# Getting It Right!

A BACKGROUND PAPER

## Models of Better Practice in Youth Health

extracts from the complete document

a project of the **Australian** **Association for Adolescent Health (NSW)**

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**Models of Better Practice in Youth Health**
**A Background Paper**
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# EXECUTIVE SUMMARY

## *The Better Practice Project*

### History of the project

This document is an outcome of the Models of Better Practice project. It aims to enhance the quality of health services for young people by generating discussion on issues in youth health and providing a model which can be used wholly or in part by youth health services. In 1996/97, The Innovative Health Services for Homeless Youth program (IHSHY) provided funding for the Better Practice Project to complement the 1992-3 and 1996-7 evaluations of IHSHY. The Australian Association of Adolescent Health (AAAH) NSW made a submission to examine practice in NSW youth health services to see what works and how to build on it. It was supported by the Commonwealth and State governments.

### Who is involved?

The project is a collaboration between the project worker, a Steering Committee representing AAAH - NSW, IHSHY and the Meeting of Youth Teams in Health (MYTH), youth and health services across NSW and young people.

### Project Aims

- To identify and document "models of better practice."
- To provide a framework in which youth health services can identify and further develop their current models of service delivery.
- To link the development of "models of better practice" to the IHSHY guidelines, existing state and national youth health policies, and other appropriate government and non-government documents.

### The social context of the project

The Models of Better Practice project arose in a time of increasing social stress for young people both locally and globally. Unemployment, homelessness, powerlessness, exploitation, alienation, sexism, racism, ageism, violence, exclusion and suicide are a part of a vicious social landscape for many young people. At the same time, the continuation of current funding levels for health, including youth health, is in doubt. Funding cuts would be disastrous for the continuity of care for the most disadvantaged youth, and for future health and social costs.

### What is "better practice"?

I use "better practice" to mean "what works" to promote health for young people.

## *What is "youth health"?*

### Youth

The term **"**youth" is used here to encompass the age group 12 to 24 years. It partly incorporates the World Health Organisation (WHO) definitions of "adolescence" (10-19 years) and "youth" (15 - 24 years**).**

### Health

The term is used here to mean physical, mental and social wellbeing - not merely "the absence of disease or infirmity" (see WHO definition). This positive and holistic concept of health implies a model of health practice that addresses both the impacts and determinants of health problems. This requires both direct and indirect health work.

### Direct health work

Direct work targets individuals and groups. It deals with impacts on health with treatment, rehabilitation, support and primary health care. This includes clinical services (e.g. counselling, medical/dental treatment), individual advocacy, recreational activities, education and training and primary health care services (e.g. cervical screening, immunisation).

### Indirect health work

Indirect work targets populations. It deals with the underlying basis of health problems with prevention initiatives. This includes building supportive environments (e.g. lobbying for gun control, job creation, healthy working conditions, sexual health promoting schools, advertising codes of practice) and other health promotion initiatives (e.g. empowerment and advocacy on a collective level).

## *Youth Health Services*

- There are 13 youth health services in NSW. They are located in areas of extreme social disadvantage and provide direct and indirect health services. Direct services are the main focus due to high levels of immediate need.
- Creative and innovative processes, particularly in the areas of access and participation, have been developed.
- The insights and experience developed by these services, and the challenge of new approaches, must be utilised in coming years as the effects of global economic and social processes continue.

# *What does this document do?*

## It gives an historical background to the development of youth health services in NSW

Concern about youth health issues developed in the context of the growth of the community health movement. This movement emphasised health promotion, decentralised services, community orientation and increasing access for disadvantaged groups. Social movements such as the women's, gay and lesbian and Aboriginal movements emphasised the relationship of social context to health. The Burdekin Report increased awareness of and response to youth homelessness in the health system, e.g. the IHSHY program. Health practice was influenced by a move away from focussing on individuals towards looking at social context as a key health determinant. WHO statements reflect this holistic understanding that housing, employment, etc. are linked to health. Youth health services developed a strong social justice perspective.

## It offers a conceptual framework for thinking about health issues

The framework is based on a concept of the social determinants of health. In this theory, disempowerment (i.e. a lack of control over life for individuals and communities) is a product of social inequality. Disempowerment has been shown to have a negative relationship to health while increased social empowerment has a positive one. "Social inequality" refers not only to the risk factors of poverty but to gradations of power resulting from location in the social system. Location is marked by class, gender, ethnicity/Aboriginal & Torres Strait Island Background (ATSIB) and age factors. Health practice must address these factors. Health issues are inevitably political issues.

## It explores the implications for practice of this theory of the social determinants of health

Based on the above framework, the document identifies processes which constitute a model of better practice. It explores the components of these processes, some related strategies and gives examples of these in action.

# *What processes constitute a model of better practice*

## Addressing inequalities

- The role of social inequality as a key determinant of health means that addressing social inequality (a social justice approach) is essential for better practice.
- Understanding how social inequality operates (including the relationship between individual responsibility and structural issues beyond individual control) is necessary.
- "Deficit" theory sees social disadvantage as originating out of individual inadequacies. Consequent "victim blaming" can be health-damaging and obscure issues of inequality.
- Targeting individuals as the primary initiators of their own health status should be avoided. Freire's work shows the limitations of this approach. It emphasises the social inequalities underlying illiteracy or illhealth and the importance of working with communities to understand and change the factors that are causing disempowerment.
- Some approaches to addressing inequality are advocacy and collective empowerment. Advocacy can give a "voice" to those silenced by social inequality. Empowerment refers to an individual and/or a collective process. In this document, empowerment refers to individuals in communities having a sense of coherence, social understanding and collectivity and being able to participate together to take control of their lives through their own action. Health workers can work interactively with communities towards empowerment through strategies which develop social connectedness, critical reflection, participation and collective action.

