

ACCESS STUDY

Youth Health Better Practice

framework

Fact sheets 2nd Edition

caah
the children's hospital at Westmead
NSW Centre for the Advancement
of Adolescent Health



Health

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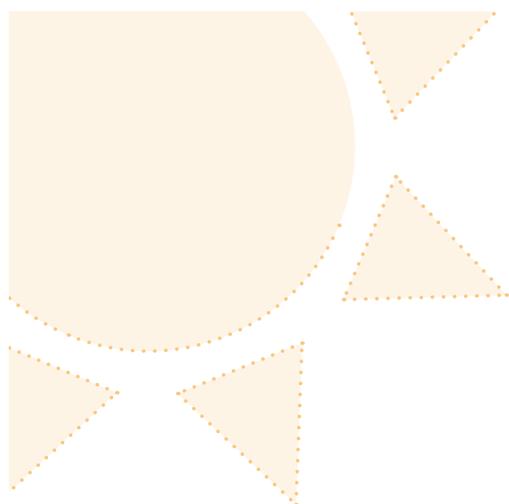
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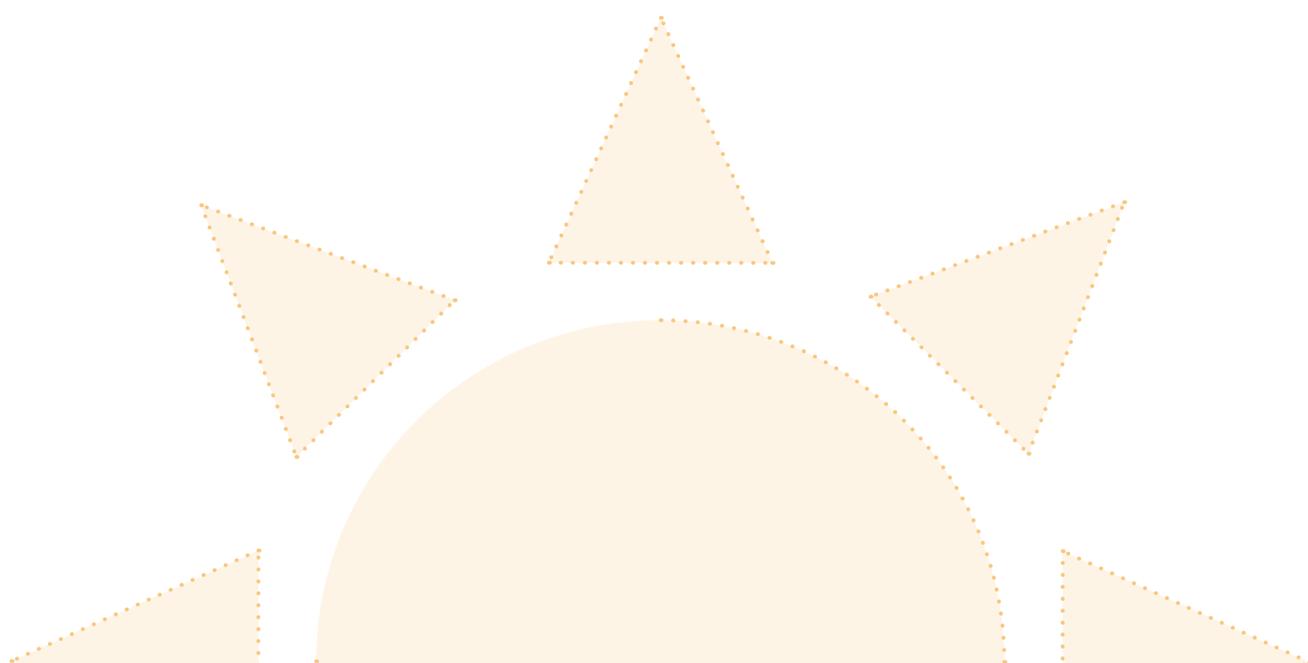
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INTRODUCTION

About this document

The *Access Study: Youth Health – Better Practice Framework Fact Sheets 2nd Edition* resource is designed for policy makers, managers and service workers involved in reviewing, planning and designing effective adolescent health-related services.

This toolkit was produced in connection with the *Better Practice in Youth Health: Final report on the research study: Access to health care among young people in New South Wales: Phase 2* (Kang et al., 2005). The quotes from practitioners and the amended case studies in the fact sheets are based on those contained within the above report.

In this second edition the resources section which were at the end of each chapter in the first edition, have been removed. The resources are now listed as ‘useful links’ on the NSW CAAH website, to allow them to be regularly updated.

‘Area Health Services/s’ in this document refers to NSW’s eight Area Health Services prior to the national health reform (2010). While they are now called ‘Local Health Networks’, in order to preserve the integrity of the case studies from the first edition of this publication, we have continued to refer to ‘Area Health Service/s’ in this document.

The *Youth Health Better Practice Framework* (NSW CAAH, 2005) has informed the current *NSW Health Youth Health Policy 2011-2016: healthy bodies, healthy minds, vibrant futures*. The NSW Youth Health Policy recommends that all health services, mainstream and youth-specific, use the *Youth Health Better Practice Framework* checklist as a planning tool to improve youth health service provision. A checklist covering the seven principles for better practice in youth health is included as an appendix in *NSW Health Youth Health Policy 2011-2016*.

What is the Access series?

The Access Series is a program comprising applied research projects and activities targeting youth health, aiming to improve young people’s access to primary health care in NSW as well as the quality of services

being provided across the State. The NSW Centre for the Advancement of Adolescent Health conducted both Access Phases 1 and 2 with the support of NSW Health.

Access: Phase 1

The *Access: Phase 1* study researched young people’s experiences and behaviours in seeking health care assistance. The findings in *Access to health care among NSW adolescents: Phase 1 Final Report* (Booth et al., 2002) discussed young people’s:

- Perceptions and definitions of health
- Priority health concerns and key barriers when seeking help
- Preferred sources of help and usage of service providers
- Recommendations for ‘ideal service provision’.

The research also explored a range of service providers’ perspectives, including barriers to providing optimal care, support and professional development needs, and suggestions for ideal service provision models.

Access: Phase 2

The following phase in the series consulted with a wide range of health, welfare and medical services across NSW, analysing different models of youth health-related service delivery and identifying better practice recommendations for youth health.

The key components of this phase were to:

- Describe the current range of service pathways to youth health – mapping services, programs and initiatives across Area Health Services, Divisions of General Practice, NGOs and other government departments
- Identify and discuss innovative and effective approaches and models of primary health care service delivery to young people
- Compile and produce practical better-practice guidelines on youth-friendly primary health care for existing services, based on lessons learned.

INTRODUCTION

The *Access: Phase 2* research aimed to:

- Identify and describe service models, principles and practice in youth health across NSW
- Discover whether any models had been evaluated for their effects upon access to services and/or the health of young people
- Determine what elements of practice constitute 'Better Practice in Youth Health'.

Where do the seven principles come from?

Access: Phase 2 researchers developed seven provisional themes, or principles, of youth health better practice from literature analyses and the interviews (access facilitation, evidence base, youth participation, collaboration, professional development, sustainability and evaluation) to create the analysis framework. In the fact sheets these appear as:

- Accessibility
- Evidence-based approach
- Youth participation
- Collaboration and partnerships
- Professional development
- Sustainability
- Evaluation

Rationale for the fact sheets

Findings from *Better Practice in Youth Health: Final report on the research study: Access to health care among young people in New South Wales: Phase 2* (Kang et al., 2005) highlighted the need for services and organisations to develop a systematic and comprehensive approach to youth programming, while incorporating existing tools and lessons learned from other programs.

Responding to this need, NSW CAAH developed the ***Access Study: Youth Health – Better Practice Framework*** fact sheets resource, using a combination of published evidence, case studies and experience from the interviewed services. This resource is a practical tool, developed to assist services in reviewing, planning and evaluating organisational processes which support youth health-related programming.

What the fact sheets contain

Each of the seven fact sheets contains:

- Definition of the principle being discussed
- Quick service assessment quiz – to help services identify priority areas
- Set of recommended indicators
- Literature review summary of evidence, and overview of major issues
- Practical ideas and strategies
- Case studies and stories from the field

Additional copies of these fact sheets are available in hard copy from the NSW Centre for the Advancement of Adolescent Health, Children's Hospital at Westmead. Alternatively, they can be accessed online at: www.caah.chw.edu.au

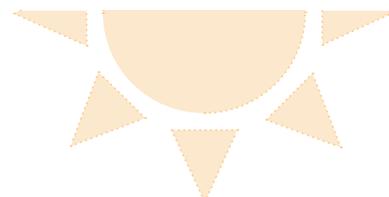
Related reading

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

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NSW Department of Health, 2010. *NSW Youth Health Policy 2011-2016: Healthy bodies, healthy minds, vibrant futures*. NSW Department of Health, North Sydney.



INTRODUCTION

What is better practice?

Best 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, 2001).

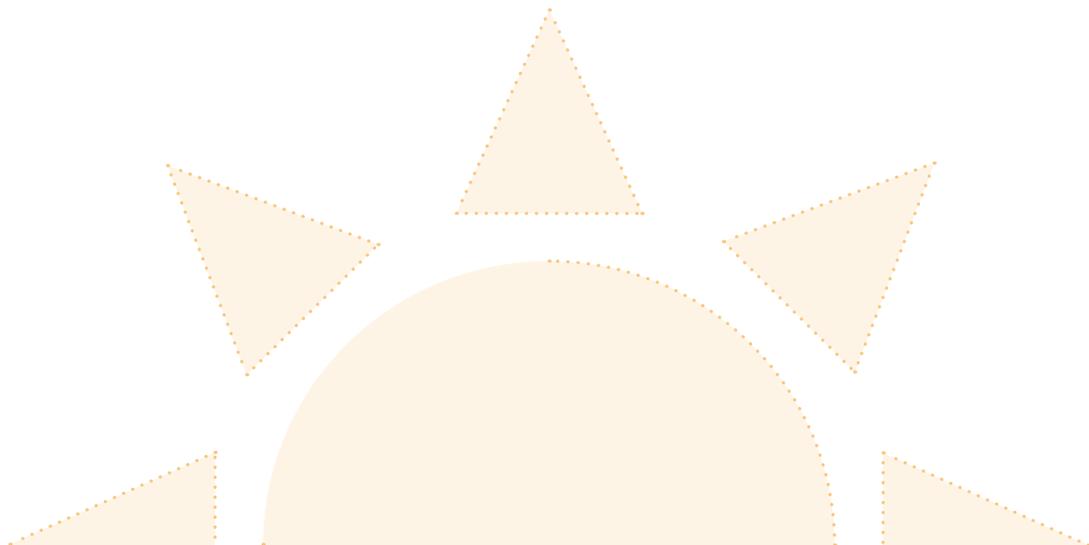
The prime objective of better practice is to improve individual or population health through the use of effective and cost-effective health care interventions. This means that evaluation (based on immediate objectives and on long-term outcomes) is a central function for improving performance. Evidence 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 organize 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 regarding 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 provides a framework for better practice in the form of a set of principles, their indicators, recommendations, practical strategies and resources.

- adapted from the Access Study Phase 2 research report: "Better Practice in Youth Health" (Kang et al, 2005)

References

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.



