A Co-ordinated Approach to Improving Adolescent Health in Rural South Australia

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INTRODUCTION

In early 1999 Yorke Peninsula, Barossa and Mid North Rural SA Divisions of General Practice put together an application for a grant through the Department of Health and Aged Care and Australian Divisions of General Practice Innovative Funding Pool. The Divisions had recognised injury prevention, particularly in the adolescent population, as a key issue to be addressed. This was supported by the fact that injury prevention and mental health are both national health priorities and the local Regional Health Services had identified mental health, injury prevention and youth health as regional health priorities. Each of the three DGPs had previously done some project work addressing injury prevention/risk management in young people.

To confirm any anecdotal information a literature review revealed that in Australia, young people are the only age group whose psychosocial health status has not significantly improved for the past 40 years. For most young people, adolescence is a time of growth and development, not of illness, however, when illness occurs it is often related to the increased risk-taking behaviour that is part of the normal adolescent process of exploration. Unfortunately, exploration can be dangerous with the major causes of death in young adults being accidents, poisoning, violence, suicide and cancer. In 1996, 71% of all deaths at age 15–24 years were caused by injury, which includes traffic accidents, sporting accidents, peer group violence and self-harming behaviours.

A significant cause or contributor to adolescent morbidity and mortality has been identified as a lack of accessibility for young people to health services. This is exacerbated in rural areas where there are often no permanent community health services and medical services provided by visiting or solo GPs. Access to health care is especially important for society’s adolescents to help modify risky behaviours and promote healthy habits. Health knowledge, attitudes and behaviours developed during adolescence relate to health outcomes throughout adulthood. The Society for Adolescent Medicine has identified criteria to improve adolescent access to health care and includes availability, visibility, quality, confidentiality, affordability, flexibility and co-ordination. Proposals to improve access must address the unique needs and characteristics of adolescents.

The National Health Policy for Children and Young People places particular emphasis on the role of primary health care providers for adolescents. But many adolescents are extremely anxious about visiting doctors, especially with regard to sensitive issues such as sexual and mental health problems. GPs are the ideal primary health care providers.
for adolescents and could meet the health care requirements of most adolescents if current barriers were overcome.

The primary aim of the project “A co-ordinated approach to improving adolescent health in rural South Australia” is to break down some of the barriers between adolescents and GPs and strengthen the relationship between them. This is currently being achieved through a variety of strategies that are described in the forthcoming text. The project is two third of the way through and preliminary evidence collected as part of the evaluation suggests that the project team are well on the way to achieving the desired outcomes.

**METHODOLOGY**

**Setting up the project**

When the project was funded it was agreed that one DGP would be the fund holders with each DGP employing their own project officer. The Inter-Divisional Co-ordinator position was advertised across the three DGPs as the appointment of an appropriate person was a key factor to the projects success. Involving three DGPs in one project also meant that the project management structure had to be innovative, and flexible. Challenges around communication and lines of accountability in the early days of the project resulted in the development of the following management structure, which has since served the project well.

**Project management structure**

The Tri-Divisions Group already existed as a networking group for the three DGPs meeting bi-monthly, and is the overall managing group for the project. The Inter-Divisional Co-ordinator (IDC) and GP Manager of the project provide a written or oral progress report to the members of this group at each meeting, and any issues requiring attention within the project are discussed.
The GP Manager was one of three GP Directors on the Tri-Divisions Group at the commencement of the project and was nominated for the role of GP Manager by her colleagues on that Group. Her role is to oversee and assist the IDC with the running of the project.

The Inter-Divisional Co-ordinator is the project co-ordinator across the three DGPs. Their role is to provide support to the project officers by developing generic resources to be used in each region; assist in the organisation of regional educational activities; access resources for distribution to each region; liaise with the external evaluator; compile reports for the funding body; and, organise monthly meetings between themselves, the GP Manager, external evaluator and the project officers.

A Project Officer was employed in each of the three DGPs to:

♦ develop and maintain links between local schools and their representatives, participating GPs, allied health workers and interested community members through the formation of a steering committee;

♦ co-ordinate educational activities for service providers and parents; and

♦ co-ordinate both school and practice visits involving the school and medical practice.