## Providing access and participation

- Developing innovative direct service models incorporating access, support and participation for marginalised young people is a significant achievement of youth health services.
- Social inequality means some people have less access to resources, services and participation. Young people may be intensely affected by this.
- Increasing access means creating an environment which is accessible geographically, physically, socially, culturally, aesthetically, financially and administratively.

- Outreach services are often used and access issues also need to be considered for these services.
- Making "youth-friendly" premises can be a community project
- First impressions and non-verbal messages are important. Service support systems for clients are useful.
- Recreation and arts programs can be a non-confronting way of allowing young people to evaluate a service and to access support and other services. Health services need to be safe, secure places with approachable staff, useful facilities and effective referral procedures.
- Promoting access requires research, understanding, consultation, liaison and sensitivity to social diversity. Also required are advocacy and empowerment strategies, a clear understanding of assumptions and representations of marginalised groups and an environment which is inclusive and affirming of young people and their communities. Cultural understanding and sensitivity are vital components. Supported affirmative action is needed for equitable representation. Clear confidentiality guidelines (within legal boundaries), privacy, promotion of health literacy, the use of interpreters, monitoring young people's views and clear complaints procedures are important.
- It is important that services without appointment can be obtained, that a service is free, that it celebrates cultural and other diversity, has welcoming premises, gives practical assistance, does not require Medicare cards, is open at hours accessible to young people and is attentive to and advocates for young people. These values must be carried through to all aspects of the service's work. Establishing the service as an integral part of a community is important as is challenging prejudice and misinformation. Open days, participation by and in the community and media information are all useful.
- Youth participation can occur informally, or formally by involvement in consultation, management or health programs. Genuine representation of young people and training are important. Peer education and peer support programs can be especially effective for some groups even though they are resource and labour-intensive.

## Building supportive environments

- A supportive environment approach is a multi-faceted way of changing social and physical environments in which individuals live rather than trying to educate people to change their behaviour. This approach can be effective for prevention and should be encouraged.
- The Haddon matrix is a successful example of this approach which developed strategies for preventing car accidents. Changes in car and road design, speed limits and seat belt laws did not depend on individual education to be effective.

- Another example, the harm minimisation approach to injecting drug use, required changes to the social environment, policy and legislation and community involvement, resource development and advocacy. Education is an important component but not the centre-piece. Well-informed lobbying is useful.

## Balancing approaches

- Better practice requires a balance between direct, reactive and indirect, pro-active approaches. The Ottawa Charter provides a foundation for a balanced health practice.
- In treatment and primary health care practice, the focus is upon individuals or groups, whereas a population focus can be more appropriate in prevention initiatives. Prevention practice based on an individually-focused "knowledge/attitude change leads to behaviour change" model is inadequate and may be counter-productive.
- A population approach does not attempt to identify "high risk" people. Instead, the aim is to lower risks for whole populations. A population approach to suicide which does not depend on identifying high risk people is discussed as an example of the potential of this approach to prevention practice.
- This approach should be balanced with youth-friendly, accessible and inclusive direct services which target individuals where appropriate.
- Youth health services have favoured an individual/group focus for prevention. Developing new approaches to prevention is inhibited by the high demand for direct services, limited resources and limited access to relief staff, time, funding, training, support and research. Support from management and highly developed links with other parts of the health system are also necessary for skills to be developed in this area.

## Coordination

- Health practice based on a social view of health encompasses a multi-dimensional rather than a mono-causal view of health.
- Health practice, therefore, must be holistic and multi-disciplinary and requires wide collaboration. Coordination is necessary to promote integrated, effective action and avoid contradictions and inconsistencies, duplication, lack of clarity, unarticulated differences, and "re-inventions of the wheel".
- Multi-disciplinary teams within youth health services, in partnership with communities, organisations and agencies, are

able to deal with various aspects of health, e.g. homelessness, mental health, employment/education, sexuality, etc. Collaboration may involve developing, implementing or resourcing programs, health promotion, community events and campaigns and social change activities.

- Coordination requires careful, ongoing discussion and documentation of a proposed initiative as well as clear guidelines for collaboration. Genuine multi-disciplinary teamwork with a commitment to open communication, shared learning and mutual respect is crucial. Documented referral pathways and contacts are necessary. These can also be utilised in orientation procedures. Services must develop a high community profile. Representation on, and contact with networks related to core health issues and links with other sections of the health system are essential and can break down barriers of prejudice.

## Collaboration

- Youth health services collaborate intersectorally and with various organisations and groups, across the wide range of areas that affect health.
- Collaboration with youth centres through outreach and co-located services arose out of the need to make contact with young people and are valuable ways to increase access and effective care for young people. These links had mutual benefits for services and helped develop knowledge, understanding, direct contact and networks for youth health workers. This emphasis however, sometimes meant that potentially useful links with the mainstream health system remained under-developed.
- Working with schools is a frequent and important collaboration for youth health services. Models used are clinically-based, issues-based or settings-based. Settings-based models such as the Health Promoting Schools Program seem to be the most promising.
- Issues-oriented health education is usually aimed at prevention through behaviour change. A personal empowerment or "knowledge/attitude change leads to behaviour change" model is commonly used. These sessions are usually one-offs with little follow-up and are single issue based, reactive, compulsory and limited in their school coverage and student involvement. Targeting individuals and groups with this health education model as the main prevention strategy is of limited effectiveness. It may be counter-productive and is not necessarily useful for promoting youth health services. It is more appropriately delivered by teachers, if at all. Reliance on such models is not consistent with a socially-based approach to health.

