

Better Practice in Youth Health

Final report on research study

Access to health care among young people in

New South Wales: Phase 2

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The Children's Hospital at Westmead

In association with

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Melissa Kang
Project Manager

Executive summary

Main findings

Better practice in youth health can be built upon seven principles. These are:

1. Access facilitation
2. Evidence-based practice
3. Youth participation
4. Collaboration
5. Professional development
6. Sustainability
7. Evaluation.

Interviews with 77 services across 5 sectors in NSW identified a wide range of practical strategies for implementing these principles. Innovative and creative use of often scarce resources featured among many services.

Several 'models' for improving access to primary health care to young people currently exist in NSW. These include:

1. The Youth Health Services (YHS) model
2. The Area-based Youth Health Coordinator 'model'
3. The GPs in Schools 'model'
4. The co-located GP-run clinic
5. The school-based clinic
6. Innovative access points (arts, music, internet, telephone).

There are many other services and programs which include some of the elements of these models.

Most of the services interviewed addressed some of the seven principles particularly access facilitation. The principle that was least addressed in general was evaluation. Many seemingly effective programs within services, and service models, had only done process evaluation (such as client satisfaction surveys) and had been minimally evaluated for outcome or impact upon young people's access or health.

Policy and research context

The NSW Youth Health Policy, *Young People's Health: Our Future*, was launched by the Minister for Health in December 1998. The NSW Youth Health Policy has four main goals: (1) to improve the health and well-being of young people; (2) to improve access to health services by young people; (3) to improve the quality of services provided to young people; and (4) to promote partnerships both within and outside the health system. *Access: Phase 2* particularly addresses goals (2) and (3) of the NSW Youth Health Policy. The NSW Youth Policy 2002–2006 was released in 2002. Arising from this is the Better Futures Regional Strategy which aims to 'achieve better outcomes for young people in New South Wales by improving how communities and services support young people and respond to their needs'.

Between April 2001 and April 2002, the NSW Centre for the Advancement of Adolescent Health conducted a broad needs analysis in order to discover from young people what their significant health concerns were, where they seek help if needed, when they do and do not access health care services, what the barriers to accessing services are and what could be done to improve access (*Access: Phase 1*). Phase 1 also developed an understanding of access to health care for young people from the perspective of health care providers, including Community Health Centre staff, general practitioners, youth health workers and Area youth health coordinators.

Access: Phase 2 provides a systematic and coordinated response to the findings of the broad needs analysis conducted in Phase 1.

Research, service delivery and policy implications of the study

Further evaluation research is required to determine which models, or elements of service delivery, have the greatest effect on improving access and health of young people in ways that are acceptable to both young people and service providers. Based on the findings of Phases 1 and 2 of the Access study, there is a clear need to further explore which models are most effective, why and how, as well as to determine which specific practices are most effective at addressing the principles of better practice.

Programs that use innovative strategies to engage young people, such as art and music programs, should be given particular attention in further evaluation research. Process evaluations of these sorts of programs provide a compelling case for maintaining them, yet they are often in danger of becoming unviable due to their non-traditional character.

Adopting the seven principles is recommended for all services. The practical strategies for addressing each principle currently existing across NSW are described in this report.

It is strongly recommended that Area-based youth health coordinators, or equivalent positions, begin to address the re-orientation and development of new services for young people. Such positions can be developed with the capacity to oversee service development across their Areas, and to collaborate across all relevant sectors.

All services should be based upon the best available evidence, and should build capacity for evaluation.

The findings and recommendations can also be used to assist in policy development and review for individual services, programs or whole sectors. The findings of *Access: Phase 2* have been analysed and interpreted in line with existing State government policies for youth and youth health. The recommendations are thus also aligned with current policy.

Section 1: Introduction

What is this document?

This document describes the background, methods and main findings of the research study, *Access to primary health care for young people in New South Wales: Phase 2*, and makes recommendations for better practice in youth health.

What is the purpose of this document?

This document aims to support policy makers, managers and service providers to identify mechanisms to *improve access to*, and *quality of*, primary health care for young people. Young people are defined as those aged 12–25 years. This document offers a *practical framework* within which to plan, develop, implement and/or restructure existing services and service policies for the provision of primary health care for young people. Principles of better practice are defined and described and practical strategies and case examples are provided.

Policy context

The recommendations from the *Access: Phase 2* study sit within the contexts of two NSW policies: (1) The NSW Youth Health Policy, 1998¹ and (2) the NSW Youth Policy 2002–2006². Arising from the latter policy is the Better Futures Regional Strategy³, which aims to ‘achieve better outcomes for young people in New South Wales by improving how communities and services support young people and respond to their needs’. The Better Futures Regional Strategy includes nine underpinning principles, five of which are identical to those in this report.

Structure of this document

Section 1 provides the background, literature review, methods and aims of the *Access: Phase 2* study and a summary of the main findings. **Sections 2–6** describe detailed findings and recommendations of the study.

Section 2 describes seven principles of better practice in youth health. These principles were initially identified via previous research in Phase 1 and other Australian and international literature. During *Access: Phase 2* these principles were tested and refined.

Section 3 uses case studies on a sector by sector basis to demonstrate the principles in practice within different organisational contexts, and to illuminate commonalities and differences. **The sectors included are:** Youth Health Services, Area Health Services, Divisions of General Practice, non-government organisations and other (non-health) government organisations.

Section 4 describes four outstanding programs that have developed a process and/or instrument for making services ‘youth friendly.’ Organisations in the early stages of developing primary health services for young people may select from these to assist them in becoming youth friendly without needing to ‘reinvent the wheel’.

Section 5 summarises a range of programs currently operating within the NSW Department of Education and Training. These complement and often work in conjunction with some of the other health programs outlined in other sections of this document.

Section 6 summarises some programs that have been developed in Victoria. These were interviewed because they related to work in NSW in schools, Divisions of General Practice and/or demonstrated collaboration between services.

¹ NSW Department of Health (1998). Young People's Health: Our Future.

² NSW Government (2002). NSW Youth Policy 2002–2006 – Working Together: Working for Young People.

³ NSW Government (2003). Better Futures Regional Strategy.

Note about terminology: 'program', 'initiative', 'service'

Primary health services that are youth specific are few in number. It was important to identify other non-youth specific organisations that had developed programs or taken initiatives to address access to, and quality of, primary health care specifically for young people. Throughout this document the words 'service', 'initiative' and 'program' are used interchangeably. These terms may describe a direct service (e.g. Youth Health Service, GP-run youth clinic), a program occurring within a service/organisation (e.g. GPs in Schools run by Divisions of General Practice, Community Health Centre project taking place within a school setting) or some other initiative directly relevant to the study goals (e.g. a government or non-government health promotion project that primarily aims to facilitate access to health care).

Chapter 1: Background, literature review and aims

Access: Phase 1: a needs analysis

Access barriers for young people

Phase 1 of the Access study explored the health concerns and barriers to seeking health care for young people in NSW and whether these varied according to age, gender, socio-economic status and urban/rural location. The views of young people in school and out of school and/or homeless were sought. Although they had a broad range of health concerns, young people were reluctant to seek health care from service providers. The primary reasons for this were fear of confidentiality breaches, lack of trust in the service provider and embarrassment in discussing personal issues. Another reason was lack of awareness and knowledge about services and how to access them. A third and the least common reason cited was cost. These barriers did not vary across socio-economic gradients. Young people who were out of school and/or homeless had the same barriers as those who were in school. Females were more likely than males to seek help for health concerns (Booth et al., 2004). Rural young people were more likely than urban young people to report structural barriers to obtaining access to health care due to limited numbers of providers, lengthy waiting times, having a limited choice of providers (such as few or no female doctors) and cost, owing to almost no bulk-billing by rural GPs (Quine et al., 2003).

Service provision barriers for service providers

Phase 1 also explored barriers to service provision for service providers. Three groups of service providers were included in the study: general practitioners (GPs) (the service provider most frequently nominated by young people as the provider from whom they would seek help), Community Health Centre (CHC) staff, and youth health workers (who most frequently saw marginalised young people). GPs and CHC staff both cited time as a significant barrier to providing optimal care. For GPs this was interconnected with financial pressures and cost. These two groups also named communication issues and lack of support and linkages with other services as major barriers. Youth health workers nominated infrastructure and resource issues as their main barrier to providing optimal care (Kang et al., 2003).

Young people's 'ideal service' characteristics

Young people articulated the characteristics that they saw as ideal in service provision. These included but were not limited to:

- being in settings where the young people themselves felt most comfortable, such as school, or a casual, friendly setting, or an outreach service such as a bus. The physical surroundings were less important to the young people than the atmosphere. Services offering activities (such as pool, TV, ping pong or music) helped to create a friendly and informal atmosphere.
- having flexible service provision, such as allowing for drop-in visits, after school and weekend opening hours, being able to use a pseudonym
- having service providers who were tolerant and whom they could trust, preferably with a choice of provider gender
- providing opportunities for group discussion or peer education
- being well publicised so that the young people knew about them
- alternative means of accessing help such as telephone services, websites and videos
- youth-specific services (many young people suggested that these would be ideal). (Booth et al., 2002)

Youth health care in a global context: principles of service delivery

There is growing interest around the world about the delivery of health care to adolescents and young people that more specifically and effectively addresses their needs and overcomes their barriers to accessing services. In 2002 the World Health Organisation released a report entitled 'Adolescent-

friendly health services: an agenda for change' following a global consultation from 2000–2001. The document described 'gold standard' services as being effective, safe, affordable, able to meet individual needs, those to which young people return, and those that young people would recommend to their friends. The document lists a variety of settings in which services can be provided, such as health centres, hospitals, youth or community centres, outreach, schools and workplaces (WHO, 2002). A decade earlier, the Society for Adolescent Medicine in the USA published its position paper on providing accessible services to adolescents. (Society for Adolescent Medicine, 1992a) They stated that there could be many appropriate settings for providing services and that adolescents are probably best served by having a variety of services available within communities to them. Rather than promoting a single 'best model' for service delivery, they proposed a selection of criteria for evaluating the effects of any proposed health care delivery. Nevertheless, some of the models suggested as worthy of notice included the school-based health clinic, the independent multi-service youth-specific centre and the employment of a state-wide youth health coordinator. At this time, the effectiveness of any of these models remain unknown due to limited evaluation research. The Society for Adolescent Medicine published a separate position paper in the same year outlining the specific needs of, and recommendations for, service provision to homeless and runaway youth (Society for Adolescent Medicine, 1992b). They proposed that creative, multidisciplinary approaches to service delivery, collaborative efforts (including with the entrepreneurial sector) and outreach services were all important components of service delivery to this population. They recommended networking and collaborative work between health and the legal, juvenile justice, education, employment and accommodation sectors with support for case management and continuity of care.

In the United Kingdom, adolescent sexual health, particularly teenage pregnancy, has been given high priority by government. The Medical Society for the Study of Venereal Diseases Adolescent Sexual Health Group published standards for comprehensive sexual health services for young people under 25 years outlining principles of service delivery which included amongst others, consent and competence, confidentiality, accessibility, acceptability, clinical care, and liaison (Rogstad et al., 2002). Such services were proposed as complementary to existing general practice and specialist care.

Youth Health Service models: local and international literature

There is very little published literature that clearly outlines the effectiveness of any particular model of, or even youth-oriented, health service delivery. A systematic review of the literature by Mathias (2002) attempted to assess the impacts of youth-specific primary care on access, utilisation, mental health, health outcomes and emergency department use. She found that youth-specific services did lead to increased access and decreased emergency department use by young people. The school-based health clinic, a model that had been more extensively evaluated than others, had been shown to significantly increase utilisation by young people compared with control groups. School-based health clinics were particularly beneficial to females, young people who were socio-economically disadvantaged, at risk, from rural areas and from ethnic minority groups. There was also a significant increase in the number of mental health consultations for young people who had access to a school-based health clinic compared to traditional primary care, especially for males. However, there was no evidence of improved self-reported mental health status and insufficient evidence to show improved health outcomes for young people. While there have been moves in Australia over the past several years to consider and implement 'whole-school approaches' to supporting young people and 'integrated school-linked services', there have been a range of barriers identified to the widespread acceptance and effectiveness of such models (Mudaly, 1999). One such model, 'The Gatehouse Project', has been subjected to rigorous evaluation and shown to be highly effective at improving certain measures of health and well-being. This model 'focuses on the school social environment and the individual student within that context with benefits across a range of adolescent health risk behaviours' and uses a range of interventions that promote a positive social climate within the classroom or the whole school, integrated curriculum-based education and the promotion of linkage between the school and the broader community (Patton et al., 2003).

Australia was one of the first countries to establish government-funded adolescent-specific health services, although these are geographically scattered and most primary health care for young people occurs in general practice. While the range of primary health care for young people includes GPs, Community Health Centres, emergency departments, non-government organisations (such as Family Planning clinics) and Youth Health Services, the findings from *Access: Phase 1* suggested a somewhat fragmented system of service delivery with little communication between mainstream

services such as general practice and youth-specific services that have expertise in engaging with their target population (Kang et al., 2003).

The joint Commonwealth/State program, 'Innovative Health Services for Homeless Young People' (IHSY), has supported the establishment of several Youth Health Services around the country, specifically targeting homeless and at-risk young people. After 10 years, this program was evaluated and found, amongst other things, that marginalised young people remain a significant part of the population for whom specialised service responses are required and are thus appropriately targeted by IHSY and that the clients of IHSY services consistently reported benefits from those services. The review identified eight key best practice principles, based on the views of young people they interviewed, as being: accessibility, environment, attitude of staff, relationships with staff, services, range of services available, cost, and contact with other young people (Community Link Australia, 2003).

There are few other youth-oriented models of Youth Health Service delivery in Australia that are described and/or evaluated in the literature and most that are focus on local needs or specific health issues. Sawyer and Kosky (1995) describe approaches to influence the effectiveness of mental health services for adolescents and there has been debate in recent years within the Australian psychiatry fraternity about the best way to provide better mental health services (Birleson et al., 2001). The discussion surrounding these issues has remained largely focused on the delivery of specialist (secondary and tertiary) care, with only vague mention of the role of primary health care providers and of the accessibility or acceptability of services for young people. Bartik et al. (2001) describe a collaborative rural and remote service model for young people with anxiety and depression that involved professional development (involving clinical placements and training workshops), partnerships between rural and metropolitan programs, and consultation using telehealth and teleconferencing interventions. Process evaluation showed improved knowledge, skills and work satisfaction on the part of rural workers. An additional outcome was the development and sustainability of networks. However, there was no information about accessibility or mental health outcomes for young people.

Murray et al. (1999) describe a service model they piloted in Melbourne targeting marginalised young people with dual disorder (mental illness and problematic substance use). Care was based upon the principles of flexibility, accessibility, mobility, respect and involvement, practical assistance, continuity, and commitment and engagement with the community. Their model has shown to be effective at engaging with their target group and has achieved a number of other positive outcomes.

Harrison and Dempsey (1998) conducted research among young people experiencing homelessness, followed by interviews with service providers to describe provision of sexual health interventions for this population. They concluded that 'good practice' involved having clear goals with systematic and strategic planning, providing knowledge and skills, a comfortable setting and/or outreach, and opportunities for small group discussions and individual counselling. Their study focused more specifically on sexual health education interventions rather than clinical practice; nevertheless, many of their conclusions resonate with principles of good practice from a range of Youth Health Service models.

Another potentially marginalised group in the Australian youth population are young people from ethnic minority groups. It has been suggested that, while there are a number of health services available to ethnic minority groups, confidentiality presents a large barrier as many people within ethnic minority communities know one another and adolescents are often required to act as interpreters for family members, which has the potential for conflict. Existing services for refugee young people have been described as particularly complex and inaccessible (Bryan & Batch, 2002).

The basis for Access – Phase 2: conclusions from the literature

Responding to the needs and barriers identified in Phase 1, both by young people and by service providers, formed the basis for the *Access: Phase 2* study. It became evident during Phase 1 that there already exist in NSW many innovative health programs and models of health service delivery for young people. The majority of these programs were not published and were discovered 'accidentally' during the Phase 1 interviews with young people and service providers. Phase 1 also identified that

there is, more often than not, lack of coordination and communication between services and sectors. Furthermore, young people have varying needs and may require a range of different services.

Reviewing the literature identified a range of principles of service delivery that may or may not be applicable to a NSW context. Several models and case examples of service delivery were also identified in the literature, almost none of which had been thoroughly evaluated. An exception to this was the school-based health clinic model from North America. Given the differences between the Australian and North American health systems, such a model may or may not be as effective in NSW and adopting such a model in NSW would require significant restructuring of health services and intersectoral collaboration. Most published literature in Australia describes single case examples, or explores single health issues, rather than a generic approach to youth health. *Access: Phase 2* sought to systematically explore how existing sectors and services in NSW are already addressing the needs identified during Phase 1.

The aims of this study were:

1. To identify and describe service models, principles and practice in youth health across NSW
2. To discover whether any models had been evaluated for their effects upon access to services and/or the health of young people
3. To determine what elements of practice constitute 'Better Practice in Youth Health'.

Chapter 2: Methods of the study

Design

There is a diverse array of youth health services and programs within and across a number of sectors in NSW, reflecting the different and changing needs of young people, as well as different institutional histories and cultures. Information had to be collected systematically (to ensure that findings could be related to the needs and barriers identified during Phase 1) and flexibly (to allow understanding of the characteristics of service provision within an organisational or sectoral context). The breadth and depth of services needed to be explored to identify areas of commonality and difference between services and sectors. Qualitative methods were deemed the most appropriate to understand the perspective of the subjects (the spokespeople for the services being studied). The research tool chosen was the semi-structured interview to ensure that the same topics were covered.

Ethics

We were advised by the Secretary, Human Research Ethics Committee at The Children's Hospital at Westmead that formal ethics approval was not required for this study because we were interviewing staff in their professional capacity to describe characteristics of their services.

Sample

Five sampling frames were used to identify as broad a range of programs as possible. These were:

1. Youth Health Services
2. Area Health Service Programs
3. Divisions of General Practice
4. Non-government organisations
5. Other (non-health) government organisations

Recruitment

Services were approached by making telephone contact with the service or program manager/coordinator. All services contacted agreed to be interviewed. One or two service personnel for each service participated in the interviews. These were usually service or program managers or coordinators, or other senior member of staff +/- a project officer.

Sampling method

1. Youth Health Services: comprehensive sample

A Youth Health Service is a multidisciplinary primary health care service specifically for young people. The target age range varies between services from 12 to 20 or 25 years. With the assistance of the NSW Association for Adolescent Health (represented on Chief Investigator group), 15 Youth Health Services in NSW were identified. During Phase 1, two of these had been interviewed with respect to service provider perspectives on access. This information was retrieved and enhanced by additional knowledge provided by some of the Chief Investigators and Reference Group members to include for analysis in Phase 2. The remaining 13 Youth Health Services were all interviewed. Thus there was a comprehensive sample of Youth Health Services.

2. Area Health Services (AHS): snowball sample

At the time of the study, NSW contained 17 Area Health Services. Three AHSs had created youth health coordinator positions (two urban and one rural) and they were all interviewed. In addition, NSW Health provided a list of AHS programs relevant to youth health. Because of the eclectic range of programs on this list, AHS programs for interview were selected on the basis of the range of health issues identified by young people during Phase 1. AHS programs addressing one or more of those health issues were chosen. This initial wave of recruitment revealed that some of the programs on the

list were no longer operating. Those programs which were operating were interviewed first and snowball sampling used to identify more AHS programs, until sufficient programs to cover the range of health issues had been included.

3. Divisions of General Practice (DGP): comprehensive sample

Divisions of General Practice are Commonwealth funded, geographically based organisations to support general practitioners and improve the quality of GP services. Each division has its own programs, depending on needs in its region. There are 37 Divisions of General Practice in NSW. Due to the clearly defined nature of DGP and their outcomes-based funding structure, all DGP that had youth health programs could be identified and were all interviewed in person. DGP that were still developing youth health programs were interviewed by telephone. Thus a comprehensive sample of DGP providing youth health programs was obtained.

4. Non-government organisations (NGOs): snowball sample

Non-government organisations are independent from governments and their policies. They are usually non-profit organisations, and may gain funding from government, private or corporate sources. NGOs were selected in the same way as AHS programs (that is, based on their running programs that addressed one or more health issues identified by young people in Phase 1). NGOs that were well known by the Chief Investigator or Reference Groups were recruited first. Snowball sampling was then used to identify and recruit other NGOs.

5. Other (non-health) government organisations (OGOs): convenience sample

Other government sectors, such as education, employment and juvenile justice, were thought to constitute an important sampling frame, given the complex nature of health issues facing many young people. During Phase 1 young people identified many factors beyond the physical or psychological that could impact on their health (such as school bullying, safety and employment). OGOs were selected on the basis of the remaining health issues (identified by young people in Phase 1) not covered in the AHS and NGO sectors, and where the link with the health sector was felt to be particularly crucial. The programs included for interview were suggested following brainstorming sessions by members of the Reference Group and Chief Investigators and thus constituted a convenience sample.

The NSW Department of Education and Training (DET) offers a range of school-based health or health promotion programs which complement or work in collaboration with the health sector. Because executive and senior DET student welfare personnel were represented in the Chief Investigator and Reference Groups, these programs were readily identified. Due to time constraints only a small sample were interviewed in depth. For the remaining programs brief summaries were obtained from the relevant program coordinators.

Data collection

Identification of issues for interviews

The process of identification of issues to be covered during interviews was critical, extensive and ongoing. The interviews aimed to collect information about how and to what extent services were providing accessible, high quality primary health care to young people. Issues for discussion during the interviews were decided on the basis of:

1. Phase 1 findings about access needs and barriers, and ideal service provision characteristics that young people and service providers described
2. Reviewing the literature
3. Expert opinion within the Chief Investigator and Reference Groups.

The process informed the research team about domains that *appeared* to be central to better practice in youth health. The interviews tested the face validity of these domains, as well as eliciting from services the strategies used to address each domain.

Mapping instrument

A mapping instrument was developed (see Appendix 1). This was a series of questions or discussion prompts to guide the interviews. The topics to be covered arose from the process of identification of issues described above and included:

1. Organisational characteristics such as service structure and context, target group, staff number, gender and discipline, and physical setting
2. Strategies used to facilitate access and/or overcome barriers to access that had been identified in Phase 1
3. Extent and nature of youth participation
4. Resource issues such as funding and sustainability
5. Evidence base for the development of programs
6. Extent, nature and results of evaluation of programs.

Although the instrument would help to standardise data collection, it was understood that the interviewer was at liberty to modify or add questions as the interviews progressed. This process was reviewed by the Chief Investigator and Reference Groups to ensure that all information collected remained meaningful and relevant to the aims of the project.

Interviews

All interviews were conducted by the Project Coordinator. Most of the face-to-face interviews were tape-recorded and transcribed. Extensive hand-written notes were taken during telephone interviews and those face-to-face interviews that could not be tape-recorded. Supplementary hand-written notes were taken during all tape-recorded interviews.

Data analysis

Development of an analysis pro forma

The issues for identification during interviews were initially grouped into 8 domain areas. After review following the first few interviews, these were collapsed down to 7. These domains were initially called:

1. Access facilitation (how did services facilitate access for young people)
2. Evidence base (what evidence was used to establish services and their programs)
3. Youth participation (how and to what extent did young people participate)
4. Inter/intra service collaboration (how and to what extent did services collaborate)
5. Professional development (what training was required or expected of staff)
6. Sustainability measures (what made a service sustainable)
7. Evaluation measures and outcomes (how did the service evaluate its programs and what were its outcomes).

These domain headings guided the development of the mapping instrument but also provided the basis for data analysis. By the end of data analysis the terms had been further refined (see Chapter 3, 'Summary of Main Findings').

Underneath the 7 domain headings on the analysis pro forma, specific criteria against which to match service characteristics were developed (for example, under 'Access facilitation', criteria such as 'confidentiality concerns addressed' or 'service promoted/made aware to target group' were listed).

The analysis pro forma can be found in Appendix 2.

Data entry and analysis

Transcripts from tape-recorded interviews were formatted for entry into NUD*IST 4 (Gahan & Hannibal, 1998). This software program enabled information to be grouped under a 'theme heading' based on the domains. Sub-headings could also be formed using the criteria against which service characteristics were matched. For example, where the theme, or domain heading, was 'access facilitation', the sub-headings included confidentiality, service promotion (to raise awareness) and cost. The headings and sub-headings could be used to search for information across transcripts, allowing different services to be compared.

Given the enormous range of service characteristics, this program allowed efficient management of information without losing the richness of the data. All interviews with hand-written notes only were manually analysed in the same way (under headings and sub-headings).

All transcripts and hand-written notes were entered and/or analysed by the Project Coordinator. In addition, the Project Manager manually analysed one in four transcripts for comparison. This was done to ensure inter-rater reliability (Patton, 1987).

Chapter 3: Summary of main findings

Description of the sample

A total of 77 NSW services across 5 sectors were included in the sample. The majority were interviewed face to face. Due to time and logistical factors, some interviews were conducted by telephone. Information about 2 services was obtained from internet and printed materials owing to time limitations and service availability.

The sample is summarised in Appendix 3 in a series of tables and figures:

Table 1 summarises the NSW sample by sector (excluding NSW Department of Education and Training programs), according to the service or program title.

Table 2 summarises the sample by all sectors, including Victorian programs, according to the name(s) of interview participants and their service or organisation.

Table 3 shows the sample of Area Health Service programs, NGOs and OGOs by health issue.

Figures 1 and 2 describe the sample by Area Health Service boundaries.

Main findings

1. Principles of better practice in youth health

The 7 domains that were identified at the commencement of the study remained robust across all services and sectors interviewed. In other words, they were deemed relevant and significant by all services interviewed and each service was able to describe elements of their program(s) that addressed each domain.

- i. **Access facilitation:** *Services are flexible, affordable, relevant and responsive to the needs of all young people (regardless of age, sex, race, cultural background, religion, socio-economic status or any other factor).*

Access facilitation was the principle that was most often addressed more thoroughly than the other principles. Different services and programs facilitated access in different ways, including innovative program development or access points such as websites, telephone or locating within schools. Youth Health Services facilitated access well for their target group (marginalised young people). Division of General Practice youth health programs tended to favour schools-based access facilitation. Strategies for promoting awareness of a service to the target group were often not part of the service's objectives. Confidentiality policies were often not clearly articulated for the target groups or service providers.

Programs were more accessible when they addressed:

- Young people's lack of awareness of services, their nature and how to access them by building dissemination strategies into program planning, using promotional strategies such as newsletters, local media, youth magazines, internet, peer education and presentation by 'those who had experienced the problem' at school and community events, and presentations at school assemblies, as well as through community education targeting teachers and parents (with the aim of creating supportive environments for young people). Promotional activities were enhanced when written resources (e.g. hand-outs, brochures) were also provided. Locating a program within a school also raised awareness.
- Trust and concerns about confidentiality by having visible confidentiality policies in the service, discussion with young people about confidentiality and its limitations (accompanied by written materials) and a gender mix of staff, using peer strategies and groups, providing safe spaces and getting to know other local (and trusted) service providers usually through the school.
- Physical barriers such as cost and transport by providing free or bulk-billed services, locating close to transport, having outreach to where young people are using local venues, being in schools/youth centres and occasionally offering a pick-up service. Alternative media such as the internet and telephone help lines were also accessible ways to provide services (especially for young males).
- Flexible service provision by including drop in, out-of-hours services, outreach, and a range of delivery methods for programs, using local 'youth-friendly' venues and having staff able to move between roles and venues.
- Service provider barriers of cost, time, confidence, knowledge and support by removing fee-for-service remuneration (having salaried staff), having flexible reporting systems that measure achievements of staff differently (from, for example, occasions of service), ensuring appropriate training and collaboration and partnerships with other services in a meaningful and ongoing way.

- ii. **Evidence-based practice:** *Services and their programs are developed and regularly reviewed according to evidence of best practice from the most reliable and appropriate local, national or international sources.*

Most services had been established on evidence of a certain need. For some this was reliable and appropriate evidence of need (such as national published research) while for many it was anecdotal evidence only or based on assumptions about need. The use of evidence to develop programs and interventions within services also varied, with relatively fewer services using available evidence of effective interventions to determine their programs, or piloting their programs first and evaluating them. Some services with limited resources had sometimes looked at what was available and where there were gaps in service provision. Not all services had developed clearly defined aims and objectives.

