EVALUATION OF SPECIALIST ALCOHOL AND OTHER DRUG PRIMARY HEALTH SERVICES (SAPHS): YOUNG PEOPLE’S HEALTH SERVICE (YPHS)

Janette Mugavin, Heidi Strickland, Lynda Berends, & Dina Eleftheriadis

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John Ryan
Sam Biondo
Helen McNeill
Chris Hardy
Dr Fran Bramwell
Jenny Kelsall
Bernadette Lane
Elzbieta Zorska
Roland Jauernig
Kon Kon
Katie Maskiell
Anex
VAADA
Hepatitis C Victoria
North Yarra Community Health Service, SAPHS
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Harm Reduction Victoria
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Harm Reduction and Pharmacotherapy Services, Department of Health
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### ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;D</td>
<td>Alcohol and Drugs</td>
</tr>
<tr>
<td>ADIS</td>
<td>Alcohol and Drug Information System</td>
</tr>
<tr>
<td>AOD</td>
<td>Alcohol and Other Drugs</td>
</tr>
<tr>
<td>ATSI</td>
<td>Aboriginal and Torres Strait Islander</td>
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<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
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<tr>
<td>CAH</td>
<td>Centre for Adolescent Health</td>
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<tr>
<td>CAHMS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CBD</td>
<td>Central Business District</td>
</tr>
<tr>
<td>CDW</td>
<td>Community Development Worker</td>
</tr>
<tr>
<td>DHS</td>
<td>Victorian Department of Human Services</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health (Victorian State Government)</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health and Ageing (Commonwealth)</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>MBBS</td>
<td>Bachelor of Medicine/ Bachelor of Surgery</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>NSP</td>
<td>Needle and Syringe Program</td>
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<tr>
<td>PHS</td>
<td>Primary Health Service/s</td>
</tr>
<tr>
<td>QICSA</td>
<td>Quality Improvement &amp; Community Service Accreditation</td>
</tr>
<tr>
<td>RCH</td>
<td>Royal Children’s Hospital</td>
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<tr>
<td>RDNS/HPP</td>
<td>Royal District Nursing Service/Homeless Person’s Program</td>
</tr>
<tr>
<td>STD/STI</td>
<td>Sexually Transmitted Disease/Sexually Transmitted Infection</td>
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<tr>
<td>SWITCH</td>
<td>Statewide Information Technology for Community Health</td>
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<tr>
<td>TPADC</td>
<td>Turning Point Alcohol and Drug Centre</td>
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<tr>
<td>YPHS</td>
<td>Young People’s Health Service</td>
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<td>YSAS</td>
<td>Youth Support and Advocacy Service</td>
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1. **INTRODUCTION**

The evaluation of Specialist Alcohol and other drug Primary Health Services (SAPHS) includes the Young People’s Health Service (YPHS), which is auspiced by the Royal Children’s Hospital (RCH), Centre for Adolescent Health (CAH).

YPHS is one of seven fixed site SAPHS operating in Melbourne.

This section presents detailed information about YPHS. Project methods, limitations of data, detailed analysis and recommendations for the primary healthcare services overall are discussed in the overview report.

In brief, the principal data sources used in this report include:

- A site visit, including interviews with four staff members from YPHS
- Survey responses from five YPHS service users
- Service utilisation data from January 2005 to December 2009 (excluding 2008)
- Service documents and reports provided by YPHS

**Research aims and questions**

The aims of this evaluation were to:

- Assess the effectiveness of SAPHS and ancillary services in meeting the overarching objective of SAPHS which is ‘to provide services that lead to better health outcomes for their intended clientele’
- Identify ways of sustaining and improving the SAPHS service delivery model into the future

We explored and addressed the following questions:

1. What has changed since 2006?
2. What strategies have been employed by services to meet the overarching objective of the SAPHS?
3. Are services effective in achieving the overarching objective of the SAPHS?
4. What strategies, components and models are effective and transferable?
5. What can be improved?

We answered these questions in relation to four priority areas:

- Client demographics and needs
- Service delivery
- Workforce characteristics
- Data collection and measurement
2. DESCRIPTION OF YOUNG PEOPLE’S HEALTH SERVICE

2.1 Overview

The Young People’s Health Service (YPHS) is a program of the Royal Children’s Hospital (RCH), Centre for Adolescent Health (CAH). It is located on King Street, in the Melbourne central business district (CBD), and is one of the services located at Frontyard, which is a youth specific multi-service centre.

YPHS provides primary health services (PHS) for homeless and marginalised young people aged between 12 and 22 years, and it operates Monday to Friday, from 9am until 5pm, with a drop-in service from 11am until 5pm. YPHS is the only youth specific primary health care service in the CBD and it aims to provide opportunistic and strategic health interventions.

Staff were asked to describe YPHS in a few words and the response was:

Primary health services that works with young people.

YPHS offers services that are flexible, cost free, on an appointment and non-appointment basis. Services range from basic and intermediate health care, to complex care responses involving specialist staff such as psychiatrists. Access to practical and social supports and amenities such as a shower and food are available at Frontyard.

2.1.1 Organisational structure

YPHS sits under the ‘High Risk Youth’ program within the CAH organisational structure. The partnership program associated with YPHS in this structure is Adolescent Forensic Health. Other programs in CAH include: ‘Adolescent Medicine’; ‘Practice and Learning’ and ‘Research’.