## Building the infrastructure

- A supportive infrastructure for better practice requires access to research which is useful for both direct and indirect work. Linkages with universities, research-oriented units within health and other government departments and with other organisations would be mutually beneficial. Contacts, exchanges and access to technology would be useful.
- Capacity building is essential. There is no specific training required for youth health workers. Many have no formal training in health and are unfamiliar with the health system but have expertise in a range of other areas. Some workers are trained in bio-medical fields, others in youth work or social welfare fields that are highly attuned to direct service provision and do not have a sociological focus. The multi-disciplinary nature of youth health teams is valuable but all workers need to be trained to do their jobs effectively. Untrained workers are ill-equipped to undertake planning, design, implementation and evaluation of preventative health programs. To expect otherwise is setting people up to fail. Training and interaction with the broader health system may be productive for all. Basic sociological and cross-cultural training, including class, gender and ethnicity/ATSIB studies, is needed to understand social mechanisms and issues and their relationship to health. This must become a pre-requisite for the job. Cultural training by indigenous people on the impact of white invasion and its consequences is particularly important. High demand, crisis-driven work situations and lack of resources are barriers to training. Provision of resources to enable training needs to be met would be of long-term benefit. On-the-job training can be excellent but is difficult without adequate time, staff and funds.
- Relevant, standardised orientation procedures which encompass community and health agencies are necessary.
- Good planning is important. It requires the ability to accurately assess and analyse health and socio-economic status, needs and relationships and barriers to change, knowledge of information sources, systematic priority setting, use of strategic planning, evidence based procedures, program design, documentation, implementation, coordination, evaluation and monitoring skills, teamwork skills and critical analysis. Development of appropriate evaluation indicators assists services.

- Youth health work is stressful for workers due to the intense nature of the work. Most workers are dedicated and flexible and are juggling youth needs with program planning and other necessities of the job. This does not optimise learning and planning. "Burn-out" is a danger and recognition, professional support and supervision are essential.

- Comprehensive and documented policy and procedures are necessary. Familiarity with Department of Health guidelines on legal requirements is essential.

# KEY FINDINGS AND RECOMMENDATIONS TO THE NSW HEALTH DEPARTMENT AND AREA HEALTH SERVICES

## *Recommendation 1: Increased Funding*

**It is recommended that funding to youth health services, including IHSHY funding, be expanded and continuity of funding be maintained.**

Youth health services, particularly those targeting marginalised young people, need to be recognised as essential services for these groups and appropriately funded. Currently these services are working under extreme pressure due to increasing demand on available resources. Continuity of care for youth health service clients is dependent on the assurance of continuity of adequate levels of funding. Support therefore needs to be maintained and strengthened and funding increased. The costs of expanding these services is likely to be much less than future social and monetary costs if services were to be maintained only at current levels or withdrawn.

## *Recommendation 2: Partnerships with Social Research Bodies*

**It is recommended that Area Health Services support the initiation and expansion of partnerships between youth health services and social research bodies.**

Strong partnerships and communication channels need to be developed between youth health services and social research bodies, particularly universities and research units within the government sector, with a view to information exchange and the development of possible joint projects. Such links are currently under-developed and the consequent lack of adequate communication between research bodies and youth health services should be addressed at all levels.

## *Recommendation 3: Resourcing*

**It is recommended that youth health services be resourced to enhance or develop links with research bodies.**

The social determinants of health, particularly in the areas of class, gender and ethnicity/ATSIB, need to be acknowledged and processes need to be implemented to address the implications of this for the resourcing of youth health services and the training of youth health workers. Youth health services need resources (including staff time) and adequate technology to be able to enhance or develop links with research bodies.

## *Recommendation 4: Research in the Social Determinants of Health*

**It is recommended that the NSW Health Department and Area Health Services develop and expand research capacity in the areas of the social determinants of health particularly as it relates to youth health.**

Research on the social determinants of health, particularly in relation to youth health, needs to be developed. Sociological studies in gender, class, ethnicity/ATSIB and their relation to health (particularly youth health) are needed, as well as ethnographic studies of particular communities, e.g. in Western and South-Western Sydney, and rural NSW.

## *Recommendation 5: Developing Prevention Initiatives*

**It is recommended that resources, support and training be made available for youth health services to specifically develop prevention initiatives, and that partnerships be supported to enhance this capacity.**

The high levels of expertise in direct service provision by youth health services needs to be enhanced and balanced with high standards of prevention work. This can be achieved by moving away from individually-focussed, reactive, knowledge and attitude-based prevention models and focusing more on other approaches including pro-active, population-based approaches. This is impossible without available resources, support, training and linkages.

## *Recommendation 6: Training*

**It is recommended that a broad, sociologically-based youth health training course be developed focusing on class, gender and ethnicity/ATSIB and their relation to health.**

Youth health teams are enriched by the diversity of backgrounds and training of their staff. However, the lack of specific youth health

courses, particularly sociologically-based ones, means that staff training in this area is uneven or non-existent. The service as a whole and staff members individually are disadvantaged by this situation which impacts upon the taking up of opportunities for innovation. Inservice training could be implemented almost immediately while the possibility of specific university studies in the field is explored.

# INTRODUCTION

## *Origins of the Better Practice Project*

Youth health services in NSW have now been operating for about 10 years. The expertise, achievements and creativity developed within these services is awe-inspiring and often unrecognised. The need to document more fully the diverse and innovative models of practice operating in youth health services, including those within the IHSHY program, was the basis for the Models of Better Practice Project. AAAH - NSW recognised the value of looking at practice in youth health services in NSW to see what works and how it can be built on. Their submission was supported by the Commonwealth and State governments and funding was provided through the IHSHY program to implement the project. This was intended to complement the two evaluations of the IHSHY program in 1992-3 and 1996-7. This document is an outcome of the Models of Better Practice project.

## *The Innovative Health Services for Homeless Youth program*

The IHSHY program was introduced into NSW in 1989-90, administered by the NSW Health Department and jointly funded by the Commonwealth and State governments. It was developed by the Commonwealth government in response to the Human Rights and Equal Opportunity Commission Report, 'Our Homeless Children' (the Burdekin Report), which identified the serious health and social issues associated with the large numbers of homeless young people across the country (1). It also pointed out that homeless young people are unlikely to access mainstream health services. The IHSHY program aims to develop and implement a range of innovative, non-judgemental health and related services for homeless youth and young people at risk of homelessness. These services may be either provided directly or may provide assistance to young people in accessing appropriate services (2). In 1999 there are currently nine services funded through the IHSHY program in NSW.

