YOUTH HEALTH RESOURCE KIT

AN ESSENTIAL GUIDE FOR WORKERS

NSW GOVERNMENT | Health

healthy, safe and well

Published by:
NSW Kids and Families
Youth Health and Wellbeing Team,
NSW Kids and Families
LMB 961 North Sydney NSW 2059

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SHPN – (NKF) 140200
ISBN –978-1-76000-049-3

Suggested citation:

NSW Kids and Families. (2014). *Youth Health Resource Kit: An Essential Guide for Workers*. NSW Kids and Families: Sydney.

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UNDERSTANDING YOUNG PEOPLE

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1.1 ADOLESCENCE – A DEVELOPMENTAL PERSPECTIVE

PETER CHOWN

Understanding the developmental stages that young people move through in adolescence assists us to better understand the young people we work with, their behaviour and their needs. The developmental perspective helps us to determine:

- **The young person's physical and psycho-social concerns**
- **The young person's cognitive abilities and their capacity for understanding choices, making decisions and giving informed consent**
- **Appropriate communication strategies, with questions, explanations and instructions tailored to the cognitive and psychological level of the young person**
- **Appropriate intervention for health promotion**

ABOUT ADOLESCENCE

Adolescence: the developmental period between childhood and adulthood – beginning with the changes associated with puberty and culminating in the acquisition of adult roles and responsibilities.

Adolescence is a dynamic period of development characterised by rapid change in several areas:

- Physical – the onset of puberty (physical growth, development of secondary sexual characteristics and reproductive capability)
- Psychological – the development of autonomy, independent identity and value system
- Cognitive – moving from concrete to abstract thought
- Emotional – moodiness; shifting from self-centredness to empathy in relationships
- Social – peer group influences, formation of intimate relationships, decisions about future vocation

Adolescence is a biologically universal phenomenon; however, the concept of 'adolescence' is defined differently in different cultures. Cultural norms and life experiences (such as being a refugee) can affect both the timing of developmental milestones (e.g. puberty) and society's expectations of what is considered 'normal' in terms of the young person's response to these changes. The expectations, roles and duration of adolescence can vary greatly between different cultures. In some cultures, the concept of adolescence as a stage does not even exist. Young people move from childhood to adulthood.

While adolescence can be a stressful period, most young people cope well with this developmental process and do not have any lasting problems (Strasburger et al. 2006).

Puberty involves the most rapid and dramatic physical changes that occur during the entire life span outside the womb (Bennett and Kang 2001). The average duration of puberty is about 3 years, but there is great variability in the time of onset, velocity of change and age of completion. Height velocity and weight velocity increase and peak during the growth spurt (early in girls, later in boys). Although there are many variations in normal pubertal development, the experience of going through puberty is commonly expressed as having a changing body that feels out of control.

THE ADOLESCENT BRAIN

Adolescence is a time not only of enormous physical changes, but also in the structure and function of the brain. Other than the first three years of life, no other developmental stage is characterised by more dramatic changes (Steinberg 2011).

The changes in the adolescent brain have a major impact on cognitive, emotional and social development. They also have important implications for the onset of risk-taking behaviours and for the ways in which parents and service providers interact with young people and respond to risky behaviours.

In particular, the limbic system (which is the emotional, impulsive centre of the brain) experiences accelerated growth in early adolescence. The limbic system governs reward processing, appetite, sensation seeking and emotional impulsivity.

Meanwhile, the part of the brain responsible for making critical judgements, planning, controlling impulses, decision-making and regulating emotions (the pre-frontal cortex) is much slower to develop and is, in fact, still under construction until the mid-twenties (Steinberg 2008).

The effect of this mismatch in neurological development is that the teenage brain is 'wired' for impulsivity – generally, adolescents have fully ripe emotional impulsivity (limbic system) but limited inhibitory capacities (pre-frontal cortex).

A fundamental developmental task for the young person is to learn how to regulate and balance the drives and emotional impulses of the limbic system (the accelerator) with the executive control system (the brakes) (Sowell, Siegel and Siegel 2011). As

young people 'exercise' their brains by learning to better control impulses, regulate their emotions and engage the frontal brain, they are laying the neural foundations for stronger self-regulatory mechanisms (Siegel 2012).

As the pre-frontal cortex develops, the young person also acquires the capacity for more complex cognitive skills such as abstract thinking, future orientation, recognising consequences of behaviour, empathy and understanding other's viewpoints.

THE IMPACT OF TRAUMA ON THE BRAIN

Many young people who experience mental health, substance use and other psychosocial problems have experienced complex trauma resulting from neglect, abuse, emotional deprivation and attachment disruption during their development.

Research has identified the adverse effects that early-onset trauma can have on the developing brain. Complex trauma triggers a shift from a `learning' brain to a `survival' brain and disrupts the neural integration necessary to respond flexibly to daily challenges (Cozolino 2002; Kezelman and Stavropoulos 2012).

In particular, trauma impairs the development of self-regulation mechanisms – the capacity to modulate emotions, manage impulse control and self-calm during times of stress, excitement and turmoil – thus making it even more difficult for the young person to pause and engage their frontal brain in weighing risks, rewards and consequences.

FINDING OUT MORE...

Understanding the effect of trauma on the developing brain is important for anyone working with young people who have experienced abuse, neglect or other forms of trauma. Learn more in chapter 3.4 Trauma-informed practice.

OTHER INFLUENCES ON THE DEVELOPING BRAIN

The structure and functioning of the mind and brain are shaped by experiences, especially those involving emotional relationships
(Cozolino 2002)

Recent research in neurobiology shows that interpersonal relationships directly impact and shape the development of the brain. Parents and other carers directly influence the development of the brain's circuitry through their interactions and relationships with young people (Siegel 2012).

Service providers can also play a crucial role in assisting young people to learn skills for managing their emotional reactions and impulses by:

- Providing safety and stability through an ongoing trusting relationship
- Encouraging young people's use of critical judgement (i.e. by being 'the front part of the brain' for them)
- Helping them to identify, track and appropriately express their emotions
- Assisting them to develop self-calming skills for regulating limbic system arousal
- Teaching them to inhibit impulses ('apply the brakes') and develop greater capacity for reflection and weighing risks/consequences before acting.

During adolescence, a 'window of vulnerability' occurs when the disparity between the development of the limbic system (emotional impulses) and the pre-frontal cortex (regulatory mechanism) collide with an increase in risk-taking behaviour.

At this time, young people's decision-making tends to be driven more by the emotional and reward centres of the brain. This contrasts with adult decision-making, which tends to be more solidly based in the pre-frontal cortex and reflect more rational and measured processes (Steinberg 2008).

Consequently, young people find themselves in situations making emotional choices that are not always under volitional control. In these emotionally-charged contexts, the limbic system dominates the pre-frontal control system and they tend to revert to emotions and instinct (Yurgelun-Todd et al. 2002). This explains poor decisions and spur-of-the-moment behaviours such as unplanned sex, riding with a drunken driver, binge drinking, aggressive outbursts, and so on.

ADOLESCENT DEVELOPMENTAL STAGES

There are three main stages of adolescent development – early, middle and late adolescence. However, the progression from one stage to another in terms of psychosocial development varies enormously from one young person to another.

Age does not define maturity in different areas of youth development: in any particular young person, physical, cognitive and psychological changes may be 'out of sync'. For example, an early developing, mature-looking girl may be physically developed but psychologically immature and emotionally vulnerable. This presents the potential risk of early initiation of sexual activity before she has developed the cognitive and psychological capacity to fully understand the potential consequences.

Adolescence is a journey towards maturity and independence. There are many psychosocial challenges that young people must negotiate along the path to adulthood. While the nature of these tasks, and the importance placed upon their achievement, can vary greatly between cultures, these tasks usually include:

- Achieving independence from parents and other adults
- Developing a realistic, stable, positive self-identity
- Forming a sexual identity
- Negotiating peer and intimate relationships
- Developing a realistic body image
- Forming their own moral/value system
- Acquiring skills for future economic independence

The main developmental concerns, cognitive changes and psychosocial issues for each stage are shown in Table 1.

TABLE 1: ADOLESCENT DEVELOPMENTAL STAGES

	Early (10 – 13 years)	Middle (14 – 17 years)	Late (17-21 years)
Central Question	"Am I normal?"	"Who am I?" "Where do I belong?"	"Where am I going?"
Major developmental issues	• Coming to terms with puberty • Struggle for autonomy commences • Same sex peer relationships all-important • Mood swings	• New intellectual powers • New sexual drives • Experimentation and risk-taking • Relationships have self-centred quality • Need for peer group acceptance • Emergence of sexual identity	• Independence from parents • Realistic body image • Acceptance of sexual identity • Clear educational and vocational goals, own value system • Developing mutually caring and responsible relationships
Main concerns	• Anxieties about body shape and changes • Comparison with peers	• Tensions between family and young person over independence • Balancing demands of family and peers • Prone to fad behaviour and risk taking • Strong need for privacy • Maintaining ethnic identity while striving to fit in with dominant culture	• Self-responsibility • Achieving economic independence • Deciding on career/ vocation options • Developing intimate relationships
Cognitive development	• Still fairly concrete thinkers • Less able to understand subtlety • Daydreaming common • Difficulty identifying how their immediate behaviour impacts on the future	• Able to think more rationally • Concerned about individual freedom and rights • Able to accept more responsibility for consequences of own behaviour • Begins to take on greater responsibility within family as part of cultural identity	• Longer attention span • Ability to think more abstractly • More able to synthesise information and apply it to themselves • Able to think into the future and anticipate consequences of their actions

CHAPTER SUMMARY - WHAT TO REMEMBER

Adolescence is a period of change. While many of the physical changes are obvious, the adolescent brain is undergoing its most dramatic period of growth and development since early childhood.

These changes affect a young person's cognitive, emotional and social development. Understanding these changes helps us understand many of the behavioural changes that occur in adolescence too – such as the onset of risk-taking behaviours.

Many factors – including the experience of trauma – can have an effect on the way the brain develops and, in turn, on a young person's experience of adolescence.

REFLECTION QUESTIONS

Is the developmental perspective a new way of thinking about adolescence for you?

How does your practice or service incorporate some of the concepts from this chapter in the way it works with or understands young people?

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1.2 THE HEALTH AND WELLBEING OF YOUNG AUSTRALIANS

PETER CHOWN

Young people are neither over-grown children nor mini-adults. The period of adolescence is characterised by its own set of health issues and a unique developmental context that produce health issues specific to this time of life. In particular:

- **The causes of ill-health in young people are mostly psychosocial rather than biological**
- **Young people often engage in behaviours that present risks to their health but reflect the adolescent developmental processes of experimentation and exploration**
- **Young people often lack awareness of the harm associated with risk taking behaviours and do not yet have the skills to protect themselves**
- **Young people lack knowledge about how and where to seek help for their health concerns**
- **Developmental difficulties and conditions related to pubertal growth commonly occur in adolescence**

The health of young people is strongly influenced by the context in which they live, including family, social and cultural factors as well as environmental hazards. The following factors are associated with how healthy a young person is:

- Socio-economic status, including low levels of education, employment and income
- Family breakdown
- Physical / sexual abuse and neglect
- Homelessness

Most health problems that young people experience are psychosocial: that is, they emerge as a consequence of health-risk behaviours, mental health problems and exposure to social and environmental risk factors. Youth health problems rarely stand alone. Rather, young people frequently experience co-morbidities (where one health problem raises the risk of other health problems occurring). Mental health problems and substance use problems, for example, often occur together.

Many health-risk behaviours and lifestyles are established in adolescence and continue into adulthood leading to chronic health problems: smoking, poor dietary habits and alcohol consumption often begin in the teenage years. Worldwide, at least 70% of premature adult deaths are linked to behaviours which start or are reinforced in adolescence (Resnick et al. 2012).

In 2009, nearly 4 million young people (2.0 million males and 1.9 million females) aged 12-24 lived in Australia (18% of the total population). In 2006, 71% of young people lived in major cities, 26% in regional areas and 2% in remote and very remote areas.

HOW WELL ARE YOUNG AUSTRALIANS?

The Australian Institute of Health and Welfare's fourth comprehensive national report on the health of young people aged 12-24 years, *Young Australians: Their Health and Wellbeing 2011*, found that overall young Australians are healthy according to many indicators.

MENTAL HEALTH

- In 2007, 9% of young people aged 16-24 experienced high or very high levels of psychological distress, with females more likely to report high or very high distress.
- In 2011, 37% of students aged 12-17 reported psychological distress in the previous 6 months (NSW School Students Health Behaviours Survey).
- It is estimated that one in four young people aged 16-24 experienced at least one mental disorder over a one-year period. Mental disorders include anxiety, affective (mood) disorders and substance use disorders.
- According to a 2008 survey which used a slightly different method to estimate distress, 31% of Indigenous young people aged 16-24 years experienced high or very high levels of psychological distress (ABS 2008).
- Young people do not access services for mental health problems as often as other age groups.
- The health professionals most likely to be consulted by young people for mental health problems are general practitioners, followed by psychologists and then psychiatrists.

CHRONIC CONDITIONS

- Chronic conditions include asthma, diabetes, and cancer among others.
- In 2007-08, about three in five young people experienced a chronic health condition, although only 17% of young people who reported having a chronic condition reported that it limited their activity.
- The prevalence of asthma among young people aged 15-24 declined from 16% in 2001 to 11% in 2007-08. Hospitalisations for asthma have declined over the past decade.

- There was a 41% increase in the rate of insulin-treated diabetes in young people aged 15-24 from 2001 to 2007.
- Cancer rates among young people are stable. Cancer is the second leading cause of death among young people, after injury and poisoning. Overall, the most common form of cancer for young people is melanoma, with cancer of the testis for young men and Hodgkin lymphoma for young women also being common cancer diagnoses.

COMMUNICABLE DISEASES

- Pertussis (whooping cough) was the most common vaccine-preventable infection among young people in 2008, with 2,480 notifications to health authorities.
- In 2008, the reported rates of hepatitis A, B and C were 67 cases per 100,000 young people, down from 154 cases per 100,000 in 1998
- In 2008, there were 119 reported new cases of HIV infection for young people aged 12-24; most were within the 18-24 year age range.
- Chlamydia is the most commonly reported sexually transmissible infection in Australia for young people, and the rate at which it is notified has increased nearly five-fold since 1998.

SUBSTANCE USE

- In 2007, 13% of young people aged 16-24 had a substance use disorder.
- Although the rate of daily smoking had fallen, 11% of young people aged 12-24 reported smoking daily in 2007. Indigenous young people are twice as likely to smoke as non-Indigenous young people.
- Among young people aged 12-24, 30% drank at levels that risked short-term harm, and 12% drank at levels that risked long term harm. Rates of risky drinking were similar for both young men and women.
- Nearly 40% of young people reported being a victim of drug- or alcohol-related violence, including threats or intimidation, in the previous 12 months
- 19% of young people reported using an illicit drug in the last 12 months. Rates of use were similar for young men and women. Illicit drug use is a risk factor for poor physical and mental health and criminal behaviour.
- There is a high incidence of mental health disorders among young drug users.

DEATHS OF YOUNG PEOPLE

- In 2007, there were 1,418 deaths among young people aged 12-24. 70% of these young people were male. The death rate was highest for the oldest section of this age group (20-24 year olds).
- The leading causes of death were injury and poisoning (66%). This statistic includes deaths from traffic accidents and suicide. In 2009, among young people aged 12-24, there were 370 road accident deaths of young people aged 12-24. In 2007, among young people aged 15-24, there were 284 deaths from suicide.
- Death rates were higher for young people living in remote areas; living in the lowest socioeconomic status areas; and for Indigenous young people.
- Young people are more likely to be killed or injured in road traffic accidents than other age groups.
- In 2007-08, 50 young people aged 12-24 died following an assault. Two thirds of these were young men.
- Accidental poisoning is also a leading cause of death for young people, accounting for 41 youth deaths in 2007.

OTHER HEALTH RISK AND PROTECTIVE FACTORS

- In 2007-08, 35% of young people aged 12-24 were overweight or obese.
- In 2007-08, only 44% of young people met National Physical Activity Guidelines. Indigenous young people were even less likely to meet these guidelines.
- In 2007-08, only 5% of young people met Australian Dietary Guidelines for recommended daily intake of fruit and vegetables.
- In 2006-07, only 37% of young people aged 12-17 reported using sunscreen to protect themselves from the sun. 47% of those aged 18–24 reported wearing sunglasses.
- A survey of year 10 and year 12 students in 2008 found that 99.8% of those who reported that they had sexual intercourse said they had used contraception in their most recent sexual encounter.
- Rates of teenage motherhood appear stable, and are much higher for Indigenous young women than non-Indigenous young women.
- In 2010, about 12,500 young people aged 12-17 were on care and protection orders because their families were deemed unable to adequately care for them. Many of these young people (11,800) lived in out-of-home care.
- In 2008, it is estimated that 138,000 young people were victims of physical or sexual assault.
- Young people are more likely to be imprisoned. In 2009, about 5,600 young people were in prison.

POSITIVE HEALTH TRENDS

- Large decline in death rates among young people – largely due to decrease in deaths due to injury
- Decline in hospitalization for asthma, notifications for hepatitis (A, B and C), improved survival for cancer including melanoma
- Declines in smoking and illicit substance use
- In 2008, 93% of young people aged 15-24 rated their health as excellent, very good, or good

NEGATIVE HEALTH TRENDS

- 7% of 15-24 year olds having a severe disability or profound activity limitation
- 9% of young people aged 16-24 report high or very high levels of psychological distress, and 26% have a mental disorder
- 60% prevalence rate of long-term conditions amongst 12-24 year olds
- Nearly five-fold increase in notification of chlamydia since 1998

WHAT YOUNG PEOPLE WORRY ABOUT

Mission Australia regularly surveys young people asking about their worries and concerns. In 2011, the Mission Australia survey reported on the responses of 45,916 young people aged 11-24. Survey respondents included 5.8% who identified as Aboriginal or Torres Strait Islanders, 19.4% who spoke a language other than English at home, and 4.0% of whom had a disability. Nearly half the surveyed group were in some kind of paid employment.

The main issues of concern for young people were school or study problems, coping with stress and body image. Females were more likely to be concerned about coping with stress and body image, while males were more likely to be concerned about drugs and alcohol.

When asked about the things they value most, 74.3% of respondents ranked family relationships as the thing they most valued; followed by friendships (59.0%) and school or study satisfaction (36.9%).

Friends, parents and family were most commonly identified as sources of support. The internet was also identified as a source of advice and support for more than one in five respondents. Unfortunately, the survey found that 20% said that they did not have anywhere to go for advice or support about their issue of greatest concern.

YOUNG PEOPLE AT HIGHER RISK

Some groups of young people are disproportionately affected by particular health conditions and risks because of social, cultural and environmental factors, and socio-economic disadvantage.

INDIGENOUS YOUNG PEOPLE

Indigenous young people's health is poorer than the health of non-Indigenous young people (ABS 2008). Death rates, injury rates, mental distress, and rates of hospital admissions for mental and behavioural conditions are all higher amongst Indigenous young people.

- Indigenous young people are more likely to be involved in the child protection system and to experience violence.
- Young Indigenous Australians are more likely to experience health risk factors such as obesity, physical inactivity, smoking, imprisonment, and lower educational attainment.
- The history of Indigenous people means that they experience health risk factors related to loss, such as loss of cultural identity.
- Aboriginal young people benefit from having a strong sense of identity – a known protective factor.

FINDING OUT MORE...

There are many web-based resources providing useful information about the health needs and inequities faced by Indigenous Australians, including:

- The Closing the Gap Clearinghouse provides evidence-based research on overcoming disadvantage for Indigenous Australians.
  Visit www.aihw.gov.au/closingthegap
- Information and resources on federal government programs can be found at www.indigenous.gov.au
- NACCHO is the national peak body representing over 150 Aboriginal Community Controlled Health Services (ACCHSs) across the country on Aboriginal health and wellbeing issues.
  Learn more at www.naccho.org.au

YOUNG PEOPLE FROM CALD BACKGROUNDS

Young people aged 15-24 years born overseas have lower mortality and morbidity rates than Australian-born youth. Familial and cultural support may be providing a protective factor for these young people.

Some CALD young people may be at risk of poor mental health outcomes because of the stress associated with the experience of migration, resettlement and acculturation, as well as exposure to traumatic experiences (Minas et al. 1996). Stressors include:

- Settlement and adaptation difficulties
- English language difficulties
- Conflict between the cultural values of their family and the cultural values of their new society
- The experience of being a refugee
- Experience of torture or trauma in their country of origin
- Exposure to racism or discrimination
- Isolation
- Lack of access to culturally appropriate mental health services

FINDING OUT MORE...

The Diversity Health Institute offers a wide range of multicultural health information, including information about the Transcultural Mental Health Centre (TMHC). TMHC provides consultation, training and information services to health professionals on transcultural mental health, as well as services to people from CALD backgrounds. To access the Diversity Health Clearinghouse and the TMHC, visit the Diversity Health website– www.dhi.health.nsw.gov.au

YOUNG PEOPLE WHO HAVE EXPERIENCED VIOLENCE, ABUSE OR NEGLECT

The experience of the trauma of violence, abuse or neglect can have a significant impact on health and increase risk for a wide range of health problems. It is important to understand that the experience of trauma has specific and real effects on the vulnerable and development adolescent brain prompting the brain to switch from `learning' to 'survival'. (Cozolino 2002; Kezelman and Stavropoulos 2012).

FINDING OUT MORE...

Learn more about the impact of child abuse on health outcomes. Adults Surviving Child Abuse (ACSA) has produced a set of guidelines for practitioners working in health and human services: The Last Frontier. Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care And Service Delivery. Visit www.asca.org.au/guidelines

RURAL YOUNG PEOPLE

- Young people living in rural and remote areas have higher death, assault and hospitalisation rates than those in metropolitan areas
- The death rates of young males from accidents, injuries and suicide increase dramatically with increasing geographical remoteness
- The death rates for young Australians in remote and very remote areas are almost 2.5 times that for major cities
- Rates of substance use are higher in remote areas

GAY, LESBIAN, BISEXUAL, TRANSGENDER OR INTERSEX (GLBTI) YOUNG PEOPLE

- GLBTI young people may be at increased risk of depression, substance use, isolation and injury due to violence.
- There is also an increased risk of suicidal behaviour among young people who identify as gay, lesbian, bisexual or transgender

SOCIO-ECONOMICALLY DISADVANTAGED GROUPS

- Socio-economic disadvantage can include low income, poor education, unemployment, limited access to health services, living in poor housing, and working in an unsafe, unrewarding job.
- Young people who are socio-economically disadvantaged have higher death and hospitalisation rates.
- Young people aged 15–24 years in the most socio-economically disadvantaged areas of Australia had death rates almost twice as high as those from the least disadvantaged areas.

DIFFERENCES BETWEEN MALES AND FEMALES

- Young males are almost twice as likely to die as young females – mostly due to accidents and suicide.
- Females are more likely than males to experience a mental disorder, except for substance abuse disorders where the rate is higher for males than females.
- The male suicide rate is 3 times higher than female rate.

YOUNG CARERS

- In 2003, 7% of young people were estimated to be caring for a family member with disability, most often a parent. Of these young carers, one in ten was helping a parent with self-care.

CULTURAL CONSIDERATIONS FOR HEALTH SERVICES AND PRACTITIONERS

Providing effective and accessible health care to young people requires us to be aware of the diversity that exists between and within cultures. In order to provide good health care to all young people, we need to:

- Understand that our assumptions, attitudes and beliefs about culture and different cultural groups are shaped by our own cultural background and values
- Be aware of how the young person's cultural background may impact upon their developing adolescent identity
- Adopt a respectful and non-judgemental approach in dealing with different cultural norms and practices
- Be careful not to label and make assumptions about the young person based on cultural stereotypes
- Consult with specialist services or workers for advice about cultural issues and impacts on health

And while it is important to understand cultural influences operating in the young person's life, it is also important to:

- Treat each young person as an individual
- Ask how the young person identifies themselves within mainstream culture and their own culture
- Enquire about the young person's own particular experiences, cultural beliefs and health practices
- Enquire about family views of the causes of social or health problems
- Ask about the beliefs and history of their family – where this is appropriate for gaining a better understanding of the young person's concerns and background factors that may be influential

FINDING OUT MORE...

This chapter should be read in conjunction with chapters 3.6 Culturally competent practice, 3.7 Resilience and Indigenous young people, and 3.13 Working with families.

Much information about research into adolescent health is summarised in a series of articles in the Lancet, volume 379, April 28, 2012. Visit www.thelancet.com

CHAPTER SUMMARY - WHAT TO REMEMBER

The leading health problems in the age group 12 – 24 years are:

- Accidents and injuries – both unintentional and self-inflicted
- Mental health problems – depression and suicide
- Behavioural problems – including substance use

Co-morbidity is common with the occurrence of one health problem raising the risk for a subsequent problem.

REFLECTION QUESTIONS

How do the current trends in youth health affect your service?

How visible are the needs of young people in your service?

Are there any youth health needs to which you need to develop your service response?

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SECTION TWO

PROVIDING HEALTH SERVICES TO YOUNG PEOPLE

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2.1 THE AUSTRALIAN HEALTH CARE SYSTEM

MELISSA KANG

'Health' is a broad concept. More than just an absence of disease or illness, health is a holistic state of wellbeing. Youth health problems are often complex in nature and require comprehensive care and a multidisciplinary treatment approach to deal with co-morbid and psychosocial issues. Certainly, many of the determinants of youth health are beyond the scope of the health system. However, the focus of this chapter will be on health care that is delivered through the health care system.

Young people seeking help with their health often experience fragmented care, inefficient sharing of health information and lack of care coordination. Their lack of familiarity with, and inexperience with independently navigating, our complex health system compounds these problems.

The Australian health care system is large, complex and currently undergoing major reform. Two significant policy shifts since 2009, the commitment to a preventive health agenda and the integration of primary health care promise good things for our young people and the health care they receive, but these changes will take a long time to be fully realised.

Compared to some developed countries, Australia's universal health insurance scheme (Medicare) and publicly funded pharmaceutical benefits and hospitals make our health system accessible and equitable. However, even in the most equitable health systems in the world, there are some groups within the population whose access to health care is sub-optimal.

Further, in wealthy countries, the social determinants of health contribute as much or more to poorer health than the quality of the health care system itself. In Australia, major disparities exist between the health of the Indigenous population, for example, and the health of the general population. And of great concern is the fact that young people have not experienced the same level of improvement in their health status as other age groups in Australia.

COMPONENTS OF THE HEALTH SYSTEM

PRIMARY HEALTH CARE SERVICES

The primary health care system includes general practices (doctors working in private business enterprises subsidised via Medicare) and government and non-government community-based health services (state or federally funded). The primary health care system also includes emergency departments of public and private hospitals, private dental clinics and public dental hospital clinics.

Community based public health services may focus on specific health issues (e.g. drug and alcohol, mental health, sexual health and family planning services) or may target specific populations (e.g. early childhood centres, women's health centres, Aboriginal medical services, youth health centres including headspace, refugee health services). The availability of these services varies enormously across geographical regions, and they differ in terms of their funding, governance, service delivery and intake systems (Kang and Sanci 2007).

Health care reforms in the past 10 – 15 years have gradually broadened the services covered by Medicare to include psychological and allied health services and dental services. Recent structural reforms aim to improve integration between general practice and other primary health care services, and to streamline transitions and connections between primary and secondary care, bringing potential benefits for young people (Dadich et al. 2013).

SECONDARY AND TERTIARY HEALTH CARE SERVICES

Secondary health care services include hospitals (where people are admitted by a specialist following an assessment either in the emergency department or the community) and specialist out-patient or private clinics. Patients can only access these services with a referral from a GP.

Access to tertiary health care services requires a referral from a secondary service. Tertiary services include some adolescent inpatient psychiatric services (requiring referral from specialist departments within the hospital) and neonatal intensive care units (that require referral from paediatricians and obstetricians).

HEALTH CARE COSTS AND MEDICARE

Medicare is Australia's universal health insurance scheme. Most medical services delivered by doctors are covered by this insurance scheme (exceptions include some cosmetic surgical procedures). Services that are not delivered by doctors are generally not covered (e.g. physiotherapy, psychologists, speech therapy, podiatry). There are some exceptions to this and some changes planned for the future. For example, under a 'mental health care plan' completed by a GP, Medicare will cover up to ten visits in a calendar year to an accredited psychological service. Under an 'enhanced primary health care plan', visits to some allied health professionals can be claimed through Medicare (e.g. physiotherapy).

FINDING OUT MORE...

More information about what is and isn't covered by Medicare can be found in the Medicare section of the Human Services website: www.humanservices.gov.au

HOW MEDICARE WORKS IN PRACTICE

Every medical service has a 'Medicare item number'. Medicare sets a 'scheduled fee' for every item number. However, because general practices are small private businesses, GPs are entitled to set their own fees. If a GP charges the 'scheduled fee', then the client can claim back the full fee from Medicare. If a GP charges more than the scheduled fee, the client can only claim back the scheduled fee amount and will be out of pocket for a gap amount. Co-payments have also been proposed for GP visits on top of gap payments.

Some doctors 'bulk bill'. The doctor (GP or specialist) bills Medicare directly, with the client's consent. The client does not have to pay any money and the doctor claims the scheduled fee directly from Medicare.

In many cases, because they have limited incomes, young people will look for and visit GPs who bulk bill. However, a young person may want to see a particular GP and that GP may not bulk bill, or they may live in an area where there are few or no GPs bulk billing. If a young person is referred to a specialist, it is likely that further costs will be involved, even if they are Health Care Card holders.

It is useful to help young people understand how health care costs work and help them negotiate some of these expenses.

COMMON ADDITIONAL COSTS

Pathology tests (e.g. blood tests, urine tests and STI screens) as well as diagnostic tests (e.g. x-rays, ultrasounds) are performed by medical specialists. A referral is required, usually from a GP, although some other health professionals have limited referral rights (such as physiotherapists referring for some x-rays). Like any other medical services, the specialists performing these tests can charge their own fee, or bulk bill. GPs can request on the referral form that the service bulk bill the patient.

REFERRALS TO SPECIALISTS

Privately practicing specialists (e.g. gynaecologists, surgeons, physicians) are less likely to bulk bill than GPs. For these specialist services, Medicare only covers 85% of the scheduled fee. Public hospitals have specialist outpatient clinics that are free to Medicare-eligible clients but these often have long waiting times.

PHARMACEUTICALS

Most prescription medicines are available on the Pharmaceutical Benefits Scheme (PBS). Sometimes newer medications are not available (e.g. some of the newer oral contraceptives). If a doctor prescribes medication for a young person, it can be useful for the young person to ask about cost. Some medication comes in a generic formula which is cheaper. Health Care Card holders receive a subsidy for PBS products and the cost of prescriptions is capped.

