.

Two programs run in rural areas appeared to be effective in terms of effectively engaging young people. One involved CHC staff running a clinic in a school on a rotational basis to provide a range of medical, sexual health, drug & alcohol, mental health and general counselling services. Students stated that they would actually go to the service in its other setting if necessary. As one Year 11 student summarised:

“I think its (school clinic) great because its at school. If it wasn’t on site, a lot of girls would never have gone down to the centre first because of all the other people around. It gets too embarrassing. So it’s a good thing that it is at school and everyone can access them for counselling or anything. Even the boys go, to get condoms and lube.”

The other innovative program involved GPs conducting presentations at local schools, describing what GPs do, how to access them and offering one or two sessions on specific issues nominated by the students. The GPs also handed out information kits on other local services. The young people who had been exposed to this initiative were almost the only ones who knew about local services and some stated that they were subsequently more inclined to seek help from these services.

Other sources of general information for young people were parents, older siblings, relatives, the Personal Development, Health and Physical Education school curriculum, school assignments, teachers, school counsellors, year advisers, Kid's Helpline, Centrelink, the family doctor and Job Placement, Education and Training Program (JPET).

How do young people think services should advertise/educate

Young people in school thought there should be:

- “*Real life*” people coming to school, talking about their experiences and the warning signs, particularly well-known people from theatre, music, sports and/or young people
- More *interactive learning* about health care access issues in Personal Development, year groups, the syllabus and handouts which were “*to the point and written by young people*”
- *Advertising* in shopping centres, newspapers, billboards, posters and TV peak times especially around young people’s shows such as *Home and Away*. The youth centre in *Home and Away* was constantly mentioned as an ideal model.
- Advertising on bus passes and buses
- Talkback *radio*, including Star FM, JJJ
- Advertise that services are free
- Skateboard competitions/run youth days/dance parties/Mardi Gras/local bands
- *Educate parents* more so that they can inform young people
- Get school counsellors to speak at school assemblies about what they do, what issues you can go for and how to access services
- Word-of-mouth
- McDonalds and other *food outlets* frequented by young people
- *Incorporated into school life* in some way
- *In-your-face advertising* so young people will notice (like the drink/drive/domestic violence advertisements) especially on depression and eating problems
- Advertising in *magazines*: especially sport for boys (including cars, surf, rugby and basketball). *Dolly*, *Girlfriend* and similar publications for girls as well as *TV Hits* and *Smash hits*
- *Internet health sites* like the National Drug website which young people thought was good

and for out-of-school young people education/advertising should also be at the soup kitchen, JPET, Juvenile Justice, Centrelink and TAFE.

What young people want in an “ideal service”

Young people in school want:

Type of service

- Someone to talk to in schools. It is easier to make contact if services are linked with schools. “*School is one of the best places you can hear about stuff, it’s a fantastic opportunity*”...+++”...*It is a good thing it’s (special CHC clinic) at school because people can access that*” “...*if it wasn’t (at school) a lot of girls wouldn’t go down to the hospital because there are all those people around, it gets too embarrassing*” and “...*incorporated into school life in some way because it’s hard to take that first step*”

Peer education and/or real life positive role models

- who have been through it (depression, drug and alcohol problems) so they can talk about how they managed and how they got help +++

Group discussions

- with young people with similar issues *“because they understand and relate to each other, e.g., divorce, depression, bullying”* +++ and *“if they know people in the group they will feel comfortable talking about their lives”*
- General groups on special issues like stress, sex, drugs, depression, some single sex and some mixed (discussion of depression and other mental health issues were particularly requested by males to be single-sex groups) +++

Type of service/not in schools

- Something that resembles a home, casual, informal, well-publicised with welcoming and friendly staff with good listening skills (including reception staff) because as one person succinctly put it *“the first thing is to get people comfortable and get them to open up a bit.”*
- Music, comfortable sofas, TV, food, pool tables, ping pong, showers, laundry, access to people of all backgrounds, different languages, space for young people to have coffee and cigarettes and engage in informal chat, a place that is alcohol and drug free, colourful, open until late, good music, break-dancing, skateboarding, male and female workers, sexual health information and emotional counselling. +++
- Physical set up is not as important as the atmosphere
- Not to have to use your real name at the service
- Open weekends, holidays, afternoons from 3.00 +++

Well-publicised

- *“so all kids know about it because there probably are good places to go but no body knows about them”* and *“It needs to be advertised in front of teenagers (probably at school) so they know they can go there and people need to say ‘...if you need help this is where you can go and what they can do for you...’”*.