2.1.2 Philosophy

The philosophy of YPHS is based on a social model of health and ‘recognises social inequality of health as a key determinant of ill health’ (Royal Children’s Hospital, 2010b). YPHS is aligned to the vision and values of RCH, which is ‘to be a great children’s hospital’, and the values include:

- ‘Unity: we work together to achieve our goals’
- Passion: we are passionately committed to caring for sick children and improving children’s health
- Integrity: we act with honesty in all we do
- Excellence: we strive for the highest quality in every aspect of our work
- Respect: for everyone in our care and for each other’ (Royal Children's Hospital, 2010a, p. 2)

2.1.3 Eligibility criteria

Eligibility criteria for service users accessing the primary health service at YPHS comprise homeless and marginalised young people aged between 12 and 22 years. In terms of exclusion criteria, access to services may be suspended for a short period of time due to behaviours which may pose a threat to service users and/or staff. It is important to note that this event and consequent actions are rare. For example, a client is violent towards YPHS staff and threatens their safety. These criteria are consistent with practices noted in the 2006 evaluation of YPHS (Norman, 2006).
2.1.4 Funding sources

YPHS is predominately funded by the Department of Health, Drug Prevention (36%) and it receives a further 30% of its overall funding from the Community Health stream. Other funding sources include: RCH (17%) and the Innovative Health Services for Homeless Youth (IHSHY) Program\(^1\) (17%). The funding sources have changed since the previous evaluation, with a lower proportion of funds available via the Department of Health in recent years, compared to 2005.

Staff highlighted the complexities of the funding environment and the need to source funds from different sources to support the range of services available at YPHS. Whilst we report statistics for the separate funding bodies, YPHS operates as an integrated health service and therefore does not have a dedicated MDS or community health worker. All clinicians have an AOD role.

3. ENVIRONMENTAL AND SOCIAL CONTEXT

As part of the broader evaluation of SAPHS, a targeted environmental analysis was conducted to provide some insight into the socio-economic and health shifts that have occurred in recent years. The overview report for the evaluation provides key findings in this area.

4. SERVICE DELIVERY MODEL

This section provides an overview of the YPHS service delivery model. Components and features of the model are identified, along with strategies that impact service delivery.

4.1 Overview of the model

The YPHS service delivery model is based on a social model of health framework and it integrates principles of harm reduction along with a clear recognition of the social determinants of health. Elements central to the service delivery approach include: providing a holistic response; person centred non-judgemental approach; advocacy and care-coordination; and timely, appropriate and supported referrals.

As noted in the overview report of the SAPHS evaluation, YPHS was one of the SAPHS identified as operating from a ‘walk-in service hub’ model.

‘The walk-in service hub provides access to multiple health services via onsite staff, in-reach services and well established referral pathways. The premises offer space for private consultations, access to practical amenities, monitored recovery space and group activities. Overall, this model is focused on delivering clinical-type health services and less emphasis is placed on establishing a ‘drop-in’ space and access to basic services (e.g. shower, washing machine) compared to SAPHS with a service model characterised as ‘drop-in-space with wrap around services’(Mugavin et al., 2011, p. 29).

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\(^1\) The IHSHY Program is jointly funded between the Australian Government and the State and Territory Governments.
4.2 Features and components of the YPHS service model

This section examines components and processes underpinning the YPHS service delivery model including: promoting the service; access and reach; assessment; care co-ordination; secondary consults and care plans; referrals and linkages; and advocacy.

In the context of these components, key changes which occurred between the evaluation in 2005/06 and the current evaluation are also discussed.

4.2.1 Promoting the service

Knowledge of services available at YPHS is commonly gained via word-of-mouth, peer referrals and referrals from other services, and outreach.

Fostering relationships and maintaining contact with service providers, both within and outside the AOD sector was considered an effective way to raise the profile of the primary health services available at YPHS and promote the service to potential service users. Given YPHS location, developing links with other services co-located at Frontyard was also seen as important in terms of reaching potential service users. According to staff, common strategies employed to increase YPHS’ visibility and presence within the sector and local environment include: attending network meetings and fora; delivering education sessions and presentation; attending barbecues held as part of community or health promotion events; developing cross-sector partnerships; and engaging in research activities.

Since the previous evaluation, staff acknowledged that YPHS’ capacity to expend time and resources on networking and promotional activities has been reduced within the context of staff turnover and organisational changes. According to staff, the combination of these changes along with less contact with other services, has meant a reduced volume of young people access YPHS. However, the recent recruitment of two staff members to the YPHS team has increased the service’s capacity on a number of levels, including promotional and networking activities. As one staff member explained,

4.2.2 Access and reach

As noted in the overview report, ensuring access to health-related services is a fundamental requirement of programs established to reduce health inequalities for marginalised groups. For the purpose of this report, access is discussed in reference to physical and structural factors, as well as interpersonal and contextual factors.

Physical and structural factors

Physical factors encompass: centralised and reachable location; co-location with other services; hours of operation, service setting and facilities; and mode of contact.

Centralised and reachable location

Consistent with the 2006 evaluation (Norman, 2006) YPHS is located on King Street within the Melbourne CBD. The service is within walking distance of the two main train stations and readily accessible by a number of trams and buses. The geographic location of YPHS was viewed positively by staff as well as service users who completed the survey, with all five survey participants reporting that the service was easily reached.
**Co-location with other services**

As indicated previously, YPHS is co-located with a number of other services, such as Centrelink, Step Ahead, Reconnect and Youthlaw. The collection of onsite and visiting agencies at Frontyard creates a service hub tailored to respond to the multiple needs of young people. Furthermore, the co-location of services highlights the complex inter-relationship between homelessness, financial insecurity, legal issues, and health concerns for many young people and the potential benefits of an integrated model. Building relationships with co-located services is a key strategy used by YPHS to enhance the reach and accessibility of its services.