CHAPTER SUMMARY – WHAT TO REMEMBER

The Australian health care system is a complex web of services that can be difficult to fully understand, let alone navigate. It is currently undergoing major reform that will see better integration of health care and increased focus on preventive health.

General practice is the cornerstone of primary health care in Australia and funding arrangements continue to support general practice as the gateway to many other health services.

REFLECTION QUESTIONS

How does your service help young people to understand the health care system?

Do you know the local primary health providers who bulk bill? What about those with an interest in working with young people?

REFERENCES

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2.2 YOUNG PEOPLE AND HEALTH SERVICES

MELISSA KANG

Seeking health care can be difficult for many young people. Fear and embarrassment about discussing sensitive issues such as sexuality, drug use or other psychosocial problems can keep young people from seeking help, advice or information when they need it. Many young people are also unaware of the range and availability of health services they can access. For example, they may think that GPs treat only physical ailments, and be unaware that GPs can also help them with emotional and psycho-social concerns. Young people may also:

- **Have a poor understanding of their own health needs**
- **Lack knowledge about available health services and how to use them**
- **Have difficulty expressing their concerns because of the sensitivity of many of their health issues**
- **Feel self-conscious and anxious about being asked personal questions**
- **Defer treatment until at crisis stage**
- **Be reluctant health consumers, often brought along by parents or other caregivers**

General practitioners are the most visible primary health care provider and awareness of general practice among young people is high. GPs are usually the first point of contact with the health system, and see approximately two million young people under the age of 25 each year in more than 12 million consultations (AIHW 2011). GPs act as a gateway to the health system and can facilitate young peoples' access to other required health and support services.

Young people themselves perceive doctors as one of the most credible sources of health information. The quality of a young person's initial contact with a GP influences the way they perceive the health system and their future pattern of using health services. GPs can overcome barriers to access by making their services and consultations youth friendly (Booth et al 2002).

EXPLAINING GENERAL PRACTICE TO YOUNG PEOPLE...

ReachOut hosts a video produced by NSW Kids and Families which explains the role of General Practice and how to find a youth friendly General Practitioner for young people. See it at http://au.reachout.com/visiting-a-gp

There are also resources for classroom teachers to use with students about understanding General Practice at: http://au.professionals.reachout.com/Youth-Friendly-General-Practice-video

ACCESS ISSUES FOR YOUNG PEOPLE

There are some barriers to accessing health care that are commonly experienced by young people.

Confidentiality: young people who are seeking health care are often concerned that the service provider might disclose information to their parents or someone else. A lack of privacy in the waiting room and fears of being recognised may also contribute to a reluctance to seek help. This is particularly a factor for young people in rural areas or small communities: young people may be worried that staff at the service (who may know family members of the young person) will not respect confidentiality.

Staff attitudes and communication style: a health professionals approach and communication style have a significant impact on a young person's comfort level and ease of communication. Young people sometimes believe doctors will be unsym-pathetic, disapproving or authoritarian in their attitudes to young people. Young people may not feel confident that they will be heard without judgement.

The physical environment and organisational factors: the actual physical space in which a service is located can be intimidating for young people. A very formal clinic and waiting room, strict or complex appointment booking procedures, and a perceived lack of sensitivity and awareness on the part of reception staff can contribute to a young person's reluctance to seek help. Inflexible clinic hours and long waiting times can also lead to young people forgoing health care.

Cost: the cost of health care can be a major barrier for young people. The Medicare system can be difficult to understand and few young people have their own Medicare card. Young people may believe that they cannot access a service without payment or without their parents finding out. If young people can't access a bulk billing service, they may have difficulty meeting the costs of health care and other expenses such as transport.

Systemic issues: there are a number of factors in the structure of health services that restrict access for young people.. Staff often have inadequate training, knowledge, skills and confidence in understanding and managing psychosocial problems in young people. Time constraints and inadequate remuneration for providing longer consultations to young people also hamper the ability of services to work effectively with young people. Concerns about medico-legal issues can also reduce a services willingness to fully meet the health needs of young people in the community.

HOW HEALTH SERVICES CAN MAKE A DIFFERENCE

Many health services have a critical role to play in the effective management of youth health care. They can do this by providing developmentally appropriate assessment and treatment; promoting access to other services by identifying and managing pathways to care for the young person; and working collaboratively with both health and non-health services to promote health and wellbeing.

Health services can contribute to better youth health in four important ways.

1. Provide comprehensive health care appropriate to the young person's developmental needs and sociocultural background.

This means:

- Devoting time and using developmentally appropriate communication styles and tools to engage young people effectively
- Making sure that prevention activities and health interventions are developmentally appropriate
- Anticipating young people's need for simple, clear guidance about health matters
- Adopting a culturally sensitive approach respectful of the individual, their family and culture.

2. Identify, intervene early and educate young people about health-risk behaviours.

Service providers can:

- Identify and manage psychosocial risk factors and behaviours
- Make the most of their contact with a young person to educate them about health risks and to promote protective behaviours
- Address the social and environmental risk factors in the young person's life by working with the family, school, and other key people in their lives
- Provide appropriate intervention for common youth health problems e.g. smoking

3. Promote young people's access to health services.

It is important to:

- Make services youth-friendly
- Act as a gateway to the health system by helping young people to access other services they need e.g. GPs, specialists, youth workers, psychologists
- Make services culturally sensitive to the needs of young people
- Help reduce the barriers that many young people (especially those at high risk or with multiple difficulties) face when accessing services
- Act as an advocate for young people's health needs within the health system, and with their families, schools, and wider community,

4. Adopt a collaborative approach.

Service providers can promote effective, multi-disciplinary health care by coordinating their care with, and making appropriate referrals to, other health professionals involved with the young person.

FINDING OUT MORE...

The *Youth Health Better Practice Framework Checklist* in the appendix of this Kit gives further guidance on making services youth-friendly.

CHAPTER SUMMARY – WHAT TO REMEMBER

Despite its prominence in primary health care, young people continue to experience barriers to accessing general practice as well as other health services, and general practice continues to experience challenges in providing optimal comprehensive care to young people with complex psychosocial health needs.

By better understanding how the health system works and identifying strategies for overcoming barriers to health care, youth services and other organisations can work with health services to promote better health care for young people.

REFLECTION QUESTIONS

What attracts young people to your service? How do you know this?

What are the barriers that prevent young people from accessing and/or engaging with your service? How do you know this?

How does your service demonstrate youth friendliness? How do you know this? What aspects of your service could be perceived as not youth friendly?

Has your service used the *Youth Health Better Practice Framework checklist* in the appendix of this Kit?

REFERENCES

Australian Institute of Health and Welfare. (2011). *Young Australians, Their Health and Wellbeing 2011*, Cat No. PHE 140. AIHW: Canberra. www.aihw.gov.au

Booth M, Bernard D, Quine S, Kang M, Beasley L, Usherwood T, Alperstein G & Bennett D. (2002). *Access study phase I - access to health care among NSW adolescents.* NSW CAAH: Westmead, NSW.

2.3 COLLABORATION AND CASE MANAGEMENT

MELISSA KANG

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)

Youth Health Better Practice Framework (2012)

Collaboration can occur at the level of individual health care, or at a service or program level. It is important because optimal health care is achieved when clients and health care providers work together to achieve health goals. Implicit in this is the understanding that health is a state of wellbeing in physical, mental and social domains.

SOME DEFINITIONS

Before looking more closely at practical collaboration in health care, it is worth defining three key terms that we will be using.

HEALTH CARE:

- Refers to general and specialist medical care; nursing; psychological and other mental health care; and allied health care (e.g. physiotherapy, dietetics, occupational therapy).
- It can be delivered through primary care, secondary or tertiary care (see chapter 2.1 for descriptions of primary, secondary and tertiary care). These are known as clinical services.

HEALTH CARE SUPPORT:

- Refers to people or services that help young people to access health care, or that provide advocacy or assistance to optimise the health care that is provided to young people.
- It can be highly practical (e.g. providing transport to appointments or paying for health services, medications or other treatments for the young person), or less tangible (e.g. encouraging a young person to seek health care or to adhere to treatment; providing opportunities to 'debrief' or discuss health care).
- Advocacy might involve negotiating on a young person's behalf for appointments or cost reductions.
- Health care support can be provided by workers within and outside the health care system or by families and carers.

HEALTH PROMOTION:

- Refers to both the formal activities undertaken by health promotion workers in the health system and to a range of activities that can be provided by clinicians, educators and workers outside the health system.
- It involves not only providing health related information to young people but also actively seeking their participation and increasing their capacity to care for their own health.

UNDERSTANDING COLLABORATION

The 2005 Access research project (NSW CAAH 2005) identified collaboration as one of the seven principles of better practice in youth health.

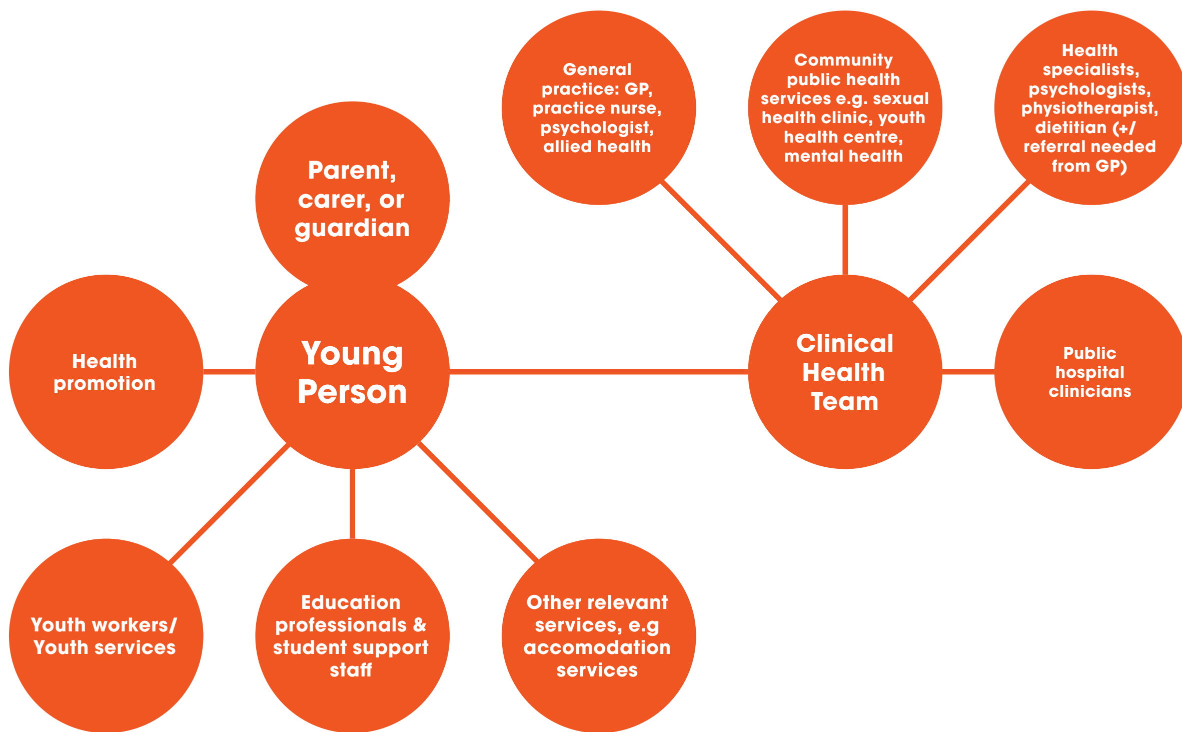
It can occur informally or formally, but always requires commitment, an attitude of cooperation, and often considerable practical time and effort. In fact, many health care and other service providers find working collaboratively with other services more challenging than the specific clinical challenges that arise from working with the young people themselves. Specifically, the Access project found that service providers working collaboratively faced challenges in:

- Successfully referring young people to other service providers
- Negotiating service pathways
- Experiencing a lack of partnership
- Feeling the pressure on services to fill service gaps
- Creating sustainable inter-service collaboration rather than ad hoc systems.

This study found that, for practitioners, collaboration involves:

- Planning
- Knowing when to refer
- Sharing information
- Exercising judgment
- Negotiating between service systems

Figure 1: What does a 'health care and support team' look like?



COLLABORATING IN PRACTICE

The process of collaborating in providing health care to a young person often evolves over time, but it usually begins at an entry point, where a young person seeks or accepts an offer of a health assessment.

Young people reach a health care entry point in a variety of ways: it might be a critical event (e.g. an acute injury, severe suicidal thinking, a sudden and serious medical illness, an unexpected positive home pregnancy test); short or longer term non-critical un-wellness (e.g. a head cold that appears to be getting worse instead of better; low back pain of a few weeks duration; tiredness or lethargy lasting a few weeks; feeling depressed or anxious over a prolonged period; concerns about weight loss or weight gain); or it might be preventive in nature (e.g. seeking advice about contraception; seeking advice about quitting smoking; getting a Pap smear).

Parents or carers often facilitate young people's access to health care and might even accompany them to appointments. If a young person does not live with a parent or carer, or does not wish for their parent/carer to know about their health concerns, they might benefit from the support or encouragement of a friend, another adult in their life, or a service provider such as a youth worker. Regardless of which adults or peers assist the young person to access health care, it is important for all parties to understand the young person's rights to confidential health care.

The arrival of a young person at one of these entry points offers a unique opportunity to begin a collaborative process of health assessment and care.

Collaboration occurs through planned and cooperative arrangements between young people, their families or carers, and workers within and outside the health care system.

UNDERSTANDING ROLES

For collaboration to work effectively, it is important to identify the key roles of different members of the health care and health care support teams. Even if the roles are not written down, it is useful for each person to have an understanding of their responsibilities.

Some collaborators will have several roles. For example, a clinician – such as a counsellor, doctor or nurse – might also provide health education and undertake advocacy on behalf of the young person (such as writing support letters to the school or the Board of Studies, or to Centrelink, or the Department of Housing). A youth worker might facilitate access to health care as well as advocating for a young person at their school.

Roles for health care support workers (non-clinicians) may include:

- Providing support to meet basic needs (e.g. helping the young person to find accommodation, food, facilitating access to income support)

- Providing information about health issues and health services
- Facilitating access to health care at all levels (through practical support or encouragement to seek health care by discussing barriers and explaining how they might be overcome)
- Providing informal supportive counselling – including debriefing about experiences with health services and listening to the young person's concerns
- Advocating on behalf of the young person to negotiate health care appointments, services and costs.

For effective collaboration, there must be clear goals, with the young person at the centre. In meeting those goals, there may be roles for several individuals, services and sectors to be involved in the health care of a young person, particularly if their holistic health care needs are complex. A young person's needs will change over time (sometimes very quickly) and thus, so will the appropriate service responses.

COLLABORATIVE CARE AND MEDICARE

GPs can play an important role in coordinating collaborative care by using Medicare item numbers to initiate multi-disciplinary shared care with other health professionals, specialists and youth services.

However, young people can be reluctant to visit GPs or engage in the health system. They may be worried about confidentiality and privacy, or may not have sufficient money to pay for a visit to a non-bulk billing GP.

Youth service providers can support and encourage young people to visit a GP by:

- Discussing the reasons for referral to a GP with sensitivity and clarity.
- Letting young people know that they can apply for their own Medicare card once they are 15 years old.

The Medicare system has a range of item numbers that GPs can use to provide collaborative health care to young people. These item numbers facilitate:

- Mental Health Care Plans to see a Psychologist or Psychiatrist
- The treatment of chronic conditions such as asthma and diabetes
- The provision of allied health care
- Referral to specialists

FINDING OUT MORE...

Learn more about communicating effectively with young people in chapter 3.1 Youth-friendly communication. You can also learn more about confidentiality in chapter 3.5 Medico-legal issues for information about confidentiality. Find out more about Medicare at www.medicareaustralia.gov.au/provider

KEEPING THE YOUNG PERSON 'CENTRE-STAGE'

As young people move through adolescence, they increasingly seek more autonomy and independence. This can require practitioners to recognise and balance the young person's increased capacity and desire to make their own decisions about their health with the relationship between the young person and their parents or carers.

The physical, cognitive and social changes that occur as part of natural development are legally recognised: young people under 18 years can consent to their own treatment without parental consent if they are competent. Even when parents are closely involved in a young person's health care, it is important to place the young person's needs at the heart of health care considerations.

FINDING OUT MORE...

Learn more about consent and competence to consent in chapter 3.5 Medico-legal issues.

WORKING COLLABORATIVELY WITH PARENTS AND CARERS

A challenge for service providers in working with the young person is to gauge the desired or required level of involvement of a young person's parents or carers– particularly if the young person presents by themselves or does not want their parents involved. Whenever it is possible and appropriate, discuss with the young person the level of involvement they want their parents or carers to have.

Decisions about the level of parental or carer involvement depends on a number of factors:

- The age and developmental stage of the young person
- The nature of the relationship between the young person and parent(s)
- The nature of the presenting problem – parents may need to be involved where major health issues are concerned (e.g. unplanned pregnancy, prescription of medications, suicidal behaviour); or when dealing with problems where the family will play a major role in supporting or implementing the management plan, such as eating disorders, obesity, and mental health disorders.

Where possible, make a collaborative decision after discussing the pros and cons with the young person. While you have a duty to maintain confidentiality, you can still encourage and assist a young person to talk to his or her parents about important issues.

Be sensitive to the concerns of parents from cultural backgrounds where health care may be viewed as a private or family matter. Where possible, respect their wishes and rights to be involved in their adolescent's health care.

BUILDING RELATIONSHIPS FOR COLLABORATION

BUILDING RELATIONSHIPS	AVOIDING PITFALLS
Communicate effectively and regularly with other health care team members	Allocate time in your diary to write correspondence, attend meetings and engage in other strategies that will enhance collaboration
Trust in the expertise of other health care team members	Rather than discouraging a young person from following advice, facilitate the young person's understanding and health literacy by helping them gather information
Trust in the capacity of the young person to comprehend what's being offered and to make their own decision	Rather than imposing yourself into the decision making process, facilitate and advocate for the young person if they seem to be struggling
Appreciate that there can be different approaches to the same health issues (e.g. harm reduction vs. abstinence in substance use management)	Rather than being critical of one approach and promoting another, help the young person learn about what these differences are and what works when and for whom

WHO CAN YOU COLLABORATE WITH?

To put you in the best position to provide youth-friendly collaborative health care, start establishing a referral network of services in your local area. Some services you might join with include:

- Youth workers
- Adolescent mental health service
- Psychiatrists
- Psychologists, mental health nurses, Social Workers and other counsellors
- Drug and alcohol service
- Community health centre
- School nurses or counsellors; student welfare coordinators
- Youth accommodation services
- Department of Community Services
- Family planning/sexual health service
- Transcultural Mental Health Centre
- Bilingual Counsellors in mental health teams
- Other CALD-specific services
- Aboriginal health services
- Refugee health services

FINDING OUT MORE...

In some situations, finding the balance between the young person's wishes and the parents or carers wishes may take some skill. For more information, see chapter 3.13 Working with families.

WHAT IS CASE MANAGEMENT?

Case management involves the dual dimensions of comprehensive (holistic) care and continuity of care. It involves a cycle of assessment, care planning, management, monitoring and review but also includes care facilitation, care coordination and advocacy. Underpinning all these activities is the element we have just reviewed – collaboration.

WHO DOES IT?

Case management can be either informal or formal. Many people accessing health services act as their own case managers – they look for the services they need, collate and filter information from a range of providers and sources, arrange their own access to care and advocate on their own behalf. They collaborate with health providers for particular issues such as deciding on management plans or agreeing to receive reminders about monitoring their health, but they manage their own 'case'.

In some cases, an individual's health needs become more complex and they require the expertise of multiple providers and services. In other cases, a person has certain vulnerabilities that limit their ability to seek, receive or coordinate care. In these cases, formal case management becomes a powerful and supportive process for optimising health care. Some services have Case Managers who are identified by that role, while others have individuals who perform case management without a formal title.

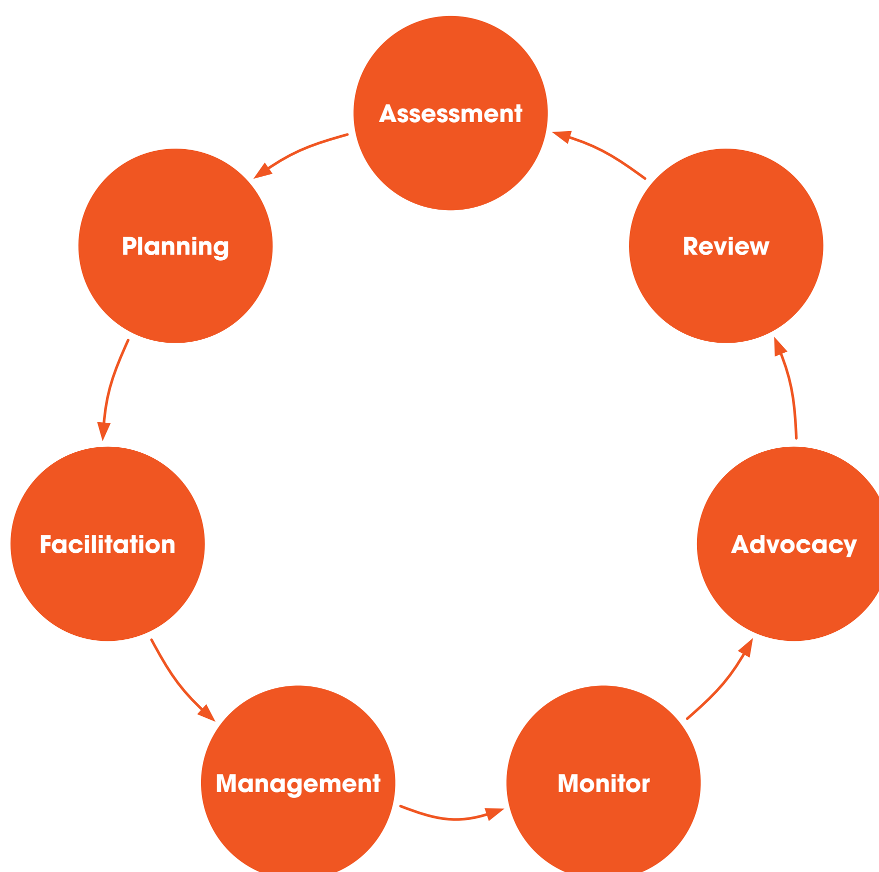
The concept of assertive case management adds to these elements by emphasising the importance of engaging closely with clients (who might be reluctant or resistant) and following- up when a client's engagement with services is fragile.

In the Australian health system, general practitioners often fulfil the role of 'case manager' for many of their clients. This is often the case for clients with chronic conditions who require both primary and secondary health care services involving medical and surgical specialists and allied health staff. Young people with chronic conditions will often have a health care team. Case management might occur informally by the GP or paediatrician. A young person with insulin-dependent diabetes, for example, will often have a GP, diabetes nurse educator and paediatrician/ endocrinologist on their health care team.

Young people with complex health issues where there are compounding factors such as psychosocial stressors (e.g. homelessness, social or cultural issues impacting on health, mental health or substance use issues) often come into contact with services in different parts of the health system that historically have not worked collaboratively (e.g. GP, youth worker/ youth service, mental health staff from education sector or mental health sector). There are times when formal case management might be beneficial in improving collaboration and therefore health care.

Case management generally moves through seven steps; however, at any time it may be necessary to revisit one or more steps. For example, a change in living arrangements for a young person may require a re-assessment of their needs. A change in their health status (for example, a period of hospitalisation for a chronic condition) may require the management plan to be reviewed. The process is fluid and must respond to the needs of the young person.

Figure 2: Seven Steps of Case Management



CASE STUDY: WORKING COLLABORATIVELY TO SUPPORT MEENA

Meena has just moved into a medium term youth refuge. The refuge accommodates up to 6 young women aged 16 and 18 and has one staff member on site 24 hours a day and one manager during business hours.

Meena is 16 years old. She was born in Australia and has grown up in a socio-economically average suburb in a capital city. She is of Indian heritage and speaks English at home, although she understands some Hindi which is her parents' native language.

Meena has been living with her parents and older brother but has just moved into a medium-term youth refuge after an unstable 3 month period of living between friends' houses. She is in Year 11 at a high school that she used to walk to from home.

The school counsellor and student welfare officer referred Meena to the refuge after Meena missed several days of school and was late on many occasions in the last 3 months. The refuge is 5km away from the school and she has to take a bus.

Meena's father has a long history of alcohol abuse and becomes verbally abusive to all members of the family when he has been drinking. He has occasionally been physically abusive towards Meena's mother. Meena's 20 year-old brother has also started drinking quite heavily and can also become verbally abusive. Meena's mother does not drink but has been emotionally abusive towards Meena. She tells Meena that she is the reason her father drinks so much; that Meena does not help enough around the house; and that she wants to spend too much time out with her friends.

Meena is very quiet and is often teary. She has been going to school but is looking tired. She does not appear to be eating much, and although is talking with the other young women a little she is mostly withdrawn.

PLANNING – IDENTIFY MEENA'S NEEDS

Basic needs

The school notified Community Services one month ago because of Meena's homelessness. Community Services has not allocated a case worker because medium-term accommodation was found and adequate shelter was available.

Meena applied for Centrelink youth allowance with the assistance of staff at the refuge.

Educational / occupational needs

Meena is continuing to go to school and intends to complete Year 12. The school counsellor is now trying to engage with Meena.

Health needs

You have concerns about mental health given her background, and because she seems withdrawn and has been teary. She appears pale and tired but looks otherwise physically healthy. As part of her intake information you know that she does not have a regular GP and has not seen any counsellors or other health professionals. She does not have her own Medicare card but staff at the refuge are trying to assist her to obtain one.

Social and cultural considerations

Meena says she identifies as Indian-Australian and has previously enjoyed some of her family's traditions. She has always eaten Indian food at home which her mother cooked and is vegetarian. She has some Indian cousins who live in the city as well. Although there are no major financial pressures on the family, she says her father's job as a bookkeeper in a small accounting firm is very stressful. Her mother works part-time as a retail assistant.

Her school friends come from various cultural backgrounds but most are Anglo-Australian. Since moving out of home, Meena has found it difficult to keep in contact with her group of friends outside of school hours as she now lives further away from her social supports.

KNOWING WHEN TO REFER

Young people who become homeless and/or who have experienced abuse or neglect have higher rates of health problems for a variety of reasons. A comprehensive health assessment that includes exploring physical, mental and social health can help identify health issues that might be responsive to health interventions, and can provide an opportunity for preventive health measures to be put in place to support Meena.

Referral for a comprehensive health assessment is ideal if Meena is willing.

EXERCISING JUDGMENT

Meena initially says she does not want to see a counsellor or a doctor. But with her permission, staff at the refuge communicate with the school counsellor once or twice a week and work collaboratively with the counsellor to support Meena as she settles into the refuge and her new living arrangements.

After the first week, one of the staff at the refuge spends some time chatting with Meena and moves on to asking her how she is sleeping and what her appetite is like. This gives the worker the opportunity to suggest that a health check might be useful, since Meena reports having difficulty sleeping. The worker talks with Meena about options (which include a GP, a headspace centre and a youth health service) and tells her about confidentiality.

After another week, Meena agrees that she would like to talk to a doctor about her sleeping problems. Together, they make an appointment with a headspace GP who has seen young people from the refuge previously.

SHARING INFORMATION

Meena has signed a consent form for staff at the refuge to communicate with her school counsellor and Centrelink. Meena wants to avoid having to retell her story as much as possible and agrees for information to be exchanged with staff at the headspace centre. The refuge staff and the school counsellor have both explained the facts about information sharing, and the limitations on confidentiality when there is concern for a young person's immediate safety or wellbeing.

NEGOTIATING BETWEEN SERVICE SYSTEMS

The staff member at the refuge offers to support Meena by going with her to the headspace GP appointment. Meena expresses relief to have someone familiar go with her. The staff member lets Meena know that if there is something she wants to discuss in private with the GP then this is also ok. Meena and the refuge staff contact Medicare to get her Medicare number and expiry date to give to the headspace centre while her application for a card is in process.

PROGRESS OVER TIME

Initially, Meena is happy to see the GP and have a medical assessment. She sees the school counsellor irregularly as she skips many of her appointments. She does not want formal 'counselling'. She opens up a little to one refuge worker in particular and talks about her family and her friends.

After 2 months though, Meena seems increasingly depressed. She attends school regularly but is not keeping up with school work. Her mother calls her occasionally and Meena always seems more withdrawn after these contacts. The refuge worker expresses their concern about Meena's wellbeing and asks Meena how she is doing. Meena admits to feeling sad and depressed most of the time. She is still not sleeping well.

The refuge worker explains that there are health professionals who may be able to help Meena, including the GP she saw. The worker reminds Meena that she does not have to undergo any 'treatment' that she doesn't want to and has the right to choose, but that she might wish to explore the options in more detail. The worker explains that while they can provide support to her, she may need other people to help address health issues.

After another 3 weeks, Meena agrees to see the GP at headspace again. The GP is concerned that Meena is depressed, but assesses that she is not at risk of suicide, nor is there any self-harm. The GP explains that formal counselling can be an effective treatment and suggests that Meena could see one of the psychologists at headspace.

The GP also knows that other supports are equally important, including safe and stable accommodation, school support and possibly facilitating some communication with the family. After conversations with the school counsellor, the GP and refuge worker both write support letters to the school as Meena has received cautionary letters for incomplete assessments.

CASE STUDY: WORKING COLLABORATIVELY TO SUPPORT TYLER

Tyler is a 14 year-old Anglo-Australian boy living in a regional town in NSW. He has started attending a youth centre after school once a week. He discovered the centre while walking home from school one day. He lives at home with his mother and 2 younger half-sisters who are 3 and 5 years old. His dad lives about three hours away in another large regional town and Tyler sees him once every couple of months. Tyler is in Year 8 at the local high school. Tyler is overweight and occasionally seems a bit short of breath when he arrives at the youth centre. He also appears to have a rash on his hands and arms that you have noticed him scratching.

PLANNING: IDENTIFY TYLER'S NEEDS

Basic needs

From informal conversations with Tyler, you have determined that Tyler feels safe and loved at home, and feels close to his mother and half-sisters. He would like to see more of his father but knows that geographical distance is the main problem. He is not close to his stepfather, who is now separated from his mother. Tyler's mother is on a Centrelink benefit and struggles financially but there seems to be adequate shelter, food and clothing.

Educational/ occupational needs

You also ascertain that Tyler has no major problems with his school work or with teachers and has a few friends at school. He does get teased by some other kids about his weight but says he has dealt with this 'all his life'.

