

**NSW KIDS
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YOUTH HEALTH RESOURCE KIT

AN ESSENTIAL GUIDE FOR WORKERS



Health

healthy, safe and well

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INTRODUCTION

YOUTH HEALTH RESOURCE KIT

An Essential Guide For Workers

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Jane also provides legal information and training for young people and those who work with them, including health professionals, youth workers and lawyers. This frequently includes topics such as young people's capacity to live independently, access to health care, confidentiality, the age of consent, and mandatory reporting of children at risk.

In 2008 Jane was awarded the NSW Law and Justice Foundation's Justice Medal, for "outstanding individual achievement in improving access to justice, especially for socially and economically disadvantaged people".

Thank you also to those who contributed to the Adolescent Health GP Resource Kit, first and second editions, from which this Kit drew inspiration.

FOREWORD

Every time a young person seeks health care, we are given a unique opportunity. We have the chance to not only talk with them about their health issues or concerns, but also to holistically assess their needs.

Because most of the health problems young people experience are related to psychosocial risk factors and behaviours, health services that take an informed and comprehensive approach to working with young people are best placed to ensure that their young clients not only receive the care they need for their presenting concerns, but also that emerging problems or concerns are identified early and addressed appropriately.

Working with young people can be challenging for health professionals. Not only are there medico-legal factors (such as consent to medical treatment) to consider, but a young person's evolving maturity, cultural values, life experiences, risk-taking behaviours, and chronic illnesses or conditions (if present) can further complicate the relationship, requiring the health professional to draw on a range of skills to work effectively with the individual.

As they move through the teenage years, young people often seek to take more personal responsibility for their health care – a normal developmental process that service providers should support. This, too, requires the health professional to have skills in working with young people both as an independent person and in the context of family relationships.

The Youth Health Resource Kit: An Essential Guide for Workers has been designed specifically for health and allied professionals working with young people. It is a practical toolkit offering tips and techniques for working with young people and is intended to enhance skills in understanding, communicating with and engaging clients within caring, positive health care relationships.

Providing services and care that are responsive and flexible to the needs of young people – that are youth-friendly – is the key to effectively meeting the health care needs of our young people. This Kit provides the information and resources needed to create accessible, relevant and welcoming services for young people and to improve the health outcomes for young people accessing services.

We would like to thank the authors, reviewers and project working group who contributed to the development of the Kit with such skill and commitment.

We are pleased to commend to you the *Youth Health Resource Kit: An Essential Guide for Workers*.



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INTRODUCTION

An adolescent who is healthy is the best foundation for a healthy adult life.

The Lancet editorial www.thelancet.com, 379, April 28, 2012 p. 1561.

Youth health problems are often complex and require a comprehensive, bio-psychosocial approach. The *Youth Health Resource Kit: An Essential Guide for Workers* is a practical guide to providing effective health care for young people. It identifies strategies and practical steps that workers can take to:

- Engage and communicate effectively with young people
- Better understand the social and cultural diversity of young people
- Assess young people's health risks
- Manage youth health problems
- Make services youth-friendly and accessible to young people

This Kit outlines the skills needed for working with the young person and their family, while addressing the developmental, cultural and environmental factors that influence their health status.

You will find the terms 'adolescents' and 'young people' often used interchangeably within the Kit, which is in line with the *NSW Youth Health Policy 2011-2016* which covers the age group 12-24 years.

WHO IS THIS KIT FOR?

The *Youth Health Resource Kit: An Essential Guide for Workers* was developed with a diverse audience in mind. It is for people working within the health system who want to learn about working more effectively with young people and it's for those who already work with young people in the health context but who want to develop their knowledge about a specific aspect of youth health.

Although the Kit was written primarily for health professionals, much of the information in this Kit will be useful for service providers and professionals employed outside the health system who work with young people to support or promote their health and wellbeing.

The Kit has been designed to provide information about the major issues associated with meeting the needs of young people and providing services that are responsive and youth-friendly.

THE KIT IS SUITABLE FOR:

- Professionals working within NSW Health services (e.g. youth health services, youth mental health services, Justice Health, drug and alcohol services, sexual health services, population health, health promotion, community health, transcultural mental health, hospitals, and transition care among others)
- People working in non-government organisations (e.g. youth health services, family planning, headspace, online services, youth support services, and Indigenous health organisations such as Aboriginal Medical Services)
- Professionals working in government agencies that focus on young people (e.g. government and non-government school counsellors, school nurses, child protection case workers, university and TAFE student support, Juvenile Justice)

HOW WAS THIS KIT DEVELOPED?

The *Youth Health Resource Kit: An Essential Guide for Workers* is based on the Adolescent Health GP Resource Kit (2008), second edition, which was produced for General Practitioners (GPs). The *Adolescent Health GP Resource Kit* can be found on the NSW Kids and Families website.

Visit www.kidsfamilies.health.nsw.gov.au

We consulted widely with representatives of the intended audience for the Kit so that we understood the context in which they were working with young people, their information needs, and how they might use the Kit. We interviewed and conducted focus groups with workers from youth health services, non-government organisations, and specialist clinical services to elicit ideas from the broadest audience possible. We included services working with young people in metropolitan, regional and rural areas.

We then contracted expert authors (see *appendix*) to draft sections of the Kit, which were then reviewed by content expert reviewers and the project's advisory group.

WHAT'S IN THE KIT?

The Kit is divided into three sections.

SECTION ONE: UNDERSTANDING YOUNG PEOPLE

- 1.1 Adolescence – a developmental perspective
- 1.2 The health and wellbeing of young Australians

SECTION TWO: PROVIDING HEALTH SERVICES TO YOUNG PEOPLE

- 2.1 The Australian health care system
- 2.2 Young people and health services
- 2.3 Collaboration and case management
- 2.4 Using technology

SECTION THREE: SKILLS FOR PROVIDING YOUTH-FRIENDLY SERVICES

- 3.1 Youth-friendly communication
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- 3.4 Trauma-informed practice
- 3.5 Medico-legal issues
- 3.6 Cultural diversity and culturally-competent practice
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- 3.13 Working with families

SECTION ONE

UNDERSTANDING YOUNG PEOPLE

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1.1 ADOLESCENCE – A DEVELOPMENTAL PERSPECTIVE

PETER CHOWN

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

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

ABOUT ADOLESCENCE

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

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

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

Adolescence is a biologically universal phenomenon; however, the concept of 'adolescence' is defined differently in different cultures. Cultural norms and life experiences (such as being a refugee) can affect both the timing of developmental milestones (e.g. puberty) and society's expectations of what is considered 'normal' in terms of the young person's response to these changes. The expectations, roles and duration of adolescence can vary

greatly between different cultures. In some cultures, the concept of adolescence as a stage does not even exist. Young people move from childhood to adulthood.

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

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

THE ADOLESCENT BRAIN

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

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

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

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

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

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

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

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

THE IMPACT OF TRAUMA ON THE BRAIN

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

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

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

FINDING OUT MORE...

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

OTHER INFLUENCES ON THE DEVELOPING BRAIN

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

(Cozolino 2002)

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

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

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

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

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

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

ADOLESCENT DEVELOPMENTAL STAGES

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

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

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

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

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

TABLE 1: ADOLESCENT DEVELOPMENTAL STAGES

	Early (10 - 13 years)	Middle (14 - 17 years)	Late (17-21 years)
Central Question	"Am I normal?"	"Who am I?" "Where do I belong?"	"Where am I going?"
Major developmental issues	<ul style="list-style-type: none"> • Coming to terms with puberty • Struggle for autonomy commences • Same sex peer relationships all-important • Mood swings 	<ul style="list-style-type: none"> • New intellectual powers • New sexual drives • Experimentation and risk-taking • Relationships have self-centred quality • Need for peer group acceptance • Emergence of sexual identity 	<ul style="list-style-type: none"> • Independence from parents • Realistic body image • Acceptance of sexual identity • Clear educational and vocational goals, own value system • Developing mutually caring and responsible relationships
Main concerns	<ul style="list-style-type: none"> • Anxieties about body shape and changes • Comparison with peers 	<ul style="list-style-type: none"> • Tensions between family and young person over independence • Balancing demands of family and peers • Prone to fad behaviour and risk taking • Strong need for privacy • Maintaining ethnic identity while striving to fit in with dominant culture 	<ul style="list-style-type: none"> • Self-responsibility • Achieving economic independence • Deciding on career/ vocation options • Developing intimate relationships
Cognitive development	<ul style="list-style-type: none"> • Still fairly concrete thinkers • Less able to understand subtlety • Daydreaming common • Difficulty identifying how their immediate behaviour impacts on the future 	<ul style="list-style-type: none"> • Able to think more rationally • Concerned about individual freedom and rights • Able to accept more responsibility for consequences of own behaviour • Begins to take on greater responsibility within family as part of cultural identity 	<ul style="list-style-type: none"> • Longer attention span • Ability to think more abstractly • More able to synthesise information and apply it to themselves • Able to think into the future and anticipate consequences of their actions

CHAPTER SUMMARY - WHAT TO REMEMBER

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

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

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

REFLECTION QUESTIONS

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

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

REFERENCES

- Bennett DL & Kang M. (2001). Adolescence. In K Oates, K Currow and W Hu (eds.) *Child Health: A Practical Manual for General Practice*. MacLennan and Petty: Australia.
- Cozolino L. (2002). *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain*. New York: Norton.
- Kezelman C & Stavropoulos P. (2012). *The Last Frontier. Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care And Service Delivery*. ASCA:Sydney.
- Siegel DJ. (2012). *The developing mind: How relationships and the brain interact to shape who we are*. 2nd ed. New York: Guilford Press.
- Sowell EA, Siegel AW & Siegel DJ. (2011). Adolescent brain and cognitive changes. In M Fisher, L Alderman, R Kreipe and W Rosenfeld (eds.) *Handbook of Adolescent Medicine*. American Academy of Pediatrics: Elk Grove Village, IL.
- Strasburger V, Brown R, Braverman P, Rogers P, Holland-Hall and Coupey S. (2006). *Adolescent Medicine: A Handbook for Primary Care*. Lippincott, Williams & Wilkins: Philadelphia.
- Steinberg L. (2008). A social neuroscience perspective on adolescent risk taking. *Developmental Review*. 28, 78–106.
- Steinberg L. (2011). Demystifying the adolescent brain. *Educational Leadership*. 68(7), 42-46.
- Yurgelun-Todd D.A, Killgore WD & Young AD. (2002). Sex differences in cerebral tissue volume and cognitive performance during adolescence. *Psychological Reports*. 91(3), 743-757.

1.2 THE HEALTH AND WELLBEING OF YOUNG AUSTRALIANS

PETER CHOWN

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

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

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

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

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

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

which start or are reinforced in adolescence (Resnick et al. 2012).

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

HOW WELL ARE YOUNG AUSTRALIANS?

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

MENTAL HEALTH

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

CHRONIC CONDITIONS

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

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

COMMUNICABLE DISEASES

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

SUBSTANCE USE

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

DEATHS OF YOUNG PEOPLE

- In 2007, there were 1,418 deaths among young people aged 12-24. 70% of these young people were male. The death rate was highest for the oldest section of this age group (20-24 year olds).

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

OTHER HEALTH RISK AND PROTECTIVE FACTORS

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

POSITIVE HEALTH TRENDS

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

NEGATIVE HEALTH TRENDS

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

WHAT YOUNG PEOPLE WORRY ABOUT

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

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

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

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

YOUNG PEOPLE AT HIGHER RISK

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

INDIGENOUS YOUNG PEOPLE

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

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

FINDING OUT MORE...

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

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

YOUNG PEOPLE FROM CALD BACKGROUNDS

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

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

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

FINDING OUT MORE...

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

YOUNG PEOPLE WHO HAVE EXPERIENCED VIOLENCE, ABUSE OR NEGLECT

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

FINDING OUT MORE...

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

RURAL YOUNG PEOPLE

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

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

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

SOCIO-ECONOMICALLY DISADVANTAGED GROUPS

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

DIFFERENCES BETWEEN MALES AND FEMALES

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

YOUNG CARERS

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

CULTURAL CONSIDERATIONS FOR HEALTH SERVICES AND PRACTITIONERS

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

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

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

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

FINDING OUT MORE...

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

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

CHAPTER SUMMARY - WHAT TO REMEMBER

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

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

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

REFLECTION QUESTIONS

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

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

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

REFERENCES

Australian Bureau of Statistics. (2008). *National Aboriginal and Torres Strait Islander Social Survey*. ABS cat. No. 4714. ABS: Canberra.

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

Cozolino L. (2002). *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain*. New York: Norton.

Kezelman C & Stavropoulos P. (2012). *The Last Frontier. Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care And Service Delivery*. ASCA: Sydney.

Minas IH, Lambert TSR, Kostov S & Borangh G. (1996). *Mental Health Services for NESB Immigrants: Transforming Policy into Practice*. Australian Government Publishing Service: Canberra.

Mission Australia (2011). *National Survey of Young Australians*. <http://www.missionaustralia.com.au/document-downloads/youth-survey>

NSW Ministry of Health, Centre for Epidemiology and Evidence. (2011). *New South Wales School Students Health Behaviours Survey: 2011 Report*. NSW Ministry of Health: Sydney.

Resnick M, Catalano R, Sawyer S, Viner R & Patton G. (2012). www.thelancet.com, 379, April 28, p. 1564-1567.

SECTION TWO

PROVIDING HEALTH SERVICES TO YOUNG PEOPLE

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2.1 THE AUSTRALIAN HEALTH CARE SYSTEM

MELISSA KANG

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

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

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

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

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

COMPONENTS OF THE HEALTH SYSTEM

PRIMARY HEALTH CARE SERVICES

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

departments of public and private hospitals, private dental clinics and public dental hospital clinics.

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

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

SECONDARY AND TERTIARY HEALTH CARE SERVICES

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

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

HEALTH CARE COSTS AND MEDICARE

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

FINDING OUT MORE...

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

www.humanservices.gov.au

HOW MEDICARE WORKS IN PRACTICE

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

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

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

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

COMMON ADDITIONAL COSTS

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

REFERRALS TO SPECIALISTS

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

PHARMACEUTICALS

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

CHAPTER SUMMARY - WHAT TO REMEMBER

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

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

REFLECTION QUESTIONS

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

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

REFERENCES

Dadich A, Jarrett C, Sanci L, Kang M & Bennett DL. (2013). The promise of primary health reform for youth health. *Journal of Paediatrics and Child Health*. 49(11), 887-90.

Kang M & Sanci LA. (2007). Primary health care for young people in Australia. *International Journal of Adolescent Medical Health*. 19(3), 229 – 234.

2.2 YOUNG PEOPLE AND HEALTH SERVICES

MELISSA KANG

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

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

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

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

EXPLAINING GENERAL PRACTICE TO YOUNG PEOPLE...

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

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

ACCESS ISSUES FOR YOUNG PEOPLE

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

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

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

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

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

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

HOW HEALTH SERVICES CAN MAKE A DIFFERENCE

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

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

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

This means:

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

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

Service providers can:

- Identify and manage psychosocial risk factors and behaviours
- Make the most of their contact with a young person to educate them about health risks and to promote protective behaviours
- Address the social and environmental risk factors in the young person's life by working

with the family, school, and other key people in their lives

- Provide appropriate intervention for common youth health problems e.g. smoking

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

It is important to:

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

4. Adopt a collaborative approach.

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

FINDING OUT MORE...

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

CHAPTER SUMMARY - WHAT TO REMEMBER

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

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

REFLECTION QUESTIONS

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

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

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

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

REFERENCES

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

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

2.3 COLLABORATION AND CASE MANAGEMENT

MELISSA KANG

Collaboration occurs when service providers develop internal and external working relationships with other agencies that share similar service goals and target groups. Actions include communicating, networking and working together, both within and beyond the service's immediate sector (e.g. health, education, welfare, drug and alcohol, recreation)

Youth Health Better Practice Framework (2012)

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

SOME DEFINITIONS

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

HEALTH CARE:

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

HEALTH CARE SUPPORT:

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

HEALTH PROMOTION:

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

UNDERSTANDING COLLABORATION

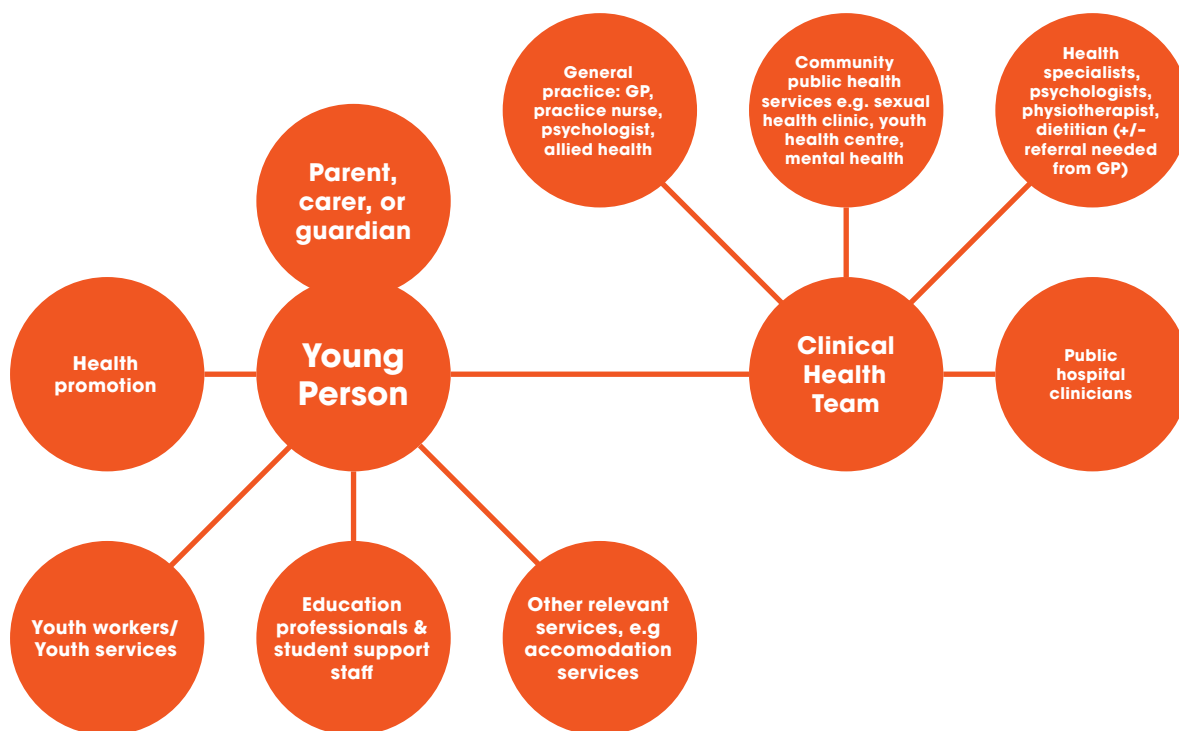
The 2005 Access research project (NSW CAAH 2005) identified collaboration as one of the seven principles of better practice in youth health.

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

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

This study found that, for practitioners, collaboration involves:

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

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

COLLABORATING IN PRACTICE

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

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

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

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

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

UNDERSTANDING ROLES

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

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

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

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

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

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

COLLABORATIVE CARE AND MEDICARE

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

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

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

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

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

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

FINDING OUT MORE...

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

KEEPING THE YOUNG PERSON 'CENTRE-STAGE'

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

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

FINDING OUT MORE...

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

WORKING COLLABORATIVELY WITH PARENTS AND CARERS

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

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

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

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

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

BUILDING RELATIONSHIPS FOR COLLABORATION

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

WHO CAN YOU COLLABORATE WITH?

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

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

FINDING OUT MORE...

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

WHAT IS CASE MANAGEMENT?

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

WHO DOES IT?

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

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

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

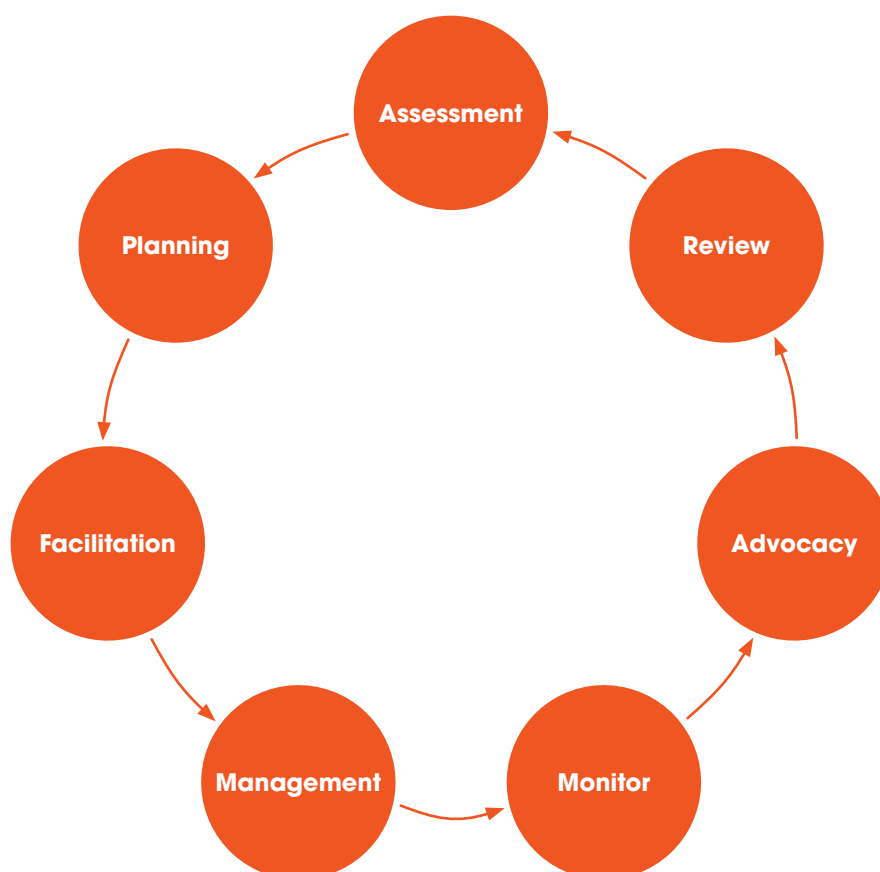
In the Australian health system, general practitioners often fulfil the role of 'case manager' for many of their clients. This is often the case for clients with chronic conditions who require both primary and secondary health care services involving medical and surgical specialists and allied health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

educator and paediatrician/ endocrinologist on their health care team.

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

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

Figure 2: Seven Steps of Case Management



CASE STUDY: WORKING COLLABORATIVELY TO SUPPORT MEENA

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

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

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

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

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

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

PLANNING - IDENTIFY MEENA'S NEEDS

Basic needs

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

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

Educational / occupational needs

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

Health needs

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

Social and cultural considerations

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

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

KNOWING WHEN TO REFER

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

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

EXERCISING JUDGMENT

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

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

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

SHARING INFORMATION

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

NEGOTIATING BETWEEN SERVICE SYSTEMS

The staff member at the refuge offers to support Meena by going with her to the headspace GP appointment. Meena expresses relief to have

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

PROGRESS OVER TIME

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

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

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

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

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

CASE STUDY: WORKING COLLABORATIVELY TO SUPPORT TYLER

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

PLANNING: IDENTIFY TYLER'S NEEDS

Basic needs

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

Educational/ occupational needs

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

Health needs

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

Social and cultural considerations

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

students are from a socio-economically disadvantaged background. Tyler sometimes feels 'different' because he is overweight.

KNOWING WHEN TO REFER

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

EXERCISING JUDGMENT

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

SHARING INFORMATION

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

NEGOTIATING BETWEEN SERVICE SYSTEMS

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

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

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

PROGRESS OVER TIME

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

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

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

CASE STUDY: CASE MANAGEMENT FOR ELISE

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

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

STEP 1: ASSESSMENT

Basic needs

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

Educational/occupational needs

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

Health needs

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

Social and cultural considerations

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

STEP 2: PLANNING

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

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

In planning Elise's management, her Case Manager:

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

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

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

FACILITATION

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

MANAGEMENT

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

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

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

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

MONITORING

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

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

ADVOCACY

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

REVIEW

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

CASE STUDY: WORKING COLLABORATIVELY TO SUPPORT JOSH

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

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

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

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

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

PLANNING: IDENTIFY JOSH'S NEEDS

Basic needs

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

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

Education/occupational needs

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

work, screen printing and using computers. He wants to undertake an apprenticeship after completing his HSC.

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

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

Health needs

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

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

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

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

Social and cultural considerations

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

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

KNOWING WHEN TO REFER

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

EXERCISING JUDGMENT

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

SHARING INFORMATION

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

NEGOTIATING BETWEEN SERVICE SYSTEMS

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

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

PROGRESS OVER TIME

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

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

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

FINDING OUT MORE...

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

CHAPTER SUMMARY - WHAT TO REMEMBER

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

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

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

REFLECTION QUESTIONS

What does collaboration mean within your service?

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

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

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

Are you falling into any pitfalls in collaboration?

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

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

REFERENCES

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

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

2.4 USING TECHNOLOGY

FIONA ROBARDS

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

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

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

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

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

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

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

- Promote events and resources
- Promote services to young people

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

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

FINDING OUT MORE...

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

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

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

USING TECHNOLOGY TO PROVIDE INFORMATION AND SUPPORT

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

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

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

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

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

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

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

FAST FACTS

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

BEFORE YOU BEGIN

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

Ask yourself:

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

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

You can then:

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

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

FINDING OUT MORE...

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

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

The Cybersmart website has a range of information and resources on online safety, accessible at www.cybersmart.gov.au

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

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

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

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

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

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

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

USING TECHNOLOGY TO SUPPORT CLINICAL SERVICES

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

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

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

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

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

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

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

PROVIDING THERAPY ONLINE

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

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

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

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

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

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

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

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

PRACTICE POINTS FOR ONLINE THERAPY

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

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

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

Remember that emails are a legal record of conversations.

USING ONLINE TOOLS AND PROGRAMS

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

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

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

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

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

Other useful Australian programs and sites include:

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

FINDING OUT MORE...

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

Reachout Pro provides access and advice for health care professionals on a range of technologies and online resources that can be used to enhance the effectiveness of psychosocial support and mental health care provided to young people. www.reachoutpro.com.au

The Young and Well CRC explores the role of technology in young people's lives, and how technology can be used to improve the mental health and wellbeing of young people aged 12 to 25. www.yawcrc.org.au

CHAPTER SUMMARY - WHAT TO REMEMBER

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

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

REFLECTION QUESTIONS

How do you use technology?

How do the young people you work with use technology?

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

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

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

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

REFERENCES

Australian Bureau of Statistics (ABS.) (2007). *National Survey of Mental Health and Wellbeing*. Available <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0>. Viewed 7 February 2013.

Australian Communications and Media Authority (ACMA). (2008). In RJ Xavier (ed.) *Australia in the Digital Economy*. Australian Communications and Media Authority: Canberra.

Burns JM, Davenport TA, Durkin LA, Luscombe GM & Hickie IB. (2010). The internet as a setting for mental health service utilisation by young people. *Medical Journal of Australia*. 192(11 Suppl), S22-6.

Ewing S, Thomas J & Schiessl J. (2008). *CCI Digital Futures Report: The Internet in Australia*. ARC Centre of Excellence for Creative Industries and Innovation Institute for Social Research, Swinburne University of Technology: Melbourne.

Mission Australia. (2011). *National survey of young Australians 2011*. Mission Australia: Sydney.

SECTION THREE

SKILLS FOR PROVIDING YOUTH- FRIENDLY SERVICES

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SECTION 3.1

YOUTH-FRIENDLY COMMUNICATION

3.1 YOUTH-FRIENDLY COMMUNICATION

PETER CHOWN

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

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

BUILDING RAPPORT

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

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

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

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

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

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

PRACTICE POINTS

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

Understanding adolescent developmental issues

Acquiring effective communication skills

Understanding relevant medico-legal issues

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

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

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

THE FIRST MEETING

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

SEEING THE YOUNG PERSON ALONE

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

Speaking with the young person alone at some point provides:

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

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

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

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

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

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

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

STARTING TO TALK

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

Example: "Mrs Smith, I'd like to talk with you both at first to get an idea of what the concerns are for each of you. Then I'd like to talk with Johnny alone for a

few minutes, just to get to know him a bit better so I can work out how best to help him. I've found that it helps teenagers learn how to communicate with adults better about their concerns."

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

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

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

EXPLAINING CONFIDENTIALITY AND ITS LIMITS

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

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

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

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

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

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

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

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

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

FINDING OUT MORE...

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

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

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

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

"How can I help you today?"

Or:

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

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

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

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

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

CASE STUDY: BUILDING RAPPORT WITH MICHAEL

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

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

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

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

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

Or:

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

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

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

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

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

"Tell me a little bit about yourself..."

Or:

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

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

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

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

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

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

COMMUNICATION AND DEVELOPMENTAL STAGES

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

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

Example:

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

Rather than:

"How is school going?"

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

FINDING OUT MORE...

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

FINDING OUT MORE...

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

TABLE 2 – COMMUNICATION PRACTICE POINTS BY DEVELOPMENT STAGE

	Early adolescence (10 – 14 years)	Middle adolescence (15 – 17 years)	Late adolescence (> 17 years)
Central question	“Am I normal?”	“Who am I?” “Where do I belong?”	“Where am I going?”
Communication practice points	<ul style="list-style-type: none"> • Reassure about normality • Ask more direct questions than open-ended questions • Make explanations short and simple • Base interventions on immediate or short-term outcomes • Help identify possible adverse outcomes if they continue undesirable behaviours 	<ul style="list-style-type: none"> • Address confidentiality concerns • Always assess for health risk behaviour • Focus interventions on short to medium term outcomes • Relate behaviours to immediate physical and social concerns – e.g. effects on appearance, relationships 	<ul style="list-style-type: none"> • Ask more open-ended questions • Focus interventions on short and long-term goals • Address prevention more broadly

COMMUNICATION SKILLS FOR WORKING WITH YOUNG PEOPLE

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

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

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

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

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

Example:

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

Other ideas:

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

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

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

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

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

FINDING OUT MORE...

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

SPECIFIC INTERVIEWING AND QUESTIONING SKILLS

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

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

ACTIVE LISTENING

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

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

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

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

PARAPHRASING AND REFLECTING FEELINGS

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

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

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

Example:

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

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

QUESTIONS

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

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

Example:

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

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

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

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

TABLE 3 - QUESTION STYLES

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

FINDING OUT MORE...

For more information about asking sensitive questions see chapter 3.2 Psychosocial assessment.

SUPPORTING YOUNG PEOPLE WITH A DISABILITY

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

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

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

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

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

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

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

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

post-school study and participation in meaningful activities (AIHW 2008).

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

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

FINDING OUT MORE...

You can learn more about working with young people with a disability in 3.11 Chronic conditions and disability.

Family Planning NSW has an extensive Disability Resource Collection for sexual education, which is available for loan: www.fpnsw.org.au

Other states may have similar resources available from their State Family Planning Service.

The Better Health Victoria website has information on adolescent sexuality and disabilities – www.betterhealth.vic.gov.au

WORKING WITH CHALLENGING YOUNG PEOPLE

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

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

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

Example:

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

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

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

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

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

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

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

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

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

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

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

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

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

"And so you felt..."

"And after that you decided to..."

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

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

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

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

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

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

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

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

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

FINDING OUT MORE...

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

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

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

PRACTICE POINTS

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

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

CHAPTER SUMMARY - WHAT TO REMEMBER

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

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

REFLECTION QUESTIONS

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

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

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

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

REFERENCES

Australian Institute of Health and Welfare. (AIHW). (2008). *Disability in Australia: Intellectual disability*. AIHW bulletin no. 67. Cat. No. AUS 110. AIHW: Canberra.

Australian Institute of Health and Welfare. (AIHW). (2010). *Health of Australians with disability: Health status and risk factors*. AIHW bulletin no. 83. Cat. No. AUS 132. AIHW: Canberra.

Bennett DL & Kang M. (2001). Adolescence. In K Oates, K Currow and W Hu. (eds.). *Child Health: A Practical Manual for General Practice*. MacLennan and Petty: Australia.

Sanci L, Sawyer , Kang M, Haller D & Patton G. (2005). Confidential health care for adolescents: Reconciling clinical evidence with family values. *Medical Journal of Australia*. 183(8), 410-414.

World Health Organization. (WHO). (2011). Disability and health Fact sheet N°352. <http://www.who.int/mediacentre/factsheets/fs352/en/index.html> Viewed 20 May 2014.

SECTION 3.2

PSYCHOSOCIAL ASSESSMENT

3.2 PSYCHOSOCIAL ASSESSMENT

PETER CHOWN

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

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

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

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

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

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

KNOW YOUR YOUTH HEALTH RESOURCES

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

Establish a database and begin developing relationships with other local services supporting young people in the area. Include youth-specific resources, (such as youth health centres, youth refuges, hospital-based adolescent units, and headspace centres)

and mainstream services that may be relevant to young people's needs (alcohol and drug services, sexual assault services, adolescent mental health services, family counselling programs, psychologists and social workers, and schools and vocational training programs).

FINDING OUT MORE...

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

USING HEEADSSS AS A SCREENING TOOL

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

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

It can be used to (Sanci 2001):

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

WHAT HEEADSSS WILL AND WON'T TELL YOU

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

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

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

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

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

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

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

FINDING OUT MORE...

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

ASKING SENSITIVE QUESTIONS

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

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

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

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

Example:

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

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

Example:

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

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

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

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

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

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

FINDING OUT MORE...

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

USING THE HEEADSSS SCREENING TOOL

(Klein, Goldenring and Adelman 2014)

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

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

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

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

FINDING OUT MORE...

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

ALTERNATIVE ASSESSMENT TOOLS FOR YOUNG PEOPLE WITH AN INTELLECTUAL DISABILITY

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

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

- YP-CORE: is a 10-item measure derived from the CORE-OM and designed for use with young

people in the 11-16 years age range. It is structurally similar to the CORE-OM but items have been rephrased to be more easily understood by the target age group.

- CORE-LD: is a variation being developed in Scotland and England. Specifically for use with people with a learning difficulty, it will include items that cover the major issues they face that are not in the CORE-OM.

FINDING OUT MORE...

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

WHAT COMES NEXT

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

PROVIDING FEEDBACK

Give the young person some feedback about the assessment.

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

Example:

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

Or:

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

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

Example:

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

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

Example:

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

PRACTICE POINT ON DISCLOSURES OF ABUSE

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

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

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

NEGOTIATING A MANAGEMENT PLAN

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

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

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

WRAPPING UP THE INTERVIEW

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

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

Example:

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

Or:

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

(Bennett and Kang 2001)

If a follow-up meeting is needed, encourage the young person to return and explain why it is important that you see them again. If you feel concerned that the young person might not keep the appointment, make a contract with them to return. You could offer to give them a reminder call; just ask

them for the best way to contact them. These steps help you to further cement the relationship you have started building with the young person.

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

FINDING OUT MORE...

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

INVOLVING PARENTS AND CARERS IN THE MANAGEMENT PLAN

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

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

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

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

FINDING OUT MORE...

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

RESISTANCE TO PARENTAL INVOLVEMENT

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

Example:

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

Or:

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

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

Examples:

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

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

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

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

PRACTICE POINTS FOR CONDUCTING PSYCHOSOCIAL ASSESSMENTS

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

CHAPTER SUMMARY - WHAT TO REMEMBER

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

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

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

REFLECTION QUESTIONS

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

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

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

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

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

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

REFERENCES

Bennett DL & Kang M. (2001). Adolescence. In K Oates, K Currow K and W Hu. (eds.). *Child Health: A Practical Manual for General Practice*. MacLennan and Petty: Australia.

Goldenring J & Rosen D. (2004). Getting into adolescent heads: An essential update. *Contemporary Pediatrics*. 21, 64-90.

Klein D, Goldenring J & Adelman WP. (2014). HEEADSSS 3.0: The psychosocial interview for adolescents updated for a new century fuelled by media. *Contemporary Pediatrics*. January, 16-28. contemporarypediatrics.modernmedicine.com. Published online Jan 01, 2014.

Sanci L. (2001). *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners: Melbourne.

SECTION 3.3

UNDERSTANDING RISK-TAKING BEHAVIOUR

3.3 UNDERSTANDING RISK-TAKING BEHAVIOUR

PETER CHOWN

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

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

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

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

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

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

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

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

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

UNDERSTANDING RISK-TAKING

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

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

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

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

PRACTICE POINT - WHAT'S NORMAL AND WHEN TO WORRY

Normal adolescent behaviours include:

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

PRACTICE POINT - WHAT'S NORMAL AND WHEN TO WORRY

Worrying behaviours include:

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

ASSESSING THE DANGER OF RISK-TAKING

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

IDENTIFYING RISK AND PROTECTIVE FACTORS

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

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

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

ASSESSING THE DEGREE OF RISK

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

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

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

TABLE 4 – RISK AND PROTECTIVE FACTORS

Risk factors Characteristics of the young person and their social environment that increase their vulnerability to harm.	Protective factors Individual and environmental factors that increase resistance to risk factors.
Youth factors	
<ul style="list-style-type: none"> • Low self-esteem • Poor social skills • Poor problem-solving skills • Lack of empathy • Homelessness • Diagnosed Attention Deficit Hyperactivity Disorder (ADHD) • Non-adherence with health treatments 	<ul style="list-style-type: none"> • Social competence • Solid problem-solving skills • Optimism • Good coping style • School achievement • Strong sense of moral values/spiritual beliefs • Creativity and imagination
Family factors	
<ul style="list-style-type: none"> • Family conflict/breakdown/violence • Harsh or inconsistent discipline • Lack of warmth and affection • Physical and/or sexual abuse and neglect • Lack of meaningful relationships with adults 	<ul style="list-style-type: none"> • Supportive, caring parents or carers • Secure and stable family environment • Supportive relationship with other adults • Attachment to family
School factors	
<ul style="list-style-type: none"> • School failure or dropping out • Bullying • Peer rejection • Deviant peer group • Learning difficulties 	<ul style="list-style-type: none"> • Positive school climate • Pro-social peer group • Positive achievements and sense of belonging at school • Opportunities for some success (at sport, study etc.) or development of a special talent/hobby • Recognition of achievement
Community & Cultural factors	
<ul style="list-style-type: none"> • Socio-economic disadvantage • Exposure to violence and crime • Homelessness • Refugee experience • Racism or discrimination • Intercultural conflict (the young person trying to 'fit in' and adapt to the new culture) • Lack of support services 	<ul style="list-style-type: none"> • Attachment and belonging to community • Access to support services • Participation in community group • Strong cultural identity/pride • Secure home/housing

TABLE 5 – OVERALL RISK STATUS

Risk level	Description	Characteristics	Example
No Risk	Not yet engaged in risk-taking behaviour	<ul style="list-style-type: none"> Well-adjusted Family, school and social functioning are stable and positive Presence of a number of protective factors 	
Low Risk	Engaged in experimentation	<ul style="list-style-type: none"> 'Safe' experimenter Risk-taking is sporadic, recreational and experimental Family, social and school profile is stable Protective factors outweigh risk behaviours May need monitoring if individual or environmental risk factors present 	A young person who has experimented with marijuana with peers, but who has stable family and peer relationships, and is doing well at school
Moderate Risk	Engaged in behaviours with harmful consequences (i.e. impairment of positive functioning and developmental tasks)	<ul style="list-style-type: none"> Vulnerable Presence of social/environmental risk factors (family problems, peer group influences; or other risk factors such as low self-esteem and family history of depression) Presence of some protective factors (such as positive family, school or peer support) Requires intervention 	A depressed young person with low self-esteem and a family history of depression, who occasionally smokes marijuana by himself
High Risk	Major disruption or risk to health, safety or life	<ul style="list-style-type: none"> Troubled or out-of-control Persistent and/or escalating harmful behaviours Persistent and/or negative consequences (e.g. disruption of relationships, poor school performance, trouble with police, conflict with family) Presence of major risk factors and few protective factors 	A young person who is involved in anti-social behaviour, at risk of expulsion from school, with frequent alcohol and substance use, and with a lack of family support

UNDERSTANDING THE EFFECTS OF TRAUMA

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

Research has highlighted the adverse effects of early onset trauma on the developing brain. Early onset trauma requires the brain to shift its focus from learning to survival and disrupts the neural integration necessary to respond flexibly to daily challenges (Courtois and Ford 2009). The effects of complex

trauma on individual functioning are pervasive and deeply disruptive to the key developmental of attachment, self-regulation and the development of competencies (Kezelman and Stavropoulos 2012; Siegel and Hartzell 2004).

