Getting It Right!

A BACKGROUND PAPER

Models of Better Practice in Youth Health

a project of the

Australian Association for Adolescent Health (NSW)

Joan Silk

September 1999

TABLE OF CONTENTS

ACKNOWLEDGMENTS

There will be something for everybody to get annoyed about in this document. The field is as full of controversy as any area worth thinking about! When I accepted the job of writing a document on Models of Better Practice in Youth Health, I didn't know what I was letting myself in for. There are no ready answers and no straight and narrow, uncontroversial path through "the literature", much as I may have hoped there was. There *isn't* a "body of literature" to go to for answers. Just working out how you know "better practice" when you see it is challenging enough! The assumption I came across a lot was that "better practice" can be identified by consensus - if we all think it is, then it is. This was often true ... but sometimes it wasn't - and there was evidence to show that it wasn't. This will get some people's backs up. Hopefully it will also encourage us to look at issues of what works and who for and how do we know. It made me think and talk and think again about these things - and realise that I know less than I thought I did. And that can't be a bad thing for anyone.

I am grateful for the assistance of the NSW Health Department and the Commonwealth Department of Health and Aged Care which funded this project through the State/Commonwealth Innovative Health Services for Homeless Youth (IHSHY) Program, and the Australian Association for Adolescent Health, (AAAH) (NSW) which auspiced the funding. The Better Practice Project Steering Committee members were always available for assistance, and I am grateful to them, particularly to Noel Fittock, manager at the Western Area Adolescent Team (W.A.A.T.), who has been consistently supportive, reflective, tolerant, good-humoured, and helpful. Thanks also to the W.A.A.T. team for making me welcome and to David Novella for his desktop publishing and his patience.

So many people helped me with this work that I haven't space to acknowledge them all. Youth and health workers gave up precious time to speak to me, as did young people. Youth health teams that I visited were welcoming and generous with their expertise. The following people made suggestions, provided information, comment, books, articles and references and shared their expertise. I am grateful to have learnt so much from them, and in the course of doing so, to have realised how much there is to learn. The shortcomings in this document are, of course, my own. Thanks to Maria Coelho, Amanda Elliott, Sally Lambourne, Victor Nosser, Denise Voros, Merin Thompson, Joyce Leong, Karen Lambert, Bernie Brown, Moira Bryant, Mark McPherson and Linley Walker. Neil Orr gave up valuable time to assist me with suggestions, comments, discussion and references and I could not have done this project without his help.

Thanks to Nick for being there - and above all, to raf, for everything.

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 IHSHY Program provided funding for the Better Practice Project to complement the 1992-3 and 1996-7 evaluations of IHSHY. 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, the IHSHY Program 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 focusing 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 ill-health 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 also 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-focused, 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 (IHSHY) 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-judgmental 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), Meeting of Youth Teams in Health (MYTH) and the IHSHY Program, 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 focused, 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 focused, 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 participatory, 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 focused 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, participatory 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.

References: (Introduction)

1. Human Rights and Equal Opportunity Commission, *Our Homeless Children: Report of the National Inquiry into Homeless Children*, AGPS, Canberra, 1989
2. Market Attitude Research Services, 'Key findings and recommendations', *Evaluation of the Innovative Health Services for Homeless Youth Program*, Vol. 1, Sydney, 1997, p.1
3. WHO 42nd World Health Assembly, Technical Discussions , Background Document, *The Health of Youth*, WHO, Geneva, May 1989, p.1
4. e.g It is generally accepted that targeting a smoker with information about the health risks of smoking is not usually sufficient to cause them to stop. Constant feelings of "failure" to stop in the face of a barrage of information may have the unintended effect of generating inadequacy feelings, discouraging future attempts and therefore damaging health.
5. Commonwealth Department of Health and Family Services, *The National Health Plan for Young Australians: An Action Plan to Protect and Promote the Health of Children and Young People*, AGPS, Canberra, 1997
6. NSW Health Department, *Young People's Health: Our Future*, NSW Health, Sydney 1999
7. Market Attitude Research Services, 'Specific issues and outcomes emerging for each IHSHY service', *Evaluation of the Innovative Health Services for Homeless Youth Program*, Vol. 2, Sydney, 1997
8. Baldwin-Jones, M.,'Aboriginal health, Canberra, 13 February, 1998' *Social Alternatives*, Vol. 17, No 2, April, 1998
9. McKinlay, J.'A case for re-focusing upstream: The political economy of illness' in Enelow, A., Henderson, J., (eds), *Applying Behavioural Science to Cardio-vascular Risks*, American Heart Association, Chicago, 1984
10. Blaxter, M., *Health and Lifestyles*, Routledge, London, 1990, pp.243
11. Crawford, R., 'You are dangerous to your health" - the ideology and politics of victim-blaming', *International Journal of Health Services*, Vol.7, 1977, pp.663-679
12. Krieger, N., Rowley, D., Hermann, A.A., Avery, B., Phillips, M.T., 'Racism, sexism and social class: implications for studies of health, disease and wellbeing', *American Journal of Preventative Medicine*, Vol. 9, No.6, 1993, pp.82-122

SECTION A - HISTORY AND INFLUENCES

Chapter 1: Theoretical and historical background to the youth health movement in NSW

Chapter 1: Theoretical and historical background to the youth health movement in NSW

1.1 Youth health services

Youth-specific health services started to be developed in NSW in the late 1980s and early 1990s in response to a number of influences, some of which are noted below. It was well known that young people did not access traditional medical services. Youth, however, was seen as a time of good health and problems were usually seen as preventable and resulting from risky behaviour. This was generally viewed as being in the province of parental and not health service responsibility. Changing social and economic forces brought the health of young people into focus with concern expressed over issues of changing family structures, sexual behaviour, sexual health and sexuality and alcohol and other drugs. The origins in adolescence of practices leading to serious health conditions such as lung cancer and heart disease was also increasingly highlighted.

1.2 Health promotion and the community health model

The 1970s saw the beginnings (in the Western world), of changes in health policy which emphasised promotion of good health rather than the curing of illness. These changes made an impact in Australia with the Whitlam government launching the community health movement which became the vehicle for health promotion and education. This movement aimed to de-institutionalise health care and was community rather than medically-based and emphasised prevention, access for disadvantaged groups and personal responsibility for health[1]. The primary health care model developed by the community health movement decentralised services and involved previously neglected groups in interventions. However, it has been argued that it remained primarily concerned with curative rather than prevention models[2]. The attention to access for disadvantaged groups and the de-centralisation and outreach aspects of the community health model played an influential part in shaping youth health services towards a community orientation and a focus on access issues.

1.3 Social context

Social context and its interaction with individuals had always captured the interest of some. But since the 1970s, with the rise of active new social movements in Australia, the relationship of social context to health was increasingly becoming a matter for discussion and attention. In Australia and world-wide, indigenous Land Rights movements and the Women's and Gay and Lesbian Liberation movements had strongly insisted that health issues were inseparable from the wider socio-economic context and specifically the broad dimensions of social inequality. The relationship of health to the total social situation of a community was emphasised continually by indigenous activists and organisations and by the Women's Liberation movement who also developed support systems based on awareness-raising about inequality, collectivity and self-help.

The 1989 Human Rights and Equal Opportunity Commission Report (the Burdekin Report) revealed to Australians the extent of youth homelessness and its consequences[3]. The IHSHY Program was developed by the Commonwealth and State governments in response to the revelation that large numbers of homeless young people were suffering a multitude of health problems associated with their socio-economic situation.

In recent times movements such as that around the Aboriginal Deaths in Custody enquiry, and Unemployed People's organisations have continued to address issues of social inequality and its effects on health[4,5]. These concerns have been taken up in the health system, for example by the NSW Aboriginal Mental Health Policy

(1997) and by the Centre for Health Equity Training, Research and Evaluation, (CHETRE) in South Western Sydney[7]. Recently, the importance of seeing health in gender terms has been re-activated by some sections of the men's health movement[6,8].

Issues of poverty and inequality, racism, gender, power and the class basis of ill-health in which working class people (employed or unemployed) suffered, were increasingly discussed and debated. Youth health services had been established in areas of intense social disadvantage and debates continued about the most effective ways to address youth health and social justice issues.

1.4 The move away from individuals

From the 1980s, in some areas of health practice, there was a movement away from health promotion which prioritised individual responsibility and behaviour change. This model had rested on the assumption that people were equally free to choose behaviours and lifestyles. There has been a move towards a broader concept which looked at the dynamic between the wider environment and positive and negative health effects on individuals. The dominant paradigm which "focused on individuals, exhorting them to change their behaviour and lifestyle in ways that are more likely to leave them healthy" has gradually given way to a more complex account of health and its determinants[9]. There has been increased recognition that health is "more complex than changing people's behaviours and that some people are better positioned to change their behaviours than others"[10].

This view emphasised that various aspects of people's lives as social beings interact in determining the options available and the individual's ultimate health status. The implication here is not that individual choice is meaningless. It is that individuals do indeed make choices but not in circumstances of their own making. This more sophisticated and holistic way of conceptualising health is having a decisive influence on the development of health services.

1.5 The WHO declaration on health

The interlinking of social with physical and mental wellbeing in a conceptualisation of health has been made by the WHO, most recently in the Jakarta Declaration[11]. The WHO declaration on health was adopted into the philosophies and service documents of most youth health services and in various ways its meaning was interpreted into practice. It formed the rationale for a holistic practice ranging over a continuum of health and social justice issues. It was recognised that the broader social issues of housing, education, employment, racism and poverty were linked to the health of young people. Connections were made between youth health services and organisations working in the above areas as well as community based youth services. Some of the ways the WHO declaration has been translated into practice have been through building contacts and referral networks inter-sectorally and in the community, representation on inter-agencies, development of programs addressing social justice issues and advocacy for young people over a range of issues including public space, education, juvenile justice, sexuality and income support.

1.6 Social class and poverty

Most recently there has been increased research interest in refining the concept of the social determinants of health and this has started to influence youth health services. The fact that social class affects health is not a new concept. The poorer you are, the worse your health is - this has become commonly recognised. People raised in working class homes as well as those belonging to the working class later in life have a shorter life expectancy and higher illness risks throughout life. This applies in prosperous as well as poor countries[12]. The WHO stated some years ago that poverty was the most serious health problem world-wide. In Australia, research into the relationship between poverty and ill-health has shown clearly that there are associations between the two which are adverse both for whole populations and for particular social groups such as single mothers who are known to be at a high risk of poverty[13].

It is clear that there is a relationship between social class, poverty and low living standards. Those relegated to the very bottom of the class structure in Australia, indigenous people, have the worst health of all Australians and the most deprived living standards[14]. Indigenous Australians have a life expectancy some 20 years less than non-indigenous Australians[15], and this pattern is the same for almost every health indicator. Diseases which have been eradicated in the non-indigenous community remain life-threatening for indigenous Australians. However, if conditions of absolute poverty and deprivation were to be addressed, would we then see equal health for all? The Aboriginal health movement, as well as a growing body of research, has drawn attention to the complex answers to this question. What we know is that the alleviation of poverty is a *necessary* condition for health, but it is *not* sufficient.

1.7 Social class and issues of control

Recent findings show that the relationship of class to health is not *only* one in which poverty increases the likelihood of risk factors such as unhealthy food, polluted environments, cigarette smoking, lack of exercise, poor housing, lack of resources to adopt healthy lifestyles, etc. It has been widely documented that risk factors are detected only in a minority of cases of ill-health, whether heart disease[16] or depression amongst adolescents in Australia[17]. Widely varying degrees of health have been found in groups where the influence of known risk factors has been adjusted for in both groups, suggesting the involvement of another factor.

Research has also shown that it is not just on the bottom of the class ladder where health starts to deteriorate. On every level, the health of those higher up is better than that of those below them. Researcher Michael Marmot from the Whitehall studies, (see below), says "...for example, in Britain, it was estimated recently that the men dying, given that most deaths occur after age 65, if we look at premature deaths ...if everyone had the same mortality as people in class 1 and 2, there would be 17,000 fewer deaths. ... And there is no known biological reason why people of class 4 and 5, the lower semi-skilled and unskilled manual workers, there's no known reason why they should not have the same mortality rates up to age 65 of people in class 1 and 2"[18].

In situations where the risk factors associated with poverty are not present, there is still a strong association between health and class. There is a gradient in which class and health status are correlated. Studies have been undertaken to find exactly what is it that determines that class position relates to health no matter where on the ladder a person is located.

The Whitehall Study was a longitudinal study looking at the health of civil servants in the UK. This middle class group was not poor but there were different occupational categories ranging from drivers to high level administrators. The study ranged over these different levels within the civil service, which were reflected in differences in salary and working conditions. The findings showed that those with less control over their working conditions were those whose health suffered[19]. For example, after controlling for risk factors, death from coronary heart disease was still over three times higher in the lower grade civil servants than in the upper grade ones[20]. The health of those civil servants ultimately retrenched as a result of privatisation also showed a serious decline in response to the *anticipation* of job loss. Not only unemployment but the removal of job security was also shown to lead to worse health[21].

The Whitehall study is part of an important body of work that shows that other components of social inequality, not only in working life but in all aspects of life, are as significant to health as the material deprivation related to poverty. Independence, power over destiny, control and autonomy are class-related determinants of health. In opposition to this view it has been suggested that factors such as "intelligence" and family background, "...individual characteristics of individuals ..." may determine *both* class position and health status, but there is little evidence to support this interpretation[22].

The health implications of relative social equality, (i.e. of a much more even social gradient), have been pointed out in the large body of literature on this subject[23,24,25]. Even in social systems which are not part

of the rich, developed world, such as Cuba or Kerala state in India, a commitment to social, economic and political egalitarianism has meant that the presence of these elements has given rise to dramatically healthy societies. In other parts of the world, the down side of a headlong rush into economic rationalism has meant the development of two-tiered societies with intensifying levels of social tension, insecurity and powerlessness for many, alongside ever-increasing wealth for a few[26]. Social research shows that such disparities are increasing in Australia[27].

It has been shown that stress associated with lack of control over life can affect the body's immune system, not only via vulnerability to health damaging behaviours but directly through the effects on endocrine and immunological processes[28,29]. At the very bottom of the ladder, working class people are worse off than anyone else. Not only is their health worse but their subjective experience of health is worse. Ironically, they are also the most likely to believe that the most important determinants of health are voluntary behaviours, as opposed to environmental factors[30]. The effects of social inequality and alienation which come with the class territory have been described as the "hidden injuries of class"[31]. One of the "injuries" may well be this internalisation of blame.

1.8 Gender

An understanding of the complex interactions between gender, class, ethnicity/ATSIB and health in specific settings, is essential to an understanding of the social determinants of health. This involves seeing "men's health issues" and "women's health issues," not as separate and competing, but as essentially integrated[32]. National education policy has taken this approach, developing a comprehensive gender equity framework in which boys' and girls' education issues are seen in relation to each other[33].

The focus must be on the links between women's and men's health issues, their relationship to dominant gender constructions in a class, ethnic/ATSIB and geographically specific context and the health implications arising out of this. For example, what will the disappearance of secure employment for young working or middle class men mean in terms of its possible function as a rite of passage to "manhood." What are the likely health consequences for both men and women? How will it affect those living in rural areas or particular ethnic groups? In the same way or differently? Are there protective factors? For whom? How will it affect inter-personal relationships, children and family life? Will violence increase? If so, by whom and towards whom? These questions need to be addressed and debated in a way which integrates gender into a cultural and class context. It is essential to avoid a lifeless compartmentalisation that negates the relational dynamic of these concepts. The gendered concept "masculinity", would be incomprehensible without the associated gendered concept of what it is *not*, i.e. "femininity".

1.9 Youth and issues of control over one's life

The findings of the Whitehall study and most other studies on the health effects of social inequality have concentrated on adult groups and there is some debate over the applicability of class-related health explanations during the period of adolescence. One US study found no evidence of economic hardship directly affecting a child's psychological functioning, but a direct relationship to that of the mother and therefore indirectly to the child[34]. The work of Resnick in the USA emphasises that close connections between young people and their families and schools are health protective. His work does not concentrate on the social location of the groups studied but consistently the data used shows that the children of families on "welfare" fare less well in making those connections[35]. Another study found some evidence that, during adolescence, class had little effect on health and on certain risk behaviours such as smoking, using "soft" drugs and drinking alcohol but that there was a resurgence of the class/health link later in life[36].

There is a need for more studies specifically on the relationship of the social to young people's health. But it is clear that lack of ownership and control over resources including one's own life options is particularly intense for both the young and the old, *because* of factors related to age, as well as class, gender, ethnicity and other social factors. A global survey quoted in New Internationalist magazine found that young people

felt that they had little control over their lives and were "ruled" by adults[37]. Young people live in a world where social inequality is a pervasive fact of life. Within families, the legal and political system, in the community and the employment, unemployment and education systems, it can be argued that young people are the most socially disadvantaged of all groups. Paul Gilligan from the Irish Society for the Prevention of Cruelty to Children says,

> *"Children are rarely consulted about their beliefs, opinions or attitudes or about their views about the laws and services influencing their lives. It has often been suggested that if children did not grow up into adults they would long ago have been identified as the most discriminated against minority"*[38].

This does not mean that simple predictions can be made about individual health, but there are however, massive implications for the health of young women and men, particularly in the areas in which youth health services operate. It is in these areas where escalating social inequalities resulting from class, gender, ethnicity/ATSIB, etc, are interacting with the most intense disempowerment of youth.

1.10 Health issues are political issues

The Marmot team, having done extensive studies on social inequality and health (including the Whitehall study) were asked by the WHO, to develop a list of health "messages" from their findings[39]. These messages point to areas, processes and approaches in health work that utilise the findings of the Marmot team and are consistent with the WHO definition of health. The "health messages" state that health policy and action needs to be holistic and to increase social cohesion and autonomy. They say that action for health means:

- Acting against social exclusion, whether due to poverty, ethnicity etc.
- Promoting work practices that tackle the stress inducing, high demand, low control jobs
- Acting against the authoritarian structure that promotes an imbalance between effort and reward
- Reducing stress
- Drawing attention to the links between poverty and inequality and addictions
- Developing social support
- Promoting public transport
- Acting against unemployment and job insecurity
- Promoting healthy food
- Understanding the effects of early influences on later life, etc.

These must be recognised as significant health issues. And they emphasise that all of these are inescapably political issues. The Royal Australasian College of Physicians, in a recent publication, states that "Australian and international research clearly demonstrates links between social, health and economic policies and social and economic disadvantage. The impact of economic policy has a related effect on the health of individuals and populations"[40].

1.11 Role of youth health services

Youth health services are usually familiar with the social environment of their areas including the effects of political and economic change on young people, their families and communities. They have also built up contacts, resources, knowledge and direct experience of working with these groups and have considerable

credibility. While total social change is not going to be brought about by a youth health service, it is brought about by people. Services can work with people to address some of the *causes* as well as the *impacts* of social inequality. They are favourably positioned to take a leading role in working with communities towards social change that can bring about a more equitable and healthier society.

References: (Chapter 1)

1. Petersen, A., 'Health promotion: A new orthodoxy', *New Doctor*, Issue 46, Summer, 1987, p.27
2. Davidson, L., Chapman, S., Hull, C., *Health promotion in Australia*, AGPS, Canberra, 1979
3. Human Rights and Equal Opportunity Commission, *Our Homeless Children: Report of the National Inquiry into Homeless Children*, AGPS, Canberra, 1989
4. Royal Commission into Aboriginal Deaths in Custody, *National Report*, Canberra, 1991
5. People Outta Work, (POW), and Wollongong Outta Workers (WOW), leaflet, Sydney, 1991
6. NSW Department of Health, Centre for Mental Health, *NSW Aboriginal Mental Health Policy: A Strategy for the Delivery of Mental Health Services for Aboriginal People in NSW*, NSW Health, 1997
7. Centre for Health Equity Training, Research and Evaluation, *Action on health inequalities through general practice*, Discussion paper, UNSW, 1999
8. Connell, R.W., Schofield, T., Walker, L., Wood, J., Butland, D.L., Fisher, J., Bowyer, J., *Men's Health: A Research Agenda and Background Report*, Report submitted to the Commonwealth Department of Health and Family Service, 1998
9. Baum, F., 'Research to support health promotion based on community development approaches', in Colquhoun, D., Kellehear, A., (eds), *Health Research in Practice*: *Political, Ethical and Methodological Issues*, Chapman & Hall, London, Melbourne, 1993, p.184
10. ibid.
11. WHO, *The Jakarta Declaration*, Website URL http://www.who.int/dsa/cat95/zjak.htm
12. Lundberg, O., 'Childhood conditions, sense of coherence, social class and adult ill-health: exploring their theoretical and empirical relations', *Social Science and Medicine*, Vol. 44, No. 6, 1997, pp.821-831
13. Saunders, P., 'Poverty, income distribution and health : an Australian study', *Social Policy Research Centre Reports and Proceedings*, No. 128, August, 1996
14. Swan, P., *200 years of unfinished business*, Redfern Aboriginal Medical Service, Sydney, 1998
15. Aboriginal and Torres Strait Islander Commission (ATSIC), *As a Matter of Fact: Answering the Myths and Misconceptions About Indigenous Australians*, 2nd Edition, Office of Public Affairs, Canberra, 1998, pp.34-35
16. McMichael, A.J., 'Current Directions in Public Health and Preventative Medicine', in McNeil, J., King, R.W.F., Jennings, G.L., Powles, J.W., (eds.), *A Textbook of Preventative Medicine*, Edward Arnold, Caulfield East, Victoria, 1990, p.320
17. National Health & Medical Research Council, Clinical Practice Guidelines: Depression in young people: a guide for mental health professionals, AGPS, Canberra, 1997 p.41
18. Marmot, M.,'Mastering the control factor, Part 2, Interview on ABC Radio National, *The Health Report*, November 16, 1998
19. Marmot, MG., Davey Smith, G., Stansfield, S., Patel, C., North, F., Head, J., White, I., Brunner, E., Feeney, A., 'Health inequalities amongst British civil servants: the Whitehall 11 study', *Lancet*, Vol.337, 1991, pp.1387-93
20. Davey Smith, G., Shipley, M.J., Rose, G., (1990), 'The magnitude and causes of socio-economic differentials in mortality: further evidence from the Whitehall study', *Journal of Epidemiology of Community Health*, Vol.44, pp.265-270
21. Marmot, 1998, op. cit.
22. Marmot, M., Ryff, C.D., Bumpass, L., Shipley, M., Marks, N.F., 'Social inequalities in health: Next questions and converging evidence', Social Science and Medicine, Vol.44, No.10, 1997, pp.901-910
23. Wilkinson, R.G., 'Income distribution and mortality: a "natural" experiment', *Sociology of Health and Illness*, Vol.12, 1990, pp.391-412
24. Vagero, D., 'Inequality in health - some theoretical and empirical problems', *Social Science and Medicine*, Vol.32, 1991, pp.367-371
25. Adler, N.E., Boyce, W.T., Chesney, M.A., Folkman, S., Syme, L., 'Socioeconomic inequalities in health: No easy solution', *Journal of the American Medical Association*, Vol.269, No 24, 1993, pp.3140-3145.
26. Baum, F., speech delivered at 'Work, Health and Wealth: From Science to Advocacy", a seminar organised by the Public Health Association and the Australian Council for Social Services (ACOSS), April 14, 1999
27. Raper, M., op. cit.
28. Wilkinson, R.G., *Unhealthy Societies: The Afflictions of Inequality*, Routledge, London, New York, 1996, p.5

29. McEwan, B., 'Mastering the control factor', Part 3, Interview on ABC Radio National, *The Health Report*, November 23, 1998
30. Blaxter, M., *Health and Lifestyles*, Routledge, London, 1990, pp.235, 241
31. Sennett, R., Cobb, J., *The Hidden Injuries of Class*, Knopf , New York, 1972
32. Connell, et al, op. cit., 1998, p.6
33. Gender Equity Taskforce, Ministerial Council on Education, Employment, Training and Youth Affairs, *Gender Equity: A Framework for Australian Schools*, AGPS, Canberra, 1997
34. The Canadian Taskforce on the Periodic Health Examination, *The Canadian Guide to Clinical Preventative Health Care*,Health Canada , Ottawa, Canada, c.1994, p.360
35. Resnick, M.D., Bearman, P.S., Blum, R.W., Bauman, K.E., Harris, K.M., Jones, J., Tabor, J., Beuring, T., Sieving, R.E., Shew, M., Ireland, M., Bearinger, L.H., Udry, R.J., 'Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health', *Journal of the American Medical Association,Vol.278, No.10, p.827*
36. Tuistra, J., Groothoff, J.W., Van Den Heuval, WJA., Post, D., 'Socio-economic differences in health risk behaviours in adolescence: Do they exist*?' Social Science & Medicine*, Vol.47, No.1, pp.67-74
37. Ride, A., *Another Planet*, New Internationalist, No.303, July, 1998
38. Gilligan, P., 'Involving children: Combating the social exclusion of children', paper presented at the 12th International Congress on Child Abuse and Neglect, Auckland, quoted in *Kids Help Line Newsletter*, November 1998
39. Marmot, 1998, op. cit.
40. Royal Australasian College of Physicians, Health Policy Unit, *For richer, for poorer, in sickness and in health..., The Socio-economic Determinants of Health*, Sydney, 1999, p.3

SECTION B - PROCESSES OF BETTER PRACTICE AND THEIR COMPONENTS

Chapter 2: Addressing inequalities

Chapter 3: Access and participation

Chapter 4: Building supportive environments

Chapter 5: A balanced approach

Chapter 6: Coordination

Chapter 7: Collaboration

Chapter 8: Building the infrastructure

Chapter 2: Addressing inequalities

Youth health services have consistently stressed that the principle of social justice underlies their practice. Sometimes the content and implications for practice of this principle have been unclear. But generally it has been used to describe the aim of an approach based on addressing social inequalities. Emphasising social justice can be seen as a response to social inequality. In a model which conceptualises health as wellbeing in the broadest sense, and as having social determinants, addressing social inequalities is essential. In this model social justice is the wellspring of health.

In the previous chapter, we saw that the relationship of social inequality to health has been shown to be crucial. An essential starting point in understanding youth health is therefore the development of an understanding of social inequality that acknowledges its complexity, is not simplistic and does not remove individuals from a social and historical context. The importance of this understanding to better practice cannot be over-emphasised. Reflection on the nature of social inequality is a necessary part of the development of youth health practice. It does not, however, mean that nothing can be done until a complete understanding has been achieved (if that is ever possible). A continual interaction of reflection and practice underlies better practice.