More education

- *“A person is nervous going to see a Dr(GP). It is too formal. We need to be educated on going to see GPs. Each school should have someone in charge of youth issues. Kids get educated on using GPs and parents get educated on drugs and young people.”*

More done about prevention

- as well as education, i.e., explaining to young people that drug and alcohol misuse are only symptoms of not being happy and to get help instead of just education on the *“effects of drugs and alcohol”*

Types of service providers

- Someone who understands. *“It makes a big difference if you feel understood”*
- Straightforward answers and counsellors who have been there
- Female doctors
- Tolerance of people from all different backgrounds

Confidentiality,

- respect, other languages, Medicare cards or free service *“if they are welcoming, you end up building a relationship”*

A youth web site

- *“with general information on sport, music, health and where you could talk to a counsellor on line if you needed to”* (particularly a male request)+++

Videos

- *“to explain things we are going through (including issues) such as “getting over wars” and “adapting to other cultures”*

Telephone services

- *“can be good because they are confidential and if you don’t feel you can get there at least you can talk about it”*

Youth specific

- *“I think if services are community orientated they won’t be used to their full effect. You should make the services exclusively for young people” +++*

Out-of-school young people also want:

More parenting assistance in the early years

To be treated with respect +++

• *“...the ones listening to you are the ones you want to go to” and “it touches our hearts when you come into a place like this (from where we come from), not knowing and being a bit confused and a bit scared and you have these nice, beautiful people come up saying ‘how are you, what can we do for you?’. It makes us feel a bit confident”.*

Training

- More DOCS training on how to help kids, not just remove them
 - Literacy, numeracy, living skills, courses on finishing year 10, help with employment
- +++

Work on self-esteem

(possibly through art, music and peers)

- Drop-in centres as well as a travelling van with a nurse, counsellor and condoms/ needles etc.

Activities

such as pool because *“street kids would rather do something, not just hang around on the street all day”*

Key: +++ means spoken about by many different groups of young people.

Service providers’ barriers to working with young people and their education/training needs

This section relates to the third aim of the project which was *“to better understand the factors which enhance or inhibit health care provision to young people from the perspective of service providers, particularly community health centre staff and general practitioners”.*

General practitioners

Table 5 summarises general practitioners’ reported barriers to working effectively with young people and Table 6 summarises their support and training needs. Barriers to service provision appeared to cluster under five main factors: cost/time factors; communication with young people; having sufficient support and backup from other services; not having the flexibility to deliver services appropriately (e.g., outreach, hours of opening) and, having the requisite skills and confidence to meet the needs of young people.

Cost and time issues are intimately related for GPs. The main issue was that GPs felt that young people needed long consultations to build a relationship and because it took some time for young people to identify the purpose of their visit. Many felt that they did not have the time for many long consultations due to excessive workloads, the type of practice in which they worked (e.g., solo practice) and because long consultations are not cost efficient. A related issue was that some GPs felt that they needed to promote themselves to young people, in order to attract them to their practice, increase awareness of the service they provided or work in different ways to work effectively with young people (e.g., outreach or drop-in clinics), but simply lacked the time to do so.

Table 5 General practitioners' barriers to working with young people

Barriers	Rural 2 groups	Urban 2 groups	Total groups out of 4
Cost/time factors			
Cost unacceptable due to long consultation or extended follow-up	2	2	4
Consultations take too long and demand for service is too high/ waiting lists put young people off/ no designated adolescent worker	1	2	3
Don't ask questions as scared to unleash long answer	1	1	2
No time to promote services due to other client demands	1	1	2
Limited opening hours	0	2	2
Fear of broken appointments and doctor shopping	0	2	2
Apprehensive about young people: Think they want short wait /long involvement	1	2	3
Adolescents don't fit with normal GP success measures: diagnosis/plan/compliance/follow-up	1	1	2
Communication			
Difficult to know why they are really here/ what we can offer	1	3	4
Want to bring in peers, raising issues of confidentiality	0	1	1
Different agenda	0	1	1
Difficult to establish good rapport especially with non-verbal boys	0	1	1
Not voluntary patient/brought by parents and not interested in working together	2	1	3
Single sex staff	1	1	2
Socio-economic differences in background	0	1	1
Support/back-up			
Sitting waiting for young people to come to us/ few referrals	1	1	2
Stress of dealing with suicidal or depressed patients with poor mental health backup	2	2	4
Community health staff turnover means no support (especially in mental health)	2	2	4
All services compartmentalised making it difficult to work together e.g., D&A, mental health	1	0	1
Skills/confidence			
Lack of skills & knowledge in area	1	0	1
Young people have drug & alcohol problems - don't want to treat these	1	1	2