Health needs

You have some concerns about Tyler's physical health. At this stage you are not sure about health risk behaviour or mental health issues. Tyler does have a family GP who you happen to know does not routinely bulk bill. He has not been to the GP in the last 12 months.

Social and cultural considerations

Tyler has always lived in this region. His parents separated when he was eight and his father moved away. His father works for a local council. He has since re-partnered and has 3 stepchildren. The students at Tyler's school are mostly Anglo-Australian, although there are some Aboriginal students and a small number of students from CALD backgrounds. Many students are from a socio-economically disadvantaged background. Tyler sometimes feels 'different' because he is overweight.

KNOWING WHEN TO REFER

Because you have observed physical symptoms and Tyler has told you he has a GP that he has not seen in 12 months, you would like to facilitate a health assessment. You also have concerns that his weight is a source of physical and social distress for him.

EXERCISING JUDGMENT

Tyler has expressed some hesitation about addressing his health needs at present. He is worried that his mother won't understand his concerns. Tyler has agreed to continue to see you at the youth centre to find out more information about the support available so that he can make a decision.

SHARING INFORMATION

You have discussed consent and confidentiality with Tyler and how this affects his medical care. You feel that he would benefit from involving his mother in his health care. Tyler says he would like his mother's support in getting his weight under control, but he doesn't feel confident in talking to her about this. He has asked for some help explaining to his mother how difficult things have been for him and how he has been bullied about his weight. He is also troubled by his breathing difficulties and his rash; sometimes these keep him awake at night. You arrange for Tyler's mother to meet you and Tyler at the youth centre after school one day. Tyler and his mother provide consent to exchange information with Tyler's GP, his school, the local hospital and the community health centre.

NEGOTIATING BETWEEN SERVICE SYSTEMS

You know of a paediatrician at the local hospital who sees adolescents, but a GP's referral is needed in order to see him. You contact the local hospital and find out that the paediatrician has recently commenced a limited multidisciplinary weight management clinic for overweight children and adolescents up to the age of 16.

You help Tyler and his mother get an appointment with his GP for a health review and to consider referral to the adolescent Weight Management Clinic. You discuss the financial strain on the family with the GP and he agrees to bulk bill this appointment.

You contact the school welfare coordinator to explain your concerns that Tyler is being constantly "teased" about his weight.

PROGRESS OVER TIME

The GP assesses that Tyler has mild asthma and eczema and provides him and his mother with information about treatment. Tyler takes the prescribed medications and finds that his symptoms improve dramatically. The GP refers Tyler to the weight clinic because this also offers group activities and dietician support.

Tyler's mother finds it difficult to attend the family appointments with Tyler because of childcare issues, which makes it difficult for her to provide the necessary family support for healthy eating. You help Tyler's mother identify potential childcare options so that she can attend Tyler's appointments with him. On one occasion, you accompany Tyler, his mother and sisters to the clinic and stay with the younger children while his mother goes in with Tyler to see the dietician.

At the youth centre, you initiate a new group physical activity program. Tyler comes along and participates in a weekly basketball tournament. He enjoys this much more than school sport because he does not feel as self-conscious. Tyler introduces another boy from school to the youth centre and they both continue to attend regularly. Tyler reports still being teased occasionally at school but says he is not as bothered by it.

CASE STUDY: CASE MANAGEMENT FOR ELISE

Elise is a 14 year old Anglo-Australian girl who was placed in the care of the Minister three weeks ago. She is staying in a supported accommodation service run by a Non Government Organisation (NGO). The NGO has allocated her a carer within the accommodation service as well as a Case Manager. Elise also has a Community Services case worker.

She is in Year 8 and has changed schools since moving into supported accommodation. In her previous high school she had a history of truancy.

STEP 1: ASSESSMENT

Basic needs

Elise did not have regular access to food at her family home. She was often left unsupervised for long periods while her parents worked. Elise has stolen food from other school bags because she was hungry.

Educational/occupational needs

Elise missed most of the school year at her previous school. Her new school is the fourth high school she has enrolled in.

Health needs

Elise mentioned that she has trouble concentrating at school and some reading difficulties. She experiences sudden mood swings that she finds hard to control. She appears thin and pale. Elise finds alcohol use helps with the mood swings and has reported some instances where she cannot remember what has happened due to blackouts. Elise has disclosed that she has had unprotected sex.

Social and cultural considerations

Elise has struggled to maintain friendships with her peers as she has moved schools several times. There is concern that Elise may be spending time with an older group of young people who buy alcohol for her.

STEP 2: PLANNING

There is an opportunity to plan for and facilitate a comprehensive assessment of Elise's health and developmental needs.

Needs	Potential services that can respond
Cognitive/psycho-metric/developmental assessment	Paediatric/ adolescent specialist services, psychological services, education sector
Physical assess-ment: sexual and reproductive health, physical issues relating to substance use, physical growth and development	General practice, youth health, paediatric/adolescent specialist services, sexual health, drug and alcohol services
Mental health assess-ment: particularly to identify a possible mood disorder	General practice, youth health, headspace, mental health

In planning Elise's management, her Case Manager:

- Gathers as much information as possible from any previous assessments
- Discusses Elise's needs and possible service responses with Elise and her carer
- Identifies the most appropriate services (considering one-stop-shop options, cost, location, waiting time)
- Considers the 'real world' – what is practical and feasible for Elise and what Elise wants to do
- Prioritises the assessments if necessary

Elise does not want to attend multiple appointments. She does not express any health concerns of her own, except she states she does not want to become pregnant.

Many of Elise's health needs can be assessed at the local youth health service. Past psychometric and developmental assessment reports can also be obtained. The school counsellor can do an updated psychometric assessment at the school in which Elise is currently enrolled (although she has not been attending).

FACILITATION

Elise's Case Manager sets up an appointment for Elise at the youth health service where she can see a nurse and a doctor. The Case Manager makes sure Elise has her Medicare card and organises transport for the carer to take Elise to and from the appointment. She has also sent Elise's previous psychometric and health assessments to the youth health service in advance. At the same time, she provides the name and contact details of the school counsellor to the youth health service.

MANAGEMENT

Following Elise's appointment at the youth health centre, a number of further assessments are recommended. Elise needs a dental review and possible orthodontic work; a vision assessment with an optometrist; and a referral to a Family Planning Clinic for the contraceptive implant. She has had some blood tests done and needs follow up with the doctor at the youth health service.

An internal referral to one of the youth health counsellors is offered and Elise reluctantly agrees. Elise is offered ongoing counselling in the youth health service but is ambivalent about attending.

With Elise's knowledge and consent, the Case Manager works with the youth health nurse to plan and facilitate these assessments and treatments. The Case Manager also liaises with Community Services to seek funding for orthodontic assessment and for glasses (i.e. services not covered by Medicare).

After Elise has attended these appointments, a case management meeting is arranged, organised by the Case Manager. The meeting is attended by the Case Manager, the youth health nurse and doctor, the youth health counsellor, the school counsellor, the Community Services caseworker and Elise.

MONITORING

Elise continues to engage in some health risk behaviours (including binge drinking); however some of her health needs have been addressed, including immunisation updates, obtaining contraception and sexual health screening.

The Case Manager is not privy to all the details of Elise's health risks or to results of all tests, but has an understanding of Elise's health needs more broadly. The Case Manager identifies a GP who can provide ongoing care for Elise and discusses this with the youth health doctor and nurse. The Case Manager ensures a smooth transition from the medical team at the youth health service to the GP.

ADVOCACY

Elise misses her appointment at the dental clinic as she has truanted from school and could not be contacted in time. Elise is told by the dental clinic that she will have to wait six months for another appointment. Her Case Manager is able to effectively advocate for special consideration and she is offered another appointment in one month's time.

REVIEW

Four months after entering out of home care, Elise meets with her carer and the Case Manager to formally review her health and other needs. Many of Elise's physical health needs have been addressed, but she continues to binge drink and there is some concern that she engages in unprotected sex. Her school attendance is also problematic. The Case Manager obtains recommendations from the school counsellor, the youth health counsellor and the GP to assist in preparing for further management.

CASE STUDY: WORKING COLLABORATIVELY TO SUPPORT JOSH

Josh is 15 years old and lives in the western suburbs of Sydney with his mum and dad, 3 brothers and a newborn sister. Josh identifies as an Aboriginal person and has a large extended family. Josh had a kidney transplant in 2006 and has an acquired brain injury.

Josh's home is busy. Both Josh's parents work and the new baby is taking up a lot of his parents' time and energy. Josh is close to his parents and says he misses having time with his parents. There is not a lot of spare money for entertainment or outings.

Josh also has a large extended family of aunties, uncles and cousins. He gets a lot of support and encouragement from his older cousins and an uncle and auntie who live nearby.

Josh admits to having a problem with his temper. He has a behaviour management program to help him better manage his emotional responses.

Josh has been referred to you for help with planning his transition to adult health services. You arrange to see Josh and his family at home.

PLANNING: IDENTIFY JOSH'S NEEDS

Basic needs

Josh has good verbal communication skills but has difficulties with reading, writing and remembering information. He needs practical help with transport, remembering to take his medication, money management, completing school work, and (at times) with behaviour management. Josh has received some assistance but he will need ongoing support.

Josh says he's not really sure why it's important to talk about transition: he feels he's got plenty of time until he's 18. You explain that transition planning starts early so that the transition goes smoothly.

Education/occupational needs

Josh plans to stay at school and complete his HSC. He is given extra time to do his school work and exams, and he has help from someone who takes notes during class. Josh does well in creative subjects such as art but struggles with maths and English. He understands his limitations with schooling, as do his mum and dad. Josh loves doing design and painting work, screen printing and using computers. He wants to undertake an apprenticeship after completing his HSC.

Josh has a part-time job in a café. He enjoys the financial independence this gives him and has helped build his confidence in being part of the workforce and providing customer service.

You provide Josh with information on apprenticeships that are being offered to Aboriginal people.

Health needs

Josh needs to take regular medication to stay well. His mum and dad are supportive and remind him to take his medication. You talk with Josh about ways to help him manage his medication such as setting reminders on his phone and learning how to keep a diary.

Josh doesn't have a GP but would like to find one, as he knows it will be important when he turns 18 and becomes more responsible for his health. You and Josh agree that finding a GP is a high priority. You talk to Josh about finding a new GP and talk with him about helpful questions to ask so he can find the right person for him.

When Josh finds a GP, they can complete a GP Management Plan to help support Josh through his transition. You offer to call some GPs for Josh to help him in his search and give him a list of others he can contact.

Josh sees a psychiatrist regularly for help with managing his behaviour.

Social and cultural considerations

Josh knows that his kidney transplant makes it even more important that he lead a healthy lifestyle. He knows his peers are starting to drink alcohol and that he won't be able to do that. He talks about how this could isolate him from his friends, but he accepts he needs to put his health first. You give Josh some helpful websites where he can access information about staying healthy.

Josh's family can't afford many social outings as a family. Josh feels frustrated and would like to be doing more with his family. You know that the local community centre has regular family days, and you give Josh some information about these and other free local activities.

KNOWING WHEN TO REFER

Josh's ability to understand the implications of sexual relationships is limited. You refer Josh to NSW Family Planning so that he can talk to one of the professionals about sex and relationships. Josh found this appointment helpful and was happy the services were free and confidential. He said he learnt a great deal about contraception and really liked getting free condoms.

EXERCISING JUDGMENT

Josh understands his own limitations in cognition and how his medical condition will affect his social life. You will need to consider these needs when planning and coordinating Josh's care during transition. Monitoring Josh's health during his transition will be an important part of the transition plan. Encouraging Josh to develop a good relationship with his GP, to see his GP when he is feeling unwell, and to talk openly about his life is important because the GP will become an important health professional for Josh when he turns 18.

SHARING INFORMATION

Josh has signed a consent form to be enrolled in the transition service and you explain how information sharing works. Josh says he's happy for you to share his information with other health professionals and will let you know if there is something he doesn't want shared.

NEGOTIATING BETWEEN SERVICE SYSTEMS

Once Josh has a GP, the GP will assume responsibility for coordinating Josh's care. Liaising with Josh's GP is integral to a successful transition and to ensure Josh's health outcomes are optimised. You start collating Josh's medical information, discharge summaries and outpatient clinic letters to assist the GP in looking after Josh.

You and Josh visit the adult hospital so he can see what it is like and meet some of the professionals who work there. Josh comments on the visual differences between the hospitals, and asks if his parents can attend appointments with him. You explain that in adult health services he will be encouraged to see his health professionals on his own so he can talk freely with them. Josh likes the idea of having his own health professionals, but seems a little concerned. You reassure him that if he wants his parents or a family member or friend there for any reason, he can always talk to the health professional about it.

PROGRESS OVER TIME

Josh calls you two weeks later to say he has found a GP he likes. It wasn't easy, but Josh said he was determined to find the right person for him so he contacted GP surgeries in his area and met with them to see how much they knew about his condition; if they were happy to talk to him about sex and relationships; and if he could see them when he wasn't feeling good within himself. He made sure the GP was happy to meet these needs.

With Josh's permission, you contact the GP to discuss preparation of a GP Management Plan. Josh asks you to organise a meeting with all his health professionals so everyone is aware of what they are doing during his transition. Because Josh cannot get around easily, you organise a teleconference, giving Josh the chance to talk to all his professionals at once. Josh also gets to hear who is responsible for what with his care.

Josh tells you that he and his family went to a picnic in his local community and it was great for his family to spend some time together. And he said it was free!

FINDING OUT MORE...

For more information about transition, see chapter 3.11 Chronic conditions and disability.

CHAPTER SUMMARY - WHAT TO REMEMBER

Collaborative care produces good health outcomes. For young people, a positive experience of being involved in making decisions about their health and wellbeing helps develop their confidence and their ability to engage in future help-seeking behaviours.

Collaborative care may, in fact, be essential when trying to address complex or psycho-social conditions which often emerge in adolescence.

In some cases, where the needs of the young person are particularly complex, a more proactive approach to aligning the health services and resources around the young person may be required through case management.

REFLECTION QUESTIONS

What does collaboration mean within your service?

Who do you collaborate with? Who should you be collaborating with and why?

Develop a pathways map to demonstrate the connections into, and beyond your service, from a young person's perspective.

What are you doing well? How are you effectively building relationships?

Are you falling into any pitfalls in collaboration?

What resources do you need to strengthen your collaboration and who is best placed to help address these needs?

Does anyone in your organisation perform a case management role either formally or informally?

REFERENCES

NSW CAAH. (2005). *Better practice in youth health: final report on research study Access to health care among young people in New South Wales Phase 2.* NSW CAAH: Westmead, NSW.

NSW CAAH. (2012). *Youth Health Better Practice Framework.* 2nd ed. NSW CAAH: Westmead, NSW.

2.4 USING TECHNOLOGY

FIONA ROBARDS

For many young people, the place they feel most comfortable and at ease is online. They form valuable relationships, express themselves freely and are comfortable finding out information and communicating using social media and other platforms.

Services supporting young people to be healthier and happier can use technology to engage with young people and to provide health information, advice and support, and even to provide clinical services.

Technology changes rapidly. Platforms, sites and applications (commonly referred to as 'apps'), that are popular today can be obsolete tomorrow. Rather than focus on specific technological options, this chapter focuses on helping you identify the sorts of services and interventions that health services can deliver using technology.

This chapter provides a broad overview of the ways that a service provider may engage young people using technology in a clinical context including health promotion and providing clinical services.

Young people tell us that it is important for professionals to engage them in the spaces where they are…and, overwhelmingly, young people are online. There are many reasons to think about delivering health information, support and even services to young people online:

- It is a cost effective way of reaching large numbers of young people
- Information is available 24 hours a day
- The web can be accessed anonymously and can be a non-threatening source of information for young people when embarrassing or sensitive issues are worrying them
- Information and advice can reach young people in areas where face-to-face services may not be available

There is a growing body of evidence supporting this way of working and an increasing number of good practice examples. However, many organisations continue to restrict access to the internet and other forms of technology because of a lack of infrastructure, concern about internet costs and a limited understanding of the benefits technology offers to young clients. This means the organisation is limited in the ways it can:

- Promote events and resources
- Promote services to young people
- Build community awareness about the organisation and its services
- Communicate and engage directly with young people.

NSW Government policies, such as the *NSW Youth Health Policy 2011-2016: Healthy bodies, healthy minds, vibrant futures*, emphasise the importance of technology in young peoples lives, and the need for service providers to find new ways to make services meaningful and attractive to young people. Being connected online means that organisations can connect widely and rapidly to promote their services. Organisations that are visible online gain increased credibility.

FINDING OUT MORE…

For more information about using technology for improved health outcomes for young people, see:

Campbell AJ & Robards F. (2012). *Using technologies safely and effectively to promote young people's wellbeing: a better practice guide for services*. NSW Centre for the Advancement of Adolescent Health: Westmead, NSW and the Young and Well Cooperative Research Centre: Abbotsford, Vic.

It is available from the Young and Well website www.youngandwellcrc.org.au

USING TECHNOLOGY TO PROVIDE INFORMATION AND SUPPORT

Despite some of the risks the internet brings, technology can also support young people's social and emotional development. Social media allow young people to maintain connections with friends and family and find out about their local community and the broader world. The internet is also a space where young people can experiment with their self-identity and how they express their identity to the world. There is also the potential to be exploring identities online when it may not feel safe to do so face to face – this can be important for young people experimenting or exploring their sexual identity.

There are many online databases of youth and health services available in communities across Australia. Some are very comprehensive and require teams of staff to maintain their accuracy and relevance. Search for your service's details online and ensure that information about your service is up-to-date so that young people seeking help and other service providers can find you.

Most services have a website. Websites can provide basic information about your service and how to access it, but websites are also a useful and non-threatening way to provide health information

to young people. Consider linking to fact sheets and including a 'frequently asked questions' section (this could include what to bring, the cost of the service etc.). Some websites give young people the opportunity to send in questions which are then answered by health professionals on the site.

Remember that information found on the internet can be a young person's main source of health knowledge. For this reason, ensure that any fact sheets, information or advice you provide online is evidence based and designed to encourage young people to seek support if they need it.

To make your website more dynamic, consider using videos and interactive content. You could think about creating a video from a visitor's perspective from the moment they walk through the front door. Workers could introduce themselves, saying a little about what they do. These ideas can help your service build a more youth-friendly online presence and begin to build an ongoing relationship with website visitors.

Social networking can also be a useful tool for service promotion. Social networking is most successful when it invites two-way communications rather than being used as a "bulletin board". Consider how you could facilitate discussion with young people using social media sites and services.

FAST FACTS

- 77% of young people with a mental health problem do not access the care they need (National Survey of Mental Health and Wellbeing 2007)
- 91% of 12-17 year olds indicated that the internet was a 'highly important' part of their life (ACMA 2008)
- Over 95% of young Australians use the internet (Ewing et al. 2008)
- The majority of young people spend between 1 - 3 hours per day on the internet (Burns et al. 2010)
- Online chatting was ranked at the most favoured leisure activity by young people (ACMA 2008)
- Mission Australia (2011) found more than 1 in 5 Australian young people aged 11-24 ranked the internet highly as a source of advice and support for concerns about sexuality, discrimination, body image, depression, and self harm.

BEFORE YOU BEGIN

When you are thinking about a new website or a social media presence for your service, there are five points to address before you even begin thinking about content, design or platform.

Ask yourself:

- What do you want to achieve?
- What kind of technology will best help you in what you want to achieve?
- How will you achieve your goals?
- What will be your key messages?
- How will you know you are successful?

Your answers to these questions will help you decide the best forum for your service (e.g. Facebook, Twitter, a website, somewhere else?) And what you should be doing online.

You can then:

- Involve young people in designing your website or presence so it appeals to a diverse group
- Direct young people to websites that have quality information
- Make sure the information you post is current, relevant and accurate – and keep it that way.
- Think about the best options for your service. You can create a Facebook page, for example, that does not allow comments to be posted. This is less engaging for young people, but a good option if you have limited resources to actively moderate the comments.
- Plan for privacy and confidentiality. For example, create a Facebook page that people can "like" rather than a profile page where "friends" are identified.
- Include useful information so that young people know about confidentiality, consent, the services and support you can and can't provide, and how to access help in an emergency.
- Keep the page or site updated regularly. If your service is closed for a period (for example, public holidays), post an update reminding young people about the closure and offering alternative points of contact for help in a crisis.

It is very important to maintain professional boundaries while using social media. The informality of online communication and relationships can make distinctions blurry for some people. Manage the privacy settings on your personal accounts and do not accept friend requests from clients. In the case of Twitter, it is not possible to control followers (except by blocking) and content is public. Content should be professional and clinicians should not in engage in identifiable discussions online.

FINDING OUT MORE...

For more information about staying safe online and combating cyberbullying, see:

The Cybersafety Help Button is an online resource hub that gives young people instant access to help and information on cybersafety issues. When the button is clicked, users are taken directly to a web page where they can talk, report or learn about cybersafety issues. Visit http://www.communications.gov.au/online_safety_and_security/cybersafetyhelpbutton_download

T he Cybersmart website has a range of t informaion and resources on online safety, at www.cybersmart.gov.au accessible

Taking Action, Keeping Safe (2005) is a resource provided to public schools in NSW which provides strategies and support materials for student leaders and teachers to increase students' knowledge and understanding of bullying. Find it at www.schools.nsw.edu.au

The NSW Department of Education & Communities provides advice on cybersafety; information on risks; online games to help students work out how to stay out of trouble; and a quiz to help students confirm if they are being cyber bullied. The Department has developed a resource entitled Cyberbullying: Information for Staff in Schools which identifies the impacts of cyberbullying and provides practical responses for teachers. It's available from www.det.nsw.gov.au/policies

Schoolatoz - The NSW Department of Education and Communities has also established a website aimed at parents and children which provides articles and instructional videos on cyberbul lying. Visit www.schoolatoz.nsw.edu.au

Childnet International - a multi-media cyber safety training program for teachers, parents and young people developed in consultation with young people. Visit www.childnet.com

The ThinkUknow cyber safety education program delivers interactive training to parents, carers and teachers through primary and secondary schools. Find the program at http://www.thinkuknow.org.au

eSmart is an evidence-based and tested system to help schools manage cybersafety and deal with cyberbullying and bullying. Visit https://www.esmartschools.org.au

Skoodle is a safe social network where 6-14 year olds experience first-hand how to keep themselves safe online. Find it at www.skoodle.com

USING TECHNOLOGY TO SUPPORT CLINICAL SERVICES

For some young people, even making contact with a health or youth service can be daunting. Many young people are ambivalent consumers of health care and want to check out a service and get to know them before 'signing up' for services.

Multiple points of contact will give them options for how they access your service, but when a young person takes that first crucial step to seek help, the way they do it must be comfortable for them. Methods of contact can include:

- Calling a mobile or landline number
- Sending an email to a service's email address
- Sending a text to a mobile number
- Completing an online contact form

If you are working with young people, give them options for how they can interact with your service.

Text messages can be helpful for appointment reminders. As always, find out whether this is the sort of service the individual would find useful and, if possible, give them the option to confirm the appointment or change it by text too. You should get their permission to send appointment reminders by text and let them know when they'll receive the reminder.

Also discuss what will happen if the young person sends a message that indicates they are at risk. Ensure your service has a protocol in place for responding to such an event.

Consider sending a text or email in between sessions as a form of encouragement, and as a way of maintaining contact and building rapport with the client.

PROVIDING THERAPY ONLINE

The use of technology to deliver counselling and mental health interventions online is growing. Many service providers use a chat service or email to work with their clients and it can be particularly appealing to young people.

Being online affords them a level of privacy or anonymity that they cannot achieve if they are face-to-face with a counsellor. However, there are limitations to this privacy that must exist. As in any therapeutic encounter, confidentiality cannot be kept when a young person is at risk of causing significant harm to either themselves or others. In these instances, safety is more important than confidentiality. Ensure that your service has a clear protocol about how to handle such situations.

If you intend to offer therapy online, you will need to find a way to record interactions with your clients,

whether you store the files electronically or in a paper-based system. Ensure that electronic files are secure, just as you would with paper-based records of counselling. Access to records can be ordered by a court. Make sure that young clients understand that your files include details of all interactions, face-to-face and online.

In an online group therapy setting, young people may not realise that what they say over time may lead to them being identifiable. Group rules around confidentiality and privacy need to be discussed and made clear as it is in offline group therapy settings.

When contacting a client via email, phone, or messaging system, be mindful that there is a potential that other people may see the communication. Limit the details of the message so that you maintain the young person's confidentiality. Discuss this aspect of confidentiality with young people and encourage them to actively protect their own confidentiality by logging out, not sharing passwords and keeping their mobile devices with them.

Consent for treatment can be gained online or via the phone, and does not need to be obtained face-to-face. Be aware that this means you cannot verify the identity of the person.

As in any health service, a practitioner needs to be aware of when to refer on if a more intensive service is required. They should also negotiate a crisis management plan with a young person, should this be needed. Information about crisis services should be included on out of office replies, email signatures, and service websites.

PRACTICE POINTS FOR ONLINE THERAPY

Establish clear expectations about communication and availability: provide a time-frame for responding to emails or text messages; let young people know your days and hours of work; and provide crisis contacts in case you cannot be contacted.

When counselling online, you won't have access to the range of non-verbal cues you would in a face-to-face session. Be very aware of the tone of your messages and the language you use: keep it clear and jargon-free.

Check regularly that what you are hearing is what the young person is saying and that they are hearing your messages clearly too. Use emoticons to indicate tone and facial expression.

Remember that emails are a legal record of conversations.

USING ONLINE TOOLS AND PROGRAMS

There is a wide range of tools and programs available on the web that services can consider using with young people. Online treatment programs can be useful as a stand-alone treatment option; as a "stop-gap" measure while a young person waits to see a therapist; or as an adjunct to therapy. A young person who finds it difficult to talk about his or her experiences, feelings and concerns might prefer an online therapeutic tool.

E-couch is a self-help interactive program with modules for depression, generalised anxiety and worry, social anxiety, relationship breakdown, and loss and grief. It provides evidence-based information and teaches strategies drawn from cognitive, behavioural and interpersonal therapies as well as relaxation and physical activity. Visit ecouch.anu.edu.au

Mood Gym is an interactive web program that teaches the principles of cognitive behaviour therapy and is designed to prevent depression. It consists of five modules, an interactive game, anxiety and depression assessments, downloadable relaxation audio, a workbook and feedback assessment. Visit moodgym.anu.edu.au

Become familiar with the range of online tools available for your clients and offer ideas about how the tool might be used. For example, if you think it might be useful for a young person to monitor and track their moods, talk with them about whether they might prefer to use an online tracking program (like those available at www.medhelp.org) or an app on their phone or tablet (like Moody Me).

You can demonstrate how a program works by using a test login. Ask clients how they are going with the online treatment program and provide encouragement. Also ask for feedback about the online tool so you can better recommend it to other young people: for example, "Young people who have tried this program have told me that it was particularly useful for…"

Other useful Australian programs and sites include:

- Headspace online counselling service provides online and telephone support and counselling to young people aged 12 to 25. It is a confidential, free, anonymous, secure space where young people can chat or email qualified youth mental health professionals. Visit www. eheadspace.org.au
- Kids Helpline provides free, private and confidential, telephone and online counselling service specifically for young people aged between 5 and 25. Visit www.kidshelp.com.au
- Virtual clinic (which provides online treatment programs for anxiety and depression). Visit www.virtualclinic.org.au
- Mood swings (an online self-help tool for people with bipolar disorder). Visit www.moodswings.net.au
- On Track (free access to online programs, information, quizzes and advice to promote mental and physical health and wellbeing).Visit www.ontrack.org.au

FINDING OUT MORE...

Beacon is an online Hub for health and wellbeing websites. A panel of health experts provide guidance about websites for mental and physical health. www.beacon.anu.edu.au

Reachout Pro provides access and advice for health care professionals on a range of technologies and online resources that can be used to enhance the effectiveness of psychosocial support and mental health care provided to young people. www.reachoutpro.com.au
The Young and Well CRC explores the role of technology in young people's lives, and how technology can be used to improve the mental health and wellbeing of young people aged 12 to 25. www.yawcrc.org.au

CHAPTER SUMMARY - WHAT TO REMEMBER

Most young people are extremely comfortable using a variety of technologies and platforms to communicate, build relationships, transact and find information. Using technology effectively gives services an opportunity to engage with young people in a space and mode that is familiar and feels safe for young people.

There are a number of factors to consider when using technology for health promotion, to promote services, or to provide clinical services directly to young people, but these issues do not outweigh the benefits of using technology effectively when working with young people.

REFLECTION QUESTIONS

How do you use technology?

How do the young people you work with use technology?

How well do you use of technology to engage young people?

What areas of your service might be enhanced by using technology?

What do you need (Knowledge? Skills? Something else?) To use technology more effectively?

What are the barriers to using technology more effectively in working with young people? How can you overcome them?

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SECTION THREE

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SECTION 3.1

YOUTH-FRIENDLY COMMUNICATION

3.1 YOUTH-FRIENDLY COMMUNICATION

PETER CHOWN

Working with young people requires an understanding of the unique emotional, psychological and cognitive changes of adolescence. Young people vary enormously in age, developmental stage and cultural background. The approach you adopt with a younger adolescent may be very different from how you would deal with an older adolescent.

Good communication skills are essential for working effectively with both the young person and their family. The challenge is finding the balance between working with the young person within the context of their family and their culture and respecting the young person's developing identity and independence.

BUILDING RAPPORT

Building rapport with the young person (sometimes called engaging) is a crucial first step in developing a trusting relationship (Bennett and Kang 2001).

Many young people will be anxious or nervous about seeing a service provider for the first time: they may be worried about what you will think, concerned about their own health, fearful of their parents' finding out, or they may have previously had negative experiences with health care providers. Warmth, openness and some time spent building rapport will help you to better connect with the young person.

Building rapport (and, through that, a relationship) is an ongoing process. It may take some time for a young person to feel comfortable and to trust your relationship with them. However, the initial meeting sets the tone for future interactions. Goals for the first meeting may be to:

- Successfully engage the young person
- Clarify confidentiality
- Highlight some of their key concerns/issues
- Make a follow-up appointment

When engaging young Aboriginal or Torres Strait Islander people, find out about their cultural identity, as this is a major protective factor and help to promote their overall wellbeing. You can do this by acknowledging country and enquiring about local cultural attributes such as language.

Spending time in the first session building rapport with the young person makes it much more likely they will return for another appointment where you can begin to go into issues in greater depth.

PRACTICE POINTS

If you want to develop good rapport-building skills, work on:

Understanding adolescent developmental issues

Acquiring effective communication skills

Understanding relevant medico-legal issues

Becoming familiar with strategies for working with young people and their families

Understanding the cultural factors that can influence a young person's sense of themselves and their role in the family and the community

Understanding different cultural concepts of health. For Indigenous people, for example, health is an inseparable part of spiritual, cultural and social wellbeing, with the wellbeing of the individual, family and community inextricably linked.