**Hours of operation**

Staff at YPHS are available Monday to Friday from 9am to 5:00pm, and a drop-in clinic typically operates from 11am until 5pm each weekday. The hours of operation have changed since the previous evaluation in 2006 with clinic services now accessible an hour earlier (11am compared to 12pm). All the survey participants (n=5) were satisfied with the opening hours. Similarly, staff considered the opening hours were appropriate.

**Service setting and facilities**

As Frontyard is a multi-service centre, individual services such as YPHS are located in different parts of the building and access to services is initially managed via a third party, typically a youth worker stationed at the front reception. The reception area at Frontyard features a security window, a waiting area, and a drop-in space with couches. Both rooms are accessible and managed by the duty staff (i.e. youth workers). Access to basic amenities such as a shower and toilet are also available via reception.

Consistent with the 2006 evaluation (Norman, 2006), YPHS is located on the lower ground floor of Frontyard. YPHS staff will normally meet a client in the reception area and walk with them to a consultation room. Following the consult, the staff member will walk the client back to the reception area. As with other services at Frontyard, the location of YPHS means the service is not visible from the reception area. YPHS staff acknowledge the short-comings of its physical location, and are acutely aware of the importance of encouraging access via promoting the service to young people through direct service provision on site and via outreach, and promoting the primary health services (PHS) via other service providers. It is equally important for YPHS to work closely with the co-located services to ensure that they are actively promoting health access.

> If people know about the service then they have direct access to us but otherwise there’s a step in between accessing us which is the youth workers upstairs.

Consultation rooms in the YPHS space have a number of standard features such as comfortable chairs in the rooms assigned to counsellors, and examination beds in rooms used by the GP and nursing staff. Duress alarms are not available in the rooms, however, staff will conduct assessments or consults in pairs upstairs if there are safety concerns.

As part of the survey, survey participants (n=5) were asked to assess aspects of YPHS such as facilities and comfort. All participants reported that they liked the facilities all or most of the time, and the majority of participants reported that YPHS had a friendly environment, found the space comfortable and spent time relaxing or ‘chilling out’ at YPHS.
Mode of contact

YPHS offers a mix of non-appointment and appointment based contacts. Care coordinator at FY has a combination of appointments and drop-in. The doctors and nurses operate on an outreach basis. Staff reported that a street-outreach service is provided approximately once a week, and ADIS statistics are recorded against the street-outreach contacts. Outreach is typically conducted in pairs in partnership with Youth Support and Advocacy Service (YSAS). At the time of the site visit, YPHS also provided an outreach service to local youth refuges, the Young Women’s Art (YWART) program.

Over the past 12 months, YPHS has strengthened its outreach service, and outreach was also highlighted as an area for further development. For example, a joint assertive outreach response is currently being developed between YPHS, YSAS and Living Room in response to the volume of young people accessing Living Room and the surrounding area. This service commenced in October 2011, and involves YPHS and YSAS providing a clinician one day a week to the Living Room. This project is not funded by MDS.

The five survey participants reported they had seen a staff member without making an appointment all or most of the time.

Contextual and interpersonal factors

As noted in the overview report, creating a welcoming, safe and inclusive environment where people feel valued and respected is a hallmark of the SAPHS and it involves a complex interplay between contextual and interpersonal factors. The factors include having a non-judgemental approach and creating a welcoming, safe and cohesive environment.

Non-judgemental

Providing non-judgemental support to service users was considered by YPHS staff as a critical aspect of service delivery in terms of fostering a friendly and safe environment.

The non-judgemental approach of staff was supported by findings from the survey. All participants (n=5) reported that staff were non-judgemental all of the time or most of the time.

Welcoming, safe and cohesive environment

When staff were asked what makes YPHS a welcoming and safe environment, responses focused on the level of experience within the staff group, specifically holistic approach to health, and staffs’ non-judgmental, relaxed and professional manner.

In agreement with the 2006 evaluation (Norman, 2006), other service delivery aspects and approaches associated with creating a welcoming environment include:

- Anonymity:
  - Confidential files
  - Consultations within private spaces
  - Clients’ issues discussed only within health team unless release of information form signed

YWART is safe and supportive arts program provided by the Jesuit Social Services. The program is for young women aged 15 to 28 years, experiencing mental health or substance use problems, homelessness and/or involvement in justice services (Jesuit Social Services, 2010).
A feeling of safety
  - Welcoming non-judgemental staff
  - Clients are asked if they feel safe
  - Private individual consultations

- Multi-cultural environment
  - Networks are maintained with groups and organisations that work specifically with young people from non-English speaking backgrounds

Survey participants were also asked about the extent to which they felt safe, and all five participants reported feeling safe all or most of the time (4 all the time; 1 most of the time).

4.2.3 Assessment

In line with the overview report, this section covers three aspects of assessment:

- Initial contact and needs identification
- Tailoring the assessment to fit the context
- Managing walking overdose and recovery spaces

Initial contact and needs identification

YPHS staff reported that the service users’ first point of contact is the Frontyard duty worker positioned at the reception desk. The duty worker will conduct a mini triage, and direct the young person to the appropriate service, or the young person will self-refer to a specific service.