Quality services were informed by published literature, had performed local needs assessments and/or community consultation or used local, state or national studies to inform their programs. They had explored anecdotal evidence and existing programs and then piloted programs before fully implementing them. They used evidence for the establishment of the service and also for program development within the service. Programs were reviewed using evaluation methods that would measure results against aims and objectives, with findings incorporated as new evidence.

- iii. **Youth participation:** *Young people are involved in the development, implementation, review and evaluation of services and programs in ways that create a sense of ownership of, importance to, influence within and/or belonging to that service or program, and a sense of mutual respect.*

There was a recognised need for this to occur, although youth participation as a principle was less developed in many services and often minimal. Participation ranged from token to ongoing remunerated involvement of young people through committees, focus groups and training.

Services with a culture of youth participation (those who articulated this in their mission or as a principle, policy or protocol of service delivery) were more likely to be using strategies that involved young people in a meaningful, ongoing way. These strategies ranged from one-off consultations on specific issues or projects to peer training, payment for input, question boxes, surveys, involvement on key committees, focus groups, and changes, as a result of their input, which were further monitored by ongoing consultation with young people.

- iv. **Collaboration:** *Service providers within a service, as well as different services within and across sectors, who share common service goals and target groups, network, communicate and/or work together to plan, deliver, review and evaluate their service provision to young people with a clear delineation of responsibilities.*

Collaboration overall was not extensive. Some services were ambivalent about the benefits of collaboration while others found it difficult to work without collaborating due to limited resources sharing. Some of these had developed sophisticated protocols and processes to collaborate effectively and had examined benefits and roles of partners.

Better practice collaboration involved adopting it as a principle in the strategic or business plan, identifying benefits to each partner and outlining responsibilities of each, identifying partners and the purpose and roles for collaboration, forming local committees, considering formal procedures and joint protocols, having multiple opportunities to meet representatives from key stakeholder groups and better communication among providers, capacity building other services, and being in partnership and complementing rather than being in competition.

- v. **Professional development:** *Appropriate, adequate and ongoing professional development, support and supervision are available to health service providers working with young people.*

Professional development budgets were generally low. Professional development ranged from a minimal amount of in-service training to ongoing professional development with appropriate budgets, the involvement of young people in training for providers, supervision, annual appraisals of training needs and creative budgeting to provide what was needed.

Better practice professional development included providing an adequate budget for staff professional development, innovative budgeting to make the most of available funds, assessment of individual needs and abilities in regard to training and improvement, initiatives targeting gaps in provider knowledge, mandatory basic and ongoing training, rotating staff to gain broader skills, sharing expertise across services and building worker training into 'certificates' so that they are transportable for workers.

- vi. **Sustainability:** *Services develop and implement strategies that optimise the longevity and/or recurrent funding for the service or program where appropriate.*

Sustainability had not been considered by some services, some thought it was not their 'job' (particularly in government organisations), while others (mostly in non-government organisations or those with difficult 'multi-need' client groups) embraced the need to address sustainability for purposes of funding or programs and had developed partnerships or transferable programs or sought independent sources of funding.

Better practice sustainability strategies included cooperative and sometimes corporate partnerships and/or collaboration that led to improved capacity of local providers in terms of skills and resources, strategies that promoted joint ownership of programs, integrating innovative programs with mainstream programs, developing replicable or adaptable programs, local community ownership and attempts to access other sources of funding or financial independence. Evaluation to ensure continued relevance and viability of programs was also crucial.

- vii. **Evaluation:** *Services regularly examine the relevance, quality and results of their programs using appropriate evaluation methods which include measuring the outcomes of the service for young people and service providers against their program goals, objectives and indicators.*

Little thorough evaluation had been done: most was process evaluation, such as client satisfaction, with few services measuring against their aims and objectives. Few services had the inclination, resources or skills to evaluate more thoroughly so that impact or outcome evaluation was minimal and outcomes for young people were often assumed or anecdotal. Service outcomes were also discussed. Some services (mostly non-government organisations) had used outside agencies in an attempt to evaluate more thoroughly.

Better practice evaluation included having clear aims and objectives with appropriate evaluation methods to measure process (e.g. to determine satisfaction, learning and that the program did what it intended to); impact (e.g. pre- and post-program changes in service provision or behaviour); and outcome (such as changes in health status). Services that built evaluation into their program planning were more successful in meeting this principle. Services that involved young people in their evaluation (planning and/or measurement) were also considered better practice. In summary, a service plan where 'evaluation is the key part of the organisation's approach to service delivery' was the most effective.

Some services were exemplary on several principles.

2. Models of service provision

One of the study goals was to identify models of service provision that had been shown to improve access and/or quality of health care for young people. A range of models was found and, although none had yet been subjected to rigorous evaluation, some showed promise on anecdotal evidence or initial evaluation. Further evaluation needs to occur to determine whether they have actually improved access, quality of health care or health outcomes for young people. 'Model' refers to either a service's structure and organisation or to a program or strategy that was replicated in more than one site.

- i. **The Youth Health Services (YHS) model** While it would be inaccurate to describe all 15 Youth Health Services as using one model of service provision, common elements across all YHS could loosely be used to define the 'youth health service model'. All YHS (except one, see Table 1) were youth specific and had physical environments that could be described as 'youth friendly', including the décor, layout (such as space for a pool table, more 'casual' furniture

settings), nature of reading material and posters in the waiting areas and so on. All YHS had multidisciplinary teams, including where appropriate specialised workers (such as bilingual workers, Aboriginal workers).

The concept of 'multiple access points' was highly valued by many YHS, attracting young people because of other, less threatening services (such as arts, drop-in and basic needs, including showers and laundry). YHS worked hard at engagement of young people through these channels (which also in themselves provided needed services), acknowledging that if young people felt comfortable and trusting of a service they would be more likely to approach a counsellor, nurse or doctor to discuss other health problems. These were consistent with findings from Phase 1 and the literature. We noted that some NGO programs also used the 'multiple access point' approach. Informal linkages between many YHS and other services and sectors were also a feature of service provision (for example, with education, Centrelink, accommodation agencies, Juvenile Justice, legal services and others. This aimed to help particularly marginalised and homeless young people with their navigation of complex systems and bureaucracies to receive support to ultimately improve their health and wellbeing. YHS (and many NGOs) had strong youth participation also. While many YHS had excellent quality assurance procedures, including policies and procedures relevant to principles of better practice in youth health and good process evaluations, they had not, on the whole, evaluated the impact or outcome of their service or programs. Much of this was due to lack of resources (including necessary expertise and funding) and acknowledgement that any redirecting of resources could negatively impact on already overstretched workers (rather than increasing efficiency).

ii. **The Area-based Youth Health Coordinator 'model'** This 'model' of service provision was able to address all the principles of better practice to a greater extent than many other models in Area-based services. An Area Youth Health Coordinator aimed to:

- facilitate and support activities and projects that assisted in the strategic development of youth health within the Area
- develop and maintain a coordinated approach to youth health care within the Area
- work in collaboration with key stakeholders, relevant agencies and young people, both within and external to the health sector, to enhance access to appropriate health services by youth.

This was particularly well demonstrated in a rural Area that had previously had fragmented, geographically separated, isolated services.

However, being relatively new positions at the time of our study, the main impact and outcomes had been the creation of new services and networks. There had not yet been any evaluation of the utilisation of services by, or health outcomes for, young people.

iii. **The GPs in Schools 'model'** This was not a direct service model but an awareness-raising and education program. However, given its popularity among Divisions of General Practice and the schools with which they liaised, this program deserves further mention and consideration as a strategy to facilitate access to GPs and the quality of care delivered by GPs, as well as improving GPs' understanding of young people. The primary aim of all the GPs in Schools programs was to improve the accessibility of GPs to young people. This involved educating young people about overcoming barriers to access, and GPs, about youth-friendliness. Additional content was flexible and open to students' feedback and suggestions, sometimes including health-issue specific information. GPs involved in such programs were usually required to undertake training in working with young people, and process evaluations invariably showed improvement in the participating GPs' knowledge and confidence. One such program had been able to demonstrate an increase in 'intention to seek help' by students who had received the intervention. None of the programs operating at the time of the study had yet demonstrated increase in GP attendance by young people or in health outcomes, although such measures are being planned.

- iv. **The co-located GP-run clinic** Another popular model among Divisions of General Practice was the co-located GP-run clinic and we found several of these operating or being trialed in

NSW. The primary aim of all the GP-run youth health clinics was to improve the accessibility of GPs to young people, particularly those who were marginalised. This involved overcoming barriers to access by providing a clinic in a youth service that they often already attended. When a young person developed trust with the GP through this clinic, they may also have felt more comfortable to access the GP's 'usual' surgery. GPs involved in their Division's program were sometimes trained and then provided services on a sessional basis, on occasion rotating with other GPs from the Division. All sessions were bulk billed or GPs were paid by their Division. Liaison between Divisions of General Practice and the youth centres varied from informal (but based on strong linkages, trust and familiarity) to more formal arrangements (e.g. joint funding of GP sessions between DGP and Area Health Service).

Some innovative systems were developed to deal with other cost barriers such as vouchers for medication, free pathology and reduced provided by specialist groups. Some of these clinics had been able to demonstrate increase in utilisation of services, and all had demonstrated improvement in GP confidence and knowledge. Some had not been sustainable due to insufficient service utilisation for the cost incurred by the DGP.

- v. **The school-based clinic** This is the provision of a direct clinical service and/or health education and resources within the school campus and during school hours. The first program of its kind in NSW, a rural Community Health Centre (CHC), provided a drop-in service during lunchtime, staffed by CHC personnel who rotate through the service. Other CHCs have attempted to copy this model. Evaluation had found the service well utilised by students but needing excellent collaboration between the school and CHC staff. Other models of service to schools have been developed by NGOs (particularly around drug and alcohol issues) or in one case as a collaboration between Area health, GPs and a school (see Case Studies in Section 3).
- vi. **Innovative access points (arts, music, internet, telephone)** Rather than a 'model', these are strategies which could be used by services, and were particularly well demonstrated among many NGOs and Youth Health Services. Evaluation of a national telephone counselling service has shown high levels of awareness of the service among young people due to promotion and advertising strategies and a high level of satisfaction with the service. The main problem was the unacceptably low rate of access to counsellors owing to the disparity between supply and demand (insufficient counsellors for the number of callers) (King, 2000). Evaluation of a health promotion internet site has shown high levels of accessibility and acceptability, increased help-seeking and coping skills among young people and that the opportunities to participate were particularly valuable (Inspire Foundation, 2001). Telephone and internet services help to allay young people's extreme concerns regarding confidentiality, with the internet being a popular access point for young men particularly. Art and music programs appear to be very effective at engaging some of the most difficult to reach target groups such as alienated young people, homeless youth and young people with mental health issues.

3. Other findings

- i. The NSW Youth Health Policy was not generally cited as a resource for planning service delivery, although the main policy goals of improving access and improving quality of health services were well recognised.
- ii. Resource issues were very frequently mentioned by services in both government and non-government sectors.
- iii. Non-government organisations addressed the principles of collaboration, sustainability and evaluation somewhat more extensively compared with other sectors. Many youth-specific services had excellent processes of youth participation and access facilitation.

Conclusion

There are many quality, innovative youth health programs in NSW attempting to improve access and quality of care for young people. There are several robust principles of better practice in youth health as well as several 'promising' models of service delivery.

However, there is a clear need for further evaluation of these models in order to better inform service managers, planners and policy makers about how and where to direct resources to improve services for young people.

There is also a need to further evaluate practices to determine which are more effective at addressing which principles.

Notwithstanding the need for further evaluation, the evidence collected from *Access: Phase 1* and *Phase 2*, review of the existing literature about access and service delivery for young people, and considerations about current NSW youth and youth health policy contexts can be synthesised to produce strong and clear recommendations, principles and practical suggestions for Better Practice in Youth Health.

Section 2: Principles of better practice in youth health

This section is divided into seven chapters, each covering one of the principles of better practice. Each chapter:

- Defines* the principle
- Lists *indicators* for the principle
- Summarises *relevant supporting literature*
- Provides a selection of *quotations* from the Phase 2 interviews that relate to the principle
- Lists *recommendations* for sectors and services
- Offers practical suggestions about how to apply each principle in practice.

What is 'better practice'?

The term 'best practice' originated in the industrial sector some two to three decades ago. It referred to the most efficient and practical ways of producing high quality products – it was about the performance of an industrial system (involving machinery and people) and the desired outcomes were tangible products with measurable characteristics.

The adaptation by the health sector of this concept has taken hold across the world. 'Best practice' is intricately linked with the concept of 'quality health care' as well as 'quality improvement' and 'quality management'. Since what is 'best practice' at any given time is based on available knowledge, which needs constant updating, the term 'better practice' has been chosen for this document. However, the literature which is reviewed and referred to here uses both 'best' and 'better' practice.

Better practice in health care is about the delivery of health care that is of high quality in an efficient and acceptable manner to consumers and providers, at affordable costs. High quality means that the care offered is known, or strongly believed by 'experts', to improve health, or reduce or prevent illness, but also that it has few or no adverse effects and can be delivered in a manner that is acceptable to its recipients. It is not surprising given all of this that there may be tensions and conflicts of interest between policy makers, health system funders, individual service managers, individual service providers, and consumers.

Better practice may be defined as 'the best way to identify, collect, evaluate, disseminate and implement information as well as to monitor the outcomes of health care interventions for individuals/population groups and defined conditions' (Perleth et al., 2001).

In the health sector, best practice has been applied for longer, and more extensively, in medicine and in treatment (or prevention) of illness. Applying principles of best practice to service delivery and whole organisations is more recent. Elements of better practice common in the literature include the need for an evidence base; the importance of coordination and collaboration; examination of cost, efficiency, effectiveness, outcomes and sustainability; the development of performance indicators; a movement towards inclusion of consumer needs and views; a need for the appropriate setting of goals and objectives with a view to subsequent evaluation; and appropriate professional development and team building to facilitate service provider competencies (Fry & King, 1986; Graham, 1995; Kazandjian & Sternberg, 1995).

The prime objective of better practice is to improve individual or population health through the use of effective and cost-effective health care interventions. This means that evaluation (based on immediate objectives and on long-term outcomes) is a central function for improving performance. Evidence for better practice also needs to be disseminated and made available for widespread use (implementation). This assists with the adoption of better practice and can include professional development, quality management, collaboration and pathways which organise and sequence care.

The adoption of better practice by an individual provider, within a service, sector or whole system, can take place in a number of ways. Examples include the development and use of guidelines, evaluation

processes and performance indicators. 'Guidelines' have developed mainly in the medical domain where there is strong evidence for which interventions work and which don't. Due to the paucity of longer term evaluatory research in the area of youth health service delivery, this document has been prepared to provide a framework for better practice: a set of principles, their indicators, recommendations and practical strategies.

Chapter 4: Access facilitation

1. Definition of principle



Services are flexible, affordable, relevant and responsive to the needs of all young people (regardless of age, sex, race, cultural background, religion, socio-economic status or any other factor).

2. Indicators

- **Awareness** Service has a strategy for its promotion and the target population is aware of the service and how to access it.
- **Confidentiality** Confidentiality is defined and explained at every appropriate point of contact between service and target population, including during service promotion. Explanations include clearly describing circumstances where confidentiality may be breached (such as self-harm and child protection).
- **Trust** Young people's self-consciousness, embarrassment and potential cultural sensitivities are acknowledged by service providers at appropriate points of contact and appropriate efforts are made by service providers to gain trust.
- **Cost** Service is provided at no or low cost.
- **Physical accessibility** Service is located close to public transport or otherwise made physically accessible and is open at appropriate hours for young people.
- **Flexibility** Service has the capacity to be flexible around appointment and/or consultation times and staff roles.
- **Time** Sufficient time is allowed to consult with young people and service removes time/financial pressures for service providers.
- **Knowledge** Service providers have knowledge about the health and access needs of young people.
- **Confidence** Service providers are confident in working with young people.
- **Support** Support is provided for service providers via appropriate training, supervision and peer support, back-up, intra- or inter-service linkages and opportunities to collaborate.

3. Key literature

Access to health care for young people is central to promoting and protecting health. Young people have the potential to become marginalised when it comes to access, even if socio-economically secure. Research around the world, whether from developed countries with youth health services and policies or from developing countries with different cultural constructions of adolescence, highlights the importance of creating accessible services that are acceptable to young people, if their health and well-being are to be maintained. Although the literature suggests that certain sub-groups of young people may be more at risk for not accessing health care, Phase 1 of the Access study showed quite clearly that young people of both genders and from all socio-economic strata experience very similar barriers to access. Personal barriers such as fears about confidentiality and embarrassment about

discussing one's own concerns were the most prominent reasons why young people do not seek help in spite of having a broad range of health concerns (Booth et al., 2004).

Understanding and addressing service provider and systemic barriers to providing optimal health care are also important if significant progress is to be made in creating accessible and acceptable services. Barriers to providing care for service providers were also identified during *Access: Phase 1* and have been described in Section 1 (Kang et al., 2003).

The NSW Health Youth Health Policy (1998) recognises the importance of access to the extent that improving access is one of the four main policy goals.

While *Access: Phase 1* confirmed and explored in more depth the barriers to access for young people and service providers than previous research, there is less evidence about what facilitates access. Much of the available literature describing accessible service delivery has been summarised in Section 1. With barriers to access now quite well understood, it is the active facilitation of access which needs attention and forms the first guiding principle in better practice in youth health.

4. What some services interviewed during *Access: Phase 2* said about access facilitation

'Young people said it was difficult to talk to service providers about [sensitive issues] ... so we keep in mind how we personalise our promotion. Confidentiality is always a huge issue and we always ensure that they know [about it] ... and it is just another source of information that they can grasp if that is all they want and they don't want to engage yet ...'

Non-government organisation

'It's breaking down the barriers just by being there in their environment [referring to GPs visiting schools] ... they see GPs as providers as credible ... and [we] encourage [young] people [to] take responsibility for their own health and access health independently if needed ...'

Division of General Practice

'The service [art and music program] provides an opportunity for them [young people] to come in and express themselves in a safe way, in a non threatening environment ... and that often helps them work through a lot of issues that are happening in their lives. It re-engages them.'

Non-government organisation

5. Recommendations



1. For Area Health Services:

- i. Area Health Services in NSW *develop a lead role* in improving access to and quality of primary health care for young people across the state by:

assigning responsibility to a suitable delegate for coordinating youth health or ideally
creating Youth Health Coordinator positions, sitting across various streams (health promotion, drug and alcohol, mental health, sexual health).

- ii. The Youth Health Coordinator (or equivalent) would be a *leadership* position with the power to influence, and should be provided with *appropriate infrastructure support and budgets*. Their role should include capacity building of services (such as ensuring suitable training and support for service providers),

service improvement (via implementation of 'youth-friendly' policies and practices), facilitating youth participation, and networking and collaboration across sectors, particularly with local *Divisions of General Practice*. Their role should *not* be concerned with seeking funding to maintain the viability of their own position.

iii. In the interim, Area Health Services (particularly in rural areas) should establish local youth health working parties to begin the development of local projects as well as to lobby for a Youth Health Coordinator.

2. For Youth Health Services:

i. Youth Health Services (most of which in NSW are administered by Area Health Services) work with Youth Health Coordinators (or persons with equivalent responsibility) to *develop strategies for sharing their expertise with mainstream and NGO service providers* about facilitating access for young people.

ii. Youth Health Services maintain their direct work focus on targeting marginalised and at-risk young people.

3. For Divisions of General Practice:

i. All Divisions of General Practice *develop policies and procedures* to improve access to general practice for young people in their geographic areas. Divisions explore existing models of youth-friendly general practice to assist and inform them.

ii. Divisions of General Practice intending to go into schools to promote GP services should map all schools in the Division area and formulate a strategy for prioritising school visits based on clearly defined need, rationale or request. This should be done in consultation with the schools. Collaborate with schools beforehand to plan visits to maximise the potential to promote access to GPs or other health services.

iii. Since 'whole of school strategies' have been demonstrated to be more successful, it would be advantageous to examine 'MindMatters Plus GP'⁴, which employs a unified strategy for GPs working with schools or linking with aspects of school curriculums that are already developed. The models used by 'health promoting schools'⁵ and MindMatters Plus GP are encouraged, while one-off talks are discouraged as a whole of school approach is more effective.

iv. Personnel responsible for implementing MindMatters Plus GP explore and communicate with existing *Division of General Practice* GP in Schools programs prior to commencement.

4. For all sectors:

i. *Area Health Services, Divisions of General Practice, Youth Health Services and NGO service providers* in overlapping geographic areas *develop formal links* through *Better Futures*⁶ to provide support for one another in the provision of accessible services for young people and to facilitate pathways to referral and care. The Area Youth Health Coordinator (or equivalent) could be responsible for developing these links.

⁴ Australian Principals Associations Professional Development Council and Curriculum Corporation in partnership with the Australian Divisions of General Practice (2003). MindMatters Plus GP initiative. See also Section 4.

⁵ NSW Health Department (2000). Health Promotion with Schools: a policy for the health system. ISBN: 07347350543.

⁶ NSW Government (2003). Better Futures Regional Strategy.

- ii. Health care providers establish links with *other government sectors, particularly education*, to promote their services.
- iii. Delivery of the health syllabus *in schools* includes practical information about how to access health services.
- iv. Sectors with excellent models of collaboration, such as *non-government organisations* and *Youth Health services* develop protocols and share their expertise with other sectors, possibly through *Families First*⁷ initiatives.
- v. The *school clinic model* has much support from the international literature and should be properly piloted and evaluated to examine the effectiveness of the model for Australia.
- vi. Services review their *accountability and reporting structures*, so that innovative engagement strategies (such as arts-based and health promotion activities) can be counted statistically.

6. Practical suggestions

Awareness

- Define the target group (e.g. school students, all young people in local area, young people of particular ethnic, cultural or other background, young people who are same-sex attracted) and be aware of relevant sensitivities
- Identify setting(s) for promoting service or program (e.g. local schools, community groups including youth centres, parent and family groups, media).
- Develop promotional materials, preferably in consultation with young people from target group, including key information that will facilitate access (confidentiality, services offered, cost, transport, opening hours).
- Develop 'word of mouth' strategies where appropriate, such as inviting young people to 'bring a friend', engaging youth networks to promote service.
- Consider alternate promotional methods (such as peer education, group work) and media that young people may access (e.g. internet).

Confidentiality

- Develop policy about confidentiality and involve young people in the process.
- Make policy visible and accessible to target group and key support people (such as parents, guardians, youth workers) via, for example, pamphlets, notices in waiting areas.
- Ensure that all staff within service are familiar with confidentiality policy, principles and practice and that they discuss these in detail with the young people at the first appointment.

Trust

- Acknowledge and address the sensitivities and difficulties that young people may have in presenting for help.
- Ensure that all staff within service understand the importance of trust for young people.
- Train all staff in basic communication techniques that will assist in engaging young people by overcoming barriers such as embarrassment and self-consciousness.
- Identify and liaise with trusted support people (e.g. youth workers, school personnel, parents) who can facilitate referral to your service.
- Review physical space within service (e.g. waiting room configuration, location of front door and corridors) and physical access points, such that young people's concerns about visibility and privacy are addressed as much as possible.

⁷ Families First: a NSW Government Initiative. See www.parenting.nsw.gov.au

- Advertise confidentiality policy.
- Allow for young people to present anonymously (once trust is gained it is likely that young people will disclose their identity).

Cost

- Offer free or low cost service to target group. For medical care, doctors offer bulk-billing to all young people who present.

Physical accessibility

- Where possible, locate service near public transport and near venues frequented by young people such as schools, well-utilised youth services, recreational venues.
- Review and/or improve physical accessibility to target group/s, including physical layout of service (entry and exit doors, waiting areas), opening hours, flexibility of appointments and outreach.

Flexibility

- Open service in afternoons and evenings.
- Offer some drop-in service.
- Develop links and referral pathways with after-hours services.
- Have outreach to other locations.
- Have anonymous service provision where feasible (similar to some sexual health and needle exchange services).

Time

- Offer long appointments to all young people, but particularly new clients.
- Wherever possible, remove fee-for-service consultations, or utilise fee structures that are acceptable to provider and enable long consultations.

Knowledge

- Ensure all providers and related personnel have sufficient skills and knowledge to feel confident in forming trusting relationships with young people who are or become clients of their service. This must include, as a minimum, basic training in youth health issues, communication skills, young people's barriers to health care and how they can be overcome.
- Develop professional development review system to allow regular update in skills and knowledge.

Confidence

- Review providers' confidence and implement strategies above (knowledge) and/or below (support).

Support

- Ensure that every provider has regular supervision or regular peer review forums (such as client review meetings, collegiate/peer review meetings, debriefing meetings).
- Ensure that relevant linkages/support systems/protocols are in place with mental health services, in particular psychiatric support for GPs and other health staff dealing with mental health issues.
- Develop a local directory of relevant youth (+/- family) services and ensure all providers have a copy.
- Establish and/or maintain inter-agency meetings. Where service is not youth-specific (e.g. general practices, community health centres), delegate representative to inter-agency who can feedback to service.

Chapter 5: Evidence-based practice

1. Definition of principle



Services and their programs are developed according to evidence of need and of better practice from the most reliable and appropriate local, national or international sources.

2. Indicators

- Evidence is provided for the establishment of a service and/or programs within a service.
- Evidence is regularly updated about changing or emerging needs of target population/s, personnel and other stakeholders.

3. Key literature

Few concepts are more important to health services today than *evidence-based practice* (EBP). A natural extension of the more narrowly focused evidence-based medicine movement, EBP calls on health care practitioners and health service managers to adopt ***the conscientious and judicious use of the best available scientific evidence in the health care of individuals and populations***. In reality, management decisions about service delivery are often based on short-term demands, meaning that policies and programs may be developed from anecdotal evidence alone. EBP provides information and some of the tools to help with priority setting. It promotes better practice and better use of resources.

At first glance there is nothing that is radically new about evidence-based practice. Modern health care professionals have always maintained that health care interventions have been based on sound scientific knowledge and training. However, in recent years, improved conceptual and research methodologies have allowed more rigorous concepts of evidence to emerge and for these to be incorporated into decision-making processes. Particularly important have been the development and application of fine-grained statistical techniques that characterise the effects and health outcomes of interventions at a population level rather than an individual level.

EBP calls on individuals and organisations to ground their work in a growing world-wide literature that draws on sound ***experimental design and systematic observations of outcomes***. Anecdotal evidence based on case studies or the valuable opinions of learned and experienced individuals (although often complementary) are not generally regarded as sufficient in themselves. As the pressure on resources increases there will be a transition from opinion-based to evidence-based decision-making. EBP enables those managing services to determine the mix of services and programs that will give the greatest benefits and eliminate ineffective interventions.

The key components of EBP (Brownson et al., 2003) are:

1. Convert the information needs into *answerable questions*.
2. *Search* for the best evidence to answer questions from the literature, clinical examination and other sources.
3. *Appraise* evidence for its validity and clinical applicability.
4. *Apply* the results of this application.
5. *Evaluate* performance.

To appraise the evidence (and plan evaluation) a hierarchy of *levels of evidence* has been developed and is regularly revised. These 'levels of evidence' (Gray, 1997) in order of preference are:

1. Systematic review comparing randomised controlled trials
2. Systematic review comparing cohort studies (involves pre- and post-measures)
3. Well-designed non-experimental studies from more than one research group or centre.
4. Opinion of well-respected authorities based on clinical evidence, descriptive studies or reports from experts.

It is obvious that adopting EBP could place enormous demands on service providers and managers. Health policy makers and researchers are endeavouring to address this through such measures as 'clinical practice guidelines', which typically consist of recommendations based on the best available evidence which are regularly updated. A current relevant example in Australia is the National Health and Medical Research Council's guidelines for the management of depression in young people.⁸ In addition to such guidelines, workers have access to primary and secondary sources of evidence. Databases such as Cochrane provide evaluation and summaries of outcomes of health trials. Health workers can familiarise themselves with such tools to inform and augment day-to-day practice and program design. In Australia, access to the Cochrane library (online) is free (subsidised by the Australian government).

A common misconception is that evidence-based practice emphasises a particular biomedical approach and has no part to play where problems reflect personal, social or cultural issues. Indeed, the exponential growth of qualitative research and complex system evaluation methodologies reflects the need to understand the 'how' or 'why' rather than just the 'what'.