FINDING OUT MORE...

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

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

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

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

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

YOUNG PEOPLE AT HIGH RISK

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

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

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

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

FINDING OUT MORE...

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

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

WORKING WITH YOUNG PEOPLE AT HIGH RISK

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

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

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

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

DISCUSSING RISK

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

Example:

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

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

Example:

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

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

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

Example:

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

PROMOTING BEHAVIOUR CHANGE

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

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

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

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

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

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

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

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

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

TABLE 6 – STAGES OF CHANGE

Stage of change	Issues	Strategies
Pre-contemplation	<ul style="list-style-type: none"> • Hasn't thought about change • Young person doesn't see the problem as an issue 	<ul style="list-style-type: none"> • Increase awareness of risks associated with current behaviour • Identify risks and benefits of their behaviour • Identify effects on others • Provide information on health/social consequences
Contemplation	<ul style="list-style-type: none"> • Considering the benefits of changing and the risks associated with not changing • Young person thinking about change 	<ul style="list-style-type: none"> • Reinforce benefits of changing • Elicit person's own reasons for changing • Motivate, encourage to make goals for change • Examine pros and cons of changing • Support young person to reduce risks associated with their behaviour
Decision/Determination	<ul style="list-style-type: none"> • Ready to make a change • Young person is making a plan to change 	<ul style="list-style-type: none"> • Strengthen young person's belief in their ability to change • Provide a range of options for action • Assist in developing concrete action plans, setting gradual goals
Action	<ul style="list-style-type: none"> • Carries out specific action plans for change • Dealing with barriers to change 	<ul style="list-style-type: none"> • Provide positive reinforcement • Assist with problem solving • Identify barriers to change • Identify social supports • Teach coping skills • Identify harm reduction strategies • Refer to specialist services
Maintenance	<ul style="list-style-type: none"> • Developing strategies for sustaining changes 	<ul style="list-style-type: none"> • Affirm and support behaviour change • Teach coping skills • Foster strengths and protective factors • Provide reminders • Identify alternatives • Identify social supports
Relapse	<ul style="list-style-type: none"> • Re-engagement in problem behaviour 	<ul style="list-style-type: none"> • Empathise and normalise as part of the change process • Assist in resuming the change process • Return to 'Determination' and 'Action' stages • Avoid guilt, blame and demoralisation

MOTIVATIONAL INTERVIEWING

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

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

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

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

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

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

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

FINDING OUT MORE...

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

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

INTERVENTIONS

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

TABLE 7 – INTERVENTIONS FOR RISK-TAKING BEHAVIOURS

Risk status	Possible interventions
No risk/low risk	<ul style="list-style-type: none"> • Aim to prevent the emergence of problem behaviour • Provide preventative health education and health promotion messages • Enquire about their level of knowledge and provide objective information about the health consequences associated with a particular behaviour • Build a trusting relationship so that they might return if concerns arise in the future
Moderate/high risk	<ul style="list-style-type: none"> • Reduce modifiable risk factors/behaviours • Assess other external risks to safety: if a young person discloses violence or abuse, develop a safety plan with the young person and people in their identified safety network, and notify police • Use harm minimisation strategies to help reduce the dangers associated with risky behaviours • Develop a management plan with the young person to reduce risks associated with the behaviour and find safer alternatives • Provide health education and counselling • Refer as necessary to specialist treatment and support services • Strengthen protective factors • Identify and reinforce the young person's strengths • Identify ways to enhance protective factors in their lives – e.g. family counselling, school mediation • Teach the young person protective behaviours to reduce risks – e.g. safer sexual practices, refusal and assertiveness skills

STRATEGIES FOR PROMOTING RESILIENCE

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

CASE STUDY: WORKING WITH MARK TO REDUCE RISK

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

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

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

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

RISK ASSESSMENT

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

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

He is engaged in the following risk-taking behaviours:

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

You have identified the following protective factors:

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

RISK STATUS

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

MANAGEMENT APPROACHES

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

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

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

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

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

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

CASE STUDY: SAMANTHA'S RISK

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

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

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

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

RISK ASSESSMENT

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

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

You also identify the following protective factors:

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

RISK STATUS

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

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

MANAGEMENT APPROACHES

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

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

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

PRACTICE POINTS - ASSESSING AND ADDRESSING RISK

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

CHAPTER SUMMARY - WHAT TO REMEMBER

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

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

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

REFLECTION QUESTIONS

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

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

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

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

REFERENCES

- Baer JS & Peterson PL. (2002). Motivational interviewing with adolescents and young adults. In W Miller and S Rollnick (eds.) *Motivational Interviewing: Preparing People for Change*. 2nd ed. Guildford Press: London.
- Blum R. (1998). Healthy youth development as a model for youth health promotion – a review. *Journal of Adolescent Health*. 22(5), 368-375.
- Bond L, Thomas L, Toumbourou J, Patton G & Catalano R. (2000). *Improving the lives of young Victorians in our community: A survey of risk and protective factors*. Centre for Adolescent Health: Melbourne.
- Clarke S. (2000). Adolescent Risk-Taking Behaviour. *Australian Doctor*. 111, 1.
- Courtois CA & Ford JD. (2009). *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide*. The Guilford Press: New York.
- Fuller A. (1996). *From Surviving to Thriving – Promoting Mental Health in Young People*. ACER Press: Melbourne.
- Garcia K & Mann T. (2003). 'I Wish' to 'I Will': social-cognitive predictors of behavioral intentions. *Journal of Health Psychology*. 8, 347-360.
- Gomez F. (2002). Harnessing the winds of change. *Australian Doctor*. 35-36.
- Kezelman C & Stavropoulos P. (2012). *The Last Frontier. Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care And Service Delivery*. ASCA: Sydney.
- Prochaska JO, DiClemente CC & Norcross K. (1992). In search of how people change: applications to addictive behaviours. *American Psychologist*. 47(9), 1102-1104.
- Resnick M, Harris L & Blum R. (1993). The impact of caring and connectedness on adolescent health and wellbeing. *Journal of Paediatric Child Health*. 29, S3-S9.
- Rogers N. (2005). *The prevalence of mental health needs in young drug users: Implications for service delivery*. Paper presented at the Australasian Professional Society of Alcohol and Other Drugs (APSAD). Melbourne.
- Sanci L. (2001). *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners: Melbourne.
- Siegel DJ & Hartzell M. (2004). *Parenting from the Inside Out: How a Deeper Understanding Can Help You Raise Children Who Thrive*. Penguin: New York.
- Toro PA, Dworsky A & Fowler PJ. (2007). Homeless Youth in the United States: Recent Research Findings and Intervention Approaches. In D Dennis, G Locke & J Khadduri (eds). *Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research*. 6-1, 6-33. U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development: Washington DC.
- West R. (2005). Time for a change: Putting the Transtheoretical (Stages of Change) model to rest. *Addiction*. 100(8), 1036-1039.

SECTION 3.4

TRAUMA-INFORMED PRACTICE

3.4 TRAUMA-INFORMED PRACTICE

LETICIA FUNSTON

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

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

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

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

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

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

VIOLENCE, TRAUMA AND AUSTRALIA'S YOUNG PEOPLE

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

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

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

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

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

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

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

SEXUAL VIOLENCE

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

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

Sexual violence can include:

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

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

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

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

FINDING OUT MORE...

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

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

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

PHYSICAL ABUSE

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

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

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

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

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

EMOTIONAL ABUSE AND BULLYING

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

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

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

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

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

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

DOMESTIC AND FAMILY VIOLENCE

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

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

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

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

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

We also know that:

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

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

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

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

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

TECHNOLOGY-BASED RISKS

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

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

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

HOW TRAUMA AFFECTS A YOUNG PERSON

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

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

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

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

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

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

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

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

TRAUMA-INFORMED PRACTICE

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

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

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

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

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

Trauma-informed practice is inherently strengths-focused and emphasises the young person's ability to survive. It specifically resists the idea that a young person has a distorted or pathological world view

in the aftermath of violence (Burstow 2003) and instead requires the practitioner to understand that a young person's responses or ways of coping have developed in the context of trauma. Trauma-informed practitioners will validate and attempt to understand a young person's resilience even if the chosen coping strategies are now causing difficulties.

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

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

TABLE 8 – COMPARING THE APPROACHES

(HENDRICKSON 2010)

Punitive Approach	
	<ul style="list-style-type: none"> • Punishment is used to enforce obedience to a specific authority. This can re-traumatise young people who have been abused by caregivers and other adults who are in a position of power. • Punitive language and rules can escalate conflict. • Punishment is usually used to assert power and control and often leaves a young person feeling helpless, powerless, and ashamed. • Punishment often benefits service providers but not young people who may be expressing extreme distress and trauma.
Trauma-Informed	
	<ul style="list-style-type: none"> • Intentionally designed to teach and to shape behaviour within firm limits using non-blaming, non-shaming and non-violent communication. • Trauma-informed practice means discussing consequences that are clearly connected to the behaviour, delivered with genuine empathy and respect. • Trauma-informed practice uses words that encourage thinking, and preserve connections between people.

SAFETY: PHYSICAL, EMOTIONAL AND CULTURAL

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

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

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

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

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

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

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

UNDERSTANDING DISCLOSURE

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

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

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

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

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

FINDING OUT MORE...

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

CASE STUDY: SUPPORTING VIV

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

PART ONE: STANDARD CARE

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

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

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

PART TWO: TRAUMA-INFORMED PRACTICE

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

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

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

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

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

CHAPTER SUMMARY - WHAT TO REMEMBER

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

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

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

REFLECTION QUESTIONS

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

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

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

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

REFERENCES

AIDS Council of New South Wales. (2008). *Another Closet: Domestic Violence in Gay and Lesbian Relationships*. Sydney: ACON.

Attorney General's Department of NSW. (2003). *You shouldn't have to hide to be safe. A report on homophobic hostilities and violence against gay men and lesbians in NSW*. Available <http://www.acon.org.au/sites/default/files/YouShouldntHaveToHidetoBeSafe2.pdf>. Viewed 20 May 2014.

Australian Institute of Family Studies. (2012). Child Sexual Abuse [Online]. Australian Government. Available <http://www.aifs.gov.au/cfca/pubs/factsheets/al42086> Viewed 20 May 2014.

Australian Institute of Health and Wellbeing. (AIHW). (2013). *Child Protection Australia 2011-12*. Child Welfare Series no. 55. Cat. No. CWS 43. AIHW: Canberra.

Bell-Gadsby C, Clark N & Hunt S. (2006). *It's a Girl Thing! A Manual on Creating Girls Groups*. McCreary Youth Foundation: Vancouver.

Brown L. (2004). Feminist paradigms of trauma treatment. *Psychotherapy, Theory, Research Practice, Training*. 42, 464-471.

Burstow B. (2003). Toward a radical understanding of trauma and trauma work. *Violence Against Women*. 9, 1293-1317.

Courtois CA & Ford JD. (2009). *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide*. The Guilford Press: New York.

Cusack KJ, Morrissey JP & Ellis AR. (2008). Targeting trauma-related interventions and improving outcomes for women with co-occurring disorders. *Administration and Policy in Mental Health*. 35, 147-158.

Demetrius J & Ware C. (2012). *Ombudsman's Audit for the implementation of the New South Wales Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011*. National Yarn Up: Sharing the Wisdoms and Challenges of Young People and Sexual Abuse. Sydney.

- Domestic Violence and Incest Resource Centre Victoria (2005). Young people and domestic violence fact sheet A. Available <http://www.burstingthebubble.com/YoungPeopleDV%20FactSheet.pdf>. Viewed August 2013.
- Elliott DE, Bjelajac P, Fallot RD, Markoff LS & Reed BG. (2005). Trauma informed or trauma denied: Principles and implementation of trauma informed services for women. *Journal of Community Psychology*. 33, 461-477.
- Fallot RD & Harris M. (2006). Trauma-Informed Services: A Self-Assessment and Planning Protocol. Community Connections. Available <http://smchealth.org/sites/default/files/docs/tiscaprotocol.pdf>. Viewed 20 May 2014.
- Felitti V. (2002). The relationship between adverse childhood experiences and adult health: Turning gold into lead. *The Permanente Journal*. 6, 44-47.
- Herman JL. (1992). *Trauma and Recovery*. Pandora: London.
- Hopper E, Bassuk E & Olivet J. (2010). Shelter from the storm: Trauma-informed care in homelessness service settings. *The Open Health Services and Policy Journal*. 3, 80-100.
- Hummer VL, Dollard N, Robst J & Armstrong M. (2010). Innovations in implementation of trauma-informed care practices in youth residential treatment: A curriculum for change. *Child Welfare*. 89, 79-95.
- Hunter C. (2011). *Responding to Children and Young People's Disclosures of Abuse*. National Child Protection Clearinghouse: Practice Brief. Australian Government Institute of Family Studies: Melbourne.
- Indig D, Vecchiato C, Haysom L, Beilby R, Mamone N, Muir P, van den Dolder P & Whitton G. (2011). *2009 NSW Young People in Custody Health Survey: Full Report*. Justice Health and Juvenile Justice: Sydney.
- James M. (1994). Child abuse and neglect: Incidence and prevention. *Family Matters*. 37, 80-85.
- Luke KP. (2009). Sexual violence prevention and technologies of gender among heavy-drinking college women. *Social Service Review*. 83, 79-109.
- Kezelman C. & Stavropoulos P. (2012). The Last Frontier. *Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care And Service Delivery*. ASCA: Sydney.
- Laing L. (2000). *Children, Young People and Domestic Violence*. Australian Domestic and Family Violence Clearinghouse, University of New South Wales: Sydney.
- Laing L, Mikulsk J & Kenneough C. (2006). *Evaluation of Newstreet Adolescent Service Sydney*. Social Work and Social Policy Studies, University of Sydney: Sydney.
- Lenhard A. (2009). Teens and sexting: How and why minor teens are sending sexually suggestive nude or nearly nude images via text messages. Pew Internet and American Life Project: Washington, DC. Available http://www.pewinternet.org/files/old-media//Files/Reports/2009/PIP_Teens_and_Sexting.pdf. Viewed September 2013.
- McKenzie-Mohr S, Coates J & McLeod H. (2012). Responding to the needs of youth who are homeless: Calling for politicized trauma-informed intervention. *Children and Youth Services Review*. 34, 136.
- National Society for the Prevention of Cruelty to Children. (NSPCC). (2012). A qualitative study of children, young people and 'sexting'. Available www.lse.ac.uk/media@lse/documents/MPP/Sexting-Report-NSPCC.pdf Viewed 23 April 2014.
- NSW Ombudsman. (2012). *Responding to Child Sexual Assault in Aboriginal Communities: A report under Part 6a of the Community Services (Complaints, Reviews and Monitoring) Act 1993*. NSW Ombudsman: Sydney. Available http://www.ombo.nsw.gov.au/data/assets/pdf_file/0005/7961/ACSA-report-web1.pdf. Viewed 20 May 2014.
- Oliver C & Candappa M. (2007). Bullying and the politics of 'telling'. *Oxford Review of Education*. 33, 71-86.
- O'Hagan M. (2004). Recovery in New Zealand: lessons for Australia? *Australian e-Journal for the Advancement of Mental Health*. 3(1), 1-3.
- Quadara A. (2008). *Responding to young people disclosing sexual assault: A resource for schools*. Australian Centre for the Study of Sexual Assault. Vega Press: Melbourne.
- Quigley B & Leonard K. (2004). *Alcohol use and violence among young adults*. National Institute on Alcohol Abuse and Alcoholism, US Department of Health and Human Services. Available <http://pubs.niaaa.nih.gov/publications/arh284/191-194.htm>. Viewed 20 May 2014.
- Rich J, Corbin T, Bloom S, Rich L, Evans S & Wilson A. (2009). *Healing the Hurt: Trauma Informed Approaches to the Health of Boys and Young Men of Colour*. School of Public Health, Centre for Non-Violence and Social Justice, Drexel University, College of Medicine, Department of Emergency Medicine, Drexel University.
- Rutherford A & Zwi AB. (2007). Preventing violence in New South Wales: data sources and their adequacy. *New South Wales public health bulletin*. 18, 75.
- Siegel DJ & Hartzell M. (2004). *Parenting from the Inside Out: How a Deeper Understanding Can Help You Raise Children Who Thrive*. Penguin: New York.

Stefanidis N, Schneir A, Ballin D, Kmett C, Carmichael H, Gore P, de Gyarfas L, Hendrickson C, Hubbard E, McGaffey J, Phillips L & Rodriguez M. (2010). *Trauma Informed Consequences for Youth Experiencing Homelessness: Putting Theory into Practice*. The Community Trauma Treatment Center for Runaway and Homeless Youth: Los Angeles.

Toro PA, Dworsky A & Fowler PJ. (2007). Homeless Youth in the United States: Recent Research Findings and Intervention Approaches. In D Dennis, G Locke and J Khadduri (eds). *Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research*. 6-1, 6-33. U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development: Washington DC. Available <http://aspe.hhs.gov/hsp/homelessness/symposium07/toro>. Viewed 20 May 2014.

Tutty L. (2011). *Healthy Relationships Preventing Teen Dating Violence: An Evaluation of the Teen Violence Prevention Program*. Canadian Women's Foundation: Toronto.

US National Research Council. (1993). *Understanding child abuse and neglect*. National Academy Press: Washington, DC.

Wood J. (2008). Special Commission of Inquiry into Child Protection Services in NSW. Report of the Special Commission of inquiry into Child Protection Services in NSW. State of NSW: Sydney. Available http://www.dpc.nsw.gov.au/_data/assets/pdf_file/0008/33794/Executive_Summary_and_Recommendations_-_Special_Commission_of_Inquiry_into_Child_Protection_Services_in_New_South_Wales.pdf. Viewed 20 May 2014.

SECTION 3.5

MEDICO-LEGAL ISSUES

3.5 MEDICO-LEGAL ISSUES

MELISSA KANG AND JANE SANDERS

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

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

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

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

UNDERSTANDING MEDICO-LEGAL TERMINOLOGY

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

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

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

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

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

UNDERSTANDING CONSENT

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

Health practitioners may have concerns about these questions because:

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

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

To be valid, consent requires certain qualities:

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

INFORMED CONSENT

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

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

THE CAPACITY OF ADULTS TO CONSENT OR TO REFUSE TREATMENT

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

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

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

THE CAPACITY OF YOUNG PEOPLE TO CONSENT TO TREATMENT

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

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

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

PARENTAL CONSENT FOR TREATMENT

If a child under 18 does not have the capacity to consent to treatment, in general a parent may consent on their behalf.

In many cases, even if a child is competent to consent on their own behalf, a parent may still validly consent on their behalf. However, if a health practitioner considers that a child is competent, it may be appropriate to obtain both parental and patient consent. For some types of major and special treatment (such as sterilisation) parental consent is not sufficient, and a court order is required.

EMERGENCY TREATMENT

In general, treatment may be performed without the consent of either the parent or the child if the health practitioner is of the opinion that the treatment is necessary, as a matter of urgency, in order to save the child or young person's life. In practice, that means that emergency medical and first aid treatment may be provided without the consent of the minor or a parent or guardian.

THE LAW ABOUT CONSENT TO MEDICAL TREATMENT FOR CHILDREN

Australian law is a mixture of statute law (Acts and Regulations, also known as statutes or legislation, made by Parliament) and common law (which is made by the courts when they make decisions which set a precedent for future cases).

In all Australian states and territories except South Australia, there is no legislation specifying when a child may consent to medical treatment on their own behalf. Instead, the common law applies.

At common law, a child under 18 may legally consent to most types of medical treatment on their own behalf if they are competent to do so. If the child is not competent, parental consent must usually be obtained (Bird 2005).

The common law position relating to a minor's competence to consent to treatment was established by the English House of Lords decision in a case known as 'Gillick' (*Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112) and was adopted by the High Court of Australia in a case known as 'Marion's case' (*Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218).

The Gillick case concerned an application by a mother for an order to prohibit the local health authority from giving contraceptive advice to her teenage daughters without parental consent. The court dismissed Mrs Gillick's claim and held that parental authority over their child diminishes as the child becomes increasingly mature. The court held that a child with the maturity to understand the nature and consequences of the treatment has the legal capacity to consent on their own behalf, without the necessity for parental consent or knowledge.

The term 'Gillick competence' is now widely used by lawyers and health practitioners dealing with young people (Wheeler 2006). It is also common to refer to the 'mature minor principle'.

For a child to be 'Gillick competent' he or she must have "sufficient understanding and intelligence to enable him or her to understand fully what is proposed". This must be assessed on a case-by-case basis depending on the nature of the treatment proposed.

SOUTH AUSTRALIA

Section 6 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides:

"A person of or over 16-years-of-age may make decisions about his or her own medical treatment as validly and effectively as an adult." This means that

a child aged 16 or over has the capacity to refuse treatment as well as consent to it.

A child under 16 can validly consent to treatment if:

"The medical practitioner is of the opinion that the child capable of understanding the nature, consequences and risks of the treatment and that the treatment is in the best interest of the child's health and well-being, and

That opinion is supported by the written opinion of at least one other medical practitioner who personally examines the child before the treatment is commenced. (Section 12, Consent to Medical Treatment and Palliative Care Act 1995 (SA))"

If emergency medical treatment is required "to meet an imminent risk to life or health" and the patient is incapable of consenting (e.g. because they are unconscious or lack competence), treatment may proceed without their consent. However, if the patient is 16 or over, they have the right to refuse treatment (*Consent to Medical Treatment and Palliative Care Act 1995 (SA)* Section 13).

NEW SOUTH WALES

New South Wales does not have any legislation specifying when a child has the capacity to consent to medical treatment (NSW Law Reform Commission 2008).

However, under the *Minors (Property and Contracts) Act 1970*, if a minor aged 14 and above consents to their own medical treatment, the minor cannot make a claim against the medical practitioner for assault or battery. Also, where medical treatment of a minor aged less than 16 years is carried out with the consent of a parent or guardian of the minor, the minor cannot make a claim against the medical practitioner for assault or battery.

This law is intended to protect doctors and dentists from liability, but it does not alleviate the need for a practitioner to make an assessment of the young person's competence in each individual case. A child younger than 14 may be competent to consent to treatment. Conversely, a child aged 16 or over may lack competence.

MAKING A COMPETENCY ASSESSMENT

Health practitioners need to make an assessment of competency to consent for all young people aged under 18 years (or 16 years in South Australia).

Competency will depend on age, maturity, intelligence, education, level of independence, and ability to express their own wishes. It will also depend on the gravity of the treatment proposed. For more drastic, invasive or risky types of treatment,

a medical practitioner will need to take special care to ensure that the young person possesses the required competence to consent to treatment.

Health practitioners must form their own opinion about a patient's 'intelligence and understanding'. For a young person, a full understanding involves appreciating:

- What the treatment is for and why the treatment is necessary
- Any treatment options or alternatives
- What the treatment involves
- Likely effects and possible side effects/risks
- The gravity/seriousness of the treatment
- Consequences of not treating
- Consequences of discovery of treatment by parents/guardians

If a health practitioner is unsure whether a minor is competent they can:

- Seek the opinion of a colleague.
- Seek the consent of the minor's parents or legal guardians. Keep in mind, however, the young person's right to privacy and confidentiality and the risks of disclosing sensitive information to a parent, particularly in challenging family situations, or with sensitive areas such as contraception and pregnancy.
- Obtain legal advice about applying for a court or tribunal order if the practitioner considers the treatment to be necessary and in the patient's best interests.

A health practitioner should make a file note about the outcome of the competency assessment. The file note should form part of the patient's medical record.

YOUNG PEOPLE WITH INTELLECTUAL DISABILITIES

A young person with an intellectual disability is not automatically deemed incompetent to consent to treatment. The competence of a young person with an intellectual disability must be assessed on a case-by-case basis.

YOUNG PEOPLE WHO ARE PARENTS

A minor who is a parent has the legal capacity to consent to treatment for his or her child, in the same way as adult parents. However, the minor may not necessarily have legal capacity to consent to his or her own treatment.

LANGUAGE AND CULTURAL ISSUES

A medical practitioner's assessment about a child's competency could be influenced by cultural

differences between the doctor and the young person. A cognitively mature adolescent may come across as socially or emotionally immature (or vice versa) because of different cultural expectations about their roles in the family/society (e.g. they may seem less independent), or differences in the way their thoughts or wishes are communicated. If in doubt, seek advice from a colleague or an appropriate agency.

Valid consent can only be obtained if the young person understands what is being presented in a language in which they are fluent. Health care interpreters should be used where appropriate, particularly when working with a family from a non-English speaking background.

Children should not be used as interpreters for their parents.

Over the telephone interpreting is available through the *Translating and Interpreting Service* (TIS) – telephone 131 450. This is a national service provided through the Department of Immigration and Border Protection and is free to GPs and pharmacists. The TIS is available 24 hours a day, 7 days a week, and is accessible from anywhere in Australia for the cost of a local call.

THE RIGHT TO REFUSE TREATMENT

The Gillick principle that allows for a competent minor to consent to treatment does not allow for a corresponding right to refuse treatment.

In many cases, a health practitioner would be reluctant to perform treatment over a young person's objection, especially if the young person is relatively mature and it is not major or life-saving treatment.

However, treatment may be performed against a child's wishes, even if they are Gillick competent where the treatment is urgent. In such cases, treatment may proceed without obtaining parental or patient consent. Otherwise, parental consent to refuse treatment or a court order would be necessary.

COMMON AND NOT-SO-COMMON MEDICAL ISSUES

PROVIDING SEXUAL HEALTH EDUCATION, INFORMATION AND CONDOMS

There is no restriction on providing these to children of any age, although health workers should ensure that these are being provided in an age-appropriate way.

PRESCRIBING CONTRACEPTION

Hormonal contraception (the oral contraceptive pill, injectable and implantable hormones) can be prescribed for a minor, regardless of the reason/s

why, without parental consent, provided that the young woman is deemed competent by her doctor to give informed consent. This is also true for emergency hormonal contraception ('morning after pill').

STERILISATION

Sterilisation for contraception purposes cannot generally be performed without a court or tribunal order, even if the parent or child gives consent (see further discussion of sterilisation below).

Each state and territory has slightly different laws. In NSW, for example, sterilisation is regarded as a "special medical treatment" and may not be performed on a child under 16 without an order from the Guardianship Tribunal, unless it is performed to remediate a life-threatening condition.

If sterilisation is an unwanted consequence of another treatment which is necessary to save a young person's life or prevent serious damage to their health, treatment can generally be performed with the child's consent (if deemed Gillick competent) or otherwise with parental consent.

However, if sterilisation is sought for contraceptive purposes, or for other purposes (such as menstrual management for a young woman with an intellectual disability) then a court or tribunal order may be required.

For a child who does not have the capacity to consent to non-therapeutic sterilisation (i.e. the sterilisation is not for the purpose of treating a disease), parental consent is not sufficient and a court or tribunal order is required.

This is the effect of the decision of the High Court of Australia in 'Marion's case', which concerned a young woman with an intellectual disability. Her parents were gravely concerned not only about the risk of pregnancy, but also about her ability to cope with menstruation. The court held that where the child is not Gillick competent and the medical procedure is non-therapeutic, a court order is required. This is because there is a significant risk of making a wrong decision about the child's capacity to consent or the child's best interests, and the consequences of making a wrong decision are grave.

In most states and territories, it seems that a Gillick competent child aged 16 or over may be able to consent to sterilisation. However, in accordance with the Family Court's decision in *Re: Jamie* (see the discussion of this case under *Treatment of transgender children*), there may be a need for a court to determine whether or not the child is Gillick competent.

TREATMENT OF TRANSGENDER CHILDREN

The law about treatment of transgender children has been uncertain for some time. It has recently been clarified by the full court of the Family Court of Australia in the case of *Re: Jamie* [2013] FamCAFC 110.

The issues surrounded a child seeking treatment to transition from one gender to another.

The court drew a distinction between stage 1 treatment (which involves hormonal treatment, is reversible and is considered to have few, if any, side effects) and stage 2 treatment (which involves additional treatment with oestrogen and may also involve surgical intervention).

The court held that stage 1 treatment may proceed without court authorisation if the child, parents, and treating medical practitioners agree.

However, stage 2 treatment is another matter. Because there is a significant risk of the wrong decision being made as to a child's capacity to consent to treatment, and the consequences of such a wrong decision would be particularly grave, the court held that:

- If a child *is not* Gillick competent, the court must decide whether or not to authorise stage 2 treatment.
- If a child *is* considered Gillick competent, the child can consent to stage 2 treatment without court authorisation; however, only the court can determine whether the child is Gillick competent.

TERMINATION OF PREGNANCY

In most Australian states and territories, abortion is not completely legal. There are minor variations from state to state, but in general abortion is legally available if it is necessary to avoid serious danger to the woman's life or physical or mental health. Performing an abortion in other circumstances can amount to a criminal offence.

The Australian Capital Territory, Victoria and Tasmania are the only jurisdictions in Australia where abortion has been decriminalised (i.e. where abortion is not referenced in any criminal laws). In those states, medical practitioners are permitted to carry out abortions under the following legislation:

- Australian Capital Territory: *Medical Practitioners (Maternal Health) Amendment Act 2002*
- Victoria: *Victoria Abortion Law Reform Act 2008*
- Tasmania: *Reproductive Health (Access to Terminations) Act 2013*

In most Australian states and territories, the same laws governing consent and confidentiality will apply in the case of a young woman seeking termination, as with any other form of health care. However, in some states and territories parental consent for women under 18 is required:

- Northern Territory – parental consent is required if the young woman is under 16 (section 11, *Medical Services Act*)
- Western Australia – If the young woman is under 16, her parents must be informed and be given the opportunity to be involved in counselling and medical consultations. If the young woman does not wish her parents to be informed, she must apply to the Children's Court to maintain confidentiality (section 334, *Health Act 1911* (WA))
- South Australia – if the young woman is under 16 and can't talk to her parents, she can still give consent for the procedure; however, two doctors will need to certify that she understands her decision and the procedure, and that it is in her best interests.

The legal onus falls on the medical practitioner who will conduct the abortion to ensure that informed consent is obtained from the woman seeking the termination, regardless of her age.

In order to allow the woman to make an informed choice about the decision to terminate the pregnancy, thorough pre-termination counselling and explanation of all possible adverse effects should be provided.

A doctor (or other health provider) can refuse to discuss, refer or assist a termination based on his or her own religious or personal beliefs, without risk of anti-discrimination action. However the provider would have a duty to take appropriate action to explain and offer alternatives, including referral to another practitioner.

These legal principles are the same regardless of whether a young woman is having a surgical or a medical abortion.

MENTAL HEALTH

All states and territories have their own mental health legislation governing voluntary and involuntary treatment for patients with mental illnesses.

In NSW, the Act specifies the surgical procedures and special medical treatments which require consent and who may provide that consent, including, where relevant, the need to get a court or tribunal's authorisation for treatment.

CONFIDENTIALITY, PRIVACY AND ACCESS TO HEALTH RECORDS

CONFIDENTIALITY

All health practitioners have a duty of confidentiality that arises from the nature of the information provided in the course of the therapeutic relationship with the patient. A patient is entitled to expect that information discussed during a consultation will not be shared with other parties without their explicit permission.

If a child has the capacity to consent to medical treatment on their own behalf, they are generally also entitled to confidentiality. This includes the right for the child's health information to be kept confidential from their parents.

If a child is not competent to consent to treatment, and a parent has consented to treatment on their behalf, the parent would be entitled to information about the child's health care.

EXEMPTIONS TO CONFIDENTIALITY

The exemptions to the duty to maintain confidentiality are both legal and ethical.

WHERE THE PATIENT CONSENTS TO DISCLOSURE

A patient can give express verbal or written permission or implied permission for their health provider to disclose information to a third party – e.g. a parent, or another professional involved in their care. Such consent should not be coerced and should be adequately documented. It is important to discuss and clarify with the young person whether they consent to others having access to their health information, and under what circumstances.

WHERE DISCLOSURE IS NECESSARY TO TREAT A CLIENT

If there are multiple providers involved in a young person's health care, it can be considered reasonable that communication between providers would serve in the best interests of the patient: the concept of 'team confidentiality' can be explained to patients when working within a multidisciplinary team. However, it is advisable to seek a patient's permission to disclose any non-urgent communications outside these parameters.

WHERE THE PROVIDER IS COMPELLED BY LAW TO DISCLOSE

Note that in these instances, information disclosed is usually kept in confidence and not divulged to outside parties:

- Court proceedings – these may involve a provider giving evidence in court or producing health records under subpoena. However, the

provider may be able to claim privilege over this information and should not simply disclose them to the court without obtaining legal advice.

- Notifications – medical practitioners have specific requirements to notify public authorities of matters such as:
 - » Evidence of a notifiable disease (including HIV infection, AIDS, all forms of hepatitis, tuberculosis, and several others)
 - » Reporting of blood alcohol level test results for patients admitted to hospital after a motor accident
 - » Births and deaths
- Mandatory reporting of child abuse (see Mandatory Reporting, below).
- Best interests of the patient – this exemption relates to a situation where a provider believes there is a real risk of serious harm to the patient – e.g. a young person at risk of suicide – if information is not disclosed to a third party. Such a decision and the basis upon which it is made should be well documented in the patient's medical record, especially in circumstances where the patient has not consented to the disclosure.
- Public interest – in practice, this could include a situation where a provider is made aware by a patient that they have committed, or intend to commit, a serious criminal offence. Practitioners should obtain legal advice about whether or not they have an obligation to disclose the information depending on the circumstances.

PRIVACY AND ACCESS TO HEALTH RECORDS

Privacy and confidentiality are very similar concepts. As well as a common law right to confidentiality, patients have a statutory right to privacy over their health information and health records.

The *Privacy Act* 1988 (Commonwealth) applies throughout Australia and applies to personal and health information held by private sector providers. It does not cover state and territory public hospitals and clinics.

States and territories have their own laws covering privacy and health records. These apply to public sector agencies, and some apply also to the private sector (e.g. the NSW Health Records and Information Privacy Act 2002 applies to both)

In general, patients have a right of access to their health records, a right to demand that the records be corrected if inaccurate, and a right to ask for their health information not to be shared with other health providers or third parties.

There are exceptions to the right to privacy in certain circumstances, similar to the exemptions to confidentiality discussed above.

Young people under 18 can exercise their own privacy choices (e.g. not allow parents to see their records) once they are able to understand and make their own decisions. Generally, this will go hand-in-hand with competence to consent to medical treatment (Australian Law Reform Commission 2006).

MEDICARE AND PRIVACY

Children can apply for their own Medicare card (and number) when they turn 15, without parental consent. Those under 15 can apply with parental consent.

Young people do not necessarily have to have their own Medicare card to seek a health service that attracts a Medicare rebate independently of their parents. Health professionals may accept the Medicare number linked to the patient's parents without physically seeing the card.

Medicare records include the identity and specialty of the provider of a health service and the type of service received. If a young person has their own Medicare card, parents and guardians cannot access Medicare record information without the consent of the young person. If the young person is still on the family Medicare card and aged 14 or 15, generally their consent must be obtained before information about Medicare records is released to parents or guardians.

Parents and guardians have the right to request Medicare Australia to approach health providers about whether they will release information about their adolescent child.

Once a child is 16, Medicare can only give information to parents or guardians with the young person's consent.

EHEALTH RECORDS AND PRIVACY

The eHealth system is designed to contain an electronic summary of a person's key health information such as prescribed medications, allergies and treatments they have received. Health practitioners can upload health information to the eHealth record for individual patients and view the information in it uploaded by other practitioners.

Young people under 18 may have an eHealth record.

A person with parental responsibility for a person under 18 can register for an eHealth record on their child's behalf. The parent can then access and control the eHealth record of that young person

on their behalf as an "Authorised Representative", until the young person takes control of their eHealth record or turns 18.

If the young person has capacity to consent to treatment and confidentiality in their own right, a parent cannot be their "Authorised Representative" unless the child consents to this.

When a young person turns 14, information from both the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) will cease to be included in their eHealth record. This information will only be made available again if the young person takes control of their eHealth record and consents to the inclusion of MBS and/or PBS data.

If a young person is under 14 and would like to take control of their existing eHealth record or register for an eHealth record, they will need to prove to the System Operator that they can make decisions about their healthcare and can manage their eHealth record.

CHILD PROTECTION AND MANDATORY REPORTING

All states and territories in Australia have legislation pertaining to the care and protection of children and young people. All have mandatory reporting requirements for health professionals, and many extend the mandatory reporting requirements to a range of other people who work with children. Mandatory reporting refers to the legislative requirement imposed on certain people to report suspected cases of child abuse and neglect to government authorities.

Each state has its own laws concerning who has to report, what types of abuse and neglect need to be reported, and the threshold of concern of harm which triggers the obligation to report.

NEW SOUTH WALES

In NSW, for the purposes of child protection legislation a child is a person under 16 years of age, and a young person is 16 or 17 years old.

It is mandatory for any professional working with children to notify if they have reasonable grounds to suspect that a child under 16 is at risk of significant harm. In addition, health workers may make a report about a young person aged 16-17 or class of young people that they suspect are at risk of significant harm.

Factors that may indicate a child is at risk of significant harm include physical, sexual or emotional/psychological abuse, neglect, or exposure to family violence. (Sections 23 & 27, *Children and Young Persons (Care and Protection) Act 1988* (NSW)).