According to staff, initial contact with Frontyard is often driven by a health or housing crisis, or multiple crises. Due the range of services available at Frontyard, and the circumstances leading a person to present to Frontyard, the duty worker’s ability to engage with the young person and identify their priority concerns and effectively triage the person is vital. While the duty workers are generally trained youth workers, their experience and skill-base varies. Staff at YPHS were cognisant of the importance of building a strong relationship with the duty workers as a way to enhance appropriate referrals. As YPHS staff members articulated,

And so [access to YPHS] depends on the skill of the youth worker, it depends on the experience of the youth worker, it depends on the mood of the youth worker, and it depends on the insight of the youth worker. And that's enhancing and limiting at the same time.

We're at the mercy of the front line worker. It depends who you get on the day and what they might say and what questions they might happen to ask.

Tailoring the assessment to fit the context

Conducting a culturally appropriate and holistic assessment is a critical aspect of the YPHS service response. Nurses and the care-coordinator are responsible for conducting assessments at YPHS, and these staff have extensive experience. Consistent with the 2006 evaluation (Norman, 2006), YPHS staff typically use the HEADSS assessment, which is a youth specific standardised tool covering seven domains: Head, Education, Activities, Drug and alcohol use, Suicide and Safety. Staff noted that the HEADSS tool facilitates a broad assessment and helps the clinician and young person identify priority issues, and map the inter-relatedness of behaviours, contexts, and physiological

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3 The HEADSS assessment was developed by Goldenring and Cohen (1988).
factors impacting a person's health. The assessment process is also designed to encourage an open
discussion about possible strategies to address or minimise risks, and goals the person wants to work
towards. Staff acknowledged that, while the assessment was comprehensive, it can be conducted
over a number of visits and young people are willing to engage in the process. As one staff member
noted,

> Most of these people don't know about all their issues or they've never sat down and had
them mapped out before. So we can be asking you the questions, and for a lot of people this is
their first opportunity to revisit some of those concepts. At the same time, we're asking very
specific questions because we need to work out what it is the most important.

According to staff, the assessment also has a practical purpose as it enables staff to record
presenting issues, assessment notes, and outcomes such as a referral to another organisation. Staff
also indicated that plans are in process to develop a database which captures both the breadth of
information captured in the assessment along with specific details. Furthermore, once an assessment
is completed the young person's information is stored on a file and the person is registered as a
client.

In the context of outreach, a formal assessment is not conducted as contact is focused on
engagement, building a relationship, providing information and first aid where required. As one staff
member emphasised, outreach is about 'getting their trust, getting them to be comfortable' with the
service. At an appropriate time, the young person will be offered the opportunity to meet a YPHS staff
member at the Frontyard site and an assessment will be conducted.

*Managing walking overdose and recovery spaces*

Consistent with the 2006 evaluation (Norman, 2006), YPHS provides a recovery space, typically a
consultation room, for people experiencing acute, unwanted drug effects or at risk of an overdose.
Overdoses are managed in accordance with organisational polices.

4.2.4 Care co-ordination

Care co-ordination is central to the service delivery model at YPHS. Key aspects of the care co-
ordination response include: care planning and case management; counselling and support; and
supported referral and advocacy. Staff acknowledged that effective care co-ordination is enhanced via
access to experienced nurses and a counsellor with highly developed interpersonal and clinical skills
and a good knowledge of the service system. As one staff member noted the goal is 'how to navigate
these young people through the service sector as best they can'.

The care co-ordination service also aims to help young people gain a better understanding of the
factors impacting their health. As one staff member indicated, approaching issues indirectly is often
more effective than directly identifying risk behaviour,

> So you try and sometimes look at the issue sideways so that you're not going to be met with
that resistance about 'this is what I do and I'm not going to change it'. So you try and reframe
it, redirect it and get them to approach the issue from a different angle. So that's what we can
do well because we're primary health. We look at lots of different things. Young girls come in
post sexual assault because they were so incredibly intoxicated their friends left them on their
own. After you deal with a sexual assault and the referrals and all the rest and the important
counselling, then you just talk about the very real risks.
The recent employment of a counsellor/care co-ordinator has enhanced the service’s care co-ordination capacity and the service aims to further develop this aspect of the service.

[We are] looking at beefing up our capacity to deal with complex care issues through strengthening care coordination. We want to expand EFT for care coordination because that’s an area we can really value add.

4.2.5 Secondary consultation and share care plans

Secondary consultation occurs both on an informal and formal basis. Obtaining a young person’s consent prior to sharing information with another staff member occurs in line with standard practice. Staff participating in the site visit interview reported that YPHS staff readily seek another clinician’s expertise and experience regarding a service user’s health needs when required. As one staff member noted,

The policy for Frontyard says that if you believe it’s in the best interest of the client, that you’re meant to contact another service and share the information if the clients are vulnerable or at risk.

Care plans are not formally developed for every young people presenting to YPHS, instead, care plans focus on client-driven goals, and facilitating for example, access to services such as mental health, dental, housing or specialist AOD services. The involvement of different staff in the care plan process will depend on the nature of the service user’s goal.

4.2.6 Referrals and linkages

Staff indicated that referrals occur on an informal and formal basis, and the process may vary according to the agencies involved. Given the plethora of services available both within and outside the AOD sector, staff noted that having a good understanding of available options, and requirements of different services, enables staff to help navigate young people to the appropriate services, and streamline access.

