Health services for young people – how do you rate?

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INTRODUCTION

Young people are generally healthier and less vulnerable to disease than both adults and children. However, young people have not enjoyed the same improvement of health status when compared to other sections of the community. The psychosocial health status of young people in Australia has not shown significant improvement over the last four decades. Whilst the causes are more complex, morbidity and mortality in young people are associated with the increasing rates of alcohol and other drug use; teenage pregnancy; increased smoking rates in young women; violent crime and mental health issues such as eating disorders, depression, self-harm and suicide. Two main reasons for the lack of improvement of health status are that causes of ill health for most young people are social rather than biological and that it is often assumed that the health needs of young people can be adequately met within existing adult and child services.

Adolescence particularly is a time of physical and psychological development and exploring “self” and life’s boundaries. A potential consequence of this is young people may engage in experimentation and high-risk behaviour that can have long-term health consequences. Such behaviour may include binge drinking, substance abuse, dangerous driving, unsafe sexual practice, self-inflicted injury and suicide. Potentially these behaviours can be preventable and effective early intervention can improve the long-term health outcomes for young people. Young people (demographic 12–24 years) are not a homogenous group. They have issues and concerns that are affected on an individual basis with development and changing needs as they grow. In addition, young people are often ill-informed about health issues and where they can seek assistance. If we accept adolescence as a developmental period where young people are commencing to make their own decisions and can form health behaviours and choices, then adolescent mortality and morbidity should be largely preventable. However young people are generally low users of health services and consequently the ability of health professionals to positively influence health behaviour can be limited. One of the major reasons that young people don’t access or utilise health services is that they do not consider them to be “youth friendly”.

This paper describes the rationale behind the development of a tool to measure and support health services to better provide for the needs of young people with respect to health care. This is particularly important in rural, regional and remote areas where services are generally more limited such that there is less choice and flexibility to access services. Young people can’t “shop” for services between towns and there may be certain barriers to access such as perceived lack of confidentiality. In rural areas it is important to develop and provide equitable service access for young people. These services need to be flexible and recognise young people’s unique health needs.
Health issues for young people

Determining young people’s access to health services needs to be considered within the context of understanding their specific health care needs. In accepting that the population of young people is generally healthy, an acknowledgment of morbidity and mortality is important because these are likely reasons why young people should access health services.

- Injury is the leading cause of death in young people and in almost all cases is preventable. Males aged 15–24 years are at greater risk from injury-related death than females (1). In Australia, motor vehicle accidents account for more than one third of deaths in young people. In NSW the standardised rate of road injury death for young people is approx 24 per 100,000 (2).

- Suicide is the next major cause of death among young people with a standardised rate of 15 per 100,000 (males 23/females7) (2). With concerted national and state strategies over the last 3 years, this age group is now displaying a downward trend in the data.

- Depression among adolescents is high with 14–20% of adolescent reporting moderate to severe depression (3).

- Nutritional or dietary behaviour amongst young people is increasingly of concern particularly the development of dieting disorders among young women. Young men have also become an increasing area of concern for dieting disorders. Obesity acquired during childhood that persists into adulthood increases later risk for chronic conditions such as diabetes, heart disease and high blood pressure (4).

- In terms of sexual health, it is reported that 25% of people registered as HIV+ in Victoria are under 25 years of age (5). Around 43% of young people have reported their first experience of sexual intercourse when 15 or 16 years with condoms used in about 60% of cases (4).

- Violence — young people are most likely to be both perpetrators and victims in violent crimes. It has been estimated that one out of five women less than 25 years has been a victim of sexual abuse and this often begins in adolescence and goes unreported. Adolescents physically abused or neglected as children are twice as likely to be arrested for a violent offence or to be admitted to hospital for suicidal behaviour (6). More than 90% of young people who are homeless have been victims of physical abuse since leaving home (5).