In NSW mandatory reporters are those who deliver the following services to children as part of their paid or professional work:

- Health care - doctors, nurses, dentists and other health workers
- Welfare - psychologists, social workers and youth workers
- Education - teachers
- Children's services - child care workers, family day carers and home based carers
- Residential services - refuge workers, community housing providers
- Law enforcement - police

Any person with direct responsibility to provide the services listed above must report risk of significant harm to children. Managers, including both paid employees and volunteers, who supervise direct services are also mandated to report. If you are a mandatory reporter, you can call the Child Protection Helpline on 133 627. Members of the general public should call 132 111.

In NSW Child Wellbeing Units (CWUs) exist within four government departments – NSW Police Force, Department of Education and Communities, NSW Health and the Department of Family and Community Services. CWUs provide advice to mandatory reporters within the agency in which they are based. The NSW Health Child Wellbeing Units can be contacted on 1300 480 420. Agencies without a CWU can contact the Keeping Them Safe Support Line for information and advice on 1800 772 479.

FINDING OUT MORE...

In NSW, mandatory reporters are encouraged to use the Mandatory Reporter Guide to guide their decision making and determine whether or not to report to the Child Protection Helpline. The interactive online guide can be visited at www.keepthemsafe.nsw.gov.au.

Find out more about mandatory reporting in NSW at www.community.nsw.gov.au

Information and advice on domestic violence in NSW is available at www.domesticviolence.nsw.gov.au.

A NEW APPROACH TO CHILD PROTECTION

Child safety and wellbeing is a whole of community responsibility. Therefore reporting children at risk of significant harm is only a part of the health worker role. Health workers participate in a shared system of child wellbeing and child protection by identifying risk of harm,

consulting the Mandatory Reporter Guide and their Child Wellbeing Unit if appropriate, and responding to the vulnerabilities, risks and needs of families, children and young people that they identify. For example, the Health worker may provide family support services and refer to other services for additional family support.

The role and responsibilities of NSW Health workers in the new approach to child protection are outlined in the fact sheet that can be found at:

http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_007.pdf

AUSTRALIAN CAPITAL TERRITORY

In the ACT, health professionals must notify if they believe on reasonable grounds that a child or young person has experienced or is experiencing sexual abuse or non-accidental physical injury (section 356, Children and Young People Act 2008 (ACT)).

NORTHERN TERRITORY

In the NT, any person must make a report if they believe on reasonable grounds that a child of any age has suffered or is likely to suffer harm or exploitation, physical or sexual abuse, emotional/psychological abuse, neglect, exposure to physical violence (e.g. a child witnessing violence between parents at home) (sections 15, 16 & 26, Care and Protection of Children Act 2007 (NT)).

In addition, a registered health professional must report if they have reasonable grounds to believe a child aged 14 or 15 has been, or is likely to be, a victim of a sexual offence and the age difference between the child and the offender is greater than two years (section 26(2), Care and Protection of Children Act 2007 (NT)).

QUEENSLAND

In Queensland, a doctor or registered nurse must report if they become aware of, or develop a reasonable suspicion of, harm or risk of harm due to factors of physical, psychological/emotional abuse, neglect, sexual abuse or exploitation (sections 191-192 & 158, Public Health Act 2005 (Qld)).

SOUTH AUSTRALIA

In SA, doctors, pharmacists, registered or enrolled nurses, dentists, psychologists, employees/volunteers in a government department, agency or instrumentality, or local government agency that provides health services wholly or partly for children must report if they suspect or believe on reasonable grounds that a child has been or is being emotionally/psychologically abused or neglected (Children's Protection Act 1993 (SA)).

TASMANIA

In Tasmania, registered medical practitioners, nurses, midwives, dentists, dental therapists / hygienists, registered psychologists and employees/volunteers in a government department, agency or instrumentality, or local government agency that provides health services wholly or partly for children must report knowledge, belief or suspicion on reasonable grounds that a child has been or is being abused or neglected or is an affected child whose safety, psychological wellbeing or interests are affected or likely to be affected by family violence; or there is a reasonable likelihood of a child being killed, sexually/physically/psychologically abused or neglected by a person with whom the child resides (sections 3, 4 & 14, Children, Young Persons and Their Families Act 1997 (TAS)).

VICTORIA

In Victoria, registered medical practitioners, midwives or registered nurses must report a belief on reasonable grounds that a child is in need of protection because they have suffered, or are likely to suffer, significant harm as a result of physical injury, sexual abuse, emotional/psychological harm and the child's parents have not protected, or are unlikely to protect, the child from harm of that type or the child has been abandoned by their parents or the parents can't be found or are incapacitated /dead and there is no-one else willing to take the child (sections 182, 184 & 162, Children, Youth and Families Act 2005 (Vic))

WESTERN AUSTRALIA

In WA, doctors, nurses and midwives must report a belief on reasonable grounds that child sexual abuse has occurred or is occurring (sections 124A & 124B, Children and Community Services Act 2004 (WA)).

VOLUNTARY REPORTING

In situations where a health practitioner does not consider that the threshold of 'risk of significant harm' is met, reporting is not mandatory. However, voluntary reporting is provided for under the relevant legislation (for example, in NSW, it is not mandatory to make a report in relation to a young person aged 16 or 17).

PROTECTION FOR HEALTH PRACTITIONERS

Under the relevant legislation, a health practitioner is protected from civil or criminal liability (e.g. breach of confidentiality litigation, professional misconduct action, defamation proceedings) if they make a report (whether voluntary or mandatory) in good faith to the relevant child protection authority.

They are also protected from having their identity disclosed to the extent that this is possible.

In NSW the legal framework for information exchange allows organisations to share information relating to the safety, welfare and wellbeing of children or young people without consent. The safety, welfare and wellbeing of children and young people is considered paramount and takes precedence over the protection of confidentiality or of an individual's privacy. While consent is not necessary, it should be sought where possible. Organisations should at a minimum advise children, young people and their families that information may be shared with other organisations.

FINDING OUT MORE...

In NSW there are specific policies which provide guidance and agreed interagency procedures for exchanging information related to the safety, wellbeing and welfare of children and young people, and which allow information exchange to occur irrespective of whether a report has been made to the Child Protection Helpline. Visit www.health.nsw.gov.au/policies (use child wellbeing as a search term) or www.KeepThemSafe.nsw.gov.au.

RECOGNISING RISK OF HARM

In practice, because adolescence is a time of experimenting with high risk behaviours, it can be difficult to determine what constitutes a mandatory reporting concern. If a report is going to be made, it is nearly always advisable to inform the young person and to explain why you are going to make a report.

A number of things should be considered in determining whether a child/young person is at significant risk of harm, including:

- The age, development, functioning, and vulnerability of the child or young person
- Behaviours of a child that suggest they may have been harmed by another person (e.g. mimicking violence; sexualised behaviour, unexplained physical complaints)
- Behaviour of another person which might have a negative impact on healthy development, safety or wellbeing (e.g. drug abuse; domestic violence)
- Physical signs of abuse or ill-treatment (e.g. bruises; lacerations; burns; fractures or other injuries)
- Concern about other family members (e.g. recent abuse or neglect of a sibling, or parents experiencing mental health problems)

Under-age sex does not necessarily equate to abuse, and is not automatically a ground for mandatory reporting.

If you have any concerns or are uncertain about whether you should make a report, call the relevant authority in your state or territory and discuss your concerns with them.

FINDING OUT MORE...

The Australian Institute of Family Studies (AIFS) has a factsheet that examines legal provisions requiring specified people to report suspected abuse and neglect to government child protection services in Australia. It is available at www.aifs.gov.au/cfca/pubs/factsheets/a141787

CULTURAL ISSUES

Some traditional cultural practices may place a young person at risk of harm. For example, the practice of female genital mutilation (FGM), which is practised in a number of countries, is a criminal offence in Australia.

It is important to be aware of different cultural practices and to determine whether there is any risk of harm to the young person before reporting such practices.

Handle such situations sensitively – explain to patients that legal and ethical issues may override cultural considerations and that all Australians are bound by Australian law, regardless of cultural traditions.

There have been cases in which a child or young person has been wrongly assessed by a mandatory or voluntary reporter as suffering from abuse from culturally determined health practices (e.g. “coining” or “cupping” in Vietnamese and Laotian communities) which are in fact acceptable and safe practices within the Australian context. If you are in doubt about a particular cultural practice, consult with a culturally appropriate or bilingual health professional.

FINDING OUT MORE...

There is a wide range of resources available to help health practitioners understand and navigate medico-legal issues.

For further information about relevant laws applying to young people the Australasian Legal Information Institute (AustLII) provides an online database of Australian legislation and case law - www.austlii.edu.au

For information on a range of legal issues affecting young people in each Australian state and territory, visit the National Children's and Youth Law Centre's lawstuff at www.lawstuff.org.au

The Shopfront Youth Legal Centre is a free legal service for disadvantaged young people. It provides fact sheets on legal issues, including young people and health care in NSW. Visit www.theshopfront.org

For information on Medicare - www.medicareaustralia.gov.au

For information on sexual health and family planning issues - Sexual Health & Family Planning Australia - www.shfpa.org.au

The Office of the Australian Information Commissioner has factsheets on health, eHealth and privacy.

Queensland Health has produced a Guide to Informed Decision-making in Healthcare.

Community based workers may find this guide useful - Working with Youth: A legal resource for community based health workers. Child and Adolescent Health Service, WA. (2009).

Chapters by Kang and Sanders (2013) and Sanci (2001) also provide overviews of medico-legal issues for health professionals.

CHAPTER SUMMARY - WHAT TO REMEMBER

Medico-legal issues that arise when working with young people are rarely clear-cut. Much responsibility is placed on health practitioners to make an assessment of the young person's capacity to consent to treatment or to refuse treatment. There are, however, some circumstances where common law or legislation establishes exactly what is required.

REFLECTION QUESTIONS

How comfortable are you with your understanding of medico-legal issues and how they affect the work you do with young people?

Are you a mandatory reporter? Do you understand your obligations in this area? Do you understand how to support families where children are at risk of harm?

Do you know where you can get advice about medico-legal issues?

REFERENCES

- Australian Law Reform Commission. (2006). *Capacity and health information. For Your Information: Australian Privacy Law and Practice*. (ALRC Report 108). <http://www.alrc.gov.au/publications/68.%20Decision%20Making%20by%20and%20for%20Individuals%20Under%20the%20Age%20of%2018/capacity-and-health-info>
- Bird S. (2005). Can children and adolescents consent to their own medical treatment? *Australian Family Physician*. 34(1/2), 73-74. <http://www.racgp.org.au/afp/200501/200501bird.pdf>
- Child and Adolescent Health Service, WA. (2009). *Working with Youth: A legal resource for community based health workers*. http://www.health.wa.gov.au/docreg/Education/Population/Child_Health/Child_Health_Services/HP010283_working_with_youth_FNL_legal_resource.pdf
- Kang M & Sanders J. (2013). Medico-legal issues in adolescent health care. In M Kang, R Skinner, L Sancil and S Sawyer (eds.) *Youth Health and Adolescent Medicine*. IP Communications: Melbourne.
- Lennings N. (2013). Children and refusal of medical treatment: In urgent need of reform. *Journal of Law and Medicine*. 21(1), 122.
- NSW Law Reform Commission. (2008). *Young people and consent to health care: final report*. http://www.lawreform.lawlink.nsw.gov.au/agdbasev7/wr/lrc/documents/pdf/report_119.pdf
- Office of the Australian Information Commissioner. (2013). Fact sheets on health, eHealth and privacy. <http://www.oaic.gov.au/privacy/privacy-resources/privacy-fact-sheets/health-and-ehealth/>
- Queensland Health. (2011). *Guide to Informed Decision-making in Healthcare*. <http://www.health.qld.gov.au/consent/documents/ic-guide.pdf>
- Sancil L. (2001). *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners: Melbourne.
- Wheeler R. (2006). Gillick or Fraser? A plea for consistency over competence in children. *British Medical Journal*. 332, 807.

SECTION 3.6

CULTURAL DIVERSITY AND CULTURALLY- COMPETENT PRACTICE

3.6 CULTURAL DIVERSITY AND CULTURALLY-COMPETENT PRACTICE

PETER CHOWN AND MELISSA KANG

Australia is a country of many cultures. Almost one in four Australian residents were born outside of Australia. Many are first or second generation Australians whose parents and grandparents were migrants or refugees. In the adolescent years, cultural identity and experiences can have a profound impact on health and wellbeing.

Young people from CALD backgrounds face the dual challenge of dealing with the developmental tasks of adolescence and growing up between two cultures. The concept of 'adolescence' - and the expectations, roles and duration of adolescence - may be defined differently in different cultures. Indeed, in some cultures the concept of adolescence does not exist as a developmental stage, and young people are seen as going straight from childhood to adulthood.

Workers need to understand the cultural influences operating in a young person's life and take into account in their practice the range of cultural, ethnic, and social diversity among young people.

CULTURALLY AND LINGUISTICALLY DIVERSE YOUNG PEOPLE

Australia has large and growing numbers of young people from Culturally and Linguistically Diverse Backgrounds (CALD). This includes young people who were born overseas; young people whose parents were born overseas; and young people who have strong affiliations with their family's culture of origin.

In 2011, according to the census, 17% of Australian 12-24 year olds were born overseas.

Of young people born overseas aged 12-24, 157,081 were born in other English-speaking countries, notably New Zealand and the United Kingdom, and around 442,085 were born in non-English speaking countries, including China, India, Philippines, Malaysia, Hong Kong, Vietnam and South Korea.

There continues to be a strong increase in the proportion of young people born in China, India and Nepal and significant increases since 2006 in those born in Zimbabwe, Philippines, Afghanistan, Iraq and Burma.

A young person's experience of belonging to or identifying with a particular culture can be a major protective factor in promoting their overall wellbeing. A sense of belonging, identity and support enables young people and their families not only to survive the hardships, traumas, and losses associated with migration and resettlement, but in fact to be strengthened by these experiences. Strong cultural identification enhances resilience and mitigates such risks as:

- The experience of being a refugee
- Exposure to war
- The impact of their parents' refugee experience (for example, their parents' experience may generate pressure on the young person to succeed in the new country or cause difficulties for parents in providing adequate support because of their own traumatic experiences)
- Separation from family
- Being subjected to torture or trauma
- English language difficulties
- Racism and discrimination
- Post-traumatic stress

ADOLESCENCE AND CULTURAL DIFFERENCE

Many young people from CALD backgrounds face the challenge of dealing with the tasks of adolescence while growing up between two cultures. This involves not only two languages but often very different behavioural and social expectations (Bashir and Bennett 2000).

There may be great variation in cultural values and norms regarding the central tasks of adolescence - such as developing a sense of identity and independence. The achievement of independence and an individual identity are highly valued outcomes of adolescent development in Australia. However, this may conflict with the values of some cultures where "competence" as a young person is primarily defined as someone who meets their obligations to their family (Lau 1990). In some cultures, adolescence is a time of strengthening one's family bonds and taking on increased responsibility and new roles within the family - young people may be more restricted than before and their activities closely monitored. Girls in particular may be subject to stricter controls - especially if parents feel threatened by their exposure to the values of the new and unknown culture.

Young people tend to adapt to the values and ways of the new culture more readily than their parents do, so young people from CALD backgrounds may feel torn between meeting their family's expectations of

them and adopting the norms of the new culture in order to fit in with their peers.

Traditional family roles may also change due to the influence of the new culture. Young people may have to adopt a more adult role in the family because they have greater English literacy and are more familiar with social norms than their parents.

The development of a healthy individual identity is a major task of adolescence. Young people from CALD backgrounds face the additional challenge of deciding about their cultural identity (Bennett et al. 2009).

Some cultures place less emphasis on the importance of the individual – the family and cultural mores are valued above the attainment of an individual identity, and play a central role in shaping the development of the young person's identity (Bennett et al. 2009).

Young people can experience an identity crisis as they attempt to work out their affiliation to their culture of origin and their place within the dominant culture (*Am I Australian? Am I Chinese? Can I be both?*).

This struggle can also give rise to potential conflict with their parents and family members, who may fear losing influence or control over the young person and fear that the young person will abandon their native cultural identity.

Even second and third-generation children of migrants may still have an affiliation with their parents' culture of origin and may therefore face issues related to ethnicity, identity, language and their parents' cultural mores.

The way in which young people resolve these cultural identity conflicts has important implications for their mental health (Bennett et al. 2009). Young people who manage to retain the most important elements of their culture of origin, while developing the skills to adapt to the new culture, appear to cope best in their psychosocial adjustment (Bashir and Bennett 2000).

WORKING WITH YOUNG PEOPLE FROM CALD BACKGROUNDS

It is important to remember that young people from all cultural backgrounds require confidential care and a youth-friendly approach. What is most important is a willingness to engage in a dialogue with the young person about their cultural background and its influence, as well as an awareness of your own cultural biases and perceptions.

Successful engagement with CALD young people may have an extra layer of complexity. However,

the principles of youth-friendly engagement and communication (as outlined in earlier chapters) apply to all young people, regardless of their cultural background.

It can be helpful to have a basic understanding of some of the different customs and cultural beliefs in the populations you work with. Many cultures have specific beliefs and practices for:

- Significant life events or situations (e.g. births, deaths, transitions to adolescence or adulthood, etc.)
- Family relationships and structure (e.g. the role of family authority and decision-making in regard to health care)
- Beliefs about illness and the meanings of symptoms
- Culturally-based health practices and treatments
- Beliefs about food or the use of medications
- Specific cultural or religious practices (e.g. fasting)

While it is useful to have a broad understanding of different cultures, cultural competence is really about the ability to communicate with young people from CALD backgrounds. Cultural competence involves being aware of your own attitudes and beliefs about different cultures and how these influence the way you perceive and communicate with young people from different backgrounds.

No matter their background, the young person you are working with is your most important source of cultural information. Their experience of their cultural background, family history and cultural identity is unique to them, so be open to discussing these things with them (Bennett et al. 2006). Where relevant, ask about beliefs within their culture of origin regarding:

- The cause and management of health issues
- Cultural or traditional health practices
- Cultural differences that might affect treatment (e.g. attitudes to sexuality, mental health issues, eating habits)

CULTURALLY-SENSITIVE COMMUNICATION

Effective communication is the key to addressing many of the cross-cultural issues that arise with CALD young people (Bashir 2000; Bennett et al. 2006, 2009). The skills required to communicate in a culturally appropriate manner are the same skills that apply to working with any young person:

- Adopt an open, non-judgemental approach
- Show positive regard and respect for differing values

- Provide reassurance about confidentiality
- Conduct interviews in an empathetic, sensitive way
- Ask questions in an open-ended style
- Keep language simple and avoid using jargon
- Provide reassurance of normality and allay fears and anxieties
- Be sensitive to gender issues, particularly the needs of young women when asking about sexual health. Many young women, regardless of their background, prefer to see a female nurse or doctor.

On a practical level:

- Ask the young person his or her preferred form of address, and do your best to pronounce their name correctly
- When conducting a psychosocial assessment enquire about acculturation and identity issues. How do they view themselves within the context of their culture?
- Engage them in a dialogue about their family history and relevant cultural background: enquire about various roles and responsibilities that a young person may have in their family and find out how decisions are made in the family/community

Example:

"Thuy, you said that your parents were born in Vietnam and that you grew up here in Australia. How do you mostly think about yourself – as Australian or Vietnamese, or both?"

It is also worth exploring:

- Ways in which they follow/do not follow the norms of their culture?
- How do they feel about their own/their parents' culture/their host culture?
- What has changed since they became an adolescent? Are they treated differently by parents, siblings, relatives, the community?
- Assess whether intergenerational and cultural differences are impacting on their health and development e.g. *What expectations do your parents have for you? How do you see things differently? Who supports you in the family (or outside)? When you feel down, who do you talk to? How do your parents feel about this?*

Be sensitive to signs of misunderstanding. These might include a puzzled expression or unusual response. You can also check their understanding of instructions or information you have provided by asking them to explain it to you.

FAMILY AND CULTURE

In many cultures, participation in health care is a family rather than individual responsibility, and it is common for family members to be involved in decision-making (Bennett et al. 2006). Engaging the family and gaining the trust of parents is critical to working effectively with young people from other cultures.

Respect parental authority with regard to decision-making while helping them to recognise the young person's growing need for independence appropriate to their age and stage of development (Lau 1990).

You may need to explain to both the family and the young person that your role is not to separate the child from his/her family, but work with them to ensure the young person's health and wellbeing. Try to spend some time alone with the young person, and explain to the parents your reasons for wanting to do this. Understand, however, that this may not be possible as it may be culturally inappropriate and disrespectful of the parental role.

FINDING OUT MORE...

The Transcultural Mental Health Centre (TMHC) is a statewide service that provides clinical consultation services and training and information for professionals working with people of CALD background including children, young people and families. These services include clinical assessment and short-term intervention provided in the language of the client by qualified bilingual health professionals who are registered by appropriate professional bodies in NSW. TMHC also provides over the phone advice and consultation on cultural/religious issues, mental health issues and other general health issues.

TMHC welcomes referrals and provides reports on the referred case as well as recommendations regarding care plans. All TMHC services are free of charge both to the referring agency and the young person. TMHC Clinical Services can be contacted on (02) 9912 3851 or Toll Free on 1800 648 911 (rural areas) or visit the Diversity Health Institute's website: www.dhi.health.nsw.gov.au/tmhc

The NSW Multicultural Health Communication Service provides information and services to assist health professionals to communicate with non-English speaking communities throughout NSW. Visit www.mhcs.health.nsw.gov.au

WORKING WITH YOUNG REFUGEES

The Refugee Council of Australia describes a refugee as *"an individual who has fled his or her home country due to a genuine fear of persecution based on race, religion, nationality, membership of a particular social group or political opinion."*

- Between 1991 and 2012, 77,883 young refugees aged 12-24 arrived in Australia. This represents 13% of the total migrant intake for this age group.
- 14% of these young refugees were from Iraq, 12% from Afghanistan, 11% from Sudan and a further 22% from other African countries.
- Most refugees in this age group settled in NSW and Victoria.
- The most commonly spoken languages for newly arrived young refugees were Arabic, Dari, Persian, Serbian and African languages.
- Most recently arrived refugees are aged under 30.

Young people who arrive in Australia as refugees may have experienced persecution or prolonged periods in refugee camps, often in transition countries, and many will have experienced some or all of the following:

- Forced departure from their country of origin
- Conflict, organised violence and human rights abuses
- A dangerous escape from their country of origin
- Torture and trauma

Consequently, the refugee experience is characterised by persecution, displacement, loss and grief, and forced separation from family, home and belongings. For refugee young people, the developmental tasks of adolescence are compounded by the traumatic nature of the refugee experience, cultural dislocation, loss of established social networks and the practical demands of resettlement. Sometimes young refugees may be harmed by the impact on their parents of traumatic experiences.

Refugee young people who do not have family in Australia may be at even greater risk because of their lack of support (Centre for Multicultural Youth 2006).

THE HEALTH OF YOUNG PEOPLE WHO ARE REFUGEES

Young people of refugee background will experience many typical adolescent health problems. However, they may also have health issues stemming specifically from their refugee experience. Common health issues for refugee young people include:

- Nutritional deficiencies and poor overall physical health as a result of living in unsanitary conditions in refugee camps
- Parasitic and infectious diseases (e.g. intestinal parasites; hepatitis B)
- Poor oral health due to poor diet and disruption to oral hygiene
- Limited past availability of preventative health programs (e.g. immunisation; vision and hearing screening)
- Mental health concerns arising from the deprivation and loss of extended family, friends and home, and the trauma of the refugee experience
- Physical and psychological effects of torture, trauma or witnessing violence or warfare
- Psychological symptoms – such as depression, anxiety, grief, anger, stress – that are often expressed as physical ailments

Whatever the presentation, refugee young people (especially new arrivals), should have a thorough physical and psychosocial assessment. A collaborative approach is essential – especially in working with the mental health concerns of refugee young people. It is important to involve the family where possible

(Victorian Foundation for Survivors of Torture 2007)

FINDING OUT MORE...

Learn more about the health of refugee young people. There is a range of resources available online that can help you better understand the health needs and issues of refugees.

- Promoting Refugee Health: A guide for doctors and other health care providers has been produced by the Victorian Foundation for Survivors of Torture website. Visit www.foundationhouse.org.au
- The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) provides a comprehensive range of information and services for assisting refugees in their recovery and resettlement. Visit www.startts.org.au

It is helpful to know about specialised services for refugees that are available in your area. Ongoing support and advice may be available from specialised refugee health clinics. In NSW, for example, the Refugee Health Service provides health services directly to refugees and support and assistance to doctors and health professionals working with refugees. GPs can also use specific Medicare item

numbers for comprehensive assessment of newly arrived refugees. For more information, visit www.refugeehealth.org.au

Language and communication difficulties should be addressed quickly. Do not use a family member as an interpreter: not only is confidentiality not assured but you can't be confident that what is said is being accurately interpreted. Contact the Telephone Interpreter Service on 131 450 for assistance.

It is important to take time to build trust and rapport with the young person and his or her parents or carers. Remember that many may have come from a background with little or no health care, or their experience may lead them to distrust people in positions of perceived authority.

You may need to explain concepts such as:

- The family doctor and ongoing/preventative care
- Appointments and the referral process
- Confidentiality and consent

Be sensitive to specific health issues relating to the experience of grief, violence, torture and trauma. Explore these issues with sensitivity, as there is a risk of re-traumatising a young person.

CHAPTER SUMMARY - WHAT TO REMEMBER

All young people, regardless of cultural background, require confidential care and a youth-friendly approach. Where possible, check health risk behaviours and protective factors

Young people from Culturally and Linguistically Diverse backgrounds (CALD) face the challenge of dealing with the tasks of adolescence while growing up between two cultures. The most important source of cultural information is the young person himself or herself: be sensitive to how the young person sees their cultural background, family history, and how they define their cultural identity. How a young person looks does not reveal their cultural identity.

Young people who have a refugee background may have specific health issues relating to their experience as a refugee. You may need to seek specialist support from a Refugee Health Service to meet the health needs of these young people.

REFLECTION QUESTIONS

What is the cultural profile of the community you serve?

What are some of the specific challenges young people you work with face in terms of culture?

How well does your service address the needs of young people from CALD backgrounds?

Do you have staff members with CALD backgrounds? Why or why not?

Are staff trained in skills in working with young people from CALD backgrounds?

Do you know the cross-cultural resources available to your service and our clientele? Are these resources on display in your service?

Does your service use culturally appropriate assessment tools?

REFERENCES

- Bashir M. (2000). Immigrant and refugee young people: Challenges in mental health. In M Bashir and D Bennett. (eds.) *Deeper Dimensions – Culture, Youth and Mental Health*. Transcultural Mental Health Centre: Sydney.
- Bennett D, Kang M & Chown P. (2006). Cultural Diversity in Adolescent Health Care, In D Greydanus, D Patel and H Pratt (eds.). *Essential Adolescent Medicine*. McGraw-Hill: New York.
- Bennett D, Kang M & Chown P. (2009). Promoting cultural competence in adolescent health care. In D Bennett, S Towns, E Elliott and J Merrick (eds.) *Challenges in Adolescent Health: An Australian Perspective*. Nova Science: New York.
- Centre for Multicultural Youth. (2006). *Refugee Young People and Resettlement*. Information Sheet, No. 14. September. Available http://www.scoa.org.au/resources/460984_72752_RefugeeYouthResettlement_Sept06.pdf. Viewed 20 May 2014.
- Cox L. (2001). Young Indigenous people in Australia: Issues for the GP, in *The Missing Link – Adolescent mental health in general practice*. Alpha Biomedical Communications: Sydney.
- Lau A. (1990). Psychological problems in adolescents from ethnic minorities. *British Journal of Hospital Medicine*. 44, 201-205.

SECTION 3.7

RESILIENCE AND INDIGENOUS YOUNG PEOPLE

3.7 RESILIENCE AND INDIGENOUS YOUNG PEOPLE

SHANE HEARN

Aboriginal health means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community

(National Aboriginal and Islander Health Organisations definition reproduced in NSW Aboriginal Health Plan 2013-2023)

Most young Australians are healthy and in recent decades we have seen great improvements in their health and wellbeing. However, these health gains have not been shared equally amongst young people. It is widely accepted that the health of young people is influenced by a range of factors including the social and economic determinants of health, health behaviours and risk. The prevalence of risk is higher among socially and economically disadvantaged individuals and adolescents, including Indigenous young people.

This country is home to its first people - the Indigenous people of Australia. The history of Indigenous Australians and their experiences in the generations following white settlement have had a dramatic effect on the health of Indigenous people today. The relatively poor health outcomes for Indigenous young people are a direct result of an exposure to high levels of risk including ongoing social and systemic discrimination which influences risk-taking behaviours; high levels of socio-economic disadvantage; and the intergenerational impacts of assimilation, and dispossession. From 1909 to 1969 it was Australian Government policy to remove Indigenous children from their families in order to assimilate them into white Australian culture, a policy which resulted in the "Stolen Generation".

The significant disparities in health status between Indigenous people and other Australians are evident across the life cycle and include:

- **Lower birth weight**
- **Earlier onset of some chronic diseases**
- **Much higher occurrence of a wide range of illnesses**

- **Higher prevalence of many stressors impacting on social and emotional wellbeing**
- **Higher death rates**
- **Lower life expectancy (Department of Health and Ageing 2012).**

For health professionals, understanding the principles of risk, protective factors, and resilience are central to understanding and improving the conceptual and methodological rigour of prevention and treatment programs for Indigenous young people.

Compared to the broader population, the Indigenous population is relatively young. The Indigenous population has a median age of 21 years compared to 36 years for the non-Indigenous population (AIHW 2011). Aboriginal young people represent 3.6 per cent of all 15–19 year-olds and 2.8 per cent of all young people 20–24 years (Office for Youth 2009). In contrast, more than one-third (38 per cent) of NSW's Indigenous population are aged under 14, twice the proportion for non-Indigenous children (19 per cent).

Alarming, young Indigenous people die at a rate 2.5 times higher than non-Indigenous young people. They are also more likely than other young Australians to experience risk factors such as obesity, physical inactivity, smoking, imprisonment, and lower education attainment (AIHW 2011). Indeed, almost half of young people in juvenile detention in 2009 identified as Aboriginal (Indig et al. 2011).

Indigenous children and young people are 6.6 times more likely to be victims of a sexual assault than non-Indigenous children, despite them being a minority of the total population of children (NSW Ombudsman 2012).

The impacts of sexual abuse can be seen in the over representation of Indigenous children and young people in self-harm and suicide statistics (Georgatos 2013). A recent report compiled by the Northern Territory Select Committee on Youth Suicides reveals that the self-harm and suicide rate for Indigenous youth is now amongst the highest in the world (Legislative Assembly of the Northern Territory 2012). Indigenous children and young people are also over-represented in child protection and Out-of-Home Care populations (AIFS 2013).

Indigenous young people are more likely than non-Indigenous young people to experience homelessness, with 8 per cent of Indigenous children receiving a service from a supported accommodation service provider compared to 1.2 per cent of non-Indigenous children (AIHW 2012). The vulnerability of Indigenous young people is also evident in the higher proportion of Indigenous children and young people who are the subject of

a substantiated child protection notification (3.5 per cent for Indigenous children compared to 0.5 per cent for non-Indigenous children and young people) (AIHW 2012).

The prevalence of risk-taking behaviours among Indigenous young people remains a concern. Smoking remains one of the main factors influencing the lower life expectancy of Indigenous people. Indigenous young people aged 15 years and over are more than twice as likely as non-Indigenous people to be current smokers (ABS 2008). In a sample of students in NSW schools from similar socio-economic backgrounds, Indigenous young people were more likely to be everyday smokers than non-Indigenous young people. Even when adjusted for socio-economic status, smoking is more common among Indigenous than non-Indigenous adolescent students (White, Mason and Briggs 2009).

FINDING OUT MORE...

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

The Closing the Gap Clearinghouse provides evidence-based research on overcoming disadvantage for Indigenous Australians. Visit www.aihw.gov.au/closingthegap

Information and resources on federal government programs can be found at www.indigenous.gov.au

NACCHO is the national peak body representing over 150 Aboriginal Community Controlled Health Services (ACCHSs) across the country on Aboriginal health and wellbeing issues. Learn more at www.naccho.org.au

The Aboriginal Health and Medical Research Council of NSW supports Aboriginal Community Controlled Health Services. See www.ahmrc.org.au

UNDERSTANDING RESILIENCE

The concept of resilience has much to offer public health strategies to improve the health of Indigenous young people. Resilience is not a rare quality found in a few, extraordinary people. Every person has some degree of resilience. It develops from our normal, everyday capabilities, relationships and resources. Resilience is often described as the ability to bend rather than break when under pressure or difficulty, or the ability to persevere and adapt when faced with challenges (Reivich and Shatté 2003). We can be naturally resilient in some situations or at some times in our lives and not resilient in others. Each person and each situation is different (Masten and Wright 2010).

Resilience relates to patterns of adaptation in the context of adversity (Masten and Obradovic 2006). Much of the published literature in this field describes resilient people as acquiring a set of traits or behaviour patterns. These traits include insight, independence, initiative, creativity, humour, morality and the ability to establish relationships (Bickart and Wolin 1997).

The presence of these traits helps explain how people bounce back to pre-crisis levels of functioning following an adverse event (Fredrickson 2009). The traits seem to act as protective positive attributes that may improve self-perception, literacy and social engagement, and might result in reduced discrimination (Boon 2008; Burack et al. 2007; Bradshaw et al. 2007).

The degree of health risk attached to a young person's behaviour depends in part on the balance of risk and protective factors in a young person's life.

AN INDIGENOUS PERSPECTIVE ON RESILIENCE

For Indigenous people, resilience is an expression of culture that is overtly linked to a support system consisting of family, friends and community (NAHO 2007).

For Indigenous young people, resilience is deeply linked to culture, kinship, family, history and the level of family conflict or cohesion experienced.

More specifically, when asked about the meaning of resilience in a NSW study (Hearn 2010), Indigenous respondents explained it as 'maintaining focus' and:

- Keeping something intact
- Keeping at a particular task
- Coming back, bouncing back
- Overcoming certain circumstances of life
- As a set of coping mechanisms.

In addition, respondents felt that resilience was enhanced by seeking family support or by obtaining help or guidance from others, such as friends or health professionals.

When asked to describe resilience, they used the following words: "toughness"; "intellect"; and "physical emotional spiritual aspects of life". Further, resilience was described as "a framework or some sort of structure" for life, or as being able "to be the people they really want to be and allowed to achieve their full potential".

Participants were adamant that "*the survival through extreme adversity by Indigenous people, and to be here in the 21st century today*" indicated a high level of resilience.

The presence of resilience in young people is linked to success in life and the prevention of substance abuse, violence, and suicide (Hampshire and Borer 2005). There is also growing interest in the concept of resilience as a factor in adjustment following trauma (Connor 1991). Health professionals can minimise the impact of risk factors and maximise a young person's health outcome following trauma by providing education and support to build resilience.

A recent NSW study (Hearn 2010) surveyed 996 young people, of whom 359 were of Indigenous descent.

The survey comprised 54 questions, including items from the Attitudes to School Scale (LSAY); Health Behaviour and Lifestyle Survey (HBLSS); and the Wagnil and Young Resilience Scale (RS).

The results provide an interesting snapshot of the link between resilience and health in young Indigenous and non-Indigenous young people.

RELATIONSHIP OF RESILIENCE TO HEALTH BEHAVIOURS

When asked about risk behaviour including use of tobacco, alcohol, and any illicit substances; levels of physical activity; and self-assessed mental health:

- Indigenous young people who reported using tobacco scored a significantly lower resilience measure than those who had never used tobacco.
- Daily smokers showed markedly lower resilience compared to those respondents that experimented and tried tobacco only once.
- Indigenous young people who reported having been drunk more than twice had lower resilience scores than those who had never been drunk or had only been drunk once in their lives.
- Similar results were evident for the use of illicit substances, with lower levels of resilience reported for those who used illicit substances.
- Indigenous young people who engaged in physical activity outside school had significantly higher resilience scores than their less active peers.
- Respondents who were members of a sporting club also had significantly higher resilience scores than those not in a sports club.
- Resilience was significantly related to all mental health variables: young people who described themselves as 'not very happy' reported significantly lower resilience, as did those who felt lonely, lacked confidence, or reported that they were depressed.

- Family support and peer support were associated with higher resilience: scores were lower for those respondents who did not have support from family or friends.
- Young people who felt strongly involved in their community reported substantially higher resilience than those that felt only a little involved.

WORKING WITH INDIGENOUS YOUNG PEOPLE

Resilience operates as a protective factor against behavioural risk factors such as smoking, hazardous alcohol use, low physical activity, and poor mental health such as low self-confidence. The presence of these risk factors has direct links to poorer health outcomes. Resilience in young Indigenous people therefore has significant relevance to population health outcomes.

Sometimes young people may engage in risky behaviours in response to trauma. For example, a young person may use drugs or alcohol as a way to survive pain or to connect with others. Their risky behaviour may be a way to survive that can be seen as serving a purpose for the young person. Those working with young people can understand that some apparently risky behaviours may represent a way of coping or surviving.

Many young Indigenous people do not engage with mainstream health services because they can be perceived as racist or culturally unsafe. The priority for services that wish to work more effectively with young Indigenous people is to establish cultural safety. This involves incorporating Indigenous culture, healing and worldviews into programs and services that support children and young people. Building cultural safety requires meaningful, accountable and equitable long-term relationships with communities built on an understanding of their culture, worldviews, needs and strengths. This involves reaching out into the community to understand Indigenous viewpoints on family and culture and creating a culturally safe service. The notion of cultural safety extends the idea of cultural competence to include the capacity of service providers to engage in critical reflection about their service delivery (Herring et al. 2012; Funston 2013).

One way a service can begin this process is by informally "yarning" with communities in the lead-up to establishing a service. This provides an opportunity to listen to the experience of the local Indigenous peoples and to hear their concerns, hopes, challenges and strengths. It also allows you to gauge the resilience of the community itself – which is critical to helping young people establish their own resilience.

FINDING OUT MORE...

Learn more about working with Indigenous young people at:

<http://aboriginal.telethonkids.org.au/kulunga-research-network/working-together-2nd-edition/>

The Australian Indigenous HealthInfoNet provides comprehensive and up-to-date information on the health of Indigenous Australians. Visit www.healthinfonet.ecu.edu.au

PRACTICE POINTS

- Work to establish cultural safety by “yarning”.
- Spend time building rapport with young Indigenous people who have lower levels of resilience (those who are engaging in more risk-taking behaviours and harmful activities). Consider how you might work with the young person and their family to identify and build their strengths and resilience attributes.
- Risky or harmful behaviours should be understood within the context of the young person’s life. For many young Indigenous people, using drugs and alcohol is a way of surviving pain and adversity and connecting with others.
- Explore family functioning and think about how you might support the family to build life skills where needed and improve family functioning.
- As the relationship develops, ask the young person about their stories of ‘resistance’: an exploration of all of the day-to-day actions a young person took to survive interpersonal and political violence including racism, lack of meaningful opportunities, grief, and loss. For more about this idea, see www.vikkireynolds.ca/Writings.html
- Building resilience with young Indigenous people might include empowerment at the individual, family and community level.
- For Indigenous young people, building resilience may be community-driven but also focus on individual resilience attributes and strengths (see Aboriginal Healing Foundation Research Series: Mangham et al. 1995).
- Help to identify ways to bounce back and build emotional resilience by finding a way to frame the issue within a resilience-building framework which focuses on protective factors.