Issues of communication were more likely to be raised by urban GPs and focussed primarily on the difficulty many young people have with directly explaining their health concerns. Communication problems were sometimes exacerbated, when young people were forced to attend by their parents, when they wanted to take a friend into the consultation, when they perceived very different backgrounds of doctor and patient and ideas GPs had on what constituted success in doctor-patient relationships (e.g., compliance), as well as different perceptions of what represented a significant issue (e.g., relationship concerns). Connections with and support from other specialist services was a very significant issue for all GPs, but more so for rural GPs, particularly for specialist mental health services as they had fewer services to begin with. Finally, GPs mentioned that they need to further develop their skills in communicating and dealing effectively with young people and further improve their knowledge about specific adolescent health issues and understanding the matters most relevant to them (e.g., relationships).

Table 6 summarises GP's suggestions for improved training and professional support. Although GPs identified some key areas in which they would like to improve their knowledge, they placed greater emphasis on the need for greater professional support and networking (particularly mental health). One of the key areas for development was collaborative approaches with other disciplines (particularly mental health), a second was to become more involved with outreach programs, schools and participating in workshops with young people. Financial support was also crucial to enable these activities.

Table 6 General practitioners professional support and training needs

Professional support & training needs	Rural 2groups	Urban 2 groups	Total groups out of 4
Training			
Eating disorders, mild mental illness, how to deal with adolescents, grief/loss counselling, crisis intervention, treating depression, conflict mediation between parents and adolescents	1	1	2
Support			
Hearing from other practitioners about what works with adolescents	1	0	1
Division web site information on services	0	1	1
Workshops where young people are involved	1	0	1
More mental health consultancy/support	1	1	2
Improved linkages with other health services/ ongoing relationships/ develop interest groups	2	2	4
More outreach. Working with schools, school counsellors and other staff, Student Representative Council	1	0	1
Use GPs who want to work with or are experienced with adolescents	0	1	1
Work on workers' attitudes, biases and myths	1	0	1
Division payment for work, training, facilitating in schools. Adolescent health program in Divisions to raise profile	2	0	2
Develop systematic approach for feedback to GPs	1	0	1
Have multi-skilled service centre where young people participate	1	0	1
Do more group work, drop-in	0	1	1
Have a group practice where some GPs do more long consults, others short	0	1	1

Community health centre staff

Table 7 summarises community health centre staff's barriers to working with young people and Table 8 summarises their support and training needs. The reported barriers to service provision were generally very similar to those reported by general practitioners. They appeared to cluster under three main factors: time (i.e., work load limiting time for follow up); skills (having the requisite skills and confidence to meet the needs of young people); and, service organisation issues (e.g., the main brief of most CHCs not being adolescents). The last seemed to be of greatest importance.

Most of the desired types of support were related to the organisation of the service and the limitations that placed on the capacity of staff to meet the needs of young people in innovative ways, including outreach.

Table 7 Community health centre staff barriers to working with young people

Barriers	Rural 3 groups	Urban 3 groups	Total groups/ 6
Time factors			
Time demands unacceptable due to extended follow-up required	0	1	1
No time to promote services in community due to other client demands	0	1	1
Limited opening hours	1	2	3
Not voluntary patient/client-brought by parents and not interested in working together	1	0	1
Skills			
Demand for service is too high/ no designated adolescent worker	1	0	1
Lack of relevant skills & knowledge	2	0	2
Staff access to appropriate training difficult	2	0	2
Community health practice not good fit with adolescents eg. CBT therapy	0	1	1
Service organisation			
Service is in hospital so they don't come	2	0	2
All services compartmentalised/makes it difficult to work together e.g., D&A, mental health	2	1	3
Area/Practice has inflexible service/prohibits outreach/lack of cars	1 regional	2	3

Table 8 Summary of community health centre staff training and support needs

Professional support & training needs	Rural	Urban	Total/6
Communicating with adolescents, especially those with serious mental health problems	1	1	2
Workshops where young people are involved	1	0	1
Improved ongoing relationships with other service providers especially schools/development of interest groups	1	1	2
More outreach. Work with schools, school counsellors, teachers, Student Representative Councils	2	0	2
Linking young people more with their communities and family systems	1	1	2
Use workers/GPs who want to work with/are experienced with adolescents	1	1	2
Work on workers attitudes, biases and myths	1	0	1
Funding for continuing education (high cost for rural staff)	1	0	1
Have multi skilled service centre where yp participate	2	1	3
Do more group work /drop in	2	0	2

Youth health workers and youth health co-ordinators

Youth health workers chose specifically to work with young people, had some training in the field and therefore seemed to be more comfortable with working with them. However, they did mention that some workers:

- were scared of young people in groups
- were overwhelmed by the number of depressed or suicidal adolescents they had to see
- stated that drug and alcohol issues were sometimes too difficult to deal with.