An exploration of social inequality may look at the theories about it, the forms it takes, the social forces involved, the historical background, concrete examples of who is affected, how and why, the health and other effects manifested in communities and individuals and the issue of responsibility. Without an understanding of social inequality, health practice can be ad hoc and equivalent to lumbering about in the dark. Even situations which may appear to be very straight-forward such as the taking of medication may have an underlying logic that relates to issues of inequality. Some years ago on an Aboriginal mission in Queensland, it was noticed that residents went to great lengths to avoid taking the compulsory vitamin pills issued. To those without an understanding of the historical and social background, this action appeared as an incomprehensible piece of willful ignorance to be addressed by increased control, surveillance and education. To many residents, some of whom had bitter memories of communities wiped out by deliberate poisoning, this action was an expression of autonomy, defiance and survival in the face of an authoritarian and suspect regime[1]. Without an understanding of social inequality, the development of a health enhancing practice is difficult.

Some of the approaches that flow from an understanding of social inequality include advocacy and empowerment. While these examples are discussed below they do not exhaust the range of possible approaches. Other examples are discussed in later chapters.

2.1 Social class and inequality

Ownership and control form the core of a concept of social class. Social inequality is the outcome of a class-based social structure in which there is inequitable access to resources, whether those resources are material ones, i.e. property or the products of people's labour, or those which usually flow from the material ones and have to do with power and control. The groups who have least access, i.e. those who lack ownership, power and control and all that these imply, will usually have worse health than those above them. Lack of ownership and control affects not only the amount of goods and services a person can access but how much control they have over their own (individual or group) destiny. Located at the bottom of the class ladder are those who may or may not be employed, but whose relationship with property and power is marked by the absence of both. This in turn can affect levels of stress and may be expressed through feelings of anger, frustration, isolation, lack of confidence and of self-esteem, acceptance, pro-activity, independence, self-efficacy. These effects then operate to constrain the choices individuals make that affect their health status. However, it is important to remember that there is a social gradient and that alienation and powerlessness are not confined to the most socially disadvantaged.

2.2 "Disadvantaged groups" and inequality

There are groups whose social position is one of unequal and discriminatory treatment but who are not necessarily *materially* disadvantaged. Young people are one of the most significant of these. Others are women, same-sex-attracted people, certain ethnic or religious groups, people practising behaviour regarded as socially unacceptable such as injecting drug use. The nature of the connections between social class and issues of gender, ethnicity/ATSIB or sexual preference are complex and beyond the scope of this work. However, it is almost invariably true that the people in these "disadvantaged" groups who are at the working class end of the scale will be worse off in terms of control and autonomy - and therefore health - than those above them.

2.3 Inequality - who's responsible?

Inequality is the basis of, and inseparable from, class society. There is a pervasive ideology of social mobility in class-based societies. It is, however, not matched by the reality in which the general class parameters of a person's birth will usually be those that are maintained for life. This does not deny that individuals can "make good" and dramatically increase their income and power, or conversely "fall on hard times." But rising and falling individual fortunes don't alter the fundamental class divisions which characterises the society.

The interaction of class and individual psychology is hugely complex. But a refutation of the simplistic, "talk-back show" sociology that says that class position is due to individual capacities or lack of them is vital to an understanding of inequality. The old pop song that says "you can make it if you try" cannot apply to everyone, no matter how hard they try. Differential access to power and property is a structural requirement of a capitalist society which could not operate without it. Further, these differentials promote group or class interests that are in conflict. By necessity, what is usually "good for the goose is not good for the gander." For instance, a certain level of unemployment may be viewed as a benefit by some who see it as a means of keeping wages at a "manageable" level (when there's always someone desperate for work who will undercut someone else) but as a tragedy for those who, no matter what they do, are unable to find work because there are many more unemployed people than job vacancies. Social inequality is an outcome of social class and its intrinsic power dynamic.

2.4 Individual responsibility

Theories about social determination are sometimes misinterpreted as absolving people from responsibility for their actions. However, recognising inequality as a major determinant of health does not preclude individual responsibility for decisions, only for the parameters within which they are made. People still make decisions and act on them, but they don't make their own living situation or "socio-economic environment" within the boundaries of which situations arise and decisions and actions are made.

2.5 Deficit theory

"Deficit theory" has been commonly used as a basis for theories about individual responsibility. Remnants of deficit theory still survive in the fields of education, criminology and health, where it has been historically entrenched. The notion of the (de-contextualised) individual as the primary determinant of their own life situation is characteristic of this theory. The significance of structural inequalities based on property and power is silenced.

Deficit theory assumes there is only one playing field, there is an equal starting point for everyone, and the winners are the "best and fairest," those who, by their own efforts, are best able to play and therefore most

deserving of their rightful rewards. This theory dissolves a structural inequalities-based conceptualisation of the effects of social class. The causes of social disadvantage are seen as located within the individual and are regarded as consequences of an individual's or family's deficiencies in socially acceptable attitudes, skills or knowledge.

Because certain qualities that are pre-requisites for "getting ahead" are seen as within the reach of all people, it is the task of the "disadvantaged" to equip themselves accordingly. If they seem unable or unwilling to do so, the role of the "professional" is to assist them, thus enabling them to take their place within the established system. The "system" itself remains un-analysed. Once equipped, "low health values" may be invoked to explain the "knowledge-action gap". This purports to explain why some people act on the knowledge imparted to them and others don't. A familiar moralistic agenda is very much in evidence[2]. The process has also been described as "social policing" or social control exerted by privileged middle class professionals who, by fitting out their potentially rebellious clients for passive acceptance of the class system, unwittingly maintain the status quo, which ultimately contributes to ill-health.

2.6 Freire's theories

The educationalist Paolo Freire's work embodies a sustained attack on theories of individual responsibility for social inequalities[3]. He developed his theories through teaching literacy in Latin America, but his methods and principles are not confined to this field. With social inequality established as the crucial social determinant of health, Friere's work is highly relevant to a health work practice that must address inequalities in order to improve health.

Freire's own practice of education was as a weapon of social transformation where educators, together with students, critically reflect on and interpret their world and act to transform it. He saw education as a potentially liberating practice in which teacher and student could work and learn together to develop a "critical consciousness" with the aim of understanding and changing an oppressive system revolving around social inequality.

Friere said that education could work two ways. It could work towards addressing inequalities and developing social empowerment (and therefore be health enhancing), or it could collude with the system that produces social inequality and its consequences (and therefore be health damaging).The collusion model uses the "narration method" or the "banking concept of education" where the teachers role is *"to fill the students with the contents of his (sic) narration" ... "it turns them into containers, into receptacles to be filled by the teacher. The more completely he (sic) fills the receptacles, the better a teacher he (sic) is. The more meekly the receptacles permit themselves to be filled, the better students they are."* In this top-down, authoritarian, unquestioning and unreflective type of interaction, there is a projection of ignorance on to those who are oppressed which negates "education and knowledge as processes of inquiry." This process can be seen as reinforcing powerlessness and alienation and strengthening inequality. Today we might describe the process as the "dumbing-down" of possible dissent, a strategy not unknown for the protection of the powerful and the maintenance of social inequality. Freire quotes Simone de Beauvoir's statement that the interests of oppressors lie in "changing the consciousness of the oppressed, not the situation which oppresses them."

Freire attacks this approach, which combines with a "paternalistic social action apparatus, within which the oppressed receive the euphemistic title of "welfare recipients." They are treated as individual cases, as marginal men (sic) who deviate from the general configuration of a "good, organised and just" society. The oppressed are regarded as the pathology of the healthy society, which must therefore adjust these "incompetent and lazy" folk to its own patterns by changing their mentality"[4]. As the Women's Liberation movement has pointed out, the pathologising of dissent can be a powerful tool used to avoid and disarm challenging social critiques[5].

Friere's work highlights the dangers of de-contextualising and de-historicising individuals and seeing them, not as the subjects of social processes at a particular time but as individuals whose actions are unrelated to their place in a particular social system. Some of the inadvertant consequences of doing so are described below.

2.7 Problems with seeing social disadvantage as originating within the individual - "blaming the victim"

Ignoring the socio-economic factors that determine health and shifting responsibility on to the individual, creates a situation known as "blaming the victim"[6]. Health practice based on theories of individual deficiencies can actually increase ill-health by loading people with impossible tasks and blaming them when it doesn't work out, thus increasing stress on the individual. In addition, the status quo of social inequality with its health-damaging consequences, is maintained by taking attention away from structurally determined social and physical environments[7,8]. Targeting of responsibility for environments that are health threatening can become very hazy, if not completely lost in the welter of victim-blaming.

Addressing inequalities necessitates developing a view of individuals and groups as actors in a social landscape in which the determinants of their actions are intimately linked with their class location as well as sexual, ethnic and gender identities. To expect individuals to change their behaviour simply on receipt of health information, with unchanged social situations, may be setting them up for failure and making their health worse. People are not passive receivers of information - or "receptacles" in Freire's words[9]. Health messages delivered to people will be interpreted in the light of their own experiences and needs within a specific set of social locations (i.e. class, gender and cultural configurations)[10].

Unless this interplay of factors beyond the individual is understood, people's actions may seem mystifying, self-defeating or "stupid." However, they can often be understood in the light of increased knowledge of the social context. This point is strongly made by Fullilove et al, in their work on HIV prevention in African-American communities. They stress, for example, that HIV prevention efforts targeting African-Americans must incorporate job development programs. Unemployed and under-employed people who may be coping with vicious levels of social inequality and seeking a sense of belonging, achievement and creativity, may find in sex a means to demonstrate "manhood or womanhood through having children and being sexually active"[11]. It is dangerous to de-contextualise actions and assume that they have universal meanings. Without a work practice that is based on an understanding of the wider dimensions of social inequality, this can easily happen. The social reality of the health worker is often very different to that of their "target group." It is sometimes easy for us to make a "common-sense" interpretation of events or actions which may be correct in our own social context but entirely wrong in others.

Surveys, national and locality studies and ethnographic materials can be useful for finding out how people view health, their perceptions of health initiatives and socio-economic factors that influence their lives.[12]. This material is an essential adjunct to more subjective assessments. There is a shortage of this type of material and it is often difficult getting that which is available. Many health services do not have the technology to access the Internet nor the staff time available for sustained library research. The lack of institutional links with research bodies also means that accessing research is often an ad hoc process that depends on a staff member having the time, interest, perseverance and resources to do so.

When the focus is restricted to the individual and inadequacies are located within people, it is more likely that the broad meaning of a health-damaging action will not be interrogated at all. Lack of analysis may also preclude an understanding of the barriers to change[13], or lead to stereotyping, discrimination and inadvertently upholding oppression through approaches based on narrow and uncritical foundations.

2.8 Problems with seeing social disadvantage as originating within the individual - "Changing their mentality"

"Changing their mentality" is sometimes the objective underlying programs which focus on the individual with the aim of addressing inequality. Unfortunately some may well work in the opposite direction. For example, some "employment" programs imply that unemployment is an individual failing. If the structural causes of unemployment are not carefully spelt out, the implication of individual responsibility for joblessness can be inadvertently drawn. Clearly people should be assisted in all aspects of job-seeking if they require it, and protected from the devastating health effects of unemployment. But the possibility that unemployment will be internalised as personal inadequacy needs to be avoided. With fewer jobs than jobseekers, everyone who gets a job deprives someone else of one. While some people do find jobs, the underlying situation where there are more unemployed people than jobs must be acknowledged and addressed.

Policies of assimilation of immigrants or indigenous people which were accepted practice in postwar Australia were also underlaid with the sorts of assumptions that characterise theories of individual deficit. It was felt that if only the blacks and migrants could be taught to overcome their "inadequacies" and be more like "us" they would fit in to society and gradually take their allotted place (which was usually doing the worst, lowest paid and most dangerous jobs that no-one else would do)! The logical consequence of this type of thinking was the removal of Aboriginal children from their families. Families were seen as inadequate in the skills, knowledge and practices laid down by the dominant society. In the name of helping indigenous people to adjust to accepted social norms, children were taken to fill the lowest places on the class ladder, gross human rights abuses were perpetrated and inequality in Australia given another grotesque dimension.

2.9 Problems with seeing social disadvantage as originating within the individual - "Saving them" and cultivating dependency

For many working class young people, and, it could be argued for youth generally, part of the nature of their social inequality is the removal of opportunities to exercise autonomy and independence - in almost all aspects of their life. From the time a person is born, they may be without control over significant aspects of their lives. At the lower end of the class ladder, almost all decisions may be made by someone else - government officials, social workers, employers, health authorities, pharmacists, charity workers, - the list can go on endlessly. This may contribute to feelings of disability and incompetence. Inadvertently fostering dependence and passivity, while it may promote a resentful docility and gratitude, and may be hooking into the emotional needs of the worker, is not an interaction that will bring health benefits to anyone. It can be argued that optimal health practice should make the practitioner obsolete!

Clarity about the meaning and impact of inequality and documented guidelines about boundaries for appropriate action are necessary. Lack of understanding about these can contribute to fostering a "client/worker" dependence which exacerbates inequality. "Learned helplessness" is a psychological state that can occur when people are treated as inadequate and incapable of undertaking tasks or decision-making and become actually unable to do so[14]. This can be an unintended outcome of a "welfarist" practice in which a health worker oversteps boundaries in an attempt to "save" a client. For example, a well-meaning worker, genuinely concerned about the welfare of a young client, may give out their home phone number and invite them to stay when they have nowhere to go. Not only is the ethical and legal situation potentially perilous here but the young person is actually being encouraged into a health-damaging and inappropriately dependent position.

2.10 Problems with seeing social disadvantage as originating within the individual -

"Keeping them off the streets"

Another variation on individual-focused practice is the health worker-as-provider-of-entertainment to young people to "keep them off the streets." The youth health service becomes a substitute for the entertainment that is beyond the reach of the clientele and operates more as a holding centre. Often the very companies which actively promote and advertise the exploitation of the "youth market" in consumer goods or whose work practices in relation to their young employees are actively detrimental to health, will contribute to these sort of uncritical programs. These are variants of the 19th century philanthropic idea of keeping the poor busy because "idle hands make devils work," except in the late 20th century it has become keeping them distracted and entertained. Such programs can be the result of well-intentioned youth work. However, they need a broader health-related context in which to operate effectively.

Young people know the reality with which they are confronted and for many of them it is bleak. A pool table and video games don't make up for disempowerment and lack of meaning, hope and joy. Writing about youth unemployment, one social commentator emphasises the need to listen to and acknowledge what is the reality for many young people. He says that:

> *"They know they're in a holding pattern, before descent into permanent uselessness and hopelessness"*[15].

A committee of Catholic bishops investigating youth issues has also identified a "malaise which is denying young people hope"[16]. While this is not the total picture, for some people it is an accurate representation of their situation - and entertainment and "humouring" doesn't change that reality. Denial, or avoidance of this reality does a disservice to young people.

However, it is also true that well-planned recreation programs can play a valuable part in youth health work. Some have a developmental aspect and can obliquely address social issues in a critical way. Recreation programs are sometimes the *only* way the most marginalised young people will access a service. One youth centre where the boys generally monopolised the pool table started a girls-only pool tuition program, with a female tutor, one afternoon per week. The workers found that the girls began to discuss the sexual division of recreation activity as well as improving their pool game and their confidence. Some services such as Cellblock Youth Health Service in the inner-West of Sydney have developed hip hop and other arts-based groups which articulate the experiences of a community of marginalised young people.

Muralappi Aboriginal Health Project in Redfern organises "cultural camps" which creatively combine recreational activities with Aboriginal culture. In this program young urban Aboriginal people who may be disconnected from much of their traditional culture participate in a combination of excursions, recreation and cultural knowledge. As well as participating in a full recreation program during the camp, they visit sacred sites, Aboriginal Land Councils, Aboriginal Medical Centres and Arts Centres. The groups meet with elders in each area they visit. Discussions on indigenous culture, both traditional and contemporary, frequently occur during the camp. The camps are also open to non-Aboriginal young people and are valuable in increasing mutual understanding. The participants have the opportunity to discuss, learn and share information with Aboriginal people in the areas they visit. Such programs which may use sports, arts and recreational activities, are valuable in promoting cultural pride, social connectedness and understanding, and can link resources and health programs to a community and promote communication and trust[17]. And they can be fun, too!

2.11 Implications for practice

Speaking on mental health, social analyst Richard Eckersley says,

> *"Obviously people in the health professions have a critical role in changing the situation. They are in the front line ... it is imperative they recognise depression as more than problems of individual pathology and dysfunction and do more to confront the broader social, cultural and political implications of the deterioration in our well-being"*[18].

Avoiding individual-deficit based practice does not mean that workers should avoid helping individual young people to deal with their situations. Clear information on health issues and services, skills to deal with situations or programs tailored to individual needs may be necessary or even sufficient for changes in health behaviour, particularly in highly motivated individuals. But an awareness of the limitations of this approach is vital. A continual awareness of the person as a social being moving within a network of relations of power and property over which they may have little control is necessary. This recognition, as well as a commitment to critical reflection and action in a wider social context is an essential component of better practice. Otherwise the health worker's efforts will be a "drop in the ocean" and may not necessarily even be health promoting for a particular individual.

A socially informed, developmental approach can be used rather than one which, consciously or not, views young people as "receptacles." Such an approach would help young people to identify and develop their strengths, critical awareness, social links, and resiliency while at the same time building with them and learning from them an active understanding of their social context. Working alongside members of other cultures can assist understanding of cultural interpretations. Learning is an interactive process that benefits everyone involved, the "professional" as much as the "client."

One of the dangers inherent in using concepts driven by an individually-focused deficit theory is that it gives rise to a potentially health-damaging interpretation of inequality. If the health service adopts a "social policing" role it will ultimately harm the health of young people by maintaining or exacerbating the social inequalities that contribute to their health status. Constant critical reflection, exploration, research and discussion on one's own health practice, as well as continual consultation, interaction with and listening to people in the target communities can mean the difference between becoming part of the solution or part of the problem.

2.12 Some approaches to addressing inequality - advocacy

What is advocacy?

Advocacy means speaking on behalf of a group or person who is ill-equipped to do it themselves and voicing their concerns, needs and points of view. It requires the consent (at least implicitly) of those spoken for and is an attempt to "equalise " a situation in which the person or people would be at a disadvantage if they were to be expected to speak directly for themselves. The disadvantage generally derives from the inability of the person to defend their interests on an equal basis in a particular system due either to personal disability or to the technical complexity of the system. Advocacy attempts to make the "playing field" a little flatter. (However, it can't eliminate the game, change its rules or withdraw from play.) The term originates in the legal system where someone who is unfamiliar with the language, processes and general culture of the law courts is under a great disadvantage if they do not have an advocate to represent them.

Advocacy is a major part of the work of youth health services. It is especially important in the wide range of areas affecting health such as housing, employment and income support, legal issues, community facilities, education, and in the re-orientation of government and private services towards accessibility for young people. It is a particularly significant part of the work of all those engaged in direct or clinical services with homeless young people, giving it a holistic dimension. Workers point out that the advocacy process can also be important in encouraging trust and confidence to enter therapeutic counselling or groups at a later stage.

Most youth health services have a Keyworker system which prioritises this aspect of direct service

provision. The Keyworker is a stable point of contact and support for the young person through-out their dealings with the health service. The Keyworker is familiar with the young person's situation and may provide practical assistance, help with accessing other services and working out personal strategies and priorities, accompanying clients to other services and assisting in articulating their needs if necessary. For example, at the Western Area Adolescent Team, (WAAT) in Mt Druitt, the Keyworker will assist young people and their families negotiate the court system if required. While the worker does not intervene in the court process, she or he is available to explain the processes to the young person and give general support and assistance.

Youth health workers may provide advocacy in various ways. They frequently advocate for young pregnant women or young mothers within the government sector, particularly in the health system. They have on occasions assisted in the development of activist groups. The young women often feel intimidated within the health and social security system which may not always be respectful, sensitive or sympathetic to young, single mothers or pregnant women . This is particularly so if the women have other issues such as injecting drug use. NESB and indigenous people have often experienced institutional (and other) racism including in the health system. Sometimes this experience has been so overwhelming that they will relinquish benefits to which they are entitled rather than negotiate "the system".

Advocacy services can be particularly important in cases where a young person may "fall between services". Negotiating service intake procedures in complicated cases can be a source of extreme stress for young people and their families. Canterbury Multicultural Youth Health Service (CMYHS), provided advocacy services in such a case for a young person with both mental and drug-related illness. CMYHS advocated for the young person both within the health system and with social security and accommodation services. Entrance guidelines to such services can sometimes preclude people with multiple health issues. In less complex cases, young people are nevertheless sometimes turned away from accessing medical treatment because they do not have a Medicare card. CMYHS and other youth health services often find it necessary to accompany and assist young homeless people to acquire Medicare numbers. In the process it is often necessary to try to re-orient health providers towards a more empathic attitude to young people.

Advocacy tasks are an important responsibility for all youth health workers. Young people often feel intimidated, reticent, or unfamiliar with the system. The youth health worker may assist with obtaining accommodation, education, health care or social security and similar services. The support of an advocate in these situations may help in negotiating the system confidently later. Sometimes a great deal of paperwork and an understanding of certain complicated or technical terms is necessary and literacy problems as well as anxiety can make the experience terrifying for young people and their families. In some cases, the experience is simply too harrowing and people give up in despair. In others, misunderstandings can mean legitimate claimants for educational subsidies or other benefits are rejected. Some refugee young people who may be without family support are particularly isolated and vulnerable and may not be aware of assistance that is available. Services such as CMYHS, The Corner and Fairfield-Liverpool Youth Health Team (FLYHT) which employ multi-lingual and/or ethno-specific workers have found their advocacy services are vital.

2.13 Does advocacy foster dependency and "welfarism?"

It would be hard to argue that "dependency" or "welfarism" are fostered through advocacy. To do so would require taking a view that all people were equally equipped, socio-economically and individually, to speak for themselves. It would require the denial, against all evidence, of all socio-economic influences on people and in practice, promote a world where the strong are unimpeded in devouring those who are less so. Assisting young people, either individually or as a group or community, with particular health-related issues is an important part of youth health services. It would not only be heartless but also negligent to leave the person or group to their own resources for fear of fostering "dependency." For many marginalised young people, youth health services and their associated networks are their only "safety net." Through their advocacy activities, services are often able to promote opportunities for developing personal autonomy and

independence as well as connectedness into support networks in the community. Services such as Penrith Streetwork Project (PSP) are sometimes able to act in an advocacy role to help a homeless young person negotiate resolutions to family conflicts.

Articulating the views of young people is a delicate task and care needs to be taken that advocates are actually representing young people's views. Services are generally aware of the pitfalls that can occur when advocacy is used to give credibility to someone's own personal views. The often repeated (by adults) statement that "young people *want* strong discipline" (so let's bring back the cane) is a classic!

2.14 Advocating for groups

In addition to individual support and assistance over a broad range of life areas, advocacy is also important in raising concerns about the situation of particular communities of young people. TraXside Youth Health Service has produced a regular radio program with young people on Macarthur Community Radio addressing the needs and concerns of young people in general but also of specific groups. Community Health for Adolescents in Need (CHAIN) addressed the concerns of marginalised young people in partnership with TAFE in a peer project resulting in an award-winning video series. These videos looked at young people's experiences of and responses to stress as well as their views about attitudes and actions of agencies and services in the health and welfare system. Young homeless people interviewed themselves and other young people and were trained in video production skills for the project. The positive self-esteem effects on the young people involved in the project are apparent in the videos. Procedures at CHAIN itself have been informed by the findings of the project and it is also a valuable resource for other organisations and workers with youth.

When some social groups are excluded from having a "voice" it becomes clear that *not* advocating for them is intensifying the exclusion with all the negative health effects that this will entail. There are not many avenues for young people generally to express their views. It is even more difficult for particular groups to do so. Single mothers, indigenous people, women, particular religious groups, people with ill or disabled parents, state wards, gays and lesbians, people with disabilities, NESB people, the unemployed and injecting drug users, are much more frequently talked *about* than given the opportunity to speak for themselves, or to have their views empathically and accurately recounted. There are young people in all these groups who, in addition, are subjected to age-related discrimination.

Increases in violence, cuts in benefits and entitlements, increasingly draconian surveillance and regulation, elimination of organisations controlled by those communities and restrictions on activists are just some of the events these groups may have to deal with on a day-to-day level. Clearly the negative health effect of the associated social stress is enormous and has been recognised by health workers who are well-placed to see and articulate its consequences.

Advocacy is an interactive process with the health worker using verbal and technical resources to assist the group or individual with constant monitoring by the relevant group and feedback from the worker. High levels of trust have been built up through the close contact many youth health services have developed with their target groups. This is a vital component of successful advocacy.

Access to information is more readily available to "professionals" than anyone else and can be a useful resource for community groups. Its use by such groups can be a very important part of their own advocacy activities. For example, health workers can access comparative studies about blood-borne diseases and the significance of Needle and Syringe Programs (NSP), overseas studies on safe injecting rooms or new approaches in the Alcohol and Other Drug (A&OD) field. This sort of information is much more difficult for many (although not all) injecting drug users to obtain to use in defence of their health facilities and the promotion of new approaches.

Advocacy can develop capacity for reflection, critical consciousness and self-directed action for change.

It can build a movement that can have concrete effects. An example of this is the "public space" projects that originated with youth workers and their peak organisations advocating for an end to discriminatory treatment of young people in relation to public space[19].

For effective advocacy, familiarity with existing advocacy and support groups is essential, e.g. youth peak bodies, IDU's associations, unemployed people's groups, trade unions, State wards organisations, women's groups. Space, a support and social group for young people with issues around sexuality, gender and identity, run by Cellblock Youth Health Service has a strong advocacy focus. They have close links with community groups such as the Pride Centre, the AIDS Council of NSW, (ACON), 2010 refuge, the Gay and Lesbian Anti-violence Project and other support groups.

2.15 Empowerment - Concepts of personal empowerment

Evidence shows that powerlessness or lack of control over destiny, a product of social inequality, is a broad risk factor for ill-health[20,21]. It follows that empowerment is a process which can address this. The concept of "empowerment" is often used to describe individual change. It can mean "individual competency", "self-efficacy", "self-esteem"[22], or "self-empowerment", the ability to act rationally and purposefully towards self-determined interests[23]. Counselling and certain forms of health education pursue this as an outcome for clients.

Psychosocial literature has shown that having an "internal locus of control" or a self-concept of one's autonomy in decision-making, can be an important health enhancing individual characteristic. However, we need to be aware that this concept is culturally biased towards societies based on the primacy of individuality. Better practice necessitates a culturally sensitive perspective that does not restrict health care to particular communities. This awareness is promoted by most youth health services and links with ethno-specific workers and community groups can be of great assistance here in developing a general understanding of different cultural values.

Sense of coherence, rather than individual control over one's life has been put forward as encompassing cross-cultural social processes in which individuality is not primary. Sense of coherence implies that a person's situation is comprehensible, manageable and meaningful to them[24]. This may or may not include individual control. Empowerment in this sense is a health enhancing response that can be actively pursued in cultural contexts where the collective rather than the individual has primacy.