FACT SHEETS

Accessibility

1

Evidence-based approach

2

Youth participation

3

Collaboration and partnerships

4

Professional development

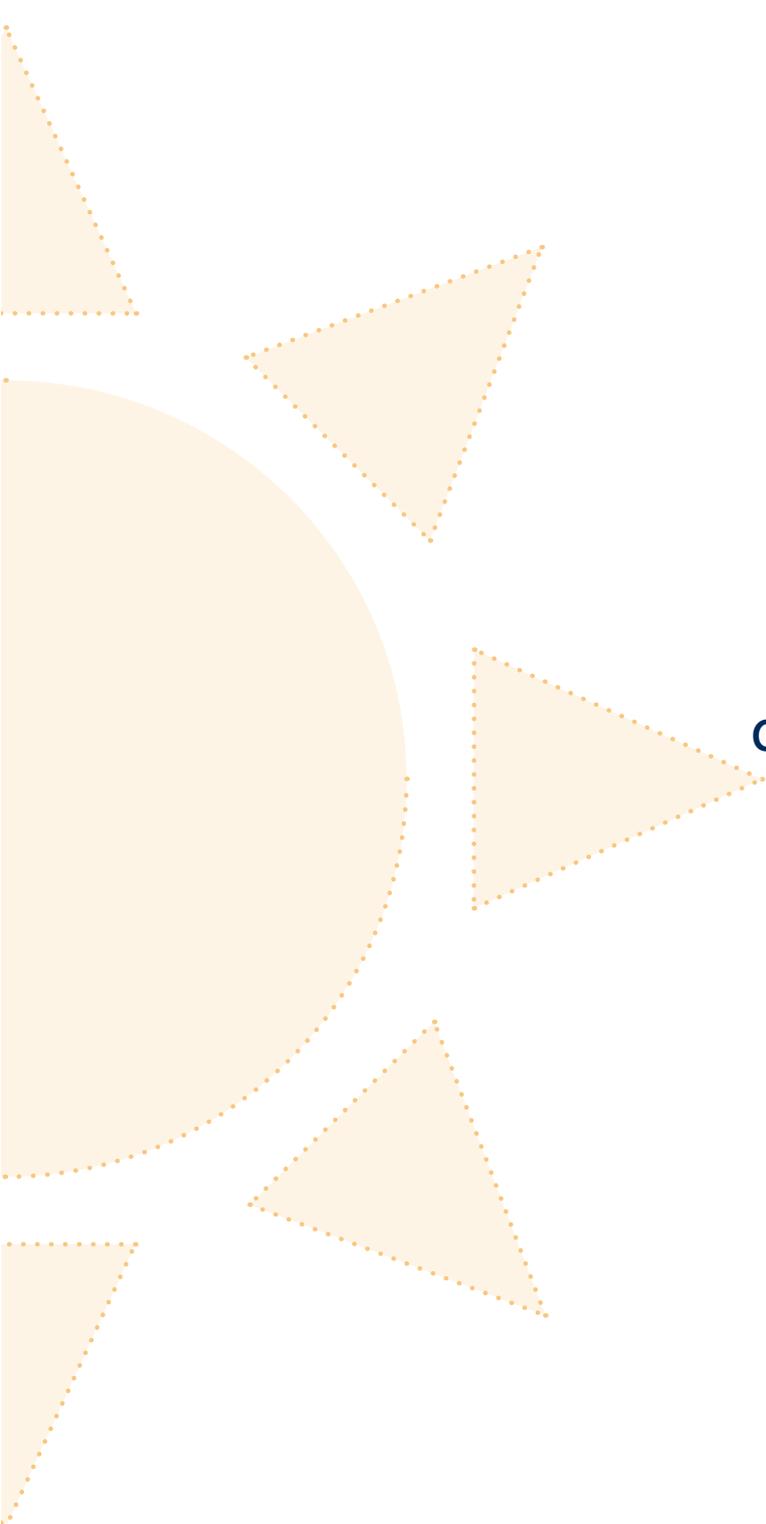
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Sustainability

6

Evaluation

7

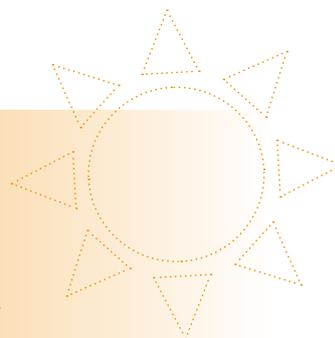




ACCESS STUDY

youth health better practice framework

ACCESSIBILITY fact sheet



1

What do we mean by accessibility?

Accessibility describes a flexible, affordable health service which is 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).

Checklist: How accessible is your service?

Basic indicator checklist	yes	partly	no
1. Does your service have a promotion strategy for targeting young people?			
2. Is there a confidentiality policy? Is this widely publicised to your target group?			
3. Does your service actively seek to understand young people's concerns and needs, and have the capacity to respond to their needs?			
4. Does your service use creative, innovative activity-based strategies to improve young people's access to, and engagement with, youth health services?			
5. Are services provided free, or at a cost affordable to young people?			
6. Can young people reach the service easily (e.g. by public transport)?			
7. Is the service open after hours when young people can get there?			
8. Is it possible for young people to drop in and use the service without having to make an appointment?			
9. Is there flexibility around consultation times, and the capacity to offer longer sessions to deal with complex issues that may arise?			
10. Are staff provided with training, supervision and support to maintain the knowledge and skills required for working with young people?			
TOTAL			

ACCESSIBILITY

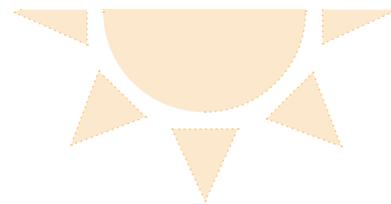
literature review + indicators

Lessons learned: What does the literature say?

International research highlights the importance of creating accessible health services that are relevant to young people. It also suggests that provision of an accessible, affordable and responsive health service is a major factor in the maintenance of young people's health and well-being.

Although it is noted that certain subgroups of young people (Parslow et al., 2002), for example young men and indigenous youth, may be more at risk because they are not accessing health care, Phase 1 of the Access Study shows 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 health 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).



Indicators

Key features of an accessible service include:

Effective service promotion	The service has a promotion strategy for its target population; young people are aware of what the service does, who it's for and how to get there.
Confidentiality	The service has a clear policy on confidentiality. Staff routinely define and explain the confidentiality procedure to all of their clients – this includes describing circumstances when confidentiality may be breached (e.g. when child protection or the risk of self-harm makes it necessary to disclose information to other parties).
Safety, respect and trust	Staff understand and acknowledge young people's concerns, self-consciousness and embarrassment in seeking assistance for health issues, and are able to address cultural needs (e.g. providing gender-appropriate staff). Service providers are able to build trust by demonstrating respect for, and responding to, young people's needs and concerns.
Multiple access points	Service provide multiple ways a young person can engage with the service. Arts programs and other engaging health promotion activities may better suit a young person's needs or it may allow them to get to know the service before engaging in clinical services.
Affordability	Services are provided free, or at an affordable cost to young people.
Physical accessibility and flexibility	Young people can easily get to the service by public transport. The service is open during hours when young people can attend (e.g. evenings) and offers drop-in consultation times. The service has the capacity to offer longer consultation periods to deal with complex issues.
Staff confidence, knowledge and skills	Service staff are provided with the necessary training, supervision and peer support required to maintain a sound knowledge about adolescent health and access needs, and to build confidence in communicating with young people.

ACCESSIBILITY

practical ideas + strategies

1

When promoting and raising awareness about your service or program activities:

- It's important to clearly define your target group and learn about their characteristics. For example, do you want to promote your service to young people in the local area, from a particular cultural or ethnic background, or to those who are same-sex attracted (gay, lesbian, bisexual)?
- Identify places where your target groups frequent and/or seek information (e.g. local schools, community or youth centres, libraries, the internet, parent/family groups, the media).
- Always develop and pilot-test promotional ideas in consultation with young people from your target group – getting their feedback on which types of materials, images and communication methods would be the most appropriate and appealing to their peers. Basic information should include the type of services offered, cost, opening hours, how to get there, and confidentiality.
- Develop multiple strategies to publicise your service – consider peer education, group work, 'word of mouth', the internet, 'using youth networks and other services to get the message out'. Regularly monitor where new clients have first heard about your service.

On having General Practitioners visit schools:

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

Division of General Practice Member

To let young people know that your service is confidential:

- Develop a confidentiality policy that's easy to understand – and involve young people in the process.
- Make the policy visible to your target group and the support people who come in contact with them (e.g. parents, guardians, youth workers etc.) by having notices in waiting areas and including it in your promotional material.

"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 ... we always ensure that they know [about it] ..."

Non-government Organisation Worker

To build trust, safety and respect:

- Listen and understand young people's concerns and difficulties in seeking help for health matters – by learning about their experiences and discussing their feelings with them.
- Allow young people the option to access services anonymously (this may be particularly important for sexual health and needle and syringe exchange programs). Once their trust is gained it's likely they'll feel more comfortable about disclosing their identity, if necessary.
- Build strong links with other trusted support people or services which can refer young people to you.
- Review the service's physical space, considering whether the layout (e.g. entry/exit doors and waiting areas) provides your clients with as much privacy and anonymity as possible.

ACCESSIBILITY

practical ideas + strategies

To provide multiple access points:

- Offer a variety of activities that appeal to diverse group of young people.
- Activities may include physical activity, cooking and nutrition, arts and music, games, competitions, and groupwork programs.
- Make the activities fun and engaging- involve young people in the planning.
- Consider the principles of the Ottawa Charter so your health promotion program is multi-strategic.
- Consider ways you can outreach by going to spaces where young people are eg. youth refugees.

To ensure that young people don't miss out on services because of cost barriers:

- Offer free or low cost services to your target group.
- Link closely to other services that can also provide affordable care – for example, doctors who bulk bill.

When making the service physically accessible and flexible enough to suit young people's needs:

- Try to locate the service near public transport and in areas frequented by young people.
- Explore other options for service delivery – outreach/mobile services in other locations can help you to access groups in their own environments.
- Offer a combination of drop-in and appointment-based services.
- Allow young people longer appointments to deal with complex issues, especially when seeing new clients.
- Offer services at times when young people can visit them, including outside school hours, evenings etc.
- Develop links and referral systems to after-hours and back-up services.
- It may help to establish and maintain a local directory on relevant youth and family services for referral purposes, ensuring that all services in your area have a copy. Some local councils maintain comprehensive directories listing local services and organisations.

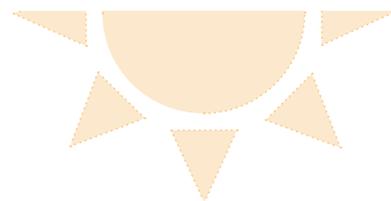
On providing an art and music program for young people:

"The service provides an opportunity for them 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 Worker

To build staff awareness, skills and confidence in working with young people:

- Ensure that staff are aware of, and understand, policies and procedures such as confidentiality.
- Ensure that all staff have basic awareness and skills training in youth health issues and communication skills.
- Provide ongoing opportunities for staff reflection and learning – peer review, supervision, debriefing can provide support.
- Join a youth health committee or other youth-focused inter-agency network to regularly share experience and strategies with other service providers.



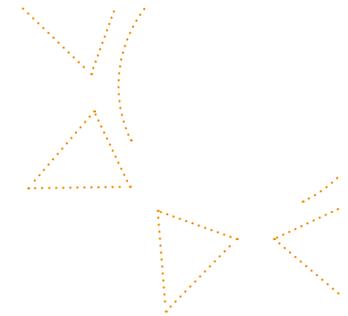
CASE STUDIES

other people's stories

1

Key attributes

- effective service promotion
- confidentiality
- safety, respect and trust
- multiple access points
- affordability
- physical accessibility and flexibility
- staff confidence, knowledge and skills



Case study 1

Rural youth centre promotes its on-site medical clinic

One staff member described their promotion strategy as follows:

'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. During that there is an orientation where they let them know there's 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 are 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.'

Case study 2

Rural Area Health Service program supports pregnant and parenting teenage women

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, linking young women to appropriate services. In order to address the lack of local transport options, the program provides transport for young women who would otherwise have difficulty attending the group.

The presence of a peer can help to promote *trust*. This program was established because of evidence (local statistics) showing that young pregnant women did not attend antenatal care. Their outcomes (physical and mental) have also improved since.

Case study 3

NGO youth centre delivers flexible and holistic services

One NGO operates a free centre-based service, offering an enormous array of programs under one roof. Available services include: 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, as well as drug & alcohol and general counselling.

The centre promotes its confidentiality policy through written materials. It operates an outreach bus on Saturday afternoons in three local suburbs, promoting and delivering services to young people in their areas. The centre promotes its programs and activities through pamphlets and brochures at bus stops, schools and education programs. Young people can also access the centre during the flexible drop-in sessions (3-9pm, Tuesday to Saturday).

Staff members receive training and are rotated through different parts of the service, to broaden their skills and confidence, and make the job more dynamic.