Other barriers to providing an optimal service tended to be service provision issues:

- Unsuitable buildings
- Lack of finances in general and financial support for training, in particular
- Inadequate infrastructure and support (e.g., staff, fax machines, supervision)
- No payment for overtime

Youth health workers and youth health co-ordinators felt that they were successful in working with young people because of their flexibility as individuals and in service provision. Most were working with marginalised young people rather than those who still felt well supported by family and school.

Youth health co-ordinators

Youth health co-ordinators generally had responsibility for an Area Health Service and, because there were no youth-specific health services or youth centres in their areas, were there to represent youth issues. Both they, and the youth health workers had an excellent understanding of young people's health issues and the difficulties they experienced in seeking help, although they also thought that the physical aspects of a service represented a significant barrier for young people, whereas young people said it was more about the atmosphere of a place. They also involved young people more in feedback about the service and connected with other youth services, but not necessarily with GPs or community health.

The following quote indicates how they see the provision of service “we see it as our responsibility to hear what young people are wanting and then fit in the health bit” and “health services should not be waiting for young people to come to them, but should use a settings-based approach, going into settings where young people live, work and play.”

Service providers’ perceptions of young people’s barriers to using services

Service providers’ perceptions of the barriers to accessing health care services can be classified into three categories:

- Structural issues such as: time available for consultations; long waiting lists; the need for an appointment; opening hours; cost; transport; inflexibility of service delivery provision/response time/multiple service locations and GPs too old
- Personal issues such as: pressure by others on them to seek help; not being able to take a buddy (especially females); feeling vulnerable or ashamed about their health concerns; concerns about confidentiality and lack of confidence
- Lack of awareness of the existence of services and the kinds of health concerns GPs were able to address

How do service providers currently advertise their services?

- Newsletter to young people from data base of clients
- Pamphlets
- ‘Phone in’ for adolescent reference groups, focus groups, graffiti/pizza parties for information from young people
- Incentives for young people to participate e.g., transport
- Unique CHC model: Drop-in clinic at school creates word-of-mouth. Take part in: school welfare committee; youth reference group for the area (including in-school and out-of-school young people); planning day: D & A program at school
- Asked by school to participate in special modules and their presentation e.g., bullying
- Word of mouth through GPs – can’t advertise as could not cope with more work; several said this
- Do Resourceful Adolescent Program (RAP) in schools
- Sometimes have stands in shopping mall during youth week
- Have a representative young person on their health advisory committee (but they were usually from the Student Representative Council i.e., a high achiever so not necessarily very representative)
- Mardi Gras, advertisements in local newspapers, telephone directory, website

What do service providers want in an “ideal model”?

General practitioners

Type of service

- A shopfront model somewhere in the middle of town; a one-stop shop with local GPs/psychologists /D&A/links with school counsellor/community partnership; a casual place that is a bit shabby, relaxed with a facade so that it is not too obvious
- GPs relaxed with youth. Be flexible and resilient
- After hours, weekends, drop-in, bulk billing, friendly receptionists, younger GPs, confidential, respectful
- An accessible, free service that just happens to have a GP attached

Funding

- Division funding of school work for GPs
- Special item numbers for youth consultations

Support and linkages

- Working together with community health and education: getting to know each other and developing a system for triaging referrals; working as team like GP/D&A services
- Email contacts with other workers and updated internet directories of services
- Have each Division run a website to show local health workers what GP's special interests and training are
- Mental health back-up with a systemic approach
- Forums with GPs and community agencies represented
- Psych consultants that sit with GPs when needed

Education

- educate young people in early childhood about accessing health services and going to see GPs
- GPs going in to schools. *"If they get to know you in schools, they will come and see you in your other place (practice)."* In an ideal world, go to every school, train local GPs and have a separate GP clinic
- Could also have education of parents and focus on local needs