Nevertheless, there have been arguments for and against evidence-based practice. Difficulties in evaluating the arguments and counter-arguments arise out of a lack of any empirical evaluation of the effectiveness of EBP itself, the inconsistencies of EBP across disciplines, differences between a population-based and individual approach, and how to combine 'the evidence' with clinical experience and consumer perspectives.

There are in fact some compelling reasons for providers within the health care sector to adopt an evidence-based approach, wherever relevant, and these resonate strongly across all sectors and disciplines in health care:

1. **As a strategy to promote quality and consistency across the health care system** The adoption of EBP will help ensure that health care interventions are delivered in accordance with the highest standards across the whole health sector by promoting only those that have been shown to work according to the best possible evidence. EBP can improve provider skills and confidence, identify gaps in knowledge or service provision and measure the extent to which government policies are working.
2. **As a strategy to protect consumers and health service providers alike by minimising preventable adverse events** Many interventions long believed to be effective treatments for health problems have been discarded as useless or harmful due to the application of EBP. By promoting only those interventions that have been shown to work and to have an acceptable (and clearly communicable) risk profile, evidence-based practice endeavours to reduce the high number of preventable adverse events that occur in the health system due to poor interventions. It is important to eliminate interventions ranging from no to minimal benefit (and thus costly) to those that are simply harmful. History has produced countless examples of both, from the over-prescription of antibiotics to the medical hubris of deep sleep therapy.
3. **As a strategy to promote efficiency in health care funding** Evidence-based practice allows funding bodies to concentrate resources on interventions that have been shown to have the most benefit in line with community values. It also helps minimise wastage on ineffective but historically entrenched programs. Organisations and service providers that embrace evidence-based practice and can combine it with the growing number of health economics tools available (such as cost-benefit, cost-effectiveness and cost-utility analyses) will be at a distinct advantage over the coming years.

The implications of evidence-based practice are broad and will be further discussed below in the sections on Professional Development; Inter- and Intra-Sectoral Collaboration; Sustainability and Evaluation.

4. What some services interviewed during Access: Phase 2 said about evidence-based practice

⁸ National Health and Medical Research Council. *Depression in young people*. <www.nhmrc.gov.au/publications/pdf/cp37.pdf>

'In a small town you need to look at the evidence, what is available and define what you can do with these resources and where the gap is.'

Youth Health Service

'People don't necessarily want to back something with you till you get the evidence but you can't get the evidence until people back it. I see that as a difficulty with anything that takes an innovative approach.'

Non-government organisation

5. Recommendations



1. All services have clear aims and objectives in accordance with the best available evidence defining the needs of the target group. Target group participation or consultation is ideal to gain or enhance this knowledge.
2. All services develop and review their programs based on evidence of what works.
3. All evidence is reviewed in the context of local needs.
4. For further assistance with evidence-based practice refer to the NHMRC series on 'Guide to clinical practice guidelines', particularly 'How to put the evidence into practice: implementation and dissemination strategies'.⁹
5. Where there is not much evidence but there appears to be a need for a service or program, rather than discarding an innovative idea, build up evidence prior to, or as part of, the service or program.

Such evidence can include:

- published local, national or international literature
- quantitative research such as epidemiological and other surveys, intervention studies
- qualitative research such as stakeholder consultations, focus groups and/or individual interviews.

The nature of research may include:

- scoping study – a broad exploration of the area or community to help define the target population, their needs and available services
- needs assessment – where there is a clearly defined target group, identify their needs via the literature and direct consultation with them, as well as obtaining information from relevant others, such as service providers and other stakeholders (e.g. parents)
- pilot study – where a program is developed, implemented and evaluated
- epidemiological study
- intervention or other evaluation study.

Anecdotal evidence alone is generally inadequate.

6. Allocate resources (including funding) only to programs which describe the evidence and clearly articulated goals, or which include a proposal to create new evidence (e.g. pilot study).

⁹ Available at www.health.gov.au/nhmrc/publications/pdf/cp71.pdf

7. Develop evaluation tools to measure the impact and outcome of innovative programs, such as arts and music based programs (which historically have not been subjected to 'scientific enquiry').

8. Regularly review the evidence and consult with young people to detect changing or emerging needs, ensuring that the service responds accordingly.

6. Practical suggestions

Evidence provided for establishment of service and/or programs within service

- Consult first and/or collaborate with evidence-based practice expert, or more experienced service, if required.
- Seek evidence from anecdotal data and published local, national or international literature regarding the needs of local young people for the development of the program. This evidence can also include surveys, focus groups and consultations.
- Ensure evidence is of a proper standard. If evidence is only anecdotal, carry out preliminary studies first, e.g. scoping studies, formal needs assessments using appropriate sampling techniques from target group and appropriate techniques to gather information.
- Use this evidence to formulate aims and objectives.
- Incorporate evidence of what works (from the same sources) into program development.

Evidence regularly updated about changing and emerging needs of target population/s, personnel and other stakeholders

- Consult with research and evaluation experts, or a more experienced service, if necessary about how to review evidence.
- Evaluate service and programs regularly against aims and objectives.
- Consult with the target group in order to detect changing or emerging needs and effectiveness of the programs.

Further reading

Goldman HH, Ganju V, Drake MD et al. (2001). Policy implications for implementing evidence-based practice. *Psychiatric Services*; 52, December: 1591–1597.

Haynes RB (2002). What kind of evidence is it that evidence-based medicine advocates want health care providers and consumers to pay attention to? *BMC Health Services Research*; 2(3). Accessed 06/01/2004, <<http://www.biomedcentral.com/1472-6963/2/3>>.

Murray CJL, Mathers CD, Salomon JA. (2003). Towards evidence-based public health. In Murray and Evans (eds), *Health systems performance assessment: debates, methods and empiricism* (pp. 715–726). Geneva: World Health Organization, Geneva.

Niessen LW, Grijseels EWM, Rutten FFH (2000). The evidence-based approach in health policy and health care delivery. *Social Science and Medicine*; 51(6), 859–869.

Ramchandani P, Joughin C, Zwi M. (2001). Evidence-based child and adolescent mental health services: oxymoron or brave new dawn? *Child Psychology and Psychiatry Review*; 6(2), 59–64.

Trinder L et al. (eds). *Evidence based practice: a critical appraisal* (2000). Oxford: Blackwell Science.

Chapter 6: Youth participation

1. Definition of principle



Young people are actively involved in the development, implementation, review and evaluation of services and programs (in ways that create for each young person a sense of ownership of, importance to, influence within and/or belonging to that service or program, and a sense of mutual respect).

2. Indicators

- Service has policy, protocols and procedures in place for appropriate youth participation and consultation.
- Service has mechanism to regularly review the effectiveness of its youth participation strategies.
- Young people's input is sought about how they can participate.
- Young people are given appropriate knowledge and skills about how to participate (e.g. how to have a voice in meetings, how to facilitate meetings, how to consult with their peers in ways that bring useful information back to service providers).
- Young people are given credit for their participation and appropriately remunerated for their expertise, in monetary terms where possible, or in kind.
- Service has mechanism to ensure that youth participation is sufficiently representative so that the needs and views of the whole target group and/or different target groups are canvassed.

3. Key literature

Community participation as a concept was developed in the post-World War II period as a means of addressing poverty. The strategy originally attempted to resolve health and living conditions for the poor in urban areas of the industrialised world and developing countries. Consumer participation is now widely accepted as a strategy in health planning. It is considered to provide 'a mechanism for potential beneficiaries of health services to be involved in the design, implementation and evaluation of activities with the overall aim of increasing the responsiveness, sustainability and efficiency of health services or health programs' (Mubyazi & Hutton, 2003). It can, when implemented judiciously, facilitate the development of successful programs with excellent health gains. It fosters efficiency, self-reliance, good governance and democracy. It builds broad-based capacity for decision-making and control at the local level, increasing motivation and improving skills within the community. It can help to reduce inequities and inequalities in health and make providers more accountable to the communities they serve. Active consumer participation leads to more accessible and effective health services; effective strategies for consumer participation use methods that facilitate participation of those who are traditionally marginalised.

However, the evidence base for the effectiveness of community participation is not straightforward. Research into consumer participation is still emerging and much has not employed the 'higher level' research methodologies. Qualitative research is likely to be equally as important as, if not more than, the 'gold standard' systematic review. Outcomes reported by studies are very varied in terms of their success. The main reason for the variation in results is the different perspectives of what community participation is, resulting in different approaches in implementing public participation. Participation ranges from, for example, parents turning up to a program to have their children immunised (that is, a more passive involvement in predetermined activities) to full control of organisations and health-

related affairs where agendas are set, implemented and evaluated by the community, for the community.

At its worst, participation can be thought of as a way to mobilise community resources to supplement health services, rather than being at the forefront and contributing to the way in which services are run. It can therefore easily continue to ignore the poorest and those most in need and as a result not contribute to reducing health inequities.

Apart from clarity of definition and purpose of participation, other factors identified as impeding the success of participation programs include reluctance of professionals to involve the community; mistrust by the community; inadequate representation from the community; poor communication; 'projectisation'¹⁰ and inadequate resource allocation. In the majority of these cases participation is perceived as a concept rather than as a practice.

Participation can backfire when it creates consolidation of power rather than broad-based local involvement; when programs are designed by professionals based in health services who use the rhetoric and not the practice of participation; when there is a lack of responsiveness by the system to consumer needs and when there is a lack of representation at key decision-making forums. It isn't a magic solution when all other strategies have failed. It is a continuous strategy that requires flexibility, adequate time and resources, commitment, dedication and frequently the initiation of local strategies for local issues.

Real participation is relevant. It can provide more cost-effective health care; assist in problem-solving that lies outside the domain of health care; promote self-reliance, diminishing dependence on professionals; change people's attitudes to causes of ill health; decrease misuse or under-use of services; make a community-based intervention relevant; and contribute to better resource allocation.

Participation by youth is acknowledged by the United Nations' Convention on the Rights of the Child (1989), which affirms the right to participation for all people up to 18 years of age. As an integral element of community life, 'all children have a right to express their views and to have them taken into account in all matters that affect them'. The Convention recognises the status of a young person as 'a subject of rights, who is able to form and express opinions, to participate in decision-making processes and influence solutions, to intervene in the process of social change and in the building of democracy'.

Barriers to youth participation include:

- cultural norms that favour hierarchical relationships between young and old
- economic circumstance (in other than income-generating activities)
- lack of access to information
- adults'/youths' mindsets fixed on 'ageism'
- judgemental attitudes between generations based on age
- conflicts that arise from differences in learning and working styles, time-management,
- communication patterns and means of involvement.

Youth participation must therefore be founded on the knowledge that youth are assets to the community, active agents of change, and contribute energy, insight and idealism to problem-solving. They are already making strong contributions to others and too often remain an untapped source in developing strategies to improve health. Generally people are willing to participate in activities when the issue affects them personally. Often participation is generated under extreme circumstances, bringing together people within a geographical area, or people with common ideals, who may not normally meet together, to solve a shared problem. People may participate because of their own vision and personal motivation. Others need to be motivated through encouragement by committed adults, peers and organisations.

¹⁰ 'Projectisation' – a short-term activity that provides inadequate time frames or unsustainable levels of funds to show benefits and, even when successful, uncertainty that it can be effectively and sustainably replicated or adopted on a large scale. 37

4. What some services interviewed during Access: Phase 2 said about youth participation

'Even in these difficult circumstances [referring to young people in custody], representation can be sought.'

Other government organisation

'If young people don't own something they don't become engaged so it is often a compromise between us and them in terms of what we end up doing. That can sometimes be a challenge for the organisation.'

Youth Health Service

'You need to get the right people [service providers] with a passion for young people, who are close to them, who know what they want from a service. If you keep young people up to date they will tell you what they think. With any partnership it's about being flexible.'

Non-government organisation

5. Recommendations



1. Services and programs that target young people incorporate youth participation as a service/program principle, articulated in their mission statements and strategic and/or business plans.
2. Services and programs that target young people develop strategies for enhancing youth participation in their service or program development, implementation, delivery and evaluation. A variety of strategies may be utilised including committee representation, focus group or other consultations, and group, meeting or workshop facilitation.
3. Any review of a service or program always seeks the views of its target group through appropriate and representative consultation.
4. Services and programs regularly review their youth participation mechanisms to ensure that they are broad, meaningful and representative.
5. Young people are appropriately trained and remunerated to represent the target group.
6. **Youth Health Services** develop a lead role in writing protocols to ensure *meaningful and representative* youth participation, to be shared with other organisations.

6. Practical suggestions

Service has policy, protocols and procedures in place for appropriate youth participation and consultation

- Formulate clear reasons and objectives for wanting young people to participate in your service as this will guide your implementation.
- If available, contact your local Youth Health Service or Youth Health Coordinator to obtain advice or copies of youth participation policies and strategies to assist.
- If you already have one, offer to share this with local services and sectors, such as Divisions of General Practice.
- All health services can contact local high schools to obtain their policies and strategies for youth representation.

Service has mechanism to regularly review the effectiveness of its youth participation strategies

- Include this item at your annual general meeting, planning days or other review forums.
- Invite young people to (at least) this part of meetings.

Young people's input is sought about how they can participate

- Ask young people how they want to participate and offer options (committees such as management committees, reference groups, advisory boards; attendance at meetings and, if so, which ones; via surveys, focus groups, suggestion boxes).
- Give young people feedback about their participation from the providers' perspectives as well as getting their feedback about their experience of participating.
- At regular intervals, ask those young people who have participated how useful they found the participation mechanism.

Young people are given appropriate knowledge and skills about how to participate if these are lacking (e.g. how to have a voice in meetings, how to facilitate meetings, how to consult with their peers in ways that bring useful information back to service providers)

- After deciding on the mechanism/s for participation, ask the young people whether they have ever had experience in these roles and whether they want or need to be given knowledge or skills to enhance their confidence and capacity to contribute.
- Liaise with other services to organise 'training seminars' with and for the young people – it helps pool resources and expertise, as well as modelling networking and collaboration.

Young people are given credit for their participation and are appropriately remunerated for their expertise where possible, in money or in kind

- Work towards a culture of acknowledgement of young people as experts who deserve to be valued and remunerated in the same way that any other expert colleagues would be.
- Pay young people for their participation either in cash or 'in kind' (e.g. cinema tickets, CDs).
- Inform people who have participated about the outcomes of their contribution, either verbally, in person or in writing.

Service has a mechanism to ensure that youth participation is sufficiently representative so that the needs and views of the whole target group and/or different target groups are canvassed

- Regularly review the 'list' of individuals who make up your youth representatives.
- Make sure that you have different individuals and groups of young people represented, not just the 'same few'.
- Avoid having a particular young person simply because he/she represents a particular special interest group if that special interest group is not relevant to your program aims (this goes back to being clear about your objectives).
- You may need to use different strategies to obtain the views of young people who are not naturally outspoken or who do not want leadership roles.

Further reading

Barnett, K & Associates (2000). Youth participation handbook: a guide for organisations seeking to involve young people on boards and committees. Adelaide: Department of Education, Training and Employment, Government of South Australia, Office of Employment and Youth.

Consumer Focus Collaboration (2001). The evidence supporting consumer participation in health. <www.participateinhealth.org.au/clearinghouse/#E> (Accessed June 2005).

NSW Commission for Children and Young People (2001). Taking PARTicipation seriously. <www.kids.nsw.gov.au> (Accessed June 2005).

NSW Government Action Plan Implementation Group (2001). Consumer and community participation draft report. SHPN (HPA) 010022. Sydney: NSW Health Department.

Chapter 7: Collaboration

1. Definition of principle



Service providers (within a service, as well as different services within and across sectors) who share common service goals and target groups network, communicate and/or work together to plan, deliver, review and evaluate their service provision to young people.

2. Indicators

- Collaboration within and between services is articulated in service's strategic plan.
- Potential collaborative partners are identified within service's strategic and/or business plans. The plan/s identify the purpose and potential benefits of collaboration and the roles and resources of different partners.
- Protocols are developed to operationalise the collaboration and review process, including communication channels, referral pathways and feedback mechanisms.
- Young people are informed about collaborative practices and involved as equal partners where appropriate.

3. Key literature

'Collaboration is a complex process requiring time, resources and commitment.'

Hoatson & Egan, 2001

Human health and well-being are complex phenomena, and the determinants of health are diverse, varied in origin and often outside the direct control (but not interest) of the health care sector itself. Maintaining the health of an individual and of a society thus needs to occur at multiple levels and multiple fronts.

As different government bodies, institutions, organisations and agencies throughout society can influence health outcomes, health service providers need to identify in a concrete manner those with which collaboration will be fruitful.

Below are brief summaries from the literature of the reasons for, barriers to and implementation of collaboration.

Some of the *reasons for* collaboration (Sebuliba & Vostanis, 2001; Wise, 1995) include:

- better use of health resources
- reduction in duplication of services
- working together to find solutions to commonly agreed problems that are complex in nature
- addressing inequalities in health status
- developing sustainable solutions
- joint training
- mutually supportive relationships
- greater cost effectiveness than with fragmented services
- improved impact
- greater credibility.

Some of the *difficulties* of collaboration (Hoatson & Egan, 2001; Wise, 1995) include:

- loss of autonomy
- time required to facilitate it (so that commitment needs to be high)
- issues from past collaborations (negative experiences)
- balancing what the parties feel they have to gain with the effort required
- survival in a competitive environment.

Partnerships can be developed in a range of areas besides service delivery, including training, education, policy development and improving access. A number of factors have been identified as being important for successful collaboration, including openness and honesty, mutual respect, flexible dynamic leadership, secure funding, adequate resources, flexible funding, providing training, having a program champion, patience and encouragement, as well as creating an organisational climate where risk-taking and innovation are encouraged and failure is not punished (Wise, 1995).

Implementing collaboration needs to be an active process led by committed managers or team leaders. Some of the issues identified as important in *implementing* collaboration (Wise, 1995) include:

- recognition of why it is important to work together
- acknowledgement that the process is changing
- having clearly articulated, achievable goals
- an agreed way of working
- opportunities to renegotiate the relationship at every stage
- a sense of joint ownership
- establishment of designated staff who have the resources to undertake action.

4. What some services interviewed during Access: Phase 2 said about collaboration

'To bring young people up well you need a network village and collaborative work.'

Youth Health Service

'We have a good partnership between the government and the non-government sector because of the fact that we are in partnership rather than competition. This is extremely important. It allows you to specialise in certain areas and get a wide range of skills from other sources. We have joint protocols to assist us in the set-up addressing confidentiality/duty of care/room usage and times available.'

Non-government organisation

'Collaboration is a great thing providing there is a purpose. We like to ask what is the purpose, what is the benefit to young people, or to other services, and how are we going to do it, and then we get a service agreement together ... so both parties know exactly what the expectations are, and I think it's important that it's reciprocal ... it's typed up and signed ... I don't know if you need the document, but it's a commitment. We try to be quite strategic about what collaborative project we take on. So there needs to be a focus on our strategic plan ...'

Youth Health Service

'... collaboration is essential but ... it has to be respectful, meaningful and planned so that it facilitates working with young people rather than being a barrier to it.'

Youth Health Service

5. Recommendations



1. Services for young people review current strategic or business plans to incorporate collaboration as a guiding principle.
2. Services identify strategic partners and mechanisms for collaboration. 'Mechanisms' may include partnerships, service agreements, memoranda of understanding, contracts, joint committees, inter-agencies, formal and informal networks.
3. Youth Health Services extend their collaborative practices to include mainstream services, such as general practice and community health.
4. Expertise and resources are shared wherever possible.
5. Services share case management and co-locate where possible.
6. Education and training activities for service providers are interdisciplinary whenever appropriate.
7. Organisations identify conflicts of interest and attempt to overcome resistance to change.

6. Practical suggestions

Collaboration within and between services articulated in service's strategic plan

- Articulate principle of collaboration in strategic plan.
- Allocate resources (particularly time) to explore this with your service/team such as including it in a planning day.
- Identify potential barriers to collaboration (such as time constraints, concerns about client confidentiality, losing clients, fear or anxiety about different approaches to managing health problems) and discuss with your team ways to overcome these.

Potential collaborative partners identified within service's strategic and/or business plans, which identify the purpose and potential benefits of collaboration and the roles and resources of different partners

- Find out whether there is a Youth Health Coordinator in your Area and, if so, make contact with them to discuss collaboration.
- Map services in your area or sector to help identify potential collaborative partners.
- Consider all the sectors described in this document, not just the sectors and services that you are familiar with. If you have rarely had contact with another sector, make time to get to know them. This is particularly recommended for services which rarely communicate with one another (e.g. between mainstream and youth-specific services such as general practitioners and Youth Health Services or non-government organisations). Remember that young people identified general practitioners as the health professional they would most likely turn to if they had a health problem.¹¹
- Organise a forum to meet and perhaps plan collaboration.
- To plan collaboration, compare aims and objectives of services and programs, examine where skills overlap and are different, define roles, clarify how and why a collaboration would be useful for the target group/s and service providers.

¹¹ Booth M, Bernard D, Quine S, Kang M, Beasley L, Usherwood T, Alperstein G & Bennett D (2002). Access to health care among NSW adolescents: Phase 1: Final Report. Sydney: NSW Centre for the Advancement of Adolescent Health, The Children's Hospital at Westmead. ISBN: 0 95779 513 0.

Protocols developed to operationalise the collaboration and review process, including communication channels, referral pathways and feedback mechanisms

- Develop protocols for 'partner seeking', review of collaboration, communication channels with other providers, referral pathways and feedback mechanisms.
- If you have never done this before, contact a more experienced service. If you have experience with different ways to collaborate, share your protocols and experiences with other services.
- Obtain samples of memoranda of understanding and/or service agreements from other services.
- Identify conflicts of interest and possible change strategies to overcome these.
- Identify respective roles and responsibilities.
- Always turn to your initial 'map' and any partners when planning training to see where expertise can be shared.
- Share resources, training, expertise and case management where possible and/or co-locate where appropriate.

Young people informed about collaborative practices and involved as equal partners where appropriate

- Make information about collaboration and partners available and accessible to young people (e.g. pamphlets, written notices, via youth reference groups or other committees).
- In clinical practice, ensure that young people understand how, when and why there would be communication between service providers and the nature of information to be exchanged (e.g. a GP referring to a counsellor or a medical specialist and vice versa). Obtain written consent from the young person where appropriate.

Chapter 8: Professional development

1. Definition of principle



Appropriate, adequate and ongoing professional development, support and supervision should be available to health service providers working with young people.

2. Indicators

- All staff have access to **core** professional development activities such as orientation to a new position, appropriate supervision and in-service training.
- All staff have a mechanism to review and discuss their professional development needs and plan training activities around those needs. This will include seeking the most appropriate and accessible training activities to meet needs.
- Services provide an adequate and appropriate budget for staff professional development.
- Wherever appropriate, young people are involved in training.
- Services provide feedback mechanisms for staff to share newly acquired knowledge.
- Services collaborate around training to maximise resources and share expertise.
- Where appropriate, staff are rotated through, or exposed to, different roles within a service to gain a broader knowledge and skill base.
- Evaluation of quality and outcomes of training is planned. For some disciplines and some activities, this is pre-built into the training activity (e.g. general practitioner continuing education programs). Thus professional development activities that are known to improve young people's and/or service provider outcomes are favoured.

3. Key literature

The health care professions have always recognised the value of life-long professional development. Knowledge, practice and treatments, as well as the health care system itself, evolve over time. It is imperative that service providers keep up with developments relevant to their work in order to maintain professional competency and, importantly, that their day-to-day practices reflect this.

The emergence of evidence-based practice has introduced a recent and challenging dimension to ongoing professional development. For the goals of EBP to be realised (see Chapter 5) the growing body of evidence needs to be translated into practice. A common theme in the professional development literature is that historically entrenched and traditional forms of continuing education (for example, the attendance of conferences and lectures) are failing to do this, the result being that many health care consumers consistently fail to receive care that is commensurate with the best available evidence (Grohl & Grimshaw, 1999).

Recognised barriers to the implementation of evidence-based practice include:

- the sheer amount of information that health care professionals are now expected to be familiar with
- the broad range of skills required to access and critically evaluate the validity and generalisability of evidence as it emerges

- the increasing complexity and multi-disciplinary nature of health care provision, requiring collaboration between traditionally separate training and education programs (see Chapter 7) the forces of habit and inertia that govern a good deal of human behaviour and practice.

In response to such challenges, and in the spirit of EBP itself, a body of evidence is emerging detailing the relative effectiveness of various continuing education strategies. A recent overview of 41 systematic reviews of educational interventions **designed to change health care provider behaviour** across professions (Grimshaw et al., 2001) concluded that results are mixed and heavily dependent on the quality of the design and follow-up of the educational intervention itself. Nonetheless, a common theme is the recognition of the generally ineffective nature of passive strategies alone. These include distribution of printed material (including clinical practice guidelines), conferences, lectures and workshops. Other kinds of interventions such as patient mediated interventions, audit cycles and direct office support were found to be more promising but only under specific circumstances. Multifaceted interventions involving combinations of the above and tailored to the local practice needs of providers were more likely to be effective (Oxman et al., 1995).

Continuing education for health professionals must aim to improve performance, not just increase knowledge. Thus professional development activities are increasingly coming under scrutiny and, seemingly, need to include strategies that achieve and measure changes in behaviour or performance of clinicians. Vital components of designing professional development activities are conducting prior needs assessments and ensuring that the activity is based around the work that the health professional does (Cantillon & Jones, 1999).

Australian research (Sanci et al., 2000) has demonstrated from a randomised controlled trial that educating general practitioners in adolescent health was effective at improving knowledge, attitudes and self-perceived competency and that these changes were sustained or even improved after 13 months.

Importantly, practice reinforcing and enabling strategies were built into the education program. These included 1) being provided with an adolescent assessment chart for patient audit; 2) being required to complete a logbook for reflection on experience with audited patients; 3) being required to assemble a list of adolescent health services in the GP's local area; 4) being provided with a tutor who could be accessed by phone for professional support between workshops; and 5) being encouraged to participate in a refresher and feedback session to reflect on experiences in practice six weeks after the final workshop.

4. What some services interviewed during Access: Phase 2 said about professional development

'I think the GPs are taking the skills they are learning back into their practices and I think they are sharing their skills too.'

Division of General Practice

'We have a fairly small budget we can use for training but for new staff there is a bit more of an allowance made in getting them skilled up. Also there is a lot of free training around. We try to access as much of that as we can, and if we can't do it the ones who do go report back to the staff and feed back some of the information they have been given. We try to spread it around a bit, so everyone gets an opportunity to go and if anyone has a particular area of interest ...'

Youth Health Service

'All staff have their own training plans around what they need to do in relation to their jobs. We do it regularly with staff, see what their training needs are and try and provide that as best as possible ...'

Youth Health Service

5. Recommendations



1. Services and programs for young people review current strategic or business plans to incorporate professional development as a guiding principle.
2. There needs to be a *standardisation of training* in basic knowledge and skills across disciplines and sectors (a flexible, replicable program). Access to such training and budget allowances should be incorporated into all services.
3. Services and programs develop protocols to review staff professional development needs, identify gaps, plan future activities and evaluate staff training.
4. Adequate resources are made available to services for equitable and adequate access to professional development of their staff.
5. Expertise and resources are shared wherever possible – inter-agency forums could include professional development as standing agenda items to discuss and negotiate shared and interdisciplinary training. Representatives from all sectors should be included.

6. Practical suggestions

All staff have access to core professional development activities

- As part of the strategic planning process, decide what the core professional development activities of the service should be. Examples include new staff orientation, regular in-service attendance, peer review, appropriate supervision, regular presentations to staff or other professional forums about a particular topic, clinical audits and journal clubs. For some services, regular (e.g. annual) attendance and/or presentation at a national conference might be an appropriate core activity. For professionals with mandatory professional development requirements (such as GPs), discuss and plan continuing education activities relevant to the youth health programs being developed.
- These core activities should be incorporated into service or program policies and staff work plans.

All staff have a mechanism to review and discuss their professional development needs and plan training activities around those needs, including seeking the most appropriate and accessible training activities to meet needs

- Develop protocols to assess and review staff professional development needs, identify gaps, plan future activities and evaluate staff training.
- Include mechanisms to implement professional development policies, such as a professional development committee, individual staff appraisals, service review and planning days, quality improvement activities.
- Record activities in individual logbooks, staff diaries, a central database. Some professions (e.g. GPs) have central records kept by their quality assurance governing body.