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

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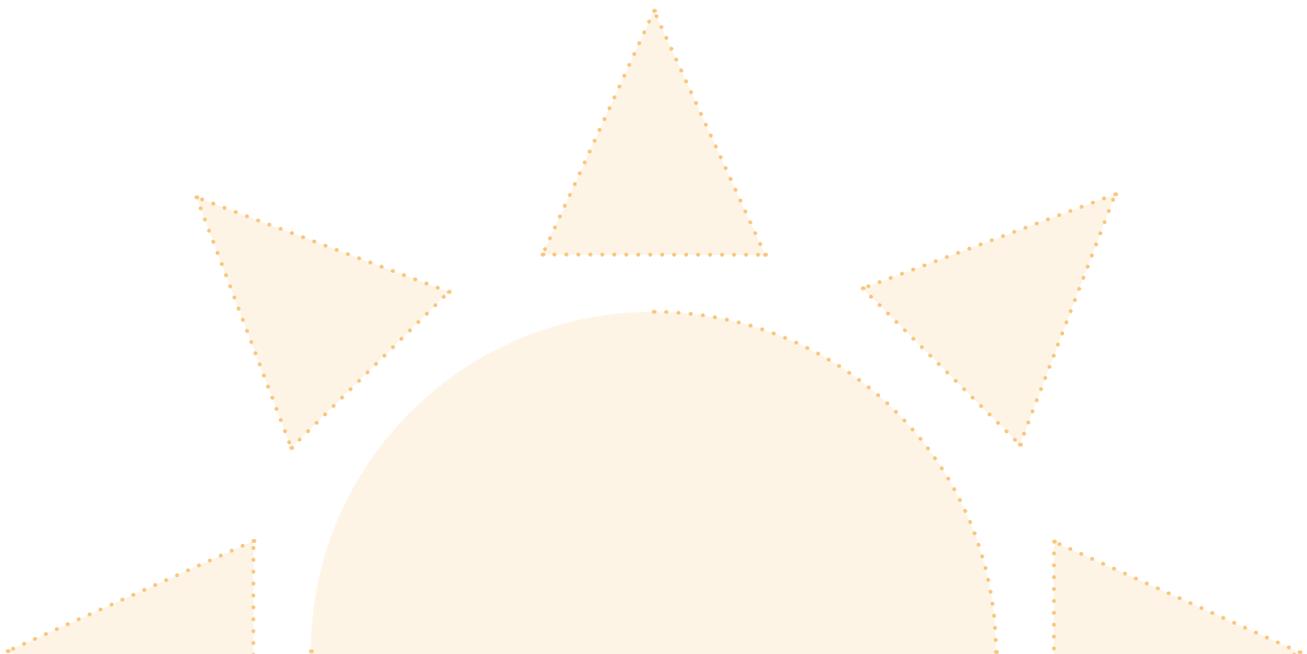
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EVIDENCE-BASED APPROACH

fact sheet



2

What do we mean by evidence-based?

An evidence-based program is able to demonstrate that its development has been based on a reliable assessment of need derived from a range of information sources ('evidence'), and also that its strategies were designed according to better practice standards determined by local, national and international guidelines.

Adopting an evidence-based approach uses lessons learned from other programs, thus reducing the risk of 're-inventing the wheel'. Also, an evidence-based approach helps to ensure an efficient use of resources as well as producing services that reflect beneficiaries' priorities and actual needs.

Checklist: Which types of evidence does your service use?

Basic indicator checklist	yes	partly	no
1. When undertaking a systematic needs assessment, does your service utilise: <ul style="list-style-type: none"> Existing policies and background documents? 'Normative' research reports (such as epidemiological data, qualitative research studies)? Comparative studies of similar populations or issues – but from a different area? Surveys and direct consultations with key stakeholders and target populations? 			
2. When reviewing programming priorities, does your service systematically monitor changes to the target population or issue (e.g. emerging needs) through regularly reviewing the above?			
3. When starting a new program, does your service: <ul style="list-style-type: none"> Use current evidence on the issue, including existing models, standards and practice guidelines? Locate and review reports, articles and publications (e.g. tools and guidelines) from similar programs? Develop expected outcomes based on existing performance indicators (where possible)? 			
TOTAL			

EVIDENCE-BASED APPROACH

literature review + indicators

Lessons learned: What does the literature say?

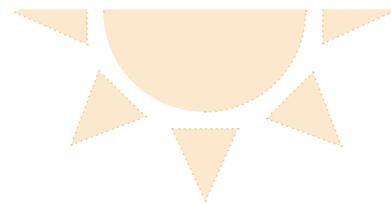
The concept of 'evidence based practice' (EBP) first began in the field of medicine and has now spread to all parts of the health sector, including areas such as nursing, health promotion, population health and public health. Evidence-based practice refers to the development, implementation and evaluation of effective programs and policies through the application of evidence, including systematic appraisal of research and use of program planning models.

This means that programs and policies can be directly linked with evidence that demonstrates effectiveness. Also, with the application of evidence-based practice, those managing services are able to determine the mix of services and programs that will give the greatest benefits and eliminate ineffective interventions. Anecdotal evidence, that is evidence based on case studies or the opinions of experienced individuals, is not generally regarded as sufficient, although it is often seen as complementary to the evidence gathering process. As the pressure on resources increases there will be a transition from opinion-based to evidence-based decision-making.

The key components of EBP are: a) convert the information needs into *answerable* questions; b) search for the best evidence to answer questions from the literature, clinical examination and other sources;

c) appraise evidence for its validity and clinical applicability; d) apply the results of this appraisal; e) evaluate performance (Brownson et al., 2003). It should be noted that the adoption of evidence-based practice 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 and 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. In addition to such guidelines, workers have access to primary and secondary sources of evidence. Databases such as the Cochrane Collaboration provide evaluation and summaries of systematic reviews of the effects of health care interventions. In Australia, online access to the Cochrane Collaboration is free as it is subsidised by the Australian government. Health workers should familiarise themselves with such tools to inform and augment day-to-day practice and program design.



Indicators

Key features of an evidence-based approach include:

Systematic planning	Services systematically draw upon a comprehensive range of information types and sources ('evidence') in order to determine needs and plan their programs.
Monitoring changes to context and practice	Services regularly update their 'evidence' to keep track of changing or emerging needs of target populations, service personnel and other key stakeholders.
Using 'what works'	Services draw upon a comprehensive range of information types and sources, in order to help them design their program's content, choose effective methodologies and achieve identifiable outcomes.

EVIDENCE-BASED APPROACH

types of need

2

When designing new programs, a needs assessment must be conducted in order to gather rigorous and reliable evidence. Bradshaw (1972) suggests four different types of need. It is important to tap into each type of need to increase the chance of constructing a comprehensive picture of community health needs.

Normative need

- Generally includes formal research reports (qualitative or quantitative) conducted by specialists or 'experts' – often found published in reports and journals.
- Studies tend to identify major trends or issues within larger population groups, or seek to answer a specific question.

Typical examples of normative research

- Australia's young people: their health and wellbeing 2003 (Australian Institute of Health and Welfare, 2003)
- Secondary students and sexual health 2002: results of the 3rd national survey of Australian secondary students, HIV AIDS and sexual health (Smith et al., 2003)

Benefits and limitations

- Normative research results should be rigorous and reliable, and based on formal research design protocols (participant selection, enquiry process, measuring and rating responses).
- They may not take into account local contexts or variation.
- The research may indicate the prevalence of a problem, but not identify the range of complex causes or be able to give detailed suggestions on how to change it.

- Scope of enquiry may not be wide enough to reflect actual community concerns or priorities. For example, where a study of teenage pregnancy and STD rates is undertaken to see if the school sexuality education program has made a difference, the analysis might show that although students have increased knowledge, behaviours have not changed. Students and parents may see this as a result of lack of leisure activities and poor employment prospects for young people in their area, rather than the program itself.

Comparative need

- An existing study or set of findings on young people is used, because the context and issues are very similar despite having been carried out in a different geographical area.

Benefits and limitations

- Using comparative research can reduce the need to replicate complex and time-consuming research in another geographical area if enough characteristics remain the same (e.g. gender, urban/rural, age) to retain validity.
- Research may be incomparable. The local context may have distinctive characteristics such as culture or socio-economic status which reduces comparability.
- Data collected may be a reflection of over-servicing or under-servicing by service providers rather than an indication of true need for the service by health consumers.

Example of selecting comparative research

A program officer consults a study of drink driving attitudes and behaviours among Brisbane suburban teenagers, because it contains enough similarities to teenagers in Sydney in terms of age, gender, socio-economic status and social/cultural context.

EVIDENCE-BASED APPROACH

types of need

Expressed need

- Refers to what can be inferred about the health need of a community by observation of the use of services, e.g. long waiting lists, demand for a new service.

Benefits and limitations

- Can be misinterpreted – long waiting lists at a health service can be a result of inefficiency and not indicative of the size of the group waiting to be treated.
- A need may exist but because there is no service in place to meet it, the expressed need may not be identified.

Felt need

- Refers to what communities and/or individuals say or feel they need.
- Structured methods of recording felt needs include surveys, phone interviews and focus discussion groups.
- Less formalised sources would include anecdotal evidence. This may be expressed as a perception, such as a feeling or 'sense' of something. For example, a peer educator perceives that new drug taking behaviours have emerged among school students. He/she may have heard this from random anecdotes but doesn't yet have 'hard evidence' to support the perception.

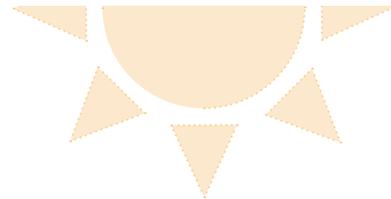
Benefits and limitations

- Can identify the community's priorities as an entry point when starting a program. For example, normative research shows that smoking affects young people's health and development, and has been identified as a particular problem in one region. Interviews with young people indicate that to alleviate boredom they would like more sporting and recreation facilities. The new program might combine recreation and fitness activities with a smoking prevention program.
- Felt need is sometimes based on perception and may or may not be accurate – for example, members in the community may believe that teenage pregnancies

are on the increase (due to recent inaccurate media reporting), even though the reality may be the opposite.

Sources – where to get evidence

- Journals
- NSW Health websites (e.g. Chief Health Officers report)
- Systemic review websites (e.g. Cochrane)
- Data from local organisations
- Local schools, police, courts, ambulance services etc.
- Health information services (e.g. healthInsite)
- Clearing houses (e.g. Australian Clearinghouse for Youth Studies)
- Clinical and therapeutic guidelines
- Newspapers
- Stories from the public (e.g. Art work or by young people)



EVIDENCE-BASED APPROACH

practical ideas + strategies

When conducting a needs assessment:

- Consult with other workers and services to find out which types of evidence they have used and which sources were the most helpful.
- Ensure that the needs assessment process draws upon a range of information ('evidence') rather than relying on one source. Using a combination of normative research and comparative, survey and anecdotal data will be more effective than just relying on one method alone.
- Critically appraise the reliability and standard of the information, and consider how systematically it was collected. A key informant's 'perception' of a problem can always be followed up and validated by undertaking a number of community recorded interviews and organised focus groups.
- Remember that all evidence should be reviewed/reframed within a local context.

[We discovered that] "in a small town you need to look at the evidence, what is available, define what you can do with these resources and where the gap is."

Youth Health Service Worker

there is a logical connection between your identification of risk factors, choice of strategic activities and expected outcomes. What critical assumptions are you making?

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

Non-government Organisation Worker

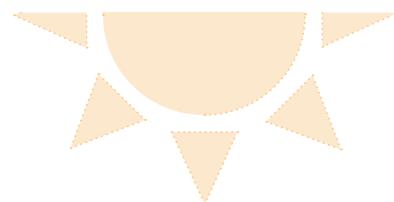
- Create an evaluation plan to assess whether or not the program's objectives and activities have resulted in the expected, or unexpected, outcomes.
- Document your lessons learned; what has worked, what hasn't and why. This is all part of contributing to a dynamic and growing evidence-based framework – planning, experimenting and systematically recording your outcome observations.

When developing a new program or intervention:

- Broaden your enquiry to include international, national and local sources, to find out what has been tried before.
- Contact individuals, organisations and networks to obtain details about how their program worked, what they found to be effective and what they would do differently next time. Not all programs are written up and reported as journal articles.
- Choose your methodologies according to what has been shown to work with your target group.
- Identify the underlying risk factors. How will your objectives and activities address these? Ensure that

Where to get evidence

- Clinical guidelines
- Literature searches
- Focus groups
- Surveys
- Previous studies
- Producing your own study



CASE STUDIES

other people's stories

Case study 1

Urban youth health service draws on international evidence

One of the first Youth Health Services established in NSW was modelled on an existing and evaluated service model in New York – a 'one stop shop' for disenfranchised young people providing a holistic range of services.

Other Youth Health Services developed programs based on emerging needs and focusing on youth suicide prevention and keeping young people engaged in education, founded on national and international evidence demonstrating that retention in education leads to better health outcomes. The program evaluation has since demonstrated that innovative and parallel pathways to education are an acceptable alternative for disengaged young people, who have in turn achieved high course completion rates.

Case study 2

Research study paves the way for mental health support program

An epidemiological study conducted by a mental health service revealed that among 269 children (all of whom had at least one parent with a mental illness) isolation and stress featured as prominent issues. The Area Health Service developed, implemented and evaluated a comprehensive program in response to these findings, which involved teaching coping strategies, forming a peer support network for children and providing respite from home.

Case study 3

Anecdotal evidence leads to Women's Health Unit research study on date rape

A sexual health service observed an increasing number of clients accessing its rape crisis centre and sexual health clinics, many of whom had experienced date rape associated with spiked (drugged) drinks. This anecdotal

evidence led to a Women's Health Unit conducting formalised focus groups to assess university students' awareness of 'spiked drinks'. The study's results then provided evidence for an awareness raising campaign about spiked drinks and date rape.