- Substance use — the most common licit substances used by young people are tobacco and alcohol. There is evidence that early onset of regular drinking is associated with increased risk of adult alcohol misuse and a range of alcohol-related health and social problems. Twenty six percent of 15–16 year olds identified as having been intoxicated to the point of vomiting (4). Smoking is widely acknowledged to be the single most preventable cause of premature death and disability. Around 40% of girls aged 16-17 years and about 35% of boys smoke tobacco. Marijuana use is around 7% for 13 year olds to about 34% for 16 year olds, with a quarter of this group using monthly, weekly or daily (4). Other illicit substance use by adolescents is relatively low at between 1–10% (5). Also of concern
is the increasing prevalence of young people with co-morbid mental health problems and substance abuse disorder (7).

- Chronic illness — about 8% of young people (5) live with a chronic condition with advances in medical technology resulting in a growing population of people surviving what would once have been life-threatening conditions. There is a need for the social and psychological issues surrounding the diagnosis of life-threatening conditions to be more carefully addressed with researchers claiming that young people with chronic conditions are more likely to have significantly lower emotional well-being.

- Aboriginal youth have high levels of mortality and morbidity associated with external causes such as accidents, poisoning and violence. High levels of depression, suicide and substance abuse are influenced by a complex interaction of factors within the social environment (8).

AIMS

The Youth Friendliness Assessment Tool (Y-FAT) was designed to provide a review method for Health Services in the New England Area on the issue of improving youth health. It identifies the key areas of youth health for a health service to be reviewed against with these broadly grouped into access, physical environment and health service policy. It also contains a resource section to provide ideas of how the health service can be improved to have a positive impact on the health of young people in the area. The key areas have been designed to be achievable rather than suggesting high cost alternatives that may never be implemented.

New England Area Health Service (NEAHS) in NSW has a higher than average proportion of young people aged between 12 and 24 years yet young people have not been a specific priority of the health service. The context of formulating a youth health plan gave rise to the notion of reviewing the health service and its youth friendliness.

Three staff from the health service began the process of developing a “tool” to measure how friendly NEAHS Services are to young people with the aim being that these services can be tailored to meet the needs of young people across the area.

METHOD

The initial development phase involved:

- determining whether such a tool was already in existence
- a literature review
- seeking broad representation to include the views of both young people and health staff.

Broad consultation was undertaken with a number of key youth agencies. This included The Centre for Adolescent Health (Melbourne), The Youthealth Project (Northern Sydney Area Health Services), The New South Wales Association for the Advancement of Adolescent Health — The Children’s Hospital at Westmead. This
consultation led to the understanding that although many youth agencies are concerned with this issue, to date no such tool exists.

A literature review was undertaken to canvas previous research in order to determine the factors that influence young people’s access to services and what can be done to enhance access. The literature review was sourced primarily from The YoutHealth Project. From this was drawn a comprehensive list of 50 Youth Friendly Criteria. Some examples from this list are: a skilled and friendly receptionist familiar with adolescent specific concerns and who remembers individual clients; convenient opening times for young people; assure and respect confidentiality; promote awareness of health services to young people. These criteria were used to develop the draft key areas for the Y-FAT. A more recent research report (9) has identified similar findings in relation to young people’s attitudes about and access to health services.

Focus groups

A series of focus groups was held with young people in towns across New England to test and further develop the draft key areas. These focus groups sought to reference a variety of young people across the 12–24 years demographic including school and TAFE students, older TAFE and university students, young people employed and young people unemployed and living out of home. Two youth health staff facilitated the groups with one staff member being from the health service where the focus group was held. Participants were encouraged through group discussions, to talk about aspects of their health service or health services in general, and what things did or did not encourage their attendance. The venue chosen was either neutral or already delivering some form of youth service and food and drink were provided at the end of the consultation session. This same process was undertaken with a larger group of health service staff who were members of a Youth Health Advisory Group responsible for development of the Area’s Youth Health Plan. The focus groups reiterated many of the main issues raised in the literature review. The tool and the resource information were developed also in consultation with Health Service Managers and Community Health Managers across the Area. Because many of the criteria relate to staff attitudes, understanding and empathy with youth health issues, an attitudinal survey was also developed to allow individual staff to assess their knowledge and attitudes.