CHAPTER SUMMARY - WHAT TO REMEMBER

The changes of adolescence can be particularly challenging for some Indigenous young people. Historical factors including the forced removal of children from their families, discrimination, disadvantage and intergenerational trauma exert extreme pressure on young Indigenous people.

Indigenous young people may have specific health issues and needs, and their culture may affect their health and how they use health services (Cox 2001). It is critical, therefore, that service providers learn about and understand the cultural underpinnings of health for Aboriginal young people.

For Indigenous young people resilience is an expression of culture that is overtly linked to a support system of family, friends and community.

The concept of family in Indigenous culture differs from traditional Western concepts – it may be necessary to identify and involve important members of the young person's extended family system in the consultation process.

Health professionals can help young Indigenous people to build resilience and to make positive healthy choices. A key aspect of this is providing services that are culturally respectful, informed and safe.

In addition, the health professional plays an important role in initiating strategies that reinforce patterns of resilience or teach health behaviours that strengthen the young person's capacity to self-manage and cope with adversity.

Innovative multi-level programs and interventions to increase resilience (programs that address environmental/community, interpersonal and social, and individual factors that influence young people) are likely to improve adolescent health and mental health in Australian Indigenous and non-Indigenous young people alike.

There is enormous diversity among Aboriginal people – languages, beliefs and cultural meanings and practices are complex and vary widely across regions and communities. Where available and appropriate, consult with Aboriginal-specific health services – especially if you are unsure about whether particular cultural issues might be influencing the young person's health.

REFLECTION QUESTIONS

What are some of the risk and protective factors that influence resilience in young Indigenous people?

How does risk behaviour influence resilience levels in young people?

How is resilience described in an Indigenous context?

REFERENCES

- Australian Bureau of Statistics. (ABS). (2008). *National Aboriginal and Torres Strait Islander Social Survey*. Available <http://www.abs.gov.au/csusstats/abs@nsf/mf/4714.0> Viewed 20 May 2014.
- Australian Institute of Family Studies (AIFS). (2013). *Child Protection and Aboriginal and Torres Strait Islander Children*. Available <http://www.aifs.gov.au/cfca/pubs/factsheets/al42117/>. Viewed 20 May 2014.
- Australian Institute of Health and Welfare. (AIHW). (2011). *Young Australians: Their Health and Wellbeing 2011*. Cat No. PHE 140. AIHW: Canberra.
- Australian Institute of Health and Welfare. (AIHW). (2012). *Children and young people at risk of social exclusion: links between homelessness, child protection and juvenile justice*. Data linkage series no 13 Cat.no. CSI 13, AIHW: Canberra.
- Bickart TB & Wolin S. (2007). Practicing resilience in the elementary classroom. *Principal*. 77 (2).
- Boon HJ. (2008). Risk or resilience? What makes a difference? *Australian Educational Researcher*. 35(1), 81-102.
- Bradshaw J, Hoelscher P & Richardson D. (2007). An index of child well-being in European Union. *Social Indicators Research*. 80, 133-177.
- Burack J, Blidner A et al. (2007). Constructions and deconstructions of risk, resilience and wellbeing: a model for understanding the development of Aboriginal adolescents. *Australasian Psychiatry*. 15, S18-23.
- Connor KM. (1991). Assessment of resilience in the aftermath of trauma. Strategies for assessing the potential for positive adjustment following trauma. *Journal of Traumatic Stress*. 4, 93-111.
- Department of Health and Ageing. (DOHA). (2012). *Aboriginal and Torres Strait Islander Health Performance Framework*. Available <http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih-hpf-2012-toc>. Viewed 20 May 2014.
- Fredrickson BL. (2009). *Positivity*. Crown: New York.
- Funston L. (2013). Aboriginal and Torres Strait Islander worldviews and cultural safety transforming sexual assault service provision for children and young people. *International Journal of Environmental Research and Public Health*. 10(9), 3818-33.
- Georgatos G. (2013). Australia's Aboriginal Children: The World's Highest Suicide Rate. Available <http://thestringer.com.au/australias-aboriginal-children-the-worlds-highest-suicide-rate>. Viewed 22 May 2013.
- Hampshire A & Borer A. (2005). *Developing resilience at every stage of a young person's life*. Paper presented at the 9th Australian Institute of Family Studies conference. Melbourne. Available <http://www.aifs.gov.au/conferences/aifs9/hampshire1.html>. Viewed 20 May 2014.
- Hearn S. (2010). *Adolescent Health in an Indigenous Context- the Potential Role of Resilience*. PhD thesis. School of Public Health, University of Sydney.
- Herring S, Spangaro J, Lauw M & McNamara L. (2012). The intersection of trauma, racism and cultural competence in effective work with Aboriginal people: Waiting for trust. *Australian Social Work*. 66, 1-14.
- Indig D, Vecchiato C, Haysom L. et al. (2011). *2009 NSW Young People in Custody Health Survey: Full Report*. Justice Health and Juvenile Justice: Sydney.
- Legislative Assembly of the Northern Territory. (2012). *Parliamentary Select Committee on Youth Suicides in the Northern Territory. Gone too Soon: A Report into Youth Suicide in the Northern Territory*. Available http://www.nt.gov.au/lant/parliamentary-business/committees/ctc/youth-suicides/Final_Report_on_Youth_Suicides.pdf. Viewed 10 June 2013.
- Mangham C, McGrath P, Reid G & Stewart M. (1995). *Resiliency: Relevance to health promotion*. Dalhousie University, Canada: Halifax.
- Masten AS & Obradovic J. (2006). Competence and Resilience in Development. *New York Academy of Science*. 1094, 13-27.
- Masten A & Wright MO. (2010). Resilience over the lifespan: Developmental perspectives on resistance, recovery, and transformation. In J Reich, A Zautra and J Hall. (eds.) *Handbook of Adult Resilience*. pp. 213-237. The Guilford Press: New York.
- National Aboriginal Health Organisation. (NAHO). (2007). *Resilience: overcoming challenges and moving on positively*. Available www.hc-sc.gc.ca/hppb/alcohol-otherdrugs/pube/resilncy/analysis.htm. Viewed 20 May 2014.
- NSW Ombudsman. (2012). *Responding to Child Sexual Assault in Aboriginal Communities. A Report under Part 6a of the Community Services (Complaints, Reviews and Monitoring) Act 1993*. NSW Ombudsman: Sydney.
- Office for Youth. (2009). *State of Australia's Young People*. Australian Government: Canberra. Available [http://www.youthpolicy.org/national/Australia 2009 Youth Reality Report.pdf](http://www.youthpolicy.org/national/Australia%20Youth%20Reality%20Report.pdf). Viewed 20 May 2014.
- Reivich K & Shatte A. (2003). *The Resilience Factor*. Random House: New York.
- White V, Mason T & Briggs V. (2009). How do trends in smoking prevalence among Indigenous and non-Indigenous Australian secondary students between 1996 and 2005 compare? *Australian and New Zealand Journal of Public Health*. 33(2), 147-153.

SECTION 3.8

SUBSTANCE USE

3.8 SUBSTANCE USE

PETER CHOWN

Substance use is a major threat to young people's health. Illicit drug and alcohol use are the risk factors accounting for the greatest harm among 15-24 year-olds. And although the rate of daily smoking by young people has fallen, 11% of young people aged between 12 and 24 still report smoking daily (AIHW 2011). Poly-substance abuse is common among young people and has a range of health implications.

YOUNG PEOPLE, DRUGS AND ALCOHOL

In 2007, 13 per cent of young people aged 16-24 had a substance use disorder. Substance use is common amongst young people who have experienced trauma such as sexual or physical assault, domestic and family violence and child abuse or neglect; but experimenting with smoking, drugs and alcohol is also often a part of adolescence for young people who have not been exposed to traumatic events such as these.

FAST FACTS

- According to the Australian Institute of Health and Welfare (2011):
- 17 per cent of 14-19 year-olds and 27 per cent of 20-24 year-olds are regular or occasional smokers. Indigenous young people are twice as likely to smoke as non-Indigenous young people.
- It is estimated that 37 per cent of 16-19 year-olds and 45 per cent of 20-24 year-olds drink at risky or high risk levels for short-term harm.
- Nearly 40 per cent of young people reported having been a victim of drug- or alcohol-related violence, including threats or intimidation, in the previous 12 months.
- 19 per cent of young people reported using an illicit drug in the preceding 12 months. Rates of use were similar for young men and women.
- There is a high incidence of mental health disorders among young drug users.
- Marijuana is the most commonly used illicit drug among young people – 5 per cent of 12-15 year-olds, 22 per cent of 16-19 year-olds and 27 per cent of 20-24 year-olds reported having used marijuana in the last 12 months.

KEY FEATURES OF YOUTH SUBSTANCE USE

Alcohol and tobacco are the substances most commonly used by young people and account for the highest rates of harm and death. High proportions of young people engage in high risk drinking behaviour such as binge drinking.

Illicit drug use is decreasing, but use of marijuana, amphetamines, ecstasy and hallucinogens still pose health risks. Marijuana is the most frequently used illicit drug: the mean age of starting use is 15.9 years old.

Co-occurrence is common: there is a high prevalence of mental health problems and distress among young drug users, especially depression, anxiety and other mood disorders. In fact, substance use is frequently a contributing factor in the early onset of psychosis. Cannabis use in particular is thought to cause psychosis.

There is also a strong association between substance use and the incidence of other health problems in young people, especially:

- Motor vehicle accidents, pedestrian accidents
- Being both perpetrators and victims of assault
- Unplanned sexual activity
- Blood-borne viral infections, and also sexually transmitted diseases (especially Hepatitis C; HIV)
- Violence and criminal behaviour
- Disruption of schooling and education
- Impact on relationships with families and peers (AIHW 2011; Bonomo 2001; Rogers 2005)

FINDING OUT MORE...

You can learn more about individual substances and their effects from:

Australian Drug Information Network. Visit www.adin.com.au

Australian Drug Foundation Clearinghouse for information on drugs. Visit www.druginfo.adf.org.au

Youth Substance Abuse Service (YSAS) – for information about working with high risk, co-morbid young people. Visit www.ysas.org.au

National Drug & Alcohol Research Centre (NDARC). Visit www.ndarc.med.unsw.edu.au

Your room – for drug and alcohol information and resources for young people. Visit www.yourroom.com.au

ALCOHOL AND YOUNG PEOPLE

The adolescent brain is highly vulnerable to the damaging effects of alcohol, and the earlier a person commences drinking, the higher the risk of the person subsequently becoming alcohol dependent. Starting drinking at an early age increases the risk of alcohol dependence in adulthood four-fold.

Young people under 15 years of age are at most risk of harm from drinking alcohol, and so this age group should be particularly discouraged from drinking alcohol (National Health and Medical Research Council 2009).

RISK FACTORS FOR SUBSTANCE ABUSE AMONG YOUNG PEOPLE

In general, young people are more likely to use alcohol and illicit substances if some of the following factors are present:

- Peer use of substances
- Family factors
- Family history of genetic predisposition
- Parental substance use
- Family attitudes favourable to substance use
- Poor parental control and supervision
- Family breakdown including domestic and family violence, child abuse
- School difficulties and truancy
- Early onset of substance use – especially before the age of 15
- Unemployment
- Low self-esteem and poor social support
- Emotional and behavioural problems (e.g. depression, anxiety, conduct disorder)
- Childhood trauma, physical or sexual abuse (Rowe 2000; Spooner and Hetherington 2005)

WHAT DOES SUBSTANCE ABUSE LOOK LIKE?

Substance abuse might show up in some of the following ways:

- Changes in school/work attendance or achievement – frequently absent or late; apathy and lack of effort
- Poor physical appearance and an unusual lack of regard for personal hygiene, red eyes, dilated or constricted pupils
- Marked changes in emotional state – e.g. unusual irritability or aggression, temper flare-ups, sullenness, mood swings (lability)
- Seeming excessively tired or withdrawn

- Withdrawal from usual social, family or recreational activities, reduced social repertoire
- A change in peer group and reluctance to introduce friends to the family
- Furtive behaviour – including lying, stealing or borrowing money

Remember, however, that these are not definitive signs of substance abuse: there may be other explanations for changes in a young person's health and behaviour.

ASSESSING THE EXTENT OF THE PROBLEM

A structured approach to communicating with the young person and learning about their use of drugs and alcohol is beneficial. The HEEADSSS psychosocial assessment (which is outlined in 3.2 Psychosocial Assessment) will help you detect alcohol or drug use (Rowe 2000). It will also help you find out how the substance is affecting the young person, the role it plays in the young person's life and other risk behaviours associated with its use.

FINDING OUT MORE...

Review chapter 3.2 Psychosocial assessment to become more familiar with the HEEADSSS tool. You will also find useful information on building rapport, discussing sensitive issues and asking non-threatening questions.

THE CRAFT SCREENING TOOL

While HEEADSSS looks very broadly at the range of factors that might be affecting a young person's health and wellbeing, the CRAFT screening tool examines drug and alcohol use more closely. It comprises six questions which will help you determine whether you should conduct a more detailed assessment.

C: Have you ever ridden in a CAR driven by someone (including yourself) who was high on alcohol or drugs?

R: Do you ever use alcohol or drugs to RELAX, feel better about yourself or fit in?

A: Do you ever use alcohol or drugs while you are ALONE?

F: Do you ever FORGET things you did while using alcohol or drugs?

F: Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?

T: Have you gotten into TROUBLE while you were using alcohol or drugs?

If a young person answers yes to two or more questions, the screen is positive and further assessment is warranted. (Knight et al. 2002 in Milne, Bonomo and Whitton 2013)

TAKING A DRUG HISTORY

If the HEEADSSS or CRAFFT screens are positive for the use of drugs or alcohol, you should take a more in-depth history focusing on the substance use. Many young people do not consider alcohol or tobacco to be drugs, so you need to specifically ask about these.

Explain to the young person why you want more information and remember to request permission to ask sensitive questions.

Example:

"If it's okay with you, I want to ask you some questions about your drug/alcohol use so that I can get a better picture of how it fits into your life. I'd like us to explore what you think the positive effects of your drug use are and what harm it might be causing you. From there you can decide whether you want to do something about your use. How does that sound?"

Adopt an interactive rather than interrogative style. This may help them feel safe enough to open up and share details of their substance use history. The history should cover:

What	<p>What substances are being used?</p> <p>Remember that poly-substance use is common among young people so ask specifically about each substance or group of substances over the last few months:</p> <ul style="list-style-type: none"> • Licit drugs (alcohol, tobacco, pain medications, cough mixture, over the counter and prescribed medications – especially sedatives and anti-psychotics) • Household products – paints, glues, aerosols, petrol • Illicit drugs – sedatives and stimulants (cannabis, ecstasy, amphetamines, LSD, cocaine, opioids, 'designer' drugs)
How	How often are they using drugs?
Preference	Do they have a "drug of choice" which dominates their usage, or do they use whatever is available?
How Much	<p>What dose is being used?</p> <p>How many drinks on a given occasion? How many times are they smoking cannabis in a day/week?</p>
Method	<p>How are they ingesting the drug?</p> <p>Are they smoking, taking orally, snorting, injecting, sniffing?</p>
Patterns	<p>Does binge use ever occur?</p> <p>Do they experience withdrawals or cravings?</p> <p>Common patterns of drug use include; Experimental, Recreational, Abuse, Dependence, Recovery/relapse</p>
Context	<p>When, where and who with?</p> <p>Do they use drugs/drink alone? With friends? When depressed? When stressed? When angry? Etc.</p> <p>Do they use drugs/drink to be part of the crowd?</p>
Effect	<p>What effect do they achieve when they use drugs or alcohol?</p> <p>What are the effects on them physically, in terms of mood, in terms of their behaviour, socially?</p>
<p>How do they obtain and pay for the substances?</p> <p>Have they attempted to stop using drugs/drinking before? What happened?</p> <p>What do they want to do about their drug or alcohol use?</p>	

Other areas to explore:

- **Mental health** – are there any mood, anxiety or depressive symptoms? What about irritability or paranoia?
- **Concurrent problems** – are there problems with sleep? Auditory or visual hallucinations, or other symptoms suggestive of early psychosis?
- If these symptoms are present, refer the young person for a thorough mental health assessment which will take into account past history of mental health symptoms. See 3.9 Mental health for more information.
- **Tolerance** – is the young person developing tolerance to a substance (do they find that they need more of the drug to get the same effect?)? If there is heavy use, do they have trouble controlling their use of the substance? How do they feel when they don't use the substance (withdrawal symptoms)?
- **Problems** – what problems are they experiencing as a result of their drug use (physical, legal, financial, social, school, relationships)?
- **Risk-taking behaviours** – are they involved in any risk-taking behaviours while using drugs or alcohol (drink driving, unplanned or unsafe sex, criminal activity)?
- **Cultural factors** – what is the young person's cultural background and how does that influence their attitudes to substance use? Are there any factors related to their cultural background (migration, refugee status etc.) that may be contributing to their substance use?
- **Morbidity and mortality risks** – what is the toxicity risk associated with the pharmacological action of the drug? What are the risks of the mode of administration the young person is using? Have there been any instances of overdose – deliberate or accidental? What happened and how was it managed?

(Bonomo 2001; Kang 2002)

FAST FACTS - UNDERSTANDING ALCOHOL

The short-term harms of binge drinking include physical symptoms such as nausea, shakiness and vomiting and increased risk of injuries, unsafe sex, and drug use. Alcohol poisoning can cause coma and death.

The long-term harms of regular heavy drinking include physical problems such as stomach, liver, heart and brain damage; increased risk of infections, cancers, depression; and all the legal, financial, and family and relationship harms of addiction.

(AIHW 2011)

A 'TYPICAL WEEK'

Asking the young person to describe a 'typical week' (or day or month) can be a useful way to learn more about a young person's substance use. A 'typical week' assessment:

- Encourages disclosure of the individual's story
- Provides a clinical picture of quantity & frequency of use
- Provides personal context of use
- Increases information & builds rapport

Start with something like:

"The things we've talked about in this session have given me a bit of an idea about what is going on for you. But I really don't know a lot about you and the kind of life you lead. I wonder if I could ask you to

tell me a little more about your life and the problems you are coping with right now. It would help me to understand the situation better if you could pick a typical week in your life and take me through it"

Or:

"Tell me about what usually happens from the moment you wake, and move through the day, until the end of your day (or, when you are getting ready for a night out; etc.)"

Allow the young person to continue with as little interruption as possible. If necessary, help the young person move the story along with open-ended questions:

- *"What happened then? And before that? And between doing this and that? What next?"*
- *"What things do you find hard to cope with? How do you feel when that happens?"*
- *"Can you tell me where your substance use (drinking, smoking, etc.) fits in to your usual routine?"*
- *"Are there any times of the day when you use (alcohol, drugs, etc.) more than at other times?"*
- *"How does your week (one of these sessions etc.)? usually end? How do you feel at the end of the week (after one of these sessions etc.)?"*

When the young person has finished, try to summarise their week and remember to ask:

"Is there anything else about this picture you've painted that you would like to tell me?"

WHAT TO DO WITH WHAT YOU KNOW

As with all youth health problems, a trusting relationship forms the basis for effective treatment of substance abuse. A key principle of management is to adopt a holistic approach rather than focusing solely on the drug use. Addressing other areas of concern in the young person's life can often ameliorate the substance use (Kang 2002).

Family members or service providers may think that a young person needs 'detox'. But this may not be what is required. Young people's patterns of use are different to adults. They are also less likely to be physically dependent and need detoxification. The social, familial, cultural and physical environment in which the substance abuse occurs is also not changed by detoxification processes.

If substance use is identified as problematic (rather than 'normal risk-taking' or experimental), base your recommended interventions on the young person's pattern of substance use, as well as their readiness and motivation to change.

The Stages of Change model is useful in determining the young person's awareness about the consequences of their substance use and their readiness to change. It enables therapeutic work with the person based on 'where they are at', rather than expecting them to be ready or able to change their substance using behaviour. The model also helps in identifying interventions appropriate to the young person's stage

FINDING OUT MORE...

The Stages of Change model is covered in chapter 3.3 Understanding risk-taking behaviour.

MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) provides a practical set of strategies for increasing the person's motivation to change and in assisting the young person to make behavioural changes

Motivational Interviewing aims to:

- Increase the person's motivation and commitment to change
- Provide a range of skills and strategies for decreasing substance use and modifying risk behaviours. (Miller and Rollnick 2002)

Motivational Interviewing is person-centred – it focuses on the concerns and perspectives presented by the young person, and is based on the belief that the resources and motivation for change already exist within the person. At times, the practitioner must also be directive helping the young person to identify the resources and motivation they have. MI is based on research which indicates that people

who talk about making change are more likely to do so than those who don't. The core aim of MI is to elicit this 'change talk' from clients, so that they hear themselves talk about their reasons, ability and intention to make change.

There is a core set of skills that practitioners using MI draw on. The micro-skills of MI are remembered by the acronym OARS:

O	Open-ended questions – "How do you think your drug use affects your health?"
A	Affirm – "It's good that you decided to talk to someone about your drug use"
R	Reflectively listen – "It sounds like you're starting to....."
S	Summarise – "Let me see if I understand what you're saying..."

Motivational Interviewing aims to move a young person towards change and commitment talk. The types of change and commitment talk to listen for, elicit and reflect back to the client are remembered by the acronym DARN-C:

D	Desire – "Why do you want to make this change?"
A	Ability – "If you were to make the change, how might you go about it?"
R	Reason – "What are the three main reasons you would want to make this change?"
N	Need – "On a scale of 0-10, how important is it for you right now to make this change? Why are you a 6 and not a zero?" (Frame in the positive to elicit change talk from the person)
C	Commitment – "What do you think you will do?"

(Sanci and Cahill 2006)

When working with a young person using MI, remember to reinforce the young person's belief and confidence in their ability to make changes or to cope with a specific task or challenge. Assist them to learn skills that will help them to achieve change. For example, help them identify alternative ways of coping with problems that drive their substance use; help them identify the risk situations and triggers to substance use and learn new skills for dealing with these (such as assertive communication/refusal skills); and help them identify strategies for coping with barriers to changing.

STEPS IN MOTIVATIONAL INTERVIEWING

1. Assess the young person's readiness to change.
2. Create a favourable climate for change – establish rapport and an atmosphere of collaboration with the young person; adopt a non-judgemental approach
3. Use communication skills – such as reflective listening and open-ended questions to identify the person's concerns – avoid persuasion or coercion
4. Identify the young person's motivation to change:

"How important would you say it is for you to cut down on your alcohol use?"

"On a scale of 0-10 where 0 is not at all important and ten is extremely important?"

5. And – their belief in their ability to change:

"How confident would you say you are, that if you decided to cut down, you could do it?"

Use same scale 0-10 (0 = not at all confident; 10 = extremely confident)

6. Ask about the perceived benefits of substance use for them

"What are the good things for you about drinking alcohol/smoking marijuana, etc.?"

7. Ask about concerns or disadvantages of their substance use (to their health, their family/relationships, financial, etc.)

"Tell me about any concerns you have about how alcohol/marijuana, etc. is affecting your health or any other parts of your life..."

"How is it affecting your relationships/family?"

"How is it affecting your school/work?"

8. Increase motivation to change:

Provide objective information on the potential health effects and social impact of the substances they are using

Identify associated risks – e.g. unsafe sexual activity; drink driving

For each individual – identify potential triggers for motivating them to change

9. Assist the person to make the decision to change – engage the person in a 'decision balance' process to tip the balance toward changing. (Skinner 2001)

FINDING OUT MORE...

Learn more about MI from:

- The Motivational Interviewing website – www.motivationalinterviewing.org
- Miller W and Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. (2nd edn). Guildford Press: London.
- Sanci L and Cahill H. (2006). *Topic 5. Communicating with young people, part two. Youth Health in Primary Care Module* of the Postgraduate Certificate in Primary Care Nursing, Department of General Practice, University of Melbourne.
- Rollnick S, Mason P and Butler C. (2006). *Health Behaviour Change: a guide for practitioners*. Churchill Livingstone: London.

You may also like to review chapter 3.3 on risk-taking assessment.

TABLE 9 – THE DECISION BALANCE PROCESS

Decision balance	Reasons not to change	Reasons to change
Stay the same	Benefits “What do you like about your drinking (smoking, drug use)?” <ul style="list-style-type: none"> • Drinking/smoking with my friends • Feeling relaxed/relieving stress • Forgetting about my problems • Helps me sleep • Fun 	Concerns “What concerns you about it?” <ul style="list-style-type: none"> • Hangovers • Can’t study • Get into fights • Poor school performance • Appearance – pimples; weight gain; effects on teeth etc. • The expense
Change	Concerns “What concerns would you have about changing?” <ul style="list-style-type: none"> • Lose my friends • No fun • Stress • Not coping with my problems 	Benefits “What benefits might you get from changing?” <ul style="list-style-type: none"> • No more hangovers • Weight loss • Improved appearance • Can study better • Save money

BRIEF INTERVENTIONS

Even if the young person chooses not to change their drug use, you can still assist them by providing information and education on the effects of substance use, safer using strategies, and support services available.

Harm minimisation is an approach to addressing drug and alcohol issues by reducing the harmful effects that abuse of these substances has on individuals, families and the community. It has been a key element of state and federal government policy since 1985. The goals of harm minimisation are to promote safe usage of a substance where abstinence is neither possible nor chosen.

The policy of harm minimisation is based on an understanding that:

- Drug use occurs within our society
- Drug use occurs across a continuum, ranging from occasional use to dependent use
- Different harms are associated with different types and patterns of use
- A range of approaches can be used to respond to these harms.

A harm minimisation approach recognises that abstinence may not always be an achievable goal, and that it is important to focus on the immediate harm that may result from the use of a particular substance and implement strategies to reduce the risk of harm.

For health practitioners, a harm minimisation approach includes educating a young person about the likely effects of the substance they are using and the potential harm associated with such use. It also includes helping the young person to make healthy choices to reduce those harms. Health practitioners practice harm minimisation when they educate young people about:

- Safe injecting procedures for IV users
- Strategies for reducing alcohol consumption
- Safe sex practices such as condom use
- The increased risks associated with driving, swimming, climbing and other activities while drinking or using drugs
- The risks of mixing drugs
- Safer partying
- How to look after a friend who may be experiencing an overdose (including the importance of calling 000)
- Where to get help if needed

You can also ask the young person to monitor their drug use. Monitoring can involve keeping a diary or logbook, recording the amounts consumed, patterns of use and high risk situations. It should be done over a period of weeks in order to see patterns emerging

Work with the young person to develop goals based on a shared understanding of the problem. Keep the goals realistic and achievable like cutting down on alcohol/drug use, having drug-free days, or not combining drugs.

COMPREHENSIVE INTERVENTIONS

Young people who have developed substance dependence or an entrenched pattern of abuse require comprehensive management. It may include:

- Referral to specialist drug and alcohol treatment services
- Supervised detoxification
- In-patient treatment
- Substitution – e.g. nicotine chewing gum/patches; methadone replacement therapy (for over 18 year-olds)
- Collaborative case management – depending on your role, you may be able to play a central role in a treating team of professionals (including drug and alcohol services; mental health services; counsellors)

Wherever possible, involve and work with the family of the young person. The support of parents or carers and family can be instrumental in helping a young person recover from drug or alcohol dependence. Family members and carers can often help you get a fuller understanding of the young person's patterns of substance use. Be prepared to support a young person's parents, carers and family members by offering:

- Education about substance use
- Guidance about parenting strategies and effective responses to the young person's substance use
- Counselling for their own anxiety and stress
- Referral to specialist services for family counselling or other support if needed

QUITTING SMOKING

Stopping smoking is the single most important thing an individual can do to improve their health. It can often be overlooked, particularly for young people if their lives are chaotic and the consequences of smoking can seem a long way removed from their immediate concerns.

Quit smoking programs can be effective with young people. All health professionals should be able to offer information and support to quit smoking for the young people they see.

For advice and information about how you can support a young person to quit smoking, contact:

- National Quitline – 131 848
- National Tobacco Campaign – <http://www.quitnow.gov.au>
- Cancer Council – www.cancercouncil.com.au
- Smarter Than Smoking – www.smarterthansmoking.org.au
- Oxygen – www.oxygen.org.au
- Quit Coach – www.quitcoach.org.au
- Quit now – www.quitnow.gov.au

CASE STUDY: WORKING WITH ROB

Rob is 18 years old and has come to see you because he is becoming concerned about his drinking. His latest girlfriend, whom he says he loved very much, broke up with him after two months saying that she could not tolerate his drinking. Rob says that he has been drinking heavily on weekends for the past few months and from time to time gets into fights.

You take a drug history. Rob smokes up to 20 cigarettes a day and drinks up to 15 standard drinks on Friday and Saturday nights. He uses marijuana occasionally but no other substances, although has tried speed and ecstasy in the past. He enjoys drinking but is also becoming concerned about the pattern that is now established. He finds he is feeling increasingly aggressive and has trouble controlling his anger.

Rob is unemployed. He currently lives with friends, though this is not working well. He has a longstanding history of family conflict. His father is alcoholic and Rob has little contact with him. Rob finished year 9 at school and would like to complete his education so that he can look for an apprenticeship.

YOUR APPROACH

You talk with Rob about the effects of his alcohol use and he agrees to see you once a fortnight or so. He misses his appointments every now and then, but you focus your interventions on:

- Monitoring his drinking and physical and mental health.
- Motivational interviewing – to explore the costs and benefits of his substance use and to explore alternatives to drinking – such as exercise; recreational activities. You also explore his level of motivation to change and assess his readiness using the Stages of Change model.
- Harm minimisation – you talk to Rob about ways to reduce harm, such as switching to beverages with a lower alcohol content; alternating alcoholic and non-alcoholic beverages; not drinking on an empty stomach; not driving when he has been drinking.
- Collaborative case management – you refer Rob to a GP for a Mental Health Care Plan as his increasing levels of aggression and anger are concerning him. Rob is referred to a private psychologist for counselling. Rob is not interested in abstaining from alcohol, but says he'd be willing to talk to someone about his drinking. You refer him to a drug and alcohol counsellor at the community health centre. Because Rob wants to finish school and get a job, you also refer him to a youth support officer at Centrelink. You also locate a local housing support provider who can help Rob find a more positive living arrangement.

CHAPTER SUMMARY - WHAT TO REMEMBER

Working with young people who have a drug or alcohol problem can be difficult. Young people may be secretive about their use of substances and may be fearful of both the consequences of the use and the consequences of revealing their drug and alcohol history.

It is important to work in a collaborative, non-judgemental way with young people. Tools such as HEEADSSS and CRAFFT can help you identify areas of concern and highlight emerging issues in a young person's health and wellbeing.

It is important to identify possible mental health problems, particularly those that may be associated with drug and alcohol use, and (if indicated) refer the young person for a complete mental health assessment.

Harm minimisation is an important element of any management approach you adopt.

REFLECTION QUESTIONS

How well does your service identify substance use issues in the young people you work with?

Do you routinely ask about substance use?

What approaches are appropriate for your service to take with substance use issues?

What current treatments are available within your service or service network for young people?

How well do staff work with substance use issues? Is any training needed?

Are staff able to provide education in harm minimisation?

What resources are available to you?

Do you know your service network and how to access treatments?

REFERENCES

- Australian Institute of Health and Welfare. (2011). *Young Australians, their Health and Wellbeing*. Cat No. PHE 140. AIHW: Canberra.
- Kang M. (2002). Substance abuse in teenagers. *Australian Family Physician*. 31(1), 8-11.
- Bonomo Y. (2001). Adolescent drug and alcohol abuse. In *The Missing Link – Adolescent mental health in general practice*. Alpha Biomedical Communications: Sydney.
- Kang M. (2002). An approach to adolescent drug use. *Australian Family Physician*. 31(1):14-17.
- Miller W & Rollnick S. (2002). *Motivational Interviewing: preparing people for change*. 2nd ed. Guildford Press: London.
- Milne B, Bonomo Y & Whitton G. (2013). Alcohol and other drugs. In K Steinbeck and M Kohn (eds.) *A Clinical Handbook in Adolescent Medicine*. World Scientific Publishing: Singapore.
- National Health and Medical Research Council. (NHMRC). (2009). Alcohol guidelines: reducing the risks. Available <https://www.nhmrc.gov.au/your-health/alcohol-guidelines>. Viewed 20 May 2014.
- Rogers N. (2005). Bridging the gap: Enhancing co-morbidity services for young people. *Parity*. 18 (8), 10-11.
- Rowe L. (2000). *Clockwork: time for young people. Making general practice work for young people*. Clockwork Youth Health Service: Geelong.
- Sanci L & Cahill H. (2006). *Topic 5. Communicating with young people, part two*. Youth Health in Primary Care Module of the Postgraduate Certificate in Primary Care Nursing, Department of General Practice, University of Melbourne: Melbourne.
- Skinner H. (2001). *Engaging the Adolescent Drug User*. Presentation for the Northern Rivers Division of General Practice. Lismore, NSW.
- Spooner C & Hetherington K. (2005). *Social determinants of drug use. Technical report no. 228*. National Drug and Alcohol Research Centre: Sydney.

SECTION 3.9

MENTAL HEALTH

3.9 MENTAL HEALTH

PETER CHOWN AND MELISSA KANG

Mental health problems affect young people's psychological growth and development, their health care needs, their educational and occupational attainment, and their involvement with the justice system. Many mental health disorders – such as anxiety, depression, schizophrenia, and eating disorders – have their initial onset in adolescence. Adolescence is also a period marked by increased exposure to risk factors and risk-taking behaviours that may lead to poor mental health outcomes. Early identification and intervention of emerging mental health issues is the key to effective management and treatment and to better health and social outcomes.

Mental health disorders account for the highest burden of disease (almost 50 per cent) among young people in the 16-24 year age group. Around 1 in 4 Australians aged 16–24 experience at least one mental health disorder (AIHW 2011; ABS 2008).

In 2007, 9 per cent of 16-24 year-olds experienced high or very high levels of psychological distress. The most commonly reported disorders are anxiety disorders (15 per cent), substance use disorders (13 per cent), and mood disorders (6 per cent). In 2011, 37% of students aged 12-17 reported psychological distress in the previous 6 months (NSW School Students Health Behaviours Survey).

Overall rates of mental health problems are higher in females than in males: 30 per cent compared to 23 per cent. Behavioural disorders, such as ADHD and Conduct Disorder (CD) are more common among young males than females with around 16 per cent of those with ADHD or CD having both disorders.

The rapid social and emotional changes of adolescence can complicate the presentation and recognition of mental health problems in young people. Behavioural and emotional turmoil is often a part of adolescent development and may be easily dismissed as 'transient'. Mood changes, irritability, poor school performance, or interpersonal conflicts may also mask emotional distress or an underlying mental health problem.

TRAUMA AND MENTAL HEALTH

There is increasing recognition that many mental health problems and disorders are trauma-related (Kezelman and Stavropoulos 2012)

A trauma-informed approach to working with young peoples' mental health problems is widely accepted as best practice.

The landmark Adverse Childhood Experiences (ACE) study conducted in the United States (Felitti et al. 1998; Felitti 2002) found that many problematic symptoms and behaviours stem from coping mechanisms that were initially protective attempts to deal with the adverse experiences associated with complex trauma.

Complex trauma refers to exposure to stressors that are interpersonally generated, ongoing and cumulative, often occurring in childhood or adolescence – such as abuse, neglect or emotional or physical deprivation (Kezelman and Stavropoulos 2012)

In some cases, depression, anxiety, substance abuse, conduct disorders, eating disorders, and self-harming may in fact be symptomatic of the experience of trauma and attempts to cope with it.

For more information about trauma-informed practice, see chapter 3.4.

PRIMARY HEALTH CARE AND SPECIALIST MENTAL HEALTH SERVICES

The first point of contact most people will have with the mental health system is their GP. In Australia, the Better Access Scheme gives GPs a Medicare-supported pathway for referring people to a psychiatrist or psychologist for specialist mental health assessment and/or provision of psychological treatment for a range of mental health problems. Headspace centres are also a first point of contact for mental health care.

However, young people are often reluctant to visit GPs or engage in the mental health system. Youth service providers can play a key role by supporting young people to access a GP. Be sensitive in discussing referral with the young person and explain the reasons why you think they should see a GP. You will also need to explain confidentiality and privacy provisions.

Where possible stay in contact with the young person and support them in practical ways (such as helping them to understand the role of psychiatrists, psychologists and counsellors; accompanying them to appointments; and helping them to adhere to medication and other treatment components).

Approved psychological treatments that can be provided by a psychologist under the Medicare scheme include:

- Cognitive Behavioural Therapy (CBT), including both behavioural and cognitive interventions
- Psycho-education (including MI)

- Relaxation strategies – progressive muscle relaxation; controlled breathing
- Skills training – problem-solving skills and training; anger management; social skills training; communication training; stress management
- Interpersonal therapy (especially for depression)

FINDING OUT MORE...

There are many online resources about mental health. The Head to Health website combines mental health resources and content from the leading health focused organisations in Australia. You can access a range of mental health resources including online programs, fact sheets, audio and video, and online communities as part of the National E-Mental Health Strategy. Visit www.headtohealth.gov.au

DISABILITY AND MENTAL HEALTH

People with a disability exhibit the same range of mental health disorders and problems as general population, however young people with disabilities are more likely than those without a disability to experience mental health problems or disorders early. Fourteen per cent of those with severe or profound disability and mental health problems experienced the onset of mental health issues in childhood or adolescence compared to seven per cent of those without a disability (AIHW 2010).

Children and adolescents with an intellectual disability have a higher risk of developing mental Health problems (Einfeld et al. 2006). Identifying mental health problems and disorders in children and adolescents with an intellectual disability is complex and requires a collaborative approach. Fletcher et al. (2007) provide a clinical guide to diagnosis of mental health problems for people with intellectual disability.

Parents of children with disability may also be at increased risk of mental health problems. Mothers who parent more than one child with a disability, or a child with autism, or have an additional child of preschool age may be more vulnerable to poor mental health (Bourke-Taylor et al. 2012).

FINDING OUT MORE...

Learn more about mental health and young people with a disability in 3.11 Chronic conditions and disability.

SPECIFIC MENTAL HEALTH CONDITIONS

This section provides general guidelines to help you understand and identify some major youth mental health problems. The extent to which particular professionals are able to diagnose and treat mental health disorders will depend on their training, knowledge, experience and work role.

Even if you are not a treating professional, an understanding of common assessment and treatment approaches can help you to know when and how to refer a young person to specialist mental health services.