In terms of referring young people to an external service, a variety of factors are taken into consideration such as the young person’s knowledge of the service, the young person’s previous experience and current contact with services, their motivation, and the accessibility of the referral point in terms of location and opening hours. Common strategies employed by YPHS to support the referral process and increase the likelihood of successful engagement include:

- Fostering a young person’s sense of ownership of the process and involving them in each stage of the process
- Knowing in advance the necessary requirements of a referral agency and streamlining the process as much as possible
- Where possible, reduce the need of the young person to “retell” their story multiple times through providing comprehensive referral letters and reports to agencies
- Facilitating contact between the young person and the referral point before the referral is formalised as a way to familiarise the young person with the staff and service environment

According to staff, referrals are typically followed-up with both the young person and the agency the young person was referred to. In situations where the young person did not engage with the service, staff indicated the exploring and discussing reasons associated with young person’s decision may provide useful information for future referrals.
In the context of referrals, staff indicated that the relationships between the co-located services at Frontyard could be improved. Given the tendency of agencies and services to work independently with the young person there is a potential for multiple services to place referrals to similar, or the same, organisation for the one young person. The duplication of referrals is considered onerous for staff as well as young people. Staff indicated they are advocating for regular case conference meetings within Frontyard.

We talk about the co-location here and there’s a lot of talk about integrated service but the reality is that the services largely operate in silos and so there’s referral to services [external providers] but the services [at Frontyard] don’t talk to each other about what they’re doing with the clients.

Common referral points to, and from, YPHS include:

- Mental health services such as Orygen and Headspace
- Emergency Department (for acute health issues)
- Royal Women’s Hospital (RWH)
- YSAS (for treatment interventions)
- Melbourne Sexual Health Centre (MSHC)
- Centre for Adolescent Health (CAH)
- Refuges such as Stopover
- Other drug and alcohol agencies for counselling

**Linkages**

Staff indicated that they are improving linkages with other services within the AOD and homeless sectors. For example, YPHS is part of the homelessness protocol working group which is looking at creating better connections between welfare, homeless, and health services to enhance cross-referrals. Over the past 12 months YPHS has also developed relationships with other SAPHS such as Living Room and YSAS.

### 4.2.7 Advocacy

Part of the role of YPHS is empowering young people to navigate the treatment system. Staff highlighted the importance of providing young people with knowledge about the services available, and their right to access services, and be treated with respect. As one staff member stated,

*We're here to inform and educate, advocate and lobby for better service provision to this demographic.*
5. **PROFILE OF SERVICE USERS**

Drawing upon three data sources, including registered and unregistered service utilisation data provided via DH for 2005 to 2007 and 2009, the group interview with staff from YPHS, and service users’ survey responses (n=5), this section describes the demographic profile of service users, and examines the reasons people present to YPHS.

Data were not available for the full 12 months in each year (see individual tables for details) therefore data only provides a conservative picture of service utilisation between 2005 and 2009 (excluding 2008).

**Data definitions and caveat**

Service use data reported in this section, and the service provision section (section 6), include registered contacts and unregistered contacts. According to the Department of Human Services ADIS Data Dictionary (version 4) a registered contact refers to a contact made by a ‘registered LDS PHS client (i.e. client details are stored)’(2008, p. 26), whereas an unregistered contact refers ‘to a contact made an unregistered client (i.e. no client details are stored)’(2008, p. 32). For the most part, these definitions are consistent with YPHS staffs’ interpretation and recording of a registered and unregistered contact. Staff at YPHS also highlighted that registered contacts refers to those people who attend the clinic, whereas outreach contacts are unregistered.

Despite general consensus on the meaning of registered and unregistered contacts, it is important to note that there are a number of caveats with these ADIS data and analyses presented in this, and the following section:

- Data are based on contacts not the actual number of registered YPHS service users. For example, one person may receive multiple interventions during the one visit, and each service ‘activity’ will be recorded.
- Due to the removal and inclusion of recording fields within health domains (i.e. specific service activity such as ‘Medical complications (e.g. abscess due to injecting)’ over the reporting period, conclusive trends are difficult to discern
- Limited information is available on some service activities as items such as ‘other’ are used

In summary, while ADIS data provides a useful indicator of services provided by YPHS, these finding are likely to be a conservative measure of service activities delivered.

### 5.1 Gender and age

Table 1 (see next page) shows the demographic profile of registered YPHS contacts. In 2005, approximately two thirds (62.8%) of registered contacts involved male service users, whereas in the following years males accounted for approximately half the registered contacts.

In 2005 and 2009 approximately one in three registered contacts involved people aged between 12 and 21 years, whereas in 2006 and 2007 approximately 90% of registered contacts were made by people aged 12 to 21 years.

Staff indicated that the age eligibility for other co-located services at Frontyard extends to people aged 25 years, whereas YPHS’ eligibility criteria comprise people aged up to 22. In cases where a person aged 23 to 25 is accessing other Frontyard services, and is unwell, YPHS will attend to the person’s health needs. YPHS is considering extending its age eligibility to 25 in line with other Frontyard services.
Consistent with youth service practices, YPHS supports service users approaching, and over, 22 years to transition to an appropriate adult service.