Wallerstein in her exploration of "empowerment education" notes the use of the term "psychological empowerment" to combine the above personal characteristics with concepts of "skill development and participatory behaviour in collective actions." Although the "unit of analysis is still the individual, it is embedded in participation in one's socio-political context"[25]. This enriches and carries the concept of empowerment further.

2.16 Concepts of collective empowerment

There are also other usages that have a collective rather than an individual focus. Youth worker Taj James describes moving beyond a "youth development model" (delivering skills and information to individuals) to youth empowerment as a necessary step in addressing inequality. James argues that viewing young people merely as individual clients and recipients of services precludes this. While individual access to skills and information can be an important part of the empowerment process, the key, in James' view, is a shift in focus from the individual to the collective as the only way empowerment can be expressed and realised[26].

"Democratic management theory" and "community empowerment" literature take the organisation or the

community, respectively as their unit of analysis. They emphasise developing ability to exert influence for system level change in the larger context. The community model is concerned with developing participation, social action, a sense of community, capacity to identify and solve problems, with the recognition that the individual is part of a larger social entity which can act in a transformational way. The concept of "social capital" has also been used to describe this process[27]. Recognition of the individual as potentially part of a socially activated community and action based upon it for social transformation is the end product of the process of critical reflection and action advocated by Freire. Empowerment in this sense means that people *as a community* comprehend and take control of their collective future through their own action.

2.17 A synthesis

In a synthesis of these concepts of empowerment, Wallerstein puts forward a definition, based on the work of Friere:

> *"Empowerment ... reflects an understanding of the perceived and actual components of powerlessness and encompasses the linkages and interactions between change processes on an individual, organisational and community system-wide level. Empowerment becomes the avenue for people to challenge their internalized powerlessness while also developing real opportunities to gain control in their lives and transform their various settings ... this model includes dimensions of improved self-concept, critical analysis of the world, identification with others as a member of a community, participation with others in organising for community change and actual environmental/political change"*[28].

2.18 Social connectedness

This model of empowerment contains both personal and collective elements and is highly relevant to a youth health service which must work with young people both directly and indirectly. One of the most important elements in this model is social connectedness. The feeling of being connected to a wider social group with a common interest and experience has been found to exert a protective influence on individuals. One of the most intense experiences for many homeless and "at risk" young people is their feelings of hopelessness and complete disconnection from everything, of being alone and powerless or as one young person described it, "fuckin' just me ... pushed around ... moved on ..."[29]. Studies have found that social support or connectedness is an important coping resource and can act as a protective factor even in extreme socio-economic circumstances[30]. Marmot's "health messages" also emphasise the importance of "social connectedness" to health[31].

One of the prime functions performed by youth health services is encouraging the construction of networks and social connectedness through a diversity of support, therapeutic, skill development, arts, social and recreational groups as well as community and health promotion development projects. A commitment to the empowerment of young people is an essential feature of youth health work, whether a worker is involved primarily in clinical or direct services or in a broader capacity An educational "re-connection" program has been developed at High Street Youth Health Service which aims to assist young people back into education. The OTEN program is a partnership between the government services of Health and Education. It is jointly run by the youth health service which is part of Western Sydney Area Health Service and OTEN, the distance education facility of TAFE. The young people involved in the project have been unable to complete schooling, with some disconnected from the education system from an early age. Operating in a welcoming and attractive environment, the program is non-compulsory and allows participants to set their own pace. Results have been successful educationally with some of the group going on to TAFE courses. The program now has a waiting list of young people keen to join the course. The work of Resnick et al. shows that a close connection with the school and the family is health enhancing for young people[32]. For many young people, particularly homeless young people, this has not been possible. The construction of other forms of connection such as the one described here has had a positive effect for many young people.

A number of youth health services provide support groups for young women with children, many of whom are economically disadvantaged, isolated and disconnected from social support, facilities and services. Many of these women experience hardship and discrimination on many levels and are often under considerable stress. Central Coast Youth Health Service, in partnership with several community services, responded to these needs in their area with the development of three groups for young mothers. These groups are located in three areas on the Central Coast and provide support, education and social activities for young women with children. Some of these young women are homeless or "at risk" and the support can be crucial. These groups are run in partnership with local community organisations such as Centacare and the Samaritans Outreach Team as well as The Cottage at Woy Woy Hospital. Penrith Streetwork Project also operates a "youth-friendly" ante and post-natal clinics for young homeless women. CHAIN has also been operating a successful program for some time.

2.19 Community participation and competency

A community can be a group drawn together by shared interests, values, history or experiences or it can be a geographical entity or both. The term could be as appropriately applied to injecting drug users, Pentecostal Christians or homeless youth as to the residents of a suburb or town. One person's "gang" may be another person's "community"! Gays and lesbians have identified themselves as a community, as have religious, disabled, ethnic groups and many others. There can be communities within communities within communities.

Participation in a "competent community" is a step further on from social connectedness. It is a movement away from the subjective outwards into participation in collective action. The concept of a competent community has been defined as one whose members participate and collaborate to identify problems, can reach consensus on goals and strategies and can work together to do what is required to address problems. Wallerstein sees this as one of a number of significant components of the empowerment model shown in Diagram 1 below. The diagram uses a synthesis of the individual and the collective concepts of empowerment, linked by the Freirean concept of "conscientization" or critical consciousness, to create a model for health enhancing practice[33].

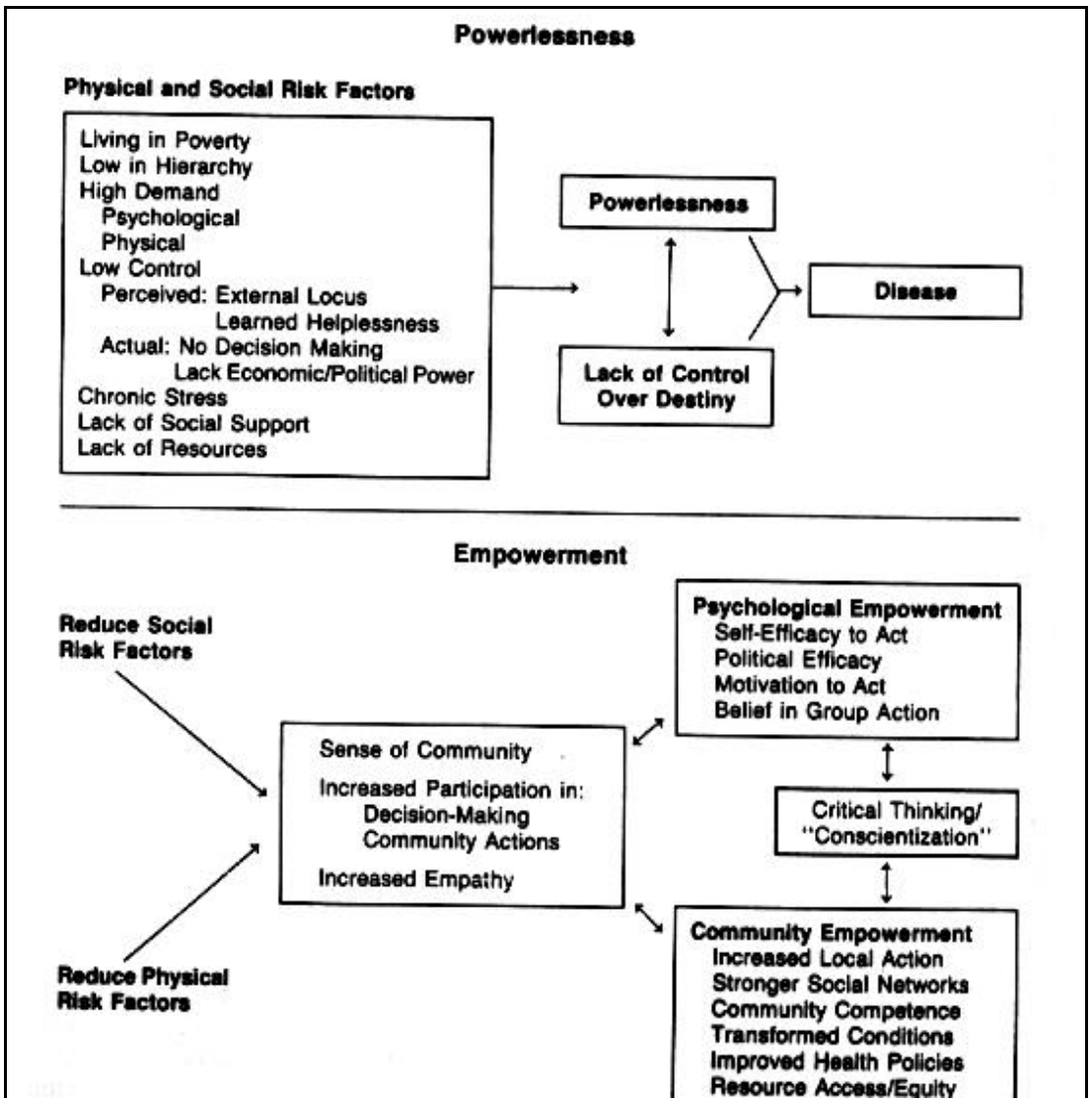


Diagram 1

Wallerstein stresses the important health effects of "community organising," described as working with a community to increase self-determination and control over its resources. Indirectly, community organising affects health through enhancing the other community empowerment variables: social support and networks, psychological empowerment, community participation, sense of community, community competence, and ultimately, control over destiny[34]. The practical ways in which this can be done will depend on the nature of the communities and the community organisers as well as the resources that can be brought into such projects.

In South West Sydney, FLYHT is working as part of a partnership between Area Health services, the University of Western Sydney, Liverpool Council, Non-Government Organisations (NGOs) and the community in the Miller area. This project aims to revitalize Miller, an area of massive social disadvantage, through community development strategies. FLYHT is managing the youth initiative within this project and is working with the resident-based Miller Recovery Group, the local police, service organisations and local businesses, NGOs such as Sydney City Mission, as well as the project partners. Youth was identified as one of the key areas for attention in this project. Needs were explored and structures are being set up to promote sustainable development. This will include some employment generation in the form of youth work

traineeships. Facilities have been made available by Liverpool Council, local businesses are providing support and activities for young people are being generated. A youth advisory group is to be set up and new approaches to issues between security guards and young people in the local shopping centre are being developed.

A broad concept of empowerment is one that is particularly relevant to youth health teams with their combination of direct and indirect services and their location within and close connections with socially disadvantaged communities. It necessitates building a class and gender perspective into all aspects of health work. It is an approach which is both resource-intensive and demanding of innovation, determination, commitment, continued monitoring and reflection from services. The scope of such projects demands effective partnerships, planning and evaluation. Although wrong turns and false starts can be inevitable in such ambitious enterprises, they offer great promise for the future.

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 traveled 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?

References: (Chapter 2)

1. Personal communication, 1977
2. Legge, D., 'Towards a politics of health', in Gardner, H., (ed), *The Politics of Health: The Australian Experience*, Churchill Livingstone, Melbourne, 1989, p.475
3. Freire, P., *Education for Critical Consciousness*, Sheed &Ward, London, 1973
4. Freire, P., *Pedagogy of the Oppressed*, Penguin, Harmondsworth, Middlesex, 1972
5. Ernst, S., Goodison, L., In Our Own Hands: A Book of Self-help Therapy, London, 1981
6. Nutbeam, D., Haglund, B., Farley, P., Tillgren, P., (eds),*Youth Health Promotion: From Theory to Practice in School and Community*, Forbes, London, 1991, p.16
7. Goltz, K., Bruni, N., 'Health promotion discourse: Language of change?' in Gardner, H. (ed), *The Politics of Health - The Australian Experience*, 2nd edition, Churchille Livingstone, Melbourne, New York, 1995, pp.510-549
8. Kreiger, N, Rowley, D., Hermann, A.A., Avery, B., Phillips, M.T., 'Racism, sexism and social class: implications for studies of health, disease and wellbeing', *American Journal of Preventative Medicine*, Vol.9, No.6, 1993, pp.82-122
9. Freire, 1973, op. cit
10. Aggleton, P., Hart, G., Davies, P., (eds), *AIDS: Social Representations, Social Practices*, Falmer Press, New York, 1989, p.222
11. Fullilove, MT. Fullilove RE, Haynes, K. & Gross, S., 'Black women and AIDS prevention; A view towards understanding the gender rules', *Journal of Sex Research*, No.27, 1990
12. The Canadian Taskforce on the Periodic Health Examination, *The Canadian Guide to Clinical Preventative Health Care*, Health Canada, Ottawa, Canada, c.1994, p. xx
13. McMichael, A.J., 'Current Directions in Public Health and Preventative Medicine', in McNeil, J., King, R.W.F., Jennings, G.L., Powles, J.W., (eds.), *A Textbook of Preventative Medicine*, Edward Arnold, Caulfield East, Victoria, 1990, pp.316-326.
14. Garber J and Seligman, M. (Eds), *Human Helplessness: Theory and Applications*, Academic Press, New York, 1980
15. Morton, T., 'Let our young lions roar, we need their courage', *Sydney Morning Herald*, April 30, 1999
16. Wilson, G., 'Young People and the Future: Catholic Church Calls for action', *Yaprap*, Vol. 8., No. 7, August, 1998
17. Hunter, E., and Garvey, D., 'Indigenous mental health promotion: Mind over matter', *Health Promotion Journal of Australia*, Vol.8, No1, 1998, pp.4-11
18. Eckersley, R., 'Failing a generation: the impact of culture on the health and well-being of youth', *Journal of Paediatrics and Child Health*, 1993, p.29
19. Youth Action and Policy Association, NSW, *No Standing: Young people and Community Space Project Research Report*, YAPA, Sydney, 1997
20. ABC Radio National, 'Mastering the Control Factor', 4-part series on *The Health Report*, Interviews with Marmot, M., Syme, L., McEwan, B., Ellis, N., Douglas, B., Weeranmanthri, T., November 9,16, 23, 30, 1998
21. Adler, N.E., Boyce, W.T., Chesney, M.A., Folkman, S., Syme, L.,'Socio-economic inequalities in health: No easy solution', *Journal of the American Medical Association*, Vol.269, June, 1993
22. Aggleton, op. cit.
23. Aggleton, ibid.
24. Wallerstein, N., 'Powerlessness, empowerment and health: Implications for health promotion programs', *American Journal of Health Promotion*, Vol. 6, No 3, 1992, p.p.197-205
25. ibid.
26. James, T., 'Empowerment through social change', James Colgrove, (Ed), *Bridges*, Electronic journal, Summer, 1997, Website URL: http:// www.hify.com),
27. Hyde, J., 'Social Capital and Health Inequality', Extract from paper prepared for WHO and Society for International Development seminar, Geneva, July 1999
28. Wallerstein, op cit.
29. Personal communication, 1997
30. Blaxter, M., *Health and Lifestyles*, Routledge, London, 1990, p.240
31. Marmot interview, ABC Radio National, op. cit.

32. Resnick, M.D., Bearman, P.S., Blum, R.W., Bauman, K.E., Harris, K.M., Jones, J., Tabor, J., Beuhring, T., Sieving, R.E., Shew, M., Ireland, M., Bearinger, L., Udry, J.R., 'Protecting adolescents from harm: Findings from the national longitudinal study on adolescent health', *Journal of the American Medical Association*, Vol.278, September, 1997
33. Wallerstein, op. cit.
34. Wallerstein, op. cit.

Chapter 3: Access and participation

One of the challenges for health services has been to ensure that health-care is accessible, equitably delivered and involves the meaningful participation of young women and men. This aspect of health care addresses the impact of social inequalities on health rather than its determinants and is an important part of the operation of youth health services. One of the significant achievements of youth health services has been their innovative and creative approaches to access and participation. These are essential aspects of better practice.

3.1 Who participates and how?

Many different groups participate in a youth health service - as clients, accompanying family members or friends, meeting with workers, planning activities, using the premises for youth and community-related activities, etc. Young people accessing services are the main participants, but there are also families, friends, community members, young people "checking the place out" and youth, community and government workers.

Major issues that need to be addressed are about how participation will take place and on whose terms? Done badly, participation can degenerate into paternalism or tokenistic practices that will be sensed by young people who respond by "voting with their feet." While the terms of participation are obviously weighted towards the health service, there is leeway for negotiation, compromise and divergence. Participation can take place on a number of levels depending on the size and orientation of the service. It can range from the informal "dropping-in" and "having a chat" to more formal processes of consultation and feedback to taking an active role in management, program planning and delivery and resource development. Evidence suggests that the involvement of young people in planning and implementation, will be important to the success of programs designed to help them[1].

But before participation can take place, the service must be able to engage with young people in a meaningful and positive way. A very basic requirement for this, and one which youth health services have creatively developed, is the construction of an environment which is accessible to young people, particularly those who are marginalised.

3.2 Making the service accessible

The youth health service is the place from which activities and programs radiate out into the community as well as the place where the community, and young men and women in particular, come for a variety of health related reasons. If the service can become an organic part of the community in which it is located, it can ease the social exclusion experienced by many young people and become a resource for the whole community. For some marginalised young people, the youth health service operates as a life-line[2]. Young people, as a group, are often disconnected both from their own communities and from services which operate on a top-down model. High levels of exclusion can mean that there are few places in the community where young women and men feel comfortable and welcome and where their creativity and interests can be affirmed and developed. Often, the presence of groups of young people in public is met with attitudes of fear, suspicion and distrust.

3.3 Achieving "youth-friendliness"

Accessibility means more than just being able to get there. A "youth-friendly" health service must be accessible geographically, physically, culturally and in all its procedures including financial and administrative

arrangements. It is well-known that young people generally and in particular certain groups such as young homeless, NESB, gays and lesbians, Aboriginal young people, people with disabilities, rural and other isolated groups, etc., do not access mainstream health services. Indeed, lack of access to health care is a significant aspect of their marginalisation. Making the service "youth-friendly" is an attempt to redress this situation and an affirmative statement to and about all young people. On a practical level, the single most important youth-friendly consideration for many clients is access to free service without a Medicare card. But youth-friendliness is more than this. It is about making the service accessible in the broadest possible way. Most of the youth health services in this study have prioritised the accessibility of their services.

3.4 Premises

Youth health services operate out of a variety of premises and have used imagination and input from workers and young women and men to try to make these centres a welcoming environment. Some services are able to provide space for a variety of activities to take place simultaneously. Others have problems reconciling the needs of staff for a quiet work-space with the activities of "drop-in", groups or workshops. It is difficult for staff when offices are close to activities which may involve loud music and talk and consequently also difficult for young people to relax. Some services have major problems to overcome, with premises which were not purpose-built or in which it is difficult for young people to feel comfortable. Some young people feel that attending a youth health centre may cause others to think that there is "something wrong with them" and prefer to access a multi-purpose service where their reasons for attendance cannot be easily identified or assumed.

Space limitations often circumscribe the activities that can be run on the premises. Some services have no suitable space for large numbers of young people. The Corner Youth Health Service in Bankstown has managed to overcome space limitations by using a marquee for outdoor events in the backyard of their converted suburban house. Their annual Young Women's Festivals usually attract a large number of participants. Over 300 young women attended their most recent festival. CMYHS operates out of Council premises and use a booking system to share space on the premises with other youth services.

Placing a youth health service in the grounds of a hospital can be off-putting for some young people who may prefer to access a service located in a less medicalised environment. This is not necessarily so for all young people, however. While a formal and medicalised environment is possibly not optimal for accessibility, this should not be assumed. Services which are hospital-based such as the Mid-North Coast Young Person's Mental Health Team have made their premises attractive through the use of posters, dream webs, bean bags, etc. The Department of Adolescent Medicine at the New Children's Hospital at Westmead uses art works made by young people and has a separate recreation area equipped with sporting and arts equipment, cooking facilities and music.

3.5 Physical access and outreach

Physical access is basic. For young people who have disabilities, getting into the premises at all can be an insurmountable problem if there is no wheelchair access or appropriate facilities. Not all youth health services have appropriate facilities for young people with disabilities. Some such as TraXside, however, are equipped with wheelchair access, disabled toilets and TTY facilities.

An accessible service must have appropriate opening hours. Youth health services usually open during the day until 5 or 6pm. Most also maintain a evening "drop-in" service, usually until 7 or 8pm one night per week. Some services such as WAAT, FLYHT and High Street Youth Health Service also operate on an outreach basis on weekends for special events such as dance parties and festivals. After hours outreach services also take into account the needs of services such as refuges, where the residents may only be available in the evening. Counsellors in most services also take on clients out-of-hours by arrangement.

Being able to obtain services without appointments (or at least on short notice), is important to many young people, particularly homeless ones, whose situation may not allow them to plan ahead. Crisis cases are seen without appointments and most services try to at least set aside a time for "drop-in" clinical services such as FLYHT's First Stop youth health clinic, the Warehouse sexual health services and Penrith Streetwork Project's (PSP) clinics for young homeless people affected by alcohol and other drugs. When this is not possible, a developed and accessible referral network is important so that clients can be assisted by other services. Cellblock Youth Health Service uses the services of a dental therapist one day per week. The therapist checks teeth and advises on what needs to be done. Cellblock has a regular block of appointments reserved at the United Dental Hospital so that most young people do not have to wait longer than two weeks for dental attention. This can make an enormous difference. The need for dental services is extreme, particularly for homeless young people, and without such a service they may not access dental services at all.

A service should be situated close to public transport. This may not be difficult in urban areas, but in the country, transport can be non-existent or its costs prohibitive. For young people living in the Shoalhaven area, a return trip to Nowra from outlying areas can cost around $10. Even in some parts of Western and South Western Sydney, the costs of private bus services, (the only bus services that operate there) are prohibitive for many people. In rural areas such as the North Coast, public transport may be extremely limited - for example, one bus a day runs between Coffs Harbour and Bellingen. Some health workers, particularly in rural areas, operate under an extended outreach model to address this problem in delivering direct services. They may work out of several centres across a wide area and use an outreach bus or van to access smaller centres. Huge areas are covered by rural youth health teams where isolation can exacerbate the health needs of young people.

The building of trust in some isolated communities is an important pre-requisite for outreach work. Even in some urban communities a strong sense of locality can generate a distrust of "outsiders", especially in communities such as Mt Druitt or Cabramatta that have been dogged with negative images. Sensitivity, care, respect and willingness to learn are vital to building a good working relationship. Sometimes this can be a slow and painstaking process that may need to be repeated as individual workers leave and new ones take their place[3].

Most youth health services operate partly on an outreach basis. Mobile outreach services are used by High Street, FLYHT, WAAT, The Warehouse and others to access young people after hours, on weekends or in outlying areas. The WAAT bus is a well-known resource for many young people in the Blacktown Local Government area. It operates on a regular basis as an information, referral and support service, as a needle exchange and a distribution point for safe sex materials. It also provides healthy food for many street-frequenting young people. It is used by young people who for various reasons do not access the WAAT premises. These include young Kooris, sex workers and IDUs. It has a harm minimisation role at a high risk time for young people, (i.e.weekends) when sexual activity and injecting drug use is likely to take place. The service is well-used and labour-intensive. For safety reasons the WAAT bus is staffed by a minimum of three people. It can be difficult to maintain a consistent service when staff numbers are low due to holidays, sickness or staff turnover. It is a service that is essential for the many young people who use it. Familiarity with the bus and the WAAT workers has led in some cases to further use of health facilities such as detoxification, rehabilitation and counselling.

Most services conduct some of their activities in local refuges, schools, community, Juvenile Justice or youth centres. Outreach may be used because of the geographical isolation of some young people. For example, Central Coast Youth Health Service has close links with local youth centres and often conducts activities in their premises rather than requiring young people to travel to the youth health service premises. Outreach can also be a way of working with young people in a context with which they identify, such as a youth centre.This can feel safer to many young people who may be suspicious of entering the territory of possible judgmental or authoritarian attitudes and unknown health workers. However, it should not be assumed that all young people will feel this way. Careful consultation will be necessary to find the best venue for outreach services. Flexibility in responding to particular needs is essential. What works in one area with

one group will not necessarily translate to anywhere else. Some young people may prefer to access medical services, particularly sexual health services, in a more traditional setting. In the words of one health worker, "Would you want to take your pants off in a youth centre?"

The appropriateness of outreach venues needs careful consideration. For instance, a centre that is traditionally associated with women may find it difficult to access men. Some organisations may place restrictions on distribution of safe sex materials on their premises. If the outreach service is located in premises time-shared with other organisations, coordination of services and good referral networks are crucial. Optimally, procedures will be in place for young people to make contact outside of the youth health worker's hours of attendance, as well as when s/he is present. These procedures are particularly important for emergencies. The Crossroads team at Shoalhaven Youth Health Service has provided inservice training in youth health issues to hospital and Community Health nurses across their large catchment area. The nurses are now better equipped to deal with the initial procedures necessary for youth health care. Consequently there may be less need for the youth health workers, who could be working some distance away, to be called upon.

3.6 Making the centre look "youth-friendly"

A service's philosophy can be reflected in the appearance of its premises. The diversity of young people, cultural and in other ways, has been affirmed and celebrated in the appearance of many youth health services. Young people's skills have been used to make centres that not only look welcoming but are thought-provoking. Community Health for Adolescents In Need (CHAIN), in Wollongong has used poetry on some of the internal walls in its premises. The poems have been written by and reflect the experiences of young people who use the service. Muralappi uses Aboriginal designs at its centre while The Warehouse in Penrith decorates its premises with a variety of youth-friendly posters challenging stereotypes. The Western Area Adolescent Team (WAAT), decorates its premises according to health occasions such as World AIDS Day or Mental Health Week or issues such as anti-homophobia or reconciliation. In response to concern in their communities, young people at Canterbury Multicultural Youth Health Service (CMYHS), have produced a mural emphasising an anti-violence theme. It was decided that this was to be a theme for the year. The portable mural, painted on a large board, uses the slogan "Increase the peace - there should be no fear".

Community participation can assist with the integration of the service into the community while celebrating cultural diversity, increasing social cohesion and understanding and developing discussion and contacts. Contacts with the community can also tap into a wealth of creativity. The learning process can be reciprocal and skills can be shared in the process of decorating the premises. It can become a community project involving young people with other community members. It may mean employing a professional to assist the process. Some local Councils employ a Community Arts worker and sometimes grants are available from various sources that can cover employment of a worker for a short term project.

Fairfield-Liverpool Youth Health Team (FLYHT), drew on the creativity of community members in the most multi-cultural municipality in Australia to design murals on the outer walls of their premises. Communities in the area suggested the use of cultural images and symbols to represent them and acted as consultants in the development of the mural on several outer walls. On another wall a "sea of hands" style mural was done by local young people under the paid supervision of Aboriginal artists. In a joint project with Fairfield Community Resource Centre and Fairfield Council, an anti-homophobia, anti-violence mural was completed by young people under the paid supervision of a local graffitti artist.