# *Implementation of the Models of Better Practice Project*

The Models of Better Practice project was funded in 1996-7 and culminates with the production of this document. The project has been a collaboration between the Project worker, a Steering Committee representing AAAH - NSW, IHSHY and the Meeting of Youth Teams in Health (MYTH), youth and health services across NSW and young people.

The project aimed to:

- Identify "models of better practice" for youth health service delivery across NSW.
- Link the development of the "models of better practice" to the IHSHY program guidelines, existing state and national youth health policies, and other appropriate government and non-government documents.
- Provide a framework in which youth health services can identify and further develop their current models of service delivery.
- Document "models of better practice". The publication was to outline a range of models of service delivery, minimum levels of service provision, minimum funding levels required, standardised policies around access and service delivery issues and the principles underpinning service delivery.

# *The social context of the project*

The Better Practice Project arose in a time of increasing social stress for young people both locally and globally. Unemployment, homelessness, powerlessness, exploitation, alienation, sexism, racism, ageism, violence, exclusion and suicide are a part of a vicious social landscape for many young people. At the same time, the continuation of current levels of funding for health, including for some youth health services, is in doubt. The implications of any funding cuts for continuity of care for many of the most disadvantaged youth, and for future health and social costs, is clear - and disastrous. The insights and experience built up by youth health services, and the challenge of new approaches, must be utilised in coming years as the effects of global economic and social processes continue.

## *What is "better practice"?*

While there are various definitions of "best (or better), practice", the one I use here is, simply, "what works". This obviously needs to be at the core of any attempt to define "better practice" and evidence is needed to show that something does (or does not), "work". This document identifies models and standards of practice in youth health and the structures upon which they can be built.

## *What is "youth health"?*

The term "youth" is used here to encompass the age group 12 to 24 years. It partly incorporates "adolescence", the term usually applied to the developmental period between childhood and adulthood. Adolescence has been defined by the WHO as being between the ages of 10 and 19 years and youth as between 15 and 24 (3). Current practice in Australia usually designates 12 years as the entry age for youth health services, with children's services covering the under 12-year-olds. In practice, accuracy about age is not always possible or appropriate due to factors such as lack of documentation for refugee families, priorities within a crisis situation, etc.

I use the term "health" in accordance with the WHO's statement that "Health is a ... state of complete physical, social and mental wellbeing and not merely the absence of disease or infirmity". To promote wellbeing, a model of health work must operate both directly and indirectly, encompassing services targeting individuals and groups such as primary health care, treatment, support, rehabilitation as well as broadly focussed, population-targeted prevention and health promotion initiatives.

## *Structure of the document*

The document is divided into two main sections, A and B. Section A gives a brief overview of the historical development of youth health services and some of the social and theoretical currents that have influenced them.

Section B looks at the processes through which high quality health services are delivered to young people. These processes delineate the following areas of practice:

- Addressing inequalities
- Ensuring access and participation
- Building supportive environments
- Developing a balanced approach
- Coordinating activities
- Working collaboratively
- Building the infrastructure

These processes, which together build a "model of better practice," are explored within Section B. Their essential components are examined as well as some suggested strategies and examples of practice in these areas. Service profiles are contained in Appendix 1. This section shows the range and diversity of youth health services in NSW as well as the variations in size and resources at their disposal. A summary of the August, 1998 Better Practice consultation appears in Appendix 2 to show something of the development of the process leading up to the production of this document. Examples from youth health services are used throughout the document. Each section concludes with a "checklist" intended to encourage discussion and reflection on practice for youth health service providers.

# *Overview - a model of better practice*

The "model of better practice" presented in this document is constructed from the elements and processes summed up in the following overview:

There is a multi-dimensional causal chain affecting whole communities which starts from the broadest socio-economic environment and reaches right down to the individual, and interventions can be made all along it. So a model of better practice must incorporate practice that is holistic, which sees individuals within a social and historical context and which ranges over the entire causal chain and is not confined to one part of it. Consequently, it must work across the landscape of young people's lives, particularly in the areas of class, gender and ethnicity/ATSIB, in a variety of ways and with a broad range of collaborations with both organisations and communities and particularly with research bodies. Activity needs to be coordinated to deliver environments that support health as well as working directly with individuals and groups. It must work for prevention, balancing this with treatment and rehabilitation.

Studies on the relationships between the social and health issues suggests that better practice necessitates working for prevention on a broader social level when appropriate and avoiding the dominance of an individually focussed, knowledge-based approach which may be health-damaging (4). Increased resources and appropriate linkages are necessary to enable this. A population focus needs to be balanced with an individual or group focus. Exclusions and inequalities that damage the wellbeing of young people need to be addressed. One of the most health damaging of these is the lack of control over one's life, or powerlessness and alienation.

Inequalities arise out of and are embodied in a social system structured by class, ethnicity/ATSIB, age and gender. It follows that practice needs to be based on a relationship with young people and their communities which, in addressing these issues, is interactive, empowering and respectful, which sees young people not as passive and dependent "receptacles," but active agents collectively constructing their lives. This approach implies the participation of young people and their communities in the work of the health service as well as a trained, multi-disciplinary team that has access to research, resources and support and is consciously and critically engaged, with the young people, in a mutual social project for wellbeing.

## *Relationship to youth health policy and practice*

The processes discussed here are "key action areas" in the National Health Plan for Young Australians. This document, endorsed by all Australian Health Ministers in 1996, is a plan outlining implementation strategies for the national youth health policy (5). The NSW government's youth health policy also endorses these broad outlines of practice (6). Many of these elements also appear as the core of the work of youth health teams across the state, and were highlighted at the August 1998 consultation for the Models of Better Practice project as well as in evaluations of the IHSHY program (7). The significant areas highlighted at the August consultation were access, equity, holism and social justice as well as development of the necessary infrastructure to bring about effective work in these areas (see Appendix 2). Youth health service workers across NSW who were interviewed for this project endorsed the importance of the processes discussed in this document.