THE FIRST MEETING

Some young people will be accompanied to their appointments by a parent, carer or family member. The support provided by an older family member or carer can be reassuring for some young people. Seeing the parent and young person together is important because it allows you to assess their relationship and observe how they interact with each other, and it gives you the chance to facilitate communication between the parent and young person.

SEEING THE YOUNG PERSON ALONE

However, most practitioners find it beneficial to meet with the young person alone for some time during the appointment. There is a balance to be struck between the need to engage the young person in a confidential relationship and the need to involve the parents or carers, who are usually the main caregivers and source of physical and emotional support (Sanci et al. 2005).

Speaking with the young person alone at some point provides:

- A way of acknowledging the young person's growing independence and need for privacy
- An opportunity to develop a relationship with them as an individual
- A chance for the young person to raise issues that they may be reluctant to discuss in front of a parent

- An opportunity to assess their developmental stage, check for risk behaviours, and provide preventive health information/education

Of course, it will not always be appropriate or necessary for you to meet with the young person alone. The decision to see the young person alone will depend on:

- The age and developmental stage of the young person – with younger or particularly immature young people, and young people with cognitive impairment, it may not yet be appropriate to see them by themselves. More involvement with parents or carers may be needed
- The nature of the relationship between the young person and their parents or carers
- The nature of the presenting problem – it may be necessary to involve parents where the consultation concerns major life decisions (even if it is against the young person's wishes)
- Whether it is considered appropriate culturally for you to be alone with the young person

In some cultures, a young person may continue to be seen as a 'child' well into adulthood. Some cultures also have strong rules around women being in the presence of men without a chaperone. In some of these circumstances, it may not be appropriate for you to see the young person alone. You can raise the issue of seeing the young person by themselves and work towards this over time:

- Develop trust and rapport with the family
- Sensitively negotiate with them about seeing their young person alone
- Identify options that might be acceptable to the family
- Respect the parent's and young person's wishes not to be seen alone
- Explain your role and how seeing the young person alone will benefit the provision of health care to him/her

Gender may also play a role in the young person's willingness to talk with someone outside his or her own culture. Let the young person know that you understand this and that they can decide what they want to share.

STARTING TO TALK

In the absence of complicating factors, set the expectation early in the appointment that you will see the young person by himself or herself at some point in the meeting.

Example: "Mrs Smith, I'd like to talk with you both at first to get an idea of what the concerns are for each of you. Then I'd like to talk with Johnny alone for a few minutes, just to get to know him a bit better so I can work out how best to help him. I've found that it helps teenagers learn how to communicate with adults better about their concerns."

Begin by asking both the young person and the parent their reasons for attending. Listen to the parents' concerns and acknowledge that you have heard and understood their perspective.

When you are negotiating to see the young person alone, communicate sensitively and directly both to parents and the young person about the need for more or less parental involvement. Frame the decision to see the young person alone in a positive way – e.g. that it is a sign of healthy development for the young person to begin to establish an independent relationship with the service provider. However, in the end it is important to respect the wishes of the parent or young person should they not want the young person to be seen alone.

After you have spoken with the young person alone, see the parent after the interview with the young person to wrap up, and discuss management and follow-up issues – ensure that you have discussed this with the young person and clarified what they are comfortable with you discussing with their parents.

EXPLAINING CONFIDENTIALITY AND ITS LIMITS

Research has consistently found that young people rate confidentiality as the most important element in consulting a practitioner. Explain the terms of confidentiality, and its limits, to the young person at the initial meeting. It is an essential part of the rapport-building process.

Young people are frequently worried that what they say will get back to their parents, friends, or the school. Let them know that information they discuss with you will be kept confidential.

Remember that you may need to explain the meaning of the term 'confidentiality'. Explain that it may be necessary to share some information with other professionals in order to provide the best possible care – stress that you would ask their permission before doing this and that other staff will also keep their personal information confidential.

You may need to reassure the young person about confidentiality at subsequent meetings – especially if you are dealing with sensitive issues such as drug use, sexuality, or mental health problems.

You will also need to explain to the young person that there are three main circumstances where it may be necessary to breach confidentiality for the young person's safety:

- If the young person is at risk of harming or killing themselves
- If someone else is threatening or harming them (e.g. physical, sexual or emotional abuse)
- If the young person is at risk of physically harming someone else (e.g. assault; abuse)

It is helpful to have a format for explaining confidentiality that enables you to discuss it in a way that feels natural and reflects your own style.

Example: "Rebecca, I like to explain to all the young people I talk with that what we talk about is confidential – that is, it's private. I won't tell anyone what you discuss with me – including your parents – unless you give me permission to do so. There are, however, a few situations where I might need to talk to other people if I believe that you are in danger in any way. For example: if I'm worried that you might harm yourself or someone else; or if I feel like you are being harmed or at risk of being harmed by somebody else it would be my duty to make sure that you are safe. I would always talk to you about it first before contacting anyone. Does that sound okay to you?"

If a cultural consultant such as an Aboriginal health worker participates in a consultation, the other service provider needs to check that they are informed about the risks associated with accidental breaches of confidentiality. Confidentiality can be accidentally breached if you or another staff member contacts the young person at home. Ask the young person about the best way to contact them for reminders. Give them options for contacting you.

FINDING OUT MORE...

Learn more in about confidentiality in chapter 3.5 Medico-legal issues.

After discussing confidentiality, ask the young person how he or she feels about coming to see you:

"Young people often feel a bit nervous the first time they see a professional. I'm wondering if you have any concerns or worries about coming to see me today?"

If the young person has come to see you alone, compliment them for their initiative. Ask about their reasons for coming to see you. Start with an open-ended question such as:

"How can I help you today?"

Or:

"Your mother mentioned a number of things that she's worried about, but I'm wondering what things you would like to talk about today."

Summarise their parent's version of the problem and enquire how they feel about that:

"Your mother said that you've lost interest in school and your friends. She's worried that you might be depressed. I'd really like to hear what you think about that and how you see what's going on."

Young people may not perceive that they have a problem at all, or they may define the problem very differently from their parents. Explore the presenting problem with a focus on the young person's point of view. While you are talking, try to get a picture of the young person within the context of his or her family, school and social life. Talk about how the presenting problem relates to other things that may be happening in their life.

Identify and agree upon which issues, if any, should be discussed with the young person's parents or carers and decide how to do this.

CASE STUDY: BUILDING RAPPORT WITH MICHAEL

Michael, a 16-year-old boy, is brought in by his youth refuge worker. He is having trouble with his parents and has been staying in a youth refuge for the past two weeks. He appears reluctant and agitated and stares at the floor while the refuge worker explains why he has brought Michael in.

Rather than launching straight into trying to identify his problems and concerns, you acknowledge his willingness to come to the appointment and the discomfort he is feeling. You ask him if he wants his youth worker to stay in the room or to leave. Michael asks him to leave.

1. Adopt a 'person-centred' approach rather than a problem-centred approach – this means focusing on the young person in the context of their life and relationships – as opposed to a narrow focus on the 'problem'

2. Respond to the young person's initial reactions with empathy and by making a reflective statement. For example:

"Michael, I understand that you might be feeling uncomfortable about coming to see me today."

Or:

"I know that it's difficult to talk about personal issues to someone you don't know. Are there any questions you'd like to ask me about what's going to happen today?"

3. Reassure him about confidentiality and discuss any concerns he has about this

4. Follow this up with a statement that gives the young person a sense of choice and control about the direction of the interview. For example:

"Michael, I can see that this is difficult for you. Let's see if we can use this time together to identify any concerns you have about your health or family situation right now and to explore how I might help you with any problems happening in your life. Perhaps there are some questions you'd like to ask me about how I work and what I can do for you."

5. Show interest in the young person – find out about his home and school life, and his interests. Ask about his interests and what it's like for him living in the youth refuge:

"Tell me a little bit about yourself…"

Or:

"What are your interests? What do you like to do in your free time?"

You can follow this up with specific questions about home, school, friends, activities, etc.

6. Identify and compliment the young person on areas in their life that are going well

7. Adopt a relaxed, unhurried, open and flexible approach – remember your goal is not necessarily to solve their "problem" – this can lead prematurely to a management plan that the young person may not see as relevant to them and their situation

"Michael, I'm happy to go slowly and use the time today to get to know you a bit until you feel more comfortable talking with me – unless there is something really important or urgent that you'd like to talk about today. How is that for you?"

By showing your genuine interest in them as a person, you will be laying the foundation for a trusting relationship in which the young person feels safe to disclose areas of concern and allow you to help them address these issues.

FINDING OUT MORE...

See chapter 3.2 Psychosocial assessment for a structured approach to gathering information.

COMMUNICATION AND DEVELOPMENTAL STAGES

In Section 1, we explored the different stages of development and how the concerns of young people change as they move through adolescence. Understanding the developmental stage of the young person you are speaking to helps you to ask questions, offer information and give explanations that are developmentally appropriate.

For example, younger adolescents are more concrete in their thinking and may need more specific questions rather than general ones:

Example:

"What are your best or worst subjects at school?"

Rather than:

"How is school going?"

Remember that the psychosocial changes of adolescence may be different for young people from culturally and linguistically diverse (CALD) backgrounds.

FINDING OUT MORE...

This might be a good time to review chapter 1.1 Adolescence – a developmental perspective.

TABLE 2 – COMMUNICATION PRACTICE POINTS BY DEVELOPMENT STAGE

	Early adolescence (10 – 14 years)	Middle adolescence (15 – 17 years)	Late adolescence (> 17 years)
Central question	**"Am I normal?"**	**"Who am I?" "Where do I belong?"**	**"Where am I going?"**
Communication practice points	• Reassure about normality • Ask more direct questions than open-ended questions • Make explanations short and simple • Base interventions on immediate or short-term outcomes • Help identify possible adverse outcomes if they continue undesirable behaviours	• Address confidentiality concerns • Always assess for health risk behaviour • Focus interventions on short to medium term outcomes • Relate behaviours to immediate physical and social concerns – e.g. effects on appearance, relationships	• Ask more open-ended questions • Focus interventions on short and long-term goals • Address prevention more broadly

COMMUNICATION SKILLS FOR WORKING WITH YOUNG PEOPLE

Be yourself throughout the consultation while maintaining a professional manner. Young people expect professionals to be authoritative, but not authoritarian.

- Adopt a straightforward and honest approach
- Use plain language
- Avoid technical terminology and jargon
- Remember that communicating effectively requires you to be aware of cultural differences between you and the young person
- Be aware of the differences in literacy levels between Indigenous and non-Indigenous Australians as they can affect communication and outcomes
- Use resources specifically developed for Indigenous young people and young people from CALD backgrounds
- Don't always rely on written information. Use alternative forms to communicate that are effective, such as social media campaigns
- Present information in a balanced way
- Respect privacy and cultural protocols
- Pay attention to non-verbal as well as verbal cues

Most experienced practitioners who work with young people find a participatory communication style works well for them. They work collaboratively with the young person, having a conversation rather than asking a series of interrogative questions.

Participatory communication involves a two-way exchange of information. Ideally, the young person would do most of the talking but it can take some time for a young person to feel confident and comfortable enough to speak freely. You can help build the conversation by:

- Giving feedback and letting the young person know what you are thinking
- Asking them for their ideas about their problems and what to do about them
- Involving them in the decision-making and management process
- Encouraging them to ask questions

Example:

"Michael, I understand that talking about these issues is difficult for you. Would it be all right if I ask you some questions about what is happening at home with your parents? This will help me to get a better understanding of the pressures you are dealing with. Perhaps then together we can look at some ways that might help you to cope better with this situation. How does that sound to you?"

Other ideas:

- Take a one-down approach and let the young person educate you:

  Example: *"I'm not sure if I've got this right…..was it a bit like….?"*

- Provide reassurance – this helps to validate the young person's feelings and establish your role as an advocate for them:

Example: *"I understand that you sometimes get frustrated with your mum. Perhaps I could talk with you and mum together to look at ways that the two of you might work out your disagreements better."*

While it is important to be non-judgemental about the things a young person reveals to you, you should not condone risky behaviour. Share your concerns about any risky behaviour they are engaged in and provide information about the health risks of these behaviours. This keeps the discussion focused on the known (evidence-based) risks associated with the behaviour rather than a judgement of the young person for engaging in the behaviours.

FINDING OUT MORE...

To learn more about how and why some young people engage in risky behaviours, see chapter 3.3 Understanding risk-taking behaviour.

SPECIFIC INTERVIEWING AND QUESTIONING SKILLS

Young people may not disclose the problem for which they are most in need of assistance until trust and rapport have been established. It may also be the case that some people have cultural beliefs or customs that discourage them from disclosing personal information or discussing "family problems" with other people.

To work towards the best possible outcome for the young person, you will need to allow plenty of time and use some specific communication skills.

ACTIVE LISTENING

Active listening means not just hearing the words that are said, but understanding the full message that is being communicated. To be an active listener, you need to:

- Pay full attention to the person who is speaking (including listening to their body language)
- Show that you are listening (through your posture, acknowledgements, verbal and non-verbal encouragement)
- Provide feedback (by checking for meaning, paraphrasing and asking questions)
- Avoid judgement (allow the speaker time to finish, don't interrupt with your opinion or facts)
- Respond appropriately (be open, honest, clear and respectful)

For example, Alice has come to see you and, when you ask how she is, she tells you that she is fine. Yet you notice Alice is slumped in her chair, her eyes are downcast, and she speaks very quietly. You might respond by saying:

"Alice, you said that you're feeling fine, but you seem a bit down today. I'm wondering if you're feeling a bit sad or depressed and what's happened for you this week..."

PARAPHRASING AND REFLECTING FEELINGS

Paraphrasing involves summarising – or restating – what the young person has said in your own words. Paraphrasing helps you to clarify what the young person has said and to check the accuracy of your perceptions

Reflecting the feelings they are expressing (consciously or unconsciously) can be a useful technique for building rapport and for helping the young person to understand what they are experiencing.

Both these skills demonstrate acceptance and understanding of the young person and their situation.

Example:

"Alice, you've said that you don't seem to be able to get on with the other kids at school and that no-one seems to understand you..." (Paraphrase)

"...It sounds like you're feeling really sad and angry about this." (Reflection of feelings)

QUESTIONS

Asking questions can be a way to get conversation started, but it is also how we elicit specific information. Because we want to engage the young person in a participative interview rather than an interrogatory interview, it is useful to use a range of questioning techniques.

Before you begin, explain and normalise the process of asking questions as your usual practice:

Example:

"I like to ask all the people I see about their family background (lifestyle, school, etc.) in order to get a better understanding about how these things may be affecting them..."

Young people feel more in control if you ask for their permission or consent to ask questions. Try:

"I'm concerned that you seem to be very down today – would it be okay if we talk about what's going on?"

"In order for me to work out the best way to help you, I need to know a few things. Would you mind if I asked you about your sexual relationship with your boyfriend?"

TABLE 3 - QUESTION STYLES

Questioning style	When, how and why to use it
Open-ended	This style encourages the young person to talk about themselves, rather than simply giving a 'yes' or 'no' answer. It enables the young person to express their thoughts and feelings about their situation. Open-ended questions are also very useful in exploring alternatives and assisting the young person with decision-making Try to avoid 'why' questions – these can put the young person on the defensive. Rather, help them to describe thoughts, feelings and events by asking 'what', 'how', 'where' and 'when' questions. Examples: *"How do you get along with your parents?"* *"What's happened in the last week that's made you feel like you want to leave school?"* *"What did you think when your parents told you that you had to see me?"* *"When you are feeling really sad or down, what do you usually do to cope?"*
Probing questions	These questions are less open-ended and more direct. They are useful with younger adolescents who are more concrete in their thinking, and with young people who are not talkative. Examples: *"What do you like/dislike about school?"* *"What are your best/worst subjects at school?"* *"How do you get along with your teachers at school?"*
Insight questions	These questions ask the young person to think about their experiences and describe abstract feelings or concepts. They are useful in getting a broader sense of the young person in the context of their life experience. They also help you to establish rapport with the young person, and give an insight into how the young person sees himself or herself. Examples: *"What things do you do well?"* *"How do you feel about yourself most of the time?"* *"What do you like most about yourself?"* *"If I were to ask your friends, how do you think they would describe you?"* *"If you had three wishes, what would they be?"* *"If you could describe in one word how you feel about your life right now, what would it be?"* *"What do you want to do when you finish high school?"* *"What are your main interests?"*
Scaling questions	Scaling questions ask the young person to give a rating on a scale. They can be useful to elicit information about feelings or moods, or for describing the severity of a problem. Examples: "On a scale of 1 to 10, where 1 is really calm and chilled-out and ten is out-of-control angry, how angry have you felt on average over the last week?" "On a scale of 1 to 10, how bad is the pain right now?" They can also be used to draw comparisons and to help the young person monitor their progress towards their goals. Examples: "On a scale of 1 to 10, with one being the worst you feel and ten being really great and positive, how would you rate your mood today?" "On a scale of 1 to 10, where 1 means little or no control and ten means total control, how would rate your control over your anger since I last saw you?" "What would it look like being at (one point higher)? What would be different?"

> **FINDING OUT MORE...**
>
> For more information about asking sensitive questions see chapter 3.2 Psychosocial assessment.

SUPPORTING YOUNG PEOPLE WITH A DISABILITY

Disability can have a significant effect on the psychosocial development of a young person and their ability to engage in social activities, recreation and employment (Groce 2004 in AIHW 2010).

Some studies have indicated that people with disabilities have higher rates of risky behaviours such as smoking, poor diet and physical inactivity (WHO 2011).

A young person with a disability may be accompanied by a parent, carer or support person; however it is important to talk directly to the person with the disability and to see the young person alone.

Additional factors to consider when conducting a psychosocial assessment with a young person with a disability include their communication capabilities, mobility levels, and self-care ability.

To communicate with young people with an intellectual disability, Easy English is recommended (as opposed to standard English). You can find more information about Easy English at www.scopevic.org.au/index.php/site/resources

The young person may also have a communication system with which they feel comfortable (for example, pictographs).

Young people with an intellectual or developmental disability, like all adolescents, experience physical and psychological changes. Adolescents may experience strong sexual feelings for the first time, and many adolescents with an intellectual or developmental disability will not have the maturity and social skills to cope with these feelings appropriately. Immature sexual curiosity may lead to embarrassing behaviour such as masturbating in public or inappropriate touching of other people. Such behaviour can make an adolescent with a disability vulnerable to abuse.

People with intellectual disability encounter challenges in learning and applying knowledge and in decision-making. They often have difficulty adjusting to changed circumstances and unfamiliar environments and therefore need high support during times of change (Western Australia Ministerial Advisory Council on Disability 2006 in AIHW 2008). Two of the most significant transition points for young people with a disability are from home to school and from school to adult life – work, post-school study and participation in meaningful activities (AIHW 2008).

Begin to foster an independent relationship with the young person as early as possible in their development. As always, raise the issue of spending "time alone" and confidentiality early with both the parents/carers and the young person, mentioning it as part of routine practice, but acknowledging that the involvement of parents is appropriate at present.

Building a strong relationship with a young person with a disability will enable you to help the young person acquire the knowledge and skills to become an informed health consumer who can make informed decisions.

> **FINDING OUT MORE...**
>
> You can learn more about working with young people with a disability in 3.11 Chronic conditions and disability.
>
> Family Planning NSW has an extensive Disability Resource Collection for sexual education, which is available for loan: www.fpnsw.org.au
>
> Other states may have similar resources available from their State Family Planning Service.
>
> The Better Health Victoria website has information on adolescent sexuality and disabilities – www.betterhealth.vic.gov.au

WORKING WITH CHALLENGING YOUNG PEOPLE

Some young people are resistant or angry because they have been coerced into attending an appointment or assessment. They may be silent and withdrawn. Regardless of how they present, your goal is still to build rapport and give the young person every opportunity to open up.

Remember that off-putting behaviour – such as monosyllabic answers or hostile body language – may be a normal response in the context of their developmental stage, and the circumstances by which they have come to see you. Such behaviour may also be a reflection of their anxiety or nervousness about engaging with the health system.

Your attempts to engage them will be more successful if you aim to validate their feelings and experience, rather than struggle with them for cooperation.

Example:

"My guess is that you're not too happy about being here today and that you're unsure about what is going to happen..."

Of course, different adolescents will respond to different approaches. Here are some strategies for engaging uncommunicative or resistant young people:

- Use reflective listening – make a reflective statement to acknowledge and validate their feelings. For example:

  "I imagine it must feel quite strange to have to come along and talk to someone you don't know about your problems…"

  "I guess you must be wondering how seeing me is going to help you…"

  "You seem pretty upset about being here, but I sense you're also feeling pretty down about some things in your life right now…"

- De-personalise – Start with a less personal focus by using a narrative approach:

  "Tell me what it's like being a teenager in the world today"

  "What do young people think about coming to see a health professional?"

- Use multiple choice questions – offer choices within a question or sentence and invite them to agree or disagree:

  "When that happened I imagine that you might have felt sad/angry/confused/hurt/scared. Can you remember how you felt?"

- Try sentence completion – use unfinished sentences based on what you know about the young person and their situation to help them express themselves. Ask the young person to complete the sentence:

  "Your father was shouting at you and you were thinking…"

  "And so you felt…"

  "And after that you decided to…"

  "When your mother insisted that you come here today, your first response was to…"

  "Then when you realised you had to come, you thought…"

- Use comparisons – form comparisons in a question to elicit a response:

  "Do you feel better or worse about yourself than you did before this happened?"

- 6. Use 'Imagine' questions – these can be particularly useful when the young person repeatedly responds with "I don't know":

  "Just for a moment, imagine what you would have been thinking when the teacher kicked you out of the classroom….."

- 7. Offer normalising questions or try the third-person approach – by reducing the personal focus of your questions, you can normalise their behaviours and begin to indirectly explore the young person's concerns:

  "Many young people your age experience problems with their parents. How do you usually get along with your parents?"

  "Some young people your age are starting to try out alcohol or drugs. I'm wondering if any of your friends have tried these. What about yourself?"

FINDING OUT MORE...

A range of resources for health professionals working with young people and useful links can be found at the NSW Kids and Families website – www.kidsfamilies.health.nsw.gov.au

The Centre for Adolescent Health, University of Melbourne – provides training, research, resources and distance education programs in Adolescent Health – www.rch.org.au/cah

Another useful resource is McCutcheon LK, Chanen AM, Fraser RJ, Drew L. and Brewer W. (2007).Tips and techniques for engaging and managing the reluctant, resistant or hostile young person. Medical Journal of Australia, 187 (7 Suppl.), S64-S67.

PRACTICE POINTS

- Spend time building rapport with the young person: give them a reason to trust you
- If the young person is accompanied by a family member, make sure you spend some time with the young person alone
- Discuss confidentiality and privacy with the young person
- Communicate in a way that is appropriate to the developmental stage of the young person

- Be sensitive to and respect cultural difference when seeing young people from culturally diverse backgrounds
- Adopt a non-judgemental perspective
- Take a comprehensive approach to youth health and wellbeing: where you can, conduct a psycho-social risk assessment to identify broader concerns in the young person's life
- Involve the young person in developing and deciding on any management or treatment plan
- Decide with the young person which issues to discuss with parents/guardians
- Address the concerns of the young person's parents and involve them wherever it is appropriate

CHAPTER SUMMARY – WHAT TO REMEMBER

Communicating with young people takes time. Young people need to feel safe to share information before they can open up. You can help them reach this point more smoothly by taking the time to build rapport and investing in understanding the young person, their family and their view of the world.

There are a variety of basic and more advanced communication skills you can employ to help you build rapport and learn about the young people you are working with, but treating the young person with respect, empathy and openness will start the process well.

REFLECTION QUESTIONS

How well does your service engage with young people? How do you know?

What are some of the difficulties and barriers you experience in communicating and engaging with young people?

What concerns do young people who attend your service have about privacy and confidentiality?

What training do you need to strengthen your communication and engagement skills with young people?

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SECTION 3.2

PSYCHOSOCIAL ASSESSMENT

3.2 PSYCHOSOCIAL ASSESSMENT

PETER CHOWN

Psychosocial and behavioural concerns are the major cause of health and social problems in young people. A systematic process for assessing a young person's psychosocial status and identifying underlying health concerns and risk factors can help practitioners provide the best possible care.

The HEEADSSS screening tool allows you to conduct a comprehensive psychosocial assessment of the young person (Goldenring and Rosen 2004; Klein, Goldenring and Adelman 2014). It helps you elicit relevant information about the young person's functioning in key areas of their life in a systematic and engaging way.

As we identified in Section 1, many of the major health issues facing young people are psychosocial. Any health assessment of a young person should take into account the range of factors affecting their health and wellbeing. One of the most effective ways of developing a good picture of a young person's health and wellbeing is to use a structured process, such as the HEEADSSS screening tool.

HEEADSSS is a framework, not a formal interview. It is not a checklist but an approach you can apply responsively to the needs of the young person.

The HEEADSSS assessment is not just an exercise in information gathering. It is important that you listen carefully to the young person's verbal and non-verbal responses. Explore in more detail any areas of ambiguity and any area where you identify a risk – especially in sensitive areas such as drug use and sexual activity.

You may not have time to cover all of the HEEADSSS domains in the one interview. If some areas take more time, explain to the young person that what they are telling you is important and make another time to explore further with them.

KNOW YOUR YOUTH HEALTH RESOURCES

A psychosocial assessment takes into account the complex and often layered nature of many youth health issues. Addressing some of these problems will require a collaborative and multidisciplinary approach with referral to other youth health or youth services professionals.

Establish a database and begin developing relationships with other local services supporting young people in the area. Include youth-specific resources, (such as youth health centres, youth refuges, hospital-based adolescent units, and headspace centres) and mainstream services that may be relevant to young people's needs (alcohol and drug services, sexual assault services, adolescent mental health services, family counselling programs, psychologists and social workers, and schools and vocational training programs).

FINDING OUT MORE...

Learn more about collaboration in chapter 2.3 Collaboration and case management.

USING HEEADSSS AS A SCREENING TOOL

The HEEADSSS categories reflect the major domains of a young person's life and the risks to their health and psychosocial status:

H– Home
E – Education & Employment
E – Eating & Exercise
A – Activities & Peer Relationships
D – Drug Use/Cigarettes/Alcohol
S – Sexuality
S – Suicide and Depression
(including mood &possible psychiatric symptoms)
S – Safety (also Spirituality)

It can be used to (Sanci 2001):

- Develop rapport with the young person while systematically gathering information about their world
- Guide enquiry into different areas of the young person's life in a non-judgemental way
- Move questioning smoothly from relatively 'safe' to more sensitive areas
- Perform a risk assessment and to screen for specific risk behaviours and underlying risk and protective factors
- Determine the current degree of risk (e.g. low, moderate, or high) and identify areas for intervention and prevention (young people at low risk require health promotion messages that are preventative in nature while young people at moderate or high-risk require more intensive interventions).

WHAT HEEADSSS WILL AND WON'T TELL YOU

At the end of the HEEADSSS assessment, you should have a profile of:

- The young person's psychosocial health
- The overall level of risk of the young person
- Specific risk factors in their lives – as well as protective factors and strengths
- Areas for possible intervention

This information will serve as a guide to intervention and providing health education.

The HEEADSSS assessment will form part of your overall comprehensive assessment of the young person – supplementing other information you gather in your initial contacts with the young person.

The HEEADSSS assessment can be used to systematically ask a young person about risk-taking behaviours and to identify social and environmental risk factors in their lives. It is equally important to develop a picture of the young person's protective factors and strengths, so you should also ask about:

- Family history
- Cultural background
- Recent life events (e.g. change of schools; separation of parents; death of a relative; migration history; etc.)
- Coping skills
- Medical and psychiatric history
- Available support systems
- Personality factors

This will enable you to plan appropriate interventions aimed at reducing risk behaviours, modifying risk factors and strengthening protective factors.

FINDING OUT MORE...

Learn more about young people and why they take risks in chapter 3.3 Understanding risk-taking behaviour.

ASKING SENSITIVE QUESTIONS

The HEEADSSS format is designed to start with less sensitive areas of a young person's life and move towards more sensitive areas.

For some young people, however, the first domain (Home) can be a difficult and highly sensitive area:

- There may be conflict or violence in the home environment
- Young people from CALD backgrounds may initially feel uncomfortable talking about their parents and other family issues
- They may think that they do not have the right to complain or fear being perceived as complaining about their parents
- Some young people may be living in out of home care arrangements

Young people are often more willing to engage with these topics if you seek their permission to ask sensitive questions:

Example:

"I'd like to ask you a few personal questions. You don't have to answer them if you don't feel comfortable. The reason I want to ask you these is because it will help me to get a picture of your life and your overall health and give you a chance to talk about any things that you might be concerned about. Remember that anything we discuss will be kept confidential. Is it OK if I ask you some more questions?"

You can use the third-person approach, which normalises the process of what you are doing and lessens the impact of sensitive questions:

Example:

"Many young people your age are beginning to experiment with drugs or alcohol (or sex). Have you or any of your friends ever tried these (or, had a sexual relationship)?"

"Sometimes when people feel very upset they can think about hurting themselves. Have you ever had any thoughts like this?"

Progress from neutral to more sensitive topics – for example, if the young person mentions that they have a boyfriend or girlfriend, a further question might be:

"Can I ask what his/her name is? How long have you been going out with him/her? Has the relationship become more sexual? Have you thought about having sex?"

When exploring the area of sexuality, don't assume the young person's sexual orientation, enquire about both opposite and same-sex relationships, and adopt a gender-neutral and non-judgemental approach:

"Have you ever had a relationship with a boy or girl or both?"

FINDING OUT MORE...

See chapter 3.1 Youth-friendly communication for other ways to ask questions that help young people to discuss sensitive or difficult topics.

USING THE HEEADSSS SCREENING TOOL

(Klein, Goldenring and Adelman 2014)

This is a guide designed to help you conduct a HEEADSSS assessment with a young person. You can add other relevant open-ended or probing questions. We have provided a guide to HEEADSSS questions below. You will find a form in the Kit Appendix that you can use to capture the information related to each of the domains in the screening tool. Remember, this is a guide only. Try to keep the conversation flowing and be guided by the young person rather than following the structure rigidly.