Bearing in mind that there is not just one style of "youth-friendly" decoration, youth health service premises are usually large enough to encompass variety. Some have used art works made by groups associated with the service and cut costs by using recycled materials. CMYHS premises are decorated with portable murals. TraXside Youth Health Service created a native garden outside their premises in Campbelltown and painted

a welcoming signboard. WAAT staff and young people painted their mobile outreach service bus employing the expertise of a local graffitti artist. Even a transient population can participate creatively. Some art work at the New Childrens Hospital has been made by a succession of young people who are patients in the Adolescent Ward. When one leaves there is always another to take their place and the work becomes an ongoing group project. The art works are made from various found and recycled materials. Creative use has been made of plaster, bandages and other materials used in the hospital.

3.7 First impressions are important

For most people, approaching an organisation can be an intimidating experience, even more so if dealing with government agencies is an unavoidable and unwanted part of everyday life. For young people, problems can be compounded by age-related bias. Many people have negative associations with health centres. They may represent powerful controlling officials or worse. And there is no reason to expect that people who have had bad experiences with one part of the "system" such as Immigration, Housing, Social Security or Education, will differentiate and approach a health service with an open mind. Some Aboriginal people view health centres as places where children are removed[4].

Even an organisation which sees itself as open and accessible can be inadvertently off-putting. Sometimes non-verbal messages can be carried through the appearance of the centre, confronting, stereotyping, or patronising staff behaviour, or insensitive expectations. Being presented with forms to fill in can be a challenging experience for the most literate, let alone those, who for whatever reason, are not. If asking for assistance may result in patronising or trivialising treatment, sometimes it is easier to leave than to persevere. A barrage of questions upon entry and/or too many forms to fill out has been identified as negative by young people at several centres[5]. It can put too much pressure on young people who may feel they are constantly accounting for themselves to authorities.

Data collection, however, is an essential part of better practice that cannot be bypassed. Sensitive assistance with the provision of information is necessary. Several youth health workers emphasised the importance of not assuming that people are *able* to fill in forms or understand technical language.

CHAIN has used young people's views on information collection, provided through their peer video project, to inform the ways in which essential data collection can take place in their service. The video described some young people's experiences of intrusive information collection in various services and the effects it had on them. As a consequence, while the necessary data is obtained, it is done with care, in a way that is not overwhelming to the clients.

The Worker-On-Duty and/or Keyworker system can overcome the barriers that information collection can present for young people. These service support systems ensure that there is a particular worker who will act as a support, advocate and (non-therapeutic) counsellor for the young person at their initial presentation and throughout the system if required. The Worker-On-Duty is the first point of contact with most youth health services. They will explain why certain information is needed as well as providing an orientation to the service. Front-desk staff also have a crucial role to play in making first impressions positive ones. Some services offer reading materials, drinks and toys for children in waiting areas for family members who may be accompanying clients. Positive attitudes in the reception area have been identified as one of the important factors associated with "adolescent compliance"[6].

3.8 Programs and services that can enhance access

Non-traditional health programs which use arts or other non-clinical content are a means of allowing young people to "check out" the service at their own time and pace, (something that is a rare experience for many). This non-confronting process can be crucial for developing further contact. Kids Help Line, the telephone counselling service, reports that young people use the format of a "general chat" to assess the suitability of the support provided"[7].

Various recreation and arts programs that have been developed by youth health services provide an opportunity for an informal, non-threatening "chat" as well as recreation and the possibility of learning new skills. CMYHS developed a music skills program targeting young people who came to "drop-in" but did not access other health services offered . The program employed a music teacher and his band who, as well as being suitably qualified, shared the cultural background of many of the young participants and was able to understand and communicate effectively on a peer level. Some of the participants, particularly the young men, later accessed other CMYHS services such as counselling. Self-esteem was noticeably raised after the musicians staged a concert for friends and families at the end of the program.

Programs that operate similarly are the TraXside young people's radio program and Cellblock arts programs. The Corner runs arts focused health promotion activities and involves young people in production of The Corner Youth Newsletter. The school excursion program run by CMYHS takes groups of young people on day trips to the Blue Mountains, the beach, and other places of interest. Some of the excursions as well as some drop-in activities, are girls-only and participants take this opportunity to find out more about health services.

Activities that are enjoyable can also have a health related objective - exercise, living skills such as cooking, arts projects focused on the experience of a community or sub-culture, cultural action theatre, car maintenance or self-defence courses for women, dance, meditation and relaxation groups and many other activities. TraXside Youth Health service developed the Barbie is Bullshit program. This was a circus skills program for young women which, as well as training participants in skills such as acrobatics and juggling, also explored issues related to self-esteem and body image.

The 3D Fashion Parade was an innovative event which also focused on body image. It was developed by Central Coast Youth Health Service for Youth Week. Supported by local services and media, the program involved various activities including participants staging a fashion parade of "wearable art" which promoted the message that young people were more than the two-dimensional images propagated by fashion magazines - they were, in fact, 3D!

Groups run in some youth health services have sometimes led to related work outside the service and group cohesion that can outlast the original program. Some young people have gone on to deliver presentations at conferences and training sessions for youth health workers. A large influx of friends and acquaintances of the original group is a frequent consequence as word gets around. Being able to experience the ambience of a health service without any pressure to become a "client" can be a valuable and educational experience. One young person said,

> *"I didn't know what a psychiatrist looked like until I saw one at the centre ... didn't want to know, neither. But I was surprised ... I didn't even know she was one."*[8]

For many homeless young people the youth health centre in a very literal sense is their lifeline. Food and use of a kitchen, a safe and quiet place to rest, a postal address, laundry, bathroom and locker facilities as well as someone to talk to who wants nothing from them, can be a unique experience. Penrith Streetwork Project, Crossroads, CHAIN, and most other services also provide toiletries, condoms, lubricants and dams and other essentials including pharmaceuticals when necessary.

Youth health services have responded to the intense need of many young people for some unpressured time for reflection in a safe environment. The youth health service can provide a secure place from which to discuss and consider treatment or rehabilitation options or obtain support and referrals for abuse or assault, alcohol or drug related problems. Some time in which to relax, think and not have to be alert, responsive or on guard can be very important to young people who may be continually coping with high levels of stress. The name of the Cellblock program, Space, (for young people with issues around sexuality), reflects the understanding that "space" - to reflect, relax, problem-solve or just "check things out" - may be something to which many young people have little access.

Being able to see medical practitioners who are experienced and comfortable with young men and women, who can communicate with them, whose language is understandable and who are perceived to be non-judgmental, is important to young people. So is the possibility of accessing long appointments if necessary. The reality for many young clients of youth health services is that there may be *nowhere* else where they could feel safe, relaxed, unpressured and unchaotic. For some, their use of the service is the first time since early childhood that they have accessed healthcare, and certainly the first time they have initiated it themselves. Referral policies which disallow forced or pressured referrals are important in maintaining respect for and from young people and in giving a clear message about the values of the service.

3.9 Developing access through diversity, cultural understanding and sensitivity

Cultural sensitivity means more than empathy for the marginalised[9]. It necessitates working to address the socio-economic inequalities which form the structural basis of cultural hierarchies. This may mean working on a number of levels using advocacy and empowerment strategies in day-to-day practices, social, organisational and management issues, visual, verbal and non-verbal message-giving, cultural understanding and action and promotion of all of these in a wider arena. Cultural understanding requires research, training (preferably delivered by members of the relevant communities), communication, reflection, regular liaison with communities and ongoing monitoring of the implementation of changes.

At Melbourne's Royal Children's Hospital, a comprehensive strategy based on trust, understanding and partnership, was employed to establish an Aboriginal Liaison Unit. One of the issues that was addressed was recognition of the communal nature of Aboriginal society. Sometimes up to 20 family members would accompany a child to hospital. The need to give attention to all was recognised, as well as the fact that Aboriginal English and culturally specific Aboriginal approaches to situations could be misunderstood by staff. The need for "cultural interpreters" was recognised and the service worked closely with Aboriginal workers who were known and trusted by the community[10]. Some youth health services have also utilised the concept of "cultural interpreters" by employing workers from specific communities or with specialist skills in particular areas such as re-settlement or refugee issues. They have also done this by working jointly with or resourcing ethno-specific youth and community workers. In some areas close links have been developed between health services and organisations such as Migrant Resource Centres.

Workers and young people from some Non English Speaking Backgrounds have pointed out the cultural assumptions that may underlie the work of some services. The primacy of the individual that permeates Western capitalist society is one major assumption that does not necessarily translate across cultures. In cultures in which the group has primacy, a health practice based on Western notions of individuality is meaningless at best. This can be a particularly delicate area for young people juggling generational as well as cross-cultural and personal issues. Assumptions about communication styles are also common. Cultural understanding can make an important difference to the effectiveness of health practice. For example, a youth health worker who has a youth segment in a Arabic language radio program pointed out that this is an appropriate communication style in a culture in which an oral tradition is strong.

An interpretation of racism as simply prejudice or "wrong ideas" to be ameliorated by enlightened understanding is another common cultural assumption that usually comes only from those who are not on the receiving end of it. Removal of the power dimension from racism so that it is conceptualised merely as an almost "natural" suspicion of that which is "different" underlies a cultural bias that says that "everyone is racist"[11]. If power differentials are not recognised, they cannot be addressed and will continue to exert negative effects on health and wellbeing. Some health services have developed specific anti-racism policies.

The silencing of the diversity of the real world can be subtle and as damaging as outright prejudice - and much more frequent. That which is not said can often be harder to deal with than the articulated. Non-verbal messages conveyed by the appearance of a service can sometimes mean the beginning or the end of client contact. Universalising images of dominant cultural forms or practices transmit messages of exclusion.

Posters or other representations that show only young, conventionally attractive, white, Anglo-Saxon, middle-class, able-bodied, heterosexuals make and encourage assumptions that are damaging to the majority of the population who are not these things. One youth health worker pointed out that ironically, even in materials aimed at countering stereotyped images of women, the women photographed are often obviously models and are certainly not representative of most women. Environmental images in the health care system need to give messages that allow various groups to feel safe and affirmed[12]. Maintaining an awareness of class, ethnicity/ATSIB and gender issues is essential for this.

Researchers into health care have noted that young gays and lesbians found that some major barriers to accessing services were the language used by workers which was not gender neutral, and sexual and social history questions asked by health care providers which made unwarranted assumptions about sexual life. There also needs to be awareness and sensitivity to those who do not subscribe to any particular sexual identity. For gay, lesbian and bi-sexual young people, the social isolation, discrimination and fear many of them experience has resulted in high health risks, including suicide, particularly for those living in rural areas[13]. It is essential that a youth health service is accessible to these young people who may well have no other avenue for support. This is particularly important in rural areas. Several youth health services have prioritised support, social and information groups for young gays and lesbians and young people with sexuality issues. TraXside runs the Fun and Esteem program for young men and the Sista group for young women. The Cellblock program, Space, is also for young people with issues around sexual identity.

Making access for marginalised groups requires respect, openness, sensitivity, patience and creativity as well as research into the social and local issues affecting these groups and communities and development of links with them. Sometimes this can be extremely difficult when some groups are so marginalised that they are almost "made invisible". Sometimes not accessing a service is taken as evidence that a particular group does not exist in an area. For instance, although world-wide there are approximately 500 million people with severe disabilities, or one in ten of the world's population[14], people with disabilities are often marginalised into invisibility. Ensuring appropriate facilities and physical access to the premises is necessary but not sufficient for building links with these communities. Advocacy organisations for people with disabilities must be consulted to find out what is appropriate for their diverse needs. TraXside Youth Health Service runs a group for young people who are deaf, hearing impaired or Children of Deaf Adults (CODA). It aims to increase access to services for this group and to provide social activities and support.

On a day to-day basis, an affirmative approach may require culturally informed advocacy and support for clients in their dealings with other services. It will also require flexibility in working with organisations and groups from other cultures. It is important that other community members (workers, friends or families), as well as young people, feel comfortable in accessing the centre and relating to the youth health workers. What may appear to be a small detail can make a big difference. For example, CMYHS has a bi-lingual message on its answering machine, (English and Vietnamese).

Many youth health services work in partnership with organisations and workers from various cultures. Assumptions, including about participation in meetings, should be avoided. Conducting meetings in a less formal atmosphere may (or may not), be appropriate. Rotating meetings so that different premises are used as well as changing meeting procedures to be more inclusive can make a difference. The common practice of rotating minute-taking amongst group members assumes a certain level of literacy in English that many people, including English-speakers, do not have and a familiarity with procedures that assumes a certain type of training.

Promotion of strategies to other services may include co-presentations with Aboriginal, NESB or people from other groups at conferences, provision of training and advisory sessions by relevant workers to other services, production of training materials for workers in other services and assistance with policy development in areas such as anti-racism.

On an organisational and management level, initiatives need to be pro-active to ensure representation from various communities on advisory groups, planning committees, etc. Cross-cultural training on a regular basis also ensures ongoing awareness of the issues for different communities. Optimally, staff in the service will be representative of various communities although, without identified positions, this can be difficult to achieve. However, efforts can be made to advertise vacancies within communities that may not have ready access to this information. Sometimes, people who have the necessary skills for a job are not familiar with application procedures, which may appear bureaucratic and baffling. Some organisations conduct workshops for potential applicants to overcome this and so create more multicultural teams[15].

The developers of the Royal Children's Hospital project, (see above), were aware that affirmative employment can become tokenistic if one isolated worker is put into the field unsupported. Disempowered, alienated and burnt-out workers will be the almost inevitable result. Better practice in Equal Employment Opportunity (EEO) is not to isolate a worker but to ensure that a group or enclave of a particular group is established so that its members can support each other. While it may not be possible to employ people for this purpose, support can still be marshalled in the form of advisory groups drawn from the relevant community[16].

3.10 Confidentiality

The assurance of confidentiality has been identified as a vitally important concern for young people in accessing health care[17,18]. Confidentiality, within certain legal limits, is mandatory for health care workers and the development of trust is dependent on workers respecting this right in *all* aspects of their practice. As well as observing mandatory practices associated with client records, workers should guard against violating confidentiality through careless discussions about identifiable young people in meetings or public areas. Accidental viewing of client details on computer screens or files is also a concern, particularly in smaller communities and rural areas[19]. Ethics related to the discussion of clients is sometimes an area of confusion to workers who may be unclear about the circumstances in which they may do so. Some services have utilised a code of team confidentiality where team members working with a young person can share information. This code is explained to the client and has the advantage that they do not have to repeat their story over and over again. Clarity for workers and clients about confidentiality procedures is absolutely necessary. Legal conditions and boundaries on confidentiality are of utmost importance and need to be made clear to both clients and workers. Policy manuals and related documents need to be easily accessible for workers. Highly visible statements about rights and responsibilities in relation to confidentiality can be placed in the centre and in any outreach facilities. High Street Youth Health Service runs information sessions with young people to explain and discuss their codes of confidentiality as well as requiring all workers with young people to explain verbally the conditions of confidentiality to their clients.

Confidentiality is not only verbal but includes the right to physical privacy. Some young people do not want others to know that they are "seeing a counsellor" (or nurse, etc). This is difficult in some services where the premises do not include private waiting areas. When a service is able to offer a variety of activities, the visibility of the client accessing it for specific and potentially embarrassing reasons, is reduced. Making sure that some recreational activities are available at least during clinic times can make things easier.

3.11 Promoting health literacy to increase access and participation

To be more than tokenistic, the participation of young people in their health care must be supported in ways that develop capacities for meaningful, informed and coherent decision-making. Being able to negotiate the health system is an important part of taking control, which, as we have seen, is significant to health enhancement. Outside of exceptional and/or legal circumstances, no person should be treated as unable to comprehend their situation and make decisions about it. The responsibility of the service is not only to give information so that decisions are made with adequate understanding, but also to ensure that the information is given in a way that is appropriate and non-demeaning. There needs to be adequate time and opportunity for questions. The element of choice should always be highlighted and young men and women treated with

respect and dignity.

Clarity about the rights and responsibilities of staff and clients and about procedures undertaken at the centre or at other health services is essential. Workers themselves need to be absolutely clear on these issues in order to pass information on. Clients need to know what the service does and what to expect from it as well as what is expected from them. Is information going to be passed on to parents, schools, police or government departments - always, sometimes, never? What is mandatory under child protection legislation? Under what circumstances will information be conveyed outside the service? Will permission for medical procedures be asked from parents? Where are procedures carried out? By whom? Who does what? What will happen? Who are these people? What happens if appointments are missed?

Concern about health issues can make concentration and comprehension difficult, so patience is necessary. Dependence only on information available in written form (even plain English written form) should be avoided. Not everyone is literate in English, even if they appear to be. Low literacy materials can be useful but as an adjunct to other methods of giving information. For various reasons, some NESB people are not literate in their first language, either, so depending on translated material is not necessarily the answer. Staff training in use of the Healthcare Interpreter Service is essential. The use of non-professional interpreters should be avoided. The health worker should offer the assistance of an interpreter, although the decision is that of the client alone.

The Corner Youth Health Service, many of whose clientele are predominantly from Non English Speaking Backgrounds, regularly uses the Healthcare Interpreter Service as well as telephone interpreters. It emphasises the importance of using these services and also encourages their use in counselling sessions involving family members. It avoids placing an extra burden on young people when family involvement in the session can be facilitated in this way. The service also calls upon specialist clinical services from the Transcultural Mental Health Service when necessary.

3.12 Monitoring of young people's views about the service

For genuine participation and continued access to occur, there should be avenues available for young people to give their views about the service - and to have them taken seriously and acted upon if appropriate. Regular monitoring is essential and formalised procedures for doing this can complement informal ones. Thought needs to be given to obtaining a representative sample of views, the methods used to obtain them and the inherent problems of survey methods.

Allowing services or schools to choose participants without preliminary discussions and choosing by calling for volunteers can make for quite unrepresentative groups where the more marginalised are left out. The "naughty ones" or the "quiet ones" may always be difficult to access but it should at least be noted that they are absent if this is the case. Payment of young people involved in the process and careful consideration of community profiles appear to be effective ways to obtain some sort of cross-section.

Varying literacy levels can affect the results of written survey forms. Levels of comprehension, the desire to please the interviewer or to "get it over as quick as possible" are also considerations in all surveys. Focus groups are often used, as well as larger consultations. A major issue is how to get input that is genuine and "un-*adult*-erated". It is hard for anyone to be completely impervious to what a questioner wants to hear. Young people, trained in giving the "correct answer" are often *expected* to deliver this sort of response, so it may be even harder for them. Market researchers put a great deal of effort into designing and analysing questions that will elicit genuine information. Health services should do no less and can sometimes get assistance from specialised units within the health system. Tokenistic consultations or surveys which simply reinforce preconceptions may give information about their instigators but will be of limited use for any other purpose.

3.13 Complaints procedures

Clients need to know not only that they have the right to complain if they are dissatisfied with a service, but how to do it. And it needs to be easy. Optimally, information on this will be visually accessible but also should be explained and reinforced.

3.14 Establishing participation in a youth health service

Establishing youth and community participation in a youth health service is not easy. To succeed in this the service must become an accessible, open and valued part of the community. Especially in smaller, more isolated or more pressured communities there may be deep suspicions about the activities and effects of a youth health service. In services whose clientele includes marginalised young people, community fears and prejudices can be quickly awakened and can jeopardise the operation of the service and the health of the young people in the community. All youth health services cater for homeless and 'at risk' young people and integrating the service into the wider community requires patience, reflection and sensitivity.

The structural bases for prejudice are deep-seated but need to be recognised. Deep social and economic problems experienced by people searching for but unable to find explanations, make fertile ground for negative messages to take hold. Addressing the structural bases of prejudice has been discussed in previous chapters. It is not easy. Action around unemployment, poverty, racism, housing, education, reconciliation issues and social fragmentation including the decline of country towns are essential to a socially based response. Building a community network through partnerships with organisations and groups who are also committed to such action is a major part of this response. Government departments have policies on anti-discrimination issues and where appropriate, combined action on the basis of these can be useful.

Most youth health services are regular participants in inter-agency activities, particularly youth worker networks. Close links with community service workers in local government as well as service organisations such as Lions Clubs have also been developed by services. An elderly group from a local Lions Club, on request from a youth health worker, organised a barbeque for young people on World AIDS Day. The barbeque was an outstanding success for young people and the Lions reported that they enjoyed the activity and felt it developed their understanding of the issues.

3.15 Countering misinformation can challenge prejudice and increase access and participation

Control over information is an important aspect of disempowerment. With rapidly increasing media concentration this is becoming even more intense. It is simplistic to see racist, religious or other types of prejudice as arising purely from misinformation that can be 'set right' by 'the facts'. But it is also important that the agenda about controversial health issues such as the Needle and Syringe Program or perceptions of marginalised groups such as young homeless or disabled people, is not dominated by misinformation.

Youth health services can put forward a counter-information campaign which challenges prejudice through encouraging reflection and critical thought and making available up-to-date and accurate information. Factual information about health and social issues is often not easily available to communities leaving the way open for "infotainment" to take hold. This encourages knee-jerk, sensationalist stereotyping and scapegoating reactions which, if unaddressed, can become the norm. Newsletters, flyers, radio programs, public speaking engagements and fact sheets are some of the ways information can be spread to the community, utilising the diverse skills of all members of the youth health service.

Working with communities to address issues of access to information and countering misinformation can be important in addressing the social exclusion of certain groups. It can also help the service to become an inclusive and affirming part of the community. Often people do not have the opportunity to learn anything about the lives of members of marginalised groups. While care must obviously be taken not to expose people

to danger, it can sometimes make a huge difference to prejudiced views when people can meet and hear the story of an 'ordinary person' who happens to be HIV positive or an Aboriginal person who was removed from their family. There are also other ways that these stories can be told. The AIDS Memorial Quilt movingly tells the stories of people who have died of AIDS and those close to them. It can be transported to community venues such as shopping centres where it is easily accessible. WAAT displayed the Quilt at its 1998 Young Women's Festival and received a very positive response. Youth health services can initiate, sponsor and promote such events that can help develop understanding and empathy in the community.

3.16 Building a profile in the community

People can learn about the work of the youth health service through Open Days, participation in community events, information stalls at shopping centres and community facilities, talks to P&Cs, Migrant Resource Centres and service organisations such as Rotary, Apex and Lions, and regular media information about the service and its activities. Community members can be encouraged to take an active part in youth health service advisory bodies and consultations and to use facilities available at the centre. WAAT has a video editing suite which is available for the use of community groups and most services promote community hire of buses or video cameras, and low cost photocopying, laminating, etc. This inter-change can have advantages for both sides with the health workers establishing a relationship with other groups through this process and community use of resources being promoted. Canterbury Multicultural Health Service, for example, has guitars and a CD player available for young people to use during "drop-in". Supervised access to electronic instruments is also available at certain times. WAAT provides access to computer games and TraXside has Internet access available for young people. These are not cheap and are resources which many young people may not otherwise be able to explore. Families and workers with young people from a range of different organisations and communities can be encouraged to make links with the youth health service through these sorts of avenues.

Openness and information about the work of the service can dispel concerns. Familiarity can promote understanding. As people become aware of the work of the service and understand the reasons for certain programs such as NSP or sexuality programs, a positive image of the service can develop. As it does, access and participation for young people and their communities can develop alongside.

3.17 Types of participation in management

Once young people begin to access the service, participation can naturally follow. Various forms of youth participation in service management structures can take place in youth health services. Youth representation on management or advisory committees, separate youth advisory groups operating alongside those comprised of workers and adult community representatives and representation on project development and planning groups, steering committees, interview panels and policy forums are some possibilities.

Clarity about the roles and responsibilities of the young people is important and appropriate policies and procedures should be in place and in writing. Provision of training is essential to enable genuine and meaningful participation. Meeting facilitation and procedural skills are necessary. Even if the youth or community meetings are more informal, an understanding of formal meeting procedure can be useful.

Relevant issues for youth participation are similar to those described elsewhere in this document - how to get proper representation and how to ensure that input is not influenced by differential power relationships based in wider social relations and operating independently of the intentions of workers and young people.

Several services have explored setting up Youth Advisory Committees or youth representation on general advisory committees but have found the structure to have shortcomings that are difficult to resolve. There are unavoidable limitations on input when a service is part of a much larger institutional structure such as the health system. In this context sustainability of youth participation is an issue. After operating for some

time, the High Street Youth Health Service Youth Advisory Committee structure was reviewed (with the Committee) and subsequently discontinued. It was replaced by the more dynamic input available from 6-monthly youth consultations feeding into the service's planning cycle. This has proved to be a more effective vehicle for incorporating young people's views into strategic planning.

Youth consultation in various forms is frequently used by most services. The Corner Youth Health Service in Bankstown is developing a youth database for information exchange with young people. Young people who wish to be on the database are contacted with surveys as well as information on forthcoming events and programs. The Corner also uses youth focus groups before a project commences with input fed into its development. Young people often participate in the implementation and evaluation of the project. Consultation with clients of the WAAT Outreach bus is also undertaken every four months. Services have developed ways of accessing young people's views which may include barbeques, sports days or other recreational activities as well as paid participation in project development, management and implementation.

Most youth health services routinely consult with young people in the development of specific programs. Some, such as TraXside and Cellblock have youth representatives on employment panels. CMYHS consulted widely with young people to develop the anti-violence "theme" for the year. TraXside has organised youth participation on panels at anti-homophobia events in schools. Input into some areas of policy is also obtained from young people. Obtaining meaningful youth representation within management however, remains a challenging issue for services.

3.18 Participation in health programs - peer programs

What is peer education and support?

Peer education and support programs have been used in Australia in the gay community in response to the HIV/AIDS pandemic, in programs for legal and illegal drug users such as the Tribes projects[20], in indigenous communities and in secondary schools. Within the gay subculture and in a number of youth health projects, peer programs were designed to promote and sustain safe sexual and drug use practices. There have also been peer initiatives implemented in juvenile justice settings[21]. The Peer Support Foundation funded through the NSW Health Department, operates in schools and peer projects have also been developed in the area of sexual health[22,23]. Several youth health services conduct peer programs. Central Coast Youth Health Service runs the Safe Summer Safari program on beaches along the coast during the summer months. The Warehouse in Penrith ran a Young Fathers Program using a peer model and FLYHT, working with Parks Community Network, trained a group of young people as peer educators working at local band nights. Training guidelines were developed from this project to assist future peer training. The Fun and Esteem Program operating at TraXside Youth Health Service in Campbelltown is a peer program for young men who have sex with men based on the successful AIDS Council of NSW program. Adapted to the South West Sydney area, it offers safe sex education and negotiation skills workshops as well as social support to reduce the isolation felt by many of these young men. The participants have also created a travelling photographic exhibition whose theme explores these young men's perceptions of life in South West Sydney. The exhibition was on show at a local gallery and was well received by the community.

A peer is defined as a person who self-identifies with a particular subculture, community or behaviour. In peer programs, training and ongoing support is supplied by health workers. Programs may be devised, delivered and evaluated by peers and may involve different degrees of formal structure. They may rely primarily on building supportive relationships through group activities, advocacy and providing a link between peers and health organisations or use formal workshop sessions to deliver programs specifically designed for the needs of a particular group.