Table 1: Demographics for registered service users, YPHS, 2005-09

<table>
<thead>
<tr>
<th>Years</th>
<th>2005 (6 months)</th>
<th>2006 (9 months)</th>
<th>2007 (3 months)</th>
<th>2009 (4 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=239</td>
<td>n=294</td>
<td>n=187</td>
<td>n=109</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>37.2</td>
<td>47.6</td>
<td>46</td>
<td>45</td>
</tr>
<tr>
<td>Male</td>
<td>62.8</td>
<td>52.4</td>
<td>54</td>
<td>55</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-11</td>
<td>1.3</td>
<td>0.7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12-21</td>
<td>69</td>
<td>88.4</td>
<td>92.5</td>
<td>69.2</td>
</tr>
<tr>
<td>22-29</td>
<td>29.7</td>
<td>10.9</td>
<td>7.5</td>
<td>30.8</td>
</tr>
<tr>
<td>30-39</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>40-49</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>50-59</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>60 and older</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cultural background</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>93.7</td>
<td>91.5</td>
<td>78.1</td>
<td>92.7</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>2.5</td>
<td>1</td>
<td>20.3</td>
<td>0</td>
</tr>
<tr>
<td>North-East Asia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.9</td>
</tr>
<tr>
<td>Southern and Central Asia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>North-West Europe</td>
<td>0</td>
<td>0.7</td>
<td>1.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Southern and Eastern Europe</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1.8</td>
</tr>
<tr>
<td>North Africa</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Middle East</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Northern America</td>
<td>0</td>
<td>3.1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>South and Central America</td>
<td>1.3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Oceania and Antarctica</td>
<td>2.5</td>
<td>2.7</td>
<td>0</td>
<td>1.8</td>
</tr>
<tr>
<td>Indigenous status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Islander</td>
<td>5</td>
<td>9.2</td>
<td>1.1</td>
<td>5.5</td>
</tr>
<tr>
<td>Not Aboriginal nor Torres Strait</td>
<td>93.3</td>
<td>90.8</td>
<td>94.7</td>
<td>94.5</td>
</tr>
<tr>
<td>Not stated</td>
<td>1.7</td>
<td>0</td>
<td>4.3</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Department of Health, ADIS, September 2010
Note: Data for 2008 and 2010 not available via DH
5.2 Cultural background

Apart from 2007, in which approximately 20% of registered contacts involved service users recorded as being born in South-East Asia, less than 10% of registered contacts were made by service users born outside Australia.

According to staff at YPHS, the number of Horn of African people making contact with the service has slightly increased since 2006. As Table 1 shows, in 2009 contacts by young people born in sub-Saharan Africa accounted for less than 2% of registered contacts, however in previous years this category did not register in the statistics. While staff acknowledged the small number of young people from African countries accessing the service, they felt these young people face ‘triple-disadvantage’. Also, accessing a non-refugee type service is the often the preferred option. As one YPHS staff member explained,

They’re actually incredibly estranged from their cultural community and the idea of having a worker that’s from their cultural community, the community that they’re estranged from, seems to be a real conflict for them. There’s a lot more rejection issues and there’s a lot of loss and there’s a lot of abandonment and there’s grief and there’s a real desire to engage with a non-refugee service.

Approximately 5% of registered service users identified as Aboriginal or Torres Strait Islander in 2005 and in 2009.

5.3 Reasons for accessing YPHS

As part of the service user survey, participants were asked to indicate reasons for initially contacting YPHS. While the sample was small (n=5), the responses varied from a general health enquiry (e.g. ‘proof of pregnancy certificate’, ‘back pain’), to support and assistance (e.g. ‘homeless’, ‘to talk to someone’). A further participant accessed YPHS due to its good reputation (i.e. ‘heard they were very good and helpful’). These responses were similar to those reported by the overall sample of survey users who commonly reported that the main reason for accessing SAPHS was for medical assistance and social or psychological support.

Participants were asked how often they attended YPHS, and responses ranged from a few times a week to a few times a year.
5.4 Presenting issues

As Table 2 shows, general health was the most common presenting issue for unregistered contacts at YPHS, although the proportion ranged from 57.9% in 2005, to 22.6% in 2007. Information seeking was the second most common presenting issue in 2009, accounting for 16% of unregistered contacts. Other common presenting issues were: dental; drug treatment; mental health; and sexual health. The volume of contacts for these issues fluctuated from year to year.