Case study 4

Regional Division of General Practice

While many DGP projects conduct local needs assessments to inform their projects, one DGP stood out as having a very strong evidence base and an ongoing evidence review for their youth health program. Their program was initially developed in response to national and local trends in mental health and high suicide rates among young people.

The first two years were spent reviewing existing services and the most current national and international literature identifying barriers to accessing care for young people. During this planning phase, they collaborated with a range of organisations and conducted stakeholder consultations, including investigating similar projects from other DGPs to see what could be learned from previous experience. The DGP undertook a large local needs assessment, which included 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. The main strategies identified as a result of the survey were training and the need to develop a resource kit for GPs. During the design phase, the project also developed measurement tools that they validated, in order to be able to evaluate rigorously. The validation process involved research across Australia with 1800 school students about their 'intentions to seek help' using standardised measures and focus groups.

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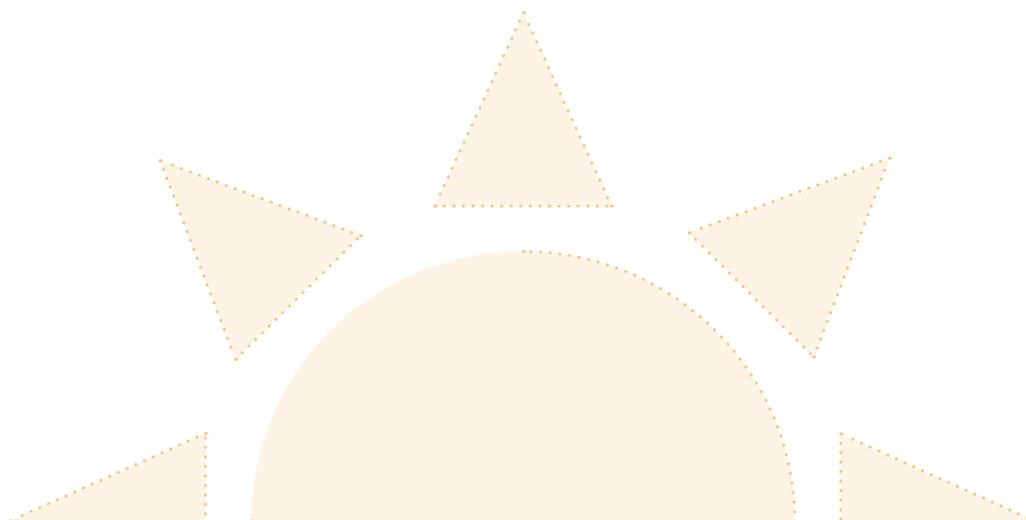
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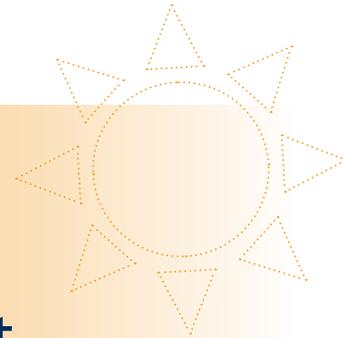
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YOUTH PARTICIPATION fact sheet



3

What do we mean by youth participation?

Youth participation describes young people’s active involvement in developing, implementing, reviewing and evaluating services and programs intended for their benefit. It requires designing formal structures and youth-friendly mechanisms through which young people can express their opinions and exercise decision-making power.

Young people’s participation increases mutual respect between service providers and adolescents, and increases the latter group’s sense of ownership and involvement in programs.

Checklist: How does your service involve and promote youth participation?

Basic indicator checklist	yes	partly	no
1. Does your service have policies and procedures in place that outline how young people’s participation and decision-making can be used in program development, implementation, review and evaluation?			
2. Does your service regularly review and revise its youth participation mechanism in consultation with young people?			
3. Does your service provide opportunities for increasing young people’s confidence, knowledge and skills in using participation mechanisms?			
4. Does your service have specific ways in which it acknowledges and values young people’s input and contributions?			
5. Does your service ensure that its youth representatives reflect the diversity of young people’s views and needs?			
TOTAL			

YOUTH PARTICIPATION

literature review

Lessons learned: What does the literature say?

In the literature, the concept of community participation has been defined in a number of ways, from passive participation where people receive benefits from health programs to more active participation where people actively make decisions about the health program policies and activities that affect them.

Although there is no general agreement on how to define participation, there is a growing understanding among health professionals and policy makers that participation is best seen as a process, rather than as an outcome of an intervention.

The literature also raises questions on how to evaluate participation and how to assess participatory achievements. Traditionally, community participation has been assessed in quantitative forms – for example, by asking how many young people have come to a meeting or how many people have joined in a community activity.

The dilemma, however, is that presence does not indicate participation. Young people can come to a meeting but may not have any commitment or understanding of what it is about or how it might affect their health, risking accusations of tokenism.

Arnstein (1969) wrote about this situation and developed an analytical visualisation called the 'ladder of participation'. This ladder consisted of eight levels where the bottom step is that of informing people, while the top step is citizen control.

Midway, where partnership begins to develop, the degree of participation moves from mere tokenism to degrees of citizen power. Others theorists have adapted the 'ladder metaphor', to create different models of participation and empowerment, each with different goals, purposes and methods.

Below is a diagram depicting the eight levels of Arnstein's ladder of participation:

Citizen control		
Delegated power		Degree of citizen power
Partnership		
Placation		Degree of tokenism
Consultation		
Informing		
Therapy		Non-participation
Manipulation		

Consumer participation has now been accepted as a strategy in health planning and 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).

Real participation is relevant and important. It can assist in problem-solving that lies outside the domain of health care as well as promote self-reliance and decrease misuse or under use of services. It can also make a community-based intervention relevant and contribute to better resource allocation.

Participation by youth is acknowledged in 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'.

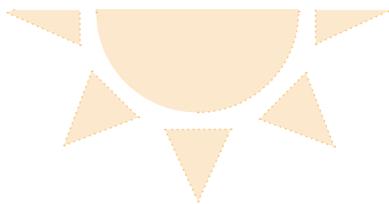
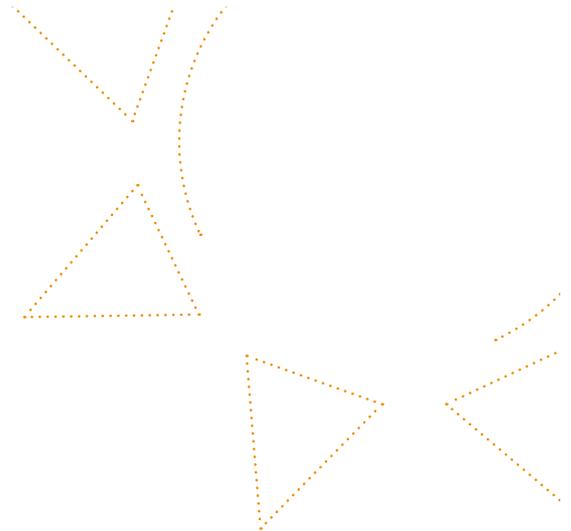
The Convention recognises the status of a young person as 'a subject of rights, who is able to form and express opinions, to participate in decision-making processes and influence solutions, to intervene in the process of social change and in the building of democracy'.

YOUTH PARTICIPATION

literature review + indicators

Barriers to youth participation include:

- Cultural norms that favour hierarchical relationships between young and old
- Economic circumstance
- Lack of access to information
- Adults’/youths’ mindsets fixed on ‘ageism’
- Judgmental attitudes between generations based on age
- Conflicts that arise from differences in learning and working styles, time-management, communication patterns and means of involvement.



Indicators

Key features of youth participation include:

Policy and practice	The service has policy and procedures in place, creating specific opportunities for young people’s participation and decision-making during program development, implementation, review and evaluation.
Reviewing policy and practice	The service regularly reviews the effectiveness of its youth participation policy/ procedures in consultation with young people.
Supporting young people’s development	The service increases young people’s confidence, knowledge and skills in using participation avenues and frameworks.
Acknowledgement	The service acknowledges and values young people’s input and contributions, by providing payment or in-kind contributions where possible.
Appropriate representation	The service regularly reviews young people’s representation, ensuring that the needs and views of all diverse target groups are canvassed.

YOUTH PARTICIPATION

practical ideas + strategies

When developing a youth participation policy or mechanism:

- Use existing policies on youth participation and representation as a starting point, in addition to consulting with young people.
- Be clear on why you want young people to participate, negotiating both parties' roles and expectations. Explain to young people the specific ways in which their input will influence your service. (For example, they can make decisions determining a youth centre's activities, but cannot change pre-allocated program budgets.)

On negotiating roles and expectations:

"If young people don't own something they don't become engaged, so it's 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 Worker

- Consult with young people, identifying their preferred participation mechanisms (e.g. suggestion boxes, surveys, focus groups, attending meetings, management committees, working parties, advisory boards).
- Develop links with existing youth participation bodies and organisations (such as the Youth Advisory Council and Commission for Children and Young People) that can provide valuable advice, contacts and participation tools.

When reviewing your service's youth participation policy and procedures:

- Include youth participation as a regular agenda issue (e.g. during service reviews, planning days, annual general meetings).
- Provide regular opportunities for young people to review and adapt the range of participation options.

"Young people have a voice by representation on our advisory committee, and as [paid] facilitators on certain programs."

Youth Health Service Worker

To support young people's confidence, knowledge and skills in participation:

- Gather information on young people's previous roles, experiences and advice on participation.
- Enhance young people's confidence and capacity to participate, by providing any necessary mentoring or training (e.g. how to facilitate meetings, how to conduct peer research and surveys). Develop these opportunities in partnership with other organisations, in order to increase widespread youth participation and representation.
- Provide opportunities for young people to take leadership roles, such as chairing meetings committees, having a regular presence on advisory boards.

To demonstrate respect for young people's input and contributions:

- Address common barriers to participation - by providing travel allowances to meetings, and scheduling them at times when young people can attend.

YOUTH PARTICIPATION

practical ideas + strategies

- Develop a culture where young people are acknowledged as valued experts, and are compensated in the same way that any other expert colleagues would be.

On respect

"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 Worker

- Demonstrate appreciation for young people's time and contributions in the form of cash, vouchers, cinema tickets, CDs.
- Inform participants about the outcomes arising from their contributions, either verbally, in person or in writing.

To ensure that your service addresses the needs and views of diverse groups:

- Identify and enlist the assistance of young people according to your program's aims and objectives – for example, selecting youth representatives from a particular cultural background may help guide a specific intervention with that target group.
- Review and refresh your youth representative group's composition on a regular basis, ensuring that the participating individuals represent different target audience interests and needs.
- Adopt a range of inclusive strategies to ensure that young people with low literacy levels or who are not naturally outspoken can also have their say, e.g. voting tools, individual peer-to-peer discussions.

On young people in custody

"Even in these difficult circumstances, representation can be sought..."

Government Organisation Worker

Which tools are people using to bring about youth participation?

Youth Advisory Council

The NSW government has established a Youth Advisory Council, which was set up in 1989 in order to ensure that young people participate in the development of government policies and programs that affect them.

<http://www.youth.nsw.gov.au/yac>

NSW Commission for Children and Young People – Taking participation seriously (2001)

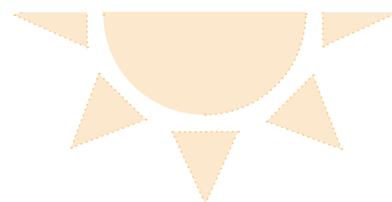
This is a resource for organisations who want practical advice about how to involve young people in activities, events and decision-making about issues that affect their lives.

<http://www.kids.nsw.gov.au/kids/resources/participationkit.cfm>

Youth consultation checklist

Produced by the department of local government, this checklist provides suggestions for practice in relation to consulting young people.

<http://www.dlg.nsw.gov.au/dlg/dlghome/documents/information/check.pdf>

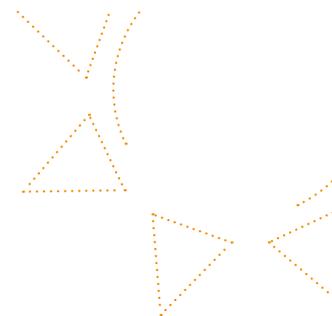


CASE STUDIES

other people's stories

Key attributes

- policy and practice
- reviewing policy and practice
- supporting young people's development
- acknowledgement
- appropriate representation



Case study 1

Schools involve young people in drug and alcohol education program

Schools invite student volunteers to become part of the organising committee for the education forum, and provide training in facilitation skills. Young people promote the forum throughout local high schools using 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.