Assessment Area	Questions
H - Home	**Explore home situation, family life, relationships and stability:** Where do you live? Who lives at home with you? Who is in your family (parents, siblings, extended family)? What is your/your family's cultural background? What language is spoken at home? Does the family have friends from outside its own cultural group/from the same cultural group? Do you have your own room? Have there been any recent changes in your family/ home recently (moves, departures, etc.)? How do you get along with mum and dad and other members of your family? Are there any fights at home? If so, what do you and/ or your family argue about the most? Who are you closest to in your family? Who could you go to if you needed help with a problem? Do you provide care for anyone at home? Is there any physical violence at home?
E - Education / Employment	**Explore sense of belonging at school/work and relationships with teachers/peers/workmates; changes in performance:** What do you like/not like about school (work)? Do you feel connected to your school? Do you feel as if you belong? Are there adults at school you feel you can talk to about something important? Who? What are you good at/ not good at? How do you get along with teachers /other students/workmates? How do you usually perform in different subjects? What problems do you experience at school/work? Some young people experience bullying at school, have you ever had to put up with this? What are your goals for future education /employment? Any recent changes in education/ employment?
E - Eating & Exercise	**Explore how they look after themselves; eating and sleeping patterns:** What do you usually eat for breakfast/lunch/dinner? Sometimes when people are stressed they can overeat, or under-eat – Do you ever find yourself doing either of these? Have there been any recent changes in your weight? In your dietary habits? What do you like/not like about your body? *If screening more specifically for eating disorders you may ask about body image, the use of laxatives, diuretics, vomiting, excessive exercise, and rigid dietary restrictions to control weight.* What do you do for exercise? How much exercise do you get in average day/week?

A - Activities & Peer Relationships	**Explore their social and interpersonal relationships, risk-taking behaviour, as well as their attitudes about themselves:** What sort of things do you do in your free time out of school/work? What do you like to do for fun? Who are your main friends (at school/out of school)? Do you have friends from outside your own cultural group/from the same cultural group? How do you get on with others your own age? How do you think your friends would describe you? What are some of the things you like about yourself? What sort of things do you like to do with your friends? How much television do you watch each night? What's your favourite music? Are you involved in sports/hobbies/clubs, etc.? Do you have a smart phone or computer at home? In your room? What do you use if for? How many hours do you spend per day in front of a screen, such as computer, TV or phone?
D - Drug Use / Cigarettes / Alcohol	**Explore the context of substance use (if any) and risk-taking behaviours:** Many young people at your age are starting to experiment with cigarettes/ drugs/alcohol. Have any of your friends tried these or other drugs like marijuana, injecting drugs, other substances? How about you, have you tried any? *If Yes, explore further* How much do you use and how often? How do you (and your friends) take/use them? – *Explore safe/unsafe use; binge drinking; etc.* What effects does drug taking or smoking or alcohol, have on you? Has your use increased recently? What sort of things do you (& your friends) do when you take drugs/drink? How do you pay for the drugs/alcohol? Have you had any problems as a result of your alcohol/ drug use (with police, school, family, friends)? Do other family members take drugs/drink?
S - Sexuality	**Explore their knowledge, understanding, experience, sexual orientation and sexual practices – Look for risk-taking behaviour/abuse:** Many young people your age become interested in romance and sometimes sexual relationships. Have you been in any romantic relationships or been dating anyone? Have you ever had a sexual relationship with a boy or a girl (or both)? – *if Yes, explore further* (If sexually active) What do you use to protect yourself (condoms, contraception)? What do you know about contraception and protection against STIs? How do you feel about relationships in general or about your own sexuality? (For older adolescents) Do you identify yourself as being heterosexual or gay, lesbian, bisexual, transgender or questioning? Have you ever felt pressured or uncomfortable about having sex?

S - Suicide / Self-Harm/ Depression / Mood	**Explore risk of mental health problems, strategies for coping and available support:** Sometimes when people feel really down they feel like hurting, or even killing themselves. Have you ever felt that way? Have you ever deliberately harmed or injured yourself (cutting, burning or putting yourself in unsafe situations – e.g. unsafe sex)? What prevented you from going ahead with it? How did you try to harm/kill yourself? What happened to you after this? What do you do if you are feeling sad, angry or hurt? Do you feel sad or down more than usual? How long have you felt that way? Have you lost interest in things you usually like? How do you feel in yourself at the moment on a scale of 1 to 10? Who can you talk to when you're feeling down? How often do you feel this way? How well do you usually sleep? It's normal to feel anxious in certain situations – do you ever feel very anxious, nervous or stressed (e.g. in social situations)? Have you ever felt really anxious all of a sudden – for particular reason? Do you worry about your body or your weight? Do you do things to try and manage your weight (e.g. dieting)? Sometimes, especially when feeling really stressed, people can hear or see things that others don't seem to hear or see. Has this ever happened to you? Have you ever found yourself feeling really high energy or racey, or feeling like you can take on the whole world?
You can also explore: S - Safety S - Spirituality	**Sun screen protection, immunisation, bullying, abuse, traumatic experiences, domestic violence, risky behaviours.** Have you ever been seriously injured? When did you last send a text message while driving? When did you last get into a car with a driver who was drunk or on drugs? Beliefs, religion; What helps them relax, escape? What gives them a sense of meaning?

FINDING OUT MORE...

If you would like more information about the HEEADSSS assessment, we recommend the latest version: Klein D, Goldenring J & Adelman WP. (2014). HEEADSSS 3.0: The psychosocial interview for adolescents updated for a new century fuelled by media. Available online at http://contemporarypediatrics.modernmedicine.com

ALTERNATIVE ASSESSMENT TOOLS FOR YOUNG PEOPLE WITH AN INTELLECTUAL DISABILITY

HEEADSSS may not be suitable for use with all young people you work with. In particular, alternative screening tools might be considered for young people with an intellectual disability. The Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) measures psychological wellbeing and health in 4 domains; Wellbeing, Symptoms, Functioning, Risk.

It takes 5-10 minutes to complete. Adaptations include:

- YP-CORE: is a 10-item measure derived from the CORE-OM and designed for use with young people in the 11-16 years age range. It is structurally similar to the CORE-OM but items have been rephrased to be more easily understood by the target age group.
- CORE-LD: is a variation being developed in Scotland and England. Specifically for use with people with a learning difficulty, it will include items that cover the major issues they face that are not in the CORE-OM.

FINDING OUT MORE...

For more information about CORE-OM and the range of adaptations available, visit www.coreims.co.uk

WHAT COMES NEXT

After you've completed the assessment, the next step is to work with the young person (and, where appropriate, their parents or carers) to develop a management plan. Developing the management plan is a process of shared decision-making. By actively engaging the young person in identifying what they want to work on and how they want to go about it, you will empower them to be an active partner in their own health and wellbeing. It also increases the likelihood that they will stick to any plans that you make.

PROVIDING FEEDBACK

Give the young person some feedback about the assessment.

- Identify and compliment them on areas of their life where they are handling things well and reinforce their strengths.
- Give them your understanding of their main concerns (that is, the things that they have identified themselves that are not going as well as they would like).
- Provide information and education about their psychosocial development – including the fact that the 'executive' and regulatory functions of their brain are still developing. Review 1.1 Understanding young people for more information on the developing adolescent brain.
- Where it is appropriate, reassure the young person that they are normal and that many young people experience similar issues or problems:

  Example:

  "Many people experience anxiety when they are under a lot of stress…but we can check this out further to see if there is anything else that may be contributing to your anxiety."

  Or:

  "It's not unusual for young people your age to feel confused and uncertain about sexual feelings and sexual relationships…perhaps we can talk about this some more and look at any concerns or questions you have."

- 5. Highlight areas of concern where intervention may be needed. Help them understand the connection between their concerns and other problems they may be experiencing. It is best to take a straightforward and honest approach to this:

  Example:

  "Michael, your anxiety is something we can deal with by helping you to cope better with stress at school. However, I am concerned about how depressed you're feeling and I think we need to look at what we can do about this."

- If the young person is engaged in risky behaviours, share your concerns about that. Provide information about the risks associated with these behaviours and discuss ways they can protect themselves against these risks:

  Example:

  "Rebecca there are a few things you've mentioned that I'm concerned about – especially your alcohol use. I know you've said that it's a big part of what you do when you're with your friends. But I'm wondering how much you know about the effects of alcohol, and some of the risks that it has for young people. If you like, I can give you some information about this and we can discuss ways to make sure that you stay safe…"

PRACTICE POINT ON DISCLOSURES OF ABUSE

Many service providers are Mandatory Reporters under child protection legislation and are required to report suspected cases of child abuse and neglect. The ages for mandatory reporting and mandatory reporting laws and procedures vary from state to state.

If a young person discloses physical, sexual or other abuse, or you if you suspect they are at risk of harm, it is important that you are understand your responsibilities to make a report or otherwise act in the interests of the young person's safety.

Learn more about your responsibilities when a young person discloses violence or abuse in chapter 3.5 Medico-legal issues.

NEGOTIATING A MANAGEMENT PLAN

Begin talking with the young person about options for addressing their concerns.

- Ask directly what the young person's concerns are and what outcomes they would like to achieve
- Outline the various treatment or management options
- Explain the options or actions you recommend and why

- Involve them in making decisions about their treatment and management options
- Working together, set realistic therapy and behaviour change goals that are relevant to the young person's concerns, developmental stage and life circumstances
- Make sure that the management plan comprises actions that the young person can understand and manage
- Initiate early intervention for problems or risk factors identified in the interview or HEEADSSS assessment

WRAPPING UP THE INTERVIEW

Invite questions or comments from the young person. Ask if they have any other problems or concerns that they would like to talk about. Then:

- Identify possible sources of support – who can they talk to about things that are troubling them?
- Adopt an 'open door' approach – let them know that they can speak to you about problems and encourage them to contact you if they need assistance.
- Explain how they can make an appointment if they need to see you.
- If they have come with a parent or carer, discuss what they would like to tell their parents or carers, and identify those things don't want to discuss.
- Offer to talk to the parent(s) on their behalf about any sensitive issues, but respect the young person's wishes to not discuss certain issues with parents.

  Example:

  "Rebecca, before your mum comes back in, I'd like to be clear about what to tell her and what not to talk about. What would you like mum to know about what's going on for you? What sort of support would you like to get from your mum?"

  Or:

  "If you'd like, I could talk to your mother about some of the things that are happening for you. But I need to be clear about what you'd like me to say or not say to your mum."

(Bennett and Kang 2001)

If a follow-up meeting is needed, encourage the young person to return and explain why it is important that you see them again. If you feel concerned that the young person might not keep the appointment, make a contract with them to return. You could offer to give them a reminder call; just ask them for the best way to contact them. These steps help you to further cement the relationship you have started building with the young person.

If it is necessary, this is the point at which you would facilitate a referral to a specialist or other agency (such as a counsellor or youth agency). Explain to the young person how referrals work and what they need to do. Offer them information about the service to which you are referring them, and remind them that they can always contact you if they have questions or need more information or advice.

FINDING OUT MORE...

For more information on referral and collaborative care, see chapter 2.3 Collaboration and case management.

INVOLVING PARENTS AND CARERS IN THE MANAGEMENT PLAN

For most young people, parents are the main providers of physical and emotional support. For some young people, a carer (perhaps a member of the extended family, or another trusted adult) will be their main source of support. Generally, management or treatment plans are more successfully implemented if the parents or carers are involved. This is especially the case with younger adolescents and in situations where the young person's cultural background necessitates their involvement.

Carefully assess the level of parental involvement required. You may need to consider the best ways to balance the young person's needs for confidentiality and autonomy with the need to keep the parents or carers engaged and involved. Wherever possible, make a collaborative decision with the young person on parental or carer involvement: discuss the pros and cons with the young person.

From a medico-legal perspective, this also means taking into account the young person's capacity for decision-making and informed consent. Be sensitive to the concerns of parents from cultural backgrounds where health care may be viewed as a family matter.

You may need to guide parents or carers in the most effective ways they can support they young person to complete the treatment plan: sometimes, this will involve helping them identify more positive responses to their adolescent's risk-taking behaviours.

FINDING OUT MORE...

For more information, see chapters 3.5 Medico-legal issues and 3.13 Working with families.

RESISTANCE TO PARENTAL INVOLVEMENT

Some young people are adamant that they don't want their parents to know about their concerns or to be involved in a management plan. It is important to tread carefully and gently explore their reasons.

Example:

"What are your fears or concerns about your parents knowing about your situation?"

Or:

"How do you think your mother would react if you were to tell her about this problem?"

Your duty of confidentiality does not prevent you from encouraging and assisting young people to talk to parents about important issues. You can play an important role in helping the young person communicate with their parents or carers about difficult or sensitive issues.

Examples:

"If you could, what would you like to be able to tell your parents?"

"How would you like your parents to respond so that you felt supported?"

"What do you need from your parents to help you with this problem?"

Remember, there may be situations where you need to inform the parents or carers about the young person's situation because of medico-legal issues and/or the age of the young person. Where this is not the case, hand back the choice and responsibility to the young person for the decision of whether to inform parents.

PRACTICE POINTS FOR CONDUCTING PSYCHOSOCIAL ASSESSMENTS

- Help the young person to identify risks associated with their behaviour and to deve lop strategies for reducing those risks
- Use the findings of your assessment to identify areas for intervention and follow-up
- Give the young person feedback about your assessment and actively involve them in developing a management plan
- Remember to also identify what is going well for the young person and congratulate them on what they are doing well
- Work collaboratively with the young person to set realistic treatment goals that fir with the young person's health concerns, developmental stage and lifestyle
- Where appropriate, let the young person decide the level of involvement they wish their parents or carers to have
- Give guidance to parents and carers on how they can support the management plan and on effective responses to their adolescent's risk-taking behaviours

CHAPTER SUMMARY – WHAT TO REMEMBER

The process of the HEEADSSS assessment can help you form a better picture of the range of issues and risks affecting a young person. It can help you identify areas of concern and highlight factors that might be contributing to the issues a young person is facing.

A challenge in responding to the issues identified through the assessment is weighing up the needs of the young person for independence and confidentiality with the potential value of involving their parents or carers in developing and implementing a management plan.

It is essential that you are aware of and understand how to respond to disclosures of sexual, physical or other abuse or neglect.

REFLECTION QUESTIONS

To what extent might HEEADSSS assessments be useful in your work with young people?

How can you apply this framework for psychosocial assessment in your workplace?

How might conducting a risk assessment assist you in your work with young people?

How do your assessments fit with the assessments required by other services in your service network?

What training do you need in conducting psychosocial risk assessment with young people?

How well does your service collaboratively engage young people in development of management plans?

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SECTION 3.3

UNDERSTANDING RISK-TAKING BEHAVIOUR

3.3 UNDERSTANDING RISK-TAKING BEHAVIOUR

PETER CHOWN

Most youth health problems are a consequence of risk-taking behaviours and exposure to social and environmental risk factors including accidents and injuries, substance use and mental health problems. It is important to understand, though, that risk-taking is a normal part of adolescent development: young people typically experiment with new behaviours as they explore their emerging identity and independence.

While adults almost always view risk-taking in negative terms, not all risk-taking is dangerous or detrimental to a young person's health. In fact, a degree of risk-taking is essential for personal growth and development: it allows a young person to test their limits, learn new skills, develop competence and self-worth, and assume greater responsibility for their life (Clarke 2000).

Risk-taking behaviour, however, is also central to the onset of many major youth health problems. Risk-taking behaviour can be problematic and requires intervention when it:

- Interferes with normal youth development
- Poses serious risks to the young person's health and safety
- Impairs healthy functioning
- Becomes an established part of the young person's lifestyle

Risk-taking behaviour by young people poses an even greater threat when it is characterised by:

- Ignorance (lack of prior experience or adequate information)
- Impulsiveness and thrill-seeking
- Cognitive immaturity (the inability to comprehend the consequences of behaviour)
- Low self-worth and feelings of inadequacy

Extreme risk-taking often indicates other issues, such as recent or past experience of being a victim of sexual and physical assault, bullying, or child abuse and neglect.

Service providers can play a vital role in prevention and health promotion by using their consultations to:

- Screen for health risk factors in the young person's life through the HEEADSSS assessment
- Identify risk-taking behaviours the young person is engaged in
- Provide early intervention and health education appropriate to the developmental stage of the young person

UNDERSTANDING RISK-TAKING

For some young people, risk-taking is a way of resolving developmental challenges (for example, a young male who drinks heavily to prove that he is as grown-up as his peers). For others, risk-taking may be a way of dealing with problems or escaping unhappy situations or feelings (such as a young woman who engages in sexual activity in response to her low self-esteem and feelings of worthlessness, or her experience of sexual assault).

While risk-taking behaviour can constitute a major health problem in itself, it may also be an indicator of an underlying problem in the young person's life. Angry, acting-out behaviour can mask depression, or it may reflect the young person's experience of violence.

Risk-taking behaviours which can have serious negative implications for young people's health include:

- Early and/or high risk sexual activity
- Drink driving
- Substance or alcohol abuse
- Running away from home
- Dropping out of school
- Criminal activity
- Severe dieting
- Dissociation
- Suicidal thoughts and talk
- Self-harm
- Assaulting others

PRACTICE POINT – WHAT'S NORMAL AND WHEN TO WORRY

Normal adolescent behaviours include:

- Moodiness
- Flare-ups
- Open and talkative with friends, monosyllabic with family
- Actively striving for independence
- Trying new experiences
- To be like peers
- Sleeping in
- Critical and argumentative.

PRACTICE POINT – WHAT'S NORMAL AND WHEN TO WORRY

Worrying behaviours include:

- Wild mood swings
- Dramatic and/or persistent behaviour change
- Isolation from peers
- Failing school performance or dropping out
- Violent or aggressive behaviour
- Dangerous drug and/or alcohol use
- Loss of routine
- Excessive sleeping
- Withdrawn, secretive or self-harming behaviours.

ASSESSING THE DANGER OF RISK-TAKING

Risk assessment should take place in the context of understanding that the co-occurrence of health problems and risk-taking behaviours is prevalent in young people. It is also important to screen for trauma and domestic violence as these can have an effect on a young person's vulnerability.

IDENTIFYING RISK AND PROTECTIVE FACTORS

The degree of health risk attached to a young person's behaviour depends in part on the balance of risk and protective factors in a young person's life (Sanci 2001). The greater the number of risk factors present in a young person's life, the greater the likelihood that they will engage in risk-taking behaviours (Bond et al. 2000).

When screening for risk factors, it is also important to identify protective factors in the young person's life. Research has shown that protective factors can act as a buffer to the negative effects of risk factors and risk-taking behaviours (Bond et al. 2000). The most powerful protective factors in reducing morbidity among young people are connectedness and belonging to family, school and peers (Resnick, Harris and Blum 1993).

A completed HEEADSSS assessment (see chapter 3.2), provides you with profile of the balance of risk and protective factors in a young person's life – see Table 4 (on the opposite page).

ASSESSING THE DEGREE OF RISK

The more risk factors in a young person's life, the more likely they are to experience harmful consequences from their risk-taking behaviour. When you are trying to determine the level of risk the young person faces, consider:

- The extent to which the behaviour is compromising the young person's safety, health and development.
- The range and severity of risk factors. The presence of one risk-taking behaviour raises the risk of other risk-taking behaviours co-occurring (e.g. substance abuse combined with sexual risk-taking; dropping out of school leading to the development of anti-social behaviour) (Bond et al. 2000).
- The severity of the risk-taking behaviour and whether it is escalating.
- The level of awareness the young person shows about the consequences of their behaviour.
- The extent to which the behaviour has become entrenched in the young person's lifestyle.
- Any strategies they use to minimise the harm associated with the risk behaviour.
- The protective factors in the young person's life that might safeguard them against the consequences of risk-taking behaviours.

When you have identified the risk and protective factors in the young person's life you can identify an overall risk status (Sanci 2001):

TABLE 4 – RISK AND PROTECTIVE FACTORS

Risk factors Characteristics of the young person and their social environment that increase their vulnerability to harm.	Protective factors Individual and environmental factors that increase resistance to risk factors.
Youth factors	
• Low self-esteem • Poor social skills • Poor problem-solving skills • Lack of empathy • Homelessness • Diagnosed Attention Deficit Hyperactivity Disorder (ADHD) • Non-adherence with health treatments	• Social competence • Solid problem-solving skills • Optimism • Good coping style • School achievement • Strong sense of moral values/spiritual beliefs • Creativity and imagination
Family factors	
• Family conflict/breakdown/violence • Harsh or inconsistent discipline • Lack of warmth and affection • Physical and/or sexual abuse and neglect • Lack of meaningful relationships with adults	• Supportive, caring parents or carers • Secure and stable family environment • Supportive relationship with other adults • Attachment to family
School factors	
• School failure or dropping out • Bullying • Peer rejection • Deviant peer group • Learning difficulties	• Positive school climate • Pro-social peer group • Positive achievements and sense of belonging at school • Opportunities for some success (at sport, study etc.) or development of a special talent/hobby • Recognition of achievement
Community & Cultural factors	
• Socio-economic disadvantage • Exposure to violence and crime • Homelessness • Refugee experience • Racism or discrimination • Intercultural conflict (the young person trying to 'fit in' and adapt to the new culture) • Lack of support services	• Attachment and belonging to community • Access to support services • Participation in community group • Strong cultural identity/pride • Secure home/housing

TABLE 5 – OVERALL RISK STATUS

Risk level	Description	Characteristics	Example
No Risk	Not yet engaged in risk-taking behaviour	• Well-adjusted • Family, school and social functioning are stable and positive • Presence of a number of protective factors	
Low Risk	Engaged in experimentation	• 'Safe' experimenter • Risk-taking is sporadic, recreational and experimental • Family, social and school profile is stable • Protective factors outweigh risk behaviours • May need monitoring if individual or environmental risk factors present	A young person who has experimented with marijuana with peers, but who has stable family and peer relationships, and is doing well at school
Moderate Risk	Engaged in behaviours with harmful consequences (i.e. impairment of positive functioning and developmental tasks)	• Vulnerable • Presence of social/environmental risk factors (family problems, peer group influences; or other risk factors such as low self-esteem and family history of depression) • Presence of some protective factors (such as positive family, school or peer support) • Requires intervention	A depressed young person with low self-esteem and a family history of depression, who occasionally smokes marijuana by himself
High Risk	Major disruption or risk to health, safety or life	• Troubled or out-of-control • Persistent and/or escalating harmful behaviours • Persistent and/or negative consequences (e.g. disruption of relationships, poor school performance, trouble with police, conflict with family) • Presence of major risk factors and few protective factors	A young person who is involved in anti-social behaviour, at risk of expulsion from school, with frequent alcohol and substance use, and with a lack of family support

UNDERSTANDING THE EFFECTS OF TRAUMA

Many young people with serious behavioural or emotional problems have experienced complex trauma in their childhood or adolescent development. Complex trauma refers to exposure to multiple and ongoing interpersonal stressors such as abuse, neglect or emotional or physical deprivation (Toro, Dworsky and Fowler 2007; Kezelman and Stavropoulos 2012). This exposure often occurs within the family or another care-giving arrangement that is supposed to be the source of stability and safety in a child's life.

Research has highlighted the adverse effects of early onset trauma on the developing brain. Early onset trauma requires the brain to shift its focus from learning to survival and disrupts the neural integration necessary to respond flexibly to daily challenges (Courtois and Ford 2009). The effects of complex trauma on individual functioning are pervasive and deeply disruptive to the key developmental of attachment, self-regulation and the development of competencies (Kezelman and Stavropoulos 2012; Siegel and Hartzell 2004).

FINDING OUT MORE…

A trauma-informed approach recognises that much high risk behaviour can be directly linked to the experience of trauma and may be part of a coping mechanism the young person has developed over time.

You can learn more about trauma, its effects on the developing brain and adopting a trau mainformed approach to working with young people in 3.4 Trauma-informed practice.

Adults Surviving Child Abuse (ASCA) is an Australia-wide support network that launched a set of practice guidelines in 2012 for dealing

with complex trauma: The Last Frontier. Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care And Service Delivery

These guidelines have been endorsed nationally and internationally. The Guidelines can be downloaded free at www.asca.org.au/guidelines

YOUNG PEOPLE AT HIGH RISK

Young people at high risk present a particular challenge for health workers. They are generally marginalised, under-serviced and have few resources. Their situations are typically characterised by (Rogers 2005):

- The presence of multiple risk factors and few protective factors
- Engagement in high risk behaviours
- Inter-related health problems – in particular, substance use and mental health disorders
- Disorganised living situation e.g. homeless, itinerant or living in care

Their lives and health are often made more difficult to manage by the ongoing effects of trauma, neglect and abuse, and they sometimes experience complicated grief reactions stemming from significant loss.

Young people at risk frequently have to cope with extreme circumstances in their lives, often without adequate support structures. Their risk-taking behaviour should, therefore, be viewed in this light: substance use, for example, may be a coping mechanism.

FINDING OUT MORE...

NSW Health has recently released the NSW Health Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care. The guidelines aim to provide guidance to Local Health Districts and health professionals on the recommended approach to the health assessment process for children and young people in statutory Out-of-Home Care. They reflect NSW Health's approach to the implementation of the National Clinical Assessment Framework for Children and Young People in OOHC (2011). They can be found at www.health.nsw.gov.au/policies (use Out of Home Care as a search term).

CREATE Foundation is Australia's peak body representing the voices of all children and young people in out of home care. Visit www.create.org.au

WORKING WITH YOUNG PEOPLE AT HIGH RISK

Young people at high risk are often reluctant to seek out health services. A parent, carer or youth worker may bring them, or they may have been referred by another service. Health workers sometimes come into contact with young people at outreach clinics or specialist youth health services. Regardless of how they came, if they are not seeing you because they want to, it can be challenging to engage them in positive discussion about their health, wellbeing and behaviour.

Engaging the young person in a trusting relationship is possibly the single most important thing that a professional can do. It makes it possible to increase the rate at which they access often essential treatment and services. Remember that young people at high risk often have chaotic lifestyles, so they may miss appointments. Whenever you can, try to maintain the relationship and re-engage them.

Not all service providers have the time, skill, resources or responsibility to provide comprehensive intervention. However, you can play a crucial role by:

- Detecting serious health risks and referring the young person to appropriate services
- Participating in collaborative care and case management (for more information, see 2.3 Collaboration and case management)
- Providing a safety net for the young person by linking them with crisis and support services
- Being aware of and drawing on the range of specialist services for young people in the local area.

DISCUSSING RISK

When you start speaking with the young person about their risk-taking behaviours and the possible consequences, remain non-judgemental. Explain the health risks in objective and simple terms, and explore some of the health and social consequences of the risk-taking behaviours in an interactive way. Avoid lecturing.

Example:

"Jason, you said that when you get together with your friends and smoke dope you have a lot of fun and you forget about your problems. I'm wondering how you feel the next day. What do your body and your mind feel like? What's it like trying to go to school after you've had such a big night?"

You can also help the young person explore the reasons behind their behaviour and what function it might fulfil in their life.

Example:

"How does smoking marijuana help you to deal with some of your problems? What else do you do to help cope with these problems?"

While not condoning risky behaviours, it is important to acknowledge that there are usually positive benefits that the young person attains from engaging in the risk behaviour. These include peer acceptance, having fun or relieving anxiety. You can help the young person to identify other ways to achieve the same kind of positive effects from their behaviours and to identify ways to reduce the harm associated with the behaviour.

While you should present your concerns about their behaviour, ultimately the young person will make their own decisions. Attempt to maintain contact with the young person even if they continue with their risky behaviour – your presence and availability can serve as a major protective factor in their life. Let them know that your relationship with them is important and that you want to continue to support them:

Example:

"Sara, I'm interested in you and your wellbeing. It's my job to let you know if something is a risk to your health, but what you do about that is your choice. I can help you look at some other alternatives if you like. Whatever you decide, I want to continue seeing you…"

PROMOTING BEHAVIOUR CHANGE

A major goal in health education and managing risk-taking behaviours is to promote behaviour change in the young person. It is helpful to have a model or framework for understanding the process of behaviour change – particularly as it applies to health behaviours.

The Health Belief Model (Garcia and Mann 2003) proposes that the probability that individuals will change their behaviour to improve or protect their health is directly related to:

- Their awareness and perception of the health issue
- The perceived risks and consequences
- The anticipated benefits of the behaviour change
- Their level of skills

To help young people modify their behaviour you can provide them with information and basic counselling to:

- Raise their awareness and knowledge about the behaviour and its consequences
- 'Personalise' the risk – help them to see how the risk applies to them in their particular situation
- Promote a belief that behaviour change will eliminate or lessen the risk
- Support a belief that they can make and sustain the behaviour change
- Teach them appropriate interpersonal and life skills to help make changes
- Identify and reinforce support for them in making those changes

Another useful model is the Stages of Change model (Prochaska, DiClemente and Norcross 1992) which states that people are at different stages of readiness to change their behaviour, and go through a number of stages on their way to making changes. Consequently:

- Many people are not ready/able to change their behaviour when they first come into contact with a health professional
- Interventions should be matched to the person's current stage of preparedness to change
- The objective is to assist people in moving from one stage to the next, and not push them prematurely into action

While some research has questioned the effectiveness of this model in providing practical intervention strategies for change (West 2005), it can still be a very useful framework for initial discussions with a young person. In particular, it can help you assess:

- Their awareness of the problem and acceptance of the need to address it
- Their readiness to attempt to change the behaviour
- Their belief in their capacity (self-efficacy) to make changes

TABLE 6 – STAGES OF CHANGE

Stage of change	Issues	Strategies
Pre-contemplation	• Hasn't thought about change • Young person doesn't see the problem as an issue	• Increase awareness of risks associated with current behaviour • Identify risks and benefits of their behaviour • Identify effects on others • Provide information on health/social consequences
Contemplation	• Considering the benefits of changing and the risks associated with not changing • Young person thinking about change	• Reinforce benefits of changing • Elicit person's own reasons for changing • Motivate, encourage to make goals for change • Examine pros and cons of changing • Support young person to reduce risks associated with their behaviour
Decision/ Determination	• Ready to make a change • Young person is making a plan to change	• Strengthen young person's belief in their ability to change • Provide a range of options for action • Assist in developing concrete action plans, setting gradual goals
Action	• Carries out specific action plans for change • Dealing with barriers to change	• Provide positive reinforcement • Assist with problem solving • Identify barriers to change • Identify social supports • Teach coping skills • Identify harm reduction strategies • Refer to specialist services
Maintenance	• Developing strategies for sustaining changes	• Affirm and support behaviour change • Teach coping skills • Foster strengths and protective factors • Provide reminders • Identify alternatives • Identify social supports
Relapse	• Re-engagement in problem behaviour	• Empathise and normalise as part of the change process • Assist in resuming the change process • Return to 'Determination' and 'Action' stages • Avoid guilt, blame and demoralisation

MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI) is a technique that can be used in conjunction with a number of different models of behaviour change (Baer and Peterson 2002). The technique can help you prepare a young person for change by helping to building their motivation and reinforcing their capacity to make changes (self-efficacy).