<table>
<thead>
<tr>
<th>Years</th>
<th>2005 (6 months)</th>
<th>2006 (9 months)</th>
<th>2007 (2 months)</th>
<th>2009 (6 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=270</td>
<td>n=320</td>
<td>n=150</td>
<td>n=296</td>
</tr>
<tr>
<td>General Medical/General Health</td>
<td>57.9</td>
<td>32.4</td>
<td>22.6</td>
<td>32.1</td>
</tr>
<tr>
<td>Information Seeking</td>
<td>0</td>
<td>0</td>
<td>9.4</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>2.1</td>
<td>28.5</td>
<td>6.6</td>
<td>14.9</td>
</tr>
<tr>
<td>Dental</td>
<td>3.2</td>
<td>3.4</td>
<td>0.9</td>
<td>12.3</td>
</tr>
<tr>
<td>Drug Treatment Required</td>
<td>0</td>
<td>5.3</td>
<td>19.8</td>
<td>9.7</td>
</tr>
<tr>
<td>Mental Health</td>
<td>5.3</td>
<td>1.9</td>
<td>15.1</td>
<td>6</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>6.3</td>
<td>18.4</td>
<td>0</td>
<td>4.9</td>
</tr>
<tr>
<td>Other Wound</td>
<td>4.2</td>
<td>2.4</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Employment/Training</td>
<td>5.3</td>
<td>1.4</td>
<td>0.9</td>
<td>1.1</td>
</tr>
<tr>
<td>Excess Consumption/OD</td>
<td>2.1</td>
<td>1.9</td>
<td>0.9</td>
<td>0</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>0</td>
<td>0.5</td>
<td>14.2</td>
<td>0</td>
</tr>
<tr>
<td>Housing</td>
<td>7.4</td>
<td>1.4</td>
<td>4.7</td>
<td>0</td>
</tr>
<tr>
<td>Hygiene</td>
<td>5.3</td>
<td>0.5</td>
<td>4.7</td>
<td>0</td>
</tr>
<tr>
<td>OBSOLETE - BBV (excluding HepC)</td>
<td>0</td>
<td>1.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vein Care</td>
<td>1.1</td>
<td>0.5</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Department of Health, ADIS, September 2010

Note: Items with no contacts reported in any of the four years have been deleted from the table. These activities include: OBSOLETE—Financial; HIV; and Legal.

According to staff, young people typically access Frontyard seeking support and assistance with housing, however more often than not, young people have complex and inter-related issues associated with mental health, substance use and past trauma along with housing instability. One staff member explained,

*People have presented here because of a housing issue. What's the most blindingly obvious thing we've got to fix today, it's the housing issue. After that, drug and alcohol comes up because you're using it to escape reality. You're escaping reality because you're having nightmares; your nightmares are to do with mental health issues. Mental health issues have been compounded by sleep deprivation which all goes back to your housing.*

Given the co-occurring issues, staff reported that the young people were ‘beyond school counsellors and GP clinics' and required support from specialist services.

5.4.1 Substance use

Staff reported they are not seeing as many young people who inject drugs compared with 2006. Consistent with 2006, alcohol use and poly drug use, were common among young people presenting to YPHS.

*Alcohol remains our biggest problem. It always has been really, and poly drug use.*
Other drugs commonly used by young people accessing YPHS include cannabis, prescription medication and amphetamines. Prescription medicines are either sourced from a GP or obtained illegally. People are also known to ‘swap’ prescription medication with peers. Common prescription drugs include: Seroquel® (an antidepressant), and minor tranquillisers (e.g. Serapax®, Vallium®) and to a lesser extent Xanex® and Ritalin®. YPHS staff make a conscious decision not to prescribe Xanex®, as a way to avoid an influx of requests from young people. As staff mentioned, ‘I think if we do prescribe them [Xanex®], we'd probably get just about every young person on our doorstep’.

Staff spoke about a small group of young people who use inhalants, however few of these young people engage with services.

5.5 Benefits and outcomes

Staff made the clear distinction that the purpose of the service is not to provide ‘drug treatment’ but is focused on reducing harm and working with ‘pre-contemplators, contemplators and relapses’. This is consistent with the service approach described in 2006 (Norman, 2006).

According to staff, a key benefit of YPHS is providing young people with a positive experience of a health service, whereby a person's health is assessed from a holistic framework underpinned by a strong commitment to non-judgemental support, care co-ordination and increasing a person's health literacy. As one staff member noted,

Because some people don't want to access a health clinic because they believe they're going to be perceived in a certain fashion and I think that's something that this facility does really well. You come in, you have a really positive experience of what it's like to engage with a health practitioner. Then you might be more inclined to actually attend that appointment at the Children's or at the Melbourne or at St V's.

As part of the survey, participants were asked if they thought their health was improving and all five young people reported this was the case.
5.6 Service users’ experience of the service

Survey participants (n=5) were asked to report any positive and challenging aspects associated with attending YPHS, as well as reasons for returning to the service. They were also asked to indicate what services they would attend if YPHS was not available.

The positive aspects of the service reported by survey participants included the friendliness of staff, staff’s helpful and respectful approach and the accessible location of the service.

*The fact that they are friendly, polite and helpful in many different ways and have informed me on what’s happening.*

Service users were also given the opportunity to report aspects of YPHS they didn’t like, and while most did not respond or reported ‘nothing’ one participant noted the limited available of medical staff (e.g. ‘there aren’t doctors/ nurse at some points of the day’).

Reasons associated with returning to the service related to the level of support and help received from staff, feeling comfortable at the service, and it’s accessibility (e.g. ‘because it’s easy’, ‘don’t need an appointment’).

*Because I like this service, think they are great.*

*Because they are one of the best help and I feel comfortable coming here.*

In response to the question ‘If YPHS was not available, where would you go instead?’, three participants provided a response and all indicated they would access an alternative service (e.g. ‘Salvos’, ‘Action Centre’, ‘GP’).
6. SERVICE PROVISION

This section outlines the range of services provided at YPHS. Data include registered and unregistered service utilisation data from 2005 until 2009 (excluding 2008), staff interviews and service user survey data. Health domains reported in this section include: AOD-related services; counselling services; general health; sexual health; blood borne virus-related services; and practical services.

As noted previously, service utilisation data via ADIS were not available for the 12 months of the following years: 2005-2007, and 2009. Given the incompleteness of data across the reporting period, trends are suggestive at best.