Some youth health services have developed programs in which young people develop peer appropriate resource materials such as posters, pamphlets and stickers. WAAT has a peer produced video project under way aimed at Hepatitis C prevention. Resources for the Dumping Depression program run by Central Coast Youth Health Service in partnership with mental health services were developed using the input of young

people who also designed the star logo. At High Street Youth Health Service the Youth Participation project, a Federally funded mental health program, produced a directory of mental health promotion resources for young people called Air Your Laundry. The project employed 15 young people, supported by High Street Keyworkers, who undertook needs assessments, consultations and issues identification with other young people and health workers. This type of resource was identified as useful by young people. In addition to contact and service details it includes information about what to expect when accessing services. The resource was produced and designed by the young people and includes a postcard and booklet. It will be available in NGOs and schools.

3.19 Why peer education?

Peer education was developed as an appropriate way to deliver education in a clearly defined community or sub-culture with a high degree of cohesion which was marginalised from mainstream institutions. Behavioural dynamics are often built in sub-cultures. For instance, information about illicit activities is often passed on through this sort of peer contact, so it may work in a similar way to incorporate safer behaviours. The use of bleach for disinfecting needles and syringes in prisons or methods of using heroin without injecting are examples of the sort of information often informally transferred by peers.

Members of a particular community or subculture are also familiar with the issues, barriers and politics affecting its members, feel a bond with peers that probably does not exist outside the group, may have a high degree of credibility and opportunities for one-to-one discussion[24]. Barriers to health education with some groups which may include a lack of culturally appropriate intervention methods and resource materials can be overcome by use of the peer approach. A survey of adolescent drug prevention programs found peer programs to be effective on a number of measures[25].

3.20 Developing a peer program

The AIDS Bureau guidelines outline considerations for establishing a peer program in HIV/AIDS prevention. Although it recommends that it should be considered in cases where a targeted group is marginalised and isolated from sources of information, this should not be used as a blanket formula. The guidelines quote a study of 40 homeless young people in Brisbane which found that the media and friends were *not* rated highly as sources of accurate HIV information. Highly trusted sources were youth workers, parents/relatives and pamphlets. These rated 95% compared to friends at 43%[26].

A gendered perspective is important in considering such strategies. Amongst young people, differing friendship patterns between young women and men may have implications for peer programs. In general, young women have been found to consult peers much more often than young men so peer programs may have more impact on them[27] Talking to each other is important for young women's identity construction and maintenance of their relationships[28]. It can be self-affirming and possibly culturally more appropriate to certain groups in a girls only setting. However the suitability of the peer approach can only be determined by looking at specific situations and groups.

Services that have implemented peer programs have found that they are not without problems. They can be expensive and resource intensive since only a small proportion of the target group is reached in workshop-type models[29]. While this type of peer model can be very effective, it may be better to confine such programs to populations that are unable to be reached by less intensive strategies or to particularly high risk groups such as homeless or in detention centres.

The AIDS Bureau guidelines point out that " ... they should not be seen as a cheap option ... Projects report that (sic) a number of unexpected costs, such as for the provision of meals for participants, cost of camps,

wages for peer educators for one-off events, penalty rates, travel costs, resource production costs, administration costs, and/or evaluation costs." They emphasise the need for high levels of skill and resourcefulness in training peer educators and planning programs and the importance of clarifying roles, expectations, boundaries and responsibilities[30].

Youth health services are continually exploring innovative ways of involving young people and their communities in health initiatives. Cultural action or forum theatre is being explored as a way of activating participation by young people. In the Blacktown area WAAT is commencing a cultural action theatre project aimed at violence prevention. The three South Western Sydney youth health services, The Corner, TraXside and FLYHT, are working in partnership with each other and with the Powerhouse Youth Theatre on the Theatre for Living. This is an inter-active drama project exploring the experience of being a young person. These initiatives present exciting possibilities for the future.

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 generally? 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, e.g. 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?

References: (Chapter 3)

1. WHO, *The Health of Young People: A Challenge and a Promise*, Geneva, May, 1993, p.52
2. Market Attitude Research Services, *Evaluation of the Innovative Health Services for Homeless Youth Program*, Vol.1., May, 1997, pp.29-30
3. Personal communication with rural health worker, 1998
4. Andrews, S., Austin, N., Clarke, A., Goodman, H., Miller, J., 'Promoting Koori children's health - an affirmative approach', *Health Promotion Journal of Australia*, Vol.8, No.1, 1998 p31
5. CHAIN & Illawarra TAFE , *Breaking Barriers: Young People Speak Out*, video
6. The Canadian Taskforce on the Periodic Health Examination, *The Canadian Guide to Clinical Preventative Health Care*, Health Canada, Ottawa, Canada, c.1994, p.542
7. Personal communication by youth health worker, 1998
8. Personal communication by young person, 1998
9. Airhihenbuwa C.O., 'Culture, health education and cultural consciousness', *Journal of Health Education*, Vol 26, No5, September-October, 1995, p.317
10. Andrews, et al., op. cit., p.31
11. Hage, G., *White Nation: Fantasies of White Supremacy in a Multicultural Society*, Pluto Press, Sydney, 1998, p.33
12. Nelson JA, Gay, 'Lesbian and bi-sexual adolescents: providing self-esteem enhancing care to a battered population', *Nurse Practitioner*, Vol.22 No.2, February 1997
13. Hillier, L., Dempsey, D., Harrison, L., Beale, L., Matthews, L., Rosenthal, D., *Writing Themselves In: A National Report on the Sexuality, Health and Wellbeing of Same-Sex-Attracted Young People*, National Centre for HIV Social Research, La Trobe University, Melbourne, 1998
14. Davis, L.J., *Enforcing Normalcy: Disability, Deafness and the Body*, Verso, London, New York, 1995, p.7
15. Personal communication with Aboriginal worker in Juvenile Justice Centre, 1996
16. Andrews, et al, op. cit., p.32
17. Joffe A, 'Filling in the gap through research', *Archives of Paediatric and Adolescent Medicine*, Vol.151, No.2, February, 1997
18. Oppong-Odiseng, ACK., Heycock EG., Adolescent Health Services - Through Their Eyes, *Archives of Disease in Childhood*, Vol.77, No.2, August, 1997, pp. 115-119
19. McKie, L., McPherson, I., 'Health issues in remote and rural areas', *Health Bulletin*, Vol. 55, No.5, September, 1997
20. MSJ Keys Young, 'The "Tribes" Education Campaigns', 1990-91, Unpublished report, 1991
21. Juvenile Justice Branch, Victorian Department of Human Services, Evaluation of the Juvenile Justice, Specialist Support Services Adolescent Peer Education Program, Melbourne, 1996
22. Michels, D., Brown, S., 'Making Sense of Sex Youth Peer Education Program: Fact and Fantasy File Diary and Sexual Healthcare Hotline: A joint project of the Family Planning Association and South Sydney Youth Services, Final Report', Unpublished Report, 1992
23. Brooks, M., 'The Warehouse Peer Education Project', 1992/1993, Unpublished Report, 1993
24. Loxley, W., Ovenden, C., '"It's the same risk, isn't it?": Needle Sharing, Unsafe Sex, Intoxication and Risk of HIV in a Western Australian Group of Young Injecting Drug Users', Paper presented to the HIV, AIDS and Society Conference, 11-12 July, 1995, Macquarie University Unit of National Centre for HIV Social Research, 1995
25. Tobler, NS, 'Meta-analysis of 143 drug prevention programs: quantitative outcome results of program participants compared to a control or comparison group', *The Journal of Drug Issues*, Vol.16 No.4,1986, pp.537-567
26. Matthews, BR., Richardson, KD., Price, J., Williams, G., 'Homeless youth and AIDS: knowledge, attitudes and behaviour', *Medical Journal of Australia*, Vol.153, July, 1990, pp.20-23
27. Oppong-Odiseng, op. cit.
28. Harrison L., 'Distant voices, still lives: Young women, research and empowerment', Colquhoun, D. & Kellehear, A., (eds), *Health Research in Practice*, Vol.2, Chapman & Hall, London, Melbourne, 1996, p.89
29. AIDS Bureau, NSW Health Department, AIDS and HIV Infection, Statement No 9, Guidelines for HIV peer education programs, NSW Health Department,1994

30. ibid

Chapter 4: Building supportive environments

"...to change behaviour it may be necessary to change more than behaviour."[1]

As well as direct service provision such as treatment, support, groupwork, referrals, rehabilitation, youth health services also work for prevention of ill-health. While the delivery of direct support *services* targeted to particular groups of young people is effective and necessary, the development of a supportive *environments* model appears to be the most likely to deliver results in broader areas of prevention.

4.1 What is a supportive environments approach?

The development of supportive environments involves addressing health issues by concentrating on affecting the *social and physical* environments in which people act and make choices rather than attempting to directly influence individual behaviour. It differs from the individually focused, knowledge-based model of behaviour change and operates on a broader and more complex scale. It acknowledges the social determinants beyond the control of, and acting upon young people. It does not give primacy to singling out individuals or to directly affecting their levels of information although these may play a part in the total picture. It attempts to change behaviour through changing the social and material contexts in which people live.

4.2 A supportive environments approach to prevention

As we have seen in previous chapters, targeting individuals as the primary determiners of their own health ignores the connections between health and social factors such as class and gender. An approach which recognises the complexity of the influences on individual behaviour change can work to develop an environment in which it is easier for individuals to be healthier. This approach is more effective than attempting to *persuade* individuals to change their behaviour, which indeed can be counter-productive to wellbeing. In the words of one writer,

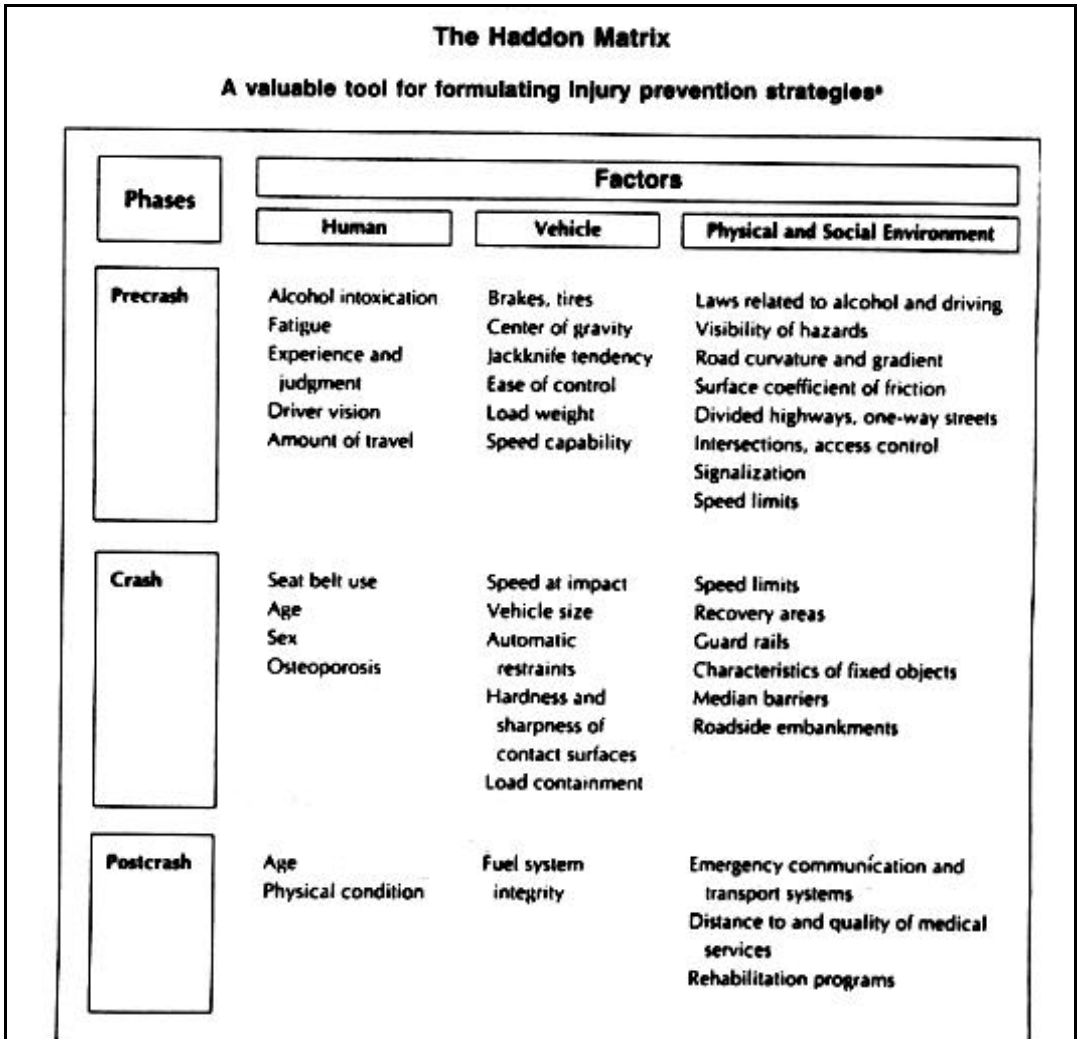
"... the likelihood of a preventative measure to succeed varies inversely with the frequency and complexity of any behaviour change required on the part of persons to be protected."[2]

4.3 Supportive environments in road safety

The history of developments in the reduction of road injuries provides a clear example of this approach. The application of a supportive environments approach to this area was pioneered in the USA. Similar developments took place in Australia. As a result of various measures designed to affect the environment in which people drive, accident fatality rates in the USA were reduced by 50% in 25 years. The results achieved have been attributed largely to changes in car design and road environment *as opposed to focusing on individual drivers*. Previous to the work of Dr. William Haddon Jnr., it was believed that changing individual driving behaviour was the way to address the motor vehicle accident rate[3].

4.4 The Haddon Matrix

Haddon developed a system known as the Haddon Matrix, which could be used to assess the variables involved in car accidents. It looked at the factors arising from the social and physical environments in operation before, during, and after the crash, as well as the driver and vehicle. See Diagram 2.[4]



The Haddon Matrix

A valuable tool for formulating injury prevention strategies*

Phases	Factors		
	Human	Vehicle	Physical and Social Environment
Precrash	Alcohol intoxication Fatigue Experience and judgment Driver vision Amount of travel	Brakes, tires Center of gravity Jackknife tendency Ease of control Load weight Speed capability	Laws related to alcohol and driving Visibility of hazards Road curvature and gradient Surface coefficient of friction Divided highways, one-way streets Intersections, access control Signalization Speed limits
Crash	Seat belt use Age Sex Osteoporosis	Speed at impact Vehicle size Automatic restraints Hardness and sharpness of contact surfaces Load containment	Speed limits Recovery areas Guard rails Characteristics of fixed objects Median barriers Roadside embankments
Postcrash	Age Physical condition	Fuel system integrity	Emergency communication and transport systems Distance to and quality of medical services Rehabilitation programs

Diagram 2

The accident was no longer viewed simply as a result of an individual's personal characteristics, and prevention was subsequently focused on a range of changes operating in each of the identified areas. Design and performance safety standards were adopted for motor vehicles. These were credited with saving at least 10,000 lives per year without affecting the behaviour of the driver[5].

4.5 Passive interventions

These "passive interventions" could be implemented without requiring the compliance of the user. The difficulties associated with "active interventions" or attempting to change individual behaviour, is shown in the history of seat belt usage in the USA. While car manufacturers were required to install seat belts from 1967 onwards, the problem was how to get people to use them. Award-winning media campaigns encouraged people to use seatbelts and public education blitzes focused on the virtues of seat belts and the "dire consequences of non-use"[6]. To no avail! Usage remained static despite all this until the advent of compulsory seat belt laws which dramatically reduced accident rates[7].

The introduction of the 55mph speed limit in the USA as an oil conservation measure in 1974 was also estimated to have had an enormous impact in reducing motor vehicle accidents and injuries. In 1987 an increase to 65mph on rural highways was permitted. In the first state to adopt the new speed limit, the

number of fatalities which could not be attributed to any other change increased by 50%[8].

The results of Haddon's techniques in road injury prevention suggests that the supportive environment approach is more effective for prevention than an individual one-to-one approach. However, it should be noted that this particular example of the approach offers no analysis of the fact that young men comprise the majority of people involved in road accidents. The lack of a gendered conceptualisation acts as a limitation upon addressing the factors in the social environment that account for the overwhelming presence of young men in the road injury statistics[9].

4.6 Building a supportive environment for addressing Injecting Drug Use, (IDU) issues

The supportive environment approach has been used by youth and other health services in conjunction with specialist Alcohol and Other Drug (A&OD) services. It addresses health risks associated with illicit drug use, in accordance with the National Drug Strategy. Youth health services play an important part in this strategy as much illicit drug use starts at an early age. The policy of harm reduction or minimisation was instituted when the limitations of an abstinence model became starkly obvious with the advent of the HIV/AIDS pandemic to Australia. "Just say No" to drugs was a version of an individually focused prevention program that assumed that drug use behaviour could be changed by the provision of accurate information. It was assumed that when young people had correct information on the effects of illicit drugs, they would duly stop using them. When HIV/AIDS started to devastate communities overseas, the abstinence model was abandoned in favour of a more realistic and workable strategy of developing a supportive environment for safer injecting drug use. It acknowledged that, while abstinence may be a desirable end result, there was no time to wait around for people to adopt this as a goal and change their behaviour accordingly. It also recognised that there were people who would continue to inject drugs despite efforts to encourage or enforce abstinence. The new approach acknowledged that relying on individual behaviour change alone was not a viable option.

4.7 Legislative change

Major legislative changes were made to allow pharmacists to sell needles and syringes and authorised persons to supply needles and syringes to IDUs through the Needle and Syringe Program (NSP). These major changes indicated recognition that ready availability of new injecting equipment was essential to minimise the transmission of Hepatitis and HIV[10].

4.8 A supportive environment is multi-faceted

Building a supportive environment for addressing injecting drug use has involved multi-faceted changes in social environment and public policy. In the implementation of this approach, the NSP has been like the tip of the iceberg. The development of the necessary legal and social infrastructure was necessary to make it effective. While the legislative basis has been put into place, the social aspects of this strategy are still in the process of being built and are sometimes subject to conflicting pressures within geographical communities.

Services have set up NSPs as part of a continuum of strategies for addressing harm associated with injecting drug use. The provision of information to individuals has been an important part of this initiative, but *not* the centrepiece. The strategy incorporates measures to control supply and demand, treatment and rehabilitation as well as trying to address safe using issues such as the the promotion of alternative methods of drug administration. The promotion of abstinence retains a place in the strategy but no longer *is* the strategy.

This approach has had a major impact on risk behaviour amongst IDUs. The numbers of HIV-positive IDUs in Australia remains small[11]. The relatively low rate of HIV infection in the IDU community in Australia shows the success of this strategy and the need to expand the approach, particularly to meet the health risks

of other blood-borne infections such as Hepatitis C. In those countries which have a punitive, knowledge-based approach, the victims are not only blamed when their behaviour doesn't change but often end up with a death sentence as well.

FLYHT has been established as a low-key secondary outlet for the NSP for some years in an area where injecting drug use touches many families. FLYHT also conducts a mobile service in conjunction with Cabramatta Community Centre. A supportive environments model was used from the outset. Working in partnership with community organisations and relevant health services, an integrated and broad approach to Injecting Drug Use was developed. The services jointly initiated community "clean-ups" and targeted certain areas where many disgarded needles and syringes were found. The "clean-ups" also became a way of linking in with the community and raising awareness of IDU issues. Community action groups in the Liverpool and Fairfield/Cabramatta areas were developed through the combined action of FLYHT, HIV/AIDS and A&OD services, community groups and local and state government representatives. Resources were developed by young people including posters used externally on local buses. The groups lobbied local government highlighting the need for disposal facilities. Disposal bins were installed in some parts of the Local Government Area. They developed other supporting measures including the resourcing of IDUs with information on safe disposal and other issues, safe sex materials and appropriate referrals, Hepatitis B immunisations, advocacy and anti-discrimination lobbying, the development of close links with young IDUs and their families as well as with treatment and rehabilitation facilities. Care has been taken to accord IDUs the same respect and service that is offered to all other clients. The promotion of equity for IDUs within the health system and elsewhere has been an important part of the supportive environment approach. FLYHT emphasises that their IDU clients are "first and foremost" young people. They should not be defined by their drug use any more than others are defined by their health issues.

4.9 The need to lobby

Lobbying for change is a vitally important part of building a supportive environment. There will always be someone, somewhere to convince. It is important to know who those people or organisations are and to have well-researched and appropriate supporting arguments. The holistic nature of the supportive environments approach makes cooperative work essential. Effective lobbying often calls for services, groups and individuals to work together in a coordinated way to plan and implement change and to counteract opposing influences.

Youth health services that work with homeless or "at risk" young people use the supportive environments approach extensively in relation to this group. Their approaches range from promoting a wider range of educational, skill development and accomodation options for young people to lobbying media for more accurate representations of young people. Services have worked in partnerships with peak organisations such as the Youth Action and Policy Association (YAPA) to lobby politicians about youth issues or develop policy in areas such as "youth wages" and anti-discrimination.

Successful policy developments have been initiated by health workers in Australia and elsewhere - controls on advertising of tobacco and alcohol are well-known examples. Lobbying for gun control is emerging as a crucial issue. In France, health workers have been instrumental in developing codes of conduct for car manufacturers to stop them promoting car sales on the basis of their cars' speed[12].

Youth health services, with their well-developed links in the community, are potentially well-positioned to lobby effectively for initiatives that are conducive to a health promoting social and physical environment. With further development of research back-up and linkages with other parts of the health system their position can be strengthened. This type of work may not always be easy, particularly since a recognition of the social determinants of health removes the demarcation between "health" issues and "political" issues. So every economic and social policy is also a health policy that will inevitable impact upon young people, their families and communities!

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-focused 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?
- ✓ 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?"

References: (Chapter 4)

1. Wilkinson, R.G.,*Unhealthy Societies: The afflictions of inequality*, Routledge, London, New York, 1996, p.64
2. Wintemute, G.J., 'From research to public policy: the prevention of motor vehicle injuries, childhood drownings and firearm violence', *American Journal of Health Promotion*, Vol 6, No 6, July/August, 1992, p.454
3. ibid.
4. Baker, S.P., O'Neill, B., Karpf, R.S., *The Injury Fact Book*, 2nd ed., Oxford University Press, New York, 1992
5. Robertson, L., 'Automobile safety regulation: rebuttal and new data', *American Journal of Public Health*, 1984 pp.1390-94
6. ibid: p.455
7. ibid: p.456
8. Wintemute, op. cit.
9. Walker, L., Butland, D., Connell, 'R.W., Boys on the Road: Masculinities, Car Culture and Road Safety Education', abstract for the *Journal of Men's Studies*, Special Issue on Boys, Men, Masculinity and Schooling, December, 1999
10. Crofts, N., Herkt, D., 'A History of Peer Based Drug-User Groups in Australia', *Journal of Drug Issues*, Vol.25, 1998, pp.599-616
11. National Centre in HIV Epidemiology and Clinical Research, *Australian HIV Surveillance Report*, Vol.14, No.1, 1998
12. WHO, The Health of Young People: A Challenge and a Promise, Geneva, May, 1993, p.59

Chapter 5: A balanced approach

It is important for youth health services to be able to maintain a balance between provision of direct services such as primary health care, treatment, support, rehabilitation, individual and group work, in combination with broader, indirect and more pro-active prevention strategies. The difficulties associated with prevention based solely on the individually-focused knowledge-attitude-behaviour change model have been noted previously.

A balanced service requires workers who are appropriately trained, have access to research findings, have support and supervision and feel confident to work both directly and indirectly and to explore and develop new approaches. Often, services are unable to develop staff skills because of financial and time constraints. This may apply even to short-term training. It is unrealistic to expect balance to be achieved by services that are unable to send workers to training because it costs over $50[1]!

The problems involved in releasing staff from regular duties for training and research are also formidable. Some services have few staff so it is almost impossible for them to take time for this. Even those with many staff find it difficult. The high demand for direct services can mean workers feel almost a dereliction of duty if they take time away from them. Sometimes entrenched views about the role of youth health services reinforce this attitude both within the service and from outside. An understanding of and support for the needs of youth health services from higher management is absolutely essential in developing this important balance in service delivery.

5.1 The Ottawa Charter

The Ottawa Charter[2] is a compilation of prevention approaches. Optimally, a combination of these elements makes a sound foundation for delivering effective prevention and health promotion. An integration of all the strategies is not always possible or appropriate. It is important to know which strategies can be used in what context.

The Ottawa Charter's five areas of strategy are:

- developing public policy;
- building personal skills;
- re-orienting health services;
- creating supportive environments;
- enhancing community action.

5.2 Balancing individual and population approaches

Youth health workers provide both direct, reactive (support, referral,primary health care, treatment and rehabilitation) and indirect, pro-active (prevention and health promotion) services. The same techniques are not necessarily applicable to both.

Youth health services have been very successful in targeting young people who often have no other access to health care. Some of their situations are desperate and the availability of non-judgmental, sensitive services can be crucial. But sometimes services have tilted towards an individual and group focused approach to prevention as well as to those situations that obviously call for an one-to-one or one-to-some response. This model, in which prevention strategies are based on direct services to individuals or groups has been criticised as labour-intensive, costly and of uncertain outcome[3].

Limited resources and access to staff, research and training, as well as the urgency and volume of direct service demand, all play a part in inhibiting development into broader areas of prevention. Services under high pressure, without the staff time and resources to commit to training team members and accessing the latest research findings in preventative approaches, cannot be expected to utilise these approaches. Acknowledgment by higher management of the specific contexts in which services must work, and recognition of training and resource needs of services is also essential for further development of innovative approaches.

Recent work on the population-based approach, particularly in suicide prevention, indicates that it would be productive to ensure that direct responses to the needs of individuals are balanced with a population focus. The argument put forward by a number of researchers is that prevention, to be most effective, must be done on a population not an individual basis.

5.3 What is a population-based approach?

The work of Haddon in the USA on reducing road accident rates has been cited previously as an example of the development of a supportive environment for health[4]. His work shifted the emphasis from the high risk "nut behind the wheel" to an approach which applied preventative measures to the whole population and did not depend on targeting individuals. The population approach concentrates on shifting whole populations (or sub-populations) to lower risk levels rather than focusing on high risk individuals or groups. In proposing this strategy, a number of researchers argue convincingly that it is more effective in reducing mortality rates than an individual approach[5,6].

For example, the majority of cases of coronary heart disease are people with low to medium risks. Most of the would be missed in a strategy that targeted only high risk people[7]. In the words of one writer on this subject,

> *"Small reductions in risk factors multiplied across the total population may achieve great health gains, sometimes greater than those that might be won by the identification of high risk individuals and their effective medical treatment"*[8].