MI is person-centred. It focuses on the concerns and perspectives presented by the young person and is based on the belief that the resources and motivation for change already exist within the person. The technique aims to get the young person talking and voicing the advantages of change, plans for change, readiness for change and confidence in ability to make a change.

The role of the health professional is to reflectively listen, which reinforces the change talk.

MI focuses on understanding the person's beliefs and priorities in the following areas (Gomez 2002):

1. Problem recognition – Ask questions that help to define the problem clearly. *What is the issue?*
2. Perceived impact on life – Ask questions that bring out what effect it is having on the person's life. *What effect is it having?*
3. Beliefs about capacity to change – Ask questions that explore what the person believes it would be possible to do. *What could be done to make the problem better?*
4. Intention to change – Ask questions to find out whether the person wants to commit to making changes. *What do you think you might be able to do/ change in regard to the problem?*

Motivational Interviewing can be used with the Stages of Change model to assess the person's change potential at different stages – e.g.:

1. Thinking of changing: *What would you like to discuss? Tell me more about…? How do you feel when…?*
2. Preparing for change: *How confident are you? What has worked in the past?*
3. Making changes: *How can we plan for this? What are the likely barriers?*
4. Maintaining changes: *How is it going?*
5. Dealing with relapse: *What has happened? How can we get back on track?*

FINDING OUT MORE…

To learn more about conducting Motivational Interviewing visit the Motivational Interviewing website – www.motivationalinterviewing.org

You can also refer to Miller W. And Rollnick S. (2002). Motivational Interviewing: Preparing people for change. (2nd edn). Guildford Press: London.

INTERVENTIONS

The extent of intervention required varies. For some risk-taking behaviours, a good response may be to simply provide some health education. Other behaviours may need more active intervention, particularly if the young person is at high risk. It is worth noting that interventions that are effective in reducing one type of risk-taking behaviour are likely to positively affect other risk-taking behaviours. The level of intervention required depends on the balance of risk and protective factors and the severity of the risk-taking behaviour.

TABLE 7 – INTERVENTIONS FOR RISK-TAKING BEHAVIOURS

Risk status	Possible interventions
No risk/low risk	• Aim to prevent the emergence of problem behaviour • Provide preventative health education and health promotion messages • Enquire about their level of knowledge and provide objective information about the health consequences associated with a particular behaviour • Build a trusting relationship so that they might return if concerns arise in the future
Moderate/high risk	• Reduce modifiable risk factors/behaviours • Assess other external risks to safety: if a young person discloses violence or abuse, develop a safety plan with the young person and people in their identified safety network, and notify police • Use harm minimisation strategies to help reduce the dangers associated with risky behaviours • Develop a management plan with the young person to reduce risks associated with the behaviour and find safer alternatives • Provide health education and counselling • Refer as necessary to specialist treatment and support services • Strengthen protective factors • Identify and reinforce the young person's strengths • Identify ways to enhance protective factors in their lives – e.g. family counselling, school mediation • Teach the young person protective behaviours to reduce risks – e.g. safer sexual practices, refusal and assertiveness skills

STRATEGIES FOR PROMOTING RESILIENCE

- Adopt a strengths perspective – focus on strengths not just problems: help the young person to recognise and affirm existing strengths & personal assets
- Enhance and reinforce protective factors in the young person's life – e.g. family support, connection to school, positive peer relationships, connection to their culture
- Foster a positive self-image and self-esteem – through participation in activities, sports, academic achievement, hobbies, artistic abilities
- Teach life skills – cognitive/social/emotional competence:
  - » Cognitive competence – identify and challenge faulty thinking, develop positive self-talk, decision-making skills, self-management
  - » Emotional self-management – teach practical skills for identifying and regulating emotions, encourage appropriate expression of emotions, self-management
  - » Social competency – interpersonal and communication skills
- Teach protective behaviours – e.g. safe sexual practices, assertiveness and refusal skills
- Encourage the young person to find a sense of meaning and purpose – exploring creativity, spirituality, relationships
- Encourage appropriate help-seeking behaviour (Blum 1998; Fuller 1996)

CASE STUDY: WORKING WITH MARK TO REDUCE RISK

Mark is an 18-year-old young man who comes to see you accompanied by his mother. He presents with low mood, anxiety and disordered thoughts.

Mark's life is chaotic. He lives in a self-contained flat beneath his mother's house, but he often spends days at a time at friend's places, usually binge drinking and smoking marijuana. His mother suspects that he and his friends have also been selling drugs. He is highly agitated and appears to have difficulty in organising his thoughts. He is very thin and his hygiene appears to be poor. His frequent marijuana use seems to be contributing to his low mood, lack of self-care, and his difficulties in performing routine tasks like cooking for himself.

Mark dropped out of school at a young age. He makes jewellery and says that he wants to establish his own business. However, he is highly disorganised and has difficulty following through on plans. This is a source of major ongoing conflict with his mother. She is trying to encourage him to live more independently in his daily life. However, because of his poor level of self-care, she feels that she has to constantly cook and clean for him. Mark resents his mother's interference and consequently they have frequent arguments during which Mark becomes very aggressive, causing stress to both parties.

His mother reports that Mark was prescribed medication a couple of years ago for similar problems but he refused to take it. She has approached a community support organisation for help to find suitable alternative accommodation for Mark. She says that she can't have him living with her anymore.

RISK ASSESSMENT

Using HEEADSSS, you identify a number of risk factors in Mark's life:

- Substance using peer group
- Low educational attainment
- Conflict with mother
- Unstable living situation
- Poor social and problem-solving skills
- History of mental health difficulties
- Lifestyle

He is engaged in the following risk-taking behaviours:

- Marijuana use
- Binge drinking
- Selling drugs
- Aggressive behaviour toward his mother

You have identified the following protective factors:

- A supportive mother
- His interest in jewellery
- His willingness to talk with you
- Involvement with community support services

RISK STATUS

Based on your assessment, you determine that Mark is at a moderate-to-high level of risk. He has some protective factors in his life, but these are weak compared to the risk factors. You are particularly concerned about his mental health history and his high risk of developing a co-morbid condition of substance use and mental illness.

MANAGEMENT APPROACHES

Your first challenge is to engage Mark in a trusting relationship. You begin to build trust and establish safety by explaining confidentiality and its limits, and by asking Mark what feels uncomfortable and what he needs to feel safe. You praise Mark for attending and being willing to look at addressing the problems in his life. You discuss the risks that you have identified but also acknowledge his strengths. You work with Mark to identify the safe people in his life.

It is also important to identify what Mark sees as his concerns and what goals he wants to pursue. This needs to be a collaborative process, especially as Mark is an adult.

You identify a series of interventions that will form a care plan to help Mark and his mother:

- You discuss the possibility with Mark of reducing his alcohol intake and marijuana use and identify specialist services that could assist him with this
- You assess Mark's general health, diet, sleep, exercise and lifestyle. You provide health education on these issues
- You arrange referral to a GP to make a Mental Health Care Plan for Mark and onward referral to a psychiatrist for specialised assessment and to identify suitable medication options for Mark

- You arrange referral to a psychologist for counselling for behavioural issues and to address the conflict with his mother

You undertake to follow-up with Mark to review the implementation of this care plan.

CASE STUDY: SAMANTHA'S RISK

Samantha is 16 years old. While you're talking with her, you discover that she drinks most weekends – often getting drunk with her friends – and smokes marijuana a few times a week, usually on her own.

She is sexually active with her boyfriend of one year. She says they usually use condoms but occasionally when they have both been drinking they have unprotected sex.

Samantha does well at school although recently her grades have begun to drop. She is editor of the school magazine and plans to go to university. She plays tennis and is one of the top players in the school's team. She has always gotten along well with her parents and they have taken a keen interest in her sporting and school progress.

However, her parents are having a lot of conflict in their relationship and Samantha is feeling upset and worried that they are going to separate. They fight frequently and, when this happens, Samantha withdraws to her room. She deals with the stress of this situation by smoking marijuana. She finds it difficult to talk about what is going on with his parents. She says that her boyfriend and friends have been complaining lately that she is always in a bad mood.

RISK ASSESSMENT

Using the HEEADSSS assessment, you identify the following risk factors in Samantha's life:

- Binge drinking
- Marijuana use
- Unsafe sex
- Parental conflict
- Decline in grades
- Lack of communication skills
- Lack of emotional coping skills
- Past and present trauma and abuse experiences were not identified as issues.

You also identify the following protective factors:

- Success at sport and school
- Connection to parents
- Relationship with boyfriend and peers
- Connection to school
- Sense of purpose.

RISK STATUS

As a result of your risk assessment, you determine that Samantha is at a moderate level of risk

Although she has a number of protective factors in his life, Sam is vulnerable because of her escalating risk-taking behaviour and the presence of conflict in her parents' relationship.

MANAGEMENT APPROACHES

You work on building rapport with Samantha. You praise her for seeking help and for staying connected to her friends and boyfriend. You feed back your assessment of the risks in her life at the moment and share your concerns. You identify some ways that you can support her to reduce the risks in her life and to build her resilience. These include:

- Health education and anticipatory counselling regarding her alcohol and drug use
- Education about safer sexual practices
- Education about building healthy and safe relationships
- Referral to a counsellor for assistance in dealing with her parents' conflict and to develop more effective communication and emotional coping skills

You negotiate with Samantha about talking with her parents to share some of your concerns and to get their support for Samantha to attend counselling.

PRACTICE POINTS - ASSESSING AND ADDRESSING RISK

- Build rapport with the young person
- Routinely screen young people for risk behaviours – especially if they present with specific psychosocial problems
- Use the HEEADSSS psychosocial assessment to identify the overall balance of risk and protective factors in the young person's life
- Provide early intervention and health education appropriate to the risk status and developmental stage of the young person
- Actively promote behaviour change by:
  - Providing anticipatory counselling and guided decision-making
  - Raising awareness of harmful consequences
  - Teaching skills for minimising risks and promoting protective behaviours

CHAPTER SUMMARY - WHAT TO REMEMBER

Risk-taking is a normal part of adolescence. By taking risks, young people build their sense of self, their capabilities and their independence.

Young people are unlikely to be at serious risk of harm from experimenting with risk-taking behaviours if they have strong protective factors. Low level interventions to manage risks include providing education and information about the health risks associated with behaviours so that young people can make educated decisions about their options.

There are, however, health risks associated with many of the behaviours that young people engage in and more extreme risktaking behaviour can be masking other issues - such as the experience of trauma or abuse. Interventions to reduce risktaking behaviour are unlikely to be effective if the young person continues to be assaulted and abused or experience other trauma. The experience of complex trauma and/or a moderateto-high level scored on a risk assessment will require a more intensive, collaborative approach t o risk reduction.

REFLECTION QUESTIONS

How might understanding a young person's risk and protective factors assist you in your work with young people?

What are some of the difficulties and challenges you experience in managing young peoples' risk taking behaviours and promoting behaviour change?

What are some ways that you or your service intervenes with young people to modify risk factors or behaviours and enhance their protective factors or behaviours?

What training do you need to strengthen your skills in managing risk taking behaviour and promoting behaviour change?

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SECTION 3.4

TRAUMA-INFORMED PRACTICE

3.4 TRAUMA-INFORMED PRACTICE

LETICIA FUNSTON

Trauma experienced in childhood and in early adulthood is increasingly being recognised as one of the primary social determinants of health and wellbeing. This is because violence and abuse experienced by young people can have severe, pervasive and lifelong effects on their health, 'identity, relationships, expectations of self and others, ability to regulate emotions and view of the world' (Elliott et al. 2005).

Young people, particularly those who face social marginalisation and who live in poverty, are more likely to experience both overt and covert forms of violence and poorer general health as a result. We also know that socially and economically marginalised young people can have reduced access to high quality health services (McKenzie-Mohr et al. 2012).

The experience of trauma affects each young person differently. That said, violence against young people (particularly child sexual assault) is associated with increased risk of self-harm and suicide, homelessness, risk-taking behaviours including drug and alcohol misuse, early involvement in the criminal justice system, chronic physical and mental health problems and gambling (Ferlitti 2002).

Given the relatively high prevalence of violence and abuse perpetrated against and by young people in Australia, it is critical that all health practitioners and those working closely with young people adopt trauma-informed practice. This framework recognises that:

- Many young people are victims of recent violence and abuse and/or may be at risk of future victimisation
- Young people sometimes victimise others
- Many young people live with the traumatic effects of past child abuse.

Service providers who take a trauma-informed approach to their work with young people are more effective in preventing ongoing and escalating violence against young people and reducing the risk of re-traumatising young people. The framework includes broad principles that provide the basis for a generalised approach, so the framework applies whether a young person has made a disclosure of violence or not. It does not, however, reduce the need for specialised trauma services and practitioners.

VIOLENCE, TRAUMA AND AUSTRALIA'S YOUNG PEOPLE

According to the Australian Institute for Health and Welfare (AIHW 2013), between 2011-2012 there were 252,962 notifications of suspected child abuse and neglect made nationally. Based on the substantiated reports of abuse in Australia, the percentage of primary abuse is as follows:

- Sexual assault (12%)
- Physical assault (21%)
- Neglect (31%)
- Emotional abuse (36%)

It is likely that the actual prevalence of abuse is much higher than this: many assaults are not disclosed by young people and it can be difficult to substantiate reports of abuse (Irenyi 2007). Young people are most likely to be abused by a family member, carer or people within their broader care-giving system. However, assaults perpetrated by strangers are also common. Young people experience violence and abuse from other young people including:

- Intimate partner violence
- Sexual harassment and assault
- Physical assaults
- Online harassment
- School and workplace bullying

Some young people also have experiences of collective or community trauma and violence including:

- Poverty
- Housing stress
- Lack of access to education and employment
- Racial and cultural tensions
- Theft
- Street assaults
- Multi-generational exposure to violence
- Oppression
- Discrimination
- Criminalisation
- War trauma
- Pre- and post-migration stress.

We can understand young people's exposure to multiple forms of violence as poly-victimisation.

SEXUAL VIOLENCE

"One time I was going to a party, and I was like… 'Well, I'm going to wear a big huge sweatshirt and jeans and a hat, and I'm going to be so unattractive and no guys are going to try to talk to me.' Opposite

was true. This guy kept trying to kiss me in front of his friends, and I didn't want to so he picked me up in the air. And like, the thing that surprises me, too, is like I am a big girl, and I think that is also a reason why I have not ever tried to lose weight is because it makes me feel like I have some arena of protection or something" (Katherine P Luke, 2009).

Sexual violence can include:

- Sexual harassment (e.g. showing a young person pornography)
- Sexualised bullying
- Unwanted kissing and sexual touching
- Sexual pressure and coercion
- Sexual assault including rape (Quadara 2008).

The Australian Bureau of Statistics reports that young people aged 10-24 years are eight times more likely to be victims of sexual assault than those aged 25 years and over (Australian Institute of Family Studies 2012). A recent meta-analysis of 55 international studies reported that the prevalence of child sexual assault ranges from eight per cent to 31 per cent for girls and three per cent to 17 per cent for boys, consistent with the estimated prevalence in Australia.

Many young people have difficulty naming an incident as sexual assault and are reluctant to use the terms 'sexual assault', 'rape' or 'sexual abuse' to describe unwanted sexual experiences (Quadara 2008). Contributing factors include the common belief amongst young people that sexual assault cannot occur within a relationship that is theoretically based on trust and care. Sexual assault survivors also commonly experience deep feelings of shame and sometimes believe they are to blame for the assault or ongoing abuse.

Indigenous young people are 6.6 times more likely to be victims of a sexual assault than non-Indigenous young people (NSW Ombudsman 2012) despite comprising a minority of the total population (Demetrius and Ware 2012; Wood Special Commission of Inquiry into Child Protection Services 2008). The high prevalence of sexual assault for Indigenous young people occurs within a context of social and political marginalisation, racism, and intergenerational trauma.

FINDING OUT MORE...

The experience of trauma can affect a population. The trauma experienced by the Stolen Generation continues to echo for Indigenous people in Australia. For more information about the health challenges faced by Indigenous young people, see chapter 3.7 Resilience and Indigenous young people.

In Australia, there are twice as many substantiated cases of sexual abuse of young women (aged 18 and under) as cases of sexual abuse of young men. Young women are also more likely than young men to be sexually assaulted in dating and other intimate relationships. The higher rate of sexual abuse of young women may be associated with widespread sexist attitudes and a 'rape culture', which normalises sexual violence. As a result, young women are often blamed for being assaulted and are made to shoulder the responsibility for preventing their own victimisation. For instance, a recent study reported that 19% of male and female respondents aged 18-35 years believed that men are 'provoked' to sexually assault women if they appear to be 'drunk' or 'flirtatious' (Tutty 2011).

Sibling sexual abuse is highly prevalent in Australia. It is mostly committed by boys and young men and is more common than sexual assault perpetrated by step-fathers and fathers (Laing et al. 2006). The impact of sibling sexual abuse can be just as severe as sexual abuse perpetrated by adult caregivers and strangers. Sexually harming behaviours sometimes indicate that a young person has been sexually abused; however not all young people who sexually harm others have been victims (Laing et al. 2006).

PHYSICAL ABUSE

"She had experienced violence from a group of students who went to her high school. She said that, after she came out as a lesbian, she was harassed and bashed by this group. They followed her home from school every day for a month" (Attorney General's Department of NSW 2003).

Approximately 5.8% of persons aged between 15 and 24 years have experienced at least one physical assault. Physical assault includes:

- Pushing
- Hair-pulling
- Hitting
- Punching
- Kicking
- Biting
- Scratching
- Strangling
- Choking
- Use of a weapon

Again, young people are more likely to be physically abused by people known to them often in the context of family violence, dating and intimate partner violence. This is particularly true for young women. On the other hand, young men are more

likely to be assaulted by strangers in public spaces, such as pubs and clubs (Quigley and Leonard 2004).

EMOTIONAL ABUSE AND BULLYING

"Bullying is when someone picks on someone else because they are different – their race, height, weight, or looks ... (it's about) prejudice and discrimination and when someone gets hurt physically or mentally, or when someone is not respected". (Young woman, year 8, quoted in Oliver and Candappa 2007).

While all forms of physical violence inflict emotional damage too, emotional abuse does not always involve physical or sexual assault or neglect. Emotionally abusive behaviours include:

- Rejecting
- Ignoring
- Isolating
- Terrorising
- Corrupting
- Verbally abusing and belittling
- Withholding of affection or attention
- Failure to provide a child or young person with the appropriate support, security or encouragement (Higgins 1998; James 1994; US National Research Council 1993).

The effects of emotional abuse can have profound long terms impacts on a young person.

Young Indigenous people and young people from CALD groups within Australia, are likely to experience high rates of emotional abuse and bullying particularly within the school system. In one Australian study, 31% of young people attending school reported being bullied at school and, of these, approximately 30% experienced racist name-calling and discrimination.

Young people who identify as gay, lesbian, bisexual, transgender, intersex or queer (GLBTIQ)also experience higher rates of emotional abuse and bullying.

DOMESTIC AND FAMILY VIOLENCE

Domestic and family violence includes any behaviour in an intimate or family relationship which is violent, threatening, coercive or controlling, causing a person to live in fear.

An intimate relationship refers to people who are, or have been, in an intimate partnership; whether or not the relationship involves or has involved a relationship of a sexual nature i.e. married or engaged to be married, separated, divorced, de facto partners (whether of the same or a different sex), couples promised to each other under cultural or religious tradition or dating.

A family relationship has a broader definition and includes people who are related to one another through blood, marriage or de facto partnerships, adoption and fostering relationships, sibling and extended family relationships. It includes the full range of kinship ties in Indigenous communities, extended family relationships in CALD communities and constructs of family within GLBTIQ communities.

Around 1 in 4 Australian young people have witnessed domestic and family violence perpetrated against their mother or stepmother (Rutherford and Zwi 2007). It is important not to assume that witnessing domestic and family violence is any less traumatic than directly experiencing the abuse. The effects of experiencing domestic violence, either directly or as a witness, commonly include:

- Anxiety
- Depression
- Social withdrawal
- Low self-esteem
- Substance abuse (Fraser 1999; Evans and Sutherland 1996 cited by Domestic Violence and Incest Resource Centre Victoria 2005).

We also know that:

- Domestic and family violence is a strong predictor of sexual and physical assault against young people (Laing 2000).
- Witnessing violence in the home can contribute to other risk factors and stressors including "loss of home, disruption of schooling and friendships, adjustment to refuge living and the public reactions to 'breaking the secrecy' of violence" (Laing 2000).
- Domestic and family violence and child abuse are the primary causes of youth homelessness both in Australia and internationally.

Intimate partner violence often consists of multiple forms of abuse and assault (e.g. stalking and harassment, emotional, sexual, financial and physical abuses) which typically escalate in severity over time. Women aged 15 to 24 are three times more likely to be the murdered by their partners and ex-partners than women aged 25 years and older (Tutty 2011).

Violence in young people's intimate relationships is mainly perpetrated by young men against young women. However, lesbian, gay, transgender, bisexual, intersex and queer-identifying (LGTBIQ) young people also experience violence and abuse in their intimate relationships. This group of young people is also likely to experience:

- Threats by an abusive partner to "out" them as a method of control and emotional abuse

- Increased isolation because intimate partner violence is commonly perceived as a hetero-sexual issue
- Additional difficulties in disclosing abuse because of the relatively small size of their communities, particularly in regional and remote areas
- Limited access to support service because only a small number of domestic violence services are both LGTBIQ and youth-friendly in Australia (AIDS Council of NSW 2008)

TECHNOLOGY-BASED RISKS

"Some boy asked me, 'Can I have a picture of you', I was like, 'My display picture' and he was like 'No I mean a special photo' and I was like, 'What special photo' and he was like, 'Like you in your bra' and I was like 'No', and I was like, 'I have one of me in my bikini' And he was like, 'can you send it anyway'". (Jodie, year 8)

The rise of social media has delivered new and creative forums for young people to connect with others and to express themselves. However, easy access to new technology and to social media has also created new risks for young people. Social media, online dating, and web-based communication such as email and live chat have increased the exposure of young people to bullying and harassing behaviour. Predators have also used these technologies to gain access to young people.

Social media has facilitated an increase in online and telephone-based sexual harassment such as sexting – sending sexually explicit text, video and photographs to other people, groups and online communities. A study in the United States reported that 15 % of young people aged 12–17 years received sexually suggestive, nude, or near nude images of someone they knew via text messaging on their cell phone, and 4% had sent such messages (Lenhard 2009). Sexting is considered to be coercive and primarily targets young women as 'it is shaped by the gender dynamics of the peer group in which, primarily, boys harass girls'. (NSPCC 2012). Sexting is also increasingly becoming common amongst aged between 10 and 14 years.

HOW TRAUMA AFFECTS A YOUNG PERSON

Trauma is not only the experience of being harmed, violated or abused: 'what is traumatising to a person is symbolically invoked by the experience and how people respond to the person who has traumatised' (Brown 2004). In other words, the personal and cultural meanings of the trauma often compound the stressors caused by interpersonal abuse and violence (Toro, Dworsky and Fowler 2007; Kezelman and Stavropoulos 2012).

The impact of trauma and violence is intensified when the violence is experienced in the context of an emotional betrayal. For example a child expects a parent or caregiver to provide a safe, secure, nurturing environment in which they are protected from harm. The experience of violence or abuse at the hands of that parent or carer is compounded by the betrayal of the child's trust in the older, more powerful person in the relationship. This is often referred to as complex trauma.

While children and young people may experience trauma from natural disasters and accidents, complex trauma has comparatively more intense and long lasting effects. Suicide, self-harm and suicide ideation are strongly associated with young people who are victims of sexual assault, particularly CSA, and physical violence. Complex trauma is also linked with higher risk-taking behaviours. Young people are more likely to act out their distress:

- They may be more likely to use drugs (particularly tobacco and marijuana) and to drink alcohol than young people who have not been abused
- They are more likely to become pregnant during adolescence and are significantly less likely to practise safe sex
- They are also more likely to experience early involvement in the criminal justice system. In a self-report survey of young people in juvenile detention in NSW, 81% of females and 57% of male young people stated that they had been abused or neglected (Indig et al. 2011).

Family members, schools, employers and service providers sometimes misunderstand and dismiss this behaviour as disobedience, delinquency, attention-seeking or as an indication of a mental illness. However, from a trauma-informed perspective, the young person's behaviours may be seen as coping responses – ways of surviving.

Research has highlighted the adverse effects of early onset trauma on the developing brain. Early onset trauma requires a shift from a `learning' brain to a `survival' brain and disrupts neural integration, which is necessary to respond flexibly to daily challenges (Courtois and Ford 2009). The adverse effects of complex trauma on individual functioning are pervasive and deeply disruptive of key developmental processes in at least three major domains (Kezelman and Stavropoulos 2012; Siegel and Hartzell 2004):

- Attachment – the capacity to form and maintain healthy emotional and mutually safe and supportive relationships
- Self-regulation – the capacity to modulate emotions, manage impulse control and self-calm during times of stress and turmoil

- Development of competencies – particularly to achieve educational outcomes and complete basic developmental tasks of adolescence

TRAUMA-INFORMED PRACTICE

"We are not suggesting that agencies and staff ignore inappropriate behaviour. Instead, we are asking staff to work with young people to identify the behaviour that was problematic, put it in the context of trauma, and to help the young person find different ways to express their anger, frustration, or sadness. We want youth to know that we can see far beyond the 'problem behaviour', and see the youth's capabilities and potential" (Stefanidis et al. 2010).

Trauma-informed practice has been described as a paradigm shift in service provision (Elliott et al. 2005, p. 462). Certainly, for many practitioners, it represents a new way of responding to 'problem' behaviour. Instead of drawing on a traditional, pathology-based approach (asking 'what is wrong with you?'), A practitioner adopting a trauma-informed approach seeks to understand the young person's experiences (asking 'what happened to you?'). This approach recognises the impact of external, socially-embedded causes of distress, trauma and disadvantage (McKenzie-Mohr et al. 2012).

While members of the sector may define trauma-informed practice differently, seven principles are widely accepted as being at the core of trauma-informed practice. Trauma-informed practitioners focus on:

1. Providing a physically and emotionally safe environment
2. Sharing power with the young people of the service, maximising their choice and control
3. Providing training and education for practitioners about the impacts of trauma and developing safety and crisis plans
4. Providing ongoing supervision and support for practitioners to mitigate the impacts of vicarious trauma
5. Providing a culturally safe and gender-sensitive service
6. Ensuring communication is open and respectful
7. Supporting young people's goals and interests
8. Referring young people to trauma-specific services and interventions

(Hopper et al. 2010; Cusack et al. 2008; Fallot and Harris 2006; Hummer et al. 2010).

Trauma-informed practice is inherently strengths-focused and emphasises the young person's ability to survive. It specifically resists the idea that a young person has a distorted or pathological world view in the aftermath of violence (Burstow 2003) and instead requires the practitioner to understand that a young person's responses or ways of coping have developed in the context of trauma. Trauma-informed practitioners will validate and attempt to understand a young person's resilience even if the chosen coping strategies are now causing difficulties.

Trauma-informed practice has a lot in common with anti-oppressive practice. It recognises that there is a power imbalance in the relationship between the practitioner and the young person and asks practitioners to 'do their best to flatten the hierarchy' (Elliott et al. 2005). Without even realising it, practitioners can actually cause further trauma if they exert power over young people by using a punitive or authoritarian style, because it repeats the experience of coercion and 'power-over' used by the perpetrator.

Trauma-informed practitioners work on educating the young person and their support network about the effects of trauma and helping them to reflect on and understand their behaviour within the context of trauma. This helps the young person understand what has happened to them without shame or blame.

TABLE 8 – COMPARING THE APPROACHES

(HENDRICKSON 2010)

Punitive Approach
• Punishment is used to enforce obedience to a specific authority. This can re-traumatise young people who have been abused by caregivers and other adults who are in a position of power. • Punitive language and rules can escalate conflict. • Punishment is usually used to assert power and control and often leaves a young person feeling helpless, powerless, and ashamed. • Punishment often benefits service providers but not young people who may be expressing extreme distress and trauma.
Trauma-Informed
• Intentionally designed to teach and to shape behaviour within firm limits using non-blaming, non-shaming and non-violent communication. • Trauma-informed practice means discussing consequences that are clearly connected to the behaviour, delivered with genuine empathy and respect. • Trauma-informed practice uses words that encourage thinking, and preserve connections between people.

SAFETY: PHYSICAL, EMOTIONAL AND CULTURAL

Safety is the cornerstone of trauma-informed practice (Herman 1992). Young people who have experienced trauma may have very few places where they feel safe. Services working with young people have the opportunity to be that safe place for young people. The safety of the young person must be established before any therapeutic work is attempted. In trauma-informed practice, establishing safety means:

1. Taking action to ensure a young person, who has been recently harmed and or who is at risk of ongoing harm, is physically safe
2. Developing emotional and cultural safety with a young person and their non-offending family members, carers and supports.

Practitioners should not assume that a young person attending a service is no longer at risk of harm. Young people need to be informed of their rights and supported to obtain police protection and take legal action.

It is important to work with the young person and safe adults (that is, non-offending parents, carers or other trusted adults) to develop a safety plan. A safety plan is a written or verbal set of strategies developed collaboratively to enable them to remain calm and safe in risky situations which may include the home, school, public transport, at parties, during dates, in intimate situations and online. It is important to convey that a safety plan does not make the young person responsible for preventing victimisation, and a safety plan does not take the place of police or legal protection when that is required.

The concept of safety also extends to how the health practitioner and broader service increases the young person's sense of emotional and cultural safety while engaging with the service. Health services are increasingly recognising that 'cultural diversity and a connection to one's own culture is the key to recovery' (O'Hagan 2004). Culture also profoundly influences the way in which a young person has experienced trauma and violence and is central to healing.

Trauma-informed practitioners must be aware of their own cultural worldviews and histories and how this may influence engagement with young people (Elliott et al. 2005). Invite the young people you work with to educate you about their cultural identity and what they need to feel safe. Cultural safety also means, whenever possible, moving outside the service building to engage young people in safe places in their communities.

Once a young person is physically, emotionally and culturally safe, you can encourage them to tell their stories and reconnect with others. You can encourage this by creating spaces for young people to meet informally or to share experiences through supportive group work contexts.

UNDERSTANDING DISCLOSURE

Many young people feel very reluctant to disclose experiences of abuse or the threat of violence. Young people can be intimidated out of making disclosures or withdraw a disclosure for many reasons, including:

- Pressure or threats from the perpetrator
- Relationship to the perpetrator
- Anticipated consequences of telling (e.g. physical injury/death, family separation, parental distress)
- Pressure from family members
- Fear of negative reactions from parents or family
- Fear of not being believed
- Feelings of embarrassment, shame and self-blame
- Fear of stigmatisation (Hunter 2011).