Local considerations meant that the profile of each steering committee was different. The Yorke Peninsula DGP had a relatively large steering committee involving local GPs, school staff (counsellor, deputy principal, and chaplain,), Child and Adolescent Mental Health Service (CAMHS) worker, Family and Youth Service (FAYS) worker, Drug and Alcohol Service (DASC) nurse, Mental Health Nurse, Department of Education Employment and Training (DEET) worker, project co-ordinators from other youth projects running in the area, and the Division project officer. A slightly smaller committee was formed in the Mid North DGP with less health workers, however also involving students, parents and a local minister of religion; and a more intimate steering committee was formed in the Barossa DGP involving only school staff, GPs and the project officer.

An external evaluator from the Centre for Health Program Evaluation at the University of Melbourne was sourced to assist in the evaluation of the project with approximately 10% of the total project funds being allocated to evaluation. The evaluator’s role is to develop evaluation tools to assist in the evaluation of the project, and also to collate and translate data collected into a meaningful form. The evaluator has also contributed greatly to the development of the evaluation skills of the project team.

**Project implementation**

The implementation of the project consisted of 6 key areas:

♦ education sessions for service providers;

♦ schools program;

♦ promoting a youth friendly general practice;

♦ parent education;
♦ development of new partnerships between GPs, schools and the community; and
♦ resource development.

**Education sessions for service providers**

The aim of the education sessions was to provide education and training to GPs, allied health workers, school staff, and interested community members in the area of adolescent health. The majority of education sessions were delivered separately in each DGP, with several activities being facilitated collectively for all those involved in the project.

Education sessions in each DGP were tackled differently to meet local needs. The DGPs with a large steering committee in place planned interactive sessions around the needs of the steering committee, as the majority of these formed the audience at these sessions. Practice staff was also invited to attend to assist them in promoting a youth friendly general practice, as were other sectors of the community that deal with youth, such as scout and guide leaders. The DGP with a smaller steering committee conducted one interactive education session, and provided written materials to all GPs to assist them to increase/reinforce their general knowledge of adolescent health issues.

Topics for local education sessions included:
♦ engaging and maintaining relationships with young people in a busy practice;
♦ effective interaction with young people; and
♦ youth depression and suicide.

One inter-divisional education session has been held thus far, and a further two are planned prior to the completion of the project. These sessions are generally for GPs across the 3 DGPs only (approximately 107), however school counsellors and CAMHS workers were invited to attend the first session to provide a venue for networking.

Continuing medical education (CME) points are applied for to the Royal Australian College of General Practitioners for each inter-divisional CME so that GPs can gain professional development credit for their attendance. The topic of the first session was “communicating with adolescents and other health care professionals” and “disclosure of sexual assault” is the topic planned for the second session.

Discussions have also been held with Second Storey (Adolescent Health Service in Adelaide) and the Adelaide Women’s Health Centre in regard to GPs visiting these centres and sitting in on consultations with experienced GPs who consult with adolescents on a day-to-day basis. The aim of these sessions will be to assist the rural GPs involved in the project to gain a better knowledge of adolescent health issues, and how to address these issues in the general practice setting.

**Schools program**

Following the initial contact with the school and the development/re-establishment of partnerships through steering committee meetings, a timetable for GP visits to the local school was drawn up (either by the project officer or the GPs and school counsellor involved). The number of GPs involved in the project in each region varied from 2 to 4,
as did their time commitment to the project, and hence the number of school visits they were prepared to do. The number of school visits within each region (of approximately 1 hour duration) ranged from 15 to 32.

Preceding the GPs visits to the school, students were surveyed to ascertain what topics they would like the GP to discuss (either by written questionnaire or focus groups run by their peers). The resultant topics were then used as a guide by the GPs when planning their lessons.

Keeping in line with the flexible nature of the project, other positive activities were also undertaken in the different DGPs as a result of the project. These included the DASC nurse visiting the school every 2 out of 3 weeks in conjunction with the GPs in the Mid North, lunchtime sessions at the school in the Barossa whereby a local GP and school counsellor were available to chat to students, and health screening days for Aboriginal students were held at the Maitland Area School on the Yorke Peninsula.