Case study 2

Young people's participation drives NGO health promotion website

One NGO operates an interactive website providing information about many health issues, including access to services. Young people are involved in determining 95% of the site's content, either through working directly with the NGO or submitting feedback through the website. The program has an Advisory Board comprising a wide cross-section of young people, where members serve three-month terms. The Advisory Board members interact daily via a live online forum throughout this period, and are later flown to Sydney to workshop their ideas at a three-day conference. After their Advisory Board term expires, members are trained in communication and promotion skills and they are invited to be part of the youth ambassador network in their community. This provides opportunities where

they can continue to give advice and/or contribute to the website, which benefits young people in terms of their confidence, and the organisation in terms of young people educating their peers.

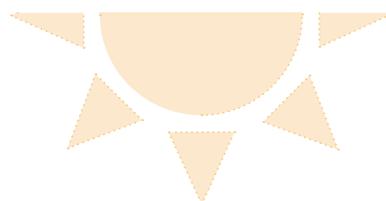
Case study 3

Young offenders program consults detainees

'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's 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.'



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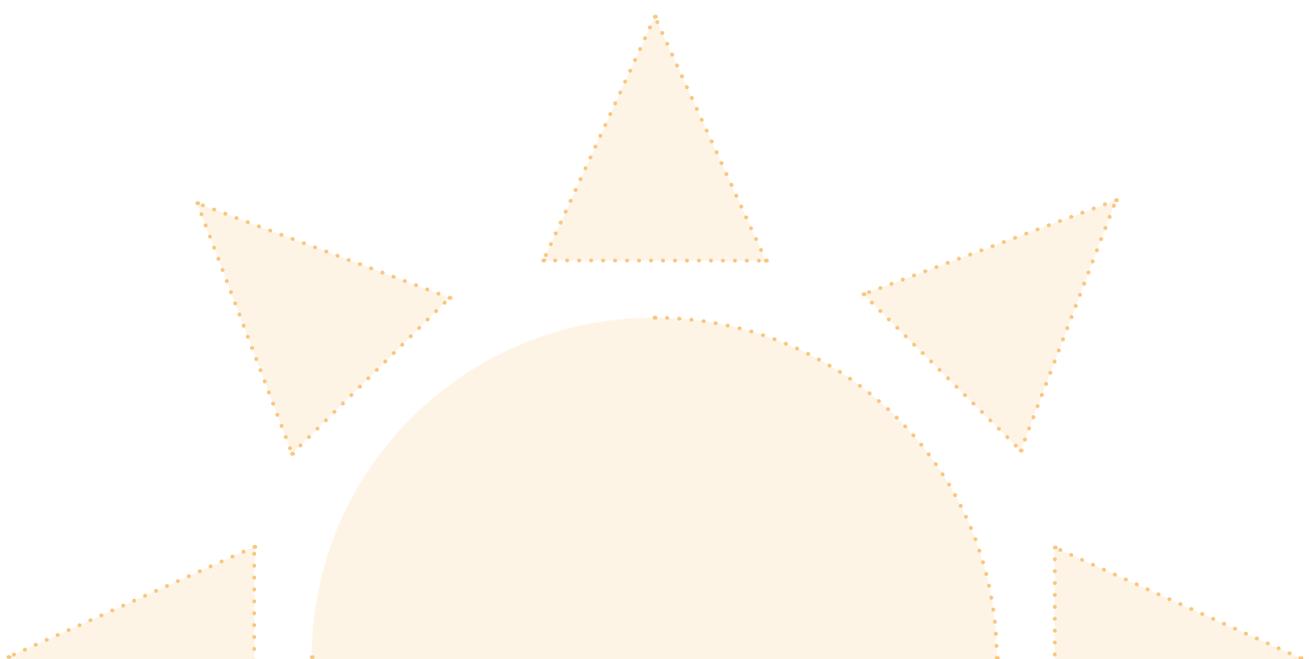
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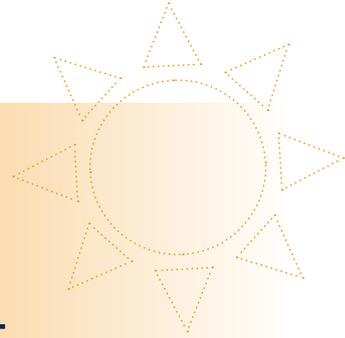


ACCESS STUDY

youth health better practice framework

COLLABORATION & PARTNERSHIPS

fact sheet



4

What do we mean by collaboration?

Collaboration occurs when service providers develop internal and external working relationships with other agencies that share similar service goals and target groups. Actions include communicating, networking and working together, both within and beyond the service's immediate sector (e.g. health, education, welfare, drug and alcohol, recreation). Collaborative partnerships often involve cooperatively working together in service planning, implementation, review and evaluation.

Working in collaboration optimises resources, reduces duplication of effort and encourages holistic service delivery to young people.

Checklist: How does your service work collaboratively with others?

Basic indicator checklist	yes	partly	no
1. Does your service propose collaboration and partnerships within its strategic or business plan?			
2. Does your service identify potential partners for collaboration and have protocols for working out roles, responsibilities and agreements between agencies or services?			
3. Does your service regularly review and evaluate its collaborative strategies, to ensure effective processes and outcomes?			
4. Does your service treat young people as equal partners where possible and appropriate?			
TOTAL			

COLLABORATION & PARTNERSHIPS

literature review + indicators

Lessons learned: What does the literature say?

According to Hoatson and Egan (2001), 'collaboration is a complex process requiring time, resources and commitment'. Furthermore, as health outcomes can be influenced by a range of stakeholders including government bodies, institutions, organisations and agencies, health service providers need to work to identify which groups it would be appropriate and beneficial to collaborate with.

Some of the reasons for collaboration 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. (Harris, 1995; Setsuliba & Vostanis, 2001)

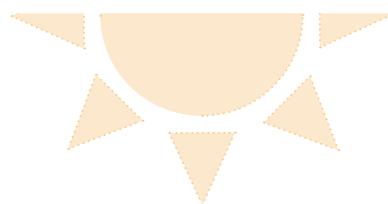
Some of the difficulties of collaboration include:

- Loss of autonomy
- Time required to facilitate it (so that commitment needs to be high)
- Issues from past collaborations (negative experiences)
- Survival in a competitive environment.

Partnerships can be developed in a range of areas besides service delivery. These include training, education, policy development and improving access. A number of factors have been identified as being important for successful collaboration. These factors are: 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 (Harris, 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 include:

- Recognition of why it is important to work together
- Acknowledgement that the process is changing
- 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.



Indicators

Key features of a collaborative approach include:

Setting collaborative goals	The service addresses collaboration and partnerships within its strategic or business plan.
Identifying partners, roles and responsibilities	The service identifies potential partners in its strategic/business/program plans, clearly stating the purpose and benefits of collaboration, as well as the roles, responsibilities and resources of each party.
Planning and review	The service and its partners regularly review the collaboration process, in order to continuously improve both the collaborative process and the outcomes.
Including young people and their organisations	The service includes young people as equal partners where possible and appropriate, and keeps them informed about the service's collaborative practices.

COLLABORATION & PARTNERSHIPS

practical ideas + strategies

When addressing collaboration in the service's strategic plan:

- Include collaboration and partnerships as a core principle or value in the service's strategic plan.
- Map services in your area or sector to help identify potential collaborative partners.
- Contact people or organisations working in a key networking or advocacy role (e.g. Youth Health Coordinator, peak body, network or inter-agency group) to help put you in touch with helpful contacts.

When creating new partnerships:

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

Youth Health Service Worker

- Compare other services' or programs' aims and objectives, identifying skill overlaps/gaps and clarifying how the collaboration would be useful (added value) for both target groups and service providers.

"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 Worker

- During service planning, ensure there is enough time allocated to discuss and address potential risks and barriers to collaboration which might include:

- time constraints
 - concerns about client confidentiality
 - potential conflicts of interest
 - different organisational ideas or approaches on how to manage health problems
 - different management styles and values.
- Identify and develop mutually agreed procedures outlining how the collaboration will work. This might include all parties:
 - deciding how to balance differing agendas and priorities of the parties involved
 - choosing which types of communication channels will be needed to ensure that processes are transparent
 - designating specific roles and responsibilities to each party
 - agreeing on each individual agency's input, in human resource and financial terms
 - articulating how decision-making will happen and how disagreements will be resolved.

"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?"

"Then we get a service agreement together, so both parties know exactly what the expectations are ... I think it's important that it's reciprocal. It's typed up and signed ... it's a commitment. We try to be quite strategic about what collaborative project we take on ... So there needs to be a focus in our strategic plan ..."

Youth Health Service Worker

COLLABORATION & PARTNERSHIPS

practical ideas + strategies

To review and continuously improve collaborative processes and outcomes:

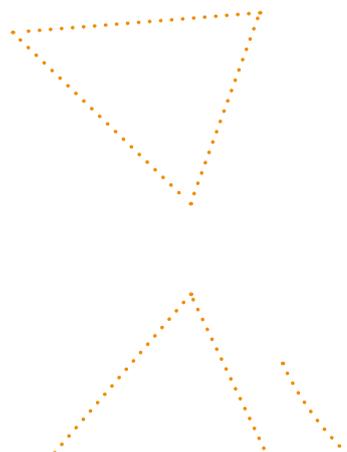
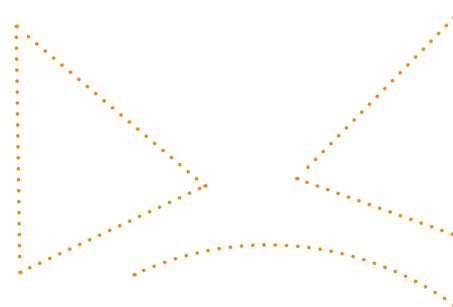
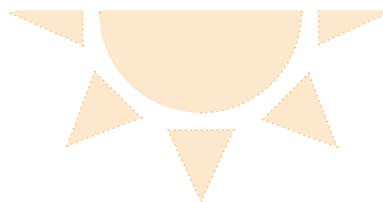
- Organise a local networking forum, inviting services to meet, share organisational information and identify new partnership opportunities.
- Document, update and disseminate partnership building protocols and other useful resources, including:
 - memoranda of understanding
 - service agreements
 - partnership evaluation tools.

When involving young people as equal partners and keeping them informed about the service's collaborative practices:

- Include this information in the service's promotional materials and via youth reference groups or other committees.
- Forge links with young people's representative bodies (e.g. student council, Youth Advisory Council).
- In clinical practice contexts, explain to young people how, when and why communication occurs between service providers, outlining the nature of information to be exchanged.

"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. 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 Worker

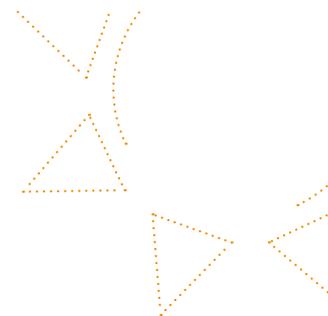


CASE STUDIES

other people's stories

Key attributes

- setting collaborative goals
- identifying partners, roles and responsibilities
- planning and review
- including young people and their organisations



Case study 1

Youth Health Coordinator establishes multi-service drop-in centre

A Youth Health Coordinator undertook survey and focus group discussions across the Area Health Service, in order to assess workers' needs for working more effectively with young people.

The Youth Health Coordinator developed an email list of workers with a particular interest in young people and distributed it through the Health Promoting Schools Coordinators in each area.

Each smaller local area developed a committee of interested people who then developed a model of co-location and partnerships for the local sector. The Youth Health Coordinator was successful in sourcing funds to rent a building, which was used as a drop-in centre for young people, and where personnel from different services (Juvenile Justice, Sexual Health, Community Health) each provided a service for an agreed number of hours per week.

Case study 2

School-based Resource Centre builds preventive health care partnership project

The efforts of a local GP (who sourced initial Women's Health funding) together with a school principal and the Area Health Service have resulted in an innovative school-based Resource Centre.

A social worker (funded from the Area Health Service) manages the service, providing support and information

to school staff, coordinating the inter-agency and running workshops for students and professionals.

All these services are represented on the centre's management committee, as are the local Aboriginal Medical Service, the local council and the 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. There are also working parties to explore wider youth health issues and develop appropriate strategies to address these.

Case study 3

Corporate partnership supports young people's creative pathways to education

One NGO's art and music program aims to engage young people otherwise unlikely to be involved in artistic activities. With funding from a Corporate Bank, young people are supported to develop artworks over twelve months for an art exhibition, while a music and entertainment corporation sponsors a six-month music course where each participant produces a CD.

A support worker helps young people deal with other issues (e.g. housing) while they are in the program. Young people often re-engage with learning during this time and later 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.