## *Using this document*

This document is not intended as a rigid prescription for the setting up of services. "Getting it right" is a collective process of reflection, research, planning, communication, learning, experimentation, action, more reflection... It is an ongoing process which has no end. The document can be used as an orientation tool for new workers to become familiar with some of the debates and concerns in the field of youth health or as an ideas manual for the development of new services and programs. It is meant to be built on, developed and adapted to different contexts in which it may find some use. Except where it is obviously inappropriate, the processes referred to are applicable across a range of roles within the service, from clerical workers, counsellors, nurses, doctors, youth workers to health promotion workers and others who, by the nature of their jobs, work in a more indirect way. They apply also to the operation of a youth health team as a whole, an entity which is greater than each of its parts. When I refer to "the service," I usually mean not only each separate individual within it, but the organism that those individuals create when they work effectively together.

## *Specific focus on youth health services*

This document focuses specifically on youth health services. The scope of the project unfortunately made it impossible to look more widely at youth services, even though many of them are involved in youth health. There are some examples drawn from youth work, and hopefully the document might be of some use to youth workers. But a project looking at youth work in relation to health would be a separate task.

## *The work of youth health services and its significance*

Youth health services operate in a number of ways. They provide direct clinical and other services that are responsive to individual and group needs. They also work in the wider field of prevention. Given the intense levels of need in the most disadvantaged areas where the services are concentrated, it is not surprising that direct service provision to individuals and groups usually makes up the bulk of the work. Youth health services have developed creative and innovative processes for direct service provision, working with a traditionally difficult-to-reach target group. This has occurred in a context of over-stretched resources in which funding levels have been fraught with continual uncertainty. Without youth health services and their unique responsiveness to young people, many of the most disadvantaged would almost certainly, never access health services. The consequences of this in human terms, as well as the cost implications for the health system in the long term, is obvious.

## *Themes of the document*

There are two themes running through the document.

- Understanding what the issues are - the relationship of the social to health
- Doing something effective about it

The two themes are separate but obviously linked.

## *The social determinants of health – class, gender, ethnicity/ATSIB*

Class, gender and ethnicity/ATSIB are used here as the basis of a concept of the social and its relationship to health. Health is related to the choices and decisions we make. But these are not made in circumstances of our own choosing. An understanding of people as social beings, of the interaction between individuals and groups and their socio-economic and political environment, of the social construction of our lives, is essential to understanding health.

- Class refers to the relationships built around ownership and control of labour and resources which are the significant factors in determining class position.
- Gender refers to the socially produced expectations, values, attributes and practices that are related to biological sex. This configuration maps a "meaning" on to biological sex that goes far beyond the physiological distinctions and is both universalised and de-historicised. The terms "masculine" and "feminine" refer to gender-based characteristics.
- Ethnicity/ATSIB refers to shared cultural values and group awareness of cultural distinctiveness. I have separated the term "ethnicity" from "Aboriginal and Torres Strait Island Background (ATSIB). This is to avoid confusion with a popular usage of "ethnic" to mean Non-English Speaking Background (NESB) people. I do not use it in this way but have made the distinction in the interests of clarity. I refer specifically to Aboriginality or indigenousness where appropriate.

## *Accessing research*

An awareness of class, gender, and ethnicity/ATSIB and their inter-relationship with other social factors helps us to act effectively. Access to up-to-date research is necessary. For instance, findings from ethnographic studies on rural and other communities, unemployed and under-employed youth, urban indigenous young people, young people with disabilities or who are carers, etc, can be crucial in planning effective youth health initiatives. Most research happens within universities and the government sector, as well as some undertaken by private or government-funded organisations and by individuals. The further development of partnerships and communication links with research bodies would be mutually enriching. Without some understanding of the social determinants of health we run the risk of blaming the victims and becoming part of the problem, not part of the solution.

## *Linking the social with health*

People involved in Aboriginal health and women's health have long been aware of the inseparability of health and social structures, and of the intensely political nature of the field. The concept of the social determinants of health is outlined below in an extract where an Aboriginal perspective on health was given to a group of parliamentarians (8):

> ...All have to start thinking and asking what the concept of Aboriginal health is... One of the things that comes to mind as I told them is land. Land must come first." ... During a visit with Professor Fred Hollows to an area where the people were "sitting down on their land," the significance of this to their health is described.... "One old man said, 'Girlie, I'm not sick. I'm sitting on my land, I've got my land.' This is a concept that people have to start thinking about, because they are health issues and Aboriginal land (sic). There is illness but the priority was not sickness the way the whitefellas think about it. Spiritually they were much alive, they weren't dead. And so, as I said to the politicians, the concept and the research that you whites are doing has to start considering the blackfella way."

Time and resources to fully understand the specific social nature of health problems are not always available. This does not mean that we

should stop trying or that we are helpless to intervene. We can't effectively identify all the young people at high risk of committing suicide or understand what it is that makes one person kill themself and another not. But we can control the availability of guns. Non-indigenous people are only beginning to understand the enormity of the destruction of Aboriginal society and its effects on young people. But we don't have to, to know, for instance, that supporting those communities that have chosen to substitute a non-psychoactive fuel for petrol, will prevent harm through inhalation. We can still act while in the process of trying to understand.