Promoting a youth friendly general practice
The promotion of a youth friendly general practice was broken down into 3 activities:

♦ student visits to the local general practice;
♦ the endorsement of a GP consultation protocol; and
♦ the development of a youth friendly practice manual (including a youth friendly general practice checklist and GP consultation protocol).

The student visits to the local general practice were organised by the project officer in consultation with the school and general practice. The aim of these visits was to assist students to feel more comfortable with the process and environment of seeing a GP; for students to develop and build relationships with the general practice staff and GPs; and to inform students on issues such as general practice procedures, Medicare cards, billing, and confidentiality.

The endorsement of a GP Consultation Protocol was completed via teleconference linking GPs from each of the practices involved. A number of existing protocols were sourced by the IDC and disseminated to all GPs for their perusal. The HEADSS (home, education/employment, activities, depression/drugs, sexuality, suicide) assessment tool was endorsed by the GPs as the most suitable tool for assessing an adolescent’s health status. Stickers with the acronym were developed for placing on adolescent patient files, and laminated cards with the full version, and smaller cards with the acronym were developed as a prompt for GPs. The HEADSS assessment was then “launched” to all GPs in attendance at a Tri-Divisions CME organised as part of the project.

The Youth Friendly Practice Manual is yet to be developed and will include policies for dealing with youth in the practice, a youth friendly practice checklist (to be developed using evaluation data of the student visits to the general practice) and the GP consultation protocol. It will also include information on agencies that provide training in the area of youth health.
Parent education
An informal parent education forum was run in all three DGPs. Two DGPs held the parent evening on the same night as the high school social, providing many parents with an opportunity to attend the parent evening after dropping their child off at the social, and saving them two trips into town!

A panel of speakers was utilised involving local GPs, CAMHS workers, DASC nurses, youth workers, DEET behaviour attendance officers, school chaplains and school counsellors. The intention of the evening was to assist parents to better understand the issues that face their children during adolescence. Take home resources were also available for parents.

Development of new partnerships between GPs, schools and the community
New partnerships were developed through the formalisation of steering committees, and attendance at education sessions. The project officer contacted potential members of the steering committee and invited them to be involved in the project.

A youth health management protocol is also to be developed and formalised as part of the project. This protocol will document the referral processes in existence between allied health professionals, local schools and local GPs, hence fostering sustainable partnerships between these parties. In one region a “networking breakfast” will be held to increase the awareness of the youth health management protocol, and to provide an opportunity for new health workers to meet existing workers, and for existing workers to strengthen the relationships and networks already developed through the project.

Resource development
A final “how to” manual will be developed to assist other schools and medical practices to implement this project with less effort. The manual will include sections on the GP Consultation Protocol, Youth Friendly Practice Manual, and Youth Health Management Protocol, as well as a section on education resources to assist GPs with their school visits, and general sections on setting up networks and steering committees, evaluation, management, etc. The development of resources within this project will be a key element to the transferability of this project to other general medical practices and DGPs.

RESULTS
To obtain a snap shot of the actual implementation of the project strategies semi-structured interviews were conducted in September 2000 with each of the three Divisional Project Officers, a sample of GPs who had participated in the project, school counsellors, and a sample of students who had received a school visit by a GP and/or had participated in a GP Clinic Visit. The semi-structured interview posed questions about the reasons for involvement in the project; perceptions of the various project strategies (eg, education seminars, clinic visit, school visit etc); perceptions of project management and support; outcomes experienced of those of participating in project; and future commitment and possible project developments.
This brief report presents the results of the semi-structured interviews according to five domains:

♦ beliefs and opinions of the project;
♦ facts about the project strategies;
♦ outcomes experienced by those involved in the project;
♦ processes associated with good outcomes; and
♦ pre-conditions associated with good practices.

Note: Project participants refers to Divisional Project Officers, GPs, school counsellors and students.

Beliefs and opinions about the project
Overall all participants were able to clearly articulate the objectives of the project, ie “to strengthen relationships between GPs and adolescents, and develop collaborative partnerships with other sectors (eg, education)”. Participants also stated that the project clearly fulfilled multiple purposes, as participants mentioned factors related to GPs (lack of knowledge confidence relating to young people), Division (the project fitted strategic plan), young people (misconceptions about the role of GPs), and context-related factors (eg, recent youth road deaths raised issues about how community come together to respond appropriately).