CASE STUDIES

other people's stories

Case study 4

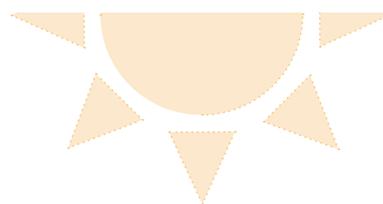
Integrated government approach to community social problems

The Partnership Project was developed to address high crime rates and social problems in a particular area utilising all the relevant agencies within and across sectors.

Each agency has clear roles and responsibilities, and the project requires collaboration 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 addressing 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' which acts as a disincentive to crime as well as being a useful indicator of collaboration.



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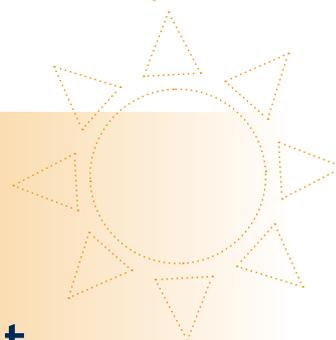


ACCESS STUDY

youth health better practice framework

PROFESSIONAL DEVELOPMENT

fact sheet



5

What do we mean by professional development?

Professional development involves developing workers' knowledge, skills and attitudes in order to ensure that they can work confidently and effectively with young people. This includes providing training, mentoring and supervision opportunities, as well as creating and maintaining organisational structures which support both individual and team performance.

Proactive professional development ensures the creation of a learning culture in the workplace, increasing individual and team competence, confidence and morale, thus resulting in a more effective service.

Checklist: How does your service support professional development?

Basic indicator checklist	yes	partly	no
1. Is professional development identified as a service objective, and are planned activities costed into service budgets and proposals?			
2. Are there formalised induction processes for staff taking up new positions – including handover, orientation and probation?			
3. Does your organisation provide regular opportunities for staff members to review and discuss their professional development needs? Does it assist workers to plan and undertake activities to improve knowledge, skills and performance?			
4. Does the service collaborate with other agencies/organisations around staff development events, in order to maximise resources, share expertise and ensure a healthy flow of ideas?			
5. Are there working mechanisms within the service (e.g. team meetings, team forums, internal newsletters etc.) where staff share newly acquired knowledge and information with co-workers?			
6. Do young people inform staff training around youth issues - and are they directly involved in its delivery?			
7. Do staff training/development programs have clearly identified outcomes (such as identified competencies) and are they regularly evaluated?			
TOTAL			

PROFESSIONAL DEVELOPMENT

literature review

Lessons learned: What does the literature say?

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.

However, it should be acknowledged that the sheer amount of information available, combined with time and budgetary pressures, can mean that health care professionals have difficulty in staying up to date with changing practices.

An 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.

However, 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.

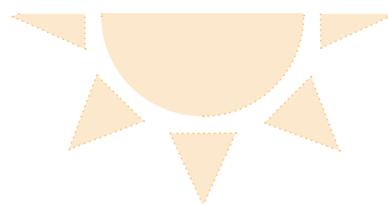
Other kinds of interventions such as patient mediated interventions, audit cycles and direct office support were found to be more promising, but only under specific circumstances. Multifaceted interventions involving combinations of the above, tailored to the local practice needs of providers, were more likely to be effective (Oxman et al., 1995).

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

Australian research (Sanci et al., 2000) demonstrated by randomised controlled trial that educating general practitioners in adolescent health was effective in 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. Some of these strategies were:

- a) being provided with an adolescent assessment chart for patient audit;
- b) being required to complete a logbook for reflection on experience with audited patients;
- c) being required to assemble a list of adolescent health services in the GP's local area;
- d) being provided with a tutor who could be accessed by phone for professional support between workshops; and
- e) being encouraged to participate in a refresher and feedback session to reflect on experiences in practice six weeks after the final workshop.



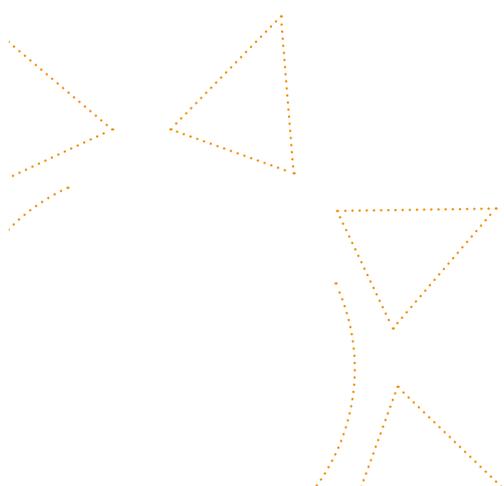
PROFESSIONAL DEVELOPMENT

indicators

Indicators

Key features of effective professional development include:

Planning and budget allocation	The service builds identified professional development goals/outcomes into its annual work plan, allocating sufficient funds from existing budgets and/or costing these into new proposals.
Comprehensive induction processes	The service has formalised induction processes for new staff or existing staff transferring to new positions. Processes include handover, orientation, probation and planned debriefing/supervision.
Regular staff performance review and ongoing development	The service has standard mechanisms for staff to review and discuss their professional development needs. It assists workers to improve their knowledge, skills and performance by providing supervision, mentoring, in-service courses and access to external training as necessary. The service provides opportunities for workers to develop broader experience and skills through mentoring and, where possible, role rotation.
Collaboration with other agencies	The service works with other organisations on staff development events, such as co-hosting/attending shared forums and training in order to maximise resources, sharing expertise and ensuring a healthy flow of ideas between different agencies.
Strong internal communication and knowledge transfer	The service promotes information-sharing opportunities within the service (e.g. team meetings, team forums, internal newsletters etc.), where staff exchange newly acquired knowledge and information with co-workers.
Young people's involvement and representation	The service directly involves young people in developing and delivering staff training around youth issues.
Identified training outcomes and performance goals	The service adopts competency and other outcomes-based professional development strategies (including accredited courses), and regularly evaluates the quality and outcomes of such activities.



PROFESSIONAL DEVELOPMENT

practical ideas + strategies

When planning and budgeting for professional development activities:

- Develop a service policy on professional development, and create a way of monitoring progress (e.g. professional portfolios, skills audits, keeping records of staff development activities and attendances for quality improvement purposes).
- Ensure that your annual work plan includes a professional development objective.
- When budgeting, anticipate costs for training, based on past figures and an assessment of current staff development priority needs.
- Not all professional development activities are costly – inviting guest speakers from other services to present information and new ideas at team meetings or organising joint information-sharing forums can be just as effective as getting information from a fee-paying workshop.
- Remember to include staff development and supervision costs when writing new proposals.

When inducting new staff:

- Try to ensure that new staff receive a personalised handover – either from an outgoing staff member or another colleague who can provide information about the service/project and facilitate useful introductions with key stakeholders and partners. Doing so can save a lot of time otherwise spent on ‘getting to know the ropes’.
- Create a standard orientation process and checklist for all members – this would include general organisational information and policies and procedures, as well as items specific to the position, e.g. contacts with various youth services, youth policies, directories, resources etc.

To support ongoing professional development within your service:

- Include professional development in each staff member’s work plan. This includes planning core activities and specific time frames for probation, debriefing, supervision, peer review, annual performance review, and attendances at relevant conferences and workshops.

“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 to provide that as best as possible.”

Youth Health Service Worker

- Ensure that your professional development policy is accompanied by standardised procedures for conducting performance reviews and includes provision of supervision.
- Support professional development in your service by getting staff actively involved in, for example, maintaining individual professional portfolios and participating in a professional development committee, service review and planning days, quality improvement activities and organisational skills audits.

When collaborating with other agencies:

- Plan a professional development calendar with other services where possible. Share your calendar with others and ask to see theirs in order to identify common gaps.
- Youth Health Coordinators (based in Area Health Services) are useful resource people who can advise on or help to arrange multi-agency training in youth health issues.
- If the budget is tight, liaise with other organisations or departments to see if your service can access their existing in-service courses.
- Alternatively, ask to attend another service’s training courses or forums, offering free training (quid pro quo) for their staff in return. This can work well if you have complementary skills and/or related fields of expertise.
- Co-hosting joint workshops or forums with different services can be done for little cost, leading to valuable exchange of skills and ideas. It may even generate revenue if other agencies want to attend on a fee-paying basis.

PROFESSIONAL DEVELOPMENT

practical ideas + strategies

To develop strong information-sharing practices within your team:

- It's important to ensure strong internal communication systems, so that workers can exchange ideas and information with each other. This can be done through regular journal clubs, scheduling presentations following staff members' attendance at a conference or workshop, and regularly distributing a staff bulletin or newsletter with worker contributions.

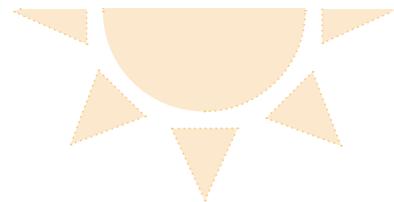
"We have a fairly small budget we can use for training, but for new staff there is a bit more of an allowance made in getting them skilled up. Also, there's a lot of free training around.

"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've been given. We try to spread it around a bit, so everyone gets an opportunity to go ..."

Youth Health Service Worker

To ensure the quality of training courses and outcomes:

- Some professions have mandatory professional development requirements, where activities are usually accredited by the appropriate industry body. In all cases, it's preferable to select courses which have been approved or accredited (this usually ensures that the course has proper evaluation processes built in) and/or courses which have clearly stated aims, objectives, outcomes and evaluation strategies.
- Prioritise programs and courses which seek to develop participants' knowledge, attitudes and skills; enquiring about the program in advance will indicate how it has been designed.



To ensure young people's participation and representation:

- Engage young people as advisors, co-trainers or speakers for events – they can provide genuine insight into what really makes youth-friendly practice and how to work respectfully with adolescent populations. Young people are valuable experts when it comes to learning about young people!
- Identify what role young people will have in your event – will they be individual presenters, panel speakers, or participants in a role play? Several organisations can provide youth advisors and speakers, including the Youth Advisory Council, which comprises a network of young people's committees active at state and local levels.

CASE STUDIES

other people's stories

Key attributes

- planning and budget allocation
- comprehensive induction processes
- regular staff performance review and ongoing development
- collaboration with other agencies
- strong internal communication and knowledge transfer
- young people's involvement and representation
- identified training outcomes and performance goals

Case study 1

NGO multiskills team by rotating staff

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

'We rotate our staff through the drop-in services as a way of engaging them with different young people. [We] also make sure that young people access other services such as counselling or employment because they actually get to know the counsellors/employment workers at 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 multiskilling workers but making sure that they are adequately resourced to do that. It also means if someone leaves there is someone with the skills who can 'fill the gap in the meantime.'

Case study 2

Area Health Service develops comprehensive training program

One Area Health Service developed a comprehensive training program in response to local requests for training from sexual health workers. This program explored homophobia, as well as dealing with attitudes and values in rural communities, sexual and reproductive health, access to health services, confidentiality and communicating with young people. The training 'package' utilised existing resources and expertise but also sought to strengthen existing 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 facilitates better communication.

'We had two teams. One [provided] generalist training in working with young people and [a] contraceptive update. Then we had an Aboriginal focus group in the next town and a one-day teacher training. With teachers and health staff ... 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, process evaluation to identify what was learned and assessment of further needs. A pre- and post-evaluation of service utilisation is also being undertaken.

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SUSTAINABILITY fact sheet

6

What do we mean by sustainability?

Sustainability describes continuing programs which eventually become self-maintaining in the longer term. It can also refer to programs, activities and effects which continue to happen, even after initial funding has been discontinued and the original implementing agency has withdrawn.

Sustainability requires a long-term vision where program longevity is supported through identifying alternative income sources, investing in strategic advocacy, adopting good practice and developing partnership capacity so that other agencies or communities can integrate the activities into existing frameworks.

Sustainable programs support long-term improvements and outcomes to the health and well-being of target populations, and reduce the vulnerability of having short-term, stand-alone interventions.

Checklist: How sustainable are your organisation's programs and activities?

Basic indicator checklist	yes	partly	no
1. Where possible, does your service develop sustainability strategies within its strategic and business plans, for example: <ul style="list-style-type: none"> • putting income generation strategies in place • developing partnerships and collaboration, and • Building community capacity and planning transition strategies with the ultimate goal of handing over project ownership within an identified time frame? 			
2. Does your service actively integrate its activities into existing mainstream programs where possible?			
3. Does your service develop programs which can be replicated elsewhere?			
4. Does your service invest in advocacy and utilisation of Board and other key stakeholder influence, in order to promote programs?			
TOTAL			

SUSTAINABILITY

literature review

Lessons learned: What does the literature say?