## *The achievements of youth health services*

Youth health services have developed processes that enable access, respect, sensitivity, social support and participation for extremely marginalised groups. They have worked for social justice and recognised the importance of an environment within a youth health centre that is inclusive and affirming of young people and their communities. Services have worked hard to ensure that this atmosphere permeates all their operations from medical and counselling services to arts and recreation and health promotion. Youth health services have been sensitive, innovative and creative in their practices, taking young people seriously and trying to combat their social marginalisation. Advocacy systems have been developed to give practical as well as social support and clinical services have been developed with an awareness of the holistic nature of health. These achievements cannot be allowed to wither away from lack of solid support. At a time when the importance of participative, community-oriented and inter-sectoral work is being recognised, particularly in areas such as health, the experience of youth health services can make a valuable contribution to developments in this field.

## *Expanding the role of youth health services*

With the ever-increasing workload of direct service provision arising out of changing economic and social processes and intensifying social

inequality, prevention initiatives, have, understandably, lagged behind. In addition, the necessary resourcing, training and partnerships with research bodies essential to do the job properly are difficult to place in the forefront when people are dying in the gutter outside the door. Nevertheless, the following story is worth keeping in mind (9):

> "There I am standing by the shore of a swiftly flowing river, and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to the shore and apply artificial respiration, and just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing, and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, and applying artificial respiration that I have no time to see who in the hell is upstream pushing them all in."

The literature on the relationships between social and health issues suggests that better practice necessitates working for prevention on a broader social level when appropriate and avoiding the dominance of an individually focussed approach. Prevention strategies which ignore social context and aim at "filling individuals up with knowledge", "raising awareness" of attitudes and expecting people to change their behaviour as a consequence, have been shown not to work (and possibly may do harm) (10). Such approaches often end up "blaming the victims" and leave untouched the key social inequalities that have been shown to be crucial (11) (12). Other approaches to prevention need to be explored, developed and expanded. These include approaches that use a population focus, targeting prevention at populations, rather than individuals, and those that clearly address the underlying social inequalities affecting the lives of young women and men.

Social inequality is widening in Australia (and globally), and has bitter effects on communities including young people. The current demand on youth health services is such that the capacity of services and workers to cope with it is seriously strained. Innovative work in prevention can't be done without the enabling resources, training and linkages. It can't be done by workers whose own health may be jeopardised by trying to address an ever-intensifying workload with inadequate resources. The community partnerships already developed by the youth

health sector and its experience in direct, participative work with young people would be a valuable basis from which to develop innovative prevention initiatives in close touch with research organisations and communities. The success of the partnership developed between the gay community, health workers and social and medical researchers has been acclaimed as an example of successful action research in the area of HIV/AIDS prevention. The fortress mentalities which have been known to operate in some areas between practitioners, activists and academics have not prevailed in this field. Australia is in the forefront of preventative work in HIV/AIDS. With sufficient support and training, this example could be reproduced in the area of youth health. There is a solid foundation from which to start.

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# CHECKLISTS

## *Checklist (Chapter 2): Addressing Inequalities*

- Does your library include works on social inequality, reports such as the Burdekin Report, Aboriginal Deaths in Custody, Stolen Children, works by Friere, sociological and anthropological studies on health in relation to poverty, unemployment, indigenousness, gender, refugee and immigration issues, sexuality, racism, and other social issues?
- Does it contain a history of the indigenous people of the area and of recent waves of immigration?
- Does it have relevant community profiles?
- Do you have time to read?
- Does your service have regular speakers from the different communities that live in your area? Are you able to keep updated on the issues?
- How does your service define "health?" Is implementation consistent with the definition used by your service?
- Can you outline the health status of young women and men and their families in your area and the major socio-economic influences on their health and on their communities? What are the main sources of people's disempowerment in your area? Are there any? If not, what makes your area different from most others?
- Do people in your area have much control over their lives? How does this affect individual young men and women?
- Have you travelled around your "catchment" area? Are you familiar with Centrelink, Department of Community Services and Department of Housing offices (from a client's viewpoint)? Have you been to local pubs, banks, doctors, pharmacies, social venues, sports areas, cinemas, shopping centres, schools?

- How does your service confront what Richard Eckesley calls, "the broader social, cultural and political influences on wellbeing?"
- What and how do you learn from young women and men who come to your service?
- What sort of advocacy does your service do? With whom? About what?
- If you are representing the viewpoints of young people, how do you know if you are doing it accurately?
- How could you explore this? Are there any feedback and information exchange mechanisms that your service can access to check this?
- Is your service involved in any social action with the community?
- What are its aims and methods? What is the role of the health service in this?
- Does your service do "critical analysis? How? About what? With whom?
- Are you able to participate in organising/lobbying for community, environmental, political change? If not, why not?
- What are the political factors that influence your target group, their families, their communities, your service?
- What does "social connectedness" mean for young men and women and their communities?
- Can your service participate in developing/enhancing it? To what end? In which areas? What can you do? What can't you do? Why?
- Does your service do any "community organising," i.e. work with communities to increase self-determination and control over resources?
- What sort of local action is your service involved in? Is it also involved in action covering a wider area, as well, e.g. regional, state or national?
- Does your service have a Keyworker system? Does it operate effectively? How do you know?
- Are there other types of internal support systems for young women and men at your centre?
- Does your service have a high profile in the community? Which community/ies? How do you know?
- What are community members perceptions about the service? Why?

- How can negative perceptions be overcome?
- Is your service involved in action groups around social issues related to health such as unemployment, working conditions, racism, gender issues, poverty, education, rural issues, sexism, ageism, reconciliation, gun control, human rights, and public housing?
- Does your service have a code of conduct for workers?

## *Checklist (Chapter 3): Access and Participation*

- What are the significant cultural features of the communities your service works with? How are they relevant to the youth health service?
- What are the major communities in your area? Are they drawn together by shared interests, experiences, values, language, religion, history, disability, ethnicity, skin colour, subculture, geography, occupation or something else?
- Are they "competent communities" (see Chapter 2 for definition).
- In what ways do young people and their communities participate in your service? In management? In advisory groups? Informally through "drop-in" and other activities?
- How do they participate? In program development? In resource development? Through consultations? Are there formal structures in place for this?
- How do you know that there is a broad representation of young men and women in your service? How do you know it's not tokenistic?
- Is your service open at hours suitable to young people?
- Is it easy to get to? Is public transport available nearby?
- How are problems of geographical isolation addressed?