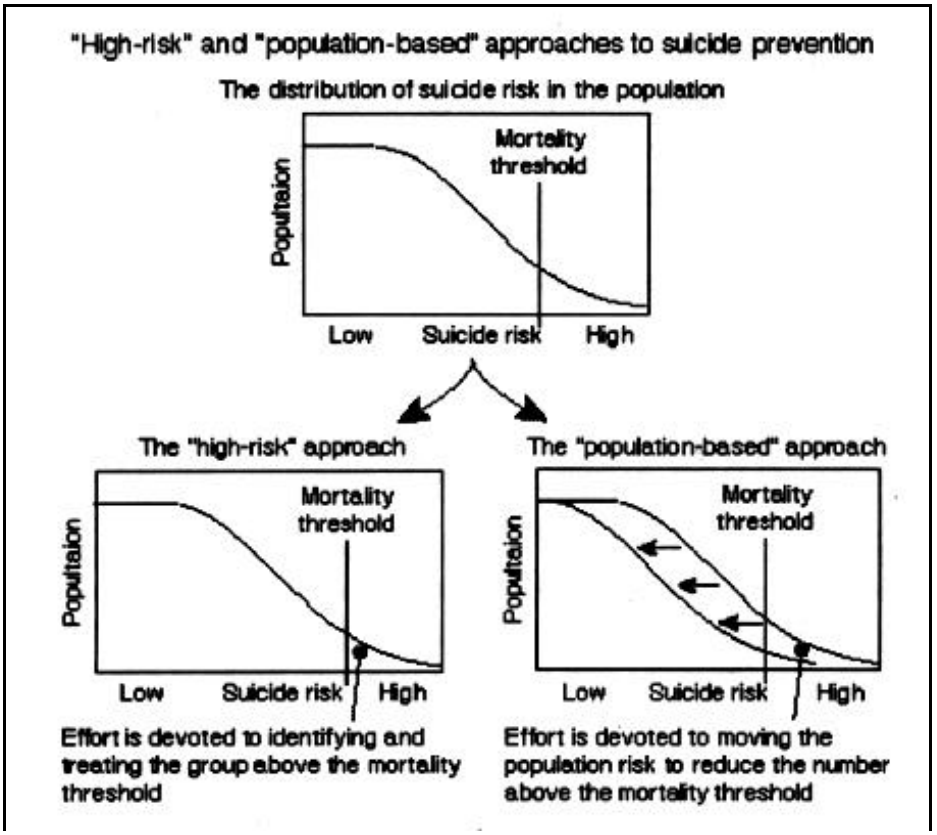


Diagram 3

5.4 The population approach to suicide prevention

In his work on suicide prevention, Rosenman argues that a population-focused strategy can shift the distribution of risk so that "at any time, fewer people are over the threshold that leads to completed suicide. We do not have to identify the individuals within the population to save them", (see diagram 3)[9]. He points out that prevention strategies targeting high risk people miss most suicides. In addition to the impossibility of gauging what works "when we can only count failures," it is difficult to identify high risk people when risk status might change at any time. He says, "Half a bottle of whisky may create a high suicide risk within an hour." In a high-risk-individual approach, the majority of youth suicides will be missed as most do not show any indicators of high risk[10,11].

In Japan, youth suicide, particularly in boys, was dramatically reduced not by identifying high risk individuals and introducing expensive counselling services for them into every school, but by comprehensive changes in the education system. These changes made the student's course through the curriculum more predictable and realistic, and reduced the intense disappointments associated with the previous system[12].

Rosenman makes a strong case for putting a population-based approach into practice by starting with that which is immediately achievable, such as restricting the means of suicide. Firearms and car exhausts are both common means[13] and lobbying for changes to restrict access to guns and to prevent car exhaust suicide may reduce deaths by these methods, and possibly total suicide rates[14].

A similar approach has been used by some isolated Aboriginal communities in response to the damaging

effects of petrol sniffing. AVGAS has been substituted for petrol in some communities because it is non-psychoactive and therefore not as attractive to sniff as petrol. It appears that the use of AVGAS will reduce health damage in these communities if costs continue to make it viable to purchase[15].

5.5 Balance between an individual and group focus and a population focus

Re-focusing in this way does not mean that we should ignore identified high risk people. Early intervention has been shown to be effective with this group[16]. Clinical services are a vital part of the work of youth health services and the process by which young people are engaged by the service is crucial. As noted earlier, the conditions surrounding a young person's decision to access clinical or other services can mean the difference between health care or nothing. The strategies referred to in previous chapters on access, participation and the development of a "youth-friendly" approach are directly applicable to the work of clinicians as well as in a broader sense to the whole service. Studies have clearly shown that young women and men will not access medical or other clinical services if they feel intimidated or judged by the practitioner or they feel that s/he doesn't understand or relate to their issues[17].

The optimum strategy is to balance the two approaches by working for prevention with a population based model incorporating elements of the Ottawa Charter and by working with individuals and groups via a counselling, clinical, support or other direct service which may include some health education. Some researchers, however, remind us to stay aware of the "social model of health which emphasises that high risk individuals from socially disadvantaged groups are less able, willing to obtain, and respond to counselling. They have less health knowledge, fewer resources, other more pressing priorities and countervailing peer group influences"[18]. This awareness makes a balance of approaches all the more necessary.

The public space campaign is emerging as a promising area for a population-based approach. This campaign arose out of the often discriminatory response to a public perception of youth violence in "public spaces" such as shopping centres. Sometimes violence does occur in these areas where youth facilities are few or expensive and there are many young people. Sometimes it is assumed that gatherings of young people are potentially violent simply *because* they are young people. Young people ask why they are singled out as "gang wars waiting to happen" and why they have less right to public space than other community members. Older people ask why they as community members have to live in fear every time they leave their houses. The consequence has been rising tension, prejudice and fear in communities. In some areas, projects to address this situation are being undertaken.

The Equal Space Project is a pilot scheme based at Stocklands shopping centre in South West Sydney. It aims to promote a more equitable use of space for all groups in the community, including young people and to ensure that this process has the effect of increasing safety and feelings of security for all. The project, financed through a mix of government and corporate funding, has a Steering Committee for the specific day-to-day work and a Reference Group with an overall direction and support function. FLYHT has representation on the Reference group. FLYHT is also working on public space related projects with young people and police in the Cabramatta area and as part of their involvement in the Miller project, (see 2.19). These activities are not focused on individuals but on a broader environmental design approach targeting communities.

5.6 Needs and requirements

Youth health services can play an important part in developing approaches and identifying strategies which may not be THE answer to health problems for young people but go some way towards addressing the issues. To do so, however, often means departing from time-honoured methods and trying something new. For this to happen, certain requirements need to be met. Keeping a population approach to the forefront of a prevention strategy is integrally tied to availability of resources, funding, support from higher management, long-term commitment, thorough research, trained staff and highly developed links and partnerships. This requires a work-place culture at all levels that values and supports such an approach. Without these, a balanced approach is not possible.

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 focused 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?

References: (Chapter 5)

1. Personal communication with youth health workers, 1998
2. WHO, *Ottawa Charter*, Website URL: http://www.who.adk/policy/ottawa.htm
3. McMichael, A.J., 'Current directions in public health and preventative medicine' in McNeil, J., King, R.W.F., Jennings, G.L., Powles, J.W., (eds.), *A Textbook of Preventative Medicine*, Edward Arnold, Caulfield East, Victoria, 1990, p.320
4. Wintemute, G.J., 'From research to public policy: the prevention of motor vehicle injuries, childhood drownings and firearm violence', *American Journal of Health Promotion*, July/August, Vol 6, No 6, (1992), p.454
5. Rose, G., *The Strategy of Preventative Medicine*, Oxford University Press, Oxford, New York, 1992, p.14
6. Rosenman, S.J., 'Preventing suicide: what will work and what will not', *The Medical Journal of Australia*, Vol.169, 1998, pp.100-102
7. McMichael, op. cit.p.320
8. Leeder, S.R., 'Strategies for prevention' in McNeil, et al, op. cit., p19
9. Rosenman, op. cit.
10. Rosenman, op. cit.
11. The Canadian Taskforce on the Periodic Health Examination, *The Canadian Guide to Clinical Preventative Health Care*, Health Canada, Ottawa, Canada, c.1994, p.457
12. Dore, R. quoted in Wilkinson, R.G., *Unhealthy Societies: The afflictions of inequality*, Routledge, London, New York, 1996, pp.21-22
13. Dudley, M.J., Kelk, N.J., Florio, T.M., Howard, J.P., Waters, B.G.H., ' Suicide among young Australians, 1964-1993: an interstate comparison of metropolitan and rural trends', *Medical Journal of Australia,Vol.169*, 1998, pp.77-80
14. Cantor, C., Baume, P., 'Access to methods of suicide: hat impact?' *Australia New Zealand Journal of Psychiatry*, No.32, 1998, pp.8-14
15. National Aboriginal Community Controlled Health Organisations and Alcohol and Other Drug Council of Australia Special Joint Press Release, *ADCA Update*, Vol.12, No.11, November, 1998
16. National Mental Health Strategy, *The Australian Clinical Guidelines for Early Psychosis*, EPPIC, Melbourne, September, 1998, p.p.15-17
17. Weaver, L., Attard, M., *Beyond Jellybean Therapy: Improving Doctor-Patient Communication with Young People in Central Sydney*, CSAHS Division of General Practice, 1998
18. McMichael, op. cit. pp. 284, 320

Chapter 6: Coordination

Because health is a multi-dimensional state encompassing the social, physical and mental aspects of a person's life, a multi-dimensional or holistic response makes sense. Indeed, the implications of a concept of health as socially determined may mean that it is unworkable to address health issues in isolation. In practice this will mean wide-ranging collaboration with other services, groups and individuals which impinge, in various ways, on the lives of young women and men. To be effective, this process needs to be coordinated. This means efficient, coherent and appropriate integration of direct and indirect work both within the health services and with "outside" bodies. "Seamless" delivery of services or the "continuum of care" in direct service provision implies a high level of coordination.As well, the planning and implementation of initiatives to address broader social issues affecting youth health also must be strategically coordinated.

6.1 Multi-dimensional nature of youth health

As we have seen, the causal chain leading to "health" or "ill-health" is complex and it is often impossible (and usually wrong) to identify a single cause out of a multiplicity of factors. This is so particularly in the case of young people whose health issues are often related to alcohol and other drug misuse, self-harming behaviours and suicide or to behaviours which lead to increased morbidity and mortality in adult life[1]. Populist moral and political agendas can influence the way particular youth health issues are viewed, increasing the dangers of associating social issues including health status with a single "cause" and targeting, pathologising and scapegoating particular aspects of young people's lives. Popular "causes" of the "problems with young people" include single parent families, marijuana use, social security provisions, lack of corporal punishment, and neglect of the "3 Rs" in school!

Finding a single "cause" for a problem behaviour can be tempting. It presents a direction to be taken to address the behaviour. But mono-causal explanations give rise to mono-causal strategies in response, which may fail to address the health issue and may result in exacerbating problems. Singling out a factor which can be seen to correlate with a condition and calling it a "cause" of that condition is often done, especially in populist media "explanations" of social phenomena, e.g. marijuana smoking "causes" injecting drug use; subjection to abuse as a child "causes" abusive behaviour as an adult. However, risk factors tend to be clustered together and it is difficult to differentiate between causes, effects and co-occurring events[2]. The underlying social factors within these conglomerations of events also tend to be overlooked when mono-causal "explanations" are used.

The WHO's Jakarta declaration states that a comprehensive approach is more effective than a single track[3]. Given the problems associated with trying to identify single causes, it makes more practical sense to address a constellation of possible factors. Coordination is essential for this approach. This is particularly (but not only) the case when working with young homeless people. The clients of those agencies that are IHSHY-funded may have issues of housing, income support, education, unemployment, family, sexuality, A&OD, legal, etc. As well, services may be working with or referring to agencies providing food, postal addresses, washing machines, bathroom facilities, as well as direct medical services. Coordinated services use a range of strategies and settings to assist the young person's successful negotiation of these issues.

6.2 Joint programs and promotions

Coordination is necessary where programs are being provided by collaboration among sectors, organisations or individuals. Some examples of joint programs requiring a high degree of coordination include young offender programs run inside Juvenile Justice institutions such as the Sexuality and A&OD program run at Reiby Juvenile Justice Centre by TraXside Youth Health Service or education assistance programs with a

Personal Development component such as the Helping Early Leavers Program (HELP) and Time Out which have input from Central Coast Youth Health Service. The success of such programs is highly dependent upon all components working in the same direction. Inconsistent or contradictory processes and messages, duplication of activities and resources, lack of clarity about goals and strategies, "re-invention of the wheel" and unarticulated policy differences are not only wasteful of resources but may be damaging to young people. Youth health services may also provide training, support and resources to services which require more specialised knowledge about particular health issues. Some youth health services act as consultants for other services in this way. WAAT is in the process of developing a Body Image resource package to be used in schools which will involve WAAT staff as consultants rather than presenters of the material. Coordination is no less important in this sort of consultative role.

Health promotion activities rely heavily on good coordination. For instance, the strategic directions of the Ottawa Charter require coordinated activity because they are conducted across a range of settings and institutions, utilising a variety of approaches and stake-holders.

Events with a community focus around Youth Week, International Women's Day, Mental Health Week or World AIDS Day are often the focus of community information or social marketing campaigns, and are often examples of coordinated activities on a large scale. In the course of such events, youth health services may be involved in joint activities with the media, activist groups, sexual health, A&OD services, hospitals, churches, schools, artists, carers, entertainers, shopping centre staff, pubs and clubs, volunteer workers, sporting organisations, etc.

Lobbying and planning for broader social change also must be coordinated. Whether this involves system-level changes in state bodies such as the social security, education or legal system or targets private corporations' actions towards young people and the community, integrated action is still necessary. Conflict can occur between the interests of health workers and those of other bodies who may be involved in health-damaging products or actions and it is important that coordinated strategic planning and actions are undertaken on as wide and varied a level as possible.

6.3 "Spelling it out"

In collaborative work, problems of coordination can arise out of lack of clarity over what is being done, why and how. This may be due to lack of understanding of basic principles, responsibilities and boundaries of services, divergences in philosophies, policies and practices between services, assumptions about other services that are not based on facts, confusion in planning and lack of information and communication. Sometimes, without careful and explicit discussion, fundamental differences in understandings about program aims, objectives and evaluation become apparent only when the program is underway. Much of this can be avoided in the initial discussion. Perhaps the services interested in collaboration are totally unsuited to doing so. Coordination requires discussion and careful discussion requires "spelling it out". Disappointments have occurred when it was realised that unwarranted assumptions of shared principles were made. Assumptions about *anything* need to be avoided.

If a joint initiative is agreed on, making enough time for detailed and ongoing discussion during planning meetings, and building this into programs, is vital. This is not only for continuous clarification of understandings but also for the monitoring of programs as they proceed. Programs need to be carefully documented from the outset. Guidelines of practice can be spelt out in policy and procedure manuals. Written agreements developed by the services involved can also be useful in helping to coordinate a coherent program with common understandings. Specific guidelines which lay down ground-rules for collaborative work are used by some services such as The Corner which has developed guidelines for working with schools. Agreement over ethical issues such as relationships and boundaries between staff and clients (especially in peer programs), confidentiality and privacy and their limits are crucial. These need to be worked on in detail by all groups involved so that misunderstandings are avoided and high quality service is delivered.

6.4 Teamwork

Coordination within the service means teamwork is crucial. At the very least, staff need to be familiar with what other team members are doing. Creating an atmosphere that is open, tolerant and responsive to views represented within different disciplines is important. A closed atmosphere where there are disciplinary hierarchies, narrow-mindedness and where mistakes are regarded as personal failures instead of learning opportunities, will ensure that workers are apprehensive about discussing problems with their work in case others think they are incompetent. "Team" meetings can become that in name only as workers are guarded about what they discuss and anxiety ridden about "exposure." Everything is always "going OK" no matter what private agonising is taking place behind the scenes! This can be avoided by staff commitment to honest, open and tolerant discussion, a process that can be encouraged and facilitated by everyone in the team. Workers are sometimes unclear about the practical meaning of team work, and "unpacking" the concept for discussion can be helpful.

6.5 Multi-disciplines - A team is an entity that is more than its individual parts

Differences in approach between different disciplines can give rise to conflicts if defensiveness or fortress mentalities develop. Communication becomes impossible. Often this happens as a result of workers feeling isolated, anxious or undervalued. Part of acknowledging the multi-dimensional nature of health is the recognition that all skills need to be brought to bear upon the issues. There is no privileged profession (A lesson can be learnt from official functions at Cuban health care facilities. The entire staff including the cleaners may attend and speak on an equal basis in recognition of everyone's significant role in healthcare).

Professional expertise can be respected without encouraging hierarchical, "gatekeeping" or closed attitudes. Also to be avoided are views that foster the myth that only certain people are capable of understanding or, in the words of one writer, are "authorised knowers"[4]. No one has privileged access to knowledge. Sometimes, the myth of "authorised knowers" surfaces in youth work circles. In this version, only young workers, by virtue of their youth, are able to understand other young people. By this logic, only ancient Greeks can understand ancient Greece, computers understand other computers or dinosaurs understand pre-history!

Sensitivity and open-mindedness between team members, commitment to continuous professional development and a shared sense of a mutual project being undertaken along Freierean lines can exert a protective influence in the team. A continuous process of dialogue within the team is essential with formal structures possibly built in to facilitate this. Some services have also instituted "journal clubs" where staff make presentations on areas of interest within their own disciplines.

Health promotion activities usually require team input. An understanding of the issues, aims, objectives and strategies for program development and evaluation needs to be shared and input invited from all team members in a formal way. A multi-disciplinary team in which there is a variety of skills, experience and training is likely to give programs a richness, creativity and imagination as well as a sound research and technical basis which will be difficult to achieve otherwise. A whole range of skills can be called upon and strengths and weaknesses balanced.

Actively pursuing input from other team members can prevent a situation arising where staff members feel they are intruding if they offer suggestions. Removing discussion from the casual to the formal may help. Developing the level of information sharing required for coordinating an effective cross fertilisation of ideas is time consuming but rewarding. Meetings with all staff involved, at least in the planning stages can later devolve into report-back sessions to the team that still invite input but are less consuming.

Within a youth health service, coordinated activities may take place in relation to the management of clients

by workers. Clients may see "Keyworkers," counsellors, "drop-in" workers, doctors, front-desk staff, Worker-On-Duty workers, etc. Procedures should be in place to deal with issues of direct client services with confidentiality guidelines ensuring that only staff involved with care of the client have access to information about them. This obviously includes being aware of the inappropriateness of casual discussions about clients within earshot of others or during meetings, as well as security of files.

6.6 Referrals

When young people make contact with youth health services they are sometimes referred to other agencies if it is more appropriate. This may happen immediately or at a later stage. It may be that the issue is not within the scope of the service, perhaps requiring specialised help or the client is outside the geographical or age limits for that particular service. In these cases a smooth transition from the initial contact into the appropriate service is needed. For this to occur, a detailed knowledge of referral pathways is necessary as well as care and communication in the referral procedure. Getting "shoved around from pillar to post" is a common experience for many young people. Levels of frustration can skyrocket if a person has mustered up the courage to approach the service only to find that they are moved on and especially if the process involves a repeat of the question and answer session that they have already endured[5]. Systems where workers take a support/advocacy role with the young person in accessing referred services have been developed in youth health services to address this issue.

6.7 Need for network development

Coordination requires wide and detailed knowledge of government and non-government sectors, activist organisations, roles, referral pathways and guidelines, and the development of good networks of contacts. Close links with community members are essential. Manuals with detailed information on relevant contacts for intersectoral work are available from various government departments, e.g. the NSW Health Department's *The Toolkit for NSW Partnerships in Physical Activity6*. Local Councils also produce Community Profiles with useful information and contacts for community organisations. (Sometimes within services, such knowledge resides entirely within worker's heads. Gaping information holes result when they leave. Systematising information within a printed and/or electronic manual or database, with lots of copies, can be a safeguard.)

A regular orientation procedure that gives new workers a tour not only of health-related organisations but community and other relevant bodies is also essential in making sure that the new worker has the opportunity to ask questions and understand "who does what, how and where." If new workers do not get this at the beginning of their work, it often can't be fitted in later, making things much more difficult than they need to be. Orientation into the health system can be an ad hoc affair and that seems inappropriate for youth health workers. It needs to be standardised across areas and broadened to become an orientation to the community generally. It should also include a thorough introduction to Community Health, hospitals, GPs and other private health practitioners, dentists and relevant Area Health Service units. Coordination is made easier by effective orientation procedures.

6.8 Regular representation on and contact with important networks around a core of issues

There are core social issues such as unemployment and housing addressed by organisations and activists in most communities. Links and networks with these need to be developed and maintained or initiated if they do not already exist. A system of designated workers regularly attending meetings can work well. With good communication channels within services, the worker can then pass on information from these networks into the team. More informal groupings in communities also take an interest in social issues but may not conduct meetings, e.g. sex workers, IDUs. Contact with these is equally important.

6.9 Working with other parts of the health system

Better prevention and treatment services necessitate close relationships with other sections of the health system. Shared expertise and resources, joint projects, efficient follow-up, education and information exchange and access to research findings can be some of the benefits of close links. For some types of approach, particularly in the areas of prevention and evaluation, partnerships with specialised services is essential. Youth health services do not have the necessary resources to single-handedly undertake population health initiatives, large scale research projects, outcome evaluations or needs analyses. There is a wealth of potential for closer links with Divisions of General Practice, Public Health, Epidemiology and Health Promotion units. These links are relatively undeveloped at present. Joint activities currently take place with Mental Health, Disability, Child Protection, Drug & Alcohol, Sexual Health and Sexual Assault services, hospital Accident & Emergency (A&E) and Social Work departments, dental services and Community Health workers. Contact with specialist units such as eating disorders clinics are also being made in some areas. Some specialist units may be outside the geographical catchment area of the youth health service but may be valuable contacts to develop.

Young people identify GPs and hospitals as their main entry into the health system[7]. At Crossroads, the Shoalhaven Youth Health Service, staff maintain a close relationship with the local hospital. They are notified when young people are admitted to Accident and Emergency services and work closely with hospital staff. This has proved to be of assistance to the hospital staff and provides continuity of care for the young person. Penrith Streetwork Project also keep contact with their clients in hospital when appropriate. CMYHS ensures that young people are referred to "youth-friendly" medical services.

An exchange of information between youth health services and GPs about relevant issues could be mutually beneficial. Potentially, this could be conducted through Divisions of General Practice to reduce the tradition of mutual suspicion that sometimes characterises such contact. Some parts of the health system can be prejudiced about youth health workers, seeing them as untidy, undisciplined and untrained. Reciprocally, some youth health workers see doctors as old-fashioned, arrogant, out-of-touch and ignorant about youth. These prejudices are obstacles that need to be overcome.

6.10 Promotion of the service

To work effectively on joint programs and to be able to make effective and appropriate referrals "out" is one side of coordination in a service. But the other side is having effective and appropriate pathways "in" to the service, both for direct or referred access and for proposals for joint activities, lobbying, advocacy, training, etc. Youth health workers need to be familiar with the community and services but the need is reciprocal. Lack of information about services has been shown to be a major reason why young people do not access them[8]. A regular visible presence in the community can be promoted through information stalls at shopping centres and community festivals, imaginative activities on particular "health days" such as Mental Health Week or World No Tobacco Day and regular targeting of video game centres, dance parties, railway stations and other areas with high concentrations of young women and men. Specific occasions on the Health Calendar such as Refugee Week or National Aboriginal & Islander Day Of Commemoration (NAIDOC) Week can be used as an opportunity to visit services that deal with youth to encourage joint activities on these issues and to provide information about the service.

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?

References: (Chapter 6)

1. Bennett, D.L., 'Adolescent health care: a challenge for the medical profession', *Medical Journal of Australia*, 1995, pp. 163-6
2. James, T., 'Empowerment through social change', James Colgrove, (Ed), *Bridges*, Electronic journal, Summer, 1997, Website URL: http:// www.hify.com),
3. WHO, *The Jakarta Declaration*, Website URL: http://www.who.int/dsa/cat95/zjak.htm
4. Sercombe, H., 'The contradictory position of youth workers in the public sphere', *Youth Studies Australia*, Volume 16, March,1997 pp. 43-47
5. CHAIN & Illawarra TAFE , *Breaking Barriers: Young People Speak Out* video
6. NSW Health Department, Sun Exposure and Physical Activity Policy Unit, *The Toolkit for NSW Partnerships in Physical Activity*, undated
7. Weaver, L., Attard, M., *Beyond Jellybean Therapy: Improving doctor-patient communication with young people in Central Sydney*, CSAHS Division of General Practice, 1998, p. 6
8. Coggan C., Patterson, P., Fill, J., 'Suicide Qualitative Data from Focus Group Interviews with Youth', *Social Science and Medicine*, Vol.45, No10, November, 1997, pp. 1563-70

Chapter 7: Collaboration

"It is well-recognised that it is the inter-play among multiple reinforcing approaches and the collaboration of numerous parties in both the public and private sector that ultimately leads to a change in individual behaviour"[1]

7.1 What is collaboration?

Collaboration refers to arrangements related to youth health where separate services or individuals work together to jointly run programs or projects, do "casework", community action, lobbying or use each others' expertise and resources to assist activities with youth. Collaboration takes place within the health sector; with some Commonwealth and State government departments such as Education, Centrelink, Ethnic Affairs, Women, Housing, Community Services, Sport and Recreation, and Juvenile Justice; and with local government. Services also collaborate with a number of community organisations such as youth services, Aboriginal, migrant, women's and gay and lesbian groups. There is also some collaboration with local service organisations and businesses and larger corporations. Areas that present possibilities for future collaborative work include trade unions in relation to young workers issues and human rights organisations as well as areas of the government sector such as the Army. In the latter case, some services are considering work related to transient families of Defence personnel.

Collaboration is common practice in youth health services which may adopt models of collaboration with varying degrees of formality. These can include health workers attending "drop-in" at youth centres, operating an outreach bus visiting youth venues, conducting joint programs with agencies such as schools, refuges, Juvenile Justice centres, community and Migrant Resource centres or with other parts of the health system. For example, CHAIN works with the Family Care Cottage and early childhood services in its Young Mothers group. Building on the success of their ante-natal program, BabyCHAIN, the Young Mothers group was developed as a support, education and social group. Several formats for the group were tried. The present one was developed after consideration of input from participants and workers and operates with high levels of participation by the young women. A play-group for children operates and a strong peer support and information sharing environment is developing. Collaboration within the health system is increasing, particularly in the area of mental health. Central Coast Youth Health Service is working in partnership with mental health services and the Area Health Promotion Unit on the Dumping Depression program and most youth health services are developing or implementing joint programs with mental health services.