Services provide an adequate and appropriate budget for staff professional development

- Ensure your service has adequate resources for equitable access to professional development activities and/or make professional development a priority if it has not been.
- Seek low-cost or free training where budgets are very limited and, if possible, share registrations and information, and liaise with other services to see whether resources and skills (such as training each other where services have different and complementary knowledge and skills) can be shared as a 'quid pro quo'.

Wherever appropriate, young people are involved in training

- When planning professional development activities, decide whether and how young people could be involved. Examples include consultation prior to the professional development activity to help inform appropriateness of content (e.g. if planning to train staff about access issues or how to create a 'youth-friendly environment, young people's views could be very helpful) or delivery (e.g. if you want young people to participate on the training day itself, you will need their input into how this could happen); inviting young people as guest speakers (individually or as a panel); asking young people to assist with role playing (very useful for teaching communication skills).

Services provide feedback mechanisms within the service for staff to share newly acquired knowledge

- This can happen, for example, at staff meetings (have a standing agenda item, 'professional development'), a separate regular 'professional development feedback' meeting or at inservices.
- Include all staff in this from across disciplines – it is useful not only for sharing information, but also for giving staff the opportunity to 'translate' what they have learned that is discipline-specific (e.g. 'update in medical management of sexually transmitted infections'; 'cognitive behaviour therapy for treating depression') into language that all their colleagues can understand. Ultimately this enhances each worker's understanding of how their work complements that of other health professionals.

Services collaborate around training to maximise resources and share expertise

- Plan a professional development calendar with other services. If this is unrealistic, share your calendar with other services and ask to see theirs. This will help to identify areas of common professional development need. If you have a Youth Health Coordinator in your Area, approach them first as this can help all relevant services in the same Area with their planning.
- Include local experts as guest speakers – this could even be someone in your own service!

Where appropriate, staff are rotated through or exposed to different roles within a service to gain a broader knowledge and skill base

- An example of a role where this works well is as 'worker on duty' or 'intake officer' – staff can be rotated or rostered and learn about the point of first contact that young people or their carers make with a service. Another example of an opportunity for staff to gain valuable experience is rotating them through a drop-in service or recreational space if the service has one.
- For more formal or traditional service settings, such as the GP surgery or Community Health Centre, this may not be practical or even desirable. However, GPs and CHC staff may gain valuable experience by visiting youth health centres, schools and other youth centres. Such visits can be incorporated into a professional development calendar or individual's training plan.

Evaluation of quality and outcomes of training is planned and enforced. For some disciplines and some activities, this is pre-built into the training activity (e.g. general practitioner continuing education programs). Thus professional development activities that are known to improve young people's and/or service provider outcomes are favoured.

- Some professional disciplines have existing mandatory professional development and those professionals can select activities that have been approved or accredited (this at least ensures that the quality assurance body is conducting reasonable process evaluation).
- Training activities can also be selected on the basis that they have been, or will be, subjected to evaluation.
- Services can also conduct internal quality assurance via individual staff appraisals (as above under the first indicator) or staff feedback.
- In general, one-off didactic lectures are not as likely to change practice as longer interactive activities based on individual needs

Chapter 9: Sustainability

1. Definition of principle



Services develop and implement strategies that optimise their longevity.

2. Indicators

- Service has, and reviews, *strategic and business plans with sustainability strategies*, such as income generation, development of partnerships and collaboration, evaluation process to measure the effectiveness of its programs.
- Programs and services are *integrated* with existing mainstream programs and services wherever appropriate
- Programs are designed to be *replicable* in other settings and/or contexts.
- Programs that measurably improve young people's or services' *outcomes* are favoured.
- The program has a 'champion' (*advocate*) who has connections with boards or funding bodies.

3. Key literature

Sustainability can be defined as long-term viability in the maintenance or continuation of a service or program. It is a dynamic process with the sense of permanence and time and the ability to respond to new needs and circumstances. A program is likely to be sustained when it can show improvement in, or maintenance of, health benefits over a long period of time.

Other definitions of sustainability incorporate clarifications to the concept by adding what are considered by some to be critical components of sustainability. For example, the U.S. Agency for International Development (1988) in its definition provides a focus on sustainability only having occurred when health benefits are being achieved without human or physical resource allocation from the initial funding body. A project is considered sustainable only when it 'delivers an appropriate level of benefits for an extended period of time **after major financial, managerial and technical assistance from an external donor is terminated**'. Alternative definitions also emphasise this shift in responsibility for program funding from the initiator to another source, be it another organisation or the community. For example, Steckler and Goodman (1989) refer to program continuation through the '**integration of a new program within an organisation**'. Yin (1979) similarly sees that sustainability is being achieved when '**new practices become standard business in a local agency**'. The need for funding becomes obsolete as an established organisation builds the program into its existing infrastructure, presumably absorbing costs and ensuring that the project is sustained. Or funding may become obsolete as the community sustains programs as their capacity is built through '**local access to the knowledge, skills and resources needed to conduct effective health promotion programs**' (Jackson et al., 1994).

These latter definitions highlight documented criticism of current funding models, such as demonstration projects and seed funding, often used by funding bodies in response to allocation of scarce resources. Altman et al. (1991) found that deficient funding and lack of a reliable long-term funding base was an obstacle to achieving program goals and objectives. This was supported by Janz et al. (1996) where inadequacy in the duration of funding and inability to locate additional funds were major factors impeding intervention effectiveness. Not only does short-term funding decrease the chance of sustainability but it also fosters poor practice in program implementation and evaluation. In

addition, any new programs receive diminished community support as trust deteriorates (Goodman & Steckler, 1987/88, 1989).

Programs need to be sustained if the problem remains or recurs or when the current model attains the desired outcomes using the most efficacious, most suitable and most cost-effective approach.

There are three main tenets fundamental to good program management and improved likelihood of sustainability. Firstly there needs to be a stable base from which the program stems. This base needs to comprise people who are fully committed to the issue and have the desire to problem solve and meet challenges head on. Participants need to be visionary leaders who can engage the participation of others. Establishing this base may require recurrent funding. Committed volunteers are more likely to organise a response when the issue is critical to them personally and can provide an alternative mechanism to resource allocation. This core group of stable members must be deeply involved in moving the program forward. Other structures can be used to facilitate different types and levels of participation that suit the capacities, time orientation and availability of youth, for example, a loose network of short-term action groups coupled with this stable working group and more regular members.

Secondly, sustainability needs to be actively planned for at the creation phase of the program and benchmarks of achievement set within the planning process. It may be the set role of an individual who is employed to seek funds or develop self-funding opportunities, or to lobby other organisations to take the program initiatives on board, or it could be the responsibility of a number of staff members. If the latter is the case, then part of the program involves building the relevant skills through training and mentoring in this area. It is also important to incorporate measures of capacity building in the recipients within training and planning processes. In addition, opportunity needs to be provided for open dialogue with potential funders.

Benchmarks need to be constantly reviewed, program strategies reflected on and evidence bases updated. Program managers need to be flexible and promote changes to programs as community needs change or as evidence of more efficacious strategies become apparent.

Lastly, 'champions' within strategically allied organisations can provide support, open doors and give useful technical, human and physical resource assistance and advice.

4. What some services interviewed during Access: Phase 2 said about sustainability

<p><i>'The more you build on other services in the area and link, the more sustainable you are.'</i></p> <p style="text-align: right;">Youth Health Service</p>
<p><i>'I interpret sustainability as partnering our clients. They have resources and so do we and together we can achieve an outcome. You are giving young people the resources so they can learn skills and options for the future. They won't necessarily come back to you but you have put them on the path to sustainable change.'</i></p> <p style="text-align: right;">Non-government organisation</p>
<p><i>'I think for us sustainability is more around things like relationships and getting better at writing up what we do because at the end of the day the only thing that does become evidence based is what people write up.'</i></p> <p style="text-align: right;">Non-government organisation</p>
<p><i>'One thing that makes the service sustainable is that we have actively sought a variety of funding bodies, in that to be reliant on one government department for funding in the community doesn't lend itself to sustainability if something happens to that funding ... and we rotate our staff ... it's multiskilling your workers and making sure they are resourced.'</i></p> <p style="text-align: right;">Non-government organisation</p>
<p><i>'Sustainability is crucial for effective programs otherwise young people's hopes will be raised only to be disappointed.'</i></p> <p style="text-align: right;">Youth Health Service</p>

‘The best sustainability is where the service has developed the enhancement themselves, that is the service providers are more likely to use (them) as they are committed to them. Optimal service enhancement is likely to be achieved with limited funding that supports a service to develop their own procedures supported by policy requirements.’

Area Health Program

5. Recommendations



1. Strategies for service sustainability are a core element of service planning.
2. Services explore independent funding sources or partnerships, particularly with mainstream organisations, where resources and expertise could be shared.
3. Services regularly evaluate their programs to stay abreast with changing needs and make programs viable.
4. Services working with schools work towards incorporation of programs into school curriculum and/or school policy.
5. Services develop the capacity building of their own staff to improve the quality of service provision available to young people.
6. Services allocate resources (time, money, human resources) to recruit an advocate (or ‘champion’) for the service.
7. Skills and resources of providers are shared to optimise efficiency and expertise.

6. Practical suggestions

Service has, and reviews, strategic and business plans that articulate and describe sustainability strategies, such as income generation, development of partnerships and collaboration, and evaluation process to measure the effectiveness of its programs

- Allow time for this at strategic planning meetings and include it on the agenda.
- Consult with more experienced services beforehand if appropriate.
- Include sustainability strategies with all program proposals.
- Include evaluation with all program proposals (see next chapter).
- Ensure service strategies for sustainability are a core element of service planning.

Programs and services are integrated with existing mainstream programs and services wherever appropriate

- Try to identify and explore existing mainstream programs and services and seek consultation, collaboration and/or partnership where appropriate. Examples include school curriculum and school-based programs, and developing networks and referral pathways with mainstream services such as general practice.

Programs are designed to be replicable in other settings and/or contexts

- Always consider ‘universal’ or ‘generic’ versus ‘specific’ or ‘targeted’ needs and responses to those needs. For example, if a service decides to invest resources in developing an arts program to facilitate access for marginalised young people, consider the needs of ALL marginalised young people as well as those of the service’s specific catchment area or target

group and determine whether and how the program to be developed can have universal applicability to other groups of marginalised young people.

Programs that measurably improve young people's or services' outcomes are favoured

This relates to seeking and using the evidence to inform practice and service or program development (Chapter 5) and incorporating evaluation into new programs (Chapter 10).

Program has a 'champion' (advocate) who has connections with boards or funding bodies

Find a program 'champion' who can function as an advocate for the service – this may in some instances, or initially, be the service manager or a delegated staff member. Develop a duties statement for this role.

Chapter 10: Evaluation

1. Definition of principle



Services regularly examine the quality, relevance and results of their programs using appropriate evaluation methods (which include measuring the outcomes of the service for young people and service providers against their program goals).

2. Indicators

- Service has clear aims and objectives, which are linked to evidence.
- Service evaluates against aims and objectives.
- Service incorporates evaluation into its operations (via business, operational, project or other appropriate plan).
- Service allows sufficient resources (financial, human, time) to conduct evaluation at timely and appropriate intervals.
- Service or program identifies appropriate type of evaluation (e.g. process, impact or outcome) and develops strategies for conducting the evaluation.
- Service incorporates evaluation findings as new evidence.
- Increase in provider knowledge, skills and confidence.
- Decrease in young people's negative health outcomes/increase in young people's help-seeking and positive health outcomes.

3. Key literature

Rigorous evaluation of health care interventions and programs is a vital component of evidence-based practice (EBP) because evaluation leads to action based on evidence. For EBP to be a viable concern there must be ongoing contribution to an evidence body of 'what works', 'why' and 'at what cost'. Although it is an unreasonable expectation that the majority of health care program evaluations will satisfy 'Level 1' criteria for evidence (i.e. randomised controlled trial), it is not unreasonable for them to make valuable contributions to Levels 2 to 4, e.g. expert opinion (see Chapter 5).

For this reason significant work has been carried out to produce generalisable evaluation frameworks to assist health care practitioners and organisations. It is not feasible to elaborate on specific models although the models of Friedman (2003), Funnell, 1997 (Program Logic) and Pawson and Tilley, 1998 (Realistic Evaluation) all have merit in terms of use in community and other health settings.

So why evaluate?

Evaluation is important to judge the effectiveness of new and existing programs (Fink, 2003) and ensures that the program makes a useful contribution to the problems it is trying to address (Hawe et al., 1994). Furthermore, evaluation is a systematic way to improve and account for public health actions (Center for Disease Control and Prevention, 1999). Evaluation provides feedback about progress. It contributes to theory building. Many health workers avoid evaluation because of fear of failure; however, discovering what doesn't work is as important as knowing what does. Strong market forces are impelling those who finance services to pay close attention to outcomes and value for

money. The choice of what is evaluated should be guided by resources and priorities. Evaluation should be a dynamic, cyclical and never-ending process.

Types of evaluation

While quantitative methods can be useful for determining facts (such as how many young people attend a service in a given time period), qualitative methods are useful for describing why things happen as they do (Patton, 1987). Weaknesses in qualitative methods may be overcome by using multiple information collection strategies called triangulation.

The following is summarised from Hawe et al. (1994):

Process evaluation addresses the question of program implementation, that is, to what extent is the program being implemented as planned (in terms of material, content, target group, etc.).

Impact evaluation assesses the extent to which program objectives are being met (intended and unintended). It gives immediate and proximal outcomes.

Outcome evaluation provides feedback on changes in health status, morbidity, mortality and quality of life that can be attributed to the program.

Indicators can be used as a measure of the extent to which targets are being reached.

The questions to consider in program evaluation (Centre for Disease Control and Prevention, 1999) include:

1. What is being evaluated and why?
2. What aspects of a program are pertinent to understanding program performance?
3. What criteria or standards of success will a program be assessed against?
4. What evidence will be used to indicate or measure program performance?
5. What 'level of evidence' is to be obtained and what conclusions are justified by the chosen methodology? (In other words, how reliable is the evidence based on the method?)
6. How will lessons learned from the evaluation be put to best use?

Evaluation contributes to evidence-based practice in showing what works and why. Evidence-based practice is essential because it determines the mix of practice that will best serve the population and eliminates less effective programs. Implementing these does not necessarily mean new personnel, although it can mean personnel participating in new learning. This can be a part of ongoing professional development or may simply involve a new way of looking at things with the skills and resources of current staff. The removal of systemic barriers also needs to be considered.

4. What some services interviewed during Access: Phase 2 said about evaluation:

'Evaluation is a key part of this organisation's approach to service delivery.'

Other (non-health) government organisation

'It's so intangible really. Sometimes the fact that they are still alive is an outcome, the fact that they might have decreased their drug use. It might be that they have got part-time work. It's so variable and so individual for each person. It might be that they have tried to commit suicide less this year than last year. But it's some sort of positive. I guess we give them some sense of hope for the future, for them to be able to see that there might be a different way. Sometimes that might only be a little glimmer ...'

Non-government organisation

'Evaluation is how we keep the program operating at a high standard, changing with the needs of the community.'

Non-government organisation

5. Recommendations



Evaluation is incorporated into all services' strategic and business plans and adequate resources are allocated.

Even minimal evaluation, such as client and service provider thoughts, can be helpful in defining the issues and guiding future directions. Evaluation of what *doesn't work* is also useful in this context.

Services define and review their goals in order to link these to evaluation.

Where services lack the skills or resources for evaluation they look to outside partners to provide these (particularly universities which often need projects for students and are free).

At a minimum, services utilise *process* measures to evaluate client and worker satisfaction and whether the program has done what it set out to do (program activities/materials/facilitation).

Where feasible, *impact* and *outcomes* are measured (for young people and service providers). These require pre- and post-measures and longer term follow-up.

Where external evaluators are employed, they are well adapted to all sectors (including the non-government sector).

Art and other creative programs are considered viable and attempts are made to show the outcomes of these programs, which we believe are measurable.

6. Practical suggestions

Service has clear aims and objectives, which are linked to evidence

- Obtain basic information to constitute evidence such as target group demographics (from sources such as the Australian Bureau of Statistics, your local Public Health Unit), health issues affecting the target group and information about other services or programs, as well as conducting a local needs assessment with target group and stakeholders.
- Invest time to determine what your aims and objectives are, being willing to change these if they are not able to be evaluated adequately.
- Think broadly when developing aims and objectives: consider not only the target group, but the service providers, collaborators, and operational and management issues. However, be as specific as possible when writing objectives (aims can be broader but must still be able to be linked with the evaluation process).

Service evaluates against aims and objectives

- Determine evaluation measures for each objective (one tool of measurement may be able to address multiple objectives).
- Return to your aims and objectives during the course of the program as well as at the end to see if you are 'keeping on track'.
- Define the indicators that will show whether the program is achieving what it is attempting to measure.

Service incorporates evaluation into its operations (via business, operational, project or other appropriate plan)

- Include evaluation as part of annual (or other) planning meetings, as they are part of a quality assurance process.

Service allows sufficient resources (financial, human, time) to conduct evaluation at timely and appropriate intervals

- Make allowance in budgets (including new grant applications for projects) for evaluation – this may involve paying an evaluation consultant.
- Develop/strengthen links with organisations such as universities and actively seek partnerships. People and organisations with evaluation and academic expertise can be viewed as potential collaborators as well.

Service or program identifies appropriate type of evaluation (e.g. process, impact or outcome evaluation) and develops strategies for conducting this

- Determine which method of evaluation best suits what the service/program wants to evaluate – quantitative (numbers); qualitative (why); process (program implementation, i.e. type of materials/content/target group reach); impact (immediate outcomes of program); outcomes (changes in health status).
- At a minimum attempt to incorporate at least a process evaluation.
- Process evaluation might include collation of statistics (e.g. service utilisation, client demographics); client satisfaction surveys; focus groups to obtain client views; change in service provider knowledge, attitudes or confidence.
- Impact evaluation might include 'before and after' to ascertain the impact on knowledge and behaviour change of young people or service providers; referral patterns within services; attendance rates; changes in provider behaviours/service provision.
- Outcome measures might include pre- and post-measures of young people about changes in health behaviours such as drug use and/or pregnancy rates.
- External evaluators may be used, provided their appropriateness is ensured and their understanding of content area is adequate.
- Determine the standard of evaluation and evidence the method will generate, that is, what 'level of evidence' it will produce and how reliable will be the findings as a result of the particular method.

Service incorporates evaluation findings as new evidence

- Incorporate findings of evaluation as evidence regarding program effectiveness (or not) and adjust programs accordingly.

Increase in provider knowledge, skills and confidence

- Part of the evaluation process can be linked directly to professional development, for example, as part of individual staff member's annual appraisal (or other professional development review process). The service can then report on changes in staff knowledge, skills and confidence based on collation of professional development reviews of staff members.

Decrease in young people's negative health outcomes/increase in young people's help-seeking and positive health outcomes

- This indicator may be more difficult to achieve; however, services should start to orientate their evaluations and service provision towards this. As a minimum, services should start to measure service utilisation by their target group as a means of indirectly measuring help-seeking.

Section 3: Principles in practice – case studies from five sectors

This section presents a number of case examples from across the five sectors that were included in the study. It is divided into chapters based on each of these sectors:

1. Youth Health Services
2. Area Health Service
 - Area Youth Health Coordinator Positions
 - Area Health Service Programs
3. Division of General Practice Youth Health Programs
 - GPs in Schools programs
 - GP-run youth health clinics
 - Other division projects
4. Non-government organisation programs
5. Other government sector programs

Note that in the **education sector**, relevant NSW government school programs are described separately in **Section 5**.

Please note that *all* organisations we interviewed in the *Access: Phase 2* study contributed to the understanding, identification and description of the principles of better practice. Case examples are featured on the basis of information provided during the interviews and where a particular issue is being highlighted. Not being featured does *not* imply a less valuable service. Not every principle in every sector is illustrated with case examples as this would have been repetitive. Many of the strategies described by services during interviews have already appeared in Section 2.

Chapter 11: Youth Health Services

A Youth Health Service is a multidisciplinary primary health care service specifically for young people. The target age range varies between services from 12 to 20 or 25 years.

In NSW some Youth Health Services receive funding from the joint Commonwealth and State program, *Innovative Health Services for Homeless Youth* (IHSY). In contrast to the other States and Territories, the majority of IHSY-funded services in NSW are administered via the Area Health Service (in other states they are mostly administered through non-government organisations). Thus most Youth Health Services sit within the health sector, often receiving their major funding from this source.

The primary aim of all the Youth Health Services in NSW is to improve access to services for marginalised young people, and a common philosophy includes a social view of health and social justice and equity principles. All Youth Health Services are free and allow for young people to attend anonymously if desired. Programs within Youth Health Services in NSW are varied. The enormous range includes drop-in, basic needs, cooking lessons, counselling, education, free medical services, links with education facilities, creative arts, music, formal service links with other government departments, bi-lingual services, after-hours, some leisure activities (such as basketball), outreach services (including buses, needle exchange facilities, sexual health services, medical clinics, mental health services, group work, peer work and parenting).

Principle 1: Access facilitation

1. Urban Youth Health Service

Indicators illustrated: all

Formal promotion strategies are built into planning. There is a promotions officer whose role is to network and promote the service to the target group. There are multiple access points into the service, such as a 'worker on duty' who responds to drop-in and crisis calls; and there are basic needs and drop-in services for young people to enter the service without feeling threatened. The service operates an outreach bus at relevant community events where young people can find out about the service. It stays open after hours one night per week and has strong links with relevant after-hours services. There is a confidentiality policy that is explained to young people during service promotion activities, via pamphlets in the waiting room, or at first contact with a staff member, and there is a sheet that young people sign during their first clinical appointment to say it has been explained. The service is located close to public transport and is wheelchair accessible. The service is free and proof of identity is not required. All staff are trained in working with young people and understand the need for trust, and can work flexibly within their roles or may work in more than one role within the service. Young people needing individual appointments are offered long consultation times. Staff receive support via debriefing meetings, client review meetings, external supervision, networking meetings and appropriate professional development activities.

2. Rural Youth Health Service: medical clinic within youth centre

Indicators illustrated: awareness

'A lot of the promotion is carried out by the youth workers. The youth workers talk to all new young people who attend. At one centre, they actually sign up each new young person who attends the centre as a member and during that there is an orientation and they let them know there is a clinic every Friday night and they give them an overview of the kind of issues they can bring to the health clinic. The youth workers work quite hard at the promotion as they have more skills in this and were more familiar with how to promote the service. They also rang the local refuges and let them know we'd have a GP here once or twice a month, that they could bring young people to, with bulk billing and no appointments etc.'

Principle 2: Evidence-based practice

Two urban youth health services

Indicators illustrated: all

One of the first Youth Health Services in NSW was *modelled on an existing and evaluated service* in New York. This was a 'one stop shop' for young people who were disenfranchised. The focus was on providing holistic services and creating multiple access points. Other Youth Health Services have developed programs based on *emerging needs*, in turn based on local or national evidence. Two examples include youth suicide prevention programs and a program aiming to keep young people engaged in education, as a result of national and international evidence demonstrating that retention in education leads to better health outcomes. The education program has also been *evaluated* and demonstrates that innovative and parallel pathways to education are acceptable to disengaged young people and achieve high course completion rates.

Principle 3: Youth participation

Various youth health services

Indicators illustrated: policy and procedures for youth participation; review mechanism; young people given knowledge and skills; young people remunerated

'Young people have a voice by representation on our advisory committee, and as facilitators on certain programs with payment.'

'Young people are always involved in our cycle. If there is a particular change we are considering in the service we set up formal consultations with them. The last one was about the change in drop-in age group and changing times of 'basic needs'. We had information sheets, feedback forms and evaluation after that. We had outside people help us with the evaluation. We often do specific youth surveys – how they are accessing counselling services, satisfaction with the service and so on. Also where we can, if we are organising formal consultation, we pay the young people for their time.'

'One of the ways we get specific feedback is we run focus groups [about] services provided. We [also] have a suggestion box ... There is also youth participation in the carrying out of our community development/health promotion projects in that young people decide what form those projects will take and those young people are involved in getting feedback from other young people who become involved in the programs. For example, for Youth Week last year, we had a production crew who were involved in the evaluation of different parts of the event, running it, gathering statistics and helping write it up.'

Principle 7: Evaluation

Urban youth health service

Indicators illustrated: aims and objectives linked to evidence; evaluation incorporated into operations; appropriate evaluation methods; evaluation becomes new evidence; health outcome changes

'We have an annual report where we review the tasks and so on, then individual projects have evaluations. We have planning forms with a section for planning, evaluation, recommendations and outcomes and we use that to work out whether a program is delivering something or not. We have a drug issue sub-committee, which identifies issues happening in the service and targets trying to address that. We document the quality improvement activities we do. Outcomes are always difficult. For us outcomes can be someone who attends education on each day they are supposed to come or a young person in drop-in might speak to a counsellor after six months or move out of an abusive home situation.'

Chapter 12: Area Health Service

1. Area Health Service Youth Health Coordinator Positions

At the time of the study, there were three Youth Health Coordinator (YHC) positions in NSW, out of a total of seventeen Area Health Services (AHS). Historically, these three positions were established in Area Health Services where there were no youth health services. These were Southern AHS, Northern Sydney AHS and South-Eastern Sydney AHS. A fourth position in Western Sydney AHS was established in 2003.

An Area Youth Health Coordinator can build capacity within the Area by linking people, resources and training, involving young people, seeking funding and advocating for change. This has been remarkably demonstrated, particularly in the rural Area, which previously had fragmented, geographically separated and isolated services.

The aims of the Youth Health Coordinator position are to:

- facilitate and support activities and projects that assist in the strategic development of youth health within the Area
- to develop and maintain a coordinated approach to youth health care within the Area
- to work in collaboration with key stakeholders, relevant agencies and young people both within and external to the health sector to enhance access to appropriate health services by youth
- to ensure quality of service provision and determine professional development needs in the relevant Areas.

Principle 1: Access facilitation

Indicators illustrated: awareness; confidentiality; trust; cost; physical accessibility; service provider knowledge; service provider confidence; service provider support

One Area Health Service examined an Area-based draft youth health policy in late 1999. This showed that there was minimal capacity for youth health service provision in the Area so two consultants suggested that the Area create the position of Youth Health Coordinator. The coordinator drove the youth health agenda and facilitated the establishment of services where there were none, close to transport, at no cost, with the collaboration of providers and young people. Service providers were trained and supported by the coordinator in working with young people, and a training package developed. Inter-agency meetings were convened and maintained. Young people who were consulted in the training through focus groups are involved in the training and are on committees.

Principle 3: Youth participation

Indicators illustrated: young people given knowledge and skills; young people remunerated

Young people were involved in focus groups in the development of a range of services throughout the Area. They were consulted during the development of training programs for health service providers. Youth reference groups were established where appropriate. A variety of youth participation procedures were implemented throughout the Area, including focus group consultations, surveys at school fetes, suggestion boxes at youth centres. Young people were appropriately trained and paid for their participation.

Principle 4: Collaboration

Indicators illustrated: partners identified; protocols developed

The YHC consulted each Area on their need for working more effectively with young people. This was done via a survey and focus groups of workers interested in working with young people. An email list of these workers was developed and coordinated through the health promoting schools coordinator in each Area. Each smaller local area had a committee of interested people which then developed a model of co-location and partnerships for the local sector. One outcome was that a building was rented using funding sourced by the YHC to establish a drop-in centre for young people where personnel from different services (Community Health Centre, Juvenile Justice, Sexual Health) provided a service for an agreed number of hours per week.

Principle 6: Sustainability

Indicators illustrated: programs integrated

For the modest outlay of the coordinator's salary the returns have been the facilitation of many partnerships, professional development, capacity building and integration into existing services. The YHC ensured strategies were linked with the Area Youth Health Policy. The position was reviewed after 12 months and is now permanent and the coordinator sourced much other funding for aspects of service provision in sub-areas.

2. Area Health Service Programs

Programs within Area Health Services were many and varied. The programs and projects selected for interview were chosen on the basis of the most prominent health issues identified by young people in *Access: Phase 1* (see Chapter 2, 'Methods of the study', and Table 1 in Appendix 3). The projects ranged from clinical activities, such as a school clinic provided by Community Health Centre staff, to primarily preventive, health promotion and/or educational activities such as one-off projects on a specific health issue and outreach into schools.