- Is the service free?
- Are Medicare cards required? Is there assistance available in acquiring them?
- Is there an outreach service operating out of your centre? Why? Where to? How? Is it effective in achieving its aims? How do you know?
- Is the outreach service accepted in the community? In the areas where it is located? How do you know?
- What sort of support does your service offer for young women and men and/or their communities?
- Why do young men and women come to your service?
- How do the premises look? Do they look "youth-friendly?"
- Does the centre reflect the community around it? How? Who decides how it looks? Who decorates it? What with? Does it cost a heap of money? If not, how did you do it?!
- Is the service "people-friendly"? ... all people, including the ones that you don't like the look of?
- How many negative experiences have you had with bureaucracies? What were they? How did you feel? Does your service have any bureaucratic echoes for you? What about for young people or community members?
- What do people say about the centre? Is that what they really think? How do you know? Do lots of young people drop in (or only to "drop-in")?
- Are the initial questions and paperwork that clients need to fill in, limited to the absolutely essential? Can they get assistance without feeling patronised, stupid or conspicuous?
- Does your service run activities that are interesting and non-confronting for young people where they get an opportunity to check the place out?
- Are these activities appropriate to young women as well as young men?
- Do many young women and men attend? If not, do you know why not?
- Can people get to look around the centre if they want to ... e.g. conducted tours? Do they get introduced to staff members and get some information on what they do?
- Are there programs running at your centre that address health needs of young men and women in a fun way? What are

they?

- Does your service get people coming in because they heard about it from friends? Where do people who come in hear about it?
- Does anyone ever complain? What about? Do they know how to make an official complaint? What happens when people do complain?
- Have you ever made an official complaint about a service? Was it difficult? What happened? How did you feel about doing it? Would you ever do it again?
- What sort of atmosphere does your service give out? To you? To the community / ies? To young men? To young women? To families? To other workers? How do you know?
- Do you know that your service is a safe place for young women and men? Do they know that it is? How?
- Are the images in your centre ones that reflect diversity? Have you ensured that there are images around other than those reflecting dominant cultural forms?
- Who are the traditional Aboriginal owners of the land your centre is on? Does anything about the centre reflect the history of indigenous people in the area? What?
- Do the local indigenous people participate and advise on this aspect of the service? Or on other aspects of the service?
- Is your centre accessible to disabled people? Do they access it? If not, why not? If so, why?
- Does your service work with disability services and activists? How?
- Do you work closely with workers from various communities? In what ways? Does your centre run cross-cultural training sessions for other organisations, eg. other parts of the health service? Do you attend cross-cultural training sessions?
- Is your centre "queer friendly?" Do gay, lesbian, bi and non-sexually identified people feel comfortable accessing services at the centre? How do you know?

- Do you ensure that your statements, comments and the questions you ask as a health worker contain no assumptions about people's values, abilities, aspirations, expectations, practices and lifestyles? If you do, CONGRATULATIONS!!

- Do you try not to make assumptions about other people and their lives?
- Does your service use gender-neutral language, e.g."partner" or "romantic interest" rather than "boyfriend" or "girlfriend"?
- Does your service take confidentiality seriously? Does everyone know what the legal procedures are ... including all the workers, the young people and others accessing the service? Are they written down? Are they explained verbally?
- Can privacy be ensured in your service?
- Are young men and women accessing your service able to make an unpressured choice about their health care and options? How do you know?
- Do you know how to use the Healthcare Interpreter Service? Are you familiar with issues relating to the use of non-professional interpreters?
- How does your service monitor young women's and men's views?
- How do you ensure fair representation of a cross-section of people?
- How do you access the views of the "quiet ones" ... or the "naughty ones"?
- How do you know young people are not feeling sorry for you and telling you what you want to hear?
- Does your service pay young people for consultations, etc? If not, why not?
- What sort of information does the service give out? Written material only? Is it visually appealing? Is it readable? Is it appropriate to the community?
- Do you make use of the local paper, community radio or television station to give out information? Do you have information stalls at community events or in shopping centres, dance parties, sports events or other places where young people gather? How do you follow these up?
- Can your service organise speakers to inform the community about relevant issues and address misinformation on social and health issues?
- Does your service have a Youth Advisory group or something similar? How does it work? How is tokenism avoided? How do you get young women and men to participate?

- Does your service do any peer education or support programs? Are you planning any? Have you read about other peer programs?
- What specific groups and needs are they addressing?
- Why a peer program? Why do you think it will work?
- Does your service have the resources to do it? What about unexpected costs? Is there any chance of extra funding from elsewhere?
- How will the peers be chosen? Who will train the peers? Who will support the peers? Who will support you?
- Is your service adaptable and flexible? What does this mean for young men and women? What does it mean for you?

## *Checklist (Chapter 4): Building Supportive Environments*

- Can you outline the health status of people in your area? How do you know?
- What are the major socio-economic influences on their health and on their communities? How do you know?
- Are you able to participate in organising/lobbying for community, environmental, political changes? Who do you lobby? What for? If not, why not?
- What are the political factors that influence your target group, their communities, your service? How do you know?
- Does your service work at developing supportive environments for health? If so, what are the basic elements used?
- In what areas?
- How do you know it works - or not?
- Is health education integrated into a more holistic practice to avoid an individually-focussed information-attitude change model of behaviour change?
- Is your service involved in any settings-based health initiatives? What settings?