Community health centres

Type of service

- Dedicated youth health workers to focus on prevention and coordination of programs (e.g., in schools)
- Drop-in centre with pool tables, phone-in access, after-school groups
- After hours, weekends, drop-in, bulk billing, friendly receptionists, younger GPs, confidential, respectful
- To be professional, but also fun and interesting so young people feel they can talk easily. Have a flexible program between what you want to provide and what their needs are

Funding/evaluation

- Non-episode funding in health as episode funding erodes ability of staff to do more innovative outreach. Find innovative ways of measuring workloads not based on number of individuals seen
- Centralised intake is a barrier

Education/training/advertising

- Make workers aware of own biases through training. Focus on staff motivation to work with young people
- Need to use local media, radio, advertising on TV
- Get young people's evaluation of what they like
- Training for A&E staff by community health and GPs as they are often the first point of contact for young people
- Specific input at school (sexual health, D&A, depression, dealing with stress and male nurses for boys)
- Work with Resourceful Adolescent Program and other school programs
- Newsletter to young people advertising what they do via database or schools
- Select young people who have done programs to educate others

Linkages

- More links with school counsellors and GPs
- Write letters back to GPs who refer, outreach to GPs, newsletter to GPs
- Be on welfare or youth committees at schools and councils
- Provide opportunities for workers to mix with young people outside community health centres

Youth health workers

Type of service

- Open reception with coffee, music, street frontage, garden, colourful, group rooms
- Job assistance, accommodation, open late, in the CBD, good transport, drop-in services, mental and physical health services
- Young people participate in development of the service
- Go to youth events and schools
- A multi-strategic approach
- Rather than isolate services, put a service in every area using younger, well-trained
- Different models for different places; relevant to local needs
- After hours, weekends, drop-in, bulk billing, friendly receptionists, younger GPs, confidential, respectful
- More outreach, more training, more facilities
- Get people interested and trained in youth health
- Fewer appointments

Funding

- Would like a training budget

Education and training

- Use a panel of GPs, young people, community health centre staff, youth health workers
- Provide training and support so work is more rewarding for workers
- Skill up target groups of young people so that they become confident to access services. Provide as many opportunities for young people to know what is available and how to access it as possible because word-of-mouth is so important

Linkages

- More flexible service provision. Form unusual partnerships, particularly in rural areas where structural barriers are greater
- Need better linkages with community health centres

Structural or policy changes

- Are needed to make things happen

Key issues

Service providers' perceptions of young people's health issues were congruent with young people's view of their own issues. However, service providers' perceptions of young people's barriers to utilising services were almost all related to structural areas of service provision (e.g., cost, appointment systems, reception staff) although less so in the case of youth health workers and consultants. Whilst these were, to some extent, relevant for young people (cost was an issue in rural areas where GPs were booked out, had long waiting lists and did not bulk bill) and non-appointment systems were usually preferred, they were not the main concern of young people. Young people's main barriers were associated with their lack of knowledge of services, their (often inaccurate) perceptions of service provision (lack of GP training, confidentiality) and, most importantly, the personal difficulties they had in seeking help due to pride and embarrassment. In an oblique way, service providers did recognise the difficulties young people experienced in attempting to present their concerns in the sense that many service providers expressed some frustration with the difficulty they experienced in trying to unearth exactly why a young person had come to see them.

Sustainable inter-service links between GPs and CHCs (especially with mental health services) were a clear deficit, making optimal service provision difficult. This represented a particularly important issue in rural areas where there was high staff turnover in community health and very limited mental health consultant expertise.

Improvements in this area were one of the most frequent requests with regard to professional support. In addition to this were: training in how to work more effectively with adolescents, the development of appropriate communication skills and training in a range of specific adolescent health issues such as mental illness, eating disorders, grief, crisis management, drug and alcohol use and conflict management within families. Service providers suggested that a centre of multi-skilled service providers practicing in centre and outreach work might most effectively meet the service needs of young people. Many suggestions were also made for systematically improving linkages between providers.

A particularly notable finding of the study was the incongruence between some of the main concerns expressed by young people and the conditions service providers felt ill-prepared or unwilling to treat. The most striking example was around mental health issues. Depression, suicide, bullying and school stress were of great concern to young people, but were one of the areas in which service providers felt least well supported, least able to meet the demands for time and had the least confidence to respond. Service providers often struggled with the idea of treating drug and alcohol problems, which were common amongst young people.