DEPRESSION

It can be difficult at times to distinguish between the turbulence of adolescent developmental changes and the onset of serious mental health concerns. We all feel down or sad from time to time. Sadness is a reaction to something in particular, like a relationship break-up. Depression means that feelings of sadness last longer than normal, affect most parts of your life, and stop you enjoying the things that you used to.

Adolescence is a key period for the onset of depression. Depression in young people is often masked by other symptoms: anger, irritability, anxiety, poor school performance, marked changes in mood or behaviour may all be hiding depression in a young person. It is important that youth service providers are proactive in enquiring about low mood in young people.

Co-morbidity is common: depression often accompanies other psychosocial or mental health problems, including substance abuse, anxiety, sexual abuse, bullying or family problems.

There are a several different types of depression. Young people often have mood swings (feeling up sometimes as well as down) and may be more irritable and sensitive than usual. This means depression is sometimes hard to diagnose, being mistaken for normal adolescent moods. Major depression usually happens in episodes, when depressed feelings build up slowly over a few weeks.

Typical symptoms of depression include:

- Feelings of unhappiness, moodiness and irritability, and sometimes emptiness or numbness
- Losing interest and pleasure in activities that you once enjoyed
- Loss of appetite and weight (but sometimes people 'comfort eat' and put on weight)
- Either trouble sleeping, or over-sleeping and staying in bed most of the day

- Tiredness, lack of energy and motivation
- Feeling worried or tense
- Difficulty concentrating and making decisions
- Feeling bad, worthless or guilty
- Being self-critical and self-blaming
- Having dark and gloomy thoughts, including thoughts of death or suicide

Dysthymia is a milder type of depression but it is often continuous and can last for months or years. People with dysthymia might still be able to perform their day-to-day tasks, but with less interest, confidence and enjoyment. Dysthymia also interferes with sleep, appetite, energy and concentration. Depression can also occur as part of bipolar disorder.

ASSESSMENT AND DIAGNOSIS

Specialist health providers such as psychologists, psychiatrists, GPs or mental health nurses generally carry out mental health assessment and diagnosis, including the assessment and diagnosis of depression. They conduct an in-depth clinical assessment obtaining a history from the young person, and where appropriate, supporting information from others.

In NSW, mental health clinicians frequently use the NSW Health's Mental Health Outcomes and Assessment Tools (MH-OAT) to assist in the assessment, monitoring and review of mental health care. The tools include diagnostic interviews, self-reporting questionnaires or rating scales that can assist in establishing diagnosis.

Youth service providers can play an important role identifying early signs of depression in a young person and in facilitating access to specialist mental health services. Providers also play an important role in supporting the young person to understand the process of consultation and treatment; collaborating with GPs, psychologists and other providers in implementing a treatment plan; and maintaining connection with the young person.

WHAT TO LOOK FOR

Depressive symptoms (such as low mood and lethargy) are common in young people. The presence of these symptoms alone may not necessarily warrant a diagnosis of depression.

When you are conducting a psychosocial assessment, look for:

- Marked changes in usual mood or behaviour such as sleep/appetite disturbance; persistent irritability; or sleeping too much.
- Underlying risk factors or precipitating events for onset of depression, for example substance use, bullying and victimisation, difficulties in sexual orientation, issues of loss, family conflict, trauma, stress, or illness.
- Deterioration in functioning in key areas of the young person's life such as a drop in school performance; loss of interest in activities; withdrawal from social contacts; or conflict with peers.
- A family history of depression or other mental illness.

A useful approach to assessment is to ask the young person to rate their own level of depression on a scale from 0 to 10 – where '0' means no depression and '10' means severe depression (Martin 2001). A score of up to 5/10 can usually be considered mild depression. A score above 5 may indicate more severe depression. It is important to ask the young person what that particular score means for them. A score of seven and above demands a careful screening for the risk of suicidality (Martin 2001). A young person who is depressed may be at risk of suicide, and if they are, they need urgent help. If a young person is thinking about suicide, referral to a mental health service is required.

MANAGEMENT APPROACHES

The treatment of depression in young people should ideally involve a collaborative partnership between the young person, a GP and a specialist mental health service provider (e.g. psychiatrist; psychologist; youth mental health worker). Youth service providers play an important role in helping the young person find and access a GP who can prepare a Mental Health Care Plan under the Medicare Better Access scheme.

Youth service providers can also support the young person's journey, listening to their concerns and facilitating referral to other professionals where that is needed.

TREATMENT OPTIONS

Treatment plans should be based on a comprehensive assessment – including the type, severity and duration of the depressive symptoms, related stressors, availability of health services and the skills and experience of workers involved.

In cases of mild depression, there are several specific strategies that can be helpful interventions, including:

- Building problem-solving skills
- Stress management and relaxation techniques
- Activity planning
- Physical exercise
- Psycho-education (in particular about the causes and symptoms of depression and the importance of activity and sleep)

- Social skills training

In more severe cases of depression, more specifically targeted treatment will be required. Current evidence (beyondblue 2010; Hetrick et al. 2013) recommends a stepped approach to treatment, involving:

1. **Establishing support, shared decision-making, multiple visits and the use of psychological therapies.** Evidence-based counselling or psychotherapy is generally considered the first line of treatment for young people (beyondblue 2010; Martin, G. 2001). Evidence-based psychological treatments include CBT, Interpersonal Psychotherapy (IPT), and Family Therapy. GPs can use a Medicare Mental Health Care Plan to refer to a psychologist or other counsellor trained in evidence-based psychological treatments
2. **Prescription of anti-depressant medication.** Available evidence suggests that for selected young people, antidepressants are an effective component of the successful treatment of certain depressive and anxiety disorders in young people (Hetrick, Parker & Purcell, 2013; beyondblue 2010.) Selective Serotonin Reuptake Inhibitors (SSRIs) may be prescribed within the context of comprehensive management of the young person, which includes regular careful monitoring for the emergence of suicidal ideation or behaviour. The key to successful anti-depressant drug treatment in young people is frequent review by a GP or Psychiatrist to monitor response, compliance and side effects.

SUPPORTING A YOUNG PERSON WITH DEPRESSION

Young people who are depressed can benefit from education about the nature of their symptoms and moods, their possible causes and effects on them, and proposed treatments. You can help a young person develop positive coping skills and to learn to manage their depression by helping them to:

- Develop social and interpersonal skills
- Build problem-solving and goal setting skills
- Build self-esteem
- Manage their emotions

Withdrawal from pleasurable or routine activities is a common feature of depression. Set the young person homework tasks to identify and monitor their daily activities over the period of a week. Encourage the young person to re-engage in doing pleasurable activities and to gradually increase the amount of time they spend exercising, playing sport and participating in social and recreational activities.

It is also important to educate and support parents, carers and family members about depression. In some cases, Family Therapy can be an important part of treatment. Specialist family counselling

may be beneficial where family issues are a major contributing factor in the onset and maintenance of the depression.

Ensure that a mental health specialist has assessed the young person before undertaking additional psychological therapies.

FINDING OUT MORE...

There are many evidence-based internet resources to help both professionals working with young people and young people living with depression:

- Beyondblue – the National Depression Initiative has resources for professionals and the public, including a specific site for young people, and a set of Clinical Practice Guidelines: Depression in Adolescents and Young Adults. Visit www.youthbeyondblue.com
- The Black Dog Institute provides assessment tools, resources and management guidelines on the treatment of depression and other mood disorders. Visit www.blackdoginstitute.org.au
- DepressionNet – provides information and resources for health consumers about the causes, symptoms and treatment options for managing depression. Visit www.depressionNet.org.au
- Reachout – provides information, resources and support for young people and professionals. Visit www.reachout.com.au
- Orygen Youth Health (OYH) – provides a range of excellent resources and fact sheets for professionals and young people. Visit www.oyh.org.au

PRACTICE POINTS

- Use the HEEADSSS psychosocial assessment to identify signs of depressed mood in young people
- Refer to a GP, psychiatrist or psychologist, or youth mental health service for more in-depth clinical assessment
- Youth service providers can play a key role in collaborative care by assisting young people to access a GP or mental health professional
- Educate the young person about their depression and help them learn skills to assist in better managing their moods
- Provide follow-up support to the young person and where, appropriate to the family, to assist them in adhering to their treatment plan.

ANXIETY DISORDERS

Anxiety disorders are among the most commonly reported disorders among young people aged 16–24 years (AIHW 2011). Common anxiety disorders in young people include social anxiety, generalised anxiety disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder. Co-morbidity is common: anxiety often occurs with depression, substance abuse and ADHD.

These disorders often have their onset in childhood or early adolescence. Females report considerably higher rates of anxiety disorders than males do (21.7 per cent compared to 9.3 per cent).

ASSESSMENT AND DIAGNOSIS

There are several categories of anxiety disorders that may affect young people:

Generalised anxiety disorder. Generalised anxiety disorder can be diagnosed after an individual has had 6 months or more of anxiety or worry.

Post-traumatic stress disorder (PTSD). A person with PTSD has usually experienced a highly traumatic event in the past, and now re-experiences that event with symptoms of heightened physical and psychological arousal. They are likely to avoid places, people, or situations that they associate with the original trauma.

Social anxiety disorder/phobia. Social anxiety disorder or phobia is characterised by a marked and persistent fear of being embarrassed in social situations. The level or intensity of the fear is usually unreasonable and excessive. Fear of exposure to social or performance situations often leads to avoidance behaviour.

Specific phobia. A phobia is an intense and irrational fear of a specific situation or object (such as fear of traveling on planes). The fear often leads to avoidance behaviour.

Panic disorder. Panic disorder refers to the presence of repeated, unexpected panic attacks compounded by worry about having another panic attack. The fear may relate to losing control or suffering a personal catastrophe.

OCD. OCD is characterised by obsessive thoughts and accompanying compulsive behaviours. A commonly used example is the fear of contamination associated with frequent or continual hand washing. OCD can also involve the fear of catastrophic consequences or events and ritualized behaviours designed to protect against those consequences (for example, stepping over cracks in a specific pattern or counting in particular patterns).

WHAT TO LOOK FOR

Symptoms of anxiety disorders usually fall into three groups:

- Cognitive: including worrying about the future, one's health, one's relationships; and decreased attention and concentration
- Behavioural: avoidance, withdrawal, self-medication with drugs or alcohol
- Somatic: palpitations, increased heart rate, flushing, hyperventilation, tiredness, nausea, sleep difficulties, sweats, shortness of breath, muscular tension

When a person is suffering with an anxiety disorder, the symptoms are usually present at a level that markedly impairs interpersonal, social, academic and occupational functioning

Young people with anxiety often present with physical complaints, school refusal, social avoidance or complex family or interpersonal problems. You can use the HEADSSS psychosocial assessment (see 3.2 Psychosocial assessment) to help identify signs and symptoms of anxiety. Look for:

- Risk factors or precipitating events that may have contributed to the onset and maintenance of anxiety, for example peer conflicts, bullying and victimisation, issues of loss, family difficulties, illness or trauma
- Avoidance behaviour
- Sleep disturbance
- The presence of co-morbid conditions (such as depressed mood or substance use)
- Indicators in the family's background: there is often a strong family history of anxiety or affective disorders.

If you think a young person you are working with may suffer from anxiety, or you're not sure, refer them to a GP or youth mental health service for more in-depth assessment, and possible referral on to a psychologist or psychiatrists for diagnosis and treatment options.

MANAGEMENT APPROACHES

The treatment of depression in young people should ideally involve a collaborative partnership between the young person, a GP and a specialist mental health service provider (e.g. psychiatrist, psychologist; youth mental health worker). Youth service providers play an important role in helping the young person find and access a GP who can prepare a Mental Health Care Plan under the Medicare Better Access scheme.

Youth service providers can also support the young person's journey, listening to their concerns and

facilitating referral to other professionals where that is needed.

TREATMENT OPTIONS

The recommended first line of treatment for young people with anxiety is usually psychological therapies. CBT has proven effective in the treatment of anxiety, particularly in addressing the patterns of negative thinking ('cognitions') that usually contribute to anxiety. CBT exposure and response prevention treatment is the recommended psychological treatment for OCD.

The use of medication for anxiety, while having proven effectiveness, should be used judiciously with young people (as in the treatment of youth depression) and should be based on a comprehensive assessment of the young person's symptoms and circumstances.

GPs can facilitate a multidisciplinary approach to treatment by developing a comprehensive Medicare Mental Health Care Plan for referral to a psychiatrist and/or psychologist.

SUPPORTING A YOUNG PERSON WITH ANXIETY

Anxiety can have a debilitating effect on young people (and their families): in particular, they risk become socially isolated, a known precipitator for the onset of other mental health problems like depression.

Young people often don't recognise their anxiety as a problem, or are embarrassed about it. Non-judgemental, informed support from a trusted source can make the experience of seeking help much easier.

Youth service providers can play a vital role in helping to identify young people who may be experiencing anxiety and referring them to a GP or youth mental health service for diagnosis, treatment and professional support.

Your role can extend to supporting treatment plans by helping to address psychosocial factors that may be contributing to the young person's anxiety. Help them to better understand anxiety and to develop positive coping strategies. It may be particularly helpful for the young person to understand how anxiety functions in their brain, including the role that the limbic system and 'primitive' brain (with its fight-or-flight response) plays in the development and maintenance of anxiety. They may also need help to understand and recognise the physiological effects of anxiety – hyper-arousal, increased breathing rate, muscle tension and nausea are common symptoms.

Avoidance behaviour will unfortunately maintain the young person's anxiety. It is helpful to encourage

the young person to overcome their avoidance by gradually and safely exposing themselves to feared situations. You can also teach them skills that might reduce anxiety symptoms and help them regulate their emotions when in an anxiety-provoking situation. These include self-calming skills (e.g. deep breathing, going for a walk), relaxation or meditation techniques to reduce hyper-arousal, and social skills training to increase their confidence in social situations.

FINDING OUT MORE...

There are some excellent internet resources with information about anxiety and resources that can be helpful to young people experiencing anxiety.

- Youthbeyondblue has a range of fact sheets for young people, families, and professionals. Visit www.youthbeyondblue.com
- Anxiety Disorders Association of Victoria provides resources and detailed information about panic disorder, social phobia, agoraphobia, generalised anxiety and depression. Visit www.adavic.org
- Headspace – is Australia's National Youth Mental Health Foundation. Visit www.headspace.org.au
- Orygen Youth Health (OYH) – the Orygen website provides a range of resources and fact sheets for professionals. Visit www.oyh.org.au

PRACTICE POINTS

- Use the HEEADSSS psychosocial assessment to identify signs of anxiety in young people.
- Anxiety is often not a 'rational' behaviour, so telling the young person to calm down or relax usually makes things worse – it's not that easy. Be patient and listen to the young person's fears and concerns.
- Refer to a GP, psychiatrist or psychologist, or youth mental health service for more in-depth clinical assessment
- Young people experiencing anxiety can benefit from developing skills in emotional self-regulation, positive coping strategies and relaxation.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

Attention Deficit Hyperactivity Disorder is a developmental behavioural disorder characterised by persistent patterns of inattention, poor concentration, hyperactivity and impulsivity. Research suggests the prevalence of ADHD in young people aged

12-17 years is between 5 per cent and 10 per cent (AIHW 2011; ABS 2007). It is much more common in boys than girls.

Symptoms usually appear before the age of seven and cause significant disruption to both home and school environments. If not treated, ADHD is associated with a high risk of future problems, including school difficulties, work difficulties, relationship problems, substance abuse and adult mental health disorders.

ASSESSMENT AND DIAGNOSIS

ADHD can be difficult to diagnose. It frequently co-occurs with anxiety and depressive symptoms, as well as other behavioural disorders such as oppositional-defiant or CDs.

A paediatrician, child psychologist or child psychiatrist can make the assessment. Diagnosis requires a complex and detailed assessment: there is no single test for ADHD. Diagnosis will be based on a range of factors, requiring information from parents and others. Internationally recognised scales and criteria are used to assess and diagnose ADHD.

Assessments include a developmental history of the child's past behaviours. They may also take into account any issues with the child's early attachment to a parent or caregiver, which may contribute to the behaviour.

WHAT TO LOOK FOR

Common symptoms of ADHD include:

- Inattention symptoms – difficulty concentrating and sustaining attention; difficulty organising tasks; easily distracted; not listening when spoken to
- Hyperactivity symptoms – fidgeting; inability to remain seated; poor impulse control
- Not all children or young people displaying these symptoms have ADHD. A paediatrician or psychiatrist will also gather information from the child or young person's school and family before making a diagnosis of ADHD.

MANAGEMENT APPROACHES

A collaborative approach is required for management of ADHD. Treatment is likely to involve medication, psychological support, counselling and learning interventions at school.

GPs can refer the young person to a psychiatrist or paediatrician for specialist diagnosis. They can also develop a comprehensive Mental Health Care Plan for referral to a psychologist as part of a collaborative treatment approach.

TREATMENT OPTIONS

Stimulant medications (like Ritalin and Concerta) are usually the first line of treatment for ADHD. There is also growing evidence for the effectiveness of psychological interventions such as CBT, which can help address self-esteem issues, difficulties with impulse control, behavioural management issues, social skills and organisational difficulties.

Counselling interventions can also assist in the treatment of co-morbid conditions such as anxiety and depression.

Young people with ADHD usually also require intensive learning interventions at school to assist them with attention and learning difficulties.

SUPPORTING A YOUNG PERSON WITH ADHD

Youth health and support services can help a young person who they suspect may be showing symptoms of ADHD to see a GP for assessment and diagnosis. ADHD can be severely disruptive in the family environment, so it is important to provide education and support to the family. Family counselling may also be beneficial.

FINDING OUT MORE...

The National Health and Medical Research Council has published Clinical Practice Points on the Diagnosis, Assessment and Management of ADHD in Children and Adolescents which are available at www.nhmrc.gov.au/guidelines/publications/mh26.

The Royal Australian College of Physicians (RACP) has developed the Draft Australian Guidelines on ADHD. You can find the guidelines on the RACP's website www.racp.edu.au.

The Australian Psychological Society (APS) has also published treatment guidelines for ADHD. Visit www.psychology.org.au

PRACTICE POINTS

- Symptoms of ADHD are usually apparent before a child is 7 years old. It is less common for a first diagnosis of ADHD to be made in adolescence or the teenage years.
- A young person with ADHD has three main difficulties: inattention, impulsivity and overactivity. Not all children with these challenges have ADHD.
- Diagnosis is made after consideration of a range of information sources and involves ruling out other causes of symptoms.

EATING DISORDERS

Eating disorders involve issues of body image, dieting and other aspects of life as well as food. They include anorexia nervosa (known as anorexia), bulimia nervosa (bulimia) and eating disorders otherwise not specified (EDNOS).

Eating disorders can lead to serious physical health problems. Malnutrition or repeated cycles of bingeing and purging can cause damaging changes in the body. Starvation, for example, can lead to osteoporosis (weakening of the bones), kidney problems, headaches, constipation or diarrhoea, fainting and heart problems.

Vomiting after eating can expose the teeth to stomach acid and cause decay, and also cause sore throats, heart problems and abdominal pain. Laxatives can cause constipation or diarrhoea, as well as dehydration and bowel disease.

Eating disorders can also lead to difficulties in concentrating causing problems in studying or at work. They also increase the chance of having depression, anxiety, substance misuse, irritability and moodiness.

Eating disorders are estimated to affect approximately 9 per cent of the population. Though they are more common in females, they affect both males and females. Anorexia and bulimia affect between two and four per cent of the population, and it is estimated that a further five per cent of the population is affected by EDNOS. It is estimated that up to 20 per cent of females may have undiagnosed eating disorders with many young women engaging in unhealthy weight loss behaviours.

ASSESSMENT AND DIAGNOSIS

There are specific diagnostic criteria for anorexia, bulimia and EDNOS. If you are working with a young person who you suspect may have an eating disorder, it is important to refer them to a GP or specialist eating disorder clinic or mental health service for support. Support is also available from school counsellors, psychologists and other counselling services.

WHAT TO LOOK FOR

People with anorexia might:

- Refuse to eat enough food despite being hungry
- Have a strong fear of gaining weight or becoming fat, even though they are underweight
- Have inaccurate perceptions of their body
- Deny serious weight loss
- Stop having menstrual periods (if female)
- Exercise excessively

- Force themselves to vomit after eating, or use diuretics or laxatives to reduce their weight

People with bulimia might:

- Repeatedly binge eat, consuming large quantities of food that is often high in fat or sugar
- Feel out-of-control when bingeing
- Try to make up for binges and avoid weight gain by making themselves vomit, or by using laxatives or diuretics, fasting, or excessive exercise
- Have a compulsive cycle of binge/purge/exercise/binge
- Manage to keep to a healthy weight making the problem difficult to recognise.

People with EDNOS have many of the symptoms of anorexia or bulimia, but do not meet all the diagnostic criteria for a diagnosis of one of these conditions. A young person with EDNOS may have very disturbed eating habits and a distorted body image and may be extremely anxious about gaining weight.

MANAGEMENT APPROACHES

Eating disorders require specialist assessment and diagnosis and a comprehensive, multidisciplinary approach to treatment. Early referral is important to optimise treatment outcomes

If you suspect a young person may be experience an eating disorder, refer the young person to a GP who can develop a comprehensive Mental Health Care Plan for initiating a collaborative treatment approach. Management of eating disorders is almost always multidisciplinary, involving medical care, dietician support and psychological/psychiatric assistance.

TREATMENT OPTIONS

People with eating disorders will benefit from professional help. Keeping the young person safe is the first priority. If the weight loss is severe or there are serious health complications, then a stay in hospital may be needed.

Treatment starts with developing a good working relationship with the young person, and then moves on to providing information, establishing healthy patterns of eating and exercise, and looking after physical health. Individual counselling, family work and medication (when appropriate) might all be required, usually provided by a treatment team.

SUPPORTING A YOUNG PERSON WITH AN EATING DISORDER

If you are concerned that a young person you are working with has an eating disorder, then first of all let them know that you are concerned about them. Even if they deny there is a problem and do not want to talk about it, gently encourage them to seek professional help.

FINDING OUT MORE...

There are a range of resources and support available to professionals working with a young person with an eating disorder:

- The Eating Disorder Service in the Department of Adolescent Medicine, Children's Hospital Westmead can provide assistance with assessment and treatment. Contact the Service on (02) 9845 2446.
- For more information about eating disorders and factsheets, visit the Eating Disorders Foundation website at www.eatingdisorders.org.au
- The National Eating Disorders Collaboration provides information for professionals on research evidence and treatment approaches – www.nedc.com.au
- Mental Health First Aid Australia also has guidelines on Eating Disorders. Visit www.mhfa.com.au
- The Butterfly Foundation provide support for young people and carers. Visit www.thebutterflyfoundation.org.au or phone 1800 334 673.

PRACTICE POINTS

- Eating or dieting disorders are nutritional, medical and psychological conditions that affect body image, personality and physical health and disrupt family life and relationships.
- Eating disorders can have serious medical complications and lead to long-term social and functional impairment.
- Eating disorders are frequently associated with other psychological and physical disorders such as depression, anxiety disorders, substance abuse and personality disorder.
- Specialist, multidisciplinary support and treatment is essential. The first step is a referral to a GP who can facilitate the involvement of appropriate services.

PSYCHOSIS

Information in this section has been adapted from EPPIC – the Early Psychosis Prevention and Intervention Centre (a specialist program of Orygen Youth Health).

Psychosis describes conditions where there are disturbances of a person's beliefs, thoughts, feelings and behaviours, and/or where there is some loss of contact with reality. Psychotic disorders include schizophrenia, drug-induced psychoses, brief reactive psychosis and bipolar disorder. Schizophrenia is the third leading cause of illness in young men aged 15-24 years, and the fifth in young women of the same age (AIHW 2011).

The peak age of onset of psychotic disorders is in the early to mid-twenties for males and mid to late-twenties for females.

ASSESSMENT AND DIAGNOSIS

If a young person is experiencing significant psychosocial difficulties, and displaying symptoms of depression, anxiety or substance misuse, it is important to consider the possibility that such symptoms are part of a psychotic disorder. Early detection is important as research suggests that the earlier treatment is commenced, the more effective it is in preventing transition to a psychotic disorder or aiding in recovery from a psychotic episode (Yung et al. 2007; EPPIC 2010).

Diagnosis requires in-depth assessment by a mental health professional, usually a psychiatrist or specialist mental health services. A clinical assessment will check for psychosis will check for:

- Thought disorder (trouble with thought processes, thought processes that seem sped up or confused)
- Delusions (concern about any unusual events recently, belief that strange things are occurring around or to them, feeling as if something bad is happening to them, or that people have turned against them)
- Hallucinations (experiencing strange or unpleasant experiences involving senses, for example hearing things or seeing things that others could not)

The assessment will also consider:

- History provided by family and friends, colleagues or others who interact with the young person
- Co-morbid issues requiring treatment – especially substance use
- Suicide risk and whether the person is a risk to others

WHAT TO LOOK FOR

The period before clear psychotic symptoms (such as delusions, thought disorder and hallucinations) emerge is known as the prodromal phase, or prodrome. The prodromal phase is characterised by a gradual change in psychosocial functioning over an extended period of time. Some of these changes may include:

- Anxiety, irritability and depression
- Confused thinking or difficulty in concentration or memory
- Preoccupation with new ideas often of an unusual nature
- Physical changes such as sleep disturbance and loss of energy
- Social withdrawal and impairment of role functioning

The person may also experience some less intense symptoms such as mild thought disorder, suspiciousness, odd beliefs and perceptual disorders that are not quite of psychotic intensity or duration. This can also include changes in their perception of objects (things looking or sounding different) or brief "bursts" of hearing voices or seeing visions. They may also experience unusual or odd thoughts about themselves or people around them (such as worries about mind control or reading personal or special messages into everyday events).

An individual in the acute phase of psychosis experiences psychotic symptoms including thought disorder (a pattern of vague or disordered thinking), delusions (fixed, false beliefs out of keeping with the person's cultural environment) and hallucinations (sensory perceptions in the absence of external stimulus).

MANAGEMENT APPROACHES

Effective management of a young person with psychosis requires a multidisciplinary approach involving primary care and specialist mental health services. GPs can coordinate a collaborative treatment approach by using the Medicare Mental Health Item Numbers to develop a care plan for the young person and to facilitate referral.

TREATMENT OPTIONS

Treatment of psychosis may involve the use of prescribed anti-psychotic medications. Specialist mental health services will generally be responsible for initiating treatment and making significant changes to the medication regime. The initial focus of treatment is the control of positive psychotic symptoms and secondary symptoms such as insomnia and agitation.

SUPPORTING A YOUNG PERSON EXPERIENCING PSYCHOSIS

Early recognition and intensive intervention in early psychosis has been shown to increase the likelihood of positive outcomes for young people and their families (Yung et al. 2007; EPPIC 2010). Youth services can help by supporting a young person to seek professional treatment as early as possible for psychotic symptoms.

If a young person you are working with is showing acute symptoms of psychosis, contact your local district mental health service by calling the Mental Health Line – 1800 011 511. Alternatively, the young person can be accompanied, with an appropriate escort, to the Emergency Department of your local hospital, or call 000 in an emergency.

FINDING OUT MORE...

For more information on the signs and symptoms of psychosis and the "at risk" mental state for psychosis, Orygen's website has factsheets on "Psychosis and Young People", "At Risk Mental State and Young People" and "Medication for psychosis". Visit www.oryh.org.au

To learn more about the treatment of psychosis in young people, see the Australian Clinical Guidelines for Early Psychosis on EPPIC's website. Visit www.eppic.org.au

PRACTICE POINTS

- Psychosis is usually preceded by a period of decreased psychosocial functioning.
- It is characterised by disturbances of a person's beliefs, thoughts, feelings and behaviours and includes disorders such as schizophrenia, drug-induced psychoses, brief reactive psychosis and bipolar disorder.
- Psychosis requires diagnosis and treatment by specialist mental health services but you can support a young person who is showing signs of disordered thinking by referring them to a GP or mental health service for evaluation and assessment.

BIPOLAR DISORDER

This section has been developed based on information from the Black Dog Institute. Visit their website at www.blackdoginstitute.org.au

Bipolar disorder is the name used to describe a set of 'mood swing' conditions. Bipolar disorder is associated with high rates of morbidity and mortality, high suicide rates and high levels of social disruption to employment and relationships. It is characterised by swings between mania (or hypomania) and

depression. Mania refers to a state of heightened energy and euphoria - an elevation of mood. Mania can vary in its intensity from hypomania (elevated mood and energy, with mild impairment of judgement and insight) to severe mania with delusions. Severe mania can be so exhausting for an individual experiencing it that hospitalisation maybe required to control the episode.

Unfortunately, bipolar disorder is commonly misdiagnosed: it can be difficult to distinguish between bipolar disorder and other conditions such as anxiety, schizophrenia and personality disorders. Bipolar disorder commonly emerges in mid to late adolescence (15-18 years old).

There are two main forms of the disorder. Bipolar 1 disorder (BP-1) affects around 1 per cent of the population (Parker 2007). A young person with BP-1 is likely to experience mania, have long highs and be more likely to experience psychosis. Individuals with BP-1 are also more likely to be hospitalised. Bipolar 2 disorder (BP-2) is milder in terms of its symptoms; however, the impairment associated with it may be as serious as it is for a person with BP-1. A young person with BP-2 experiences the symptoms of a high but does not experience symptoms of psychosis present for individuals with BP-1. Hypomanic episodes tend to last a few hours or days.

Anxiety disorders and substance abuse are common in people with bipolar disorder.

ASSESSMENT AND DIAGNOSIS

Most health professionals can identify the manic phase of bipolar disorder. However, because many patients only seek help when they are in the depressed phase, it can take a long time for a diagnosis of bipolar to be made. It can be helpful to consider the possibility of bipolar disorder when a young person presents with depression, as early detection will lead to better health and wellbeing outcomes.

Some of the factors that would lead a health professional to consider a diagnosis of bipolar disorder include:

- History of recurrent depression with melancholic features
- History of depression with psychotic features
- Positive family history of a mood disorder
- Onset of melancholic or psychotic depression at a young age (before 40).

Structured screening tools assist health professionals to make the diagnosis, but most of these require specialist training and are often only used in specialist psychiatric research settings. The Black Dog Institute has developed a self-rating tool, which

can be completed online or downloaded and printed by health professionals who are screening for bipolar disorder. Visit www.blackdoginstitute.org.au

WHAT TO LOOK FOR

People experiencing bipolar disorder may exhibit a range of symptoms. Remember that you may only see them in the depressive phase of an illness, which is why screening by a mental health professional is essential before any diagnosis is made.

Nevertheless, you may notice symptoms including:

- High energy levels (feeling wired or hyper), racing thoughts, talking more and talking over people; racing from plan to plan and being constantly on the go; and describing the need for less sleep without feeling tired.
- Positive Mood. A positive or hedonistic mood is characteristic. People with bipolar disorder describe it as feeling confident and capable, being extremely optimistic, feeling that they can succeed in everything, being more creative, and perhaps feeling 'high as a kite'. Any general anxiety disappears.
- Irritability. An individual may exhibit: irritable, impatient and angry behaviour.
- Inappropriate behaviour. An individual in the manic phase of bipolar disorder may be over-involved in other people's activities. They may also exhibit increased risk-taking behaviour; saying and doing outrageous things; spending more money; an increased libido; lack of discernment in relationships; and dressing more colourfully and without inhibition.
- Creativity. People with bipolar disorder experience heightened creativity, often 'seeing things in a new light', vividly or with great clarity. Their senses are heightened and they experience a feeling of being able to achieve great things creatively.
- Mystical experiences: An individual may believe that events are connected and that there is a higher rate of coincidences occurring. They often feel at one with nature and believe that events hide signs or symbols of special significance.

MANAGEMENT APPROACHES

Correct diagnosis is crucial in providing effective treatment for bipolar disorder. Referral to a psychiatrist is recommended to assist with diagnosis and treatment. GPs can refer the young person to a psychiatrist and/or psychologist for assessment, counselling and treatment under a Medicare Mental Health Care Plan. Treatment involves a mix of both medication and psychological therapies.

Bipolar disorder is not a curable condition and requires long-term management.

TREATMENT OPTIONS

Bipolar disorder can require long-term treatment. Medications are used to treat acute episodes of mania and depression and other medications (mood stabilisers) are used to prevent episodes from occurring. While counselling can be beneficial to support a person with bipolar disorder, psychological therapies alone are ineffective.

SUPPORTING A YOUNG PERSON WITH BIPOLAR DISORDER

If you are concerned that a young person you are working with may be exhibiting symptoms of bipolar disorder, referral to a GP or specialist youth mental health services is essential. Early engagement with mental health professionals can improve the health and wellbeing outcomes for individuals with bipolar disorder.

If a young person you work with has been diagnosed with bipolar disorder, you can support them by helping them learn more about the condition, attend appointments and consultations and follow treatment plans.

If a young person you are working with is showing acute symptoms, contact your local district mental health service by calling the Mental Health Line – 1800 011 511. Alternatively, the young person can be accompanied, with an appropriate escort, to the Emergency Department of your local hospital, or call 000 in an emergency.

FINDING OUT MORE...

The Black Dog Institute's website has extensive information about bipolar disorders, their presentation, assessment, diagnosis and treatment. Visit www.blackdoginstitute.org.au

PRACTICE POINTS

- Diagnosis can be difficult and must be undertaken by a mental health professional.
- Symptoms of bipolar disorder often emerge in the late teens or early twenties. If you suspect that a young person you are working with or supporting may be experiencing mood swings, mania or severe depression help them to find a GP or access specialist youth mental health services.
- Support the young person to comply with treatment plans. Bipolar disorder is a life-long condition and requires ongoing treatment to reduce and manage mood swings and symptoms.

SELF-HARM AND SUICIDE

This section is based on information from Mental Health First Aid (MHFA) Australia's *Non-suicidal self-injury: first aid guidelines* and *Suicidal thoughts and behaviours: first aid guidelines*. Visit www.mhfa.com.au

Self-harming and suicidal behaviour are maladaptive solutions to emotional, psychological and interpersonal problems. Deliberate self-harm is common in Australian young people, especially in females: research suggests that 6-7 per cent of young Australians (aged 15-24) have self-harmed in any 12-month period, while over 12 per cent report having done so at some point in their life (De Leo and Heller 2004).

Self-harming behaviour involves directly and deliberately inflicting bodily harm or injury. It includes cutting, scratching, burning and abrading. The act or experience alters the person's mood state and reduces psychological tension. A young person may self-harm to cope with overwhelming feelings and situations. Conversely, some young people self-harm in an attempt to feel emotion.

In most cases, self-harm is not a suicide attempt: many young people use self-harm as a way to stay alive rather than end their life. Suicidal behaviour, however, is intended to end life. It consists of threats and actions that involve the intention to kill oneself and that, if carried out, may lead to serious injury or death. Suicidal ideation refers to conscious thoughts about ending one's life.

While more young females are hospitalised for suicide attempts than young males, young men have a death rate from suicide that is three to four times higher than the rate amongst females. Males tend to use more lethal methods than females. Suicide rates amongst Indigenous young people are four times the rate for non-Indigenous young people. Prevalence rates of suicide attempts in same-sex attracted young people are 4 to 6 times higher than the general population, with those in rural areas particularly at risk.

ASSESSMENT AND DIAGNOSIS

Self-harming behaviour indicates a high level of psychological stress. It is often repetitive in nature and, in some cases, may be associated with a personality disorder. A young person who is self-harming needs professional mental health support, so refer the young person to a GP or a psychiatrist for a comprehensive assessment.

Some self-harming behaviour may need urgent medical attention – because of the risk of accidental death or injury (for example, if the young person has taken an overdose or there is bleeding that is rapid or pulsing). If any of these situations occur, call

an ambulance (dial 000) or accompany the young person to the Emergency Department of your local hospital

Young people who are self-harming should be screened for depression and suicide risk. A psychosocial risk assessment using the HEEADSSS screening tool can help to identify presence of suicidal ideation and behaviour. It also allows you to determine risk and protective factors in the young person's life.

If you think the young person may be depressed or he or she discloses suicidal thoughts, it is important to enquire directly about suicidal thoughts or behaviour. Asking about suicide does not put the idea of suicide in someone's mind. Most young people feel relieved to have their distress acknowledged – it allows them to express their worries and to feel heard and understood.

If the young person has been having suicidal thoughts, it is important to conduct a more systematic assessment to identify whether the young person is at low, moderate or high risk of suicide.

In NSW, the Mental Health Line is a statewide, 24-hour mental health telephone access service. Anyone with a mental health issue can use the Mental Health Line to speak with a mental health professional and be directed to the right care for them. Carers, other health professionals and emergency service workers can also use the Mental Health Line for advice about a person's clinical symptoms, the urgency of the need for care and local treatment options.

The Mental Health Line can be contacted on 1800 011 511.

The Suicide Callback Service, a national support service for individuals and health professionals, has factsheets and guidance to support you in assessing risk. Visit www.suicidecallbackservice.org.au

If you do not feel confident to conduct a suicide risk assessment, refer the young person to a GP, psychologist, psychiatrist or a youth mental health service for an in-depth assessment.

WHAT TO LOOK FOR

Some of the factors that may indicate an increased suicide risk include:

- Previous suicide attempts or intentional self-harm
- History of previous attempts in family/friends
- Mental illness combined with harmful drug use
- Depression or hopelessness
- Concrete suicide plan
- Recent stressful life events

- Relationship breakdown
- Loss, disappointment or humiliation
- School or work difficulties
- Withdrawal from friends, family or society
- Victim of bullying
- GLBTIQ identification

The main contributing factors in youth suicide are depression and loss of hope. Empathise with the young person and show your concern and interest – use reflective listening to encourage them to express their thoughts and feelings about their current situation. Common thoughts and feelings include:

- Sense of hopelessness and/or helplessness
- Persistently thinking things will never get better and no-one can help
- Feeling overwhelmed by the expectations of others
- Loneliness, fear, feelings of abandonment and not being heard consistent high levels of anxiety and/or anger

MANAGEMENT APPROACHES

Self-harming behaviours and thoughts of suicide are indicators for referral for specialist mental health support. Young people may be reluctant to engage with the mental health system, so it is important to address concerns about referral openly. Of course, you will also need to deal with the situation of confidentiality sensitively but firmly. **It is important not to agree to secrecy.**

Example:

"Mark, you've said that you don't want anyone to know about this. However, I'm very concerned about you at the moment and my first duty really is to make sure that you are safe. In order to make sure you are safe, I need to contact some other people who can help you so that we can get you through this difficult time."

In the case of a young person who you believe may be suicidal, let them know that suicidal thoughts are common and don't have to be acted on. Refer the young person to the local youth mental health service or to a GP who can facilitate referral to psychiatrist or psychologist. Be prepared to support the young person to attend appointments and to facilitate contact between the young person and a mental health service or GP.

TREATMENT OPTIONS

Treatment for self-harming behaviours may include a range of psychological supports, including:

- CBT, including both behavioural and cognitive interventions
- Psycho-education (including MI)
- Relaxation strategies – progressive muscle relaxation; controlled breathing
- Skills training – problem-solving skills and training; anger management; social skills training; communication training; stress management
- Interpersonal therapy (especially for depression)

The treatment approach taken to support a young person at risk of suicide or who has attempted suicide will vary from case to case, but should always involve a mental health professional or team. Medication may be required, as may other therapies. Hospitalisation may also be necessary in medium-to-high risk cases, particularly where a young person has little or no social support.