Collaboration can also include acting as consultants on youth health issues and program planning to workers with youth. Services which employ ethnic-specific or Aboriginal workers have found that their collaborative input can be particularly valuable in increasing awareness of issues such as the effects of trauma and dispossession. Co-location arrangements where services share work space are another form of collaboration that is sometimes used. Collaboration between services can provide information in specific areas such as pregnancy, A&OD, eating disorders, refugee and settlement issues and support groups. The Central Coast Youth Health Service is currently planning its involvement with other services in a proposed Koori Youth Forum. Services may also collaborate to address specific social issues related to health such as youth unemployment and under-employment and unhealthy, discriminatory or abusive work practices.

7.2 "Getting them in" - accessing young people

Historically, collaborative arrangements seem to have arisen pragmatically out of access issues as well as out of more theoretically-based considerations. Initially youth health services concentrated almost entirely on direct services to individuals and groups. As well, accountability systems that were derived from primary health care done by community health workers were transposed onto youth health services. Gathering a large number of "occasions of service" was seen as a mark of efficient service delivery even though its applicability was sometimes debatable. But, it is true that, as one youth health worker put it, "you need punters!"[2] Young people are notoriously difficult for youth health services to access. As a group they are relatively healthy compared to children and adults and are reluctant to visit health services even when aware of their existence. Some say that they are wary of yet more authoritarian figures "telling us how to live our lives"[3]. Often they don't feel the need for health services. In the words of one young person, "Why should I go there, (to the health service), when I can go to my mate's place, get stoned and pissed and watch videos?"[4].

There were some initial uncertainties about how youth health services should position themselves in relation to their potential target groups. If they promoted their direct health service role too much they risked being seen as just another medical centre - where you go when you have to, and only then. On the other hand, young people flocked to youth venues. Commercial video game, music or sports venues and dance parties attracted masses of young people but were backed by substantial financial resources that health centres obviously could not match. In many of the areas where the health services were based, local youth centres were set up and funded through combinations of allocations from Community Services, Housing, Immigration, Employment, Juvenile Justice and other state and federal government departments as well as bodies such as the NRMA who fund initiatives such as youth crime prevention projects. With youth services accessing many more young people than health services were able to do, it seemed obvious that this was the place to go to reach young people. In the socially disadvantaged areas in which youth health services were established such centres attracted groups of young people who at a minimal or no cost could play pool or watch videos at "drop-in" or participate in school holiday or other recreation programs and camps. Youth workers at such centres were often overworked, under-resourced and isolated in the centres and welcomed links with other services.

7.3 "Going into their territory"

Along with access to numbers of young women and men, outreach to youth centres meant there was a sense of the power balance shifting a little away from what some young people and youth and community workers perceived suspiciously as - "the bureaucrats." A youth centre is much more likely to be perceived as young person's "territory" than a health centre and this was seen by workers to boost young people's confidence and sense of control.

As early youth health services were often operating on a shoe-string, sharing resources as well as clients with youth centres took some of the pressure off both. The down side of this collaboration was that programs were often ad hoc and unplanned, had no perceptible aims and objectives other than "making contact with youth" or "raising awareness," with no research back-up, no evaluation processes and no strategic direction. As well, health workers often became de facto youth workers and some under-funded community organisations started to increase their dependence on the youth health services for ventures whose goals were hazy and procedures chaotic. It was sometimes difficult for youth health workers to withdraw from these ventures with positive relations unaffected. In areas where youth workers were scarce and activities for young people almost non-existent, the pressure on youth health workers to become de facto youth workers was intense[5].

7.4 The good, the bad and the youth health workers!

With links to community and youth organisations being often more highly developed than links with other parts of the health system, support and shared understandings tended to come from here rather than from other parts of the health sector. This had beneficial consequences for youth health workers by making available a wider and more direct perspective on youth issues. It also brought with it links and insights into the experiences of the often under-resourced front-line youth workers and the opportunity to spend time talking with young people and their families and developing understanding and experience in their world. On the other hand, the pressure to *be* a youth worker sometimes resulted in a movement away from potentially useful input, contacts, research and support from what was perceived to be the more "mainstream" health sector.

An oppositional stance also sometimes arose between the government and non-government sectors, fuelled by mistakes, misunderstandings and distrust on both sides of the health/community divide. Youth health workers were caught in the middle of this. Some government workers acted as though youth health workers were untidy, irresponsible, brainless, drug-taking ratbags with dubious training who proudly shared these characteristics with their clients! One youth health worker was berated for wearing jeans. She was bemused by the possible response if it were to be discovered that she also had "hairy legs"!! Some community workers saw youth health workers as authoritarian, petty, humourless, boring, carping bureaucrats who couldn't possibly hope to develop understanding and empathy with young people! One youth worker when asked by a youth health worker why he rarely opened the youth centre for "drop-in" and yet failed to inform the young people that it was cancelled, replied that he preferred to be "spontaneous" than a "nit-picking bureaucrat"! Fortunately such encounters were not typical.

Valuable and enduring linkages and understandings were developed over time and referrals to youth health services flowed from youth centres whose workers had often previously had to deal single-handed with potentially disastrous situations. However, useful research being undertaken in other parts of the health sector was often not accessed or known by youth health workers because channels of communication were under-developed.

7.5 Co-location

Some youth health services have developed co-location models with youth centres so that youth worker-run recreation programs can run concurrently with health activities. This has been particularly useful for marginalised young people who may access a particular youth centre because they trust the resident youthworker but are unwilling to go elsewhere. In such a situation, young people have an opportunity to observe and assess the health service without committing themselves to anything. Co-location has meant that health and youth workers can see and understand the nature of each other's work. Communication and trust can develop and workers feel confident about referring to the other service.

In some youth health services, specialist workers such as lawyers, sexual assault counsellors, psychiatrists and dentists, social security consultants, education and accommodation workers, attend on a regular weekly or fortnightly basis or are on the staff. Being able to consult these workers at the youth health service helps to overcome some of the anxiety that can prevent young women and men accessing mainstream services. Specialist services such as "brokerage", accomodation and budgeting advice for young homeless people and a Juvenile Justice funded Pacific Island Resource Service are co-located on the premises of Penrith Streetwork Project.

Co-location of services saves time and frustration for clients. If the young person is seen as a client of "the centre" and record-keeping reflects this, there is then no need for them to repeat all aspects of their story over and over. Within the boundaries of confidentiality, co-location can make worker discussion, planning and referral relatively easy and encourage a holistic approach. Some young people have also described this set-up as more "natural." They say that it is not "natural" to compartmentalise problems "when you're feeling bad" and that "you don't want to be going here for one thing and another place for another thing"[6].

For many young people a holistic approach is not only more effective, it feels good as well.

7.6 Approaches to working with schools

One of the most frequent collaborations undertaken by youth health services is working with schools. This encompasses a wide range of collaborative arrangements. Partnerships can be developed within a school with individual teachers, with a range of stakeholders such as the student body, specific teaching departments such as Personal Development/Health/Physical Education (PD/H/PE), parent groups, Community Liaison officers, ancillary staff, school counsellors, student welfare teachers or, on a broader basis, with the Department of Education and Training, Catholic Education Office or Independent Schools Association. The style of work used by youth health services in schools generally falls into one of three categories or models - clinically-based, issues-based or settings-based. Traditionally, one or both of the first two models have been more frequently used than a settings-based model. However the settings-based approach is gaining currency with services such as Canterbury Multicultural Youth Health Service and Central Coast Youth Health Service working with the settings-based Health Promoting Schools Project (HPU) in their areas. Youth health service input into this project was initially slow but is now increasing, particularly in the area of mental health.

7.7 Clinical services

Clinical services are usually "school nurse" or doctor programs or a counselling or welfare-focused service perhaps incorporating the services of a youth worker or social worker. These workers may visit a number of schools on a regular basis to provide health services such as eyesight or pregnancy tests and make referrals when necessary. Liaison with parents and school personnel takes place and the health workers are identified by students as part of the school apparatus, similar to the school counsellor but with a physical rather than a psychological focus. Concerns expressed by young people about them are similar to those they have about school counsellors. These are mostly about issues of confidentiality and privacy[7].

7.8 Issues-based services - health education

There has been a small amount of inservice training of teachers by youth health workers on specialised issues such as HIV/AIDS. The Mid-North Coast Youth Mental Health Service works with schools to assist in developing policy on bullying and mental health issues. But by far, the major service provided in schools over the years by youth health services, has been health education delivered directly to students by youth health staff. Its aim is prevention through behaviour change. This is usually undertaken through the provision of information. Materials may be tailored to the needs and interests of the school and students, and can include leaflets, posters and videos. Small groups and other student-centred processes are often used. Harm minimisation or health enhancement is usually emphasised. A self-empowerment model may also be used in which there will be some skills training such as condom use, decision-making or negotiation. Sessions may also "explore" attitudes, "clarify" values or "raise awareness".

Health education sessions are usually based around single issues such as smoking, safe sex, healthy eating or alcohol. Decisions about content are often reactive and determined by what is seen as important by school staff or by the community and/or media. Health education sessions are usually delivered to schools on request. Coverage is therefore restricted to those schools aware of the service rather than on the basis of need. Total coverage of all the schools in an area would be impossible for most services.

Sessions are usually fitted into the school's regular 40-50 minute periods or take place on special Health Days. They are usually restricted to "one-off" sessions. There is rarely any follow-up. All students in a particular year may be selected to attend or only those categorised as "at risk". This can be a problem if the school singles out particular young people, or targets an inappropriate issue. For instance, one school targeted the Indo-Chinese boys for personal hygiene groups because some of the teachers felt that "they

smell!" The youth health service approached refused to cooperate, suggesting that if the school really wanted such groups they deliver them to all students[8]. Moral agendas often get tied up with health education.

Although there are sometimes student centred exercises within these programs, participation is limited. Attendance is compulsory and students do not usually participate in decisions about content, format or presentation style of sessions. Some teachers and health workers view these arrangements as pragmatic responses by overstressed, under-resourced schools to the mandatory requirements of the Department of Education and Training. Quality of teaching varies much more than it would with trained teachers since there is no teaching standard for health workers. Consistency in teaching is not achieved by replacing trained professional teaching staff with health workers whose expertise lies in other areas.

7.9 Issues with information-based health education

The information based model is probably the dominant paradigm in which health education is delivered by youth health services in schools and other venues. It is time and resource heavy and it is unlikely that providing information alone will result in changed health-related behaviour[9]. Research on smoking shows the shortcomings of an information-based model. Most smokers are well aware of the health risks of smoking yet this alone does not usually influence behaviour. Research shows the ineffectiveness of this approach[10,11].

Research into behaviour change has been accelerated in recent years by the global spread of HIV/AIDS and the need to promote changed sexual behaviour. Findings in this field also indicate that increases in information and/or changed attitudes (towards condom use, etc.) do not usually alone translate into changed sexual or drug use behaviour[12]. When the Department of Health and Social Security in the UK evaluated their mass information campaign which aimed to increase awareness of prevention measures, they found that although the public's levels of information about transmission and risk reduction had been increased, there were few reported changes in sexual behaviour[13]. There was, however, evidence of some higher levels of anxiety in the community that was an unintended outcome of the campaign[14]. The Grim Reaper campaign in Australia had similar unintended effects[15]. Studies done by the Centre for Sexually Transmitted Diseases amongst school students have regularly shown that most school students have high levels of knowledge about prevention but that does not translate into high levels of changed sexual practice[16].

Some useful skills can be conveyed through "group work" (assertiveness training, safe sex, self-awareness groups, etc), in schools. However, there are deficiencies stemming from their individualised focus.

> *"Thus, someone who has been through a self-awareness workshop or an assertiveness training course may feel more powerful at the end of it, but these feelings often disappear once the situation that led to the original feeling of powerlessness is re-encountered"*[17].

In the context of social disadvantage and inequality there is also evidence that change in a particular health behaviour will not be as significant as it would be in a privileged context[18]. Feelings of personal empowerment gained from such sessions must be sustained after the session/s have finished and across different contexts and situations. This approach puts a huge burden upon the individual who may be unable to withstand pressure arising from structural factors beyond their control. Taking this as personal failure can be health damaging. Blaxter points out that those most likely to blame ill-health on individual practices rather than social factors are the very people who practice risky behaviours and are at the lowest end of the class ladder. They already blame themselves. Those above them, in class terms, are much more aware of social factors and their role in health determination[19].

Some feminist writers have commented on the strains on women trying to be "assertive" or to "negotiate" in the face of massive structural inequalities that are reflected in their relationships[20,21,22]. Negotiation skills are not enough to challenge dominant institutionalised and internalised sexist practices. To rely primarily on information or personal empowerment- based models of health education is not consistent with the socially based approach to health discussed earlier and may be damaging to health. As we have seen, many factors

associated with health are not in the control of the individual and to act as though they are may be supporting tokenistic programs that do not work and that actually do harm by victim-blaming and detracting from the real determinants of ill-health.

7.10 A rationale for health education sessions in schools - health educators do it better?!

A rationale sometimes used is that health education, especially on sensitive topics, is more acceptable to young people when presented by "outside" service providers. This view has unsavoury undertones of what Howard Sercombe calls "authorised knowers", the assumption he attributes to some youth workers who feel that only *they* are able to have privileged access to the confidence of young people. It is not borne out in fact and depends on numerous factors that cannot be assumed. While some researchers report young people's preferred sources of information on safe sex and HIV/AIDS were health education and health professionals[23,24], this would depend on a lot of factors and cannot be assumed. Resourcing teachers to present up-to-date material by well-evaluated methods as part of a broader program addressing social and environmental factors underlying, reinforcing and supporting behaviours may be an optimal use of health service resources[25,26,27]. There are certainly shortcomings in the way sensitive topics are handled by some teachers and stories confirming this abound in health circles, making it tempting for youth health workers to want to intervene. Unfortunately it works both ways, and horror stories about health workers' teaching practices "do the rounds" of schools in the same way[28].

7.11 Another rationale for health education sessions in schools - "promoting the service"

Some feel that "going into schools" is an opportunity to promote the service and therefore increase access to it. The assumption is that the students will like the session and the workers and will want to see more of them! This may or may not be true. Students may equally decide, on the basis of the session, that they *don't* want to access the service. Sometimes such assumptions are based on naive views about young people who are assumed to be automatically enthralled by any presentation not done by a teacher! Enjoying a health education session does not necessarily mean that students will want to access the service, or that they actually learnt anything. And even if they did learn something, as we saw above, information, education and changed attitudes alone do not usually translate into changed health behaviours.

Promotion of the service is best done by doing just that! It can be done directly in the school either through speaking at assemblies or forums or distributing materials to staff. Invitations to staff meetings, Student Representative Councils and their equivalents and school assemblies are not difficult to obtain and these settings can be more conducive to the aim of promoting the service.

7.12 Settings-based school programs

An alternative model is one of health promotion which is not focused on groups or individuals but instead is "settings" based and comprehensive. The focus here is on the possibilities within a particular setting, in this case, the school, to build a supportive environment for health for all. In this model, an integrated "whole school" approach can form the context into which health education, reflecting research on effective teaching and learning strategies, may be appropriately placed.

Given adequate training in this method, youth health staff are able to collaborate with school staff and students to make a positive contribution. Coordination is needed to integrate various aspects of the school program and personnel into a coherent "whole school" approach, e.g. the formal curriculum, policies, practices, programs, psychosocial and physical environments, as well as partnerships between members of the school staff, students, parents, health and community organisations.

To facilitate a "whole school" approach, curriculum units can be developed, health workers can work in partnership with schools to develop the "whole school" approach, and professional development for teachers

can be instituted to equip them to deal with potentially sensitive issues that may arise. Health workers can assist in the development of appropriate resource materials for use in schools, assist schools develop an action plan, provide bibliographies of relevant materials and research findings, organise forums for discussion of health issues and approaches for school communities.

This approach seems to offer better health promotion and enhancement possibilities than an individual-focused, knowledge and attitude-based model. It utilises activities that are wide-ranging and may include attention to structural features in the school such as erection of shade structures for sun protection, compulsory hat policy, alteration of out-of-school hours to avoid full sunlight, encouragement of parent and community participation in activities, student participation in school decision-making, changed student-teacher interactions, and many other activities that use a variety of non-individually focused activities. When the focus is on individuals, there are always more individuals to take the place of those whose risky behaviour may have been (permanently or temporarily), changed. A settings-based or "whole school" approach is more likely to have an enduring impact.

The Health Promoting Schools Project is a well-known example of the settings-based approach[29]. Some recent mental health programs being introduced to schools are similarly based[30]. Emphasising the need for "a safe school culture," a recent report on same-sex-attracted young people has also recommended a whole school approach to sexuality issues[31].

One of the most popular topics for the more traditional style of health education in schools is sexual health. It is a controversial topic with potential for conflict with parents and sensational media attention! Nevertheless, studies show that young people suffer high levels of STDs and prevention in this area is urgent and necessary[32]. Whether this should take place in schools or not is debatable. The Canadian Taskforce evaluations showed that school-based sex education had little or no effect on adolescent sexual activity or pregnancy rates[33]. Probably the type of sex education referred to here is the traditional knowledge-based model although it is unspecified. Uneasy compromises characterise prevention initiatives in Australian schools. Some schools refuse to allow safe sex materials to be displayed at all, making any sort of minor, useful skills-based intervention difficult, e.g. condom familiarity workshops. Settings-based approaches have steered away from sexual health and often the field has been abandoned to outdated and discredited approaches.

In the US, however, some schools have initiated innovative sexual health promotion settings as part of their duty of care. Condom vending machines have been provided for students in some schools as part of an integrated, settings-based sexual health program. A comparative study was made of 12 schools in New York with 7000 students and 10 schools in Chicago with 6000 students. The New York schools have had a system-wide condom availability program since 1991. The Chicago schools have no program. Evaluations have shown that the students who had access to the machines were no more sexually active than those who did not, thus dispelling a popular belief that availability of condoms would result in increased sexual activity. Findings *did* show that the New York students who could obtain condoms at school were more likely to have used condoms at last intercourse. The authors conclude that condom availability programs are a low cost and appropriate addition to school-based prevention programs[34].

Schools are only one of the areas where there are exciting possibilities for collaborative programs. Other youth-related settings or even whole communities may be appropriate for the initiation of new projects. Projects developed in schools can be used in communities. Some U.S. programs using the work of Friere have developed participatory approaches in which young people become advocates for healthier schools and communities. Young people in these programs have devised a range of strategies for promoting health in their own communities which build on traditions of communal decision-making and collective responsibility[35]. Increased linkages between youth health services such as that being undertaken by the three South West Sydney services and with other health, community and government agencies and groups can help in the development of such projects.

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?

References: (Chapter 7)

1. The Canadian Taskforce on the Periodic Health Examination, *The Canadian Guide to Clinical Preventative Health Care*, Health Canada, Ottawa, Canada, c.1994, p. xxi
2. Personal communication with youth health worker, 1997
3. Personal communication with young person, 1995
4. Personal communication with young person, 1994
5. Personal communication, 1998
6. Personal communication with young person, 1998
7. Hillier, L., Dempsey, D., Harrison, L., Beale, L., Matthews, L., Rosenthal, D., *Writing Themselves In: A National Report on the Sexuality, Health and Wellbeing of Same-Sex-Attracted Young People*, National Centre for HIV Social Research, La Trobe University, Melbourne, 1998, p.56
8. Personal communication, 1994
9. WHO, *The Health of Young People: A Challenge and a Promise*, Geneva, May, 1993, p.66
10. Nutbeam, D., Haglund, B., Farley, P., Tillgren, P., (eds), *Youth Health Promotion: From Theory to Practice in School and Community*, London, 1991, pp. 4-9
11. WHO, op. cit., p. 59
12. Aggleton, P., Hart, G., Davies, P., (eds), *AIDS: Social Representations, Social Practices*, Falmer Press, New York, 1989, p.228
13. Department of Health and Social Security, 'AIDS, Monitoring Responses to the Public Education Campaign', February 1986 - February 1987, DHSS, London, 1987
14. Hastings, G., Scott, A., 'AIDS Publicity: Pointers to development', *Health Education Journal*, Vol. 46, No.2, 1987 pp.58-9
15. Mortlet, A., Guinan, J.J., Diefenthaler, I., Gold, J., 'The impact of the "Grim Reaper" National AIDS educational campaign on the Albion Street (AIDS) Centre and the AIDS Hotline', *Medical Journal of Australia*, Vol.148, 1988, pp.282-286
16. Lindsay, J., Smith, A., Rosenthal, D., *Secondary Students, HIV/AIDS and Sexual Health*, Monograph Series No 3, Centre for the Study of Sexually Transmitted Diseases, La Trobe University, 1997, pp.8-10
17. Aggleton, op. cit. pp. 225-6
18. Hastings, N., Schwieso, J., (eds.), *New Directions in Educational Psychology*, Volume 2, Falmer Press, London, Philadelphia, 1987
19. Blaxter, M., 'Who's Fault Is It? People's Own Conceptions of the Reasons for Health Inequalities', *Social Science and Medicine*, Vol.44, No.6, 1997, pp.747-756
20. Kippax, S., Crawford, J., Waldby, C., Benton, P., 'Women Negotiating Heterosex: Implications for AIDS prevention', *Women's Studies international Forum*, Vol.1, No.6, 1990, pp.533-42
21. Read, V., 'Women and AIDS', *The Australian Nurses Journal*, Vol.20, No.4, 1990, pp.22-223
22. Aggleton, P., Kapila, M., 'Young people, HIV/AIDS and the promotion of sexual health', *Health Promotion International*, Vol.7, No.1, 1992, p.49
23. Rosenthal, D., Smith, A.M., 'Adolescents, Sexually Transmissable Diseases and Health Promotion: Information Sources, Preferences and Trust', *Health Promotion Journal of Australia*, Vol.5 No.3, 1995, pp.38-44
24. Millstein, S.G., 'A View of Health from the Adolescent's Perspective' in Millstein, S.G., Petersen, A.C., Nightingale, E.O. (eds), *Promoting the Health of Adolescents*, Oxford University Press, New York, 1993, pp.97-118
25. Brooks-Gunn, J., Paikoff, R.L., '"Sex is a gamble, kissing is a game"*:* Adolescent Sexuality and Health Promotion' in ibid, pp.180-208
26. Leventhal, H., Keeshan, P., 'Promoting Healthy Alternatives to Substance Abuse' in ibid, pp. 260-284
27. Elliott, D.S., (1993), 'Health Enhancing and Health Compromising Lifestyles' in ibid, pp.119-145
28. Personal communication, 1998
29. South Western Sydney Area Health Service, *Health Promoting Schools Project, Discussion paper*, Unpublished report,

October, 1998

30. National Mental Health in Schools Project, Mind Matters, Project Brief, 1998
31. Hillier, et al, op. cit., p.73

32. Moore, S., Rosenthal, D., Mitchell, A., *Youth, AIDS and Sexually Transmitted Diseases*, Routledge, London, New York, 1996
33. The Canadian Taskforce on the Periodic Health Examination, *The Canadian Guide to Clinical Preventative Health Care*, Health Canada, Ottawa, Canada, c.1994, p.546
34. Lieberman, L., Ward, D., Freudenberg, N., Radosh, A., Des Jarlais, D., Guttmacher, S., *Condom availability in New York Public High Schools: Relationships to condom use and sexual behaviour*, American Journal of Public Health, Vol.87, No.9, 1997, pp. 1427-1433
35. Wallerstein, N., Sanchez-Merki, V., 'Freirean praxis in health education', *Health Education Research*, Vol.9, No.1, 1994, pp. 105-118

Chapter 8: Building the infrastructure

The processes described in previous chapters are unworkable without a strong infrastructure. For progress to occur, a supportive structure must be in place to address the needs and resource requirements of the youth health workforce. If support in this area is not available, it will be difficult, if not impossible, to continue to develop high standards of health care and innovative prevention projects.

8.1 Need for the development of research capacity and linkages between research and practice

Research on the social determinants of health, particularly in relation to youth health, is an important field with strong implications for the promotion of youth health. Sociological studies in gender, class, ethnicity/ATSIB and their relation to health are needed. Ethnographic studies of particular communities, e.g. in Western or South Western Sydney or in rural NSW would be useful. The development and expansion of research capacity in the area of social determinants of health is in urgent need of support by the NSW Health Department and Area Health Services.

While some work in this field is being done in universities and elsewhere, contacts between these and the youth health sector remain under-developed. A major need in youth health services is for the development of strong links between research and practice. Close and ongoing communication, partnerships and regular, formal contacts and exchanges with universities would make a huge difference in accessing as well as developing current research. Equally important is contact with specialised services within the health system. Building relations with Health Promotion units, Public Health and other research-oriented units that can assist in accessing up-to-date and useful research material is necessary. Guidelines could be developed about how services could be linked to other parts of the health system to break down the isolation and promote communication and interaction. Research-related links also need to be developed inter-sectorally, with community and other organisations so that an inter-change of ideas, information and research findings is encouraged. If links with universities and other research units could be developed to the same degree of refinement as the connections with grass-roots community organisations, services would be in a strong position to initiate and expand well-planned and balanced prevention projects with community involvement, as well as direct, individually based services.

8.2 Resourcing services to take time out from direct work

Accessing information and training is sometimes seen as a luxury in youth health services. Responding to the critically high demand for direct youth health services sometimes leaves little space for anything else. Particularly in smaller centres, staff are often unable to leave the premises so that even access to a library and the Internet becomes difficult. It is obvious what staff will choose when they feel they must make a choice between assisting with a possible crisis situation for a young person and obtaining information for program design. Resourcing services to undertake training in accessing research and to build links with relevant sections of the health system would ultimately benefit workers, young people and the health system.

Several health services have excelled in on-the-job training but it is unreasonable to expect the service to do this without due consideration to the resources (time, workers and funds) that will make this possible. Training undertaken by the health service must address the needs of youth health workers and recognise that many are not trained as health workers and therefore do not have familiarity with the formalities of the health system. Youth health workers have expertise in a wide range of areas and the interaction with other health staff can be beneficial for all. Breaking down occupational barriers can result in a rich interchange of ideas and innovation.

8.3 Training

There is little youth health-specific training undertaken by youth health workers. Many have not done formal study in a health related field and, if they have, it is often biomedical and has an individual rather than sociological focus. A number are trained in youth work or welfare, and are highly attuned to direct services with young people. But sometimes they are understandably ill-equipped to undertake the planning, design, implementation and evaluation of preventative health programs. These workers can be excellent in direct work with young people but without specific training, many will be set up to fail through no fault of their own. While the multi-disciplinary nature of youth health staffing adds strengths and creativity to the team, members need to be adequately trained for their jobs. At present, many are not. Thorough training and capacity building in all relevant aspects of health is essential. Sociological and cross-cultural training for all workers is necessary and should become a requirement of the job. Cultural training of all health workers by indigenous people on the impact of white invasion and its consequences and effects on health status is particularly important. There is a strong need for a broad sociologically-based youth health training course to be developed focusing on class, gender, ethnicity/ATSIB and their relation to health.