Youth health workers were comfortable working with and relating to young people and often had creative initiatives, but have little evidence in support of some of the innovative programs they carry out and little funding for their continuation. While they address the needs of some of the most marginalised young people, which other services do not, they do not tend to work with mainstream youth. This group may require different strategies.

Summary

The understanding many young people have of health tends to be limited to physical well-being and to exclude social, psychological and other aspects of health. They do appreciate, however, that a very broad range of conditions, events and behaviours (e.g., drug use) may have a detrimental impact on their health. Younger adolescents rely on their parents to arrange care when they are unwell, but middle and older adolescents frequently fail to access care when it may be of benefit to them, particularly males. Many young people do not regard GPs as being appropriate for treating anything other than physical ailments and turn to friends, family or other familiar and trusted adults for all other health concerns. The key is *trust*. Given an opportunity to become familiar with or to develop a trusting relationship with a service provider, young people are far more willing to avail themselves of their services. Although we found distinct differences between boys and girls, by age and between urban and rural young people in regard to their health issues and access to health services, socio-economic status appeared to be generally unassociated with health care issues or access to health care among adolescents.

Service providers identified several barriers to offering improved services to young people including: the difficulties of making sufficient time available (which is necessary to develop a trusting relationship); the skills to communicate well with young people; insufficient support and backup from other health professionals; the appropriate knowledge and training about issues which are more specific to young people and structural issues around the way services were provided which inhibited appropriate innovative work practices, most predominantly lack of outreach, funding protocols and appointment systems. There was an obvious mis-match between the reasons young people gave for not accessing health care services (interpersonal and knowledge) and the understanding service providers have of why young people do not attend (more

structural). This mis-match occurred, to a lesser extent, among youth health workers and youth health co-ordinators.

Some very significant challenges confront efforts to improve access to health care among young people, but we are encouraged by our discovery of some innovations, which appear to be having very positive effects, and by the number of service providers committed to improving the situation. The next phase of this project will consider the information presented, which affirmed the concerns of many involved, in policy and service provision and has opened the way to more far reaching application in terms of identification of 'best practice' models of service provision, including appropriate training of staff.

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Appendix 1:

NSW Centre for the Advancement of Adolescent Health

Health Care for Young People Information Sheet for Students

What is the purpose of this research?

We would like to know if young people get good health care when they want it. Your participation in the discussion groups being organised at school as part of the research can help us to improve services for other young people.

What will students be asked to do?

You will be asked to take part in a discussion group involving about 6-10 students and a facilitator (Diana Bernard). The students in a group will be from the same year and separate groups will be held for boys and girls. Diana Bernard is very experienced and will make the discussion group a positive and interesting experience. You will be asked about the kinds of health concerns young people have for which they do or do not receive help, the problems they may have trying to see a doctor, their experiences with doctors and other health providers and the kinds of services young people would like. The discussion groups will take place in school time, on school premises with the permission of school staff, although no school staff will be present.

Although you will not be pressured to say anything you do not want to, some students may feel uncomfortable about what they said or what was said to them. Of course, you can always talk about your concerns with your parents or other support people at school. If Ms Bernard becomes concerned about the safety of a student, she will tell the school principal of her concerns. All students will be provided with the telephone number of an experienced adolescent doctor whom they can call if they have any concerns or want support.

Do you have a choice?

Yes. Participation in this project is voluntary and if you decide not to take part, that is OK..

What will happen to the information I provide?

The results of the study will be presented in summary so it will not be possible to identify individual students and schools. A report on the study will be sent to every participating school and will also be available on our website <<http://www.caah.chw.edu.au>>. The information you provide will be kept confidential and secure. It will only be seen by the research staff and will be discarded five years after publication of the results.

Who is conducting this study?

The person in charge of the study is Dr Michael Booth (Head of Research and Development of the NSW Centre for the Advancement of Adolescent Health at The Children's Hospital at Westmead). The other people involved in the study are: Dr David Bennett, Dr Melissa Kang, Dr Tim Usherwood, Dr Susan Quine, Dr Garth Alperstein, Ms Lisa Beasley and Ms Diana Bernard.

What if I have further questions?

If you have any concerns about the conduct of this study, please do not hesitate to discuss them with Dr Michael Booth at the NSW Centre for the Advancement of Adolescent Health on (02) 9845-3077 or Anne O'Neill (telephone 02 9845-1316), the secretary of the Ethics Committee.

If you agree to participate, please complete the attached consent form and return it to school.