Facts about the project
Participants were asked to comment on project strategies such as the education seminars, clinic visits and GP school visits. Overall the education seminars were considered as valuable, however the extent to which the seminars were interactive was raised as an issue. Students and GPs positively received the GP Clinic visits as it provided both groups with rich insights into the differing perceptions of what makes a practice “youth friendly”. Overall, the GP school visits were considered as valuable by GPs (ie, provided the opportunity for GPs to come into contact with young people and hear their issues), students (ie, provided the opportunity for real contact with GPs and to obtain health related information) and school counsellors (ie, provided the school counsellors with a referral and support network that students could utilise).

Outcomes experienced by those involved in the project
Participants were asked how successful they felt the project had been to date. Overall, participants felt that the project had been successful, despite some project strategies having not been undertaken (eg, Development of the GP Consultation Protocol for Engaging Adolescents). Participants made a range of other comments about the outcomes they had experienced:

♦ facilitated relationships between GPs and student;
♦ increased comfort by GPs in dealing with young people and their issues;
♦ increased awareness by students of GP roles and responsibilities and health topic areas and by GPs of young people issues;
facilitated relationship between school and Division and other organisations; and

increased clarity of how Division can strengthen school links into community and how GPs can strengthen school health curriculum.

Processes associated with good outcomes
Participants mentioned a range of process-related factors that were associated with good outcomes including:

♦ having adequate planning processes in the first six months to ensure that all project participants are aware of roles and responsibilities in the project;

♦ having adequate communication channels within the project; within the Division; and between participants;

♦ having adequate time to ensure that communication and planning processes are established between Division and schools; and

♦ having inter-Divisional planning, co-ordinating and implementation meetings that enable Divisional Officers to work together.

Pre-conditions associated with good practices
Participants mentioned a range of factors or pre-conditions that were associated with good practices at several levels ie:

♦ GP level
  – having an interest, enthusiasm and commitment to adolescent health is necessary
  – having access to a Division ie, Project Officer to obtain ongoing information and support;

♦ Division level
  – Division has shared values/interests about adolescent health care needs
  – having adequate time and resources to plan, develop, co-ordinate project strategies and to develop and utilise intersectoral approaches; and

♦ school level
  – having a commitment to the “Health Promoting Schools” concept ie, the project needs to complement school curriculum, expand links into community and address the social and physical environment
  – having a school counsellor that is able to provide the linkage between the school/student and general practice (Division/GP).
Interim discussion

It is important to recognise that these interim results need to be interpreted with caution as detailed analysis of the interviews have not occurred as yet, and the project is not yet completed.

The interviews with project participants has revealed that the Project Model which can be described as centrally managed (ie, GP Project Manager and an Inter-Divisional Co-ordinator) and locally delivered (via three Project Officers) has been successful in engaging the Divisions, local GP Clinics, local GPs, local schools and their school counsellors and students.

Overall the project strategies (education seminars, GP school visits, and GP clinic visits) appear to have not only contributed to facilitating relationships between GPs and adolescents, but also between the GPs and the schools (ie, school counsellors). The project is impacting on several levels: GPs, clinic, Divisions, schools, school liaison officers and students, thus outcomes were being reported on each of these levels. Participants were also able to articulate process-related factors and pre-conditions that they perceived as important to the practices and outcomes of the project.

Further analyses of the interviews need to occur to tease out how the various opinions, experiences, process and pre-conditions identified by participants interact.

REFERENCES

2. Ibid.
3. Ibid.
AUTHORS

Meredith Appleyard has worked for Mid North Rural SA Division of General Practice for 2.5 years, first as Health Programs Manager and for the last 22 months as Executive Officer. Prior to this Meredith had a broad and varied experience working as a registered nurse/midwife in many different practice settings — from the Northern Territory to outback South Australia with the Royal Flying Doctor Service and on to Executive Officer/Director of Nursing in a hospital in the Murray Mallee. Over the years Meredith has developed a clear understanding of the issues facing rural and remote communities and the intrinsic strength and determination shown by communities in their efforts to respond to the ongoing challenges, particularly around health service delivery.