It is important to explain to young people the limits on confidentiality. This gives young people the opportunity to choose how and when they make a disclosure of abuse or violence, and gives them as much power as possible. Granting young people power to make decisions is important: the experience of trauma and abuse is one of disempowerment and control. Survivors need to exercise choice over how, when and to whom they make a disclosure, and understand the possible outcomes of disclosure.

Disclosures must be understood as a process: the young person will tell their whole story over time as they feel safe to do so. Young people rarely disclose the full extent of a traumatic event or abuse while making an initial disclosure. You can support a young person making a disclosure by:

- Telling the young person that you believe their disclosure
- Making it clear that whatever has happened is not their fault
- Telling the young person that the perpetrator is responsible for the assault
- Reassuring the young person that they did the right thing by making a disclosure
- Listening carefully to and reassuring the young person, including explaining any actions they will take next.

FINDING OUT MORE...

Learn more about confidentiality and its limits in chapter 3.5 Medico-legal issues.

CASE STUDY: SUPPORTING VIV

This case study looks at the experience of Viv – a 19-year-old female-identifying transgender person. In the first snapshot, Viv receives standard care. In the second snapshot, she receives care under a trauma-informed practice model.

PART ONE: STANDARD CARE

Viv voluntarily admitted herself to a psychiatric unit feeling distressed and suicidal. She was assessed to be at high risk of suicide and nursing staff were required to be with her at all times. Viv was placed on a mixed gender ward and became increasingly distressed in the psychiatric unit. She felt unsafe at night as there were no locks on her door. During the day, she felt some of the men in the unit were staring at her in a sexually aggressive manner. She asked to leave; however, because she had been assessed to be at a high risk of suicide, her admission had become involuntary.

Viv became extremely distressed at this news and began crying, screaming, kicking and hitting her head against the wall near the nurses station. Three male nursing staff wrestled Viv to the ground and administered a chemical restraint. This incident profoundly re-traumatised Viv, who had been repeatedly sexually assaulted as a child by her uncle.

When Viv was discharged two weeks later, she still felt suicidal and depressed. She no longer felt that the mental health system could help her.

PART TWO: TRAUMA-INFORMED PRACTICE

Viv is admitted into a women's trauma-informed psychiatric unit. Nursing staff spend a lot of time with Viv learning about what she needs to feel safe (emotionally, physical and culturally) in the environment, and develop an emotional and cultural safety plan. The plan is shared with the team.

Viv asks to have only female staff work with her and for all staff to refer to her using the female pronoun. A female health practitioner asks Viv about her trauma history. Viv discloses being sexually assaulted as a child and also discloses being recently assaulted by her ex-boyfriend who had been physically, sexually and emotionally abusive while they were together.

The recent experiences of intimate partner violence had preceded Viv's suicidal thoughts and admission. The health practitioner provides crisis counselling which includes discussing the impact of trauma and exploring Viv's strengths and resources. The health practitioner works with Viv during her admission to report the assaults perpetrated by her ex-boyfriend and to obtain an Apprehended Violence Order.

The health practitioner also involves Viv's chosen supportive network (her mother and one close friend) to participate in joint safety planning discussions. The health practitioner supports Viv to make referral to the Gender Centre, which provides many services for transgender women including accommodation, counselling and peer support groups.

Viv still feels depressed and has many bad days following her discharge from the unit; however, she feels much safer than when she was admitted. Viv feels more hopeful and knows that she has a wide range of supports including the trauma-informed in-patient unit to draw on if she becomes distressed and suicidal again.

CHAPTER SUMMARY – WHAT TO REMEMBER

Trauma-informed practice requires health practitioners to prioritise the safety of young people and to appreciate the impact that experiences of trauma, abuse and disadvantage can have on a young person.

It also requires them to work in a way that challenges and seeks to break down the power imbalances that are often present in traditional care environments, and which can be re-traumatising for young people with a history of experiencing violence or abuse.

Research suggests that young people experience practitioners who use trauma-informed principles more positively than those that do not use the framework. And because young people often learn about helpful and safe services through word of mouth, the principles of trauma-informed practice are likely to boost youth engagement

REFLECTION QUESTIONS

How does your service cater to the needs of young people with a background of complex trauma?

Have staff been sensitised to or received training in understanding the effects of complex trauma?

What steps could your service take to ensure that your organisational protocols and systems provide an environment of safety for young people and promote trauma informed practices?

What training does your service need to enhance practitioner skills in working with young people with a trauma background?

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SECTION 3.5

MEDICO-LEGAL ISSUES

3.5 MEDICO-LEGAL ISSUES

MELISSA KANG AND JANE SANDERS

Legal and ethical frameworks are fundamental to the professional conduct and practice of health care. Working with young people involves additional considerations because of their legal status and their stage of development. The law is not clear-cut in many aspects relating to young people under 18 years: much is left to the judgement of the medical or health professional as to the maturity of the young person and their capacity to consent.

This chapter provides a broad overview of the major legal and ethical issues as they might apply to young people, particularly those under 18. They include:

- The capacity of adolescents to consent to medical treatment on their own behalf
- Parental consent to treatment
- Confidentiality, privacy and access to medical records
- Child protection and mandatory reporting

This chapter is not a prescriptive statement of the law. If you are faced with a situation in which you are unsure about how the law applies, you can seek legal advice through your employer or insurer.

UNDERSTANDING MEDICO-LEGAL TERMINOLOGY

The terminology used to describe recipients of health care and health care providers is different in different pieces of legislation. In this chapter:

Medical treatment may not necessarily refer only to 'treatment' performed by a medical practitioner. In some contexts, 'treatment' may include health care or advice provided by other practitioners such as nurses or counsellors. In general, health information and education is not subject to the same laws as medical treatment, and may be provided to children regardless of their age.

Patient is used to reflect the terminology used in much of the relevant legislation although in some health care settings, the term 'client' might be used instead.

Medical practitioner and health practitioner are used based on the legislative source of the obligation. Many obligations, such as the obligation to privacy, may be covered by several pieces of legislation that apply to both medical and non-medical health professionals. To make sure it is clear, in this chapter a medical practitioners is a health practitioner.

Children or child will be used often in this chapter when referring to the legal definition of a child – which is anyone under 18 years.

UNDERSTANDING CONSENT

When can a young person under 18 years make his or her own decisions about medical treatment? Can parents or guardians make decisions about medical treatment for young people under 18? In what situations will it be necessary to seek an order from a court or tribunal?

Health practitioners may have concerns about these questions because:

- They are unsure how to assess a young person's capacity to give their own consent even if, strictly speaking, the law allows them to;
- They are unsure about where they stand from a legal perspective if they assess a young person as having capacity to consent to medical treatment and then proceed to provide that treatment;
- They are unsure whether they can, or should, involve parents in decisions about consent.

No matter the patient's age, 'consent to medical treatment' means that the patient makes a decision about their treatment, usually based on information and advice given by the health practitioner. You must have consent before commencing treatment. Lack of consent may expose a health practitioner to the possibility of civil or criminal liability.

To be valid, consent requires certain qualities:

- The patient must have the capacity to give consent
- The patient must be able to understand the general nature of the treatment
- The consent must cover the act performed
- The consent must be voluntary

INFORMED CONSENT

'Informed consent' is a separate concept to consent, but it is related.

Informed consent means consent to treatment after having been informed of all significant risks associated with the treatment. All health practitioners should try to ensure that patients are fully informed of the risks and benefits of any treatment before obtaining consent.

THE CAPACITY OF ADULTS TO CONSENT OR TO REFUSE TREATMENT

Across Australia, 18 years is the legal age of majority ('adulthood'). The law assumes that adults

are competent to make decisions (either consent or refusal) about their medical treatment even if their decision is deemed not to be in their best interests.

There is an exception for adults who lack the capacity to make treatment decisions, such as people with intellectual disabilities or those affected by certain forms of mental illness. All states and territories in Australia have laws that allow others (e.g. family members, guardians, courts or tribunals) to make decisions for people who lack the capacity to make decisions on their own behalf.

THE CAPACITY OF YOUNG PEOPLE TO CONSENT TO TREATMENT

Young people under 18 are minors under Australian law. Minors have the legal capacity to make their own decisions, independently of their parents, in a variety of situations (Lennings 2013).

In general, if the patient is under the age of 14 years, the consent of the parent or guardian is necessary.

Minors aged 14 and above may have the capacity to consent to medical treatment depending on their level of their level of maturity; their understanding of the proposed treatment and its consequences; and the severity of treatment. A health practitioner must make a case-by-case assessment of whether the young person has sufficient understanding and intelligence to enable him or her to fully understand what is proposed.

PARENTAL CONSENT FOR TREATMENT

If a child under 18 does not have the capacity to consent to treatment, in general a parent may consent on their behalf.

In many cases, even if a child is competent to consent on their own behalf, a parent may still validly consent on their behalf. However, if a health practitioner considers that a child is competent, it may be appropriate to obtain both parental and patient consent. For some types of major and special treatment (such as sterilisation) parental consent is not sufficient, and a court order is required.

EMERGENCY TREATMENT

In general, treatment may be performed without the consent of either the parent or the child if the health practitioner is of the opinion that the treatment is necessary, as a matter of urgency, in order to save the child or young person's life. In practice, that means that emergency medical and first aid treatment may be provided without the consent of the minor or a parent or guardian.

THE LAW ABOUT CONSENT TO MEDICAL TREATMENT FOR CHILDREN

Australian law is a mixture of statute law (Acts and Regulations, also known as statutes or legislation, made by Parliament) and common law (which is made by the courts when they make decisions which set a precedent for future cases).

In all Australian states and territories except South Australia, there is no legislation specifying when a child may consent to medical treatment on their own behalf. Instead, the common law applies.

At common law, a child under 18 may legally consent to most types of medical treatment on their own behalf if they are competent to do so. If the child is not competent, parental consent must usually be obtained (Bird 2005).

The common law position relating to a minor's competence to consent to treatment was established by the English House of Lords decision in a case known as 'Gillick' (*Gillick v West Norfolk and Wisbech Area Health Authority[1986] AC 112*) and was adopted by the High Court of Australia in a case known as 'Marion's case' (*Secretary, Department of Health and Community Services v JWB and SMB (Marion's case) (1992)175 CLR 218)*

The Gillick case concerned an application by a mother for an order to prohibit the local health authority from giving contraceptive advice to her teenage daughters without parental consent. The court dismissed Mrs Gillick's claim and held that parental authority over their child diminishes as the child becomes increasingly mature. The court held that a child with the maturity to understand the nature and consequences of the treatment has the legal capacity to consent on their own behalf, without the necessity for parental consent or knowledge.

The term 'Gillick competence' is now widely used by lawyers and health practitioners dealing with young people (Wheeler 2006). It is also common to refer to the 'mature minor principle'.

For a child to be 'Gillick competent' he or she must have "sufficient understanding and intelligence to enable him or her to understand fully what is proposed". This must be assessed on a case-by-case basis depending on the nature of the treatment proposed.

SOUTH AUSTRALIA

Section 6 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides:

"A person of or over 16-years-of-age may make decisions about his or her own medical treatment as validly and effectively as an adult." This means that

a child aged 16 or over has the capacity to refuse treatment as well as consent to it.

A child under 16 can validly consent to treatment if:

"The medical practitioner is of the opinion that the child capable of understanding the nature, consequences and risks of the treatment and that the treatment is in the best interest of the child's health and well-being, and

That opinion is supported by the written opinion of at least one other medical practitioner who personally examines the child before the treatment is commenced. (Section 12, Consent to Medical Treatment and Palliative Care Act 1995 (SA))"

If emergency medical treatment is required "to meet an imminent risk to life or health" and the patient is incapable of consenting (e.g. because they are unconscious or lack competence), treatment may proceed without their consent. However, if the patient is 16 or over, they have the right to refuse treatment (*Consent to Medical Treatment and Palliative Care Act 1995* (SA) Section 13).

NEW SOUTH WALES

New South Wales does not have any legislation specifying when a child has the capacity to consent to medical treatment (NSW Law Reform Commission 2008).

However, under the *Minors (Property and Contracts) Act* 1970, if a minor aged 14 and above consents to their own medical treatment, the minor cannot make a claim against the medical practitioner for assault or battery. Also, where medical treatment of a minor aged less than 16 years is carried out with the consent of a parent or guardian of the minor, the minor cannot make a claim against the medical practitioner for assault or battery.

This law is intended to protect doctors and dentists from liability, but it does not alleviate the need for a practitioner to make an assessment of the young person's competence in each individual case. A child younger than 14 may be competent to consent to treatment. Conversely, a child aged 16 or over may lack competence.

MAKING A COMPETENCY ASSESSMENT

Health practitioners need to make an assessment of competency to consent for all young people aged under 18 years (or 16 years in South Australia).

Competency will depend on age, maturity, intelligence, education, level of independence, and ability to express their own wishes. It will also depend on the gravity of the treatment proposed. For more drastic, invasive or risky types of treatment, a medical practitioner will need to take special care to ensure that the young person possesses the required competence to consent to treatment.

Health practitioners must form their own opinion about a patient's *'intelligence and understanding'*. For a young person, a full understanding involves appreciating:

- What the treatment is for and why the treatment is necessary
- Any treatment options or alternatives
- What the treatment involves
- Likely effects and possible side effects/risks
- The gravity/seriousness of the treatment
- Consequences of not treating
- Consequences of discovery of treatment by parents/guardians

If a health practitioner is unsure whether a minor is competent they can:

- Seek the opinion of a colleague.
- Seek the consent of the minor's parents or legal guardians. Keep in mind, however, the young person's right to privacy and confidentiality and the risks of disclosing sensitive information to a parent, particularly in challenging family situations, or with sensitive areas such as contraception and pregnancy.
- Obtain legal advice about applying for a court or tribunal order if the practitioner considers the treatment to be necessary and in the patient's best interests.

A health practitioner should make a file note about the outcome of the competency assessment. The file note should form part of the patient's medical record.

YOUNG PEOPLE WITH INTELLECTUAL DISABILITIES

A young person with an intellectual disability is not automatically deemed incompetent to consent to treatment. The competence of a young person with an intellectual disability must be assessed on a case-by-case basis.

YOUNG PEOPLE WHO ARE PARENTS

A minor who is a parent has the legal capacity to consent to treatment for his or her child, in the same way as adult parents. However, the minor may not necessarily have legal capacity to consent to his or her own treatment.

LANGUAGE AND CULTURAL ISSUES

A medical practitioner's assessment about a child's competency could be influenced by cultural

differences between the doctor and the young person. A cognitively mature adolescent may come across as socially or emotionally immature (or vice versa) because of different cultural expectations about their roles in the family/society (e.g. they may seem less independent), or differences in the way their thoughts or wishes are communicated. If in doubt, seek advice from a colleague or an appropriate agency.

Valid consent can only be obtained if the young person understands what is being presented in a language in which they are fluent. Health care interpreters should be used where appropriate, particularly when working with a family from a non-English speaking background.

Children should not be used as interpreters for their parents.

Over the telephone interpreting is available through the *Translating and Interpreting Service* (TIS) – telephone 131 450. This is a national service provided through the Department of Immigration and Border Protection and is free to GPs and pharmacists. The TIS is available 24 hours a day, 7 days a week, and is accessible from anywhere in Australia for the cost of a local call.

THE RIGHT TO REFUSE TREATMENT

The Gillick principle that allows for a competent minor to consent to treatment does not allow for a corresponding right to refuse treatment.

In many cases, a health practitioner would be reluctant to perform treatment over a young person's objection, especially if the young person is relatively mature and it is not major or life-saving treatment.

However, treatment may be performed against a child's wishes, even if they are Gillick competent where the treatment is urgent. In such cases, treatment may proceed without obtaining parental or patient consent. Otherwise, parental consent to refuse treatment or a court order would be necessary.

COMMON AND NOT-SO-COMMON MEDICAL ISSUES

PROVIDING SEXUAL HEALTH EDUCATION, INFORMATION AND CONDOMS

There is no restriction on providing these to children of any age, although health workers should ensure that these are being provided in an age-appropriate way.

PRESCRIBING CONTRACEPTION

Hormonal contraception (the oral contraceptive pill, injectable and implantable hormones) can be prescribed for a minor, regardless of the reason/s why, without parental consent, provided that the young woman is deemed competent by her doctor to give informed consent. This is also true for emergency hormonal contraception ('morning after pill').

STERILISATION

Sterilisation for contraception purposes cannot generally be performed without a court or tribunal order, even if the parent or child gives consent (see further discussion of sterilisation below).

Each state and territory has slightly different laws. In NSW, for example, sterilisation is regarded as a "special medical treatment" and may not be performed on a child under 16 without an order from the Guardianship Tribunal, unless it is performed to remediate a life-threatening condition.

If sterilisation is an unwanted consequence of another treatment which is necessary to save a young person's life or prevent serious damage to their health, treatment can generally be performed with the child's consent (if deemed Gillick competent) or otherwise with parental consent.

However, if sterilisation is sought for contraceptive purposes, or for other purposes (such as menstrual management for a young woman with an intellectual disability) then a court or tribunal order may be required.

For a child who does not have the capacity to consent to non-therapeutic sterilisation (i.e. the sterilisation is not for the purpose of treating a disease), parental consent is not sufficient and a court or tribunal order is required.

This is the effect of the decision of the High Court of Australia in 'Marion's case', which concerned a young woman with an intellectual disability. Her parents were gravely concerned not only about the risk of pregnancy, but also about her ability to cope with menstruation. The court held that where the child is not Gillick competent and the medical procedure is non-therapeutic, a court order is required. This is because there is a significant risk of making a wrong decision about the child's capacity to consent or the child's best interests, and the consequences of making a wrong decision are grave.

In most states and territories, it seems that a Gillick competent child aged 16 or over may be able to consent to sterilisation. However, in accordance with the Family Court's decision in *Re: Jamie* (see the discussion of this case under *Treatment of transgender children*), there may be a need for a court to determine whether or not the child is Gillick competent.

TREATMENT OF TRANSGENDER CHILDREN

The law about treatment of transgender children has been uncertain for some time. It has recently been clarified by the full court of the Family Court of Australia in the case of *Re: Jamie* [2013] FamCAFC 110.

The issues surrounded a child seeking treatment to transition from one gender to another.

The court drew a distinction between stage 1 treatment (which involves hormonal treatment, is reversible and is considered to have few, if any, side effects) and stage 2 treatment (which involves additional treatment with oestrogen and may also involve surgical intervention).

The court held that stage 1 treatment may proceed without court authorisation if the child, parents, and treating medical practitioners agree.

However, stage 2 treatment is another matter. Because there is a significant risk of the wrong decision being made as to a child's capacity to consent to treatment, and the consequences of such a wrong decision would be particularly grave, the court held that:

- If a child *is not* Gillick competent, the court must decide whether or not to authorise stage 2 treatment.
- If a child *is* considered Gillick competent, the child can consent to stage 2 treatment without court authorisation; however, only the court can determine whether the child is Gillick competent.

TERMINATION OF PREGNANCY

In most Australian states and territories, abortion is not completely legal. There are minor variations from state to state, but in general abortion is legally available if it is necessary to avoid serious danger to the woman's life or physical or mental health. Performing an abortion in other circumstances can amount to a criminal offence.

The Australian Capital Territory, Victoria and Tasmania are the only jurisdictions in Australia where abortion has been decriminalised (i.e. where abortion is not referenced in any criminal laws). In those states, medical practitioners are permitted to carry out abortions under the following legislation:

- Australian Capital Territory: *Medical Practitioners (Maternal Health) Amendment Act 2002*
- Victoria: *Victoria Abortion Law Reform Act 2008*
- Tasmania: *Reproductive Health (Access to Terminations) Act 2013*

In most Australian states and territories, the same laws governing consent and confidentiality will apply in the case of a young woman seeking termination, as with any other form of health care. However, in some states and territories parental consent for women under 18 is required:

- Northern Territory – parental consent is required if the young woman is under 16 (section 11, *Medical Services Act*)
- Western Australia – If the young woman is under 16, her parents must be informed and be given the opportunity to be involved in counselling and medical consultations. If the young woman does not wish her parents to be informed, she must apply to the Children's Court to maintain confidentiality (section 334, *Health Act 1911* (WA))
- South Australia – if the young woman is under 16 and can't talk to her parents, she can still give consent for the procedure; however, two doctors will need to certify that she understands her decision and the procedure, and that it is in her best interests.

The legal onus falls on the medical practitioner who will conduct the abortion to ensure that informed consent is obtained from the woman seeking the termination, regardless of her age.

In order to allow the woman to make an informed choice about the decision to terminate the pregnancy, thorough pre-termination counselling and explanation of all possible adverse effects should be provided.

A doctor (or other health provider) can refuse to discuss, refer or assist a termination based on his or her own religious or personal beliefs, without risk of anti-discrimination action. However the provider would have a duty to take appropriate action to explain and offer alternatives, including referral to another practitioner.

These legal principles are the same regardless of whether a young woman is having a surgical or a medical abortion.

MENTAL HEALTH

All states and territories have their own mental health legislation governing voluntary and involuntary treatment for patients with mental illnesses.

In NSW, the Act specifies the surgical procedures and special medical treatments which require consent and who may provide that consent, including, where relevant, the need to get a court or tribunal's authorisation for treatment.

CONFIDENTIALITY, PRIVACY AND ACCESS TO HEALTH RECORDS

CONFIDENTIALITY

All health practitioners have a duty of confidentiality that arises from the nature of the information provided in the course of the therapeutic relationship with the patient. A patient is entitled to expect that information discussed during a consultation will not be shared with other parties without their explicit permission.

If a child has the capacity to consent to medical treatment on their own behalf, they are generally also entitled to confidentiality. This includes the right for the child's health information to be kept confidential from their parents.

If a child is not competent to consent to treatment, and a parent has consented to treatment on their behalf, the parent would be entitled to information about the child's heath care.

EXEMPTIONS TO CONFIDENTIALITY

The exemptions to the duty to maintain confidentiality are both legal and ethical.

WHERE THE PATIENT CONSENTS TO DISCLOSURE

A patient can give express verbal or written permission or implied permission for their health provider to disclose information to a third party – e.g. a parent, or another professional involved in their care. Such consent should not be coerced and should be adequately documented. It is important to discuss and clarify with the young person whether they consent to others having access to their health information, and under what circumstances.

WHERE DISCLOSURE IS NECESSARY TO TREAT A CLIENT

If there are multiple providers involved in a young person's health care, it can be considered reasonable that communication between providers would serve in the best interests of the patient: the concept of 'team confidentiality' can be explained to patients when working within a multidisciplinary team. However, it is advisable to seek a patient's permission to disclose any non-urgent communications outside these parameters.

WHERE THE PROVIDER IS COMPELLED BY LAW TO DISCLOSE

Note that in these instances, information disclosed is usually kept in confidence and not divulged to outside parties:

- Court proceedings – these may involve a provider giving evidence in court or producing health records under subpoena. However, the provider may be able to claim privilege over this information and should not simply disclose them to the court without obtaining legal advice.
- Notifications – medical practitioners have specific requirements to notify public authorities of matters such as:
  - » Evidence of a notifiable disease (including HIV infection, AIDS, all forms of hepatitis, tuberculosis, and several others)
  - » Reporting of blood alcohol level test results for patients admitted to hospital after a motor accident
  - » Births and deaths
- Mandatory reporting of child abuse (see Mandatory Reporting, below).
- Best interests of the patient – this exemption relates to a situation where a provider believes there is a real risk of serious harm to the patient – e.g. a young person at risk of suicide – if information is not disclosed to a third party. Such a decision and the basis upon which it is made should be well documented in the patient's medical record, especially in circumstances where the patient has not consented to the disclosure.
- Public interest – in practice, this could include a situation where a provider is made aware by a patient that they have committed, or intend to commit, a serious criminal offence. Practitioners should obtain legal advice about whether or not they have an obligation to disclose the information depending on the circumstances.

PRIVACY AND ACCESS TO HEALTH RECORDS

Privacy and confidentiality are very similar concepts. As well as a common law right to confidentiality, patients have a statutory right to privacy over their health information and health records.

The *Privacy Act* 1988 (Commonwealth) applies throughout Australia and applies to personal and health information held by private sector providers. It does not cover state and territory public hospitals and clinics.

States and territories have their own laws covering privacy and health records. These apply to public sector agencies, and some apply also to the private sector (e.g. the NSW Health Records and Information Privacy Act 2002 applies to both)

In general, patients have a right of access to their health records, a right to demand that the records be corrected if inaccurate, and a right to ask for their health information not to be shared with other health providers or third parties.

There are exceptions to the right to privacy in certain circumstances, similar to the exemptions to confidentiality discussed above.

Young people under 18 can exercise their own privacy choices (e.g. not allow parents to see their records) once they are able to understand and make their own decisions. Generally, this will go hand-in-hand with competence to consent to medical treatment (Australian Law Reform Commission 2006).

MEDICARE AND PRIVACY

Children can apply for their own Medicare card (and number) when they turn 15, without parental consent. Those under 15 can apply with parental consent.

Young people do not necessarily have to have their own Medicare card to seek a health service that attracts a Medicare rebate independently of their parents. Health professionals may accept the Medicare number linked to the patient's parents without physically seeing the card.

Medicare records include the identity and specialty of the provider of a health service and the type of service received. If a young person has their own Medicare card, parents and guardians cannot access Medicare record information without the consent of the young person. If the young person is still on the family Medicare card and aged 14 or 15, generally their consent must be obtained before information about Medicare records is released to parents or guardians.

Parents and guardians have the right to request Medicare Australia to approach health providers about whether they will release information about their adolescent child.

Once a child is 16, Medicare can only give information to parents or guardians with the young person's consent.

EHEALTH RECORDS AND PRIVACY

The eHealth system is designed to contain an electronic summary of a person's key health information such as prescribed medications, allergies and treatments they have received. Health practitioners can upload health information to the eHealth record for individual patients and view the information in it uploaded by other practitioners.

Young people under 18 may have an eHealth record.

A person with parental responsibility for a person under 18 can register for an eHealth record on their child's behalf. The parent can then access and control the eHealth record of that young person on their behalf as an "Authorised Representative", until the young person takes control of their eHealth record or turns 18.

If the young person has capacity to consent to treatment and confidentiality in their own right, a parent cannot be their "Authorised Representative" unless the child consents to this.

When a young person turns 14, information from both the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) will cease to be included in their eHealth record. This information will only be made available again if the young person takes control of their eHealth record and consents to the inclusion of MBS and/or PBS data.

If a young person is under 14 and would like to take control of their existing eHealth record or register for an eHealth record, they will need to prove to the System Operator that they can make decisions about their healthcare and can manage their eHealth record.

CHILD PROTECTION AND MANDATORY REPORTING

All states and territories in Australia have legislation pertaining to the care and protection of children and young people. All have mandatory reporting requirements for health professionals, and many extend the mandatory reporting requirements to a range of other people who work with children. Mandatory reporting refers to the legislative requirement imposed on certain people to report suspected cases of child abuse and neglect to government authorities.

Each state has its own laws concerning who has to report, what types of abuse and neglect need to be reported, and the threshold of concern of harm which triggers the obligation to report.

NEW SOUTH WALES

In NSW, for the purposes of child protection legislation a child is a person under 16 years of age, and a young person is 16 or 17 years old.

It is mandatory for any professional working with children to notify if they have reasonable grounds to suspect that a child under 16 is at risk of significant harm. In addition, health workers may make a report about a young person aged 16-17 or class of young people that they suspect are at risk of significant harm.

Factors that may indicate a child is at risk of significant harm include physical, sexual or emotional/psychological abuse, neglect, or exposure to family violence. (Sections 23 & 27, *Children and Young Persons (Care and Protection Act* 1988 (NSW)).

In NSW mandatory reporters are those who deliver the following services to children as part of their paid or professional work:

- Health care - doctors, nurses, dentists and other health workers
- Welfare - psychologists, social workers and youth workers
- Education - teachers
- Children's services - child care workers, family day carers and home based carers
- Residential services - refuge workers, community housing providers
- Law enforcement - police

Any person with direct responsibility to provide the services listed above must report risk of significant harm to children. Managers, including both paid employees and volunteers, who supervise direct services are also mandated to report. If you are a mandatory reporter, you can call the Child Protection Helpline on 133 627. Members of the general public should call 132 111.

In NSW Child Wellbeing Units (CWUs) exist within four government departments – NSW Police Force, Department of Education and Communities, NSW Health and the Department of Family and Community Services. CWUs provide advice to mandatory reporters within the agency in which they are based. The NSW Health Child Wellbeing Units can be contacted on 1300 480 420. Agencies without a CWU can contact the Keeping Them Safe Support Line for information and advice on 1800 772 479.

FINDING OUT MORE...

In NSW, mandatory reporters are encouraged to use the Mandatory Reporter Guide to guide their decision making and determine whether or not to report to the Child Protection Helpline. The interactive online guide can be visited at www.keepthemsafe.nsw.gov.au.

Find out more about mandatory reporting in NSW at www.community.nsw.gov.au

Information and advice on domestic violence in NSW is available at www.domesticviolence.nsw.gov.au.

A NEW APPROACH TO CHILD PROTECTION

Child safety and wellbeing is a whole of community responsibility. Therefore reporting children at risk of significant harm is only a part of the health worker role. Health workers participate in a shared system of child wellbeing and child protection by identifying risk of harm, consulting the Mandatory Reporter Guide and their Child Wellbeing Unit if appropriate, and responding to the vulnerabilities, risks and needs of families, children and young people that they identify. For example, the Health worker may provide family support services and refer to other services for additional family support.

The role and responsibilities of NSW Health workers in the new approach to child protection are outlined in the fact sheet that can be found at:

http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_007.pdf

AUSTRALIAN CAPITAL TERRITORY

In the ACT, health professionals must notify if they believe on reasonable grounds that a child or young person has experienced or is experiencing sexual abuse or non-accidental physical injury (section 356, Children and Young People Act 2008 (ACT))

NORTHERN TERRITORY

In the NT, any person must make a report if they believe on reasonable grounds that a child of any age has suffered or is likely to suffer harm or exploitation, physical or sexual abuse, emotional/psychological abuse, neglect, exposure to physical violence (e.g. a child witnessing violence between parents at home) (sections 15, 16 & 26, Care and Protection of Children Act 2007 (NT)).

In addition, a registered health professional must report if they have reasonable grounds to believe a child aged 14 or 15 has been, or is likely to be, a victim of a sexual offence and the age difference between the child and the offender is greater than two years (section 26(2), Care and Protection of Children Act 2007 (NT)).

QUEENSLAND

In Queensland, a doctor or registered nurse must report if they become aware of, or develop a reasonable suspicion of, harm or risk of harm due to factors of physical, psychological/emotional abuse, neglect, sexual abuse or exploitation (sections 191-192 & 158, Public Health Act 2005 (Qld)).