Sustainability has been defined as long-term viability in the maintenance or continuation of a service or program. 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 US Agency for International Development (1988) suggests that sustainability has only 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. 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 '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. Or, funding may become obsolete as the community sustains the program themselves. This can occur 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 are obstacles to achieving program

goals and objectives. This was supported by Janz et al. (1996) where inadequacy in 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 (Steckler & Goodman, 1989). Programs need to be sustained when the problem remains or recurs and also 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 consist of people who are fully committed to the issue and have the desire to problem solve and meet the challenges head on. 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 they can provide an alternative mechanism to resource allocation. There needs to be a core group of stable members who are 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 a stable working group and more regular members.

Secondly, sustainability needs to be actively planned for at the creation phase of a program and benchmarks of achievement set within the planning process. It may be the set role of a staff member (or group of staff members) employed to seek funds or develop self-

SUSTAINABILITY

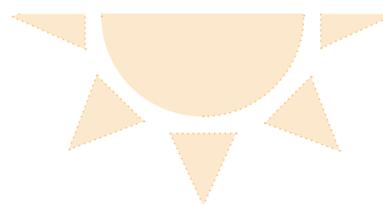
literature review + indicators

funding opportunities, or to lobby other organisations, to take the program initiatives on board. If so, part of the program should involve 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 the training and planning processes. Opportunity needs to be provided for open dialogue with potential funders. Benchmarks should 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 better strategies become apparent.

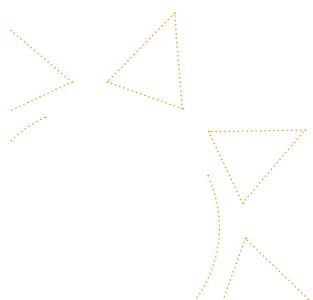
Lastly, champions within strategically allied organisations can provide support, open doors and give useful technical, human and physical resource assistance and advice.



Indicators

Key features of sustainable service include:

Long-term sustainability planning	The service develops sustainability strategies within its strategic and business plans, addressing: <ul style="list-style-type: none"> • alternative income sources and/or cost recovery options • partnership development and capacity building, and • transition procedures in order to hand over activity/program ownership within an identified time frame.
Mainstreaming	Where possible, the service actively moves to integrate its activities into existing mainstream programs or infrastructure in order to bring about longer term change.
Good practice and replicability of programs	The service develops programs which have universal applicability, and can be implemented in other areas.
Advocacy	The service invests in advocacy, drawing upon influential Board and other key stakeholders to promote and support ongoing programs.



SUSTAINABILITY

practical ideas + strategies

When addressing sustainability:

- Take a long-term view by considering each proposed intervention as one step in a long-term program.
- Anticipate what will be needed to make ALL programs sustainable as they evolve. This might include:
 - Exploring possible alternative funding sources, e.g. other organisations, corporate sponsorship and or cost recovery
 - Identifying and working with partners (other organisations or the community) which may be able to take on the intervention in the future
 - Assessing and addressing capacity building needs – what skills, knowledge and resources will partners need to be able to run the intervention by themselves in the future?
 - Developing a process in order to hand over 'ownership' within an identified time frame.

Example

A youth resource centre is allocated a grant to run a visiting GP clinic for 12 months. The clinic is a success but funding is no longer available from the donor. Centre staff explore other opportunities to keep the clinic in operation, including applying for funding from their local Area Health Service; seeking shared/outreach services from the local Community Health Centre; and covering some of the costs by promoting young people's access to and use of Medicare cards when they visit the clinic.

When developing programs:

- Remember to design programs with 'universal' applicability. Can you design your program so that others can use it as well?

"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."

Non-government Organisation Worker

When integrating activities into existing mainstream programs:

- Consider what is the 'best use' of resources – what changes need to happen at institutional levels to bring about wider change?

Example

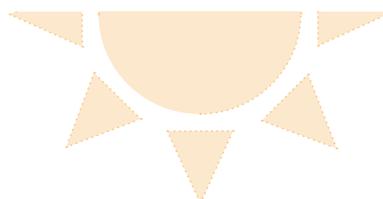
A large number of NSW High Schools regularly draw upon the services of an external agency to provide HIV/AIDS education courses to Year 9 students. Analysis and consultation with different stakeholders show that rather than two health educator staff servicing a large number of schools across the State, more can be achieved by mainstreaming this into existing curriculum. A more sustainable approach might include developing state-wide standardised sexual health curriculum for all students in all schools, as well as introducing in-service/pre-service training for all teachers, enabling them to teach the subject with competence and confidence.

To gain support for ongoing programs:

- Identify influential Board members and key stakeholders who can lend advocacy support.

"The more you build on other areas and link, the more sustainable you are"

Youth Health Service Worker



CASE STUDIES

other people's stories

Key attributes

- long-term sustainability planning
- mainstreaming
- good practice and replicability of programs
- advocacy

Case study 1

Area Health Services builds organisational capacity to manage self-harm among young people

This program developed self-harm management protocols and also trained service providers how to use 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.

The program team then:

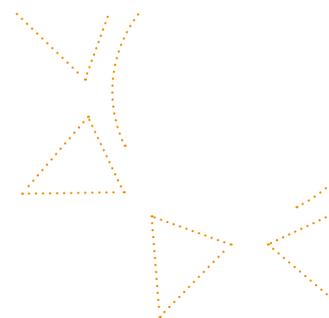
- Supported services to identify tasks for improvement in their management of self-harm
- Assisted services in changing policies and procedures
- Organised staff development activities
- Collected data to inform the services about progress with their identified tasks.

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.

Case study 2

Non-Government Organisation builds corporate sponsorship through Board influence

'We've 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've lost money we've sometimes been able

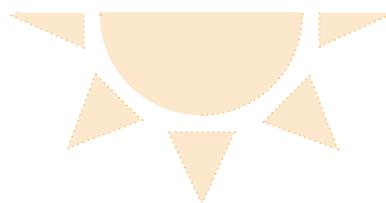


to keep programs going – because of this alternate funding that could be sourced. Our management committee also has a high representation of business people and solicitors ... more of a board than community management ... That's been incredibly stable as well, which has brought us good contacts, credibility and business linkages ... That's been significant I think. What else is probably important for sustainability is that we rotate our staff.'

Case study 3

Non-Government Organisation discovers realistic time frames is the key

'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.'



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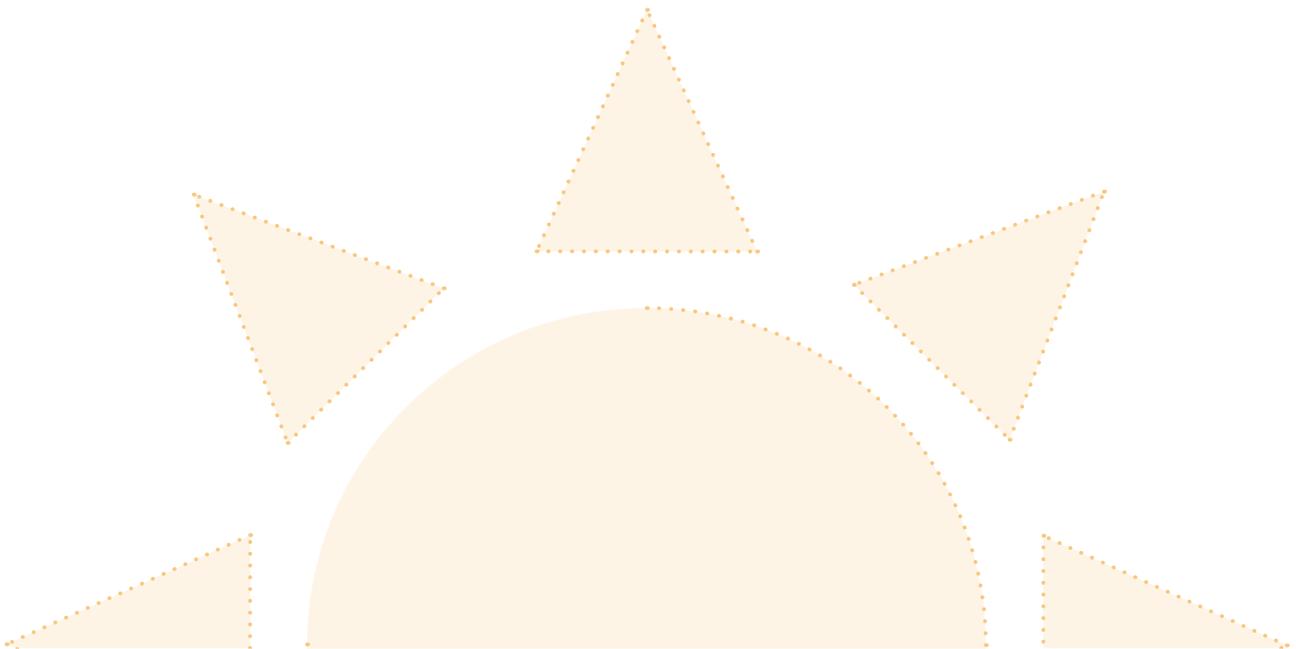
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EVALUATION fact sheet

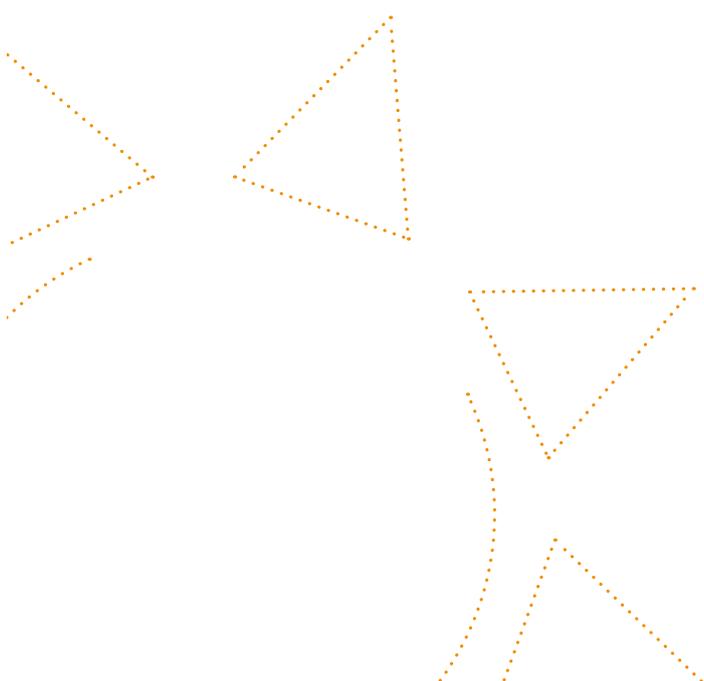


What do we mean by evaluation?

Evaluation is a process undertaken in order to review a service's or program's results. It involves determining what was done (inputs, outputs), how it was done (the process) and how well it was done (quality), as well as which changes or results were achieved (impact, outcomes) as a result of the program or intervention.

Effective evaluation engages workers, program consumers and other stakeholders in a participatory process, providing avenues for feedback and thus enabling service improvement. Undertaking regular evaluation enables services to systematically assess results, identify what has been most effective (developing 'evidence'), strengthen programs and demonstrate accountability. As such, evaluation plays a crucial role in quality assurance.

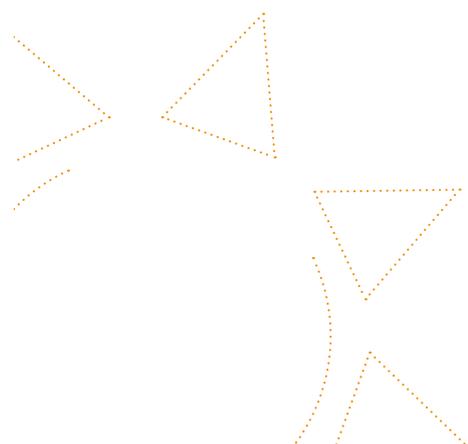
Evaluation contributes to evidence-based practice by highlighting what works and why. It provides a valuable opportunity for services to identify which strategies work best, enabling services to adapt and choose the most effective approaches.



EVALUATION

Checklist: How does your organisation evaluate its service?