Corner Hawkesbury Road
and Hainsworth Street
Locked Bag 4001
Westmead NSW 2145
Sydney Australia
DX 8213 Parramatta
Tel +61 2 9845 0000
Fax +61 2 9845 3489
www.chw.edu.au
ABN 53 188 579 090

Appendix 2:

NSW Centre for the Advancement of Adolescent Health

**Health Care for Young People
Parents' and Students' Consent Form**

Students

I have read and understood the Information Sheet and this Consent Form. I understand that I can choose to be in this study or not. I understand the purpose of the study and what is being asked of me, and that I can stop participating at any time. I understand that if I decide not to participate or to withdraw, my relationship with the school will not be affected in any way. With this understanding I agree to take part in this research.

Name: _____

Signature: _____ Date: _____

Parents

I have read and understood the Information Sheet and this Consent Form. I understand that I can choose freely to allow my son or daughter to be in this study or not. I understand the purpose of the study and what is being asked of me and my son or daughter, and that I can withdraw my son/daughter from the study at any time. I have discussed this with my son/daughter and they also agree to participate. With this understanding I agree to allow my son/daughter to take part in this research.

Name: _____

Signature: _____ Date: _____

Appendix 3:

Prompts for focus group discussions

Community Health Centre staff

- What do you think young people want in/from a health service?
- What type of health concerns do young people present to your centre for?
- Are there some concerns you think they do not present with?
- How confident are you about your knowledge and skills in communicating/working with young people?
- How would you describe your knowledge/ understanding of adolescent sexuality, lifestyle, risk taking behaviours and mental health issues?
- How are these dealt with in your organisation ie. standard process(eg. regular counselling appointments) or other innovative techniques?
- What are your personal, social and organisational barriers towards trying to provide a service to young people?
- How these might be overcome?
- What information or skills do you feel you need which are not provided in your training?
- Is health promotion /education included in your organisation?
- Does your management support innovative approaches/staff training/accessing publications on youth health/how?
- Does your service have contact with other youth-related services in your community?
- Do you have a directory of services to assist in making referrals?
- Is there an opportunity for participation of young people in your service/how?

General practitioners

- What proportion of your patients are adolescent?
- What do you think young people want from a health service?
- What do you think are some personal barriers to treating adolescents and retaining their confidence?
- What do you see as the structural barriers to treating adolescents(e.g., cost, length of consultation, available opening hours, lack of privacy) ?
- Do you think there are any social barriers to treating adolescents (e.g., lack of support from or inappropriate involvement of parents/carers)?
- How confident are you in treating adolescent concerns?
- How would you rate your knowledge of normal adolescent development?
- How would you rate your knowledge/understanding of adolescent sexuality, lifestyle & risk taking behaviours and mental health issues?
- What do you think might be the most appropriate setting for contact with young people (e.g., school, clinic, practice rooms, community health centre, youth centre)?
- What types of professional support would facilitate more satisfactory contact with and treatment of adolescents?
- What is your interest and capacity to work with other service providers?
- Does your practice have contact with other youth-related services in your community?

- What do you see as a youth-friendly environment? Would your practice be interested/able to make changes to provide something like this/why/why not?
- Does your practice management support innovative approaches/staff training/accessing publications on youth health?
- Do you have a directory of services to assist in making referrals/would this be useful to you?

Youth health service staff/ youth health workers

- What are the major communities in your area?
- What would you see as the major youth health issues in your area?
- Do youth seek help for these/from whom/where?
- Which issues (if any) do you think youth don't have enough help with/why?
- Is your service free/medicare/open all hours/when/easy access to public transport?
- What does your service look like (friendly/ colourful/ staff)?
- What would a 'youth friendly service' look like or what do you think young people want in/from a health service?
- Where do people hear about your service?
- Do you work closely with any other services(e.g., CHC/GPs) ?
- Does your service have contact with other youth-related services in your community?
- How comfortable are you about your knowledge of normal adolescent development/ lifestyle/risk taking behaviours/drug and alcohol issues?
- Does your centre/service deal with these issues/sexuality issues?
- How do you promote your service to young people, local community, other services? Local radio/TV/shopping centre stalls/dance party promos/sporting event promo?
- Does your service provide any peer education?
- Is health promotion /education included in your organisation?
- Are your local D&A services youth friendly?
- Is there a local sexual health service?
- Does your management support innovative approaches/staff training/accessing publications on youth health/how?
- Do you have a directory of services to assist in making referrals?
- Is there an opportunity for participation of young people in your service/how?