SOUTH AUSTRALIA

In SA, doctors, pharmacists, registered or enrolled nurses, dentists, psychologists, employees/volunteers in a government department, agency or instrumentality, or local government agency that provides health services wholly or partly for children must report if they suspect or believe on reasonable grounds that a child has been or is being emotionally/psychologically abused or neglected (Children's Protection Act 1993 (SA)).

TASMANIA

In Tasmania, registered medical practitioners, nurses, midwives, dentists, dental therapists / hygienists, registered psychologists and employees/ volunteers in a government department, agency or instrumentality, or local government agency that provides health services wholly or partly for children must report knowledge, belief or suspicion on reasonable grounds that a child has been or is being abused or neglected or is an affected child whose safety, psychological wellbeing or interests are affected or likely to be affected by family violence; or there is a reasonable likelihood of a child being killed, sexually/physically/psychologically abused or neglected by a person with whom the child resides (sections 3, 4 & 14, Children, Young Persons and Their Families Act 1997 (TAS)).

VICTORIA

In Victoria, registered medical practitioners , midwives or registered nurses must report a belief on reasonable grounds that a child is in need of protection because they have suffered, or are likely to suffer, significant harm as a result of physical injury, sexual abuse, emotional/psychological harm and the child's parents have not protected, or are unlikely to protect, the child from harm of that type or the child has been abandoned by their parents or the parents can't be found or are incapacitated /dead and there is no-one else willing to take the child (sections 182, 184 & 162, Children, Youth and Families Act 2005 (Vic))

WESTERN AUSTRALIA

In WA, doctors, nurses and midwives must report a belief on reasonable grounds that child sexual abuse has occurred or is occurring (sections 124A & 124B, Children and Community Services Act 2004 (WA)).

VOLUNTARY REPORTING

In situations where a health practitioner does not consider that the threshold of 'risk of significant harm' is met, reporting is not mandatory. However, voluntary reporting is provided for under the relevant legislation (for example, in NSW, it is not mandatory to make a report in relation to a young person aged 16 or 17).

PROTECTION FOR HEALTH PRACTITIONERS

Under the relevant legislation, a health practitioner is protected from civil or criminal liability (e.g. breach of confidentiality litigation, professional misconduct action, defamation proceedings) if they make a report (whether voluntary or mandatory) in good faith to the relevant child protection authority. They are also protected from having their identity disclosed to the extent that this is possible.

In NSW the legal framework for information exchange allows organisations to share information relating to the safety, welfare and wellbeing of children or young people without consent. The safety, welfare and wellbeing of children and young people is considered paramount and takes precedence over the protection of confidentiality or of an individual's privacy. While consent is not necessary, it should be sought where possible. Organisations should at a minimum advise children, young people and their families that information may be shared with other organisations.

FINDING OUT MORE...

In NSW there are specific policies which provide guidance and agreed interagency procedures for exchanging information related to the safety, wellbeing and welfare of children and young people, and which allow information exchange to occur irrespective of whether a report has been made to the Child Protection Helpline. Visit www.health.nsw.gov.au/policies (use child wellbeing as a search term) or www.keepthemsafe.nsw.gov.au

RECOGNISING RISK OF HARM

In practice, because adolescence is a time of experimenting with high risk behaviours, it can be difficult to determine what constitutes a mandatory reporting concern. If a report is going to be made, it is nearly always advisable to inform the young person and to explain why you are going to make a report.

A number of things should be considered in determining whether a child/young person is at significant risk of harm, including:

- The age, development, functioning, and vulnerability of the child or young person
- Behaviours of a child that suggest they may have been harmed by another person (e.g. mimicking violence; sexualised behaviour, unexplained physical complaints)
- Behaviour of another person which might have a negative impact on healthy development, safety or wellbeing (e.g. drug abuse; domestic violence)
- Physical signs of abuse or ill-treatment (e.g. bruises; lacerations; burns; fractures or other injuries)
- Concern about other family members (e.g. recent abuse or neglect of a sibling, or parents experiencing mental health problems)

Under-age sex does not necessarily equate to abuse, and is not automatically a ground for mandatory reporting.

If you have any concerns or are uncertain about whether you should make a report, call the relevant authority in your state or territory and discuss your concerns with them.

FINDING OUT MORE...

The Australian Institute of Family Studies (AIFS) has a factsheet that examines legal provisions requiring specified people to report suspected abuse and neglect to government child protection services in Australia. It is available at www.aifs.gov.au/cfca/pubs/factsheets/a141787

CULTURAL ISSUES

Some traditional cultural practices may place a young person at risk of harm. For example, the practice of female genital mutilation (FGM), which is practised in a number of countries, is a criminal offence in Australia.

It is important to be aware of different cultural practices and to determine whether there is any risk of harm to the young person before reporting such practices.

Handle such situations sensitively – explain to patients that legal and ethical issues may override cultural considerations and that all Australians are bound by Australian law, regardless of cultural traditions.

There have been cases in which a child or young person has been wrongly assessed by a mandatory or voluntary reporter as suffering from abuse from culturally determined health practices (e.g. "coining" or "cupping" in Vietnamese and Laotian communities) which are in fact acceptable and safe practices within the Australian context. If you are in doubt about a particular cultural practice, consult with a culturally appropriate or bilingual health professional.

FINDING OUT MORE...

There is a wide range of resources available to help health practitioners understand and navigate medico-legal issues.

For further information about relevant laws applying to young people the Australasian Legal Information Institute (AustLII) provides an online database of Australian legislation and case law - www.austlii.edu.au

For information on a range of legal issues affecting young people in each Australian state and territory, visit the National Children's and Youth Law Centre's lawstuff at www.lawstuff.org.au

The Shopfront Youth Legal Centre is a free legal service for disadvantaged young people. It provides fact sheets on legal issues, including young people and health care in NSW. Visit www.theshopfront.org

For information on Medicare – www.medicareaustralia.gov.au

For information on sexual health and family planning issues - Sexual Health & Family Planning Australia - www.shfpa.org.au

The Office of the Australian Information Commissioner has factsheets on health, eHealth and privacy.

Queensland Health has produced a Guide to Informed Decision-making in Healthcare.

Community based workers may find this guide useful - Working with Youth: A legal resource for community based health workers. Child and Adolescent Health Service, WA. (2009).

Chapters by Kang and Sanders (2013) and Sanci (2001) also provide overviews of medico-legal issues for health professionals.

CHAPTER SUMMARY – WHAT TO REMEMBER

Medico-legal issues that arise when working with young people are rarely clear-cut. Much responsibility is placed on health practitioners to make an assessment of the young person's capacity to consent to treatment or to refuse treatment. There are, however, some circumstances where common law or legislation establishes exactly what is required.

REFLECTION QUESTIONS

How comfortable are you with your understanding of medico legal issues and how they affect the work you do with young people?

Are you a mandatory reporter? Do you understand your obligations in this area? Do you understand how to support families where children are at risk of harm?

Do you know where you can get advice about medico legal issues?

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SECTION 3.6

CULTURAL DIVERSITY AND CULTURALLY-COMPETENT PRACTICE

3.6 CULTURAL DIVERSITY AND CULTURALLY-COMPETENT PRACTICE

PETER CHOWN AND MELISSA KANG

Australia is a country of many cultures. Almost one in four Australian residents were born outside of Australia. Many are first or second generation Australians whose parents and grandparents were migrants or refugees. In the adolescent years, cultural identity and experiences can have a profound impact on health and wellbeing.

Young people from CALD backgrounds face the dual challenge of dealing with the developmental tasks of adolescence and growing up between two cultures. The concept of 'adolescence' - and the expectations, roles and duration of adolescence - may be defined differently in different cultures. Indeed, in some cultures the concept of adolescence does not exist as a developmental stage, and young people are seen as going straight from childhood to adulthood.

Workers need to understand the cultural influences operating in a young person's life and take into account in their practice the range of cultural, ethnic, and social diversity among young people.

CULTURALLY AND LINGUISTICALLY DIVERSE YOUNG PEOPLE

Australia has large and growing numbers of young people from Culturally and Linguistically Diverse Backgrounds (CALD). This includes young people who were born overseas; young people whose parents were born overseas; and young people who have strong affiliations with their family's culture of origin.

In 2011, according to the census, 17% of Australian 12-24 year olds were born overseas.

Of young people born overseas aged 12-24, 157,081 were born in other English-speaking countries, notably New Zealand and the United Kingdom, and around 442,085 were born in non-English speaking countries, including China, India, Philippines, Malaysia, Hong Kong, Vietnam and South Korea.

There continues to be a strong increase in the proportion of young people born in China, India and Nepal and significant increases since 2006 in those born in Zimbabwe, Philippines, Afghanistan, Iraq and Burma.

A young person's experience of belonging to or identifying with a particular culture can be a major protective factor in promoting their overall wellbeing. A sense of belonging, identity and support enables young people and their families not only to survive the hardships, traumas, and losses associated with migration and resettlement, but in fact to be strengthened by these experiences. Strong cultural identification enhances resilience and mitigates such risks as:

- The experience of being a refugee
- Exposure to war
- The impact of their parents' refugee experience (for example, their parents' experience may generate pressure on the young person to succeed in the new country or cause difficulties for parents in providing adequate support because of their own traumatic experiences)
- Separation from family
- Being subjected to torture or trauma
- English language difficulties
- Racism and discrimination
- Post-traumatic stress

ADOLESCENCE AND CULTURAL DIFFERENCE

Many young people from CALD backgrounds face the challenge of dealing with the tasks of adolescence while growing up between two cultures. This involves not only two languages but often very different behavioural and social expectations (Bashir and Bennett 2000).

There may be great variation in cultural values and norms regarding the central tasks of adolescence – such as developing a sense of identity and independence. The achievement of independence and an individual identity are highly valued outcomes of adolescent development in Australia. However, this may conflict with the values of some cultures where "competence" as a young person is primarily defined as someone who meets their obligations to their family (Lau 1990). In some cultures, adolescence is a time of strengthening one's family bonds and taking on increased responsibility and new roles within the family – young people may be more restricted than before and their activities closely monitored. Girls in particular may be subject to stricter controls – especially if parents feel threatened by their exposure to the values of the new and unknown culture.

Young people tend to adapt to the values and ways of the new culture more readily than their parents do, so young people from CALD backgrounds may feel torn between meeting their family's expectations of

them and adopting the norms of the new culture in order to fit in with their peers.

Traditional family roles may also change due to the influence of the new culture. Young people may have to adopt a more adult role in the family because they have greater English literacy and are more familiar with social norms than their parents.

The development of a healthy individual identity is a major task of adolescence. Young people from CALD backgrounds face the additional challenge of deciding about their cultural identity (Bennett et al. 2009).

Some cultures place less emphasis on the importance of the individual – the family and cultural mores are valued above the attainment of an individual identity, and play a central role in shaping the development of the young person's identity (Bennett et al. 2009).

Young people can experience an identity crisis as they attempt to work out their affiliation to their culture of origin and their place within the dominant culture (*Am I Australian? Am I Chinese? Can I be both?*).

This struggle can also give rise to potential conflict with their parents and family members, who may fear losing influence or control over the young person and fear that the young person will abandon their native cultural identity.

Even second and third-generation children of migrants may still have an affiliation with their parents' culture of origin and may therefore face issues related to ethnicity, identity, language and their parents' cultural mores.

The way in which young people resolve these cultural identity conflicts has important implications for their mental health (Bennett et al. 2009). Young people who manage to retain the most important elements of their culture of origin, while developing the skills to adapt to the new culture, appear to cope best in their psychosocial adjustment (Bashir and Bennett 2000).

WORKING WITH YOUNG PEOPLE FROM CALD BACKGROUNDS

It is important to remember that young people from all cultural backgrounds require confidential care and a youth-friendly approach. What is most important is a willingness to engage in a dialogue with the young person about their cultural background and its influence, as well as an awareness of your own cultural biases and perceptions.

Successful engagement with CALD young people may have an extra layer of complexity. However, the principles of youth-friendly engagement and communication (as outlined in earlier chapters) apply to all young people, regardless of their cultural background.

It can be helpful to have a basic understanding of some of the different customs and cultural beliefs in the populations you work with. Many cultures have specific beliefs and practices for:

- Significant life events or situations (e.g. births, deaths, transitions to adolescence or adulthood, etc.)
- Family relationships and structure (e.g. the role of family authority and decision-making in regard to health care)
- Beliefs about illness and the meanings of symptoms
- Culturally-based health practices and treatments
- Beliefs about food or the use of medications
- Specific cultural or religious practices (e.g. fasting)

While it is useful to have a broad understanding of different cultures, cultural competence is really about the ability to communicate with young people from CALD backgrounds. Cultural competence involves being aware of your own attitudes and beliefs about different cultures and how these influence the way you perceive and communicate with young people from different backgrounds.

No matter their background, the young person you are working with is your most important source of cultural information. Their experience of their cultural background, family history and cultural identity is unique to them, so be open to discussing these things with them (Bennett et al. 2006). Where relevant, ask about beliefs within their culture of origin regarding:

- The cause and management of health issues
- Cultural or traditional health practices
- Cultural differences that might affect treatment (e.g. attitudes to sexuality, mental health issues, eating habits)

CULTURALLY-SENSITIVE COMMUNICATION

Effective communication is the key to addressing many of the cross-cultural issues that arise with CALD young people (Bashir 2000; Bennett et al. 2006, 2009). The skills required to communicate in a culturally appropriate manner are the same skills that apply to working with any young person:

- Adopt an open, non-judgemental approach
- Show positive regard and respect for differing values

- Provide reassurance about confidentiality
- Conduct interviews in an empathetic, sensitive way
- Ask questions in an open-ended style
- Keep language simple and avoid using jargon
- Provide reassurance of normality and allay fears and anxieties
- Be sensitive to gender issues, particularly the needs of young women when asking about sexual health. Many young women, regardless of their background, prefer to see a female nurse or doctor.

On a practical level:

- Ask the young person his or her preferred form of address, and do your best to pronounce their name correctly
- When conducting a psychosocial assessment enquire about acculturation and identity issues. How do they view themselves within the context of their culture?
- Engage them in a dialogue about their family history and relevant cultural background: enquire about various roles and responsibilities that a young person may have in their family and find out how decisions are made in the family/community

Example:

"Thuy, you said that your parents were born in Vietnam and that you grew up here in Australia. How do you mostly think about yourself – as Australian or Vietnamese, or both?"

It is also worth exploring:

- Ways in which they follow/do not follow the norms of their culture?
- How do they feel about their own/their parents' culture/their host culture?
- What has changed since they became an adolescent? Are they treated differently by parents, siblings, relatives, the community?
- Assess whether intergenerational and cultural differences are impacting on their health and development e.g. *What expectations do your parents have for you? How do you see things differently? Who supports you in the family (or outside)? When you feel down, who do you talk to? How do your parents feel about this?*

Be sensitive to signs of misunderstanding. These might include a puzzled expression or unusual response. You can also check their understanding of instructions or information you have provided by asking them to explain it to you.

FAMILY AND CULTURE

In many cultures, participation in health care is a family rather than individual responsibility, and it is common for family members to be involved in decision-making (Bennett et al. 2006). Engaging the family and gaining the trust of parents is critical to working effectively with young people from other cultures.

Respect parental authority with regard to decision-making while helping them to recognise the young person's growing need for independence appropriate to their age and stage of development (Lau 1990).

You may need to explain to both the family and the young person that your role is not to separate the child from his/her family, but work with them to ensure the young person's health and wellbeing. Try to spend some time alone with the young person, and explain to the parents your reasons for wanting to do this. Understand, however, that this may not be possible as it may be culturally inappropriate and disrespectful of the parental role.

FINDING OUT MORE...

The Transcultural Mental Health Centre (TMHC) is a statewide service that provides clinical consultation services and training and information for professionals working with people of CALD background including children, young people and families. These services include clinical assessment and shortterm intervention provided in the language of the client by qualified bilingual health professionals who are registered by appropriate professional bodies in NSW. THMC also provides over the phone advice and consultation on cultural/religious issues, mental health issues and other general health issues.

TMHC welcomes referrals and provides reports on the referred case as well as recommendations regarding care plans. All TMHC services are free of charge both to the referring agency and the young person. TMHC Clinical Services can be contacted on (02) 9912 3851 or Toll Free on 1800 648 911 (rural areas) or visit the Diversity Health Institute's website: www.dhi.health.nsw. gov.au/tmhc

The NSW Multicultural Health Communication Service provides information and services to assist health professionals to communicate with non-English speaking communities throughout NSW. Visit www.mhcs.health.nsw.gov.au

WORKING WITH YOUNG REFUGEES

The Refugee Council of Australia describes a refugee as *"an individual who has fled his or her home country due to a genuine fear of persecution based on race, religion, nationality, membership of a particular social group or political opinion."*

- Between 1991 and 2012, 77,883 young refugees aged 12-24 arrived in Australia. This represents 13% of the total migrant intake for this age group.
- 14% of these young refugees were from Iraq, 12% from Afghanistan, 11% from Sudan and a further 22% from other African countries.
- Most refugees in this age group settled in NSW and Victoria.
- The most commonly spoken languages for newly arrived young refugees were Arabic, Dari, Persian, Serbian and African languages.
- Most recently arrived refugees are aged under 30.

Young people who arrive in Australia as refugees may have experienced persecution or prolonged periods in refugee camps, often in transition countries, and many will have experienced some or all of the following:

- Forced departure from their country of origin
- Conflict, organised violence and human rights abuses
- A dangerous escape from their country of origin
- Torture and trauma

Consequently, the refugee experience is characterised by persecution, displacement, loss and grief, and forced separation from family, home and belongings. For refugee young people, the developmental tasks of adolescence are compounded by the traumatic nature of the refugee experience, cultural dislocation, loss of established social networks and the practical demands of resettlement. Sometimes young refugees may be harmed by the impact on their parents of traumatic experiences.

Refugee young people who do not have family in Australia may be at even greater risk because of their lack of support (Centre for Multicultural Youth 2006).

THE HEALTH OF YOUNG PEOPLE WHO ARE REFUGEES

Young people of refugee background will experience many typical adolescent health problems. However, they may also have health issues stemming specifically from their refugee experience. Common health issues for refugee young people include:

- Nutritional deficiencies and poor overall physical health as a result of living in unsanitary conditions in refugee camps
- Parasitic and infectious diseases (e.g. intestinal parasites; hepatitis B)
- Poor oral health due to poor diet and disruption to oral hygiene
- Limited past availability of preventative health programs (e.g. immunisation; vision and hearing screening)
- Mental health concerns arising from the deprivation and loss of extended family, friends and home, and the trauma of the refugee experience
- Physical and psychological effects of torture, trauma or witnessing violence or warfare
- Psychological symptoms – such as depression, anxiety, grief, anger, stress – that are often expressed as physical ailments

Whatever the presentation, refugee young people (especially new arrivals), should have a thorough physical and psychosocial assessment. A collaborative approach is essential

– especially in working with the mental health concerns of refugee young people. It is important to involve the family where possible

(Victorian Foundation for Survivors of Torture 2007)

FINDING OUT MORE...

Learn more about the health of refugee young people. There is a range of resources available online that can help you better understand the health needs and issues of refugees.

- Promoting Refugee Health: A guide for doctors and other health care providers has been produced by the Victorian Foundation for Survivors of Torture website. Visit www.foundationhouse.org.au
- The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) provides a comprehensive range of information and services for assisting refugees in their recovery and resettlement. Visit www.startts.org.au

It is helpful to know about specialised services for refugees that are available in your area. Ongoing support and advice may be available from specialised refugee health clinics. In NSW, for example, the Refugee Health Service provides health services directly to refugees and support and assistance to doctors and health professionals working with refugees. GPs can also use specific Medicare item

numbers for comprehensive assessment of newly arrived refugees. For more information, visit www.refugeehealth.org.au

Language and communication difficulties should be addressed quickly. Do not use a family member as an interpreter: not only is confidentiality not assured but you can't be confident that what is said is being accurately interpreted. Contact the Telephone Interpreter Service on 131 450 for assistance.

It is important to take time to build trust and rapport with the young person and his or her parents or carers. Remember that many may have come from a background with little or no health care, or their experience may lead them to distrust people in positions of perceived authority.

You may need to explain concepts such as:

- The family doctor and ongoing/preventative care
- Appointments and the referral process
- Confidentiality and consent

Be sensitive to specific health issues relating to the experience of grief, violence, torture and trauma. Explore these issues with sensitivity, as there is a risk of re-traumatising a young person.

CHAPTER SUMMARY – WHAT TO REMEMBER

All young people, regardless of cultural background, require confidential care and a youth-friendly approach. Where possible, check health risk behaviours and protective factors

Young people from Culturally and Linguistically Diverse backgrounds (CALD) face the challenge of dealing with the tasks of adolescence while growing up between two cultures. The most important source of cultural information is the young person himself or herself: be sensitive to how the young person sees their cultural background, family history, and how they define their cultural identity. How a young person looks does not reveal their cultural identity.

Young people who have a refugee background may have specific health issues relating to their experience as a refugee. You may need to seek specialist support from a Refugee Health Service to meet the health needs of these young people.

REFLECTION QUESTIONS

What is the cultural profile of the community you serve?

What are some of the specific challenges young people you work with face in terms of culture?

How well does your service address the needs of young people from CALD backgrounds?

Do you have staff members with CALD backgrounds? Why or why not?

Are staff trained in skills in working with young people from CALD backgrounds?

Do you know the cross cultural resources available to your service and our clientele? Are these resources on display in your service?

Does your service use culturally appropriate assessment tools?

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APPENDIX 2 - YOUR LOCAL SERVICES

Note contact details of services and resources for young people in your local area here:

Service Name	Type of Service/s Provided	Contact Details

APPENDIX 3 - YOUTH HEALTH CHECK

PROMPTS FOR YOUTH-FRIENDLY PRACTICE: *Rappport, Affirm attendance, Confidentiality statement with exceptions, Discuss billing policy if relevant, Check consent, Time alone &/vs. Time with parent/guardian/partner* **Consider developmental and physical health screening**	
Name	
Assessment Date	
DOB	
Gender	
Culture & Language	E.g. Aboriginal or TSI; Language spoken at home
Other services/adults involved	E.g. Parents, guardians, carers, agencies
Medicare card number	
Preferred client contact method & time	
Confidentiality statement with exceptions provided	( ) Yes ( ) No

YOUTH PSYCHOSOCIAL ASSESSMENT

HEEADSSS PSYCHOSOCIAL ASSESSMENT Explain reasons for delving into sensitive areas and ask permission to proceed; consider third-person approach to sensitive questions; look for protective as well as risk factors
H – Home (Consider - living arrangements, transience, relationships with carers/significant others, supervision, childhood experiences, cultural identity and family cultural background/s)
E – Education, Employment (Consider - school/work retention & relationships, bullying, belonging, study/ career progress & goals, changes in grades/performance)
E – Eating, Exercise (Consider - nutrition, vegetarianism, eating patterns including recent changes, vegetarianism, weight gain/loss, physical activity, fitness, energy, preoccupation with weight or body image, attempts to lose or control weight or bulk up including restricting, purging, supplements)
A – Activities, Hobbies & Peer Relationships (Consider - free time, hobbies, culture, belonging to peer group, peer activities & venues, involvement in organized sport, religion, lifestyle factors, risk-taking, including managing chronic illness and adjustments in adolescence, injury avoidance, sun protection, use of technology)
D – Drug Use (Consider - alcohol, cigarettes, caffeine, prescription/Illicit drugs and type, quantity, frequency, administration, interactions, access, increases/decreases- treatments, education, motivational interviewing)
S – Sexual Activity & Sexuality (Consider - knowledge, sexual activity, age onset, safe sex practices, same sex attraction, sexual identity, STI screening, unwanted sex, sexual abuse, pregnancy/children)
S – Suicide, Depression & Mental Health (Consider - normal vs clinical, mood, anxiety symptoms vs stress, change in sleep patterns, self harm, suicidal thoughts/ideation/intent/method/past attempts/treatment, depression score and mental state exam
S – Safety, Spirituality (Consider bullying, abuse, violence, traumatic experiences, risky behaviour, belief, religion; What helps them relax, escape? What gives them a sense of meaning?)

RISK ASSESSMENT

Consider R.I.S.K. guidelines: **R** - no risk = review; **I** - low risk = monitor; **S** - moderate risk = intervene; **K**- high risk = intervene			
Risk Factors		**Protective Factors**	
Suicidal ideation		**Suicidal intent**	
Current plan		**Risk to Others**	

CARE NETWORK: OTHER SERVICES/ADULTS INVOLVED IN CARE & SUPPORT

Consider any of the following	Aware of issues/ permission to share information?	Contact details
Parent/s, Carer/s, Guardian/s *(Who?)*		
School Staff *(E.g. school counsellor, Year Advisor, Teacher/s, Principal)*		
Medical / health specialists *(Including psychologist/ counsellor/ allied health)*		
Community health services		
Family support or counselling services		
Welfare services/ NGOs		
Other		

GOALS & ACTIONS

Feedback - Compliment areas going well, highlight need for on-going contact, negotiate management plan.	
Goals	**Actions**

FOLLOW UP

Referrals. Consider providing information about referral services and associated costs	
Follow up arrangements: OK to call home number? Call mobile only? SMS?	
Agreement on information to be shared with third parties:	

This document will be maintained in accordance with the relevant Privacy Legislation.

APPENDIX 4 - YOUTH HEALTH RISK ASSESSMENT

Use this form to record the responses of the young person to the HEEADSSS assessment.

Young Person's Name: **Date of Birth:**

Date of Assessment:

Assessment Area	Questions	Young Person's Responses
H - Home	**Explore home situation, family life, relationships and stability:** Where do you live? Who lives at home with you? Who is in your family (parents, siblings, extended family)? What is your/your family's cultural background? What language is spoken at home? Does the family have friends from outside its own cultural group/from the same cultural group? Do you have your own room? Have there been any recent changes in your family/ home recently (moves, departures, etc.)? How do you get along with mum and dad and other members of your family? Are there any fights at home? If so, what do you and/ or your family argue about the most? Who are you closest to in your family? Who could you go to if you needed help with a problem? Do you provide care for anyone at home? Is there any physical violence at home?	
E - Education / Employment	**Explore sense of belonging at school/work and relationships with teachers/peers/workmates; changes in performance:** What do you like/not like about school (work)? Do you feel connected to your school? Do you feel as if you belong? Are there adults at school you feel you can talk to about something important? Who? What are you good at/ not good at? How do you get along with teachers /other students/ workmates? How do you usually perform in different subjects? What problems do you experience at school/work? Some young people experience bullying at school, have you ever had to put up with this? What are your goals for future education / employment? Any recent changes in education/ employment?	

E – Eating & Exercise	**Explore how they look after themselves; eating and sleeping patterns:** What do you usually eat for breakfast/lunch/dinner? Sometimes when people are stressed they can overeat, or under-eat – Do you ever find yourself doing either of these? Have there been any recent changes in your weight? In your dietary habits? What do you like/not like about your body? **If screening more specifically for eating disorders you may ask about body image, the use of laxatives, diuretics, vomiting, excessive exercise, and rigid dietary restrictions to control weight.** What do you do for exercise? How much exercise do you get in average day/ week?	
A – Activities & Peer Relationships	**Explore their social and interpersonal relationships, risk taking behaviour, as well as their attitudes about themselves:** What sort of things do you do in your free time out of school/work? What do you like to do for fun? Who are your main friends (at school/out of school)? Do you have friends from outside your own cultural group/from the same cultural group? How do you get on with others your own age? How do you think your friends would describe you? What are some of the things you like about yourself? What sort of things do you like to do with your friends? How much television do you watch each night? What's your favourite music? Are you involved in sports/hobbies/clubs, etc.? Do you have a smart phone or computer at home? In your room? What do you use if for? How many hours do you spend per day in front of a screen, such as computer, TV or phone?	
D – Drug Use / Cigarettes / Alcohol	**Explore the context of substance use (if any) and risk taking behaviours:** Many young people at your age are starting to experiment with cigarettes/ drugs/alcohol. Have any of your friends tried these or other drugs like marijuana, injecting drugs, other substances? How about you, have you tried any? **If Yes, explore further** How much do you use and how often? How do you (and your friends) take/use them? – **explore safe/unsafe use; binge drinking; etc.** What effects does drug taking or smoking or alcohol, have on you? Has your use increased recently? What sort of things do you (& your friends) do when you take drugs/drink? How do you pay for the drugs/alcohol? Have you had any problems as a result of your alcohol/drug use (with police, school, family, friends)? Do other family members take drugs/drink?	

S – Sexuality	**Explore their knowledge, understanding, experience, sexual orientation and sexual practices – Look for risk taking behaviour/abuse:** Many young people your age become interested in romance and sometimes sexual relationships. Have you been in any romantic relationships or been dating anyone? Have you ever had a sexual relationship with a boy or a girl (or both)? – **if Yes, explore further** (If sexually active) What do you use to protect yourself (condoms, contraception)? What do you know about contraception and protection against STIs? How do you feel about relationships in general or about your own sexuality? (For older adolescents) Do you identify yourself as being heterosexual or gay, lesbian, bisexual, transgender or questioning? Have you ever felt pressured or uncomfortable about having sex?	
S – Suicide / Self-Harm/ Depression / Mood	**Explore risk of mental health problems, strategies for coping and available support:** Sometimes when people feel really down they feel like hurting, or even killing themselves. Have you ever felt that way? Have you ever deliberately harmed or injured yourself (cutting, burning or putting yourself in unsafe situations – e.g. unsafe sex)? What prevented you from going ahead with it? How did you try to harm/kill yourself? What happened to you after this? What do you do if you are feeling sad, angry or hurt? Do you feel sad or down more than usual? How long have you felt that way? Have you lost interest in things you usually like? How do you feel in yourself at the moment on a scale of 1 to 10? Who can you talk to when you're feeling down? How often do you feel this way? How well do you usually sleep? It's normal to feel anxious in certain situations – do you ever feel very anxious, nervous or stressed (e.g. in social situations)? Have you ever felt really anxious all of a sudden – for particular reason? Do you worry about your body or your weight? Do you do things to try and manage your weight (e.g. dieting)? Sometimes, especially when feeling really stressed, people can hear or see things that others don't seem to hear or see. Has this ever happened to you? Have you ever found yourself feeling really high energy or racey, or feeling like you can take on the whole world?	
You can also explore: **S – Safety** **S – Spirituality**	**Sun screen protection, immunisation, bullying, abuse, traumatic experiences, domestic violence, risky behaviours.** Have you ever been seriously injured? When did you last send a text message while driving? When did you last get into a car with a driver who was drunk or on drugs? **Beliefs, religion; What helps them relax, escape? What gives them a sense of meaning?**	