SUPPORTING A YOUNG PERSON WHO SELF-HARMS

Remember that a young person who self-harms does so to relieve overwhelming feelings or perhaps to reconnect with feelings and relieve a sense of numbness. They are often experiencing high levels of anxiety and/or depression.

Talk openly and calmly to the young person about their self-harming, in a supportive and non-judgemental way. It is important to manage your own reactions to the self-harming behaviour – stay calm and avoid expressing a strong negative judgement.

Explore the triggers to their self-harming and its function in their life:

- When and in what situations do they self-harm?
- How does self-harming help to regulate their moods?

Help the young person to identify their strengths and goals for how they would like to be able to react to these triggers. You can also help them to explore other ways of managing their anxiety and coping with emotions.

Talk with the young person about how counselling can assist them to develop positive self-soothing and emotional self-regulation techniques, problem-solving skills and communication skills. You can then refer them to a GP for referral on to a psychologist or psychiatrist for assessment and counselling under a Medicare Mental Health Care Plan. Alternatively, in NSW, you can refer the young person to a local mental health service through the Mental Health Line on 1800 011 511.

SUPPORTING A YOUNG PERSON AT RISK OF SUICIDE

If the young person is in immediate danger:

- Call 000 and ask for an ambulance.
- Go with the young person to the local hospital's Emergency Department.
- In NSW, you can contact the Mental Health Line, which provides 24-hour access to mental health service support. Call 1800 011 511.

If the young person is at moderate-to-high risk, consider:

- What steps can I do to increase the young person's safety?
- Who else does the young person trust?
- What services can I draw on to support this young person?
- What options are available when I am not here? Provide contact details for telephone crisis services.
- Which GP, mental health service or mental health professional can I refer this young person to? You may need to be proactive in facilitating contact and accompanying the young person to appointments.

You can also help by:

- Developing a safety plan with the young person. You can learn more about safety planning at www.youthbeyondblue.com
- Contacting and mobilising family and/or social supports
- Removing or limiting access to the means of self-harm if possible
- Affirming the person, affirming the problem but negating the maladaptive solution (i.e. suicide)

FINDING OUT MORE...

There are many online resources about managing self-harming behaviour and about identifying, assessing and managing suicide risk in young people.

Mental Health First Aid (www.mhfa.com.au) provides guidelines on mental health first aid for both self-harming and suicidal behaviours.

Reachout (www.reachout.com.au), headspace (www.headspace.org.au), and youthbeyondblue (www.youthbeyondblue.com 1300 22 4636) provide information and resources for young people, their families, friends and health professionals about managing mental health including self-harm and suicide.

Kids Helpline (www.kidshelp.com.au 1800 551 800) provides a free and confidential telephone and online counselling service specifically for young people aged between 5 and 25.

Lifeline (www.lifeline.org.au 13 11 14) provides free online, phone and face-to-face crisis support and suicide prevention service.

The Black Dog Institute also provides a range of resources including screening tools, factsheets and guidelines on its website. Visit www.blackdoginstitute.org.au. The Institute has a website specifically for young people (www.biteback.org.au) and also offers a training program specifically for professionals working with young people.

Headspace helps young people who are going through a tough time. 12-25 year-olds can get health advice, support and information. With centres all around Australia, headspace can help with: general health, mental health and counselling, education, employment and other services, alcohol and other drug services. Headspace also provide an online counselling service (www.eheadspace.org.au 1800 650 890). Visit www.headspace.org.au.

Suicide Call Back Service (www.suicidecallbackservice.org.au 1300 659 467) provides a few professional telephone and online counselling service for anyone affected by suicide.

QLife provides phone and online support (www qlife.org.au 1800 184 527) for lesbian, gay, bi, trans and intersex communities.

PRACTICE POINTS

- Self-harming behaviour and suicide both represent maladaptive responses to emotional and psychological distress.
- Self-harm may occur in individuals who are not suicidal (as a coping mechanism to relieve feelings of anxiety or to "get in touch" with feelings), but it can also be an indicator of a suicide risk (where the harming behaviour becomes more lethal in nature).
- Both suicidal ideation and suicidal behaviour must be treated as serious. Referral for professional mental health assessment and treatment is necessary, but an initial risk assessment should be carried out to determine whether the young person is in imminent danger of harming their self.
- There are a number of referral options:
 - » Community Mental Health Services provide free, specialist mental health services for children and adolescents up to the age of 18yrs and their families (CAMHS). You can access these services is through the Mental Health Line on 1800 011 511. Calls to the line are answered by a mental health professional who can advise whether or not a person is in need of mental health services and provide referral to the local CAMHS.
 - » Mental Health Crisis Teams operate across NSW, 24 hours a day. The team responds to mental health emergencies such as suicidal behaviour or psychosis. You can contact the team through the Mental Health Line on 1800 011 511.
 - » GPs can facilitate referral to a psychiatrist or psychologist by under a Medicare Mental Health Care Plan. A psychologist or counsellor can assist with assessment and diagnosis and specialised counselling. Referral to a Psychiatrist is recommended for in-depth assessment and diagnosis and the provision of treatment, including the prescription of medication.
 - » The NSW Transcultural Mental Health Centre is a statewide resource centre offering clinical and consultation services including assessment, short-term intervention and telephone advice on cross-cultural mental health issues. The centre can be contacted on 1800 648 911.

CHAPTER SUMMARY - WHAT TO REMEMBER

Around 25 per cent of young Australians (aged 16–24) experience at least one mental health disorder.

Many mental health issues including anxiety, depression, eating disorders, schizophrenia and bipolar disorder begin to emerge in adolescence.

The best outcomes for a young person's mental health and wellbeing occur when issues are identified early and management and treatment is implemented collaboratively. Health and youth support workers who are not qualified to diagnose and treat mental health disorders can learn the early signs of psychological distress and understand the processes and supports that need to be put in place to support the young person's mental health.

Young people with intellectual disability may have specific mental health service needs.

In NSW, advice, support and referral is available through the Mental Health Line on 1800 011 511.

In a mental health emergency, call 000.

REFLECTION QUESTIONS

How confident are you in identifying the signs and symptoms of psychological distress in the young people you work with?

Does your organisation have a protocol for referring young people who may be experiencing psychological distress to specialist support?

Can you identify opportunities to improve your organisation's response to mental health issues?

Supporting people with a mental illness can take its toll on workers. What self-care do you undertake?

REFERENCES

- Australian Institute of Health and Welfare. (AIHW). (2010). *Health of Australians with disability: Health status and risk factors*. AIHW bulletin no. 83. Cat. no. AUS 132. AIHW: Canberra.
- Australian Institute of Health and Welfare. (AIHW). (2009). *Disability in Australia: Multiple disabilities and need for assistance*. Cat. no. DIS 55. AIHW: Canberra.
- Australian Institute of Health and Welfare. (2011). *Young Australians: Their Health and Wellbeing 2011*. Cat. no. PHE 140. AIHW: Canberra.
- Australian Bureau of Statistics. (ABS). (2008). *National Survey of Mental Health and Wellbeing: Summary of results, 2007*. ABS cat. no. 4326.0. ABS: Canberra.
- Beyondblue. (2010). *Clinical Practice Guidelines: Depression in Adolescents and Young Adults*. beyondblue: the national depression initiative: Melbourne.
- Bourke-Taylor HM, Howie L, Law M, Pallant JF. (2012). Self reported mental health of mothers with a school aged child with a disability in Victoria: a mixed method study. *Journal of Paediatrics and Child Health*. 48(2), 153-159.
- De Leo D & Heller TS. (2004). Who are the kids who self-harm? An Australian self-report school survey. *Medical Journal of Australia*. 181(3), 140-4.
- Early Psychosis Prevention and Intervention Centre. (EPPIC). (2010). *Australian Clinical Guidelines for Early Psychosis*. Orygen Youth Health Research Centre: Melbourne.
- Einfeld, S.L., Piccinin, A.M., Mackinnon, A., Hofer, S.M., Taffe, J., Gray, K.M., Bontempo, D.E., Hoffman, L.R., Parmenter, T. and Tonge, B.J. (2006). Psychopathology in young people with intellectual disability. *Journal of the American Medical Association*. 296(16), 1981-1989.

Felitti VJ, Anda RF et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*. 14 (4), 245-258.

Fletcher R, Loschen, E, Stavrakaki C & First M. (eds.) (2007). *Diagnostic Manual — Intellectual Disability (DM-ID): A Clinical Guide for Diagnosis of Mental Disorders in Persons with Intellectual Disability*. NADD Press: Kingston, NY.

Hetrick S, Parker A & Purcell R. (2013). *Evidence Summary: Antidepressants and Other Newer Antidepressants to Treat Depression in Young People: What are the issues and what is the evidence?* Orygen Youth Health Research Centre: Melbourne.

Kezelman C & Stavropoulos P. (2012). *The Last Frontier. Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care And Service Delivery*. ASCA: Sydney.

Martin G. (2001). Management of depression and suicide in general practice. In *The Missing Link – Adolescent mental health in general practice*. Alpha Biomedical Communications: Sydney.

Mental Health First Aid Australia. (2008). *Suicidal thoughts and behaviours: first aid guidelines*. Mental Health First Aid Australia: Melbourne.

NSW Ministry of Health. (2011). *New South Wales School Students Health Behaviours Survey: 2011 Report*. Centre for Epidemiology and Evidence, NSW Ministry of Health: Sydney.

Parker G. (2007). Bipolar disorder: Assessment and management. *Australian Family Physician*. 36(4):193-288.

Yung AR, McGorry PD, Francey SM et al. (2007). PACE: A specialised service for young people at risk of psychotic disorders. *Medical Journal of Australia*. 187: S43.

SECTION 3.10

SEXUAL HEALTH

3.10 SEXUAL HEALTH

MELISSA KANG

The World Health Organisation defines sexual health as:

“... a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence”.

Adolescent sexuality is both a natural part of healthy development and the cause of much vexation and controversy in the public domain. In the youth, health and education sectors, there is much scope for promoting sexual health and positively acknowledging sexuality among young people.

Adolescence involves both biological and psychological changes related to sexual development. Biologically, puberty brings about the maturation of the sexual and reproductive organs and the development of reproductive capability. Psychologically, developing a positive sexual identity is an important task of adolescence

Individual, peer, family and cultural factors influence the nature and extent of an adolescent's sexual behaviour – there is enormous variation within the adolescent age group in terms of knowledge and experience. That said, sexual arousal, feelings and thoughts are a normal part of adolescent development and sexual behaviours and experimentation often begin in adolescence.

In addition, young people:

- Often lack knowledge about their bodies, sexuality and how to protect themselves, and may not appreciate the risks involved with sexual activity
- Are more commonly concerned about relationships and communication with partners than about biological risks of disease or pregnancy
- Can be at increased risk of acquiring STIs for biological, psychological and socio-cultural reasons
- Can be particularly vulnerable if they are same-sex attracted, transgender or questioning their sexual orientation
- With a chronic illness or with a disability may have their sexuality and sexual health needs overlooked.

FAST FACTS

- Chlamydia is the most common STI among young people with rates continuing to rise (AIHW 2011)
- In 2008, 12,050 babies were born to teenage mothers (17 births per 1,000 among 15 – 19 year-old women) (DOHA 2012)
- In NSW in 2011, 3.2% of mothers of newborns were teenagers (NSW Perinatal Data Collection 2011)
- In NSW the fertility rate of teenagers has declined over a ten year period from 17.2 to 13.6 births per 1,000 (NSW Perinatal Data Collection 2011)
- In 2008, among 15 – 19 year-old Indigenous women the fertility rate was 78 births per 1,000 (DOHA 2012)
- In NSW, 19% of Aboriginal mothers were under 20 (NSW Perinatal Data Collection 2011)
- It is estimated that more than half of pregnancies end in abortion for 15 – 19 year-old women.

PROMOTING SEXUAL HEALTH IN YOUNG PEOPLE

Sexual health encompasses a total sense of wellbeing in relation to one's sexuality and sense of sexual self. Many individuals, services and sectors have a role to play in promoting young people's sexual health. Many of the key concerns that young people have about their sexuality and sexual health are not related to health. Instead, they are related to the quality of their relationships; communication with their partners and with their parents about sexual activity; and how they feel within their peer group about their sexuality.

It can be useful to have informal conversations with a young person about their level of knowledge about:

- Their body and their sexuality
- Safe (including abstinence) and unsafe sexual practices
- Contraception
- Their relationships

Discussing sexuality and sexual health is deeply personal. A young person might not wish to share information with anybody, or with more than one or two professionals, in order to obtain the information and intervention they need. In some circumstances, it may be most appropriate to provide them with general information, guide them towards resources, and encourage them to visit a health or counselling service.

Whether to deepen the discussion requires you to exercise judgement. It will depend in part on the young person's level of comfort with the discussion, and also on their psychosocial maturity. If you think the discussion is suitable and might be beneficial, you might discuss:

- Where the young person is at with their sexuality and sexual identity
- How ready they feel for sex
- What they understand about STIs and the risk of pregnancy
- How comfortable they feel about negotiating a sexual relationship and communicating their feelings
- Supportive adults in their life and whether they feel able to talk with a parent, carer, adult friend or teacher.

You can also help the young person to develop skills for dealing with difficult situations such as decision-making, talking to parents about sexuality, and negotiating with a partner who is pressuring them to have sex. You can also:

- Discuss situations where sexual risk-taking behaviour may be occurring – such as with substance use; unprotected sex
- Explore ways to reduce risk-taking and how to stay safe (how to negotiate safe sex or condom use with a partner; the effects of substance use; encouraging both male and female responsibility for contraception and condom use)
- Explain correct condom use (if possible, demonstrate using a penis model)

The table below identifies some of the diverse ways in which professionals in a range of fields can promote sexual health in young people

TABLE 10 – PROMOTING SEXUAL HEALTH

Sexual health issue	Who can play a role in addressing this issue?
Providing information about available sexual and reproductive health services	All professionals working with young people
Providing or facilitating access to information about contraception options	Nurses, doctors, pharmacists, educators, health promotion officers, youth health workers with some sexual and reproductive health expertise
Prescribing contraception	Doctors (and some nurse practitioners) Pharmacists can dispense emergency contraceptive pills
Testing for and treatment of STIs	Doctors, some nurses, some health promotion officers trained to offer outreach testing Pharmacists can dispense treatments (prescription and over the counter)
Prescribing and administering vaccinations (hepatitis B, human papillomavirus)	Covered by national immunisation program (e.g. school-based immunisation nurses) but doctors can provide catch up vaccinations
Doing Pap smears	Doctors and sexual health/family planning nurses and primary health care nurses
Facilitating access to condoms	All professionals working with young people
Identification of risk behaviours and education about safe and unsafe behaviours	General information can be provided by all professionals working with young people. Specific risks associated with different practices or sexual encounters may require sexual health, medical or nursing expertise
Helping young people understand and feel comfortable with their sexuality, gender and/or sexual identity	All professionals working with young people have a role to play Young people with more complex needs may require those with expertise in counselling or sexuality-related education and health care

ASSESSING SEXUAL HEALTH

This section outlines the approach to assessing sexual health that is practised in the health and medical sector.

THE BASICS

Establishing a trusting relationship is the first step in helping a young person the young feel comfortable discussing sexual health issues. You can help to build this rapport by:

- Helping young people to understand that experimentation is normal and that the key issue is protecting their health
- Adopting a non-judgemental approach
- Being prepared to raise the issue of sexual health and show comfort in discussing the topic
- Reassuring the young person about confidentiality
- Not assuming that the young person is heterosexual
- Addressing the whole person and their developing relationships with other people rather than focusing only on the prevention of STIs and unwanted pregnancy
- Helping the young person recognise that sexuality involves relationships, values, decision-making, and behaviours

THE SPECIFICS

Whether you discuss sexual health (and to what extent if you do) will depend on the age and maturity of the young person you are seeing and their reason for presenting.

You can use the HEEADSSS assessment (see chapter 3.2 Psychosocial assessment) with younger adolescents or for a young person who presents with an apparently unrelated issue.

Remember to ask permission to ask sensitive questions:

Example:

"I'd like to ask you some personal questions about relationships and sexuality as part of a general health check up. You don't have to answer any that you don't want to. Is it OK if I go ahead?"

Use the third-person approach if appropriate:

Example:

"Some young people your age have become involved in romantic or sexual relationships. Are any of your friends at school having sex? Have you ever had a sexual relationship?"

Follow the young person's lead in discussions unless you have concerns about their safety or wellbeing. The HEEADSSS assessment can guide you through areas for discussion.

If a young person seems to be struggling with their sexual orientation, you can help a young person to understand their experiences by acknowledging that feelings of attraction to the same sex are common. Remember that adults who identify as gay, lesbian or bisexual often trace their feelings back to childhood or early adolescence, long before they commence sexual activity.

Example:

"It's normal for some people to feel attracted to people of the same sex, or to both males and females. These feelings might be confusing for some people. I'm very happy to discuss your feelings about sex and attractions, confidentially, if you ever need to."

SEXUAL HISTORY TAKING

Sexual history taking is a clinical skill practised by nurses, doctors and sometimes by other sexual health professionals (e.g. counsellors, therapists). While other professionals who support young people might talk with them about sexuality and sexual relationships, it would not be common (or necessarily appropriate) to take an in-depth sexual history. However, it can be useful for you to know what is involved, and what a young person might experience if they consult with a doctor or a nurse about sexual health.

An in-depth sexual history is appropriate:

- If the young person presents directly with a sexual health issue (such as a request for contraception; a pregnancy test, an 'STI check up' or an HIV test)
- Once they engage with a health professional in discussing more personal information such as their sexual activity

Questioning includes topics such as:

- Commencement of sexual intercourse
- Partners: number, gender, relationship duration
- Types of sexual practices
- Safer sex practices: condom use, contraception
- History of pregnancy
- History of STIs
- STI screening including HIV antibody testing
- Hepatitis B prophylaxis
- Risk (substance use, unsafe sex, exploitative relationships, sexual abuse, sex for money)

SPECIFIC HEALTH AND MEDICAL ISSUES

CONTRACEPTION

There is a range of contraceptive methods available to young people. Most of these need to be prescribed for and used by women rather than men. Contraceptive methods fall into five broad categories: natural methods, barrier methods, hormonal contraception, intra-uterine devices, and sterilisation.

This section will not address natural methods (which include withdrawal and the rhythm method) or sterilisation (which is not available for young people under the age of 18, even with parental consent). Instead, the focus will be on the three categories of contraceptive options available to young people in Australia.

1. Barrier methods

- Male condom
- Female condom
- Diaphragm

2. Hormonal contraception

- Combined oral contraceptive (the Pill)
 - Contraceptive implant (Implanon)
 - Contraceptive injection (Depo Provera, Depo Ralovera)
 - Emergency contraceptive pill (the 'morning after Pill')
 - Progesterone-only pill (the mini-Pill)
 - Vaginal ring (Nuva-ring)
 - Hormone-releasing intra-uterine device (Mirena)
- #### 3. Intra-uterine devices (IUDs)
- Copper intra-uterine device
 - Hormone-releasing intra-uterine device (Mirena)

Most (but not all) of these options are available on the PBS, which influences their cost. Some are prescription-only and some require a procedure performed by a doctor. More information about each of these methods is available on the Family Planning website www.fpnsw.org.au

Choosing a contraceptive method involves thinking about a number of factors. Apart from the obvious factors such as safety, effectiveness and side effects, other factors can be just as important such as cost, visibility, understandings and misunderstandings/myths about different methods and previous experiences. Youth health workers can help young people find good information about the range of available and accessible methods. It can be helpful to discuss that:

- Young people have a legal right to confidentiality when they seek advice about and access to contraception
- Emergency contraception is available from pharmacies without a prescription
- Condoms should be used to protect against STIs even if another method of contraception is being used to avoid pregnancy
- Gender/power/relationship issues might need to be considered (negotiating condom use, negotiating whose responsibility it is to seek and obtain contraception)
- Costs
- Ensuring that the young person knows how to use any contraception they have decided to try (how to use a condom properly, how to take the Pill properly) and encouraging them to ask their doctor or nurse if they don't know
- Involvement of parents or what the young person would/ would not want parents to know

The decision to provide contraception to a young person without parental knowledge must be considered in the light of:

- The doctor's duty of care to the adolescent patient where confidentiality must be protected unless there are extenuating circumstances
- The importance of maintaining a trusting relationship with the adolescent
- The young person's age, developmental maturity and demonstrated competence

General contraceptive advice and treatment can be given without parental/guardian consent to a young person of any age as long as the doctor makes the judgement that the adolescent is competent to give informed consent. Where possible, encourage the young person to talk to a parent or carer.

FINDING OUT MORE...

For more information about confidentiality and informed consent, see chapter 3.5 Medico-legal issues.

PREGNANCY

According to the Australian Bureau of Statistics, fewer Australian women under the age of 20 are having babies than were a decade earlier. In 2012, 11,420 babies were born to teenage mothers, down from 12,932 in 2008.

A pregnancy test is accurate about 14 days after conception (i.e. around the time, or shortly after, a period is due). Home pregnancy tests are readily available from supermarkets and pharmacies and

are very reliable. Urine pregnancy tests are about as reliable as a blood test

Pregnancy options include continuation of pregnancy and becoming a mother, continuation of pregnancy and adoption, and termination of pregnancy. Termination is lawful in all states and territories in Australia, but the laws vary slightly between jurisdictions. A young woman under 18 can consent to a termination if she is competent.

A young woman who is pregnant may wish to discuss her pregnancy options or may already know which option is right for her. If she is unsure about her options or how she wants to proceed, refer her to a doctor, family planning clinic or a pregnancy counselling service. If she seems clear about the best option for her, encourage her to seek advice and support as early in the pregnancy as possible. Explain that she can explore her options and obtain health advice and information confidentially, and explain what the exceptions to this might be (egg abuse, risk of harm).

She may need support from her partner, parents or carers, relatives or other adults she trusts. You can encourage her to identify those who she feels will support her, and help her plan how to tell them about the pregnancy.

SEXUALLY TRANSMITTED INFECTIONS (STIS)

Sexually Transmitted Infections are infections caused by micro-organisms (germs) that thrive in the genital organs or genital skin. These organisms often do not survive in other parts of the body, so they are only passed from one infected person to another through sexual contact. Two of these germs, the viruses that cause HIV and hepatitis B, can be transmitted both sexually and by blood-to-blood contact.

There is a great variety in the types of symptoms and diseases that STIs can cause as well as their infectivity, contagiousness and treatment. Most common STIs are asymptomatic.

TABLE 11 - COMMON STIS

STI	Particular features	Testing
Using condoms during vaginal, anal or oral sex reduces the transmission of all the STIs below either substantially or almost completely		
Human papilloma-virus (HPV) – many types, some linked to cervical and anal cancer, others cause genital warts	<ul style="list-style-type: none"> • Preventable with HPV vaccine • Probably the most common STI in the world BUT rapid decline since the introduction of the HPV vaccine • Most people infected don't have symptoms • Can't be cured but infections often go away after some years. 	Not tested for in a sexual health check.
Chlamydia	<ul style="list-style-type: none"> • The most common STI that is notifiable (i.e. statistics are collected), rates continue to rise • Usually no symptoms • Can lead to infertility especially in women • Curable 	Urine test or swab Australian guidelines recommend yearly Chlamydia testing for all sexually active young people
Gonorrhoea	<ul style="list-style-type: none"> • Higher rates in some groups • May have no symptoms • Can lead to infertility • Curable 	Urine test or swab Testing recommended for some groups
Hepatitis B	<ul style="list-style-type: none"> • Preventable with vaccine • Higher rates in some groups • Chronic hepatitis B infection can cause liver cancer and cirrhosis 	Blood test Testing recommended for some groups
Syphilis	<ul style="list-style-type: none"> • Higher rates in some groups • Serious consequences if untreated for individual and unborn babies • Curable 	Blood test Testing recommended for some groups Testing done on all pregnant women

Genital Herpes (herpes simplex virus – HSV)	<ul style="list-style-type: none"> • Common – many people have been exposed to the virus, but most do not have symptoms • Can be transmitted by oral sex • Sores can come and go for years • No cure, but frequent recurrences can be reduced with medication 	Not tested for in a sexual health check
Human Immunodeficiency virus (HIV)	<ul style="list-style-type: none"> • Mainly affects men who have sex with men, and people from high prevalence countries • Medication has drastically improved survival and reduced the progression to AIDS 	Blood test Testing recommended for some groups

FINDING OUT MORE...

The play safe website explains STIs testing and prevention for young people. Visit is at www.playsafe.health.nsw.gov.au.

The NSW STI Programs Unit provides a range of factsheets and resources about STIs to support the sexual health clinical and health promotion workforce. Visit www.stipu.nsw.gov.au

The NSW Sexual Health Infoline provides support services for doctors, nurses and other health professionals who need on-the-spot technical support during consultations. Call 1800 451 624.

SEXUAL HEALTH CHECK UPS

A sexual health check up varies depending on whether or not symptoms are present, and the young person's risk factors and sexual history.

Sexual health check ups can be conducted by a GP or at a sexual health clinic, Family Planning clinic, or a youth health service. After taking a sexual history, a check up might include testing for chlamydia (regular testing for chlamydia is recommended for all sexually active people aged 15-29), gonorrhoea, syphilis, hepatitis B and C and HIV. Pap smear screening should commence in sexually active women (regardless of their sexual orientation) after the age of 18 or 2 years after they first have intercourse, whichever is later.

If a genital examination is necessary as part of the sexual health check up, it will be conducted by a doctor or by a sexual health or family planning nurse. The young person must give permission, and has the right to change their mind after giving permission. The young person should be asked if they would like a support person or chaperone present: this can be a friend, relative or a female practice staff member.

In some cultures, it may be uncomfortable or shameful for a male doctor to examine a female patient. It may be appropriate to ask the parents' permission and to sensitively explain the need for the examination. Wherever possible, arrange for a female doctor or sexual health nurse to conduct the examination and to have a female support person or family member present.

Explain to the young person what will be involved in the examination and offer to show them the

equipment that will be used (e.g. vaginal speculum, swabs).

SAME-SEX ATTRACTED YOUNG PEOPLE

A young person who is attracted to members of the same sex may feel particularly vulnerable when visiting a doctor or discussing sexual health. They may already have experienced discrimination, harassment, bullying or abuse and may perceive that doctors assume heterosexuality or are uncomfortable with homosexuality.

Young people who are same-sex attracted are at an increased risk of isolation, depression, suicide, substance abuse and injury through violence.

When working with a young person who is same-sex attracted or who identifies readily as gay, you can help them feel more comfortable discussing sexual health by reassuring them about confidentiality. Adopt a non-judgemental approach to the conversation, and begin by discussing their level of comfort with their sexuality and where they are at in the "coming out" process. Identify the level of support they feel from family and peers. Do not push a young person to come out if they are not ready: disclosure of sexuality only enhances a young person's wellbeing if they choose the timing and process and if the people they come out to are supportive.

Keep the psychosocial risks in mind and, where necessary, refer for specialist support or counselling to reduce the risks. Provide them with the opportunity to discuss their sexuality and to learn about safer sexual practices. Discuss whether they would like a health check and need assistance in finding a doctor or sexual health clinic.

FINDING OUT MORE...

There are a number of web-based sources for information about sexual health and sexuality. Family Planning's state websites offer resources, education and advice about a range of sexual health and sexuality-related issues.

New South Wales – www.fpnsw.org.au

The Sexual Health and Family Planning Australia website provides information about sexual health services throughout Australia. Visit www.shfpa.org.au

NSW Health has a website specifically for young people who need information about STIs, getting tested and protecting sexual health. Visit www.playsafe.health.nsw.gov.au

Marie Stopes International also offers a website called Dr Marie, offering information about contraception, termination of pregnancy, STIs and other sexual health topics through its Ask Dr Marie service. The website is www.dmarie.org.au

If you are supporting young people working through issues associated with their sexual identity, or who identify as gay, lesbian, bisexual, transgender or intersex, you may find some of the following services helpful:

QLife offers Australia's first national counselling and referral service for Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people. The project provides early intervention, peer-supported telephone and web-based services to diverse people of all ages experiencing poor mental health, psychological distress, social isolation, discrimination, experiences of being mis-gendered and/or other social determinants that impact on their health and wellbeing. Visit www qlife.org.au

In NSW, twenty10 provides a range of support services to young people under 26 who identify as gay, lesbian, bisexual, queer or transgender, or are same-sex attracted, gender diverse or intersex. The support available includes counselling, case management, referral, information and housing support. Visit www.twenty10.org.au

Young people who identify as transgender or gender diverse can find information, resources and support at www.gendercentre.org.au

Parents, family and friends looking for support and information can visit www.pflagaustralia.org.au

The Safe Schools Coalition supports gender diversity and sexual diversity in schools. Visit www.safeschoolscoalition.org.au

CHAPTER SUMMARY - WHAT TO REMEMBER

The biological changes that occur in adolescence to bring about sexual maturity are accompanied by psychological changes that involve developing a positive sexual identity. For many young people, navigating these changes means engaging with a new series of health and interpersonal issues.

It is recommended that all people aged between 15 and 29 are screened regularly for chlamydia – an STI that can cause infertility. Women should begin having Pap smears after the age of 18 or 2 years after they first have intercourse, whichever is later.

Young people who are wondering if they are (or already identify) as gay, lesbian, bisexual, transgender or intersex may be at greater risk of experiencing isolation, depression, suicide, substance abuse and injury through violence.

Providing a safe place to ask questions and providing sexual health information, resources, knowledge and services can improve both psychological and physical health outcomes for young people.

REFLECTION QUESTIONS

Does your service have in place policies and procedures to promote sexual health for young people?

Is your service sensitive to the needs of young people?

Does your service provide a safe place for young people to disclose sensitive information?

Are resources and procedures in place to help young people when a sexual health issue is identified?

Can staff provide counselling and testing for STIs or know how to access this?

Can staff provide education using a harm minimisation approach?

Does your service need further information or training regarding sexual health?

REFERENCES

Australian Bureau of Statistics. (ABS). (2013). *Births, Australia, 2012*. Cat. No. 3301.0. ABS: Canberra.

Australian Institute of Health and Welfare. (2011). *Young Australians: Their Health and Wellbeing 2011*. AIHW cat. No. PHE 140, AIHW: Canberra.

Department of Health and Ageing. (DOHA). (2012). *National Notifiable Diseases Surveillance System*. <http://www.health.gov.au/cda>. Viewed 20 May 2014.

NSW Perinatal Data Collection 2011 (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Centre for Epidemiology and Evidence. Health Statistics New South Wales. NSW Ministry of Health: Sydney. Available www.healthstats.nsw.gov.au. Viewed 1st May 2013.

SECTION 3.11

CHRONIC CONDITIONS AND DISABILITY

3.11 CHRONIC CONDITIONS AND DISABILITY

MELISSA KANG

Ten to 20 per cent of adolescents have one or more chronic conditions. Most chronic conditions develop in childhood. Chronic conditions include, but are not limited to, asthma, diabetes and cystic fibrosis (Bennett and Kang 2001). Serious conditions or injuries, particularly those related to accidents, can also be acquired during adolescence.

The term “disability” includes impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure. An activity limitation is a difficulty encountered by an individual in executing a task or action. A participation restriction is a problem experienced by an individual in involvement in life situations (World Health Organisation (WHO) 2012).

Disabilities may be classified into five main groups as described by the Australian Institute of Health and Welfare:

- 1. Intellectual**
- 2. Psychiatric**
- 3. Sensory/speech**
- 4. Acquired brain injury**
- 5. Physical/diverse**

In young people aged 15-24, physical conditions were the main reported health condition causing disability (62 per cent of those with a disability) followed by mental or behavioural disorders (39 per cent) (AIHW 2010, p. 19).

Whereas once the diagnosis of a chronic condition or a disability might have reduced the life expectancy of a child significantly, medical and surgical advances are continually improving survival rates (Bloomquist et al. 1998).

Most young people with chronic conditions and disabilities experience the same health and social issues as their healthier peers. In responding to their healthcare needs, it is important to address a range of concerns such as growth and development, mental health, sexuality, nutrition, exercise and health risk behaviours such as drug and alcohol use (Rosen et al. 2003).

As with all young people, establishing a trusting relationship based on respect for the young person

as an increasingly independent individual is the foundation of good health care. Remember that the young person is a person first: they are an adolescent with asthma or epilepsy or a disability, not an asthmatic, epileptic or disabled adolescent.

For the best possible health outcomes, it is important to understand the developmental context of the condition or disability:

- What is the impact of the condition or disability on the young person's development?
- What is the likely impact of 'normal' developmental issues on the condition or disability and its management?

You can use the HEEADSSS psychosocial assessment (see 3.2 Psychosocial assessment) to identify concerns in different areas of the young person's life and to detect the presence of risk and protective factors.

Young people with a chronic condition or disability may experience additional difficulties on top of the normal developmental challenges of adolescence (Bennett and Kang 2001; Sanci 2001). It is important to consider the impact of the condition on the young person's development (Berg-Kelly 2007).

Chronic conditions and disabilities interact with the normal bio-psychosocial developmental tasks of adolescence. Biologically, an illness or disability can affect growth and puberty. Psychologically, it can affect identity formation, body image and cognitive development. Socially, it can have a lasting impact on the development of autonomy; family, peer and sexual relationships; the formation of sexual identity; and on educational and vocational achievements.

Adolescence can be prolonged for young people with a chronic condition or disability:

- Pubertal development may be slowed down, which is particularly related to under-nutrition.
- Parental overprotection because of the chronic condition or disability may limit autonomy.
- Peer contact and connection as well as schooling can be disrupted by hospitalisations or limited mobility.
- Young people experience reduced opportunities for employment – particularly if there is a physical disability or shortened life expectancy.
- Young people with chronic conditions or a disability often lack appropriate role models.
- A young person with a chronic condition or a disability may be highly dependent on parents and other people at a time when independence is an important psychological developmental goal.

- A young person with a chronic condition or disability may be perceived as 'different' at a time when 'normality' and peer acceptance are crucially important to young people.

You can maximise positive health outcomes for a young person with a chronic condition by promoting positive coping behaviours and encouraging participation in normal activities. Support the young person to:

- Maintain a wide network of friends
- Participate in sports and social activities where possible
- Participate in household chores or part time employment if appropriate
- See themselves as capable (Sanci 2001).

A number of factors can influence the experience of adolescence for a young person with a chronic condition or a disability. These include:

- Age at diagnosis– diagnosis in the early adolescent years when going through the rapid physical and emotional changes of puberty can be difficult.
- The degree of functional impairment – impaired mobility can be socially disabling and is not necessarily related to the severity of the disability (for example, mild gait disturbances may result in more emotional difficulties as the young person struggles to fit in).
- Prognosis – conditions associated with uncertain outcome are challenging with the stress of uncertainty affecting the young person's psychological wellbeing and hindering their ability to create a vision for their future.
- The course of the condition – a stable or predictable course is less distressing than a fluctuating and unpredictable one.
- Level of knowledge and self-efficacy – those who understand their condition are more likely to avoid high risk behaviours and have better health (Bennett and Kang 2001).

CO-MORBIDITIES

An estimated 7per cent of all young people in Australia reported some form of disability. Of this percentage just over one-quarter (27 per cent) identified as having a severe disability (AIHW 2011). Health gaps between adolescents that have a disability and those who do not remain large. In young people (15-24yrs) physical conditions were the main reported health condition causing disability (62per cent of those with a disability) followed by mental or behavioural disorders (39per cent) (AIHW 2010, p. 19).

Those with severe or profound disability had higher prevalence rates of long-term health conditions than people without a disability. They are more likely to:

- Have slightly higher rates of obesity, and more likely to do a very low level of exercise or no exercise
- Start smoking before 18 years
- Have mental health problems (48 per cent compared to 6 per cent)
- Have considered committing suicide
- Have been diagnosed with diabetes or a high sugar level (23 per cent had diabetes or a high sugar level before the age of 25 years versus 7 per cent)
- Have acquired arthritis before the age of 25 (14 per cent versus 6 per cent) (AIHW 2010)

A young person may be diagnosed with a primary disability such as autism but can experience co-morbidities (one other disabling condition) or multiple disabilities (more than one other disabling condition) at the same time. Multiple disabilities in childhood were mostly associated with intellectual disability, which affects around two to three per cent of the population. Almost 60 per cent of people with intellectual disability have severe communication limitations and are also likely to have limitations in other activities such as self-care, mobility and communication (AIHW 2008).

The most common co-morbidity with intellectual disability is mental illness.

More than half of people aged 15–44 years with acquired brain injury or intellectual disability had three or more disabilities. Support needs of people with early onset multiple disabilities vary depending on the nature of their disabilities and their life stages. As they grow older, they are likely to require more support at an earlier age than people with single or late onset disability (AIHW 2009).

DISABILITY AND MENTAL HEALTH

People with a disability exhibit the same range of mental health disorders and problems as general population, however young people with disabilities are more likely than those without a disability to experience mental health problems or disorders early. Fourteen per cent of young people with severe or profound disability and mental health problems experienced the onset in childhood or adolescence compared to 7per cent of those without disability (AIHW 2010).

Young people with a disability have many of the known risk factors for developing mental health issues. These may include:

- Pre-natal brain damage, birth injury or complications
- Physical and intellectual disability
- Poor health
- Low intelligence
- Chronic conditions
- Poor social skills
- Low self-esteem
- Alienation

Identifying mental health problems and disorders in children and adolescents with an intellectual disability is complex. It requires a collaborative approach involving a variety of health professionals.

Early intervention is important to reduce the impact of mental illness in later life. Interventions may include prevention or strategies to reduce the impact of child abuse and neglect; behavioural interventions to reduce maladaptive behaviours or enhance social competence; and educational assistance to enhance academic ability and social skill (AIHW 2009).

If you suspect that a young person you are working with is experiencing psychological stress or mental health issues problem is suspected, a referral from a GP to a paediatrician, psychologist or psychiatrist is needed. Alternatively, child and adolescent mental health services in the public system can arrange access to paediatric psychologists and psychiatrists, and can refer on to a specialist psychologist or psychiatrist working in intellectual disability. If the young person is over 18 they will be referred to adult services.

IMPROVING THE HEALTH CARE EXPERIENCE

All young people moving through adolescence have a growing need for independence and autonomy. This applies to young people with a chronic condition or a disability too. Support the young person to develop the skills and confidence they need to manage both their condition or disability and the developmental tasks of adolescence. This includes taking an active role in their own health care and making decisions about treatment and management options. Giving young people the freedom to choose is an important empowerment strategy in assisting them to take more control of their health.

Consider developing a chronic condition/disability care plan in consultation with the young person

and their family/carer. It should include emergency management plans and will need to be updated regularly. The young person can share this with their family and with school staff.