Principle 1: Access facilitation

1. Rural teen mother program

Indicators illustrated: trust, physical accessibility

This program promotes positive birth experience and ante/postnatal care to pregnant and parenting teens. It delivers a group program facilitated by a peer and a worker, and links the young women to appropriate services. The program provides *transport* for the young women to the group at the health service as transport is poor and they would otherwise have difficulty getting there. The presence of a peer promotes *trust*. This program was established because of *evidence* (local statistics) showing young pregnant women did not attend antenatal care. Their *outcomes* (physical and mental) have also improved since.

2. Rural Community Health Centre (CHC)

Indicators illustrated: awareness, confidentiality, cost, physical accessibility, flexibility

The first program of its kind in NSW, this CHC provides a clinical service in a local high school. Other rural areas have copied this model. The program provides a drop-in service during lunchtime for students to get health information and/or a clinical service provided by the CHC staff who rotate through the service. It is promoted through flyers, the school newsletter, the Student Representative Council (SRC), school staff, a sign-on door made by students, word of mouth. Promotion discusses

confidentiality and how the service works. Members of the CHC staff collaborate with school staff by going to meetings as well as being on the SRC to promote trust and understanding with young people. The service has received very positive feedback from young people about accessibility and confidentiality.

Principle 2: Evidence-based practice

1. Mental health service

Indicators illustrated: evidence to establish service

A mental health service conducted an *epidemiological study* in 1995 among 269 children who had at least 1 parent with a mental illness. The study revealed that isolation and stress were the most prominent experiences for them. The AHS developed a comprehensive program in response to these findings that involved teaching coping strategies, forming a peer support network, providing 'respite from home' and evaluation of these strategies.

2. Drug and alcohol project within Health Promotion Unit

Indicators illustrated: evidence to establish service

This unit developed an educational intervention based on *local and national evidence* that demonstrated that the prevalence of Hepatitis C was increasing. The intervention taught injecting drug users about safe injecting practices. Given the chaotic, often itinerant nature of the client group the intervention was intended to give enough useable information and skills in one visit to be useful. The *pilot program* was so successful at engaging the target group that it became the model for an ongoing program. Innovative engagement strategies included payment of the client if they then trained a friend in the same safe injecting techniques and further payment if the friend then accessed the service and demonstrated safe injecting techniques. The pilot study also led to individual tailoring of the program to meet different clients' needs.

3. Health promotion project within the Women's Health Department

Indicators illustrated: evidence to establish service

A sexual health service had observed an increasing number of clients through its rape crisis centre and sexual health clinics who had experienced date rape associated with spiked drinks. This anecdotal evidence led to the Women's Health Department conducting *focus groups* among university students to study awareness of spiked drinks. The results of their study provided evidence for a funding application by Women's Health to develop an awareness raising campaign about spiked drinks and date rape.

Principle 3: Youth participation

Drug and alcohol education forum in schools

Indicators illustrated: policy and procedures for youth participation; young people trained

Student volunteers are sought from schools to become part of the organising committee for the education forum. They are also trained in facilitation skills. The forum is promoted to all local high schools for and by young people, a 'word-of-mouth' strategy. The youth representatives have the opportunity to report back to each school following the education forums and present recommendations for drug and alcohol education.

Principle 4: Collaboration

A resource centre in a school Indicators illustrated: partners identified, protocols developed

The service was set up as a collaborative effort between a local interested GP who sourced Women's Health funding, a local interested principal and the Area Health Service, which provided funding for the social worker who manages the service. The service provides support and information to school staff, coordinates the local inter-agency and runs workshops for students and professionals. All these services are represented on the management committee of the centre, as are the local Aboriginal Medical Service, local council and local Child & Adolescent Mental Health Service. The services work together to facilitate a partnership model of 'preventive health care in a school setting' in a high risk area and school. There are also working parties to further explore youth health issues and develop strategies to address these.

Principle 5: Professional development

Training for rural workers *Note: This program describes a training program provided for workers (not how the service addresses its own professional development needs). However, the process of developing the training and conducting it model two of the indicators well.*

Indicators illustrated: services collaboration; evaluation of training

One Area Health Service developed a comprehensive training program in response to local requests for training from sexual health workers regarding homophobia, dealing with attitudes and values in rural communities, sexual and reproductive health issues, access issues, confidentiality and communicating with young people. The training 'package' utilised existing resources and expertise but also sought to strengthen networks:

'We had requests from the Area for training. We then looked at partners in our own organisations and opportunities for working together that we hadn't seen before. Workers could then network in our training which facilitated better communication. We had two teams. One [provided] generalist training in working with young people and contraceptive update. Then we had an Aboriginal focus group in the next town and a one-day teacher training. With teachers and health staff and part of the training was a panel of transgender young people. We had a local 'driver' who sorted out local needs and venues and then we provided the education. We also had a formal launch with a communication strategy so that messages were consistent. We provided teacher relief funding so teachers could attend. That was our partnership with DET [Department of Education and Training], we provided the funding and training and they provided the venue, participants and catering. Everyone knew what was expected of them and by when.'

Evaluation of the training involves a review by the Area Health Service of action plans developed and implemented by participants and process evaluation to identify what was learned and further needs. A pre- and post-evaluation of service utilisation is also being undertaken.

Principle 6: Sustainability (see also Evaluation case study 2 below)

A Mental Health Service program to improve management of self-harm among young people

Indicators illustrated: replicability; outcomes focused

This program developed self-harm management protocols and trained service providers in using them. This involved reviewing the literature, targeting service directors and clinical staff in order to engage their services, offering to assist with service re-orientation and professional development and making recommendations to the services. Once engaged, the program team helped services identify tasks for improvement in their management of self-harm, assisted services with changes to policies and procedures, organised staff development activities, and collected data to inform the services about progress with their identified tasks. A 'service activity scale' was developed to evaluate the capacity of the service to deliver the interventions. Data was also collected from clients and from a file audit. Client outcomes were measured using a standardised assessment package administered at initial contact and at one month and six months.

Principle 7: Evaluation

1. Cannabis education and skills training for teachers and parents

Indicators illustrated: evaluates against aims and objectives; evaluation incorporated into operations; evaluation becomes new evidence; increase in provider skills

This program is still working on its outcome measures but is incorporating 'capacity building indicators' into the evaluation. All parts of the actual program are measured with pre- and post-testing (at three months) for knowledge and attitudes, and in the case of service providers, confidence and knowledge in working with young people. There are also process measures of what teachers and parents learnt and liked about the program. Providers are asked if they feel more equipped to make referrals. Information collected is incorporated into the program for use in the workshops that follow.

2. Mental Health Service program to improve management of self-harm among young people (see also Sustainability case study above)

a) Camp to support young people whose parents suffer from a mental illness

Indicators illustrated: aims and objectives linked to evidence; evaluates against aims and objectives; evaluation incorporated into operations; sufficient resources for evaluation; appropriate evaluation methods; health outcome changes

Young people who participated in the camp were compared with young people who did not. Process and outcome evaluation methods were used, and included program feedback and a mental illness questionnaire (process evaluation) and the use of a range of instruments to measure outcomes in the participants. The instruments used were the Rosenberg self-esteem scale, adolescent coping scale and the Beck Hopelessness scale. Young people's sense of isolation decreased and coping increased but their self-esteem remained the same. Since the aims were to decrease isolation and increase coping skills these were appropriate outcome measures and outcomes.

b) Mental Health Service project to change provider skills

Indicators illustrated: aims and objectives linked to evidence; evaluates against aims and objectives; evaluation incorporated into operations; sufficient resources for evaluation; appropriate evaluation methods; evaluation becomes new evidence; increase in provider skills

The program aimed to improve the management of self-harm among young people, facilitate referral to the Mental Health Service and increase service utilisation by the target group of young people. The program assessed changes in the level of *service provision*, which was measured using a 'service activity scale', an instrument developed as part of the program. They assess the presence or absence of the service's capacity to deliver a list of evidence-based interventions. *Client outcomes* are assessed by a package of outcome measures administered at the initial contact and at one and six months. Measured outcomes were: service increased their delivery with more appropriate referrals and there was a decrease in time between crisis and first follow-up appointment. A new referral system using a 'greencard' to fast-track at risk young people was shown to be effective, with client compliance with follow-up increasing from 40 to 84%.

Chapter 13: Divisions of General Practice

A Division of General Practice (DGP) is a Commonwealth funded, geographically based organisation to support general practitioners and improve the quality of GP services. Each Division has its own programs, depending on needs in its region. There are 37 Divisions of General Practice in NSW.

There were two popular youth health programs being conducted by Divisions of General Practice: *GPs in Schools* and *GP-run youth health clinics*. Both types of programs aimed to improve access to GPs for young people and the quality of care delivered by GPs to young people. The application of the seven principles of better practice in youth health in these two programs are summarised in the following pages. At the end of this chapter other DGP youth health programs are summarised.

1. GPs in Schools programs

Of the 14 Divisions of General Practice in NSW who ran youth health programs, 9 ran a GPs in Schools program. The primary aim of all the GPs in Schools programs was to improve the accessibility of GPs to young people. This involved educating young people about overcoming barriers to access and GPs about youth-friendliness. Additional content was flexible and open to students' feedback and suggestions, sometimes including health-issue specific information. GPs involved in their Division's program were sometimes trained and then sent into local high schools to deliver sessions.

Liaison between Divisions of General Practice and the schools varied between programs from informal (but based on strong linkages, trust and familiarity) to more formal arrangements involving specific project liaison personnel. One Division went into schools with a specific (mental health) program only.

Principle 1: Access facilitation

Urban Division of General Practice

Indicators illustrated: awareness; confidentiality; trust; cost; physical accessibility; service provider confidence; service provider support

Their multi-strategic approach simultaneously:

- (a) recruited interested GPs from the Division who wanted to deliver higher quality services to young people, and put them through a rigorous process of training and practice review in order to become 'youth-friendly'. GPs were visited in their practices by the project officer and a young person (trained for the project). The GP's practice was assessed using a survey and checklist.
- (b) tried to develop stronger links with other youth relevant services by identifying them, contacting them and requesting information to go into a service directory for the GPs. The project officer attended youth inter-agency forums to promote the project and provide information about 'youth-interested GPs'. The GPs who became eligible to be on the youth-friendly list had to agree to bulk bill all young people. The list of youth-interested GPs was made available to schools, via the Division, and to other services. It provided information about transport and physical accessibility, opening hours, languages spoken and bulk billing.

Later in the project, the GPs targeted young people in schools directly (mapped all schools in the Area and contacted them). In consultation with schools, they developed a GP-led education program in schools to inform young people about what GPs do and how to access them. Confidentiality was thoroughly addressed in this education program.

Principle 2: Evidence-based practice

Regional Division of General Practice

Indicators illustrated: all

While many DGP projects conducted *local needs assessments* to inform projects, one DGP stood out as having a very strong evidence base and ongoing evidence review for their youth health program. Their program was initially developed in response to *national and local trends* in mental health and suicidality among young people. The first two years were spent *reviewing existing services* and the most *current national and international literature* about barriers to accessing care for young people. During this planning phase, they collaborated with a range of organisations, conducted *stakeholder consultations* and then undertook a large *local needs assessment*, including surveying GPs about their needs in order to improve their service provision to young people. On the basis of the *survey findings* it was decided that GPs' beliefs and attitudes about mental health needed to be addressed before they might be willing and more able to engage young people. A number of areas for work with GPs were then identified for subsequent training. A resource kit for GPs was also developed. The DGP *investigated similar projects* from other DGPs to see what could be learned from previous experience. The project also *developed measurement tools that they validated*, prior to commencing the project, to *evaluate their project* rigorously. The validation process involved research across Australia with 1800 school students about their 'intentions to seek help' using *standardised measures* and *focus groups*.

Principle 3: Youth participation

Urban Division of General Practice

Indicators illustrated: policy and procedures for youth participation; review mechanism; young people given knowledge and skills; young people remunerated

The project arose from a local needs assessment that extensively consulted with young people on their views about health and health care, and barriers to access. The consultations took place through interviews and focus groups and the sample was taken from a diverse group of young people. The program that subsequently evolved was informed and guided by a working party which always had a minimum of two young people on it throughout the project. The working party was consulted on every aspect of the project and met about every two months. Young people were recruited especially to be involved in the 'youth-friendly GP review' process. They were trained and paid to be involved in visiting GPs in the practices and offering feedback to them. Other young people, some recruited from local high schools' drama departments, were involved in the GP training, providing 'simulated patients' for teaching and practising communication skills. The project also involved GPs going into schools to provide information to students about how to access GPs – this process was evaluated by obtaining feedback from students to ensure that information provided was relevant to them.

Principle 4: Collaboration

Indicators illustrated: all

Three DGP projects stood out as having excellent collaboration (two involved GPs in Schools, one was a GP-run youth clinic). For all three, the initial project ideas evolved out of partnerships with other organisations (for two DGPs this was with the relevant Area Health Service, for one it was with an academic organisation and subsequently included other organisations, including appropriate education departments). These partnership arrangements were either initially, or subsequently, joint ventures with joint funding agreements. Two of the three projects formed committees or working parties to guide their projects, including representation from many other agencies and youth representation. All projects endeavoured to build or strengthen networks with other relevant services, such as schools, youth health or youth services, and local mental health and local sexual health services). These networks tended to be informal but effective at facilitating referrals and improving communication between providers and young people. For the GP-run youth clinic, workers from other agencies came in and provided a clinical service alongside the GP; similarly the GPs would outreach to provide a medical service in youth refuges.

Principle 7: Evaluation

Indicators illustrated: all

One DGP stood out as having high quality evaluation beyond process built in to its GPs in Schools project. The evaluation sought to measure change in both young people's and GPs' knowledge, attitudes, confidence and, to some extent, behaviour (impact measurement). The DGP developed an instrument to measure young people's knowledge, and intention to seek help. This instrument was validated and a pilot study was conducted to determine whether GPs going into schools had an impact on whether young people would be more likely to visit a GP. This pilot study showed a significant increase in the number of young people reporting their intention to seek help for both physical and psychological problems as well as a significant decrease in the barriers to seeking help. The pilot study also showed a correlation between young people who reported their intention to seek help, and actually doing so. The project is now planning a longitudinal study with a control group to measure sustainable changes in access to GPs by young people (outcome measurement) following the GPs in School intervention. The GP-focused evaluation was mostly process evaluation (to determine how confident they felt and how they could improve their school visits).

2. GP-run youth health clinics

Of the 15 Divisions of General Practice in NSW who ran youth health programs, 5 ran a youth medical clinic within an existing youth service. The primary aim of all the GP-run youth health clinics was to improve the accessibility of GPs to young people, particularly those who were marginalised. This involved overcoming barriers to access by providing a clinic in a youth service that they often already attended. GPs involved in their Division's program were sometimes trained and then provided services on a sessional basis, on occasion rotating with other GPs from the Division. All sessions were bulk billed or GPs were paid by their Division. Liaison between Divisions of General Practice and the youth centres varied from informal (but based on strong linkages, trust and familiarity) to more formal arrangements (e.g. joint funding of GP session between DGP and Area Health Service). Some innovative systems were developed to deal with other cost barriers, such as vouchers for medication, free pathology and free services provided by other specialist groups.

Principle 4: Collaboration

Rural Division of General Practice

Indicators illustrated: partners identified; young people involved

A GP was initially funded by the local Division for a period of three years to provide clinical services at the local youth centre. After this time the Division wished to allocate funding to other issues. The GP had built up such a reputation with young people and local workers that they advocated on her behalf. The local Area Health Service then agreed to take on the funding for the hours she provided at the local youth centre.

3. Other programs in Divisions of General Practice

Parenting programs

Rural DGP

Teen pregnancy was identified as an issue by a local high school. The Division collaborated with the local Youth Health Service to develop a project called 'Young Parents Speak Out', aiming to provide better support for young parents. The Division conducted sessions with students in the school followed by consultations with the community through a consultative committee (young parents, midwives, youth workers, Aboriginal workers, Division representatives). These consultations led to the idea that a **video** might be produced. The Division advertised for young parents to participate and were inundated. The video was produced first, followed by a **booklet**, which told young people's stories in the first half, with the second half devoted to factual information about pregnancy, birth and parenting.

A local writer was hired. All GPs now have the booklets in their surgeries and booklets have also been distributed to schools and other agencies who requested them. TAFE colleges purchased several and all the local midwives have copies. The success of this project led to a funding application by the Division to the Department of Family Services for a **parenting program** as the next phase of the project. Eleven GPs and eight other service providers were trained in the 'Triple P' parenting course. A consultative committee of stakeholders was formed to look at facilitating cross referrals so that organisations could be more accessible to young people as there was confusion about resources. The third phase involved **seminars for young parents** specifically addressing parenting issues (three in three separate locations) with discussion on how they could utilise the resources. Hand in hand with that was the development of a **resource kit** for participating parents and possibly for GPs to hand out otherwise. There is **pre- and post-evaluation** of the seminars. A whole project evaluation was being planned at the time of interview.

Urban DGP

In addition to establishing a GP-run clinic in a youth service, this DGP developed two other youth health programs:

- a) **Life Options Course** – an 8-week program for young mothers and/or pregnant young women under 25. The course runs once per week from 10am – 3pm and is facilitated by a project officer with GP presenters on certain topics. It is run twice per year.
- b) **PRAMS group** – parents, relationships and mothers support group run once per week for young mothers who are socially isolated.

Both of the programs above were developed as the result of a needs assessment. There were early evaluations but at the time of interview no further evaluation had been done. Funding was from the Division with an Area Health Service component.

Collaborative programs

Urban DGP

- a) **Medication voucher system** Funded by the local Medical Association who raise money by selling chocolates to patients in their surgeries. They raise a few thousand dollars per year. The youth worker liaising with the GPs then decides who gets these vouchers which can be used by young people to get medications from pharmacies.
- b) **Youth refuge visits** by GPs once a fortnight or 'as needed' for medical issues.

Rural DGP – 'voucher project'

This project was developed in response to discussions with local youth workers who felt that young people who needed to were not being seen by a doctor. Local doctors did not bulk bill, and so the project involved participating GPs agreeing to bulk bill the young people with vouchers. The vouchers provide the GP with an additional \$10 administration payment and act as an incentive for the GP as well as a referral pathway for young people between the youth workers who have a lot of contact with them and GPs. There is a maximum of three vouchers per young person. The Division has funded the project and it is being evaluated.

Regional collaboration with medical imaging, pathology, pharmacists

This DGP liaised with local pharmacists, medical imaging and pathology services to advocate for the medical needs of the young people being seen at the local Youth Health Service. As a result, several relevant medical agencies collaborated in this project by agreeing to reduce costs to the client. Young people from the Youth Health Service are given reductions on prescriptions by pharmacists. The local pathology service, which had a special interest in young people, has absorbed the cost for all pathology, including pick-up couriers etc. Medical imaging services bulk bill the young people from the Youth Health Service. GPs working at the clinics also bulk bill.

Chapter 14: Non-government organisations

Non-government organisations (NGOs) are independent from governments and their policies. These are usually non-profit organisations, and gain at least a significant proportion of their funding from private and corporate sources. Some do receive some funding from government sources. The programs and projects we selected for interview were chosen on the basis of the most prominent health issues identified by young people in *Access: Phase 1* (see Chapter 2, 'Methods of the study'). These organisations provide a range of diverse programs from accommodation, body image, art and music, and internet access to a range of homeless youth focused services.

Principle 1: Access facilitation

1. Holistic array of youth services in one location with outreach

Indicators illustrated: awareness; confidentiality; cost; physical accessibility; flexibility; service provider knowledge, service provider confidence, service provider support

One NGO operates a free centre-based service which offers an enormous array of programs under one roof, including recreational drop-in, programs on bullying, self-esteem, gambling, parenting and quitting cannabis; an alternative education program for Years 8 and 9 with pathway back to Year 10; vocational training; employment assistance for young people coming out of detention; sexual health promotion; general and drug and alcohol counselling. Confidentiality is addressed through policy and written materials. The service operates an outreach bus on Saturday afternoons in three local suburbs to promote the service and facilitate access. The service is promoted through pamphlets and brochures at bus stops, schools, in education programs, via the bus outreach and in different locations where the service operates other parts of the program. Drop-in is from 3–9pm from Tuesday to Saturday. Service providers receive training and rotate staff through different parts of the service to broaden their skills and confidence and make the job more dynamic.

2. Web-based 'help' service (see also Youth Participation and Sustainability case study 2 below)

Indicators illustrated: awareness; confidentiality; trust; cost; physical accessibility

One NGO sought corporate sponsorship to provide internet access around rural NSW on 'how to use the internet to access help services' with training and support for young people. Microsoft and Coca Cola provided funding for the technology and the NGO integrated this with the local youth centre program. The program provides the technology connection and training where IT resources would otherwise not be available. The emphasis is on helping the youth centre with community development, by engaging young people or reinforcing young people's connection with the centre. An advertising/promotion strategy was developed with corporate sponsors, using youth radio station (JJJ) and youth ambassadors. Young people tell their stories in one section on the website. This can be anonymous. As the program officer described it: 'By having those stories they have access to see that someone else has got through it and feel more connected to their community and peers because help-seeking can be an isolating experience. So from our experience if another young person has had CBT [cognitive behavioural therapy] and it has helped them the next young person is more likely to give it a shot, rather than rocking up to a service and having a bad experience and never giving it another go.'

3. Phone and internet help service

Indicators illustrated: awareness; confidentiality; trust; cost; physical accessibility

One NGO operates a 24-hour telephone counselling and referral service which has expanded to include a web-based service as well. The telephone counselling service is free Australia-wide (1800 number). The services are promoted through television advertising and on all school bus passes. Evaluation of their program showed 94% of 1644 high school students surveyed were aware of their service as a result of their advertising and that 80% had a clear knowledge of the kinds of services provided and that they were free and anonymous. There was also an increase in access of 24% after new equipment to enable more calls to get through was installed and more counsellors were provided.

4. Art and music program for at risk young people

Indicators illustrated: awareness; trust; flexibility

This program aims to engage young people otherwise unlikely to be engaged through involvement in artistic activities. Young people are supported to develop artworks over 12 months for an art exhibition (sponsored by Deutsche Bank) and/or music for 6 months to produce a CD (sponsored by Sony). A support worker helps them deal with other issues such as housing while they are in the program. Young people often re-engage with learning during this time and go on to mainstream education such as TAFE courses. Referrals come through word of mouth, youth workers and Juvenile Justice workers. The program is promoted to relevant services via a quarterly newsletter. The service is more sustainable because of its external financial support.

Principle 3: Youth Participation

A health promotion website for young people

Indicators illustrated: policy and procedures for youth participation; review mechanism; young people trained; young people paid

The program operates an interactive website that provides information about many health issues, including access to services. Young people are involved in 95% of the content on the site either through direct work with the NGO or via feedback through the website. The NGO program has an Advisory Board made up of young people who serve three-month terms. The NGO ensures that membership on the Advisory Board represents a cross-section of young people. The Board members interact on a daily basis via a live forum during their three-month terms and are then flown to Sydney for a three-day conference to workshop their ideas. After their Advisory Board membership expires, they are invited to be part of the youth ambassador network in their community where they can give advice or contribute to the website. They are trained in communication and promotion skills. This benefits young people in terms of their confidence and the organisation in terms of young people educating their peers.

Principle 4: Collaboration

1. NGO youth service

Indicators illustrated: partners identified

This service delivers an array of welfare programs including post-release support, street work and connection with families that target at risk young people. It collaborates with other agencies around client needs by first looking at the geographical area and examining what is provided. It then offers services to fill the gaps by providing joint services with other agencies. This makes best use of scarce resources, ensures that the services are relevant and needed, and makes communication between services easier. Some programs are true partnerships and others have steering committees that include partners such as representatives from the Juvenile Justice sector. The key is 'getting the right people involved that are passionate and know what young people want'.

2. Booklet and website for women to share their issues around body image

Indicators illustrated: partners identified; protocols developed

This NGO collaborated with a corporate organisation to the mutual benefit of both. The health issue being addressed was young women's body image and the collaboration involved establishment of a joint committee, with the roles and outcomes for each organisation outlined. The aim was to promote healthy body image among young women. The program ran groups and collected women's stories and art pieces about body image. The corporate sponsorship funded a booklet and a website page, the latter being launched by well-known media personalities. The booklets are sold, with sales going towards reprinting. Benefits for the corporate sponsor included their promotion as a 'community aware and involved' organisation, particularly as the company produces and sells cosmetic products.

Principle 5: Professional Development

Generalist youth service (see also Sustainability case study 1 below)

Indicators illustrated: staff rotate through different roles

One NGO generalist youth service had developed an innovative strategy to develop and enhance the skills of all its workers:

'We rotate our staff through the drop-in services as a way of engaging with different young people and also making sure that young people in the drop-in access other services such as counselling or employment because they actually get to know the counsellors/employment workers, working in the drop-in centre. It's a really good way of keeping the job dynamic and interesting for the workers. It increases job skills and is probably important for sustainability in terms of our staff rotating through all the programs of the service, that's our community face. It's multi -skilling workers but making sure that they are adequately resourced to do that. It also means if someone leaves there is someone with the skills that can fill the gap in the meantime.'

Principle 6: Sustainability

1. Generalist youth service (see also Professional Development above)

Indicators illustrated: strategic/business plan describes sustainability strategies; service has advocate

'We have actively sought a variety of funding bodies in that to be reliant on one government department for funding in the community doesn't lend itself to sustainability if something happens to that funding. Where we have lost money we have sometimes been able to keep programs going because of this alternate funding that could be sourced. Our management committee also has a high representation of business people and solicitors and more of a board than community management. That has been incredibly stable as well which has brought us good contacts, credibility and business linkages. That's been significant I think. What else is probably important for sustainability is that we rotate our staff.'

2. Internet health promotion site (see also Access Facilitation case study 2 and Youth Participation above)

Indicators illustrated: strategic/business plan describes sustainability strategies; service has advocate

'I think the first sustainability thing is cost-efficiency. I think in the early years the questions were more around we were new and what was working. People don't necessarily want to back something until you have the evidence but you can't get the evidence until people back it. Now we have corporate partners – they are pretty good because they understand that it takes two to three years before anything gets off the ground, for example, our relationship with [sponsor]. We spent one year doing nothing other than talking and understanding the cultures and thinking about the programs and how they could best work with us. What we found was that there were three areas where we could collaborate and now we are driving the outcomes.'

Principle 7: Evaluation

1. Program to improve access to services for young people who are homeless

Indicators illustrated: evaluates against aims and objectives; evaluation incorporated into operations; sufficient resources for evaluation

'Each of the services is evaluated on an annual basis. We visit policies and revise policies and procedures, looking at feedback from clients and trying to incorporate that. All clients are given a feedback form when they exit the program as well as annually. We have databases that help with that. It's mainly process about the experience, how approachable, how beneficial, whether confidentiality was respected, improvements to the service. A research design was also developed for the program comparing the personal circumstance of clients before and at the end of the pilot. They used key indicators such as accommodation history, family contact, participation in drug and alcohol use. Program issues were evaluated with staff. Clients were met with to get feedback about their experience. It was an indication of probable/possible benefits. While there was not a high degree of validity (small sample size) there was adequate information on key issues of the service and some indication of future issues and direction.'

2. Bullying training program for teachers

Indicators illustrated: all

This program sought to evaluate changes in teachers' classroom management as well as among students in the classroom. The changes in student bullying behaviour were evaluated via a longitudinal study over 2 years, with 1500 students in the pilot and 4000 students in the main study. Pre- and post-testing occurred at the beginning, middle and end of the program, using the Child Depression Inventory. Outcomes of the program included a 15% decrease in the level of bullying, with resultant improvement in depression levels and improved classroom management by teachers due to training.

3. Program providing a range of welfare programs for at risk young people

Indicators illustrated: evaluates against aims and objectives; evaluation incorporated into operations; sufficient resources for evaluation; appropriate evaluation methods; evaluation becomes new evidence

The program has built-in evaluation using a number of different strategies and methods. Some of these involve external and independent evaluators. Other features include annual self-evaluation of staff and internal audit processes for quality assurance (such as outstanding issues, waiting list times, demographic changes, major issues, numbers attending, client feedback forms). Workers evaluate what is enjoyable, awareness of the literature, administrative procedures, and training they attended. A casework analysis system from the UK (LAC) is used for casework evaluation.

Chapter 15: Other government organisations

Other government organisations (OGOs) are government organisations other than those in the health sector. OGOs provide a range of services that complement the services offered by health and NGOs, such as educational or justice initiatives. The programs and projects we selected for interview were chosen on the basis of the most prominent health issues identified by young people in *Access: Phase 1*. **Note:** some secondary school programs initiated by (or in partnership with) the Department of Education and Training are described in Section 5.