- Are you familiar with government services in your area?
- Who are your local Councillors and Members of Parliament?
- Who is responsible for youth issues in your local Council?
- Are there supportive structures for sexual health in your area?
- Are there 'youth-friendly' sexual and reproductive health services in your area?
- Where are free pregnancy tests available in your area? Are these services "youth-friendly?
- Where are free abortions available in your area? Are these services "youth-friendly?
- Where can people get free safe sex materials such as condoms, lubricants and dams in your area? Are these services "youth-friendly?"
- Where can people obtain gender counselling in your area? Are these services "youth-friendly?
- Are there supportive structures for safer injecting drug use in your area?
- Where is your local NSP based? Is there one? If not, where can people get new injecting equipment?
- Are there pharmacies or vending machines that dispense injecting equipment in your area. Are these services "youth-friendly?
- Are local A & OD services "youth-friendly"?

# *Checklist (Chapter 5): A Balanced Approach*

- Is there a good balance in your service between direct, reactive treatment, support, primary health care and rehabilitation and indirect, proactive prevention initiatives? If not, why not? Does your service (including higher management) encourage experimentation with new ideas? Is there a long-term commitment to innovation?
- Have you read the Ottawa Charter?
- Does your service work in each of the areas of the Ottawa Charter?
- In what ways could your service develop public policy, re-orient health services, create supportive environments, build personal skills and enhance community action?
- Does your prevention work encompass a range of models including non-individually focussed ones?
- Is there support and understanding from higher management about staff members' research and training needs?
- Are resources and funding available to develop new approaches to prevention?
- Do you feel confident that your training enables you to meet new challenges and initiate and develop new approaches?
- Do your links with other parts of the health system and the community assist in developing innovative approaches? If so, how? If not, why not - and how can it be changed?

# *Checklist (Chapter 6): Coordination*

- Do you work closely with workers from other cultures? In what ways?
- Are workers from organisations that you may work closely with, aware of your service's confidentiality procedures? Are you aware of your confidentiality responsibilities regarding other services who may be dealing with the same clients?
- Does your service collaborate with other services on programs or activities? How are these planned? Are they documented? If not, why not?
- How do you ensure compatible aims when you work with another service? Does each service know the others aims and objectives? Do they know their own?
- How does monitoring and evaluation happen when you work with another service?
- Does your service have contact with other youth-related services in the community, government and private sectors? What about with other parts of the health sector including GPs?
- Do you have a directory of services to assist in making appropriate referrals?
- How holistic is your service? In which ways? What is a holistic service, anyway?
- Are health services at your centre coordinated both within the service and with outside organisations and workers?
- Do you have a good working knowledge of local and regional services?
- Is your service represented on inter-agencies, service networks, lobby groups, etc?
- How is information fed back into the team from meetings? Is feedback ad hoc or are there procedures in place?
- Are you able to network with other health workers ... from other areas ... from other fields?
- How does your service avoid duplication of services or programs or "re-inventing the wheel?"

- How do you promote your service to young people; the community; other parts of the health system; other organisations; the media?

- Where do referrals to your service come from?
- Do you feel like you're part of a team?

## *Checklist (Chapter 7): Collaboration*

- With which communities, organisations and workers does your service collaborate? On what?
- Are there services which "share the vision"of your team? How do you know?
- Does your service do consultancy work? How? Who with? About what?
- Does your service have a code of practice for collaborative work?
- Does your service do clinical or other health services in other centres such as schools or refuges?
- What protocols are in place to ensure that these are conducted effectively?
- Are procedures for the operation of these services documented?
- Is there clarity about boundaries and responsibilities of each service?
- Does regular monitoring and evaluation take place?
- Are there opportunities for participation of young people in planning or other aspects of a program or service that is done collaboratively?
- Is confidentiality and privacy ensured?

# *Checklist (Chapter 8): Building the infrastructure*

- Have you read the document? ... Really? You're a legend!!
- Does your orientation package include research studies on the social determinants of health?
- Do you have Internet access? ... and the time to use it to access research?
- Are you able to easily access research findings on social determinants of health, ethnographic studies of communities, gender studies, surveys on attitudes and perceptions about health issues, etc?
- Does your service subscribe to a range of publications on youth, sociology, health?
- Do you see mistakes as learning opportunities or signs that you are a totally hopeless human being?
- Do you look for new ideas everywhere or only in your area of expertise?
- Do you attend cross-cultural training sessions?
- Do you have good working relationships with other parts of the health system involved in health research? Would you feel comfortable ringing them up for assistance with, for instance, health statistics or evaluation? Can you visit these units to see what they do?
- Are there possible joint projects that could involve your service with different units in health? Would they be interested? Would you be interested?
- Do you have good working relationships with university departments doing social research that is relevant to your service? Are you on the mailing list for newsletters, seminars, etc? Do you know who is doing what research where? Do you know how to find out?
- Are all policies and procedures in your service documented? Is the policy and procedure manual accessible to all? Is it reviewed regularly? Who, other than staff, is involved in the review procedure? Young people? Community representatives?
- Have you read relevant policy documents? Can you find them on your desk?
- Are you able to access training and conferences ... even if they cost money? Or are you only able to go to the freebies?

Do you have the time, even if you have the money?

- Do you feel that your job is rewarding? In which ways? Where do you see yourself in 5 years time?
- How are programs planned? Is it all documented? What procedures are used?
- When planning programs, how are needs assessed?
- Is evaluation built in from the beginning?
- How are programs monitored?
- Is there a shared vision of youth health in your team?
- Does your service work as a team ... really? How is teamwork encouraged? Are different skills, knowledge, experience and expertise respected, valued and accessed? Is there a hierarchy of roles or a "pecking order" in the service? If so, how can this be overcome?
- Are workers in your service consulted? Supported? In which ways? Is debriefing and clinical supervision available? Is it built into the service?
- Are you always too busy?
- Is there scope in your job for decision-making, autonomy, control and flexibility of work?
- Is there an emphasis on improving systems and processes rather than targeting individual performances?
- Is there support from management for new approaches in the work of your service? What about higher management? ... and on up the line?
- Can you believe this list is finished? ... Well, only until you add to it!

**...and No, you haven't won the lounge suite!**