Develop and communicate a clear understanding of the roles, responsibilities and expectations of each person in the management team, including the young person. Consider whether a referral to a psychologist or social worker for supportive counselling might be useful to help the young person negotiate any particularly stressful aspects of managing their health and wellbeing.

Parents and doctors tend to focus on the management or treatment of a young person's symptoms and condition. However, it is also important to consider the impact of the condition or disability and any treatment necessary on education, social interaction, workforce participation and other relationships. It is particularly important to consider the implications of treatment plans for an adolescent's need to participate in social and peer activities.

Provide the young person and parents with strategies for enhancing adherence, such as establishing structured routines, regularly reviewing treatment plans and building flexibility into therapy wherever that is possible.

Above all, encourage autonomy, self-reliance, responsibility and confidence for self-management of the condition or disability. Help the young person focus on what they can do – in terms of their interests, activities, and lifestyle – rather than on what they can't do

TRANSITION CARE

When a young person with a chronic condition moves from paediatric health services to adult health services this process is called transition. The transition from child or youth-focused health services to more independently oriented adult services can be challenging for young people and their families, as well as for the health professionals that support them (Steinbeck et al. 2007, 2008; Wood et al. 2011).

The ultimate aim of transition is to promote the young person's capacity for self-management of their chronic condition – (particularly during the early teenage years) and to facilitate a smooth transition to adult care (16-18 years) to improve long-term health outcomes.

Visiting adult services, attending joint clinics between adult and paediatric services, and having their first appointment with new providers arranged can be helpful in assisting the young person's transition (Craig et al. 2007).

Health professionals can play a key role in assisting patient young person in their transfer to adult health services by:

- Taking an active role in case management or shared care with specialist teams
- Collaborating with other professionals and services in the process of the young person's transition
- Empowering the young person to make decisions and attend appointments on their own
- Addressing their holistic health care needs.

It is important to include the young person and their family as active participants in the transition process. Confidentiality should be maintained for the young person as they traverse systems and engage with different health professionals.

All health professionals are encouraged to refer young people to transition services from 14 years so that these services can prepare young people well in advance for the move over to adult services. There is evidence that an early referral for transition results in better health outcomes for the young person – although it's never too late to refer.

NSW TRANSITION SERVICES

In NSW, there are comprehensive transition services for young people with chronic conditions or disabilities and their families/carers. The goal of transition services is to support young people to live a full and rewarding life while successfully managing their own health, to the best of their ability. It is important that young people feel well prepared to make the leap into adult health services. This can take time and planning. The earlier this preparation starts the better chance a young person has of making a smooth, easy and sustainable transition, resulting in long term health and social benefits. Some young people may not be able to manage their own health care once they turn 18 and parents, relatives and carers will continue to do this for them. Transition services also assist families and carers through the transition process.

Maintaining the engagement of young people during transition will improve their health outcomes and reduce the time they may spend in hospital. Raising transition with the young person's clinical team early in adolescence will encourage early planning which is necessary for an effective transition. Moving to a new adult setting in the community or a hospital can be daunting, and this may result in the young person dropping out or losing control of managing their health care. This may then impact on their health and wellbeing negatively. It is therefore extremely important for young people to

be supported through the transition process and to start planning at the age of 14.

There are two transition services in NSW working in collaboration to ensure young people with chronic conditions and disabilities are supported during their transition. Young people with chronic conditions and their families/carers known to The Sydney Children's Hospitals Network (SCHN) can be referred to Trapeze. Those who are not known to SCHN can be referred to the Agency for Clinical Innovation (ACI) Transition Care Network. The age criterion for both services is 14-25.

Transition services can assist by:

- Finding appropriate adult health care services and attending those appointments if requested;
- Preparing young people for the move to the adult health services;
- Find a GP who is sensitive the needs of young people;
- Making sure the young person's GP has updated information to provide the best possible care;
- Working close with the GP to implement a GP Management Plan and Team Care Arrangements;
- Providing information about obtaining a Medicare card, Health Care Card, and financial assistance;
- Communicating with the clinical teams and providing advocacy;
- Sending SMS appointment reminders;
- Talking through accommodation, education, and work options;
- Offering confidential telephone and face to face support;
- Assisting with obtaining medication and equipment;
- Providing information about health care rights and responsibilities;
- Linking with support groups;
- Teaching skills on how to manage their condition so young people are in control; and
- Offering support for parents/carers/guardians; and
- Providing regular contact with the young person to make sure they have successfully engaged with the adult health service.

TRAPEZE: A SUPPORTED LEAP INTO ADULT HEALTH

Trapeze is the specialist transition service for The Sydney Children's Hospitals Network (The Children's Hospital at Westmead and Sydney Children's Hospital, Randwick). Trapeze supports young people with chronic conditions and their families/carers aged 14-25 known to SCHN to make the leap from their children's hospital to adult health services.

The aim of Trapeze is for young people to better manage their conditions as they move over to adult services so they can live their own lives and stay out of hospital. Trapeze facilitates, monitors and coordinates a young person's care during transition and strengthens their links with local adult services, especially their GP. The staff at Trapeze work closely with the young person's GP as this relationship is integral for the young person. The GP is ideally placed to provide a safety net during the transition process and to take increasing responsibility as a care coordinator and advocate for the young person.

Trapeze focuses on the whole person providing an integrated and holistic approach to health care ensuring the young person is at the centre of the transition process at all times. Trapeze believes young people have the right to be heard, to make genuinely informed choices and have timely access to medical services.

Trapeze can be contacted by:

Phone: 02 8303 3600

Email: trapeze.schn@health.nsw.gov.au

Website: www.trapeze.org.au

THE AGENCY FOR CLINICAL INNOVATION (ACI) TRANSITION CARE NETWORK

The Agency for Clinical Innovation (ACI) provides three Transition Care Coordinators in NSW who are based in adult hospitals and provide a state-wide service. Their role is to ensure continuity of care for young people aged between 14-25 years of age with any chronic conditions/ disabilities as they move to the adult health service.

The Transition Care Coordinator can assist the young person in providing information about adult health services; sorting out any difficulties in finding or attending adult health services; providing guidance/support at adult clinics; helping to adjust to a new adult team and a new adult service; and providing regular contact with the young person to make sure they have successfully engaged with the adult health service.

The Transition Care Coordinators can be contacted by phone:

The Western Area – (02) 9845 7787

South Eastern Area – (02) 9515 6382

Hunter New England Area – (02) 4925 7866

FINDING OUT MORE...

There are many services offering information, education and support about chronic conditions, disability and adolescence.

- Children with Disability Australia (CDA) is the national peak body representing children and young people (aged 0-25) with disability and their families. Visit www.cda.org.au
- Livewire is an online community for young people living with a serious illness, chronic health condition or disability and their families. Visit www.livewire.org.au
- The special School-Link program hosted by the Children's Hospital at Westmead promotes collaboration between disability, health and education sectors to provide information and resources related to young people with an intellectual disability and mental health. Visit www.schoollink.chw.edu.au
- The NSW Council for Intellectual Disability (NSW CID) represents the rights and interest of people with intellectual disability in NSW. Their website has fact sheets on mental health and disability. Visit www.nswcid.org.au
- Physicalasanything.com is a web-based resource written by experts for teachers, schools, healthcare professionals, students and families. Endorsed by the NSW Department of Education and Communities and NSW Health, the website provides detailed descriptions of more than 50 conditions affecting school-aged children and young people and the educational implications of each condition. Visit www.physicalasanything.com.au.
- The NSW Agency for Clinical Innovation, Trapeze, and The Sydney Children's Hospitals Network have produced Key Principles of Care for Young People Transitioning to Adult Health Services, which is reproduced in the appendix of this Kit.

CHAPTER SUMMARY - WHAT TO REMEMBER

In managing chronic conditions and disability in young people, it is important to consider the impact of the condition on the young person's physical and psychosocial development.

It is also important to recognise that adolescent developmental issues can affect the condition itself and the young person's adherence to management plans. The search for identity, the need for greater autonomy, and the effects of peer relationships and sexual development can compromise adherence to management plans.

Focus on the individual young person and his or her capacity for healthy functioning rather than just on the chronic condition or disability.

REFLECTION QUESTIONS

How well does your service address the needs of young people with disability?

How well do you support young people with chronic conditions who need to transition to adult services?

How can you improve the transition of young people to adult services?

REFERENCES

- Australian Institute of Health and Welfare. (AIHW). (2010). *Health of Australians with Disability: Health Status and Risk Factors*. AIHW bulletin no. 83. Cat. no. AUS 132. AIHW: Canberra.
- Australian Institute of Health and Welfare. (AIHW). (2009). *Disability in Australia: Multiple Disabilities and Need for Assistance*. Cat. no. DIS 55. AIHW: Canberra.
- Australian Institute of Health and Welfare (AIHW) (2008). *Disability in Australia: Intellectual Disability*. AIHW bulletin no. 67. Cat. no. AUS 110. AIHW: Canberra.
- Australian Institute of Health and Welfare (AIHW). (2006). *Disability updates: Children with Disabilities*. Cat. no. AUS 79. AIHW: Canberra.
- Bennett DL & Kang M. (2001). Adolescence. In K Oates, K Currow and W Hu. (eds.) *Child Health: A Practical Manual for General Practice*. MacLennan and Petty: Australia.
- Berg-Kelly K. (2007). Presentation from European Training in Effective Adolescent Care and Health (EuTeach). Available www.euteach.com. Viewed 10 December 2007.
- Bloomquist KB, Brown G, Peerson A & Presler EP. (1998). Transitioning to independence: challenges for young people with disabilities and their caregivers. *Orthopaedic Nursing*. May/June, 27-35.
- Craig SL, Towns S & Bibby H. (2007). Moving on from paediatric to adult health care: An initial evaluation of a transition program for young people with cystic fibrosis. *International Journal Adolescent Medical Health*. 19(3), 333-343.
- Rosen DS, Blum RW, Britto M, Sawyer SM & Siegel DM. (2003). Transition to adult health care for adolescents and young adults with chronic conditions. Position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*. 33, 309-311.
- Sanci L. (2001). *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners: Melbourne.
- Steinbeck K, Brodie L & Towns S. (2007). Transition care for young people with chronic illness. *International Journal of Adolescent Medical Health*. 19, 295-303.
- Steinbeck KS, Brodie LS & Towns SJ. (2008). Transition in chronic illness: Who is going where? *Journal of Paediatrics and Child Health*. 44, 478-482.
- Wood D, Reiss JG, Ferriss M, Edbwards LR & Merrick J. (2011). *International Journal of Child and Adolescent Health*. Special issue on Youth Health Care Transition. 3, 1-180.
- World Health Organization. (WHO). (2012). Health Topics: Disability <http://www.who.int/topics/disabilities/en>

SECTION 3.12

HEALTHY LIFESTYLES

3.12 HEALTHY LIFESTYLES

FIONA ROBARDS

Health is much more than the absence of illness or disease. Health is about a state of wellbeing – physical, psychological, social and emotional. Helping young people to build and establish healthy habits in adolescence is one way in which health and youth workers can build resilience and encourage young people to take responsibility for their own health.

YOUNG PEOPLE AND SLEEP

Sleep is important for healing and mental alertness (AIHW 2011) and young people need adequate sleep to be able to learn well. From puberty, young people tend to go to sleep later, wake later and sleep less. But young people do require about 9 hours sleep a night: more sleep than adults, and about the same amount as younger children need.

Not getting enough sleep is associated with physical and mental health problems, including cognitive impairment, reduced alertness, poor concentration and memory, suicidal thoughts, accidents, obesity and heart disease. Social and recreational trends, especially the use of new technologies, may contribute to sleep disturbance in young people.

Sleep disorders can also reduce the quality and quantity of sleep. The impact of sleep disorders is not known at a population level. Some problems that may require further investigation include (Waters 2013):

- Obstructive sleep apnoea (sleep disordered breathing)
- Delayed sleep phase syndrome (sleep occurs later than desired)
- Narcolepsy (sudden falling asleep when otherwise alert)
- Periodic hypersomnia (excessive sleepiness)
- Insomnia (difficulty with sleep initiation, duration and quality)

Promote healthy sleep patterns and preventing sleep problems by encouraging:

- Regular and earlier bedtimes
- Parental monitoring of bedtime
- Increased exercise (although not too close to bedtime)
- Restricted caffeine intake later in the day (including energy drinks)
- Restricted use of phones, computers and tablets at sleep time

NUTRITION

Good nutrition supports the rapid growth in weight and height that occur in adolescence. Peak growth velocity occurs on average at 11.5 years for girls and 13.5 years for boys. On average, boys gain about 20 cm in height and 20 kg in weight, and girls gain about 16 cm in height and 16 kg in weight (AIHW 2011).

Young people need extra iron, zinc, calcium and protein when they are growing (O'Dea 2009).

In 2007-08, over a third of young Australians were overweight or obese (23.3% overweight and 11.3% obese). Only one in 20 young people meet the NHMRC recommended intake of fruit and vegetables. Eating fruit and vegetables and reducing salt and animal fats protects against the development of many diseases such as heart disease, some cancers, hypertension, stroke, and type 2 diabetes.

Of course, the ability to make healthy food choices requires an adequate supply of fresh food, cooking and food preparation skills, and an understanding of the importance of healthy eating. Social and environmental factors also have an effect on young people's food choices.

The Australian Dietary Guidelines (NHMRC 2013) establish some key principles for healthy eating and good nutrition. The Guidelines are a useful resource for professionals looking for information about the recommended daily intakes of food types for different age groups.

GUIDELINE 1

To achieve and maintain a healthy weight, be physically active and choose amounts of nutritious food and drinks to meet your energy needs.

Children and adolescents should eat sufficient nutritious foods to grow and develop normally. They should be physically active every day and their growth should be checked regularly.

Older people should eat nutritious foods and keep physically active to help maintain muscle strength and a healthy weight.

GUIDELINE 2

Enjoy a wide variety of nutritious foods from these five food groups every day:

1. Plenty of vegetables of different types and colours, and legumes/beans
2. Fruit
3. Grain (cereal) foods, mostly wholegrain and/or high cereal fibre varieties, such as breads,

cereals, rice, pasta, noodles, polenta, couscous, oats, quinoa and barley

4. Lean meats and poultry, fish, eggs, tofu, nuts and seeds, and legumes/beans
5. Milk, yoghurt, cheese and/or their alternatives, mostly reduced fat

And drink plenty of water.

GUIDELINE 3

Limit your intake of foods containing saturated fat, added salt, added sugars and alcohol.

In particular:

1. Limit intake of foods high in saturated fat such as many biscuits, cakes, pastries, pies, processed meats, commercial burgers, pizza, fried foods, potato chips, crisps and other savoury snacks.
 - » Replace high fat foods containing predominately saturated fats such as butter, cream, cooking margarine, coconut and palm oil with foods which contain predominately polyunsaturated and mono-unsaturated fats such as oils, spreads, nut butters/pastes and avocado.
 - » Low fat diets are not suitable for children under the age of 2 years.
2. Limit your intake of foods and drinks containing added salt.
 - » Read labels to choose lower sodium options among similar foods.
 - » Do not add salt to foods in cooking or at the table.
3. Limit your intake of foods and drinks containing added sugars such as confectionery, sugar-sweetened soft drinks and cordials, fruit drinks, vitamin waters, energy and sports drinks.
4. If you choose to drink alcohol, limit your intake. For women who are pregnant, planning a pregnancy or breastfeeding, the safety option is to not drink at all.

GUIDELINE 4

Encourage, support and promote breastfeeding.

Breast milk provides a unique mix of nutrients and other important substances that can reduce the risk of infection and may also help reduce the risk of asthma, eczema and other allergies, and sudden infant death syndrome.

Research shows that, amongst other benefits, being breastfed can reduce the risk of high blood pressure in childhood and may reduce the risk of becoming obese in childhood, adolescence and adulthood.

This, in turn, may also reduce the risk of chronic diseases like Type 2 diabetes, heart disease and stroke in later life.

For the mother, breastfeeding can help recovery from birth and, may also help mothers return to their pre-pregnancy weight and reduce their risk of some cancers.

GUIDELINE 5

Care for your food. Prepare and store it safely.

- If buying packaged food, check its 'best-before' or 'use-by' date.
- Use a cooler, insulated bag or box with an ice pack if you need to travel more than half an hour home or if it is hot outside. Store your food at home as soon as you can.
- Chill foods in the fridge to slow growth of micro-organisms.
- Keep cool foods cool and frozen foods frozen.
- Keep fridges at or below 5°C and the freezer between -15° and -18°C.
- Keep your fridge and freezers clean. And get rid of those old shrivelled vegetables, 'left-overs' or frozen foods lurking in the corners for too long!
- Store foods away from cleaning agents and insecticides.
- If you are not going to eat cooked dishes and foods straight away, put them in the fridge as soon as possible.

PHYSICAL ACTIVITY

Physical activity and exercise has many benefits. In adolescence, it strengthens the body and reduces the risks of certain cancers, injuries from falls and fractures, heart disease, high blood pressure and type 2 diabetes. It also improves mental health (AIHW 2011).

It is estimated that only 44 per cent of young people aged 15-24 met the national guidelines for physical activity (in 2007-08). Twenty seven per cent undertook very little physical activity. Indigenous youth and those living in remote areas were less likely to meet guidelines for moderate to vigorous physical activity.

Under Australia's Physical Activity and Sedentary Behaviour Guidelines (2014), young people aged 13-17 need to be doing at least 60 minutes of moderate to vigorous physical activity every day. For more information on physical activity guidelines visit www.health.gov.au/paguidelines

It is also recommended that young people shouldn't spend more than two hours a day in front of screens. The amount of time spent on small screen recreation,

which includes computer games and television time, is linked to obesity. Those who watch more than 2 hours of screen time per day are more likely to be overweight, physically inactive, eat unhealthy snacks, drink more soft drink, and have fewer social interactions.

HEALTHY WEIGHT

Obesity is both a disease with its own significant morbidity and mortality and a risk factor for other non-communicable diseases, including type 2 diabetes and cardiovascular disease (Baur and Burrell 2005)

Adolescence is one of the critical life periods for the development of obesity. There are many physical, psychosocial and developmental complications of overweight and obesity in adolescence. Obese young people have a greater than 80% risk of becoming obese adults (Baur and Burrell 2005).

Raising the issue of weight problems can be tricky. Young people are generally very sensitive about their body image. They may be reluctant or embarrassed to discuss the issue of their weight. It is important to raise the issue in the context of a trusting relationship in which the young person already believes you have their best interests in mind.

With both young people and their parents, avoid stigmatising or blaming. Stay solution-focused and supportive. You can:

- Talk about 'feeling well' and 'being fit' to engage the young person
- Make the conversation relevant to what is concerning the young person (e.g. improving the chances of playing in team sport, clearing the skin, feeling more in control and less tired)
- Make time to develop a holistic picture of the young person's situation – young people are generally very happy to talk about themselves and valuable management insights will be gained. You can use the HEEADSSS tool (see 3.2 Psychosocial assessment) to assist with enquiring about weight and diet issues: An example question might be: *"How healthy is your diet? Describe a typical day."* (Steinbeck 2007)

In many cultures, participation in health care is a family responsibility and it is common for family members to be involved in decision-making. Working with the family and gaining the trust of parents is critical to addressing healthy eating issues. Parents are often reluctant to directly address their child being overweight or obese. They may prefer to address weight indirectly by talking about 'healthy eating'.

ASSESSING AND MANAGING OVERWEIGHT AND OBESITY

- Explore lifestyle – including eating habits, exercise patterns and leisure time/recreation (e.g. hours spent watching television, computer use, etc.)
- Obtain a more in-depth history of dietary habits and food intake – this can include the young person keeping a food and activity diary
- Explore in detail the factors influencing physical activity, sedentary behaviour and dietary intake
- Obtain family history – particularly any history of overweight, type 2 diabetes, early heart disease and hypertension
- Look for depression or other mood disorders and psychosocial problems
- Body mass index (BMI) can be calculated by dividing weight in kilograms by height in metres squared (online calculation is easy) and plotted on a BMI-for-age chart. Overweight is considered >85th BMI percentile and obesity >95th BMI percentile
- It is also important to consider cultural background, as some ethnic groups may be at greater risk of diabetes

Obesity is a chronic disorder of energy imbalance, so focus on promoting changes to both sides of the energy equation – energy in and energy out. Lifestyle change is the basis of weight management. NHMRC guidelines (2013) suggest using a combination of strategies including modifying diet, reducing sedentary behaviours and increasing physical activity.

- Set realistic behaviour change and weight loss goals – help the young person to feel comfortable with their body image and self-esteem, while at the same time promoting behaviour and lifestyle change.
- Address underlying or contributing psychological and psychosocial issues, such as depression and anxiety – where necessary, refer to a psychologist or social worker to address these issues.
- Plan for a long-term intervention: behaviour change will take time.
- More intensive therapies for more severe degrees of overweight may require specialist consultation.
- For younger adolescents, work with the parents or carers and young person together.
- For older adolescents, work with them one-on-one to tailor interventions around their priorities, motivation for change and developmental concerns (such as peer acceptance,

self-image and need for independence). Then, you can work with the parents or carers.

- Actively involve family members and carers as agents of change in dietary and exercise habits, as well as providing support to the young person in their behaviour change program. (Baur and Burrell 2005; Steinbeck 2007)

FINDING OUT MORE...

Clinical Practice Guidelines for the Management of Overweight and Obesity in Children and Adolescents are available from the Commonwealth Department of Health's website www.health.gov.au

The Healthy Kids website was built with the purpose of being a 'one stop shop' of information for parents and carers, teachers and childcare workers, health and other professionals and kid and teens about healthy eating and physical activity. Visit www.healthykids.nsw.gov.au

Get Healthy is a free telephone-based coaching service to support young people aged 18 and over to make lifestyle changes. Visit www.gethealthynsw.com.au

SUN PROTECTION

In Australia, skin cancer is the most commonly diagnosed cancer in young people (AIHW 2011).

In 2006-2007, only about a third of Australian young people reported using sun protection. One quarter of young people aged 12-17, and a fifth of young people aged 18-24, became sunburnt.

Young people may not listen to messages about skin cancer but may be more concerned about ageing and wrinkles. Young people should also be warned about the dangers of tanning beds.

Encourage young people to protect their skin and to think about sun safety when planning outdoor activities. Reinforce the importance of seeking shade, wearing protective clothing, a hat and sunglasses and using a broad spectrum (UVA/UVB) SPF 30+ sunscreen. Remind young people that regular skin checks are important as the early detection of skin cancer is more likely to improve treatment outcomes (AIHW 2011). Skin checks may focus on a specific mole or part of the body (such as the face or shoulders) or involve an all-over body check.

ORAL HEALTH

Good oral health and hygiene is important for an adolescent's health now and in the future. In adolescence, poor oral health is associated with pain, difficulty eating and drinking, loss of sleep, embarrassment and poor academic performance (AIHW

2011). As an adult poor oral health is also associated with obesity, heart disease, cancer, stroke, diabetes, heart problems and mental health problems (AIHW 2011).

In Australia, 15 year-olds have twice as many decayed, missing or filled teeth as 12 year-olds (AIHW 2011). Primary care and youth services have an important role to play in educating young people about dental hygiene and encouraging young people to access dental care.

Under the Child Dental Benefits Scheme, young people under the age of 17 may be eligible for assistance under Medicare with costs associated with examinations, x-rays, cleaning, fissure sealing, fillings, root canals and extractions. More information is available from the Commonwealth Department of Human Services at www.humanservices.gov.au

You can also encourage young people to:

- Prevent tooth decay with healthy eating - limit sugars and processed foods to mealtimes (rather than between meals)
- Choose snacks such as cheese, natural yoghurt, fresh fruit and vegetables, dry biscuits, nuts and wholegrain bread
- Drink water and plain milk both with and between meals
- Limit soft drinks, sports drinks, juice, flavoured water and other carbonated drinks as they can cause decay and dissolve the tooth enamel
- Chew sugar-free gum to stimulate saliva flow and help protect teeth from decay
- Preventing tooth decay with good teeth cleaning twice a day with fluoride toothpaste
- Floss daily
- Minimise injuries to the mouth and teeth by wearing a professionally fitted mouthguard when training and playing sport where there is risk of oral injury
- Have regular oral health check ups – don't wait for a problem (Dental Health Services Victoria 2013)

INJURY PREVENTION

Injury and poisoning is the lead cause of death (66% of deaths) and hospitalisations among young people, particularly among males. Risk-taking in adolescents can contribute to increased risk of injury. Young people are vulnerable to risk-taking due to cognitive, attitudinal, behavioural and social factors.

A particular risk to adolescents is road traffic accidents. Accidents in this age group are often linked to risky driving, driving when fatigued and driving under the influence of drugs or alcohol.

Services can support young people to reduce risk of injury by reinforcing safety messages about:

- Safe driving, free from the influence of alcohol or other substances
- The importance of not texting or using mobile devices while driving
- Safe celebrations and harm minimisation strategies
- Workplace safety

FINDING OUT MORE...

Youthsafe is the peak body for 'preventing serious injury in young people' aged 15 to 25 years in NSW. They address safety across the range of settings where young people are at risk of unintentional injury including on the roads, in workplaces, while playing sport and socialising. Their website has factsheets and information about their programs. Visit www.youthsafe.org

CHAPTER SUMMARY - WHAT TO REMEMBER

Helping young people to build healthy habits in adolescence is one of the most valuable things youth services can do to promote health and wellbeing.

Healthy sleeping, dietary and physical activity patterns and good self-care practices can help young people to reduce the risks of developing conditions including overweight and obesity, poor oral health and skin cancer, and can also help reduce the effects of depression and anxiety.

REFLECTION QUESTIONS

How well does your service identify healthy lifestyle issues in the young people it sees?

Are you routinely asking about healthy lifestyle?

What approaches are appropriate for your service to take to promote health?

How well do staff members promote healthy lifestyles? Is any training needed?

What resources are available to you? Do you know your health promotion service network?

How effectively do you work with other services to promote health?

REFERENCES

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

Baur L. & Burrell S. (2005). Managing obesity in childhood and adolescence. *Medicine Today*. 6(7), 46-56.

Dental Health Services Victoria. (2013). Dental advice for young adults. Available <http://www.dhsv.org.au/dental-advice/general-dental-advice/young-adults/> Viewed 28 May 2013.

National Health and Medical Research Council. (NHMRC). (2013). Australian Dietary Guidelines. Commonwealth of Australia. Available <http://www.eatforhealth.gov.au/> Viewed 28 May 2013.

National Health and Medical Research Council. (NHMRC). (2013). Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children in Australia.

Available http://www.nhmrc.gov.au/files/nhmrc/publications/attachments/n57_obesity_guidelines_130531.pdf. Viewed 1 August 2013.

O'Dea J. (2009). Body image among Australian adolescents: A preventive school based approach. In D Bennett, S Towns, E Elliott and J Merrick (eds.) *Challenges in Adolescent Health: An Australian Perspective*. Nova Science: New York.

Steinbeck K. (2007). Adolescent overweight and obesity: How best to manage in the General Practice setting. *Australian Family Physician*. 36(8), 606-612.

Waters K. (2013). Sleep and sleep disorders in adolescents. In K Steinbeck and M Kohn (eds.) *A Clinical Handbook in Adolescent Medicine*. World Scientific: Singapore.

SECTION 3.13

WORKING WITH FAMILIES

3.13 WORKING WITH FAMILIES

PETER CHOWN

Families play an important role in adolescent development. Research shows that positive youth development is associated with a family environment characterised by close family relationships, strong parenting skills, good communication and positive adult behaviours (Aufseeser, Jekielek and Brown 2006). Good family relationships and communication positively influence adolescent sociability, reduce the incidence of substance misuse and risk behaviour (Fleming et al. 2010) and act as a protective factor for the young person's psychosocial wellbeing.

Conversely, young people who experience low levels of family cohesion have been shown to be more at risk of suicide, substance abuse and mental health problems (Toumbourou and Gregg 2001).

Understanding how to work with families and how to help young people who do not have family support are important skills for youth services and workers.

THE NATURE AND ROLE OF FAMILY

The structure of families in our society has undergone significant change in the last 50 years. Whereas once most children grew up in a home with a mother, a father and siblings, today that family model is more difficult to find.

Relationship breakdown and re-partnering is increasingly common (AIHW 2011) and young people may experience a number of family transitions, which can have significant effects on their development. The conflicts and stresses young people are exposed to during family dissolution or the re-partnering of parents can have negative effects on their mental wellbeing and their adjustment to independent life (Cartwright 2006). Conversely, when young people receive appropriate parenting and support, these transitions can help them to develop greater resilience and self-determination (Cartwright 2006).

According to the AIHW (2011), in the 20 years from 1986 to 2006, the proportion of families defined as a couple with dependent children fell from 45 per cent of all families to 37 per cent. The proportion of single-parent families increased from 8 per cent to 11 per cent in the same period.

In 2006-7, most adolescents (99 per cent) aged between 12 and 17 were living with parents. Seventy seven per cent were in couple families, with 22 per cent in one-parent families (which included

blended, step and foster families). About 28 per cent of young people aged 15-17 had a parent living elsewhere; 78 per cent of these were fathers.

Today, young people grow up in a variety of family types, including:

- Traditional 'nuclear' families (married father & mother and their children)
- Blended or step-families – a coupled family with children who may be the biological children of the couple, as well as children from previous relationships (this includes heterosexual and same-sex couples)
- Single-parent families – with either mother or father as primary carer
- Extended families – a family group consisting of the parent(s) and children, as well as grandparents, aunts, uncles, cousins, other relatives or kin

Young Indigenous people are less likely to live in two-parent families, more likely to live in single-parent families, and are more likely to live with extended family. Grandparents are likely to play a significant role in bringing up children and young people in Indigenous families.

Many young people also live in non-parental care or shared care arrangements, where the biological parents are unable to care for their children. Carers may include grandparents, foster parents, adoptive parents or other family members.

There may also be many significant others who, although not family members, play a major role in support and care for the young person, including mentors, friends or professional carers. For a young person who is disconnected from their family of origin, these significant others may be their primary source of support.

HOW YOUNG PEOPLE SEE FAMILY

Family and family relationships are a key concern for young people. The 2011 Mission Australia national survey reporting on young people aged 11-24 illustrated the crucial importance of the family in young people's lives:

- Family relationships were the most highly valued item among young people (74.3% respondents)
- Parents and relatives were seen as the major sources of advice and support for all issues of concern
- Family conflict was an issue of major concern for a third of young people in the survey

The survey concluded that:

"These findings support the need for evidence-based integrated programs and services that promote loving and nurturing home environments and support parents and carers, vulnerable families in particular, to develop high quality parenting and nurturing relationships with children".

GUIDING PRINCIPLES FOR WORKING WITH FAMILIES

Families can play a key role in both the onset and management of major youth health problems. There is evidence that a family oriented approach to service delivery improves outcomes for children and parents (Carr 2000). However, family interventions are often not widely used in many services dealing with youth mental health or substance use problems (Leggatt 2007).

It is important for services working with young people to adopt family sensitive policies and practices that seek to engage, inform and support relevant family members

Services need to address barriers to family involvement and take steps to include them, where appropriate, as part of a collaborative approach to intervention with youth clients.

In particular, it is important to take steps to engage and include fathers (and other significant men in the young person's life) who have often been marginalised or less involved as consumers of health or community-based services (FACHSIA 2009).

BUILDING RELATIONSHIPS AND WORKING WITH FAMILIES

Engaging and working with the family of a young person is a vital part of early intervention and treatment approaches – especially with young people experiencing mental health, substance use or other psychosocial problems.

Family means different things to different people and in different cultures. In some CALD families, parents act as the mediators for young people in their relationships with health and other services. Building a relationship with these parents, and gaining their support and participation is therefore essential.

Different cultures may hold different expectations and attitudes about health, help-seeking behaviour and the role of services. Approaches you might normally take with young people (such as explaining confidentiality, seeing the young person alone, and encouraging independent decision-making by the young person) may contradict family and cultural values, and so need to be handled carefully.

The family context for young Indigenous people is also different to the familial constructs for most non-Indigenous young people. Family is a broad context, and many people who may not be related by blood are family within the kinship system. It is important to understand the family influences and structures of the young people you are working with.

No two families will be alike. You will need to tailor your approach to working with a young person's family to the individual and the circumstances.

THE YOUNG PERSON IN THE CONTEXT OF THEIR FAMILY

In some cases, parents or carers will present seeking help to deal with problems in family functioning, or for assistance in managing their adolescent. If a young person has come with a parent or carer, spend some time with the parent or carer either alone or with the young person. Remember that it is also important to meet with the young person alone.

When working with a young person, an important part of understanding who they are is understanding how they "fit" in their family and how their family works. You can use the HEEADSSS assessment (see chapter 3.2) to explore their family situation and the quality of the relationships between family members and the young person. Ask the young person to describe their family to you to help you identify who is important in terms care planning, making decisions about information-sharing and working out who to include as part of the intervention process with the young person.

Even if you are working primarily with the young person, it can be helpful to observe the interactions of the young person in their family because it allows you to:

- Assess and understand the dynamics of the young person's relationship with their parents or carers
- Observe how family members interact and communicate with each other
- Identify how different family members define the "problem"
- Gain a history of the onset of the young person's or family's problems and an insight into some of the contributing factors
- Work out the roles that parent(s) and other family members play in the maintenance of the situation and their role in attempts to deal with the problem
- Facilitate communication between the parents or carers and the young person
- Assist family members, particularly parents or carers, to identify their needs in relation to the young person's concerns

Parents may need information and education about the young person's concerns, as well as guidance in how best to respond to their adolescent and what role to take in supporting any treatment interventions. In particular, they may need support on how to deal with risk-taking behaviours the young person may be involved with – e.g. substance use, sexual activity. Provide them with reassurance and support to dispel any fears or anxiety. Respond to the parents' concerns while respecting the young person's right to confidentiality.

When meeting with the family, remember that everyone has:

- The need to be heard and understood – listen to the parents' concerns and acknowledge that you have heard and understand their perspective
- The need to not be blamed – family members need to be able to discuss the factors involved in causing or maintaining the young person's difficulties without feeling at fault
- The need to be included – engage family members as partners in a collaborative approach to the care of the young person
- The need for information – depending on what you have negotiated with the young person in regard to sharing information, provide the family with information about the young person's concerns; possible treatment approaches and the role of the parents or carers and family members in supporting the young person and any treatment plans. (Headspace 2008)

BUILDING UNDERSTANDING

Adopt a positive, supportive approach to working with the family. Providing education and information to members of a young person's family may be important. Family members may know very little about normal adolescent development and the changes that occur during adolescence (including the physical, emotional and cognitive changes; the 'moodiness' of adolescents; the growing need for independence; the role of peer relationships; etc.).

If the young person has mental health, substance abuse, or other psychosocial or behavioural problems, you can provide education and reassurance about the nature of the problem, its effects on the young person's functioning, and management approaches.

Discuss the risk and protective factors related to the problem – in particular, reinforce the importance of good family functioning as a major protective factor for the young person. Where appropriate, actively involve family members in developing and supporting a management and treatment plan. Where possible, identify specific roles that family

members can take to support the young person's treatment:

- Maintaining a regular routine (including healthy eating, sleeping and exercise; attendance at school; and limits on computer usage)
- Encouraging adherence to treatment plans
- Supporting the young person to maintain social connections
- Keeping the lines of communication open with the young person
- Supporting them to attend appointments with specialist providers

STRENGTHENING FAMILIES

Adolescence is a period of major transition and challenge not only for teenagers, but also for their parents.

Parents play a powerful role in influencing the way children and young people learn to manage their emotional reactions and impulses. Research clearly demonstrates the importance of effective parenting in positively influencing healthy child and adolescent development (Bennett and Rowe 2003). The greatest changes to the brain during adolescence are in those parts that are responsible for functions such as impulse control, judgement, emotions and organisation. The way a parent interacts with their teen directly influences the development of these regulatory mechanisms in the brain and helps shape their ability to develop crucial emotional self-regulation skills (Siegel & Hartzell 2004).

Parents play a critical role in helping their adolescent sons and daughters negotiate the complex physical and emotional transitions of adolescence. Effective parenting involves both managing challenging behaviours on the part of the young person, while also helping them to develop a healthy sense of self-worth, autonomy and identity.

Many parents, however, feel unequipped to effectively parent their rapidly changing adolescent. Parents who seek services for young people may be experiencing 'normal' parental challenges that arise as their adolescent navigates the trials of a changing body, fitting into peer groups, forging an independent identity for themselves and challenging family rules and values. Even though these issues may fall into the category of normal behaviour, they can nonetheless lead to conflict, arguing, disconnection between parents and teens, frustration and despair for both parent and teenager.

Parents may need support to understand and respond effectively to their teenager's behaviour and moods, as well as skills to manage more confronting and unacceptable behaviours, such as dangerous risk-taking, aggression towards family members or disrespectful behaviour.

Effective skills for parenting adolescents include:

- Adopting a parenting style that is warm, firm and allows for increasing independence while encouraging greater responsibility (Bennett and Rowe 2003; Hawton 2013)
- Setting appropriate limits while giving reasonable freedoms and privileges
- Sharing good times, actively building the relationship and maintaining communication with the teen, even when the young person may be disconnecting from them
- Identifying those behaviours that are more serious and require active intervention by the parent (e.g. risk-taking; regularly breaking agreed-upon rules; aggression) and what behaviours to let go of because they are "infuriatingly normal" adolescent behaviours (e.g. messy bedroom; choice of clothing; loud music; etc.) (Bennett and Rowe 2003; Hawton 2013; Phelan 1998)
- Handling rule-breaking in a calm, consistent and fair manner
- Managing their emotions when faced with challenging or unacceptable behaviours by the young person, and maintaining a climate of respect in the family
- Using reflective listening skills to listen to their teenagers concerns or worries in a non-judgemental way, without problem solving or advising (Hawton 2013)
- Initiating communication about difficult or uncomfortable topics (e.g. sexuality; drugs and alcohol; going to parties; and challenging behaviours)
- Helping the young person to develop:
 - » Their capacity to understand, regulate and appropriately express their emotions
 - » Cognitive and social competence
 - » Skills for problem-solving and cooperation
 - » Resilience in the face of interpersonal, emotional and academic difficulties

MAKING REFERRALS

Many young people require referral to specialist services as part of a comprehensive assessment and treatment approach for their mental health or psychosocial problems. Carefully explain to the family the reasons for the referral and the processes involved. The family can play a major supportive role in assisting the young person to access specialist providers – such as GPs, Psychologists, Social Workers, Psychologists or specialist services – such as Adolescent Mental Health or Drug & Alcohol Services.

Where there are ongoing family issues or conflicts, or where the family issues are a major contributing factor to the maintenance of the young person's problems, it may be necessary to refer the family for specialist family counselling. Provide information about other support services and networks for the family.

Many parents themselves may be struggling with mental health or psychosocial problems, including unaddressed trauma history (Bouverie Centre 2013). These issues may not only compromise their capacity to provide adequate parenting, but may also be a major contributor to the onset of the young person's problems. Encourage and support parents to seek appropriate help for themselves and to think about their own self-care and need for support.