Principle 1: Access facilitation

Education sector: improving access to education programs (see also Professional Development below)

Indicators illustrated: awareness; flexibility

This program provides education for young people at risk of 'not completing the major competencies'. It delivers education using TAFE infrastructure (colleges) and resources (personnel), but utilises professional development of existing staff to ensure satisfactory program outcomes for the target group. It is delivered with community groups throughout NSW and is promoted through schools, TAFE colleges, youth workers and community centres through local advertising and links with relevant services. The program provides outreach education for young people who would not otherwise access mainstream education settings. The programs are 'hands on' activities.

Principle 2: Evidence-based practice

'Whole of government approach' to community social problems (see also Collaboration below)

Indicators illustrated: evidence to establish service

One local area had high rates of crime, drug and alcohol issues, violence and unemployment, evidence from *statistical data collection*. *Previous projects* to address these issues were examined and were found to have not produced the desired outcomes, thus a more comprehensive approach was planned. *Community consultation*, including a public meeting with 130 young people, was undertaken. As a result, a whole of government approach is being adopted to address these local health issues.

Principle 3: Youth participation

A program working with young offenders

Indicators illustrated: policy and procedures for youth participation

This organisation oversees programs for young people in custody or on parole or probation:

'Even in these difficult circumstances representation can be sought from young people. The organisation is reviewed twice per year against National Standards for the provision of custodial services by a review panel that speaks with a group of young people. Some centres also have detainee representative councils to discuss concerns about service provision and program evaluation. There is consultation with young people on key pieces of policy, typically through focus groups. Each centre also has official visitors who fulfil a scrutineer role related to services provided and quality. They also act as advocates for young people around service delivery in the centres.'

Principle 4: Collaboration

'Whole of government approach' to community social problems (see also evidence-based practice above)

Indicators illustrated: partners identified; protocols developed

The Partnership Project aims to address high crime rates and social problems in a particular area. A partnership approach was developed utilising all relevant agencies within and across sectors. Each agency has clear roles and responsibilities. The project involves infrastructure support and redevelopment within and between all the relevant government departments. For example, the 'safety plan' involves local representation from the Department of Housing to examine accommodation issues, Energy Australia examining street and building lighting, the Police addressing 'street policing' and visibility, and local council looking into physical and functional aspects of the local roads. In addition, there is tendering for local NGOs to provide specific services, such as counselling. The process involves regular and clear communication between agencies via local inter-agency meetings and community networks. All combine to give a picture of 'positive high visibility policing' as a disincentive to crime and to indicate collaboration.

Principle 5: Professional development

Education sector: Improving access to education programs (see also Access Facilitation above)

Indicators illustrated: review and planning of professional development needs; services collaboration; evaluation of training

This program utilises professional development of existing staff as an intervention of its own accord, to ensure satisfactory program outcomes for the target group. Professional development of staff includes training of existing managers about modifying the college environment, and training of existing teachers and community workers around attitudes and values and to help them understand the specific needs of the target group. The professional development activities are planned and delivered by collaborating with services that understand the needs of the target group and have evaluation built into the activities.

Section 4: Creating youth-friendly practice



Youth-friendly practice is practice that facilitates access for young people by promoting awareness and building trust in young people as well as by delivering care in an environment with protocols and processes that are acceptable to, and welcoming of, young people.

During the course of the *Access: Phase 2* interviews, four programs in NSW which had already developed a well-documented process and/or a practical instrument to become youth-friendly and/or measure 'youth-friendliness' were identified. The program directors have kindly given us permission to reproduce some elements of their programs. Contact details are also provided for service providers who are interested in obtaining further information about these tools.

In addition, two examples of well-developed 'confidentiality policies' are included in this section.

These are the programs, policies and youth-friendly tools summarised in this section:

1. Youth **REACH**: Central Sydney Division of General Practice
2. **YOUTHEALTH**: Northern Sydney Area Health Service
3. Youth Friendly Assessment Tool: New England Area Health Service
4. Youth HEALTH Project: South East Sydney Area Health Service
5. Confidentiality Guidelines: Department of Adolescent Medicine (The Children's Hospital at Westmead)
6. Confidentiality Policy (abridged): High Street Youth Health Service.

1. Youth REACH: Central Sydney Division of General Practice

The following pages (75-82) are reproduced with permission from Rowena Burnside, Program Manager, Central Sydney Division of General Practice. Further information can be obtained by contacting:

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All the materials reproduced below can be found on the CSDGP website:

<www.csdgp.com.au/youthreach.htm>

YouthREACH

Background

The **YouthREACH** project at the Central Sydney Division of General Practice was developed from a study called: **Beyond Jellybean Therapy**.

This was a consumer-initiated study which collected data from focus groups of young people (43) and GPs (20). The sample of young people included specific at risk groups (Aboriginal, homeless, gay, chronic illness).

Key issues in service provision and coordination were identified:

- 'There was a very strong emphasis on the need for the provision of health services that are **appealing** to young people, are **accessible** to them, are **affordable** and are **well-coordinated** with other relevant services.'
- 'There is evidence that a relatively small investment in training GPs and other primary health care workers will pay high returns in terms of delivery of appropriate health care services.'

Youth REACH is about:

Referral
Education
Access
Communication about
Health

Referral

- **GP survey**
What services for young people are in the area?
- **Youth Inter-agency meetings**
Which GPs are interested in treating more young people?

Referral network

- **Directory of youth services**
Provided to GPs
- **List of GPs who have a particular interest in young people and are happy to take referrals from services**

Provided to youth services (Disclaimer)

See over for directory of youth services ...



Central Sydney Division of General Practice

Youth Services Directory 2002

Catering for Young People in the Central Sydney Area



About this Directory.....

This directory has been developed to increase awareness of the services available to young people in the Central Sydney area.

One of the aims of the Youth R.E.A.C.H. Program is to equip GPs to help young people not just with physical health concerns, but also to provide for their mental health, emotional health and social support needs. We hope to encourage the development of stronger links between the youth sector, and GPs who have a special interest in young people.

Networking with other youth service providers will also increase the number of avenues whereby young people may be directed to a youth-friendly GP. This is particularly important for some groups of marginalised young people who may not feel comfortable contacting a GP directly and may access a youth service first.

This directory is a guide only – you may find you will be able to add to this list as a result of your own personal networking.

As with any directory, it is important to make further enquiries as to the suitability of a service before a referral or recommendation is made.

It is hoped that this directory will provide a good starting point for obtaining further support for young people, by enhancing knowledge of available services, improving access, and enabling sharing of information and resources.

We hope that you find the Directory helpful.

Regards,
The Youth R.E.A.C.H. Program Team
Central Sydney Division of General Practice

Please note the services in this directory have been listed Alphabetically by order of Suburb.

The General Practitioners (GPs) on this list have a particular interest in helping young people with their health. They are happy to take new patients and referrals from youth services in the region. All have completed the Central Sydney Division's Youth Interested Doctor process, including:

- A survey of young people who attend their practice to see if they are satisfied with the service provided to them
- A visit to their practice by a youth consumer and the Central Sydney Division's Youth REACH Project Officer to assess the practice's accessibility, billing procedures and friendliness to young people
- Feedback on their practice, ongoing professional training and development of youth health resources.

The GPs work in the Inner West region as shown in the map below. The list is sorted alphabetically by practice suburb.

The list is regularly updated and is available in both hard copy and electronic format. Please contact us if you would like to order more copies or if you have any feedback about the list. We hope you find the list useful.

☺ The Youth REACH Project Team

Central Sydney Division of General Practice

Doctor	XXXXXXXX		
Practice	XXX Medical Centre		
Address	12 XXX Road		
Suburb	Burwood 2134	Phone	1234 5678
Hours	8-1 Mon-Sat, 4-6.30 Tues & Thurs & Fri		
Appointments	Telephone call to register on day of visit		
Bulk Billing	Yes		
Languages	English, Tamil		
Other Interests	Diabetes, Family Counselling, Neurology		
Getting There	Train to Burwood		

Bulk Billing means that if you have a Medicare card, you don't have to pay cash

If you're over 15 you can get your own Medicare card: phone 132 011 or go into a Medicare office

You will need 2 pieces of ID (e.g. student card, birth certificate, bankcard)

Education

Resource folder for practices

- Resources (40) for GPs and for their patients
- Continually updated

Continuing Professional Development

- Mental Health, Drug & Alcohol, communication skills
- Open to all Division GPs
- Participation in at least one event per year expected for GPs on 'Youth Interested' list
- Role play: consumers in communication workshops

See over for practice resource for Receptionists ...

The role of reception staff in helping to create a 'youth-friendly' service

Your role is really important in helping to break down the barriers that a young person might face in seeking health care

... and you can make a difference.

Some ways you can support young people are:

- As the first point of contact when a young person walks into the practice, **a friendly, non-judgemental, positive attitude and a smile can help to relieve some of their anxiety about seeing a doctor.** Be sensitive to their developmental issues and offer support, especially if there is a long waiting period to see the doctor.
- If the young person calls first, you could **ask them whether they might require a longer consultation** (word the question in terms of 'do you think 15 minutes will be enough time for you to spend with the doctor?')
- Young people who have difficult issues to discuss can become very distressed by waiting and may feel that it is a personal slight against them and therefore leave. **Simple explanations about waiting time can help.**
- **Ask them to cancel their appointment if they can't make it.** You can also let them know that they can call before their appointment to find out whether the doctor is running on time.
- **Ensure young people are aware that medical practitioners can bulk bill without the family Medicare card** by ringing the Medicare hotline number – young people can phone 132 011 and GPs can phone 132 150 from anywhere in Australia (no prefix needed) to find out the Medicare number.
- **Explain bulk billing and what it means** (you sign a form so that Medicare pays the full cost of your visit to the doctor and a bill will not be sent to your home).
- **If they are aged 15 or over, ask them if they would like help to obtain their own Medicare card** (for times when they might need to see a doctor and can't access their family's card).
- **It is really important that the young person's visit is handled confidentially.**

Remember that you play a pivotal part in helping connect a young person with good quality health care and providing support for their wellbeing.

Information adapted from *Depression in young people: A guide for general practitioners* (NHMRC).

Access: creating youth-friendly practice

Practice visits: process

Pre-visit

- Resource folder provided (visit questions & preparation tips)
- GP to collect 15 YP questionnaires (20 questions)

Visit: Young consumer and Project Officer

- Check reception and waiting area
- GP details & consent for sharing practice details
- Young consumer surveys GP (26 questions)

Post-visit: Youth REACH Working Party

- Consumer reports on practice (de-identified)
- Feedback report on practice visit & patient survey provided to GP
- GP details added to 'Youth Interested' GP list

Practice visits: standards

- Practice review – other GPs can be streamlined
- Essential (bulk billing) vs desirable (manner)
- Not a full accreditation ('Youth Interested' not 'Youth Friendly'): GPs have implemented youth-friendly *principles* in their practice & received feedback from their young patients
- No GPs are unlisted; some were asked to make changes before listing (especially literature)
- Consumers: GPs gained a 'heightened awareness' of youth issues & facilitated access to local services & resources after using folder & being interviewed

Access and Communicating about Health

Information about 'youth interested' GPs was then disseminated widely to young people and service providers in Central Sydney. One of the mechanisms was to circulate a list of 'General Practitioners who have a special interest in treating young people' ...

Youth REACH Project

Referral Education Access Communication Health

**General Practitioners
who have a special interest
in treating young people**



**and are happy to take
referrals from youth services**

September 2002

2. YOUTHEALTH Project: Northern Sydney Area Health Service



'Demonstrate youth friendliness, don't just talk about it.'

Northern Sydney Health

Block 4, Level 3

Northern Sydney Health Promotion – Lower North Shore

Royal North Shore Hospital, Pacific Highway

St Leonards NSW 2065

Ph: (02) 9926 7764, Fax: (02) 99067529

Summary of the YOUTHEALTH project in the Northern Sydney Area Health Service

The three main **aims** of the project (developed in 1999) were:

1. To develop evidence-based guidelines on how health services can be youth-friendly
2. To develop a youth internet site
3. To establish youth consultants in the Area.

Northern Sydney Health has **employed and trained a diverse group of young people (14–20 years)** as Youth Health Consultants with a range of different experiences and backgrounds from across the Northern Sydney Health Area. The YOUTHEALTH Project takes a holistic approach when addressing 'youth friendliness':

- The Youth Health Consultants provide **presentations, training and information** to service providers on important youth health issues relevant to service needs.
- **They provide a one-hour consultation interview with services. Meeting with the staff, they discuss the youth-friendly aspects of the service and offer creative suggestions on ways to enhance the 'youth friendliness' of these services and also provide resources to staff.**
- The Consultants **provide information** about access to health services to other young people at youth events and through a fun and interactive youth access workshop designed for schools.
- Youth Health Consultants are the **youth representatives** on a variety of Northern Sydney Area health-related committees and forums.
- The YOUTHEALTH Project is also working **in partnership** with young people and service providers in the ongoing development of an Area-wide youth internet site called <www.youthsource.org>

Components of the project

Diversity

The diverse range of the Youth Consultants includes direct experience with mental illness, cultural and linguistic diversity, chronic illness, family dysfunction, sexuality issues, chronic homelessness, alcohol and other drugs issues. They come from all socio-economic groupings representing most of the local government areas across Northern Sydney.

Training of young people

The Youth Consultants are trained in presentation skills and public speaking, youth health issues and youth health services. Over the past 12 months they have received training in orientation to the health system, youth suicide issues, overview on youth health issues around drug and alcohol, sexual health and mental health, child protection, communication skills, ongoing presentation skills development and the Australian Infant, Adolescent and Family Mental Health Association (mental health consumers and carers).

Presentations to service providers

Presentations on youth health access issues in the North Sydney area to services such as Child and Adolescent Mental Health, School Counsellors, Royal North Shore Hospital Board, Consumer and Community Consultative Committee, Division of General Practitioners and Youth Services across the area.

Consultation process

An interview method of consultation was found to be easy for the Youth Consultants to use and the information easily recorded. The questions prompt service providers to think about making changes without feeling as if they are being told what to do. The questions are designed to cover most areas of service provision. Having the young people asking service providers questions ensures equal balance of power between the two groups.

There has been an overwhelming response by all service providers involved in the consultation process to the professional approach of the young people and the enormous value this process adds to the service.

Information to young people

The Youth Consultants deliver information on youth health issues and access to health services through:

- **Schools**
- **Youth events** – Youth Week, Shoreshocked, SEXPO and stalls in shopping malls, Royal North Shore Hospital Mental Health Day stall

Youth representatives on committees

Youth Consultants have served on numerous other committees, including the Hornsby KuRingGai Ryde Division of GPs, Drug Safety Steering Committee (Manly Drug Education & Counselling Centre), GMT2 (Transitional Care for Chronic Childhood Illness), Community and Consumer Participation Committee, North Sydney Police Citizens Youth Club (youth representative on Board), Lane Cove Youth Council, Adolescent Acute Inpatient Care Forum, Alcohol Summit

Partnerships

The project works in partnership with a broad range of youth services across the Area, assisting with the delivery of education, health promotion, workshops and forums. Examples of partnerships are Manly Drug Education & Counselling Centre (MDEC), Centre Care, Manly RUSH, Area Drug and Alcohol and Area HIV & Sexual Health Promotion, Phoenix House Youth Accommodation, Lower North Shore and Mona Vale – Queenscliff Adolescent Mental Health, RNSH Paediatrics Unit, Nutrition and Child Protection.

Youthsource website

The overall aims of the website are to produce a youth-friendly internet site for Northern Sydney young people that assist them to:

- access up-to-date information on youth activities and services available in the Northern Sydney Area
- raise their awareness of the resources and services available in the Northern Sydney Area for accessing help for problems
- access confidential and reliable health information.

Working with the Division of General Practitioners

As young people's first point of contact with the health system is often their GP, the project's ongoing involvement in this Division's Adolescent Training Program is a valuable way of increasing general practitioners' knowledge in youth health access issues.

Evaluation (conducted by an external consultant – Social Policy Research Centre, UNSW)

Outcomes

1. The main aims were achieved. Peer knowledge and awareness of youth-friendly services was achieved.
2. Participation in the project significantly improved knowledge of youth health issues among the Youth Consultants and increased their self-confidence.
3. Services implemented changes such as displaying a confidentiality policy and modifying their physical environments. One service was reviewing its appointment system. Service providers had also made attitudinal changes. Since one of other main aims was to make service providers youth friendly the project was successful in this respect.

Critical aspects for success

- project officer with highly developed networking and youth worker skills
- employment and payment of youth health consultants to acknowledge value of young people's work
- high level managerial support
- diversity of youth health consultants
- the project's youth-friendly philosophy applied in project management and meetings, ensuring a high retention rate of young people
- young people incorporated into structure of Area Health Service in a meaningful way so they could contribute as consumers
- youth consultants adopted a constructive approach in their visits and the report.

These factors are replicable across other Area Health Services interested in introducing or modifying the model.

3. Youth Friendliness Assessment Tool (YFAT): New England Area Health Service

Aims

- YFAT tool designed to provide a review method for health services on the issue of improving youth health
- identifies the key areas for a health service to be reviewed
- provides ideas on how a health service can be improved to have a positive impact on the health of young people in the Area
- designed to cover issues where achievable changes can occur rather than high-cost alternatives that may never be implemented
- recommended that the review process, with resulting health service changes, occur every two years

Developed by:

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The following is reproduced with permission of Warren Bartik, Area Coordinator Child & Adolescent Mental Health, New England Area Health Service.

6: YOUTH FRIENDLINESS ASSESSMENT TOOL

Please mark the box for the assessed answer: YEAR _____

1. ACCESS

1.1. Communicating what services are available to young people

School / TAFE / Uni

- | | | | |
|-------|--|------------------------------|-----------------------------|
| 1.1.1 | Does the Health Service provide information at schools about what health services are available for young people separate to Health Promotion programs? (If NO, go to 1.1.6) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.1.2 | Does the information contain: | | |
| | What the health service costs the young person? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Who the health workers are? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | What is involved in the specific health service? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | How to contact the health service? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Where the health service is located? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | What times/days does the health service operate? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.1.3 | Is the information presented in a way that young people can understand? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.1.4 | Has the information been focus tested for acceptability with young people? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.1.5 | Has the information been focus tested for cultural acceptability with Aboriginal young people? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Community

- | | | | |
|-------|--|------------------------------|-----------------------------|
| 1.1.6 | Does the Health Service provide information in the community about what health services are available for young people? (If NO, go to 1.2) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.1.7 | Does the information contain: | | |
| | What the health service costs the young person? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Who the health workers are? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | What is involved in the specific health service? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | How to contact the health service? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Where the health service is located? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | What times/days does the health service operate? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.1.8 | Is the information presented in a way that young people can understand? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Has the information been focus tested for acceptability with young people? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Has the information been focus tested for cultural acceptability with Aboriginal young people? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

SECTION TOTAL /20 /20

1.2. Confidentiality

- | | | |
|---|------------------------------|-----------------------------|
| Does the health service clearly explain about the limitations of confidentiality of the health service to young people, in the community and schools? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are all members of staff aware of NIAHS & NSW Health policies on confidentiality? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Does the health service have an appropriate & confidential method of providing a service to young people who are related or known to a staff member? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

SECTION TOTAL /3 /3

1.3. Staff and Health Service attitude to young people

- | | | | |
|-------|---|------------------------------|-----------------------------|
| 1.3.1 | Have all the health service staff been given a copy of the latest YEAT SAY (Self Assessment Yearly) and encouraged to complete it? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.3.2 | Have issues for education/training been identified through the YEAT SAY? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.3.3 | Have staff in-service education sessions on youth health been conducted during the last two years? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.3.4 | Has the Health Service completed a patient/citizen satisfaction survey with young people in the last two years? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.3.5 | Did the survey cover the issue of appropriate language/ words used by staff with young people? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.3.6 | Overall do staff use language that enables young people to understand what is being explained to them? eg avoiding jargon. (Assess team's view) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.3.7 | Overall do staff display non-judgemental attitudes in caring for young people in the following areas? (Assess team's view) | | |
| | Race and cultural background | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Sex and sexuality | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Drugs & alcohol use | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Flagging about | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Mental Health | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Appearance | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Partners | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | School assignments | Yes <input type="checkbox"/> | <input type="checkbox"/> |

SECTION TOTAL /14 /14

1.4. Youth orientated service

- | | | | |
|-------|---|------------------------------|-----------------------------|
| 1.4.1 | Does the health service provide services at times or locations that are appropriate for young people? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1.4.2 | Are appointment times flexible enough to cater for different needs of young people? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

1.4.3	Does the health service provide a broad range of services and other activities to ensure that young people aren't labelled when accessing the required service?	Yes C	No C
1.4.4	Does the health service support young people to have a friend or other person with them while receiving a health service, where appropriate?	Yes C	No C
1.4.5	Does the Health Service have clearly displayed and available information on 24 hour youth support phone lines?	Yes C	No C
SECTION TOTAL		/5	/5
1.5. Transport			
1.5.1	Is the health service able to be reached by public transport?	Yes C	No C
1.5.2	Is the health service within a reasonable 20-30 minute walk from the main part of town?	Yes C	No C
1.5.3	Does the health service provide outreach services as well as on-site health services?	Yes C	No C
1.5.4	If outreach services are provided are they available in appropriate venues for young people such as Youth Clubs, PCYC, Youth organisations?	Yes C	No C
SECTION TOTAL		/4	/4
TOTAL PART 1 - ACCESS		/10	/10

2. PHYSICAL ENVIRONMENT

2.1. Youth "Face" to health service

2.1.1	Are there appropriate youth magazines, such as <i>Stretwise</i> or <i>Deadly Vibes</i> , in waiting areas?	Yes C	No C
2.1.2	Are some of the posters or artwork displayed in the health service appropriate for young people?	Yes C	No C
2.1.3	Are some of the posters or artwork displayed in the health service appropriate for Aboriginal young people?	Yes C	No C
2.1.4	Is there a method in place to enable young people to select what posters or artwork is appropriate for display?	Yes C	No C
2.1.5	Do young people work in the reception area in after school hours?	Yes C	No C
2.1.6	Do young people work in the reception area in normal business hours?	Yes C	No C
2.1.7	Does the Health Service enable young people to have work opportunities or experiences through:		
	Job programs such as CDEP	Yes C	No C
	School work experience	Yes C	No C
	Volunteer work	Yes C	No C
SECTION TOTAL		/9	/9

2.2. Pamphlets

2.2.1	Are there pamphlets available that address the needs of young people?	Yes C	No C
2.2.2	Are there culturally appropriate resources for Aboriginal young people to access?	Yes C	No C
2.2.3	Are pamphlets displayed in a way that is accessible to young people and not cluttered?	Yes C	No C
2.2.4	Do the pamphlets and posters provide a good balance between "shock" information and positive health information?	Yes C	No C
2.2.5	Is there a method in place in the Health Service to regularly ensure that the pamphlets address the needs of young people?	Yes C	No C
SECTION TOTAL		/5	/5

2.3. Environment

2.3.1	Are there signs to the street indicating the direction to the Health Service?	Yes C	No C
2.3.2	Are there signs within the Health Service indicating directions?	Yes C	No C
2.3.3	Is the area from the front door to the reception area easy for young people to use (i.e. no obstacles, good lighting, and signs)?	Yes C	No C
2.3.4	Is there an area available to ensure that confidential matters are not discussed in public?	Yes C	No C
2.3.5	Does the waiting area contain comfortable seats?	Yes C	No C
2.3.6	Does the waiting area and health service area contain plants or fish tanks etc.?	Yes C	No C
SECTION TOTAL		/6	/6

2.4. Information Technology

2.4.1	Does the Health Service have an information phone line?	Yes C	No C
2.4.2	Is there a computer with health information and health links available for young people to use?	Yes C	No C
2.4.3	Does the Health Service display information on web sites of support services and information for young people?	Yes C	No C
SECTION TOTAL		/3	/3

2.5. Hospital care of young people

2.5.1	Does the Hospital have a specific area for caring for young people?	Yes C	No C
2.5.2	Does the Hospital have a specific program for caring for Aboriginal young people?	Yes C	No C
2.5.3	Does the Hospital provide options to young people to be cared for in an adult or a children's ward?	Yes C	No C

2.1.4	Are the timing, amount and type of food and drinks available appropriate for young people?	Yes C	No C
2.1.5	Is there a method in place to determine if the timing, amount and type of food and drink is appropriate for young people?	Yes C	No C
SECTION TOTAL		/5	/5
TOTAL PART 2 - PHYSICAL ENVIRONMENT		/28	/28

3. YOUTH CONSULTATION AND PARTICIPATION

3.1. Policy

3.1.1	Does the health service's Service Plan contain a section on youth health?	Yes C	No C
3.1.2	Is there a clear decision making pathway for placement of young people in children's wards or adult wards of the hospital?	Yes C	No C
3.1.3	Is it policy that young people have a choice of placement in children's wards or adult wards of the hospital?	Yes C	No C
3.1.4	Does the intake policy of the health service describe the intake process for young people who are clients/patients?	Yes C	No C
3.1.5	Do the case management policies of the health service meet the highest standards of care for young people?	Yes C	No C
3.1.6	Does the health service enable the services it provides to remain flexible and responsive to changing needs of young people?	Yes C	No C
3.1.7	Does the Health Service clearly identify the rights of young people about their treatment and health care?	Yes C	No C
SECTION TOTAL		/7	/7

3.2. Consultation

3.2.1	Does the health service conduct consultations with the young people of the local area to identify local health issues?	Yes C	No C
3.2.2	Does the health service conduct consultation with Aboriginal young people of the local area to identify local health issues?	Yes C	No C
3.2.3	Does the health service support staff involvement in community youth issues and community development for young people that directly and indirectly relate to health?	Yes C	No C
SECTION TOTAL		/3	/3

3.3. Participation

3.3.1	Is there youth representation in the planning and review of the health service?	Yes C	No C
3.3.2	Is there Aboriginal youth representation in the planning and review of the health service?	Yes C	No C

3.3.3	Are youth representatives actively encouraged to be involved in the planning and review process of the Health Service?	Yes C	No C
3.3.4	Do youth representatives have a real say on youth health issues?	Yes C	No C
3.3.5	Do youth representatives have a real say on all issues and not just youth issues?	Yes C	No C
3.3.6	Is there a Youth Health Council identified for the Health Service?	Yes C	No C
SECTION TOTAL		/6	/6

3.4. Health Outcomes

3.4.1	Does the health service have methods of measuring the health outcomes of interventions conducted with young people?	Yes C	No C
3.4.2	Are the health outcomes analysed for improvements in the health of young people?	Yes C	No C
3.4.3	Does the Health Service review the length of stay, admission rates, occasions of service for young people to determine if better than the state average is met?	Yes C	No C
3.4.4	Does the health service regularly review information on indicators of the health of young people in the local area through:		
	Unemployment rates	Yes C	No C
	Education levels	Yes C	No C
	Income levels	Yes C	No C
	Pregnancies	Yes C	No C
	Deaths including self harm	Yes C	No C
	Injury rates	Yes C	No C
	Single parent families	Yes C	No C
SECTION TOTAL		/10	/10

TOTAL PART 3 - YOUTH CONSULTATION & PARTICIPATION

Part 1 - ACCESS		
Part 2 - PHYSICAL ENVIRONMENT		
Part 3 - YOUTH CONSULTATION & PARTICIPATION		
GRAND TOTAL		

4. Youth HEALTH Project: South East Sydney Area Health Service

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In July 1999 NSW Health as part of the Community Health Innovation Program funded a Youth HEALTH Project (YHP) in South East Sydney Area Health Service (SESAHS). The key objectives of this project were to enhance access to health services by young people and develop youth health networks within SESAHS. To achieve these objectives the project recruited a youth health project officer (who later became the Youth Health Coordinator) to work with both service providers within and external to the health sector, and young people.

The project was evaluated by The Social Policy Research Centre UNSW.

1. Service providers

Prior to the establishment of the YHP there was no focal point for youth health within the area. The YHP was successful in increasing service providers' knowledge of the available services for young people in the Area, how to access these services, as well as bringing service providers together around joint interventions, which provided an opportunity to work collaboratively as initiatives came up (rather than ad hoc work together previously). Service providers could also access further information about youth health, which they could then pass on to other providers.

According to the service providers a significant outcome from the YHP was that health services were considering youth health issues in the development of services and a mechanism for consulting with young people had been established. Young people had been consulted through focus groups and surveys. This information had been fed back to the hospital administration and resulted in the provision of relevant training for workers.