Basic indicator checklist	yes	partly	no
1. Does your service have clearly articulated aims and objectives against which it can evaluate?			
2. Does your service incorporate evaluation into its strategic plan, designating resources as required (e.g. time, costs, fees if external evaluator support is required)?			
3. During the initial stages of project design, does your service include evaluation as an essential activity in all project work plans?			
4. Does your service take a baseline assessment of the issue or target audience prior to project implementation?			
5. Does your service evaluate both the qualitative and quantitative aspects of its work, including consumer feedback and identifying unexpected outcomes?			
6. Does your service involve consumers and other stakeholders during the evaluation process, ensuring that their views and perspectives are included as key data?			
7. Does your service enable consumer and stakeholder contributions by providing a range of appropriate feedback mechanisms, e.g. via consultation groups, surveys, interviews?			
8. Does your service check the validity of its findings by cross-referencing or triangulating (cross-referencing) results from different sources?			
9. Does your service document the evaluation process – including lessons learned and follow-up actions to be taken?			
10. Does your service disseminate the evaluation findings among staff, consumers and key stakeholders, as part of its accountability?			
11. Does your service act on issues and recommendations identified throughout the evaluation, and review its progress at an agreed time interval?			
TOTAL			



EVALUATION

literature review

Lessons learned: What does the literature say?

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 viable there must be ongoing contribution to an evidence body of 'what works', 'why' and 'at what cost'.

Significant work has been carried out to produce generalisable evaluation frameworks to assist health care practitioners and organisations and a range of models have been utilised. In particular, the models of Friedman (2003), Program Logic (Funnell, 1997) and Realistic Evaluation (Pawson & Tilley, 1998) all have merit in terms of use in community and other health settings.

Evaluation is used to judge the effectiveness of new and existing programs (Fink, 2003) and it should also ensure that a 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, and it contributes to theory building. Furthermore, discovering what doesn't work is as important as knowing what does. The choice of what is evaluated should be guided by resources and priorities, and it is important to note that evaluation should be a dynamic, cyclical and never-ending process.

Also, the process of evaluation contributes to EBP by showing what works and why. EBP 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 staff, although it can mean that staff need to acquire new knowledge and skills.

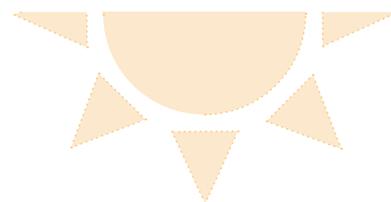
This can be a part of ongoing professional development or may simply involve new ways of developing programs by better utilisation of the skills and resources of current staff. The removal of systemic barriers also needs to be considered.

Types of evaluation

- 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 (Hawe et al., 1994).

Questions to consider in program evaluation

- What is being evaluated and why?
- What aspects of the program are pertinent to understanding program performance?
- What criteria or standards of success will the program be assessed against?
- What evidence will be used to indicate or measure program performance?
- 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?
- How will lessons learned from the evaluation be put to best use? (Center for Disease Control and Prevention, 1999)



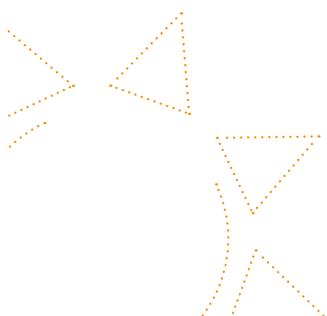
EVALUATION

indicators

Indicators

Key features of a strong evaluation process include:

Clear aims and objectives	The service develops clear aims and objectives, based on existing evidence of what works. All objectives are designed according to the SMART framework (Specific, Measurable, Achievable, Realistic and Timebound) or equivalent.
Planned and systematic evaluation	The service incorporates evaluation into its strategic plan, designating resources as required (e.g. time, costs, fees if external evaluator support is required). During the initial stages of project design, the service includes evaluation as an essential activity in work plans. This involves linking objectives to measurable goals (or anticipated results) at the very outset of a project's development.
Baseline assessments	The service undertakes baseline assessments before project implementation, and repeats the process during evaluation, in order to create an accurate 'before and after' picture of achievements.
Qualitative and Quantitative analysis	The service evaluates both the qualitative and quantitative results of its work. This includes not only what was done (e.g. number of people or events), but how well it was done, what consumers felt about the project, and which changes occurred as a result of activities. The evaluation also identifies unexpected outcomes.
Participation and consumer feedback	The service involves consumers and other stakeholders during the evaluation process, ensuring that their views and perspectives are included as key data. The service enables consumer and stakeholder contributions by providing a range of appropriate feedback mechanisms, e.g. consultation groups, surveys, interviews.
Triangulation of results	The service ensures the validity of its findings by cross-referencing results from different sources (e.g. project workers, young people, teachers, school counsellors).
Documentation of lessons learned	The service documents the evaluation – including lessons learned and actions to be taken.
Dissemination of results	The service disseminates the evaluation findings among staff, consumers and key stakeholders.
Applying findings to practice	The service acts on issues and recommendations identified throughout the evaluation, reviewing its progress after an identified time interval.



EVALUATION

concepts + practices

Common evaluation terms

Monitoring

This refers to an interim review process, carried out at designated intervals and assessing whether program objectives are being met. Examples:

- Are activities going according to plan?
- Is the expenditure as predicted?

Indicators

These are descriptive standards used to measure the extent to which targets are being reached.

Baseline

An assessment (situational analysis) of the issue or target population undertaken prior to program implementation, it enables a comparison of 'before and after'.

Process evaluation

This primarily analyses the program's design and methodology. Sample questions during a process evaluation might include:

- How useful were the consultation exercises?
- How appropriate were the strategies?
- How relevant was the chosen methodology?
- How useful were the types of materials used?
- Was the amount of time and resources allowed adequate for the activities?
- How many beneficiaries were actually involved?

Impact evaluation

This primarily identifies the program's short-term results. For example, a life skills program might measure:

- A measurable increase in students' knowledge around sexual health issues.
- An increase in students' positive attitudes towards seeking help from a school counsellor or health professional.
- An increased number of young people wanting to be peer educators.
- A change in school policy towards providing on-site youth health clinic services.

Outcome evaluation

Outcome evaluation seeks to identify results occurring in the longer term, such as:

- A definable and sustained behaviour change in the target group (e.g. adoption of safer sex behaviours, reduction in binge alcohol drinking, reduction in teenage pregnancy rates).
- Change in health status.
- Reduction of morbidity or mortality.
- Increase in well-being and quality of life.

Quantitative and qualitative analysis

Quantitative analysis is used for recording numbers of events (e.g. the number of young people accessing a service within a given time period, or the number of group sessions run in a program).

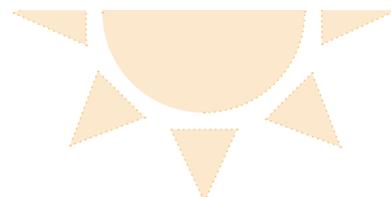
Qualitative analysis is used for describing results and/or explaining why things happen the way they do (e.g. comparing customer satisfaction levels with their increased use of services; attributing changes in the target audience's behaviour to group-work learning activities; linking young people's increased clinic attendance with health workers' improved confidence and communication skills with clients).

Inputs

Actions or events run by the service (e.g. conducting peer educator workshops, holding group consultations, providing materials and learning resources to a school).

Outputs

End products resulting directly from inputs (e.g. number of young peer educators graduating from workshops, number of communities consulted, number of art/craft sessions held for young people).



EVALUATION

practical ideas + strategies

Questions to consider:

- What is being evaluated – and why?
- Which aspects of the program or activity will give the best indication of project performance?
- Which criteria or standards of success will the program be assessed against?
- Which methods will be used to gather data or evidence – and how reliable are these methods?
- Which types of evidence can be used to measure how the program is performing?
- How will the lessons learned from the evaluation be put to best use?

When creating measurable aims and objectives:

- Design the program's aims and objectives around existing evidence that demonstrates methods that have been shown to work in the past.
- At the very outset of a project's development, support the evaluation process by creating measurable objectives according to a SMART (Specific, Measurable, Achievable, Realistic and Timebound) framework or similar. Link each objective directly to a set of measurable goals and or anticipated results.

When planning evaluation:

- Plan for different levels of evaluation as needed, i.e. into strategic plans for the service's overall evaluation, and into individual work plans for each project.
- Build in time for interim monitoring – reviewing the project's progress at regular intervals.
- Allocate time and resources for evaluation activities. These may include:
 - fees for an external evaluation facilitator, if necessary.
 - time and costs involved in developing and implementing focus groups or surveys
 - expenses relating to field visits and observation
 - report writing, production and dissemination costs
 - resources required to act on recommendations.

To create a baseline comparison:

- Take a baseline assessment of existing conditions (e.g. participants' health status or behaviours, or institutional practices) before conducting any project activities – and later repeat this process during evaluation. This will give an accurate 'before and after' picture of what has actually been achieved.
- Baseline sources can include: statistical records, reports, survey results, and community and stakeholder consultations.

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

Non-government Organisation Worker

To ensure a comprehensive evaluation:

Draw upon process, impact and outcome measures in order to gain a holistic picture of:

- What was done (e.g. number of people or events)
- How well it was done
- Consumer, staff and other stakeholder perceptions regarding project process and achievements
- Specific changes occurring as a result of activities
- Unanticipated outcomes.

Also:

- Service-led evaluations can be greatly beneficial for increasing staff skills and building a positive culture of learning and service improvement.
- External evaluators can also be beneficial for introducing an independent and objective perspective. External evaluators require a full briefing and a comprehensive understanding of the service's context, aims and objectives.
- Facilitate consumer feedback by providing a range of culturally and age-appropriate tools – for example, young people may feel more comfortable with discussion groups rather than long questionnaires.

EVALUATION

practical ideas + strategies

Evaluation feedback can also be expressed through theatre, painting and voting exercises. Ensure that this 'data' is recorded in a standardised format.

To validate findings:

- Triangulating results greatly helps to validate findings. This involves comparing a set of results from different perspectives and/or from different stakeholders. Some examples would include:
 - Following up an assessment of youth workers' knowledge with an observation of actual performance in the field, as well as feedback from their clients.
 - Comparing young people's opinions about the project's impact on their lives with the opinions of their teachers and parents.

When documenting and disseminating the evaluation:

- The key details should include:
 - list of objectives being measured – and the accompanying indicators
 - how the evaluation was conducted
 - who was involved
 - which methods were used
 - baseline information and findings
 - an analysis of what works
 - recommendations and actions to be taken.
- Disseminate evaluation findings to program/project beneficiaries and stakeholders as an opportunity to collaboratively identify, and work on, areas for improvement.
- Contribute to evidence-based service delivery by sharing lessons learned ('what works') with other organisations through newsletters, journals, conferences and forums.

When acting on findings and recommendations and taking action:

- Use the evaluation findings and recommendations to plan service improvements, clearly designating roles, responsibilities and time frames.
- Set a review time (after an agreed time interval) to check progress on implementing service improvements.

Realistic outcome expectations and critical assumptions

While it is relatively easy to measure project outputs, process and impact, outcomes are more complex to assess. This is especially true with regard to human behaviour, which requires a longer period of time to change, and may be dependent on factors and influences occurring outside the project's scope and time frame.

Achieving outcomes is closely related to addressing underlying risk factors. For example, Phase 1 of the Access Study (Booth et al., 2002) identified some key issues impacting on young people's health, including:

- Reluctance to utilise health services, because of past negative experiences
- Lack of trust around confidentiality when visiting service providers
- Lack of knowledge about which services exist.

By addressing these risk factors and improving service accessibility – for example, improving confidentiality policy and practice in services, increasing young people's knowledge of and referral to other services, and developing youth-friendly awareness and skills in service staff – the critical assumption is that young people are, in the longer term, more likely to visit services and therefore experience better health.

'Success' can be relative depending on your target group:

"Sometimes the fact that [young people] are still alive is an outcome ... the fact that they might have decreased their drug use. It might be that they've got part-time work. It's so variable and so individual for each person. It might be that they've tried to commit suicide less this year than last year. But it's some sort of positive."

Non-government Organisation Worker

CASE STUDIES

other people's stories

Key attributes

- clear aims and objectives
- planned and systematic evaluation
- baseline assessments
- qualitative and quantitative analysis
- participation and consumer feedback
- triangulation of results
- documentation of lessons learned
- dissemination of results
- applying findings to practice

Case study 1

Youth Health Service involves young people in evaluation

A youth health service worker explains how young people's views are crucial to evaluating and improving their service:

'Young people are always involved in our cycle. If there's 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.'

Case study 2

Youth to youth evaluation

A Youth Health Service Worker explains how young people can seek feedback from their peers:

'One of the ways we get specific feedback is ... [by running] focus groups [about] services provided. We [also] have a suggestion box ... There's also youth

participation in carrying out community development and health promotion projects, in that young people decide what form those projects will take.

'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.'

Case study 3

Area Health Service program evaluates teacher and parent cannabis training

One Division of General Practice (DGP) stood out as having high-quality evaluation built into its 'GPs in Schools Project'. The evaluation sought to measure change in both young people's and general practitioners' 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 GP-focused evaluation was mostly process evaluation (to determine how confident they felt and how they could improve their school visits). 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 Schools intervention.

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