Comprehensive inservice training in youth health needs to be implemented urgently. Inservice training could include staff exchanges and secondments in which services would have the opportunity to learn from each other. Benchmarking through observing the practices of other services requires time, resources, contacts and communication. Ease of access to technology would assist in the process through access to databases, information exchanges and discussion sites. Access to the work of health and social researchers and practitioners can help prevent 're-inventions of the wheel' and repeats of failed initiatives and can promote building on the results of others and working collectively despite geographical barriers.

8.4 Planning

Workers need the ability to accurately define the socio-economic and health status of the population in the locality and in relation to a wider social context and to know where to obtain further information. Priorities should be set systematically within the service in accordance with local needs and Federal, State, local government and other strategic plans. Needs should be thoroughly researched so that information can be obtained from as many sources as possible. Approaches should be chosen on the basis of sound evidence. Access to evaluative studies comparing different approaches, methods and strategies are needed in all aspects of service delivery[1]. Teams need to know what works. When consensus replaces evidence based procedures as an assessment tool for program development, problems can arise.

Program design and implementation skills are necessary with clear and evaluable aims and objectives and performance monitoring built into programs from the start. A thorough understanding of the epidemiological and the social factors that affect the health of the community and the barriers to change that exist for that community is necessary. The ability to monitor health status and understand, analyse and respond to social issues is necessary as is the ability to develop partnerships and coordinate planning with a clear strategic focus.

Meticulous and documented program planning is important as is willingness to clearly and openly assess the value of what is achieved. Some programs currently operate without clearly documented aims and objectives or evaluation strategies making it difficult for workers to understand what it is they are expected to do, what they are currently doing, and why. The development of appropriate indicators which could assist services to evaluate the effectiveness of their work would be useful.

8.5 Youth health work is high stress

Youth health workers are exposed daily to the suffering and intense hardship experienced by many young

people. In rural areas the pressure of work can extend around the clock as workers and clients live in close proximity. Sometimes workers living in country areas can feel that they *never* leave the job[2]. The chronic anxiety engendered by regular exposure to a situation that sometimes appears insurmountable can cause high levels of stress in workers as well as young people. A pressure-cooker atmosphere does not make for a calm and studious work environment in which to develop planning skills. Most youth health workers are extremely dedicated and flexible. They will deal with the urgent needs of young people and try to fit in program planning and indirect tasks between the crises and the phone. This is not good practice in anyone's terms. Stressed, under-resourced workers trying to plan programs or learn new skills, while coping with the intensity of the situations they are called upon to address, will not aid the delivery of high quality programs. Eventually, the stress will take its toll on the health of "burnt-out" workers. Professional support and supervision are essential.

8.6 Policy development and documentation

Policy and procedures should be developed and documented by the youth health team with appropriate participation from the youth community. Documentation is particularly important in the area of client contact where there are legal implications relating to issues such as child protection and victims of crime compensation. The NSW Department of Health provides guidelines on legal requirements relating to youth health such as consent to medical treatment.

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!

References: (Chapter 8)

1. Knishkowy B, Palti H, 'GAPS (AMA Guidelines for Adolescent Preventative Services - American Medical Association Guidelines for Adolescent Preventative Services): Where are the gaps?', Archives of Paediatric and Adolescent Medicine, Vol.151, No.2, February, 1997, pp.123-128
2. Personal communication with rural youth healthworker

GLOSSARY

Advocacy speaking on behalf of someone who is unable or who would be disadvantaged by speaking for themselves.

Class refers to the relationships built around ownership and control of labour capacity and property (or the lack of these).

Community group of people who collectively identify on the basis of geography, shared interests, practices, religion, sexual orientation or ethnicity.

Critical consciousness or concientizacion Frierean methodology for teaching literacy by learning together through a problem-posing dialogue about the underlying causes of people's problems, the relationship of these to social and political oppression, the classes who benefit from it, and the means of changing this situation. The Frierean method is also widely used in health and related fields, particularly in Latin-America. It emphasises the need to address the social roots of problems.

Deficit theory theory which attributes lack of attainment in spheres such as education, health, employment, etc, to a socially and historically decontextualised personal inadequacy.

Drop-in time set aside for informal, recreational access for young people in a youth centre or service.

Empowerment the process in which individuals and/or communities take control of and change their lives and environment.

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.

Equity equality of access to services, resources, rights and opportunity.

Gender Socially constructed practices, expectations, characteristics, etc. related to biological sex e.g. "male" and "female" are biological sex categories; "masculine" and "feminine" are gender categories.

Harm reduction or minimisation Usually refers to A&OD policy aimed at promoting practices which reduce the harm associated with the use of alcohol and other drugs, particularly those drugs that are injected. Strategies cover a continuum which may include abstinence, use of non-injecting methods of administration, provision of safe injecting environments, supply of new injecting equipment, etc.

Health education Learning experiences designed to facilitate actions conducive to health.

Health promotion Combination of education and environmental supports for actions and living conditions conducive to health

Infotainment – entertainment and/or advertising masquerading as news.

Middle class Relating to dominant cultural values and social practices regarded as the norm in Western capitalist societies.

Outreach Provision of services to groups or individuals in venues frequented by these groups or individuals rather than in the service provider's premises.

Participation	a continuum ranging from active involvement to sharing of power and responsibility. Based in social justice approaches and/or in educational psychology that says that people are more likely to learn if they are actively involved in the education process.
Person of non-English speaking background	a person or relative of a person brought up in a country where English is not the first language .
Queer	Sexualities outside of the heterosexual mainstream.
"Race"	a discredited theory which categorises people according to certain genetic characteristics and holds that these characteristics entail certain personal and/or social characteristics. The characteristic usually singled out is skin colour. Ignores the fact that there is more genetic diversity amongst people of the same skin colour than those of different colour.
Racism	the wielding of power held by a dominant group to discriminate against another group deemed inferior on the basis of their "race".
Social determinants of health	the relationship in which social inequality has been shown to affect health, not only in relation to absolute poverty and deprivation but also in relation to other aspects of social inequality such as degrees of control over life situation.
Social justice	the equitable distribution of political, economic and social resources and the protection of human rights.
Working class	the class which depends on selling their labour power, (whether they are actually in employment or not).
Youth-friendly	positive actions and images which promote accessibility for young people.

LIST OF ABBREVIATIONS

AAAH Australian Association of Adolescent Health

ACON AIDS Council of NSW

A&OD Alcohol and Other Drugs. Also known as D&A (Drugs and Alcohol). The latter definition, however, has been seen to imply that alcohol is not a drug.

ATSIB Aboriginal and Torres Strait Island Background

CHAIN Community Health for Adolescents in Need

CMYHS Canterbury Multicultural Youth Health Service

CODA Children of Deaf Adults

FLYHT Fairfield-Liverpool Youth Health Team

HIV/AIDS Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

IDU Injecting Drug User

IHSHY Innovative Health Services for Homeless Youth

LGA Local Government Area

MYTH Meeting of Youth Teams in Health

NESB Non-English Speaking Background

NGO Non-Government Organisation

NSP Needle and Syringe Program

NSW New South Wales

PD/H/PE Personal Development, Health, Physical Education

TAFE Technical and Further Education

WHO World Health Organisation

APPENDIX 1 - PROFILE OF YOUTH HEALTH SERVICES

Canterbury Multicultural Youth Health Service (CMYHS)

Belmore Youth Resource Centre
Building 3, Redmond Parade,
Belmore NSW 2192

Telephone: **(02) 9718 1485** (Youth Centre)
(02) 9787 0600 (Community Health)
Pager: (02) 9962 9914
Fax: (02) 9787 0700

Canterbury Multicultural Youth Health Service targets 12 – 24 year-old homeless or at risk people living in the Canterbury LGA. It is part of Central Sydney Area Health Service and offers counselling, information and referrals, support, group work, health promotion, access facilitation and drop-in.

Staff

Youth Health Worker/Social Worker F/T
Clinical Nurse Specialist (Youth health) F/T

Cellblock Youth Health Service

142 Carillon Avenue
(cnr Church Street)
Camperdown NSW 2050

Telephone: **(02) 9516 2233**
Fax: (02) 9516 3591
Email: cblock@comcen.com.au

Cellblock is part of Central Sydney Area Health Service. Services offered include medical care, dental assessment, individual counselling, support and advocacy, artistic and cultural programs, health education and health promotion programs, health/arts projects, consultancy and training to youth services, community development, policy and political advocacy, NSP. Target groups are homeless and at risk young people aged 12 - 20 years.

Staff

Program Manager F/T
Administrative Officer F/T
Doctor F/T
Social Worker/Psychologist (Male-identified) F/T
Social Worker/Counsellor F/T
Music Artist F/T
Health Promotion Officer (HIV/AIDS/Hepatitis C) F/T
Health Promotion Officer (Arts/Cultural) F/T
Dental Therapist P/T
Visual Artist F/T

Central Coast Youth Health Service

11 Ward Street, Gosford
P O Box 361,
Gosford NSW 2250

Telephone: **02 43 20 2856**
Fax: 02 43 20 2057

The Central Coast Youth Health Service operates from the Youth Health Centre, located across Ward Street, Gosford, from Gosford Hospital. Central Coast Youth Health provides young people, their families, carers and people working with them with assessment, referral, brief counselling, outreach, group programmes, health information and health education. As well as direct services, it also addresses health issues by health promoting programmes. The Youth Health Outreach Team (Y'HOT) targets health issues among 12 - 24 year old young people through outreach, assessment, referral and health education. The Aboriginal Youth Health Worker targets health issues among 12 - 24 year old Aboriginal people through outreach, assessment, referral and health education. The Youth Health counsellors offer assessment, referral and brief intervention counselling to 14 to 19 year old young people. It is recognised that some young people have greater health needs, with special attention being given to young Aboriginal people and young people who are forced to live independently.

Staff

Receptionist/secretary F/T
Service director F/T
Aboriginal youth health worker F/T
Youth health nurse -Y'HOT F/T
Youth health educator - Y'HOT F/T
Social worker F/T
Social Worker P/T
Psychologist P/T

CHAIN
(Community Health for Adolescents in Need)

1a Denison Street
Wollongong
PO Box 1614
Wollongong NSW 2500

Telephone: **0242 26 5816**
Fax 0242 272424
Email: chain@1earth.net
Website URL: www.1earth.net/~chain

CHAIN is a non-government organisation providing primary health care, clinical services, and programs including ante-natal programs. Target groups are 12 - 20 year old homeless, at risk and disadvantaged young people.

Staff

Coordinator F/T
Nurse F/T
Nurse F/T
Nurse P/T
Youth Worker P/T
Youth Worker P/T
Cleaner P/T
Administrative Officer P/T

The Corner Youth Health Service

101 Restwell Street
(Cnr. Macauley Avenue)
Bankstown NSW 2200

Telephone: **(02) 9796 8633**
Fax: (02) 9707 2344

The Corner is a community-based youth health service. It is part of the Bankstown Health Service which is a unit of the South Western Area Health Service. Services include clinical services, referrals, health promotion, community development and access services, group programs. Its target groups are 12 - 18 year olds and their families/carers living in the Bankstown Local Government Area (LGA). Target groups for health promotion, health education, community development and access also include the general community of the Bankstown LGA and other government and non-government service providers. The Psychosis Early Intervention Service located at The Corner targets young people aged 12 - 24 years living in the Bankstown LGA.

Staff

Service Manager, Full Time (F/T)
Administration Officer (F/T)
Psychologist/Bilingual Counsellor (F/T)
Vietnamese Ethnic Health Worker (F/T)
Health Promotion Officer (F/T)
Psychologist (F/T)
Social Worker (F/T)
Child & Adolescent Psychiatrist (Thursday pm)
Psychiatric Registrar (Tuesday & Thursday pm)

Early Intervention Psychosis Program
Program Coordinator (F/T)
Psychologist (P/T)

Adolescent Depression and Suicide Prevention Program
Psychologist (P/T)
Social Worker (P/T)
Psychologist/Bilingual Counsellor (as above)

CROSSROADS Shoalhaven Youth Health Service

2 Lawrence Avenue
Nowra
PO Box 55
Nowra NSW 2541

Telephone: **(02) 4423 1784**
Fax (02) 4423 3955
Email: youthhealth@shoal.net.au

Part of Illawarra Health Service. Services include counselling, health promotion, referral, primary care, outreach, GP, education and community development. Target groups are 12 - 24 year olds living in the Shoalhaven LGA who are homeless or at risk of becoming homeless.

Staff

Counsellor F/T
Counsellor F/T
Primary care worker F/T
Doctor P/T

Fairfield Liverpool Youth Health Team (FLYHT)

28 Bonnyrigg Avenue
Bonnyrigg NSW 2177

Telephone: **(02) 9823 8299**
Fax: (02) 9823 5916

FLYHT is part of South Western Sydney Area Health Service. It targets 12 –20 year-olds who live in or frequent the Fairfield and Liverpool LGAs. Services offered include drop-in medical, counselling, nursing and referral services, outreach, access, advocacy, resources, networking and community development, health promotion and education, NSP, therapeutic and support groups and mental health services.

Staff

Service Manager F/T
Administrative Assistant F/T
Youth Health Education Worker F/T
Youth Health Education Worker F/T
Youth Health Education Worker F/T (Arts)
Youth Health Education Worker F/T (Khmer)
Youth Health Education Worker F/T (New Arrivals)
Youth Health Education Worker F/T (Aboriginal)
Youth Health Education Worker P/T (Arabic-speaking)
Youth Health Nurse F/T
Doctor P/T
Youth Health Counsellor F/T
Youth Health Counsellor F/T
Youth Health Counsellor F/T
Youth Health Counsellor (Bi-lingual) P/T
Youth Health Outreach Worker F/T
Youth Activities Worker (Casual)

High Street Youth Health Service

65 High Street
Harris Park NSW 2150
c/o Westmead Hospital
Westmead NSW 2145

Telephone: **(02) 9687 2544**
Fax (02) 9687 2731
Email: high_st@hotmail.com

High Street is part of Western Sydney Area Health Service. It targets young people aged 12 - 25 years from Parramatta, Holroyd and Baulkham Hills LGAs and focuses on those experiencing homelessness or risk of homelessness. Services offered include medical, counselling, drug and alcohol, creative arts, education, health promotion, mental health, drop-in, group work, key work, crisis intervention, intake and referral, basic needs (food, showers, laundry), community development, special projects, staff training and supervision.

Staff

Coordinator F/T
Administrative Assistant P/T
Administrative Assistant P/T
Medical Officer P/T
Sessional Medical Officer P/T
Sessional Medical Officer P/T
Sessional Medical Officer P/T
Sessional Medical Officer P/T
Clinical Nurse Specialist F/T
Counsellor F/T
Counsellor F/T
D&A Counsellor P/T
D&A Counsellor P/T
Education worker F/T
Drop-in worker P/T
Mental health/worker-on-duty P/T
Health promotion officer F/T
Groupwork Coordinator P/T
Creative arts worker F/T
IT development officer P/T

Muralappi

The Settlement
Neighbourhood Centre
17 Edward Street
Chippendale
PO Box 854
Strawberry Hills NSW 2012

Telephone: **(02) 9698 3087**
(02) 9698 3199
Fax: (02) 9318 1008

Muralappi is a youth health project promoting health through cultural awareness, health education and cultural camps. Its target group is 16 - 24 year-old indigenous young people.

Staff

Coordinator F/T
(Casual staff employed for camps)

Penrith Streetwork Project (PSP)

3 Worth Street
Penrith NSW 2751
PO Box 869
Penrith NSW 2751

Telephone: **(02) 4721 7750**
Fax: (02) 4722 8029

PSP targets homeless and at risk young people affected by alcohol and other drugs. Services offered include general clinical services, ante and post natal clinics, support/advocacy for all health issues, referrals and liaison with local agencies. PSP also auspices the Pacific Island Resource Service for Pacific Island youth associated with the Juvenile Justice system.

Staff

Coordinator F/T
Adolescent Nurse F/T
Youth Worker F/T
Youth Worker (Relief) P/T
GP (Ante-natal) P/T
GP (General) P/T

TraXside Youth Health Service

4 Langdon Avenue
Campbelltown NSW 2560

Telephone: **(02) 4625 2525**
Fax: (02) 4625 2547
TTY: (02) 4625 4185

TraXside is part of South Western Sydney Area Health Service. Services include advocacy and support, sexuality and reproductive health, counselling, information and referral, groupwork, NSP, library and Internet access, health education and promotion, work with schools, resource development. TraXside has an outreach team based at the Wollondilly Community Health Centre allocated to work specifically with young people from Camden and Wollondilly LGAs. Target groups include young people aged 12 - 25 living in the Macarthur region (Campbelltown, Camden and Wollondilly LGAs)

Staff

Service Manager F/T
Generalist Counsellor F/T
Generalist Counsellor F/T
Counsellor (focus on suicide prevention and crisis counselling) P/T
Counsellor P/T
D&A Counsellor F/T
Health Education Officer F/T
Health Education Officer F/T
Health Education Officer P/T
Health Education Officer P/T
Nurse F/T
Disability Access Project Officer P/T
Mobile Outreach worker P/T
Mobile Outreach worker P/T
Administrative Officer P/T
Administrative Officer P/T

WAAT (Western Area Adolescent Team)

Buran Close Mt Druitt
PO Box 47
Mt Druitt NSW 2770

Telephone: **(02) 9881 1230**
Fax: (02) 9625 9110

Part of Western Sydney Area Health Service. Services include outreach bus and provision of health services throughout the area, counselling including drug and alcohol, group work, NSP, health education, drop-in, clinical services (sexual health doctor, school nurses, sexual health nurse), information, referral and support, health promotion projects. Target groups are young people aged 12 - 20 years in the Blacktown LGA. NSP and the outreach bus service young people aged 12 - 24 years in the Blacktown LGA.

Staff

Service Manager F/T
Administrative Officer F/T
School Nurse F/T
School Nurse F/T
Sexual Health Nurse F/T
A&OD Counsellor F/T
Counsellor F/T
Counsellor F/T
Outreach Worker F/T
Outreach Worker F/T
Mental Health Promotion Nurse F/T
Health Promotion Officer F/T
Health Promotion Officer F/T
Doctor P/T

The Warehouse Youth Health Centre

13 Reserve Street
Penrith NSW 2750

Telephone: **(02) 4721 8330**
Fax: (02) 4731 6787

The Warehouse is a non-government organisation providing clinical services (doctor, nurse, sexual and reproductive health), counselling, health promotion, outreach, NSP and special projects. Target group is young people aged 12 - 25 living in the LGAs of Penrith, Hawkesbury and Blue Mountains

Staff

Coordinator F/T
Administrative Officer F/T
Health promotion Officer P/T
Health promotion Officer P/T
Special Projects Officer P/T
Nurse F/T
Nurse P/T
Doctor P/T
Counsellor P/T
Receptionist P/T
Mobile Outreach Worker P/T
Mobile Outreach Worker P/T

Young Person's Mental Health Team

Coffs Harbour Base Hospital
Locked Bag 812
Coffs Harbour NSW 2450

Telephone: **(02) 66591 405**
Fax: (02) 66591 423

The Young Person’s Mental Health Team is part of the Mid-North Coast Area Health Service. It targets 0-25 year-olds and their families/carers living in the Mid-North Coast area. Services offered include assessment, support, health education, health promotion, community development, referral, networking and liaison, risk assessment, crisis intervention, outreach, ongoing case management.

Staff

Psychologist F/T
Psychologist P/T
Psychologist P/T
Social Welfare Worker F/T
Child and Adolescent Nurse F/T

APPENDIX 2 - THE AUGUST CONSULTATION MATERIAL

The August 1998 Models of Better Practice Consultation

The following material is an interpretation of discussion at the August consultation as well as discussions with youth and health workers and young people. I have attempted to draw out themes that indicate the thinking behind the "elements of better practice" noted at the consultation and behind many youth health initiatives. The "elements of better practice", were directly transcribed from the brainstorm and small group notes from the consultation. Their categorisation under themes, the following notes on themes and the elaboration on these themes is my own interpretation. While some of this material was not directly discussed at the consultation, I think it underlay the consultation discussion.

The need for social justice for young people was a strong theme that emerged from the consultation and discussions. Discussion at the consultation centred on the social disenfranchisement of young people and its effects. Some major health effects or consequences of disenfranchisement noted both in discussion and in the literature are feelings of powerlessness and alienation. Youth health workers have expressed the view, whether fully articulated or as a "gut feeling", that social justice initiatives are an appropriate means to address these feelings and their health implications

Youth health services address issues in many ways depending on their particular social environment. However, a common theme running through the processes discussed in the consultation was about addressing youth health issues through holistic services and programs and through increasing access and equity both to health services and in the wider society. I think that the above practices characterise services' responses to the consequences of young people's disenfranchisement.

Some related points about health and young people's relationships with health services that underlay discussion at the consultation included:

a) The individual and the social are inextricably linked.

b) Health is a complexity of interacting factors, (as in the World Health Organisation definition of health as physical, social and psychological wellbeing, not just the absence of disease).

c) Powerlessness and alienation are not conducive to health.

d) Social justice initiatives can address the broader social determinants of ill-health.

e) Young people do not readily access mainstream services, marginalised young people even less so.

Addressing Powerlessness and Alienation through Social

Justice

The concept of empowerment as a means of addressing powerlessness and alienation is integral to social justice. Social justice encompasses the following principles: empowerment through access to resources, services, rights and opportunities for participation and consultation; and equity in the distribution of these.

Social Justice Approaches - Access, Equity, Holism

I have divided the list of "elements of better practice" from the workshop into 4 thematic categories. (Many of the elements fit into more than one category.) 3 of the categories reflect social justice approaches used by services and the fourth one relates to issues of service development.The categories and their relationship to social justice are as follows:

Access

Access to resources, services, rights and opportunities for involvement is an important component of empowerment. Youth health services empower young people not only by attempting to provide a place within which they can feel relaxed, safe, engaged, "listened to", respected and in which they have some control over what happens, but in enabling access to a variety of services "outside" that can increase autonomy.
Accessibility is about creating a service which is:

a) available at times suitable to young people

b) easy to get to (geographically accessible premises and/or outreach service)

c) culturally appropriate on a variety of levels relating to ethnicity, gender, sexuality, indigenousness, disability and "youth culture"

d) "youth-friendly" and respectful in its engagement strategies

e) a deliverer of services and programs that are relevant to young people and delivered in a youth-friendly way.

f) confidential and respectful of privacy

g) free

h) consultative with young people and their communities

i) an advocate for young people in the wider society

j) A promoter of access for young people in other services

k) Enabling of youth participation

Equity

Equity is about promoting access, (as above), for **all** young people, including those that are doubly disempowered as a result of their membership of marginalised populations such as:

- socio-economically disadvantaged groups
- Aboriginal and Torres Strait Island people
- NESB communities
- homeless youth and those at risk of homelessness
- young women
- gay, lesbian and bi-sexual young people
- disabled young people
- socially isolated young people.
- youth with special needs
- young people from rural areas

Holism

Disempowerment is a complex state affecting young people on many levels and in every area of their lives. It has physical, psychological and social dimensions and as such is needs to be addressed in ways which acknowledge the young person in context, that is, holistically. The range of programs and services delivered by youth health services to ensure a continuum of care and address disempowerment in a holistic way include:

- advocacy
- clinical services
- health promotion
- employment and accomodation assistance
- arts and other cultural programs
- provision of basic needs
- recreation programs
- harm minimisation programs
- group programs

Service Development

This section refers to the structural and resource base required to support the above approaches. In a way, this is the most vital category of all since the approaches discussed above are built on this foundation. This section incorporates industrial issues, staffing, management, research, training and professional development, planning, evaluation, etc.

Elements of Better Practice noted at August workshop, categorised according to the above themes.

Access

- Peer education
- Non-judgmental
- Flexibility
- Cultural sensitivity - Koori cultural sensitivity
- Service provision guided by client
- -self-determination
- -service based on needs and rights
- Mutual respect
- Education on both sides
- Non-stereotyping
- Health is more (bigger than) the Health Department
- Youth friendliness
- Engagement
- Access - hours, physical, crisis, availability, outreach, multi-access points
- Worker-on-duty system
- Re-orient mainstream services to young people
- Affirmation of youth culture
- People make it work - relationship between workers and young people
- Co-location and appropriate services, workers come to young people, e.g. psychiatrist coming to health centre one day per week
- Facilities and environment reinforce value of young people
- Harm minimisation
- Health literacy
- Informed consent
- Participation
- Choice promotion
- Advocacy
- Sense of ownership

Equity

- Quality improvement
- Community development/work
- Social justice
- Choice promotion
- Rights and responsibilities
- Non-judgmental
- Cultural sensitivity – Koori cultural sensitivity
- Access - hours, physical, crisis, availability, outreach, multi-access points
- Community consultation
- Young people paid
- Worker-on-Duty system
- Re-orient mainstream services to young people
- Affirmation of youth culture
- Service provision guided by client; self-determination & service based on needs and rights
- Mutual respect
- People make it work - relationship between workers and young people
- Evaluation and improvement

- Education on both sides
- Non-stereotyping
- Confidentiality
- Anonymity
- Empowerment, confidence building
- Health is more (bigger than) the Health Department
- Consistency of work practice within agreed framework
- Youth friendliness
- Advocacy
- Accountability to community of interest, young people, common organisations
- Co-location and appropriate services, workers come to young people, e.g. psychiatrist coming to health centre one day per week
- Safety for workers and young people
- Facilities and environment reinforce value of young people
- Harm minimisation
- Health literacy

Holism

- Health enhancement
- Health promotion
- Community development/work
- Participation
- Social justice
- Viewing young people as spiritual, physical, emotional, psychological, community, cultural, environmental, legal.
- Empowerment, confidence building
- Health is more (bigger than) the Health Department
- Continuum of care
- Advocacy
- Community consultation
- Intersectoral work
- Working in other professional cultures, e.g. Schools, Juvenile Justice
- Case management – shared, not key worker
- Combination formal and informal
- Multi-disciplinary, team work
- Co-location and appropriate services, workers come to young people, e.g. psychiatrist coming to health centre one day per week

Service Development

- "Sucking up"
- Outside supervision

- Engagement and ongoing management of clients
- Internal referral system
- Assessment protocols
- "Resource smart" (hustling)
- Good management/management committee
- Data collection - technology
- Management
- Planning
- Outcomes/impact
- Policy and procedure
- Reading
- Research and evaluation
- Self-education
- Professional development - training, support, and supervision
- Regular debriefing
- Evaluation and improvement
- Multidisciplinary, team work
- Co-location and appropriate services, workers come to young people, e.g. psychiatrist coming to health centre one day per week
- Safety for workers and young people
- Facilities and environment reinforce value of young people
- Clarity of goals
- Attention to industrial issues, pay and conditions, etc
- Opportunities and channels for communication within health system and outside, e.g. conferences