The service providers thought another important outcome from the YHP was the establishment of a networking process that linked different types of service providers such as health and community services.

Keys to success

Locating the position of project officer within Area Health was vital to achieving outcomes in the project because the position was not associated with a specific health field (e.g. mental health, health promotion, drug and alcohol). This enabled the project officer to be independent and objective and to be perceived by service providers and other stakeholders as not being 'captured' by one of these specialised health areas.

The roles the project officer assumed within the position were responsible for the success of the project. These roles included acting as an independent mediator with a global view and assuming responsibility for tasks that service providers were unable to take on because of their caseloads. The responsibilities included networking, forming partnerships between different sectors and chairing, minuting and coordinating meetings. The project officer provided information to the service providers, as well as acting as a contact and referral point from which to navigate the health bureaucracy.

The service providers thought that the provision of funding for the YHP was crucial in establishing and developing initiatives. They felt that if there had not been an adequate budget the project might not have achieved as much.

2. Young People

One of the major aims of the YHP was to develop partnerships with young people. The key to achieving this was to create opportunities for meaningful youth participation.

In December of 1999 the SESAHS Youth Health Advisory Committee (YHAC) was established by the Youth Health Project Officer as a partnership of 12 young people, 4 health workers and 2 GPs. Not all health workers and GPs participated fully in the committee but acted as consultants and advisers.

The YHAC met for 2_ years approximately every 6 weeks for 1_ hours. Transport costs were reimbursed, food was provided at meetings and young people were paid for their participation.

The recruitment process of young people to the project was given high priority. The YHAC brought together a group of young people from a number of different backgrounds and subcultures by accessing them through a variety of sources including health services, ethnic-specific services, youth networks, youth workers, schools and advertisements.

Keys to success

The committee enabled SESAHS to listen to young people's views, respond to those views seriously and provide opportunities for young people's ideas and suggestions to be put into practice.

This was achieved by ensuring:

- The young people on the committee had time to form a group, define their objectives and terms of reference.
- Meeting times and locations were accessible. Meetings were after school, TAFE, uni and work. The location of meetings was close to public transport and some young people were picked up and dropped off at mutually agreed locations.
- Language used was accessible. Issues, concepts and ideas were explained by the project officer and discussed until everyone had a good understanding of what was being talked about.
- The YHAC members were encouraged to explore and define issues. They discussed youth friendliness, the health system and mental health services for young people and were able to articulate some of the major barriers that restrict young people's access to health services.
- They were kept informed of current issues through briefing notes, project updates, guest speakers and minutes of meetings.
- They were given time and opportunities to make decisions.
- SESAHS was open about its systems and structures that impacted on the young people's decisions.
- Adult group members did not dominate meetings or discussions.
- Young people's contributions were acknowledged through certificates, letters to schools, families, workplaces, and payment for their work.
- The YHAC was supported in developing and implementing a project to enhance young people's access to health services.

Outcomes

One of the major outcomes of the YHAC was the ability of the young people to plan, design and implement their own project based around youth health rights and youth access to health services. This involved the development and launch of resources aimed at increasing young people's access to services and in particular information on how young people can receive their own Medicare Cards at 15. The resources contain the slogan 'set yourself free ... get the card!' on posters, wallet cards and a limited number of t-shirts. The wallet cards include further information about youth health rights, including confidentiality. They also explain bulk billing and include emergency numbers, e.g. Kids Help Line and Lifeline.

Other major outcomes of the YHAC include:

- support for the **Area Youth Health Coordinator position being created** in SESAHS (This occurred through the then project officer identifying the need for a 'pivotal role' in coordinating service provision to young people. This led to the formation of the Youth Health Committee and the creation of the position of Youth Health Coordinator.)
- raising the awareness of staff community members and young people of their health rights, in particular their right to access a Medicare Care Card from the age of 15
- young people now being represented on a number of other AHS committees
- further youth participation strategies being adopted by SESAHS
- one of the committee members submitting an application to NSW Health to become a board member on the SESAHS Board
- one committee member gaining a position as the Mental Health Youth Advocacy Officer for a Mental Health facility in SESAHS
- committee members being engaged as consultants
- advice from the committee being incorporated in Area strategies and discussion papers

Other outcomes include the YHAC members developing *invaluable skills*. These skills include public speaking, the ability to articulate in a group and provide critical comments on issues, and to work effectively as part of a team. Participating in the YHAC has provided them with a unique opportunity to talk with different people and increase their awareness of health rights issues and the types of services available for young people.

SESAHS continues to create opportunities for genuine youth participation in the development of policies and programs across the Area Health Service (AHS) where young people develop mutually respectful relationships with adults and not only feel valued in their community but participate in changing their community.

3. Replicating the Youth HEALTH Project across services

The initiatives developed would be replicable across Health Services, although some modifications may be necessary to take account of the specific needs and youth profiles of other Areas.

The following factors were identified as critical to the success of the Youth HEALTH Project:

- Appointment of a project officer with a background in health, experience in working with young people and highly developed networking and communication skills. This could also be provided by appointing an **Area Youth Health Coordinator**, although the development of networks and linkages in SESAHS was crucial, so a YHC would need to begin by developing these linkages.
- Having a system of management that allowed the project officer to work with flexibility and autonomy in developing initiatives responsive to the needs of young people and the AHS.
- Having a system of management that linked the project officer to key people within the executive level of the Area Health Service.
- The position of project officer was not physically located or associated with a specific health field (e.g. mental health, health promotion, drug and alcohol services) and so was perceived to be independent by service providers.
- Having sufficient financial resources to draw on to support various project initiatives.
- Young people being incorporated into the consultative mechanisms and the service development processes of SESAHS in a youth-friendly and meaningful way and hence contributing as consumers and advocates of youth health issues.
- The responsibility for fostering youth participation and establishing a YHAC is incorporated into relevant job descriptions.
- Ensuring that there is a demonstrated commitment within the AHS to involve young people in the decision-making process.
- Initiatives to ensure youth participation need to be based on sound guidelines and principles.
- Recruitment of a group of young people broadly representative of the population. This is difficult, and recruiting true representation is almost impossible. Young people are not an homogenous group and no group, no matter how diverse, can be expected to represent an entire population

5. Confidentiality Guidelines: Department of Adolescent Medicine

(Reproduced with permission of Head, Department of Adolescent Medicine, The Children's Hospital at Westmead)

The issue of access to confidential care for young people is integral to adolescent health care. The purpose of confidential care is to respond to the adolescent's health care needs in a flexible and individualised manner.

The guidelines regarding confidentiality should be explained to the adolescent and their parent/s at the first interview.

Guidelines

Information shared between the adolescent/parent and the clinician/s will be kept confidential within the team (which is defined at this point as well), bearing in mind that:

- The clinician/s will communicate with the referrer.
- There may also be benefit in sharing information with outside professionals; written permission will be obtained from the adolescent and parent/s first.
- Confidentiality cannot be kept in the case of:
 1. Suicidal or homicidal behaviour or intent.
 2. Disclosure of physical, sexual or emotional abuse or neglect of an adolescent less than 16 years of age. This may constitute grounds for mandatory notification to the Department of Community Services.
 3. Notification of some infectious diseases to the Department of Health.

In the first two situations, the safety of the young people is of first priority. In the third situation, the purpose is for disease surveillance and the priority is public health. In each of these situations the action necessary to take will be discussed with the adolescent and parent/s.

The principles behind these guidelines are:

1. Respect for the individual privacy of the adolescent and parent/s.
2. Recognition that adolescence is a transition period where individuals are increasingly capable of exercising rational choice and giving informed consent, though need flexibly proffered guidance and support from adults.
3. Protection of health is the ultimate goal.
4. Awareness that adolescents engage in health risk behaviours which are sensitive and personal and that to deny confidentiality could be seriously detrimental to their health and to their seeking of health care.
5. Confidentiality is cited by young people as the most important quality of their relationship with a health professional.
6. Most young people will benefit by involving their parent/s because their best support usually comes from concerned and caring families. Encouragement and support should be given as appropriate for them to do this.

6. Confidentiality Policy (abridged): High Street Youth Health Service

(Reproduced with permission of Acting Coordinator, High Street Youth Health Service)

(xii) CONFIDENTIALITY POLICY

Policy Statement

HSYHS recognises confidentiality as a key principle in the provision of programs, activities and in the delivery of its services.

In accordance with the philosophy and principles of the provision of a safe and respectful approach to the confidentiality of young people across all services, HSYHS has developed an integrated and consistent approach to confidentiality policy and practice.

This policy draws on the principles of consumer rights, the rights and responsibilities of staff and young people and quality improvement and embraces the concepts of co-management and inter-sectoral partnerships. In addition, it recognises the need to provide an environment which acknowledges the unique culture of young people and the developmental tasks they face.

Team Confidentiality

To fully utilise the benefits of adopting a multi-disciplinary approach, HSYHS has developed a policy of team confidentiality. The primary objective of utilising team confidentiality is to ensure that the most appropriate service is offered to young people with the broadest range of skills of each staff member. Team confidentiality also provides a forum that facilitates accountability by encouraging an open atmosphere to discussing work practices.

The staff of HSYHS have a primary responsibility to respect the confidentiality of information obtained from young people in the course of their work as health professionals.

In adopting a team confidentiality policy, the staff of HSYHS should pay particular attention to the forums in which discussions concerning clients take place. In forums such as the Client Review Meeting, it is appropriate to discuss clients on a 'need to know basis'; however discussions in open spaces (such as the front desk, or in the courtyard) are inappropriate. Staff should also be aware of discussing clients in office areas or staff spaces with the door open.

In adopting a team confidentiality policy, gathering and subsequently sharing information is based on the concept of '*the need to know*'.

The concept of '*the need to know*' is based on the following principles:

- HSYHS's mission statement and
- Client's rights.

Will the information being shared ...

- facilitate the ongoing management of the young person in question?
- facilitate the health and well being of the young person in question?
- enhance the young person/s and other people's safety?
- increase the likelihood that the interventions by HSYHS will achieve the desired outcome?
- legislation which requires the staff of HSYHS to share relevant information (such as mandatory notification, notification of infectious diseases, etc)
- professional development.

Is the information being shared ...

- necessary to the staff member seeking support?

- necessary to the staff member seeking professional supervision?
- necessary to the staff member undertaking debriefing?
- necessary to the staff member seeking assistance to 'check-out' intended interventions?
- likely to enhance current work practice?

Will the information being shared ...

- assist the workers to enhance the health and well-being of the young person?
- assist the workers to provide a more effective and integrated services?
- be professionally ethical?

Procedure

Delivery of Services to Young People

- At the point of referral to HSYHS, young people should be asked whether it is appropriate to ...
 - telephone at home?
 - send mail? and
 - mention HSYHS when we contact you?

Provision for documentation of the above questions is made on the intake form under contact details and/or the caution alert section.

- At the point of referral to HSYHS the confidentiality policy of HSYHS should be explained to young people.

'Any information you give HSYHS is confidential within the team, except where we are required for legal reasons to release it'.

In addition, young people are provided with two resources:

- Rights and Responsibilities pamphlet and
- Confidentiality pamphlet.

After the confidentiality policy is explained to the young person, HSYHS also provides a confidentiality sheet which includes the exceptions to confidentiality and reads as follows:

I understand that all information about me and what I do at HSYHS will be kept confidential amongst staff working at HSYHS and will not be given to anyone outside HSYHS without my consent except if:

- I am diagnosed by the doctor with a notifiable disease (see confidentiality pamphlet for a list of these);
- Staff have knowledge of my involvement in a serious crime (serious means a crime that will lead to 5 years in jail or amounts to \$5,000 damage);
- Staff have knowledge of my involvement in/or suspect my involvement in:
 - any form of drug taking whilst on the premises of HSYHS;
 - acts of a violent nature whilst on the premises of HSYHS;
 - acts of a violent nature towards another young person known to HSYHS;
- I am reported as a missing person;
- I am 12, 13 or 14 years of age and my parents or legal guardian insist on information pertaining to my health care;
- I am in danger of trying to kill myself or harm other people and
- I am under the age of 16 years and the staff suspect that I or other siblings in my family are in a situation of abuse or have been in a situation of abuse and this was not reported.

This information sheet should be signed and dated by the staff member during the intake process or at the first appointment. The staff member will explain as carefully as possible the limits of confidentiality and the meaning of the information. Once the information sheet is signed by the staff member it should be placed in the client's health (medical) record.

A young person's refusal to sign the confidentiality sheet should be noted in the client's health (medical) record.

Consent for Release of Information

Staff are required to use the Consent for the Exchange of Information Form. This form provides formal recognition that the young person understands and agrees to the release of information outside HSYHS (see Appendix 9).

Where information is shared across agencies the outcomes of these discussions should be reported back to the young person and documented in the young person's health (medical) record.

If an arrangement is made as part of a co-management plan that sharing of relevant information will be an on-going occurrence, it is suggested a Consent for Exchange of Information Form be used, and noted in the young person's health (medical) record.

Co-management/ Working with Other Agencies

HSYHS encourages the development of partnerships in the co-management of young people and recognises the uniqueness and importance of a range of services in the health and well-being of young people. The young people accessing HSYHS often have complex and varied life issues which by nature require a multi-service approach.

An integral component of successful co-management relationships is the definition and clarification of roles and responsibilities within the relationship. The nature of co-management requires the exchange of information. Consent by the young person to exchange relevant information is essential and this should be a process negotiated with those agencies and the young person involved. The exchange of information is mandatory when the young person is in danger of attempting suicide or hurting other people.

Working with Families

In any work with families, the rights of each family member, particularly the young person, should be safeguarded. Matters discussed with each individual should not be discussed with other family members, unless permission has been given. Staff should note the age of the young person/s within the family and if the young person is 14 years of age or under, the rights of the parents and/or legal guardians should be accommodated unless there is evidence to suggest this would endanger the safety of the young person. In this case a DOCS report is required.

Given the importance of the family to a young person/s, the staff of HSYHS should note the exceptions to confidentiality. In working with families, negotiations concerning the release of information is an important component of the therapeutic process. In addition, those staff who work with families should consider the systems in which the young person operates and incorporate the exchange of information as an intervention to assist the young person and facilitate therapy outcomes.

Police Involvement

Staff at HSYHS have a primary obligation to maintain the confidentiality of young people attending the service.

If staff suspect, or have knowledge that a young person has committed a serious crime (imprisonable for 5 years or \$5000 worth of damage) the police should be notified and information provided.

As outlined in the Management of Aggressive Behaviour Policy of HSYHS, if a young person has been involved in, or suspected of an act of violence within HSYHS, or has assaulted another young person known to HSYHS the police should be called and information given. If a young person is at risk of attempting suicide or hurting others the mental health team or police should be called.

If the police request to search the premises of HSYHS, a search warrant should be produced. If the staff of HSYHS have knowledge of outstanding warrants they are not required by law to inform police.

In dealing with the police the staff of HSYHS should keep in mind the need to maintain a positive relationship with them, which should also be balanced with the rights of the young person/s involved.

Parental/Legal Guardian Access to Information

Parental/Legal Guardian access to information is dependent on the young person's decision on this matter, except where the exceptions to confidentiality apply. In considering parental/guardian access to information, staff of HSYHS should consider the importance of parents/legal guardians in the health and well-being of young people. Decisions concerning the disclosure of information to parents/legal guardians should be made in consultation with the young person. Staff should note that those young people under the care of the Department of Community Services and who are State Wards have departmental employees acting as their legal guardians. This only applies to those young people who are state wards and not those young people under any other type of care order and communication with these young people should be through their parents.

Section 5: Health programs within the NSW Department of Education and Training

The critical link between the education sector and every other sector involved in promoting the health and well-being of young people resonated throughout our interviews in Phases 1 and 2 of the Access program. In Sections 1 and 2, we have summarised findings and presented principles in practice based primarily on interviews with service providers in the health, non-government and other government sectors (not including education). The importance of schools as a health-promoting environment and a social setting for the majority of young people aged 12–18 in NSW made it essential that we explore the current programs in place within the NSW Department of Education and Training that promote access and quality of health care. The programs we include below are a sample of major current programs operating within NSW government secondary schools. We conducted interviews with appropriate program personnel to obtain a broad description of each of the programs. Further information about the programs can be obtained from the NSW Department of Education and Training.

Health programs within the NSW Department of Education and Training may be defined as:

Processes that are used by schools to promote mental health and which complement or enhance health service provision by other sectors. These form a continuum of processes that ‘value add’ to the student welfare focus of all policies, procedures and curriculum in schools. They fall into four broad categories:

1. Curriculum-based materials
2. Whole-school and targeted programs
3. Individual support, including counselling
4. Referral to and liaison with specialist services.

1. Curriculum-based materials

There are specialist teachers for PDHPE (Personal Development, Health and Physical Education) in NSW and there is a new PDHPE syllabus being introduced in 2004 which emphasises a ‘student centered’ approach. Current content strands for Years 7–10 include active lifestyle, composition and performance, growth and development, interpersonal relationships, movement sense and skill, personal awareness and choice, promoting health and safe living. The *Crossroads* program is a curriculum-based program that specifically targets Year 11 and 12 students.

2(a) Whole-school approach

Programs using this approach aim to build capacity within the whole school. Included in this group are *School-Link*, *Health-Promoting Schools* and *MindMatters*, as well as the *NSW Premier’s Gold Medal Fitness Program* (primary schools).

2(b) Targeted approach

These programs address specific sections of the school community and/or students with identified needs. The programs we examined were *Resourceful Adolescents Program (RAP)*, *Adolescents Coping with Emotions (ACE)* and the developing *Year 12 Senior’s Program*.

3. Individual support

Every NSW government secondary school has an allocated school counsellor (usually a person with both a teaching and a psychology degree). One school counsellor may service several schools within

a region. In addition, individual schools may seek or accept services such as support from chaplains and youth workers, programs operated by external organisations such as the Ted Noffs drug and alcohol program (providing drug and alcohol education and/or clinical services in schools) and *Pitstop*, a similar program developed by staff at community health in South-East Sydney Area Health Service (see notes on these programs in Section 2, Chapters 2 and 4).

4. Referral and liaison work (generally a role of school counsellors)

This facilitates access for identified students to the wide range of services and agencies that are external to the school and which have the ability to support the specific needs of those students.

Program details

Crossroads

This is a mandatory 25-hour personal development and health education course for Year 11 and 12 students in NSW government schools. It provides an opportunity for these students to build on outcomes achieved from Years 7–10. It reflects some of the contemporary health issues facing young people. It acknowledges and aims to support senior students as they address issues related to identity, independence and their changing responsibilities. The course is arranged around two key aspects: working at relationships and drug issues. External service providers, such as general practitioners and youth health services, may be engaged by individual schools to deliver aspects of the curriculum, or may seek to link their programs to these curriculum objectives.

School-Link

This is a state-wide collaborative program between DET and NSW Health, with a coordinator in every Area Health Service in NSW. *School-Link* aims to improve prevention, treatment and support for young people with mental health problems by strengthening formal and informal links between Health and DET, improving access to support, supporting the implementation of mental health initiatives in the school community, and facilitating training and development for school counsellors and mental health workers. The three main action areas are training and development on the assessment, treatment and management of adolescent depression and related disorders, resilience-building programs (such as *MindMatters*) and strengthening networks between health and education through collaborative programs and facilitating case management of clients. The coordinators are able to act as a resource by locating programs that fit with the school climate.

Health-Promoting Schools

Health-Promoting Schools is a model of best practice in working in the school setting and delivering health promotion messages. It brings together three elements of school life in a whole-school approach to strengthen the capacity of the school as a healthy setting for 'living, learning and working'. It also attempts to link health and education. The three elements of school life are curriculum, ethos, and school environment including parents and the local community. When all three are addressed simultaneously a sustainable, coordinated program exists that is effective and has the greatest likelihood of behaviour change. It is a framework for action within which individual schools can develop, select and/or tailor programs to meet their own needs.

MindMatters

This is a national resource for promoting well-being for all secondary school students. The program is primarily a professional development resource that trains teachers in coping skills and provides them with a range of hard copy resources, including curriculum materials, school planning documents and audits, a web-site facilitating the dissemination and exchange of information. Individual schools and teachers can use the materials to develop their own lesson plans. Since *MindMatters* was rolled out in 2000, 65% of government schools have participated in some form of professional development. Of these 98% have indicated that they intend to incorporate aspects of *MindMatters* into the school curriculum.

MindMatters Plus

MindMatters Plus builds upon the *MindMatters* program by encouraging schools to use a range of targeted programs in conjunction with the processes and curriculum implemented under *MindMatters*. These programs are chosen to address the specific needs of identified students and complement the other supports provided through the school's student welfare network. The programs include *ACE*, *Aussie Optimism* (positive thinking), *Cool Kids* (anxiety), *Kids Helpline* (peer skills), *Living Works* (suicide prevention training for teachers), *Triple P* (parenting), *RAP*, *Seasons for Growth* (grief and loss especially around divorce or death of parent) and *Heart Matters* (grief). The schools select the relevant programs and tender for appropriate facilitators. *MindMatters Plus* is currently being implemented in a selection of demonstration schools around the country.

MindMatters Plus GP

This initiative will seek to increase the capacity of the *MindMatters Plus* demonstration schools together with their local community to provide support for students with high mental health needs. In particular it will seek to promote referral pathways and networks of care for at-risk young people. It also identifies strategies for action at the school and the primary health care interface. During August 2003 a communication strategy will be developed to encourage all interested Divisions of General Practice to communicate to ensure the resources developed reflect existing good practice and that the 'demonstration' can be widely disseminated across the Divisions Network.

The NSW Premier's Gold Medal Fitness Program

This program aims to improve young people's physical activity and prevent overweight and obesity. It involves visits to schools by athletes as well as ongoing support for the implementation and roll-out of the 'Get Skilled and Active' fundamental movement skill teaching resource. There is a range of other programs run in relation to fitness, and SPAN, a surveillance tool, will begin in 2004 in primary and high schools examining physical activity, food habits and overweight.

Resourceful Adolescents' Program (RAP)

RAP is an educational program targeting whole school years (usually Year 9) and teaches resilience and coping skills. It adopts a cognitive behaviour therapy framework and presents a resilience model through the use of the metaphor of the three little pigs. Many schools have adopted parts of the program and fit these into existing components of their school curriculum. There is a 'two day' training component for teachers to assist with understanding students in this area.

Adolescents Coping with Emotions (ACE)

ACE is a psycho-educative program based on cognitive behaviour therapy principles and is delivered to students, usually from Years 8–10, identified within the school as being at risk of mental health problems. It deals with key coping issues for young people such as relationships (family and peers), communication (emotions, fear, anger, hatred, bullying), realistic thinking and support networks. The sessions involve 6–8 students and are facilitated by school counsellors, often in collaboration with a mental health worker. Participants are evaluated pre- and post-sessions with a number of psychological instruments. The program is easily integrated into the school timetable and young people can be picked up and monitored through their school career.

Senior Student's Program (being developed)

Currently a pilot of 5 sessions to complement the *Crossroads* curriculum, implemented during Year 11, covering relationships in the context of *stress management*. It focuses on seeing stress as a challenge with cognitive behavioural strategies and enhancing performance with this challenge. The plan is to implement the program in Term 4 of Year 11 and in Term 1 of Year 12. It is similar to *RAP* in terms of engaging students in concepts.

Section 6: Youth health programs in Victoria

The NSW Centre for the Advancement of Adolescent Health has strong links with the Centre for Adolescent Health in Melbourne, Victoria, particularly in the area of education and training. The Centre for Adolescent Health in Melbourne has led the way in Australia in developing evidence-based programs to support training of professionals in providing more accessible services for young people and in enhancing the role of schools in health promotion among young people. Thus we have included three Victorian programs, two of which were developed by the Centre for Adolescent Health in Melbourne.

1. The Youth Health Access Workshop (YHAW)

The Youth Health Access Workshop was developed by the Centre for Adolescent Health (CAH) in Melbourne, Victoria, following research conducted by CAH (Veit, 1996) which described barriers to help-seeking by young people. The program has been modified by the North East Victorian Division of General Practice (NEVicDGP). We interviewed staff from both the Centre for Adolescent Health and the NEVicDGP.

The YHAW is a multi-faceted program that aims to build the confidence and skills of young people to independently seek help from health professionals by providing relevant information about accessing services, who is most appropriate for what, problem-solving skills and creating opportunities to integrate knowledge, skills and behaviour around health issues. In addition, YHAW trains local providers in how to relate to young people, young people's health issues, and how to build relationships between local providers and young people. The workshops have been particularly popular among Divisions of General Practice in Victoria and have been modified according to local needs. DGP (and other service providers) in Victoria who have taken up the YHAW are trained by the program coordinator and are given resources, including a manual for GPs and an 'information bag' for young people. Local service providers (e.g. GP, community health or school nurse) go into schools and provide the workshops with all Year 9 or 10 students. Optional sessions are provided for parents and teachers. This often allays the fears of parents and teachers and helps them relate back to the young people's issues. The program, in summary, involves:

Session 1: What is health, where do I go, how to obtain a Medicare card.

Session 2: Issues around confidentiality (particularly in rural areas), anonymous mailbox questions and answers, certificates and 'showbags' with information, as well as feedback forms for students, teachers and the GPs.

There are pre- and 8-weeks post-workshop evaluations of knowledge and service usage. For further information see <<http://www.nevicdgp.org.au>>

2. The Gatehouse Project

Schools have long been used as settings for health education and promotion. Connectedness to school has been identified as protective against a range of adverse health and education outcomes for young people. The Centre for Adolescent Health's Gatehouse Project is a school-based prevention program designed to build the capacity of school communities to understand and address the emotional and mental health needs of young people. It focuses on promoting positive school environments that enhance a sense of connectedness for students, and on building individual schools and knowledge through the curriculum. The Gatehouse Project team, established in 1995, has developed, implemented and evaluated a practical whole-school strategy which can be adapted for individual school and whole-school systems. It is coordinated by a broadly representative adolescent health team and draws on the Health Promoting Schools framework. The three priority areas for action are around building a sense of security and trust; enhancing skills and opportunities for communication and social connectedness; and building a sense of positive regard through valued participation in school life. Evaluation of the project has demonstrated effects of health and educational significance, and experience in implementing the strategy is now extensive. Further details can be found on the Gatehouse website <www.gatehouseproject.com>

3. Primary Care Partnerships (Department of Human Services)

In 2000, the Victorian State Government introduced a reform strategy to better integrate general practice and other primary care funded services. The strategy aims to improve the health and well-being of Victorians, reduce health inequalities and improve people's experience of using primary health care services by developing a functionally integrated primary care service system through the development of partnerships between primary care providers, government and communities, improving service coordination and integrating service planning. Thirty-two Primary Care Partnerships (PCPs) have been established across Victoria. Within each PCP the member agencies can vary but usually include community health, local government, hospitals, Divisions of General Practice/General Practitioners and district nursing. A key component is capacity building of the service system to plan and deliver effective, integrated health promotion services. In order to develop a systematic approach to integrated health promotion a common planning framework has been introduced. The PCP structure should be a vehicle for:

- supporting the re-orientation of primary care to be population focused underpinned by the social model of health
- consolidating and enhancing the health promotion infrastructure and resources, thus reducing duplication and fragmentation of effort
- contributing to the evidence base around specific issues/population groups
- increasing the potential to involve other sectors.