RESULTS

The Y-FAT is made up of several sections. There is an overview of its development, the actual item rating components, the Self Assessment Youth (SAY) and a resources section with service recommendations. The tool measures three areas: access, physical environment and youth consultation and participation with Yes/No responses to items under each area. A “Yes” response acknowledges that the health service meets/provides the item. A “No” response allows the service to refer to the resources section for possible changes.

Access consists of 46 items that cover 5 areas:

- communicating what services are available to young people for both young people at school, TAFE, Uni and in the community
confidentiality
• staff and health attitudes to young people
• youth orientated service
• transport.

Physical environment consists of 28 items that cover 5 areas:
• youth “face” to health service
• pamphlets
• environment
• information technology
• hospital care of young people.

Youth consultation and participation consists of 26 items that covers 4 areas:
• policy
• consultation
• participation
• health outcomes.

The Y-FAT provides for key areas and all items to be totalled as a score that allows the opportunity to highlight certain areas and changes or improvements over time. The resources section is numbered to correspond to individual area and item questions. Depending on the item, a number of recommendations are made. For example, item 1.2.3 asks “Does the health service have an appropriate and confidential method of providing a service to young people who are related or known to a staff member?” The resource section 1.2.3 provides a number of responses that include: that young people have identified this as an issues that prevents them from accessing health services; that intake processes need to be flexible; reception staff are discreet in naming and recording information; in-patient information is not accessible to public; reinforcing limits of confidentiality to young people.

The SAY is a 25 item self-report questionnaire designed to explore knowledge, awareness and attitudes about young people by health service staff. The items canvass four issues pertaining to young people: culture, legal, health and general awareness. Respondents select and mark one answer from a choice of four. A scoring key indicates the correct answer with 4 points scored for each correct response up to a maximum of 100. A total score can be interpreted, as can individual issue scores. SAY was not designed for psychometric reliability or validity. Rather it allows individual respondents to assess their own knowledge and attitudes to questions raised. Correct answers are sourced from legal and health domains or developed from recognised best practice in relation to young people.
**Assessment process**

The Y-FAT contains guidelines for the process of assessing the youth friendliness of a health service that include:

- a Y-FAT review be conducted every 2 years
- a working party be formed to conduct the review that should include staff from different areas with skills in youth health. The working party should report to the respective health service manager
- an action plan be developed and implemented in response to the areas identified for change as a result of the review
- The health service manager have all staff complete the SAY and report back possible issues/areas for training or greater awareness.

Currently the Y-FAT has been distributed to all health service managers in the NEAHS. A brief questionnaire has been designed and distributed to managers to ascertain the proportion of services that have conducted reviews using the Y-FAT. The questionnaire also asks about ease of use of the tool plus any areas for amendment. The questionnaire also seeks to elicit what actions or outcomes have occurred in the health service as a result of the review.

**CONCLUSION**

Increasingly it is now recognised that there are opportunities to reduce morbidity and mortality in the population by intervening earlier and seeking better health outcomes for young people. This requires an acknowledgment that young people have specific health problems, needs and concerns and these differ from those of adults or children and traditional ways of providing health services are not always appropriate to meet the needs of young people.

In the longer term, a positive outcome for youth health would involve dollars saved as a result of better and earlier intervention. These funds could then be used to provide resources for more youth specific services including capital infrastructure. This is particularly necessary in rural areas. However until this happens, the Y-FAT is a tool that provides a mechanism to review existing services to assess youth friendliness. A strength of the Y-FAT is the identification of a range of options that health services could implement now, at minimal cost, to promote and encourage greater youth access to services.

Whilst the Y-FAT was developed specifically for health services in the NEAHS, it has broad applicability to other health services particularly those in rural locations. The Y-FAT is available as a NSW State Health Publication. It is recommended for health service use as a key initiative in improving service access and hence health outcomes for young people.
REFERENCES


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PRESENTERS

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**Peter Massey** is a clinical nurse consultant in the Public Health Unit with New England Area Health Service. He has worked in this current position for ten years. The role includes area responsibilities for the Immunisation and TB Control Programs in addition to other population health work in infectious diseases, Aboriginal health and health improvement. Peter has previously worked as the Community Health Nurse Unit Manager at Wee Waa in north-west NSW.