ETHICAL AND LEGAL ISSUES

You will need to consider both the young person's age and their level of maturity and cognitive capacity to consent and make decisions about treatment (Sanci et al. 2005),

This may involve a competency assessment to determine if the young person is a 'mature minor', as well as weighing up various factors, such as:

- The nature of the relationship between the young person and their parents
- The seriousness of the problem
- The level of risk to the young person and their safety
- The needs of parents and other family members
- The benefits of having parents/family involved
- The importance of maintaining a trusting relationship with the young person (Furlong and Leggatt 1996)

It can be challenging to balance the young person's need for and right to confidentiality with the need to engage parents and carers. If the young person does not want their parents, carers or other family members involved, sensitively explore their reasons for this:

Examples:

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

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

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

"What information do you want me to share / not share with your parents / family?"

Make a collaborative decision with the young person about sharing information with family members and involving their parents or carers and family members.

Where the young person is adamant that they don't want their parents involved, you can still work towards involving parents/family (unless the parents are unable to act in a protective or support manner)

Examples:

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

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

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

FINDING OUT MORE...

Learn more about the legal and ethical issues of working with young people and their families in chapter 3.5 Medico-legal issues.

The Bouverie Centre – Victoria's Family Institute – provides a range of resources on working with families and how services can be more family sensitive and inclusive in their work. Visit www.bouverie.org.au

Family Relationships online provides information about Family Relationship Centres and family support services. It also has resources for young people, family members and professionals. Visit <http://www.familyrelationships.gov.au>

The Family Relationship Advice Line is a national telephone service to assist family members affected by relationship or separation issues. Call 1800 050 321 from 8 am to 8 pm, Monday to Friday, and 10 am to 4 pm on Saturday, except national public holidays.

The Triple P Positive Parenting Program offers evidence-based parenting programs to help manage behaviour, prevent problems and build strong healthy relationships. Visit www.triplep-parenting.net

The Raising Children Network has extensive resources for parents, including parents of teenagers, on its website. Visit www.raisingchildren.net.au

Information and advice is available for families and health professionals where a parent is affected by a mental illness. Visit www.copmi.net.au

Information and support for young carers is available at youngcarersnsw.asn.au

Information and resources for young carers of family or friends with a mental illness is available at www.arafmi.org

CHAPTER SUMMARY - WHAT TO REMEMBER

We know that positive family relationships help young people to develop in healthy ways and act as a protective factor against many risks that young people encounter in adolescence. The converse is also true: family environments that are unstable, unsupportive or dangerous to a young person's wellbeing can increase a young person's susceptibility to risk factors.

While your service may work primarily with young people, engaging their parents, carers or other important people in the young person's care and support can improve health outcomes for the young person.

Remember that parents and carers may need support to be more effective parents and you can play an important role in helping them to build those skills.

REFLECTION QUESTIONS

How does your service cater to the needs of young people's families? What policies/protocols does your service have in regard to confidentiality for the young person and disclosure of information to parents or family members?

What are some of the barriers/difficulties to engaging and working with a young person's family? And how can you overcome them?

What are some of the ethical/legal dilemmas you experience in working with families of young people?

What are some of the benefits you see from actively involving the family in working with the young person?

What training do you need to enhance your skills in working with families?

REFERENCES

- Aufseeser D, Jekielek S & Brown B. (2006). *The Family Environment and Adolescent Wellbeing: Exposure to positive and negative Family Influences*. Child Trends: Washington, DC and National Adolescent Health Information Center, University of California: San Francisco.
- Australian Institute of Health and Welfare. (AIHW). (2011). *Young Australians: Their Health and Wellbeing 2011*. Cat no. PHE 140. AIHW: Canberra.
- Bennett D & Rowe L. (2003). *What to do when your children turn into teenagers*. Doubleday: Sydney.
- Bouverie Centre. (2013). *Guidelines for Trauma-Informed Family sensitive Practice in Adult Health Services*. La Trobe University: Victoria.
- Carr A. (2000). Evidence-based practice in family therapy and systemic consultation: Child-focused problems. *Journal of Family Therapy*. 22(1), 29-60.
- Cartwright C. (2006). You want to know how it affected me? Young adults' perceptions of the impact of parental divorce. *Journal of Divorce and Remarriage*. 44(3/4), 125-43.
- Department of Families, Housing, Community Services and Indigenous Affairs. (FAHCSIA). (2009). *Introduction to Working with Men and Family Relationships Guide*. Available <http://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/introduction-to-working-with-men-and-family-relationships-guide>. Viewed 20 May 2014.
- Fleming CB, Catalano RF, Haggerty KP & Abbott R. (2010). Relationships between level of change in family, school, and peer factions during two periods of adolescence and problem behaviour at age 19. *Journal of Youth and Adolescence*. 39(6), 670-83.
- Furlong M & Leggat M. (1996). Reconciling the patient's right to confidentiality and the family's need to know. *Australian and New Zealand Journal of Psychiatry*. 30, 614-622.
- Headspace (2008). *Working with Families and Significant Others*. Training package. Headspace National Youth Mental Health Foundation: Melbourne.
- Hawton M. (2013). *Talk Less, Listen More. Solutions for children's difficult behaviour*. Jane Curry Publishing: Sydney.

Leggatt M. (2007). Minimising collateral damage: Family peer support and other strategies. *Medical Journal of Australia*. 187(7), 61-63.

Mission Australia (2011). *National Survey of Young Australians*. Available

<https://www.missionaustralia.com.au/what-we-do-to-help-new/young-people/understanding-young-people/annual-youth-survey>. Viewed 20 May 2014.

Phelan T. (1998). *Surviving your Adolescents*. CMI: Illinois.

Sanci L, Sawyer S, Kang M, Haller, D & Patton G. (2005). Confidential health care for adolescents: Reconciling clinical evidence with family values. *Medical Journal of Australia*. 183(8), 410-414.

Siegel DJ & Hartzell M. (2004). *Parenting from the Inside Out*. Tarcher: New York.

Toumbourou J & Gregg M. (2001). Working with families to promote healthy adolescent development. *Journal of Family Matters*. 59, 54-60.

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APPENDIX 1 - YOUTH HEALTH RESOURCES & CONTACTS

FINDING OUT MORE...

This section lists a range of specialist resources and services for health professionals working with young people. These resources are taken from sections one, two and three of the Kit and are not exhaustive. Services and resources change, new resources and services emerge.

Use the 'Your Local Services' table (Appendix 1) to write in contact details of your local youth and health services.

The comprehensive report 'Young Australians: Their Health and Wellbeing 2011' can be found on the Australian Institute of Health and Welfare's website: www.aihw.gov.au

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

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

Australian health information for young people can be found at www.yourhealthlink.com.au

ATTENTION DEFICIT HYPERACTIVITY DISORDER

The National Health and Medical Research Council has published Clinical Practice Points on the Diagnosis, Assessment and Management of ADHD in Children and Adolescents which are available at www.nhmrc.gov.au/guidelines/publications/mh26

The Royal Australian College of Physicians (RACP) has developed the Draft Australian Guidelines on ADHD. You can find the guidelines on the RACP's website www.racp.edu.au

The Australian Psychological Society (APS) has also published treatment guidelines for ADHD. Visit www.psychology.org.au

CHILD PROTECTION

A fact sheet outlining the role and responsibilities of NSW Health workers in the new approach to child protection can be found at:

http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_007.pdf

Find out more about mandatory reporting in NSW at www.community.nsw.gov.au

In NSW there are specific policies which provide guidance and agreed interagency procedures for exchanging information related to the safety, wellbeing and welfare of children and young people. Visit www.health.nsw.gov.au/policies (use child wellbeing as a search term) or www.keepthemsafe.nsw.gov.au

CHRONIC CONDITIONS AND DISABILITY

Livewire is an online community for young people living with a serious illness, chronic health condition or disability and their families. Visit www.livewire.org.au

The special School-Link program hosted by the Children's Hospital at Westmead promotes collaboration between disability, health and education sectors to provide information and resources related to young people with an intellectual disability and mental health. Visit www.schoollink.chw.edu.au

The NSW Council for Intellectual Disability (NSW CID) represents the rights and interest of people with intellectual disability in NSW. Their website has fact sheets on mental health and disability. Visit www.nswcid.org.au

Physicalasanything.com is a web-based resource written by experts for teachers, schools, healthcare professionals, students and families. Endorsed by the NSW Department of Education and Communities and NSW Health, the website provides detailed descriptions of more than 50 conditions affecting school-aged children and young people and the educational implications of each condition. Visit www.physicalasanything.com.au

Trapeze is the specialist transition service for The Sydney Children's Hospitals Network (The Children's Hospital at Westmead and Sydney Children's Hospital, Randwick). Trapeze supports young people with chronic conditions and their families/carers aged 14-25 known to SCHN to make the leap from their children's hospital to adult health services. Visit www.trapeze.org.au or phone 02 8303 3600.

Agency for Clinical Innovation works to improve systems and processes for young people with chronic health problems and disabilities and to facilitate their effective transition from paediatric to adult health services. ACI provides support and advice on transition planning for young people, their parents and health care professionals. <http://www.aci.health.nsw.gov.au/networks/transition-care>

Children with Disability Australia (CDA) is the national peak body representing children and young people (aged 0-25) with disability and their families. Visit www.cda.org.au

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

You can find more information about Easy English at www.scopevic.org.au

DOMESTIC VIOLENCE

Information and advice on domestic violence in NSW is available at www.domesticviolence.nsw.gov.au

Information about the latest research in women's safety is available from Australia's National Research Organisation for Women's Safety. Visit www.anrows.org.au

DRUG AND ALCOHOL

You can learn more about individual substances and their effects from:

- Australian Drug Information Network. Visit www.adin.com.au
- Australian Drug Foundation clearinghouse for information on drugs. Visit www.druginfo.adf.org.au
- Youth Substance Abuse Service (YSAS) – for information about working with high risk, co-morbid young people. Visit www.ysas.org.au
- National Drug & Alcohol Research Centre (NDARC). Visit www.ndarc.med.unsw.edu.au
- Your room – for drug and alcohol information and resources. Visit www.yourroom.com.au

EATING DISORDERS

There is a range of resources and support available to professionals working with a young person with an eating disorder:

- The Eating Disorder Service in the Department of Adolescent Medicine, Children's Hospital at Westmead can provide assistance with assessment and treatment. Contact the Service on (02) 9845 2446.
- For more information about eating disorders and factsheets, visit the Eating Disorders Foundation website at www.eatingdisorders.org.au
- The National Eating Disorders Collaboration provides information for professionals on research evidence and treatment approaches – www.nedc.com.au
- Mental Health First Aid Australia also has guidelines on Eating Disorders. Visit www.mhfa.com.au

FAMILIES

Family Relationships online provides information about Family Relationship Centres and family support services. It also has resources for young people, family members and professionals. Visit <http://www.familyrelationships.gov.au>

The Family Relationship Advice Line is a national telephone service to assist family members affected by relationship or separation issues. Call 1800 050 321 from 8 am to 8 pm, Monday to Friday, and 10 am to 4 pm on Saturday, except national public holidays.

The Triple P Positive Parenting Program offers evidence-based parenting programs to help manage behaviour, prevent problems and build strong healthy relationships. Visit www.triplep-parenting.net

The Raising Children Network has extensive resources for parents, including parents of teenagers, on its website. Visit www.raisingchildren.net.au

Information, advice and support for young carers is available:

- For families and health professionals where a parent is affected by a mental illness. Visit www.copmi.net.au
- For young carers at www.youngcarersnsw.asn.au
- For young carers of family or friends with a mental illness at www.carafmi.org

HEALTHY LIFESTYLES

The Healthy Kids website is a 'one stop shop' of information for parents and carers, teachers and childcare workers, health and other professionals and kid and teens about healthy eating and physical activity. Visit www.healthykids.nsw.gov.au

Youthsafe is the peak body for 'preventing serious injury in young people' aged 15 to 25 years in NSW. They address safety across the range of settings where young people are at risk of unintentional injury including on the roads, in workplaces, while playing sport and socialising. Their website has factsheets and information about their programs. Visit www.youthsafe.org

Clinical Practice Guidelines for the Management of Overweight and Obesity in Children and Adolescents are available from the Commonwealth Department of Health's website www.health.gov.au

Australia's Physical Activity and Sedentary Behaviour Guidelines (2014) can be found at www.health.gov.au/paguidelines

Get Healthy is a free telephone-based coaching service to support young people aged 18 and over to make lifestyle changes. Visit www.gethealthynsw.com.au

HEEADSSS ASSESSMENT

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

INDIGENOUS HEALTH

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

- The Closing the Gap Clearinghouse provides evidence-based research on overcoming disadvantage for Indigenous Australians. Visit www.aihw.gov.au/closingthegap
- Information and resources on federal government programs can be found at www.indigenous.gov.au
- NACCHO is the national peak body representing over 150 Aboriginal Community Controlled Health Services (ACCHSs) across the country on Aboriginal health and wellbeing issues. Learn more at www.naccho.org.au
- Australian Indigenous HealthInfoNet provides comprehensive and up-to-date information on the health of Indigenous Australians. Visit www.healthinfonet.ecu.edu.au
- The Aboriginal Health and Medical Research Council of NSW supports Aboriginal Community Controlled Health Services. See www.ahmrc.org.au

Learn more about working with Indigenous young people at:

- <http://aboriginal.telethonkids.org.au/kulunga-research-network/working-together-2nd-edition/>

LESBIAN, GAY, BISEXUAL, TRANSGENDER AND INTERSEX

If you are supporting young people working through issues associated with their sexual identity, or who identify as gay, lesbian, bisexual, transgender or intersex, you may find some of the following services helpful:

- QLife offers Australia's first national counselling and referral service for Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people. The project provides early intervention, peer-supported telephone and web-based services to diverse people of all ages experiencing poor mental health, psychological distress, social isolation, discrimination, experiences of being mis-gendered and/or other social determinants that impact on their health and wellbeing. Visit [www.qlife.org.au](http://www qlife.org.au)
- In NSW, twenty10 provides a range of support services to young people under 26 who identify as gay, lesbian, bisexual, queer or transgender, or are same-sex attracted, gender diverse or intersex. The support available includes counselling, case management, referral, information and housing support. Visit www.twenty10.org.au
- Young people who identify as transgender or gender diverse can find information, resources and support at www.gendercentre.org.au
- For information, education and peer support for intersex people, visit www.oii.org.au
- The Safe Schools Coalition supports gender diversity and sexual diversity in schools. Visit www safeschoolscoalition.org.au

Parents, family and friends looking for support and information can visit www.pflagaustralia.org.au

MEDICARE AND GENERAL PRACTICE

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

Find out more about Medicare at www.medicareaustralia.gov.au

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

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

MEDICO-LEGAL

There is a wide range of resources available to help health practitioners understand and navigate medico-legal issues.

For further information about relevant laws applying to young people the Australasian Legal Information Institute (AustLII) provides an online database of Australian legislation and case law – www.austlii.edu.au

For information on a range of legal issues affecting young people in each Australian state and territory, visit the National Children's and Youth Law Centre's lawstuff at www.lawstuff.org.au

The Shopfront Youth Legal Centre is a free legal service for disadvantaged young people. It provides fact sheets on legal issues, including young people and health care in NSW. Visit www.theshopfront.org

MENTAL HEALTH

The Head to Health website combines mental health resources and content from the leading health focused organisations in Australia. You can access a range of mental health resources including online programs, fact sheets, audio and video, and online communities as part of the National E-Mental Health Strategy. Visit www.headtohealth.gov.au

There are many evidence-based internet resources to help both professionals working with young people and young people living with depression:

- Beyondblue – the National Depression Initiative has resources for professionals and the public, including a specific site for young people, and a set of Clinical Practice Guidelines: Depression in Adolescents and Young Adults. Visit www.youthbeyondblue.com
- The Black Dog Institute provides assessment tools, resources and management guidelines on the treatment of depression and other mood disorders. Visit www.blackdoginstitute.org.au
- DepressionNet – provides information and resources for health consumers about the causes, symptoms and treatment options for managing depression. Visit www.depressionNet.org.au
- Reachout – provides information, resources and support for young people and professionals. Visit www.reachout.com.au
- Orygen Youth Health (OYH) – provides a range of excellent resources and fact sheets for professionals and young people. Visit www.oyh.org.au

There are some excellent internet resources with information about anxiety and resources that can be helpful to young people experiencing anxiety.

- Youthbeyondblue has a range of fact sheets for young people, families, and professionals. Visit www.youthbeyondblue.com
- Anxiety Disorders Association of Victoria provides resources and detailed information about panic disorder, social phobia, agoraphobia, generalised anxiety and depression. Visit www.adavic.org
- Headspace – is Australia's National Youth Mental Health Foundation. Visit www.headspace.org.au

For more information on the signs and symptoms of psychosis and the "at risk" mental state for psychosis, Orygen's website has factsheets on "Psychosis and Young People", "At Risk Mental State and Young People" and "Medication for Psychosis". Visit www.oyh.org.au

To learn more about the treatment of psychosis in young people, see the Australian Clinical Guidelines for Early Psychosis on EPPIC's website. Visit www.eppic.org.au

There are many online resources about managing self-harming behaviour and about identifying, assessing and managing suicide risk in young people.

- Mental Health First Aid (www.mhfa.com.au) provides guidelines on mental health first aid for both self-harming and suicidal behaviours.
- Reachout (www.reachout.com.au), headspace (www.headspace.org.au), and youthbeyondblue (www.youthbeyondblue.com 1300 22 4636) provide information and resources for young people, their families, friends and health professionals about managing mental health including self-harm and suicide.
- Kids Helpline (www.kidshelp.com.au 1800 551 800) provides a free and confidential telephone and online counselling service specifically for young people aged between 5 and 25.
- Lifeline (www.lifeline.org.au 13 11 14) provides free online, phone and face-to-face crisis support and suicide prevention service.
- The Black Dog Institute also provides a range of resources including screening tools, factsheets and guidelines on its website. Visit www.blackdoginstitute.org.au. The Institute has a website specifically for young people (www.biteback.org.au) and also offers a training program specifically for professionals working with young people.
- Headspace helps young people who are going through a tough time. 12-25 year-olds can get health advice, support and information. With centres all around Australia, headspace can help with: general health, mental health and counselling, education, employment and other services, alcohol and other drug services. Headspace also provide an online counselling service (www.eheadspace.org.au 1800 650 890). Visit www.headspace.org.au
- Suicide Call Back Service (www.suicidecallbackservice.org.au 1300 659 467) provides a few professional telephone and online counselling service for anyone affected by suicide.

MOTIVATIONAL INTERVIEWING

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

Learn more about MI from:

- Miller W and Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. (2nd edn). Guildford Press: London.
- Rollnick S, Mason P and Butler C. (2006). *Health Behaviour Change: a guide for practitioners*. Churchill Livingstone: London.

MULTICULTURAL HEALTH

The Transcultural Mental Health Centre (TMHC) is a statewide service for NSW that provides clinical, consultation services and training and information for professionals working with people of CALD background including children, young people and families. TMHC also provides over the phone advice and consultation on cultural/religious issues, mental health issues and other general health issues.

All TMHC services are free of charge both to the referring agency and the young person. TMHC Clinical Services can be contacted on (02) 9912 3851 or Toll Free on 1800 648 911 (rural areas) or visit the Diversity Health Institute's website: www.dhi.health.nsw.gov.au/tmhc

The NSW Multicultural Health Communication Service provides information and services to assist health professionals to communicate with non-English speaking communities throughout NSW.

Visit www.mhcs.health.nsw.gov.au

OUT OF HOME CARE

The NSW Health Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care aim to provide guidance to Local Health Districts and health professionals on the recommended approach to the health assessment process for children and young people in statutory Out-of-Home Care. They reflect NSW Health's approach to the implementation of the National Clinical Assessment Framework for Children and Young People in OOHC (2011).

They can be found at www.health.nsw.gov.au/policies (search Out of Home Care).

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

QUIT SMOKING

For advice and information about how you can support a young person to quit smoking, contact:

- National Quitline – 131 848
- National Tobacco Campaign – www.quitnow.gov.au
- Cancer Council – www.cancercouncil.com.au
- Smarter Than Smoking – www.smarterthansmoking.org.au
- Oxygen – www.oxygen.org.au
- Quit Coach – www.quitcoach.org.au
- Quit now – www.quitnow.gov.au

REFUGEE HEALTH

Promoting Refugee Health: A guide for doctors and other health care providers has been produced by the Victorian Foundation for Survivors of Torture website. Visit www.foundationhouse.org.au

The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) provides a comprehensive range of information and services for assisting refugees in their recovery and resettlement. Visit www.startts.org.au.

SEXUAL HEALTH

There are a number of web-based sources for information about sexual health and sexuality. The Sexual Health and Family Planning Australia website provides information about sexual health services and family planning issues throughout Australia. Visit www.shfpa.org.au

NSW Health has a website specifically for young people who need information about STIs, getting tested and protecting sexual health. Visit www.playsafe.health.nsw.gov.au

Marie Stopes International also offers a website called Dr Marie, offering information about contraception, termination of pregnancy, STIs and other sexual health topics through its Ask Dr Marie service. The website is www.drmarie.org.au

The NSW STI Programs Unit provides a range of factsheets and resources about STIs to support the sexual health clinical and health promotion workforce. Visit www.stipu.nsw.gov.au

The NSW Sexual Health Infoline provides support services for doctors, nurses and other health professionals who need on-the-spot technical support during consultations. Call 1800 451 624.

Family Planning NSW has an extensive Disability Resource Collection for sexual education, which is available for loan: www.fpnsw.org.au

Other states may have similar resources available from their State Family Planning Service.

The Better Health Victoria website has information on adolescent sexuality and disabilities: www.betterhealth.vic.gov.au

TECHNOLOGY

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

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

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

Beacon is an online Hub for health and wellbeing websites. A panel of health experts provide guidance about websites for mental and physical health. www.beacon.anu.edu.au

Reachout provides access and advice for health care professionals on a range of technologies and online resources that can be used to enhance the effectiveness of psychosocial support and mental health care provided to young people. www.reachoutpro.com.au

The Young and Well CRC explores the role of technology in young people's lives, and how technology can be used to improve the mental health and wellbeing of young people aged 12 to 25. www.yawcrc.org.au

TRAUMA

Adults Surviving Child Abuse (ASCA) has produced a set of guidelines for practitioners working in health and human services: The Last Frontier. Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care And Service Delivery. Visit www.asca.org.au/guidelines

APPENDIX 2 - YOUR LOCAL SERVICES

Note contact details of services and resources for young people in your local area here:

Service Name	Type of Service/s Provided	Contact Details

APPENDIX 3 - YOUTH HEALTH CHECK

PROMPTS FOR YOUTH-FRIENDLY PRACTICE:

Rapport, Affirm attendance, Confidentiality statement with exceptions, Discuss billing policy if relevant, Check consent, Time alone &/vs. Time with parent/guardian/partner

Consider developmental and physical health screening

Name	
Assessment Date	
DOB	
Gender	
Culture & Language	E.g. Aboriginal or TSI; Language spoken at home
Other services/adults involved	E.g. Parents, guardians, carers, agencies
Medicare card number	
Preferred client contact method & time	
Confidentiality statement with exceptions provided	<input type="checkbox"/> Yes <input type="checkbox"/> No

YOUTH PSYCHOSOCIAL ASSESSMENT

HEEADSSS PSYCHOSOCIAL ASSESSMENT

Explain reasons for delving into sensitive areas and ask permission to proceed; consider third-person approach to sensitive questions; look for protective as well as risk factors

H - Home (Consider - living arrangements, transience, relationships with carers/significant others, supervision, childhood experiences, cultural identity and family cultural background/s)

E - Education, Employment (Consider - school/work retention & relationships, bullying, belonging, study/ career progress & goals, changes in grades/performance)

E - Eating, Exercise (Consider - nutrition, vegetarianism, eating patterns including recent changes, vegetarianism, weight gain/loss, physical activity, fitness, energy, preoccupation with weight or body image, attempts to lose or control weight or bulk up including restricting, purging, supplements)

A - Activities, Hobbies & Peer Relationships (Consider - free time, hobbies, culture, belonging to peer group, peer activities & venues, involvement in organized sport, religion, lifestyle factors, risk-taking, including managing chronic illness and adjustments in adolescence, injury avoidance, sun protection, use of technology)

D - Drug Use (Consider - alcohol, cigarettes, caffeine, prescription/Illicit drugs and type, quantity, frequency, administration, interactions, access, increases/decreases- treatments, education, motivational interviewing)

S - Sexual Activity & Sexuality (Consider - knowledge, sexual activity, age onset, safe sex practices, same sex attraction, sexual identity, STI screening, unwanted sex, sexual abuse, pregnancy/children)

S - Suicide, Depression & Mental Health (Consider - normal vs clinical, mood, anxiety symptoms vs stress, change in sleep patterns, self harm, suicidal thoughts/ideation/intent/method/past attempts/treatment, depression score and mental state exam)

S - Safety, Spirituality (Consider bullying, abuse, violence, traumatic experiences, risky behaviour, belief, religion; What helps them relax, escape? What gives them a sense of meaning?)

RISK ASSESSMENT

Consider R.I.S.K. guidelines: R - no risk = review; I - low risk = monitor; S - moderate risk = intervene; K - high risk = intervene			
Risk Factors		Protective Factors	
Suicidal ideation		Suicidal intent	
Current plan		Risk to Others	

CARE NETWORK: OTHER SERVICES/ADULTS INVOLVED IN CARE & SUPPORT

Consider any of the following	Aware of issues/ permission to share information?	Contact details
Parent/s, Carer/s, Guardian/s (Who?)		
School Staff (E.g. school counsellor, Year Advisor, Teacher/s, Principal)		
Medical / health specialists (Including psychologist/ counsellor/ allied health)		
Community health services		
Family support or counselling services		
Welfare services/ NGOs		
Other		

GOALS & ACTIONS

Feedback – Compliment areas going well, highlight need for on-going contact, negotiate management plan.	
Goals	Actions

FOLLOW UP

Referrals. Consider providing information about referral services and associated costs	
Follow up arrangements: OK to call home number? Call mobile only? SMS?	
Agreement on information to be shared with third parties:	

This document will be maintained in accordance with the relevant Privacy Legislation.

APPENDIX 4 - YOUTH HEALTH RISK ASSESSMENT

Use this form to record the responses of the young person to the [HEEADSSS](#) assessment.

Young Person's Name:

Date of Birth:

Date of Assessment:

Assessment Area	Questions	Young Person's Responses
H - Home	<p>Explore home situation, family life, relationships and stability:</p> <p>Where do you live? Who lives at home with you?</p> <p>Who is in your family (parents, siblings, extended family)?</p> <p>What is your/your family's cultural background?</p> <p>What language is spoken at home? Does the family have friends from outside its own cultural group/from the same cultural group?</p> <p>Do you have your own room?</p> <p>Have there been any recent changes in your family/home recently (moves, departures, etc.)?</p> <p>How do you get along with mum and dad and other members of your family?</p> <p>Are there any fights at home? If so, what do you and/or your family argue about the most?</p> <p>Who are you closest to in your family?</p> <p>Who could you go to if you needed help with a problem?</p> <p>Do you provide care for anyone at home?</p> <p>Is there any physical violence at home?</p>	
E - Education / Employment	<p>Explore sense of belonging at school/work and relationships with teachers/peers/workmates; changes in performance:</p> <p>What do you like/not like about school (work)?</p> <p>Do you feel connected to your school? Do you feel as if you belong?</p> <p>Are there adults at school you feel you can talk to about something important? Who?</p> <p>What are you good at/ not good at?</p> <p>How do you get along with teachers /other students/ workmates?</p> <p>How do you usually perform in different subjects?</p> <p>What problems do you experience at school/work?</p> <p>Some young people experience bullying at school, have you ever had to put up with this?</p> <p>What are your goals for future education / employment?</p> <p>Any recent changes in education/ employment?</p>	

<p>E – Eating & Exercise</p>	<p>Explore how they look after themselves; eating and sleeping patterns:</p> <p>What do you usually eat for breakfast/lunch/dinner?</p> <p>Sometimes when people are stressed they can overeat, or under-eat – Do you ever find yourself doing either of these?</p> <p>Have there been any recent changes in your weight? In your dietary habits?</p> <p>What do you like/not like about your body?</p> <p>If screening more specifically for eating disorders you may ask about body image, the use of laxatives, diuretics, vomiting, excessive exercise, and rigid dietary restrictions to control weight.</p> <p>What do you do for exercise?</p> <p>How much exercise do you get in average day/ week?</p>	
<p>A – Activities & Peer Relationships</p>	<p>Explore their social and interpersonal relationships, risk taking behaviour, as well as their attitudes about themselves:</p> <p>What sort of things do you do in your free time out of school/work?</p> <p>What do you like to do for fun?</p> <p>Who are your main friends (at school/out of school)?</p> <p>Do you have friends from outside your own cultural group/from the same cultural group?</p> <p>How do you get on with others your own age?</p> <p>How do you think your friends would describe you?</p> <p>What are some of the things you like about yourself?</p> <p>What sort of things do you like to do with your friends?</p> <p>How much television do you watch each night?</p> <p>What's your favourite music?</p> <p>Are you involved in sports/hobbies/clubs, etc.?</p> <p>Do you have a smart phone or computer at home? In your room? What do you use if for?</p> <p>How many hours do you spend per day in front of a screen, such as computer, TV or phone?</p>	
<p>D – Drug Use / Cigarettes / Alcohol</p>	<p>Explore the context of substance use (if any) and risk taking behaviours:</p> <p>Many young people at your age are starting to experiment with cigarettes/ drugs/alcohol. Have any of your friends tried these or other drugs like marijuana, injecting drugs, other substances?</p> <p>How about you, have you tried any? If Yes, explore further</p> <p>How much do you use and how often?</p> <p>How do you (and your friends) take/use them? – explore safe/unsafe use; binge drinking; etc.</p> <p>What effects does drug taking or smoking or alcohol, have on you?</p> <p>Has your use increased recently?</p> <p>What sort of things do you (& your friends) do when you take drugs/drink?</p> <p>How do you pay for the drugs/alcohol?</p> <p>Have you had any problems as a result of your alcohol/drug use (with police, school, family, friends)?</p> <p>Do other family members take drugs/drink?</p>	

<p>S – Sexuality</p>	<p>Explore their knowledge, understanding, experience, sexual orientation and sexual practices – Look for risk taking behaviour/abuse:</p> <p>Many young people your age become interested in romance and sometimes sexual relationships.</p> <p>Have you been in any romantic relationships or been dating anyone?</p> <p>Have you ever had a sexual relationship with a boy or a girl (or both)? – if Yes, explore further</p> <p>(If sexually active) What do you use to protect yourself (condoms, contraception)?</p> <p>What do you know about contraception and protection against STIs?</p> <p>How do you feel about relationships in general or about your own sexuality?</p> <p>(For older adolescents) Do you identify yourself as being heterosexual or gay, lesbian, bisexual, transgender or questioning?</p> <p>Have you ever felt pressured or uncomfortable about having sex?</p>	
<p>S – Suicide / Self-Harm/ Depression / Mood</p>	<p>Explore risk of mental health problems, strategies for coping and available support:</p> <p>Sometimes when people feel really down they feel like hurting, or even killing themselves. Have you ever felt that way?</p> <p>Have you ever deliberately harmed or injured yourself (cutting, burning or putting yourself in unsafe situations – e.g. unsafe sex)?</p> <p>What prevented you from going ahead with it?</p> <p>How did you try to harm/kill yourself?</p> <p>What happened to you after this?</p> <p>What do you do if you are feeling sad, angry or hurt?</p> <p>Do you feel sad or down more than usual? How long have you felt that way?</p> <p>Have you lost interest in things you usually like?</p> <p>How do you feel in yourself at the moment on a scale of 1 to 10?</p> <p>Who can you talk to when you're feeling down?</p> <p>How often do you feel this way?</p> <p>How well do you usually sleep?</p> <p>It's normal to feel anxious in certain situations – do you ever feel very anxious, nervous or stressed (e.g. in social situations)?</p> <p>Have you ever felt really anxious all of a sudden – for particular reason?</p> <p>Do you worry about your body or your weight? Do you do things to try and manage your weight (e.g. dieting)?</p> <p>Sometimes, especially when feeling really stressed, people can hear or see things that others don't seem to hear or see. Has this ever happened to you?</p> <p>Have you ever found yourself feeling really high energy or racey, or feeling like you can take on the whole world?</p>	
<p>You can also explore:</p> <p>S – Safety</p> <p>S – Spirituality</p>	<p>Sun screen protection, immunisation, bullying, abuse, traumatic experiences, domestic violence, risky behaviours.</p> <p>Have you ever been seriously injured?</p> <p>When did you last send a text message while driving?</p> <p>When did you last get into a car with a driver who was drunk or on drugs?</p> <p>Beliefs, religion; What helps them relax, escape? What gives them a sense of meaning?</p>	

APPENDIX 5 - YOUTH HEALTH BETTER PRACTICE FRAMEWORK CHECKLIST- (replaced by Youth Friendly Checklist for Health Services)

1. ACCESSIBILITY

How accessible is your service?	Yes	Part	No
Does your service have a promotion strategy for targeting young people?			
Is there a confidentiality policy? Is this widely publicised to your target group?			
Does your service actively seek to understand young people's concerns and needs, and have the capacity to respond to their needs?			
Does your service use creative, innovative activity-based strategies to improve young people's access to, and engagement with, youth health services?			
Are services provided free, or at a cost affordable to young people?			
Can young people reach the service easily (e.g. by public transport)?			
Is the service open after hours when young people can get there?			
Is it possible for young people to drop in and use the service without having to make an appointment?			
Is there flexibility around consultation times, and the capacity to offer longer sessions to deal with complex issues that may arise?			
Are staff provided with training, supervision and support to maintain the knowledge and skills required for working with young people?			

2. EVIDENCE-BASED APPROACH

Which types of evidence does your service use?	Yes	Part	No
When undertaking a systematic needs assessment, does your service utilise:			
1. Existing policies and background documents?			
2. 'Normative' research reports (such as epidemiological data, qualitative research studies)?			
3. Comparative studies of similar populations or issues — but from a different area?			
4. Surveys and direct consultations with key stakeholders and target populations?			
When reviewing programming priorities, does your service systematically monitor changes to the target population or issue (e.g. emerging needs) through regularly reviewing the above?			
When starting a new program, does your service:			
1. Use current evidence on the issue, including existing models, standards and practice guidelines?			
2. Locate and review reports, articles and publications (e.g. tools and guidelines) from similar programs?			
3. Develop expected outcomes based on existing performance indicators (where possible)?			

3. YOUTH PARTICIPATION

How does your service involve and promote youth participation?	Yes	Part	No
Does your service have policies and procedures in place that outline how young people's participation and decision-making can be used in program development, implementation, review and evaluation?			
Does your service regularly review and revise its youth participation mechanism in consultation with young people?			
Does your service provide opportunities for increasing young people's confidence, knowledge and skills in using participation mechanisms?			
Does your service have specific ways in which it acknowledges and values young people's input and contributions?			
Does your service ensure that its youth representatives reflect the diversity of young people's views and needs?			

4. COLLABORATION AND PARTNERSHIPS

How does your service work collaboratively with others?	Yes	Part	No
Does your service propose collaboration and partnerships within its strategic or business plan?			
Does your service identify potential partners for collaboration and have protocols for working out roles, responsibilities and agreements between agencies or services?			
Does your service regularly review and evaluate its collaborative strategies, to ensure effective processes and outcomes?			
Does your service treat young people as equal partners where possible and appropriate?			

5. PROFESSIONAL DEVELOPMENT

How does your organisation support professional development?	Yes	Part	No
Is professional development identified as a service objective, and are planned activities costed into service budgets and proposals?			
Are there formalized induction processes for staff taking up new positions — including handover, orientation and probation?			
Does your organisation provide regular opportunities for staff members to review and discuss their professional development needs? Does it assist workers to plan and undertake activities to improve knowledge, skills and performance?			
Does the service collaborate with other agencies/organisations around staff development events, in order to maximise resources, share expertise and ensure a healthy flow of ideas?			
Are there working mechanisms within the service (e.g. team meetings, team forums, internal newsletters etc.) where staff share newly acquired knowledge and information with co-workers?			
Do young people inform staff training around youth issues – and are they directly involved in its delivery?			
Do staff training/development programs have clearly identified outcomes (such as identified competencies) and are they regularly evaluated?			

6. SUSTAINABILITY

How sustainable are your organisation's programs and activities?	Yes	Part	No
Where possible, does your service develop sustainability strategies within its strategic and business plans, for example:			
1. Putting income generation strategies in place			
2. Developing partnerships and collaboration			
3. Building community capacity and planning transition strategies with the ultimate goal of handing over project ownership within an identified time frame?			
Does your service actively integrate its activities into existing mainstream programs where possible?			
Does your service develop programs which can be replicated elsewhere?			
Does your service invest in advocacy and utilisation of Board and other key stakeholder influence, in order to promote programs?			

7. EVALUATION

How does your organisation evaluate its services?	Yes	Part	No
Does your service have clearly articulated aims and objectives against which it can evaluate?			
Does your service incorporate evaluation into its strategic plan, designating resources as required (e.g. time, costs, fees if external evaluator support is required)?			
During the initial stages of project design, does your service include evaluation as an essential activity in all project work plans?			
Does your service take a baseline assessment of the issue or target audience prior to project implementation?			
Does your service evaluate both the qualitative and quantitative aspects of its work, including consumer feedback and identifying unexpected outcomes?			

NSW Youth Health Policy 2011-2016

www.kidsfamilies.health.nsw.gov.au/publications/youth-friendly-checklist-for-health-services/

APPENDIX 6 – KEY PRINCIPLES: TRANSITIONING TO ADULT HEALTH SERVICES



Key Principles of Care for Young People Transitioning to Adult Health Services



Principle 1: A Systematic and Formal Transition Process

A systematic and formal transition process is required. This should be underpinned by formal guidelines and policies outlining the transition process.



Principle 2: Early Preparation

Transition is a process not an event. Education on transition and empowerment around self-management will commence with the young person at the age of 14.



Principle 3: Identification of a Transition Coordinator/ Facilitator

A designated Transition Coordinator/Facilitator from the young person's paediatric and adult specialty teams should be identified to coordinate the transition.



Principle 4: Good Communication

Communication, processes and tools will support person-centred care for the young person throughout their transition journey. Openness, transparency, collaboration and a willingness to work together underpins all good communication.



Principle 5: Individual Transition Plan

All young people should have an individualised transition plan which focuses on all aspects of their life.



Principle 6: Empower, Encourage and Enable Young People to Self-Manage

Responsibility for decision-making should be increased gradually and adolescent friendly transition services should be put in place. Where the young person has complex special needs, it is particularly important to involve their family.



Principle 7: Follow up and Evaluation

Follow up may be required for several years to ensure that young people have engaged effectively with adult health care services. Evaluation of the transition process must be undertaken to inform future planning and policy.