Young people in school

- How would you define/what do you see as 'health'?
- What do you think some of the main health issues are for young people, particularly your age group?
- Do you discuss health issues with family members/which ones/friends/which type?
- Where would you go if you have a problem with your health (as defined above i.e., sexual/emotional/physical)?
- Are there some problems you wouldn't ask for help with (e.g., sexual/D&A) and what reasons are there for your not seeking help for these? (Issues of trust/confidentiality, discomfort, don't want parents to know)
- Do you ever come across anyone who is depressed? stressed?
- To what extent is this a problem at your age and what do you think causes it?
- Do you know what services are in your area/how did you hear about them?
- [Are they easy to get to by public transport(why/how)/speak your language] ?
- [Is it free/medicare or ??] ?
- [What are the staff like (easy to talk to, confidential, helpful)]?
- [Do they help with your problems(why/why not)]?

- [Do they have any literature/brochures etc on issues/ do young people read these]?
- [/Are they any good/ /how could they be improved]?
- Have you had any negative experiences when seeking help/what are they. Did you complain/what happened?
- What are your hopes and fears for the future (themselves/others/general) ?
- What would be the sort of health service young people would like/ go to (what would it have/look like etc)?
- Would you like to mention anything else about 'health issues'/access to care for these?

Out-of-school young people

NB Most of these prompts are the same as those above. The two different prompts are italicised.

- How would you define/what do you see as 'health'?
- What do you think some of the main health issues are for young people, particularly your age group?
- Do you discuss health issues with family members/which ones/friends/which type?
- Where would you go if you have a problem with your health (as defined above i.e., sexual/emotional/physical)?
- Are there some problems you wouldn't ask for help with (e.g., sexual/D&A) and what reasons are there for your not seeking help for these? (Issues of trust/confidentiality, discomfort, don't want parents to know)
- *Do you think health issues are more difficult for young people who are not at school/ not at home than for young people who are at home/school?*
- *What is the most pressing issue for young people not living at home*
- Do you ever come across anyone who is depressed? stressed?
- To what extent is this a problem at your age and what do you think causes it?
- Do you know what services are in your area/how did you hear about them?
- [Are they easy to get to by public transport(why/how)/speak your language] ?
- [Is it free/medicare or ??] ?
- [What are the staff like (easy to talk to, confidential, helpful)]?
- [Do they help with you r problems(why/why not)]?
- [Do they have any literature/brochures etc on issues/ do young people read these]?
- [/Are they any good/ /how could they be improved] ?
- Have you had any negative experiences when seeking help/what are they. Did you complain/what happened?
- What are your hopes and fears for the future (themselves/others/general) ?
- What would be the sort of health service young people would like/ go to (what would it have/look like etc)?
- Would you like to mention anything else about 'health issues'/access to care for these?

Appendix 4

Participating Divisions of General Practice:

A number of GPs from the following Divisions:

Barrier Division (Broken Hill)

Dubbo Plains Division (Dubbo)

Sutherland Division and St George Division (to represent South Eastern Sydney)

Western Sydney Division

and

Kim Crow and Dr Liz Cunningham from Shoalhaven Division

Dr Carol Kefford and Louise Mors from Hornsby-Kuringai Division

Participating Community Health Centres

A number of staff from the following CHCs

Blacktown

Broken Hill

Merrylands

Nowra

Orange

Sylvania

and Alison McTaggart Lamb from Bulli CHC

Out-of-school young people participated through the following youth health services

Broken Hill (through Youth Health Co-ordinator)

Cellblock

FLYHT

High St

Nowra

Traxside

Participating youth health service directors/workers

Lisa Beasley

Megan Brooks and Co-workers

Maria Coehlo

Wendi Hobbs

Participating youth health co-ordinators

Cindy Dargeville

Simone Dilkara

Kate Gooden

Sally Lambourne

And the EO of NAAH: Georgie Ferrari

and

Participating Schools

Balgowlah Boys HS
Belmore Boys HS
Blacktown Girls HS
Bomaderry HS
Bonnyrigg HS
Bossley Park HS
Bulli HS
Canobolas HS (Orange)
Canterbury Girls HS
Chester Hill HS
Cranbrook School
Dubbo Senior HS
Dubbo South HS
Holyroyd HS
Kingsgrove HS
Mackellar Girls HS
Manly HS
Menai HS
Merrylands HS
Nowra HS
Orange HS
Picnic Point HS
Queenwood School for Girls
SCECGS Redlands Co-educational Grammar School
Sefton HS
Shoalhaven HS
St John's Park HS
Willyama HS (Broken Hill)