Further details can be obtained from the website <www.dhs.vic.gov.au/phkb>

Appendix 1: Access: Phase 2 mapping instrument

- initiating organisation/s and processes
- primary aims and objectives of project/initiative
- target group (age, gender, cultural background, in school, out of school, etc.)
- description of model of health care (e.g. centre-based vs outreach; personnel involved, including professional disciplines; type of service provided, e.g. education, direct clinical service, referral/triaging service; economic/cost factors – to the project and to the target group; policy, policies and procedures)
- how service/initiative is promoted to target group
- evidence upon which the service (provision) has been based
- any barriers to the development of or ongoing provision of service
- length of operation of service
- gender of staff
- setting of health care delivery (e.g. school, youth health centre, community health centre, general practice, Division of General Practice)
- access points and what work is done to promote them
- how has the initiative obtained feedback from young people
- extent and nature of youth participation and/or consultation
- elements of difference/outreach
- inter- and intra-service collaboration
- staff training in youth health components
- funding
- sustainability measures
- method/s of evaluation of the initiative or components thereof
- outcome/s
- what is good/bad about initiative/what could be improved
- future plans/way forward
- are there any other youth-directed initiatives you know about
- does what you do relate to the current Youth Health Policy

Appendix 2: Access: Phase 2 analysis pro forma

Name of Organisation:

DOMAIN (principle)	RATING	WHY / HOW / COMMENT
Domain 1 – Access facilitation <i>Young people's barriers addressed:</i> <ul style="list-style-type: none"> • Awareness of service and how to access • Confidentiality and trust • Cost / transport / physical location <i>Service providers' barriers addressed:</i> <ul style="list-style-type: none"> • Cost / time • Support / linkages • Confidence working with young people 		
Domain 2 – Evidence on which service was based <ul style="list-style-type: none"> • National / international • Local needs assessment • Discussion between local providers • Service date • Felt needs 		
Domain 3 – Youth participation <ul style="list-style-type: none"> • None • Occasional / 'one-off' • Focus groups / interviews • Ongoing consultation / committees 		
Domain 4 – Collaboration <ul style="list-style-type: none"> • None • Informal ongoing • Occasional formal • Ongoing formal widespread 		
Domain 5 – Professional development <ul style="list-style-type: none"> • Needs • Opportunities / constraints • Mandatory • Appropriate • Quality standard 		
Domain 6 – Sustainability <ul style="list-style-type: none"> • Income generation • Can be generalised to other contexts • Shown to work / useful • Developed resources • Can be carried out with existing/ongoing staff • Has collaboration and commitment of other partners 		
Domain 7 – Measured results of program/service and evaluation done <ul style="list-style-type: none"> • Has service plan that at least thinks about what service is trying to do • Process • Impact on-service / young people • Results/outcomes on service/young people • How measured 		

Appendix 3: Access: Phase 2 sample – Tables by sector, interviewed persons and health issue

Table 1: Participating services by sector

Youth Health Services n=14 Service Name + AHS Location	Area Health Services n=222 Program + AHS + Dept	Divisions of GPs n=18 Program Name + DGP	NGO Programs n=17 Program Name NGO, Head Office Location	Other Government n=6 Name Program Government Dept, Location
Canterbury Multicultural YHS Central Sydney AHS	Spiked Drink Project Central Sydney AHS / WH	YouthREACH Central Sydney	Barnados, Ultimo	Access Division TAFE, Granville
Cellblock YHS Central Sydney AHS	Albury Mobile Service Greater Murray AHS / HPU	The Bridge Clinic Dubbo Plains	Bodyspeak, Ourimbah	Dept Job Placement, Education & Training (JPET) [j]
Central Coast YHS Central Coast AHS	Warrawong HPU Illawarra AHS / CHC	(Under development) Eastern Sydney [p]	Alive program Centacare, Enmore	Juvenile Justice, Sydney City
CHAIN / FPA Health Illawarra AHS	Dubbo D & A Forum Macquarie AHS / D & A	GPs in Schools Hastings – Macleay	HOT program Youth Accom Assoc, Redfern	Links to Learning [i]
Coffs Harbour Outreach YHS Mid-North Coast AHS	Tim Tams Mid-North Coast AHS	GPs in Schools Hornsby KuRingGai Ryde	Kids Helpline, Queensland	Redfern Waterloo Project, Redfern
The Corner YHS South-Western AHS	Moodswell Mid-North Coast AHS / MH	GPs in Schools Illawarra	Labelled a Freak, Ourimbah	Snowy Shire Council, Berridale
Fairfield-Liverpool Youth Health Team South-Western Sydney AHS	School-based clinic Mid-West AHS / CHC	GPs in Schools Manly Warringah	Art & Music program Mission Australia, Surry Hills	
High Street YHS Western Sydney AHS	Glam Northern Sydney AHS / HPU	GPs in Schools; pregnancy project Mid-North Coast AHS	Point Zero, Waverley	
Murralappi, The Settlement Neighbourhood Centre Central Sydney AHS	Galah Northern Sydney AHS / HPU	The Junction clinic; PRAMS Nepean	Reachout!, Balmain	
Penrith Street Work Project Wentworth AHS	Youth Health Coordinator Northern Sydney AHS	(Under development) North-West Slopes [p]	Roberto Pirado bullying program, Granville	
Shoalhaven YHS Illawarra AHS	Youth Health Coordinator South- Eastern Sydney AHS	GPs in Schools Northern Rivers	Rural Roadshow FPA Health, Ashfield	

TraXside YHS [i] South-Western Sydney AHS	Pitstop South-Eastern Sydney / CHC	GP-staffed youth health clinics Central Coast + CCAHS partnered	Ted Noffs, Randwick
The Warehouse/ FPA Health Wentworth AHS	YARDS [p, pm] South-Eastern Sydney / MH	GPs in Schools; pregnancy program, Shoalhaven	Ted Noffs, Wollongong
Western Area Adolescent Team Western Sydney AHS	Gaining Ground South-Western Sydney AHS / MH	(Under development) SouthEast NSW [p]	WAYS, Waverley/Bondi
	Cooma CHC / Youth Service Southern AHS / CHC	(Under development) St George [p]	Wesley Mission, Carlingford
	Youth Health Coordinator Southern AHS	GPs in Schools – depression Sutherland	Youth off the Streets, Merrylands
	Baileys Place (YC) Goulburn Southern AHS / CHC	(Under development) Tweed Valley [p]	Youthsafe, Ryde + RTA & AHS funding partners
	Mt Austin school-based resource centre (partnership) Greater Murray AHS / WH / Riverina DGP / Mt Austin High School (DET)		
	Eden YC Southern AHS / CHC		
	YIPPI Wentworth AHS / HPU		
	Cannabis Project Wentworth AHS/ HPU		
	Kirketon Rd Centre South-Eastern Sydney AHS		

KEY

- p research conducted by phone interview
- pm information obtained from printed materials
- i information obtained from internet
- AP1 information gained during ACCESS Study Phase 1 interview

Table 2: List of persons interviewed by sector and organisation

i. Youth Health Services	
Canterbury Multicultural (CSAHS)	Deslyn Raymond – Program Manager, Child & Family Belinda Luca – Youth Worker
Cellblock (CSAHS)	Tony Phiskie – Manager
Central Coast (CCAHS)	Graham Lane – Manager
CHAIN (Illawarra AHS) / FPA Health	Karen Graham – Acting Coordinator Diane Booth – Nurse
Coffs Harbour (MNCAHS)	Bronwyn Bailey – Child & Adolescent Mental Health Worker Helen Barton – MNCAHS School Link Coordinator
Crossroads (Shoalhaven AHS)	Wendi Hobbs – Manager
The Corner (WSAHS)	Voula Kougelos – Manager
FLYHT (SWSAHS) [AP1]	Maria Coehlo – Manager
High Street Youth Health Service (WSAHS)	Karen Murdoch & Tracy Feltham – Acting Coordinators
Muralappi (CSAHS)	Robert Stringer – Manager
Penrith Streetwork Project (WAHS)	Rosie Solomona – Manager
Traxside (SWSAHS) [API]	Megan Brooks – Manager
The Warehouse / FPA Health	Anthony Critchley – Manager, Population Health & Centre Coordinator
Western Area Adolescent Team (SWSAHS)	Graham Pringle – Manager

ii. Area Health Services	
South-Eastern Sydney AHS	Sally Lambourne – Youth Health Coordinator
Southern AHS	Simon Milligan – Youth Health Coordinator (from July 2003) Simone Dilkara – Youth Health Coordinator (to February 2003)
Northern Sydney AHS	Cindy Dargaville Ann White Briana Newman – Youth Health Assistant
Kirketon Rd Centre (SESAHS)	Jo Northey – Head of Counselling
Albury Mobile Service / HPU (GMAHS)	Keith Edwards – Health Promotion Officer
Baileys Place (SAHS)	Tim Bovington – Youth Worker
Cannabis Project (WAHS)	Louise Maher – Health Education Officer, D & A Team, Pop Health
Cooma CHC / YHS (SAHS)	Narelle Davis – Manager Community Health Jo Brown – Youth Worker
Drug & Alcohol Dubbo (Macquarie AHS)	Prea Lowe – Health Improvement Officer, Drug & Alcohol
Eden YHS (SAHS)	Martine Mathieson – Youth Worker
Gaining Ground (SWSAHS)	Andrew Sozomenou – Project Manager, Area Mental Health
Glam / Galah, HPU Health Access Ryde NSAHS	Michael West – Consultant HIV/Sexual Health Promotion Amanda Watkins – Youth Consultant HIV/Sexual Health Promotion
Moodswell. Mental Health Kempsey (MNCAHS)	Bronwyn Chalker – Coordinator, Child Health & Adolescent Mental Health Services
Orange CHC (MWAHS)	Deryk Slater & team – Psychologist, Child & Adolescent Mental Health
Pitstop, Sylvania CHC (SESAHS)	Fiona O'Neill – Acting Team Leader / AOD counsellor
Port Macquarie CHC (MNCAHS)	David Milligan – Manager, Community Health
Spiked Drink Project, Women's Health (CSAHS)	Katy Laurich – Project Officer

Tim Tams Kempsey (MNCAHS)	Caroline Jones – Young Parent Worker, Community Health Michelle O'Brian – Project Assistant
Mt Austin High, Wagga (Murray AHS)	Dr Geraldine Duncan – Campus Coordinator, NSW School of Rural Health, Mr Dennis Bishop – Principal Heather Boetto – Community Development Officer
Warrawong CHC (IAHS)	Janet Jackson – Health Promotion Officer
YIPPI (WAHS)	Trish Preston – Health Education Officer, Population Health
YARDS, Mental Health (SESAHS)	Liz Evans – Project Officer

iii. Divisions of General Practice

Central Sydney	Dr Yvonne Selecki – Medical Director David Winter – Project Officer
Dubbo Plains	Dr Jenny Beange – Medical Director
Eastern Sydney	Auriol Carruthers – Project Officer
Hastings Macleay – Port Macquarie	Bev Buckeridge – Youth Project Officer
Hornsby Ku-Ring-Gai Ryde	Dr Carol Kefford – Manager, Adolescent Project (Division) / PHC Research & Development Officer, Academic Unit
Illawarra	Dr Andrew Dalley – Chief Executive Officer Coralie Wilson – Youth Health Program Officer
Manly Warringah	Darryl Schaeffer – Project Officer
Mid North Coast	Deb Broderick – Project Officer, Youth & Immunisation
Nepean	Kate Weston – Youth Health Program Officer
North West Slopes: 3 DGPs – Barwon / Tamworth / North West Slopes	Natalie Evans – Youth Project Officer
Northern Rivers / Byron Bay	Dr Rob Trigger – Youth Health Project Manager
Central Coast	Dr Karen Douglas – GP Youth Health Services
Riverina (Wagga)	Dr Geraldine Duncan – Campus Coordinator, School of Rural Health UNSW
Shoalhaven	Kim Crowe – Program Coordinator, Youth Dr Liz Cunningham – Program Manager, Youth Deb Byrnes – Program Liaison Officer, Youth
South-East NSW: Cooma / Eden / Goulburn	Dr Andrew Egan – General Practitioner
St George	Marian Faraj – Project Officer
Sutherland	Yvonne Rawling – Chief Executive Officer
Tweed Valley	Karen Douglas – Child Psychologist

iv. Non-government organisations

Barnardos	Bill Hoyle – Senior Manager, Youth Services and After Care
Bodyspeak	Debbie Notara – Lecturer, Personnel & Community Services / Bodyspeak Project Developer
Centacare Alive program	Bernie McGee – Case Worker
HOT project, YAA	Adrian Foon – Coordinator
Kids Helpline	Wendy Reid – Director, Research & Development
Labelled a Freak	Nikki Fallon – Consultant
Art & Music Program, Mission Australia	Zoe Jeffries – Student Support Coordinator
Point Zero	Rachel Newhouse – Executive Coordinator
Reachout	Jonathan Nicholas – Programs Director
'Bullying program'	Roberto Parada – Child & Family Counsellor, Marist Education Centre

Rural Roadshow, FPA Health	Liz Hammond – Senior Health Promotion Officer
Ted Noffs Foundation (Randwick)	Fiona Santangelo – Manager, Schools and Out-Clients
Ted Noffs Foundation (Wollongong)	Branka Valeski – Adolescent & Family Counsellor
WAYS	Amanda Webster – Executive Officer
Wesley	Simone Walker – State Manager, Family & Youth Services Catherine Elliott – Centre Manager, Hills Family Centre
Youth off the Streets	Kevin Ko – Cluster Manager
Youthsafe	Cecilie Dell – Advocacy & Promotions Coordinator

v. Other government departments / services & education programs

TAFE – Access Division	Arydice Harris – Manager, Access Division & team
Links to Learning	Internet site
Juvenile Justice	Than Nguyen – Policy Officer, Policy Unit
JPET	Internet site
Redfern Waterloo Project	Sandy Abrahams – Manager, Street Team Melissa d'Agostini – Project Manager
Snowy Shire Council	Michelle Lindau – Community Youth Worker
Ted Noffs Collaboration	Vivienne Crawford – Relieving Manager, Student Welfare Programs
ACE	Roger Stonehouse – Coordinator, Student Counselling & Welfare / ACCESS Study Reference Group member
Crossroads	Helen Kerr-Roubicek – Manager, Student Welfare NSW DET / ACCESS Study Chief Investigator
Gold Medal Fitness Program	Michael Booth – ACCESS Study Reference Group member
Health Promoting Schools	Hanna Beard – Health Promoting Strategies & Settings Unit, NSW Health
MindMatters	Roger Stonehouse – ACCESS Study Reference Group member Helen Kerr-Roubicek – ACCESS Study Chief Investigator DET Printed documentation
MindMatters Plus	As above
Resourceful Adolescent Program & Senior Students Program	Naomi Morton – Resilience Programs Coordinator
School Link	Belinda Burgess – School Link Coordinator, WSAHS & AMHS)

vi. Interstate programs (Victoria)

Youth Health Access Workshops (YHAW), Centre for Adolescent Health, Melbourne	Jane Maher – YHAW Coordinator, CAH Melbourne Dr Trevor Adcock – Program Manager, Dandenong DGP (VIC) Julie Sutherland – Program Coordinator, Dandenong DGP (VIC) Renee Williams – Program Coordinator, SE Division DGP Benalla (Vic)
Gatehouse project Centre for Adolescent Health, Melbourne	Lyndall Bond – Project Coordinator, CAH Melbourne
PHC Partnerships	David Riley – Manager Susan Heward – Health Promotion Primary Care Partnerships Coordinator, Department of Human Services

Table 3: AHS, NGO and government departments sample by health issue

Health issue identified by young people in Phase 1	AHS programs	NGO programs	Other government department programs
Bullying		Roberto Parado Program	
Body image and diet	Canobolas High clinic	Labelled a Freak, Bodyspeak	
Drug & alcohol issues	Cannabis project – WAHS Pitstop – SESAHS SIC/YIPPI – WAHS Canobolas High clinic Spiked Drink Project – CSAHS	Ted Noffs Foundation – Randwick Ted Noffs Foundation – Wollongong Point Zero and aspects of other programs	
Employment and educational opportunities	Several youth health services have representatives on these programs or linkages with the sector		JPET, Access Division of TAFE, Links to Learning, Juvenile Justice, Snowy Shire Council
Mental health	Gaining Ground – SWSAHS Moodswell CD Rom – MNCAHS YARDS – SESAHS Dubbo School Forum and Camps – MAHS	Kids Helpline / Online Mission Australia Art & Music Program ReachOut! Roberto Parado Program	Juvenile Justice
Physical Health	Canobolas High Clinic	WAYS	
Relationships including aspects of self-esteem	Spiked Drink Project Mount Austin and Canobolas High Dubbo Camps Moodswell Tim Tams Gaining Ground Glam/Galah	Barnados Centacare Mission Australia Art & Music Program Wesley Mission Bodyspeak	Juvenile Justice, Snowy Shire Council
Safety (Physical/potential)	Spiked Drink Project, Warrawong HPU	Youthsafe Youth off the Streets Point Zero	Redfern Waterloo Project, Juvenile Justice
Sexual health	Glam – NSAHS Galah – NSAHS Spiked Drink Project – CSAHS Tim Tams – MNCAHS	Rural Roadshow / FPA Health WAYS HOT Project YAA Youth off the Streets and aspects of other programs including youth health services	
Social issues (e.g. lack of recreational activities, homelessness)	Albury Mobile Service, Warrawong HPU Eden YHS Bailey's Place Cooma CHC / YS and aspects of most youth health services programs	Barnados Centacare Mission Australia HOT project YAA Youth off the Streets	Links to Learning, Redfern Waterloo Project
Stress/school pressure	Pitstop Year 12 Senior's Program, RAP etc.	Roberto Parado 'bullying program' Ted Noffs programs	Access Division of TAFE

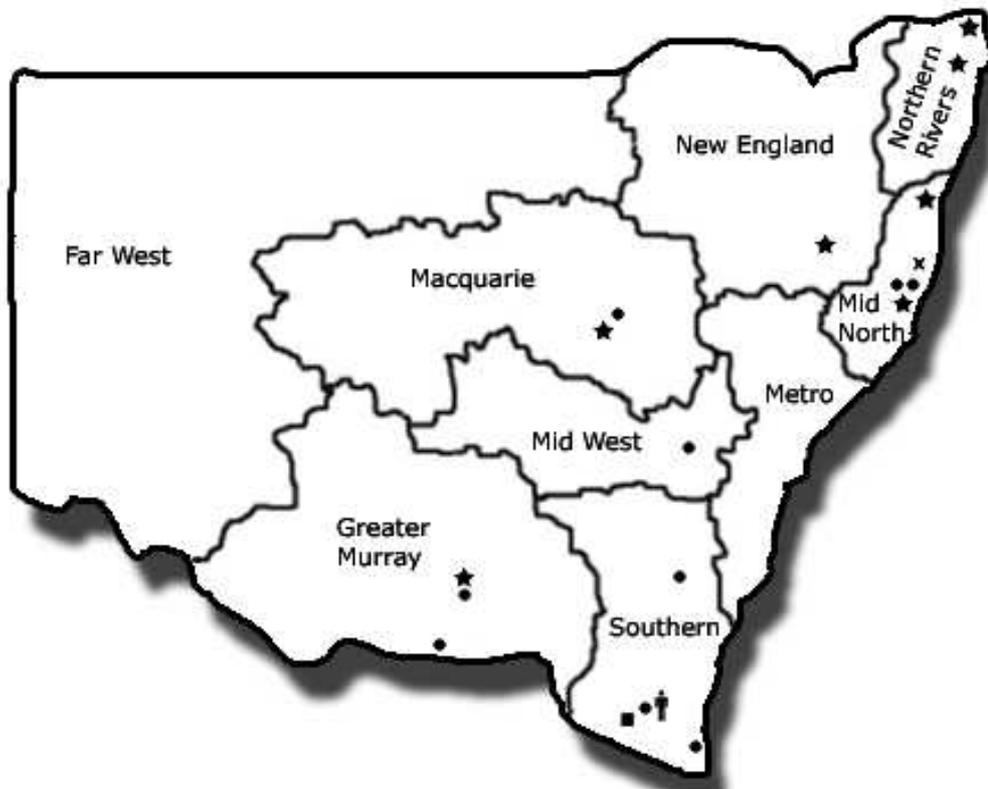
Figure 1: Eastern NSW



Legend

- ★ Division of General Practice
- Area Health Service Program
- × Youth Health Services
- † Youth Health Coordinator
- Other (non-health) government sector programs
- ♣ NGO programs (1 national NGO program based in QLD does not appear on map)

Figure 2: Greater NSW



Legend

- ★ Division of General Practice
- Area Health Service Program
- × Youth Health Services
- † Youth Health Coordinator
- Other (non-health) government sector programs
- ♣ NGO programs (1 national NGO program based in QLD does not appear on map)

References

- Altman DG, Endres J, Linzer J, Lorig K, Howard-Pitney B & Rogers T (1991). Obstacles to and future goals of ten comprehensive community health promotion projects. *Journal of Community Health*; 16: 299–314.
- Bartik W, Kowalenko N, Whitefield K & Wignall A (2001). Anxiety and depression in young people: a collaborative rural and remote model. *Youth Studies Australia*; 20(3): 38–42.
- Birleson P, Luk ESL & Mileshekin C (2001). Better mental health services for young people: responsibility, partnerships and projects. *Australian and New Zealand Journal of Psychiatry*; 35: 36–44.
- Booth M, Bernard D, Quine S, Kang M, Beasley L, Usherwood T, Alperstein G & Bennett D (2002). Access to health care among NSW adolescents: Phase 1 Final Report. Sydney: NSW Centre for the Advancement of Adolescent Health, The Children's Hospital at Westmead. ISBN: 0 95779 513 0.
- Booth ML, Bernard D, Quine S, Kang M, Usherwood T, Alperstein G & Bennett DL (2004). Access to health care among Australian adolescents: young people's perspectives and their socio-demographic distribution. *Journal of Adolescent Health*; 34(1): 97–103.
- Brownson RC, Baker E, Leet TL et al. (2003). Evidence Based Public Health. Oxford; New York: Oxford University Press,.
- Bryan B & Batch JA (2002). The complexities of ethnic adolescent health: an Australian perspective. *Youth Studies Australia*; 21(1): 24–33.
- Cantillon P & Jones R (1999). Does continuing medical education in general practice make a difference? *British Medical Journal*; 318, 8 May: 1276–1279.
- Center for Disease Control and Prevention (1999). Framework for program evaluation in public health. *MMWR*; 48(No RR-11): 1–42.
- Community Link Australia (2003). Review of innovative health services for homeless young people. Community Link Australia.
- Fink A (2003). Evaluation fundamentalism – guiding health programs, research and policy. London: Sage.
- Friedman M (2003). Results and performance accountability: decision making and budgeting. Unpublished report. Santa Fe, New Mexico: Fiscal Policy Studies Institute.
- Fry D & King L (1986). Standards for community health: the National Community Health Accreditation and Standards project. *Community Health Studies*; 10(3): 284–292.
- Funnell S (1997). Program logic: an adaptable tool for designing and evaluating programs. *Evaluation News & Comment*; 6: 5–17.
- Gahan C & Hannibal M (1998). Doing qualitative research using QSR NUD*IST. London: Sage.
- Goodman RM & Steckler AB (1987/88). The life and death of a health promotion program: an institutionalization case study. *International Quarterly of Community Health Education*; 8: 5–21.
- Goodman, RM & Steckler, AB (1989). A framework for assessing program institutionalization. Knowledge in Society. *International Journal of Knowledge Transfer*, 2: 57–71.
- Graham NO (1995). Quality in health care: Theory, application and evolution. Gaithersburg, Md: An Aspen Publication.

- Gray JA Muir (1997). Evidence based health care. New York; Melbourne: Churchill Livingstone.
- Grimshaw JM, Shirran L, Thomas R et al. (2001). Changing provider behavior: an overview of systematic reviews of interventions. *Medical Care*; 39(8) Suppl. 2: II-2 – 11-45.
- Grohl R & Grimshaw JM (1999). Evidence-based implementation of evidence-based medicine. *Joint Commission Journal of Quality Improvement*; 25: 503-13.
- Harrison L & Dempsey D (1998). Sexual health service provision to the young and the homeless. *Youth Studies Australia*; 17(3): 26-35.
- Hawe P, Degeling D & Hall J. (1994). Evaluating health promotion – a health worker’s guide. Sydney: MacLennan and Petty.
- Hoatson L & Egan R (2001). Rebuilding collaboration in a competitive environment: a case study. *Just Policy*; 21: 8-15.
- Inspire Foundation (2001). *REACH OUT!* Evaluation Report Stage Two – Impact Evaluation July 1999 – December 2000.
- Jackson C, Fortmann SP, Flora JA, Melton RJ, Snider JP & Littlefield D (1994). The capacity-building approach to intervention maintenance implemented by the Stanford Five-City Project. *Health Education Research*; 9: 385-396.
- Janz NK, Zimmerman MA, Wren PA, Israel BA, Freudenberg N & Carter RJ (1996). Evaluation of 37 AIDS prevention projects: successful approaches and barriers to program effectiveness. *Health Education Quarterly*; 23: 80-97.
- Kang M, Bernard D, Booth ML, Quine S, Alperstein G, Usherwood T, Bennett DL (2003). Access to primary health care for Australian young people: service provider perspectives. *British Journal of General Practice*; 53(12): 947-952.
- Kazandjian VA & Sternberg EL (1995). The epidemiology of quality. Gaithersburg, Md: An Aspen Publication.
- King R, Nurcombe B & Bickman L (2000). Kids Helpline Suicide Intervention Strategy Evaluation: Report 1: Awareness and Utilisation of Kids Helpline under the National Youth Suicide Prevention Strategy.
- Mathias K (2002). Youth-specific primary health care – access, utilisation and health outcomes. *NZHTA Report*; 5(1).
- Mubyazi G & Hutton G (2003). Understanding mechanisms for integrating community priorities in health planning, resource allocation and service delivery: results of a literature review. EQUINET Discussion Paper 13, October. Accessed 8/4/04 <<http://www.equinetfrica.org/bibl/discussion.php>>
- Mudaly B (1999). School-focused youth service: building coalitions amidst social and economic change. *Youth Studies Australia*; 18(1): 43-49.
- Murray D, Ellis R, Enter J & Richards C (1999). Connexions: a program of Jesuit Social Services, an integrated service for marginalised young people. *Youth Studies Australia*; 18(1): 16-22.
- NSW Department of Health (1998). Young People’s Health: Our Future.
- Oxman AD, Thomson MA & Davis DA (1995). No magic bullets: a systematic review of 102 trials of interventions to improve professional practice. *Canadian Medical Association Journal*; 153(10), 1423-1431.
- Patton G, Bond L, Butler H & Glover S (2003). Changing schools, changing health? Design and implementation of the Gatehouse Project, *Journal of Adolescent Health*; 33(4): 231-239.

- Patton MQ (1987). How to use qualitative methods in evaluation. Newbury, Par: Sage Publications.
- Pawson R & Tilley N (1998). Realistic evaluation. Sage Publications.
- Perleth M, Jakubowski E & Busse R (2001). What is 'best practice' in health care? State of the art and perspectives in improving the effectiveness and efficiency of the European health care systems. *Health Policy*; 56(3): 235–250.
- Quine S, Bernard D, Booth M, Kang M, Usherwood T, Alperstein G & Bennett D (2003). Health and access issues among Australian adolescents: a rural-urban comparison. *Rural and Remote Health*; 3: 245. Available from <<http://rrh.deakin.edu.au>>
- Rogstad KE, Ahmed-Jushuf IH & Robinson AJ, on behalf of the MSSVD Adolescent Sexual Health Group (2002). Standards for comprehensive sexual health services for young people under 25 years. *International Journal of STD and AIDS*; 13(6): 420–424.
- Sanci LA, Coffey CMM, Veit FCM et al. (2000). Evaluation of the effectiveness of an educational intervention for general practitioners in adolescent health care: randomised controlled trial. *British Medical Journal*; 320(7229), 22 January: 224–229.
- Sawyer MG & Kosky RJ (1995). Approaches to delivering child and adolescent mental health services: the South Australian experience. *Australian & New Zealand Journal of Psychiatry*; 29(2): 230–237.
- Sebuliba D & Vostanis P (2001). Child and adolescent mental health training for primary care staff. *Clinical Child Psychology & Psychiatry*; 6: 191–204.
- Society for Adolescent Medicine (1992a). Access to health care for adolescents: a position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*; 13: 162–170.
- Society for Adolescent Medicine (1992b). Health and health needs of homeless and runaway youth: a position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*; 13: 717–726.
- Steckler A & Goodman RM (1989). How to institutionalize health promotion programs. *American Journal of Health Promotion*; 3: 34–44.
- UNICEF (1989). Convention on the rights of the child.
- U.S. Agency for International Development (1988). Sustainability of development programs: a compendium of donor experience. Washington, DC: USAID.
- Veit FC, Sanci LA, Coffey CM, Young DY & Bowes G. Barriers to effective primary health care for adolescents. *Medical Journal of Australia* 1996; 165(3): 131–133.
- Wise M (1995). Working together: intersectoral action for health. Australian Centre for Health Promotion.
- World Health Organisation (WHO) (2002). Adolescent friendly health services: an agenda for change. WHO/FCH/CAH/02/14 World Health Organisation.
- Yin RK (1979). Changing urban bureaucracies: how new practices become routinized. Lexington, MA: D.C. Health and Company.