Overview of services provided at YPHS

YPHS provides a range of health services including: comprehensive health screening and assessment, harm minimisation risk assessment and education; pre/post HIV/Hep C test counselling; immunisations for health conditions such as hepatitis B, and rubella; emergency contraception; treatment of sexually transmitted infections (STIs); treatment of acute health conditions such as viral infections; wound care and skin related infections; mental health crisis response and support; specialist health referral and advocacy (The Royal Children's Hospital, 2010).

Table 3 (next page) provides an outline of service availability. The range of services and their availability as of October 2010 closely mirrors the services available in 2006. As noted previously, the clinic services are now available from 11am, as opposed to midday.

Table 3: Services provided by YPHS

<table>
<thead>
<tr>
<th>Service</th>
<th>Hours available per week</th>
<th>Times available</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>3 hours</td>
<td>2 – 5 pm Wed</td>
</tr>
<tr>
<td>Nurse (Youth Health) 2.8 positions</td>
<td>80 hours</td>
<td>Mon - Fri</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>15 hours</td>
<td>Mon - Fri</td>
</tr>
<tr>
<td>Dietary advice</td>
<td>25 hours</td>
<td>11am – 5pm Mon - Fri</td>
</tr>
<tr>
<td>Women’s health care</td>
<td>25 hours</td>
<td>11am - 5pm Mon-Fri</td>
</tr>
<tr>
<td>Counselling</td>
<td>15 hours</td>
<td>1.40 - 5pm Mon, Wed &amp; Fri</td>
</tr>
<tr>
<td>Other Adolescent Fellow (medical)</td>
<td>3 hours</td>
<td>2- 5pm Mon</td>
</tr>
<tr>
<td>Outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td>At Frontyard</td>
<td>Fruit – most days</td>
</tr>
<tr>
<td>Material support; Shower access</td>
<td>At Frontyard</td>
<td>Limited</td>
</tr>
<tr>
<td>Access to a telephone; Mail pickup; Tea &amp; coffee facilities</td>
<td>At Frontyard</td>
<td>7 days per week 10am – 8pm</td>
</tr>
</tbody>
</table>

Source: YPHS, April 2006, and updated in October 2010. Only funded A&D services shown in table.

6.1 Volume of contacts

Table 4 shows the occasions, reason for service, and referral source for registered contacts at YPHS, from 2005 to 2009. As data are not available for the full 12 months of each year, it is difficult to assess trends in the volume of registered contacts at YPHS over time.

According to staff approximately 45-50 service users access the health care team (HCT) per week, and this is consistent with contacts reported in 2006. Outreach contacts, which are not captured in ADIS, range from two to 12 per outreach posting.

Staff also reported that the number of contacts on a given day varies and is often associated with the service schedule. For example, more young people may present on a day when the care
co-ordinator/counsellor is available. Staff estimated that approximately 10 to 16 people contact the service on an average day, and the average monthly volume of contacts may vary from 100 to 240.

Staff noted that the number of contacts in the previous 12 months was below average, the service is continuously working on strategies to increase accessibility and contact with young people (e.g. outreach to Living Room, networking with other services, promoting the service).

I would say overall in the last year our contacts have gone down but we are turning that around this year.

Based on the available data, the two most common reasons for contact with YPHS were ‘new client’ and ‘new issue’. The proportion of contacts recorded as a ‘new client’ has gradually declined from 45.6% in 2005 to 28.4% in 2009. Similarly, the proportion of contacts for ‘new issue’ declined from 50.2% of contacts in 2005 to 34.9% in 2009. Contacts recorded as ‘ongoing management’ increased overtime from no record of ‘ongoing management’ as a reason for service in 2005 and 2006, to 26.7% of contacts in 2007 and 34.9% in 2009. This indicated that a proportion of service users are engaged with the service over a period of time. The vast majority of contacts were recorded as ‘self-referral’, accounting for 75% of contacts in 2005 and 80% and higher in the following years (see Table 4, next page).

Table 4: Occasions of service for registered contact, YPHS, 2005-09

<table>
<thead>
<tr>
<th>Reasons of service</th>
<th>2005 (6 months)</th>
<th>2006 (9 months)</th>
<th>2007 (3 months)</th>
<th>2009 (4 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New client</td>
<td>45.6%</td>
<td>38.4%</td>
<td>30.5%</td>
<td>28.4%</td>
</tr>
<tr>
<td>New issue</td>
<td>50.2%</td>
<td>54.4%</td>
<td>42.8%</td>
<td>34.9%</td>
</tr>
<tr>
<td>Ongoing management</td>
<td>0.2%</td>
<td>0.2%</td>
<td>11.4%</td>
<td>34.9%</td>
</tr>
<tr>
<td>Referral to other service</td>
<td>1.7%</td>
<td>1.7%</td>
<td>0.2%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Only</td>
<td>2.5%</td>
<td>5.4%</td>
<td>0.2%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Referral source</td>
<td>239</td>
<td>294</td>
<td>187</td>
<td>109</td>
</tr>
<tr>
<td>Needle &amp; Syringe Program</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Self</td>
<td>75.7%</td>
<td>88.8%</td>
<td>91.4%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Primary Health Outreach Worker</td>
<td>10.5%</td>
<td>0.3%</td>
<td>1.6%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Other</td>
<td>13.8%</td>
<td>10.9%</td>
<td>7.2%</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

Source: Department of Health, ADIS, September 2010

Based on the two quarterly data reports for 2010, over 400 contacts were recorded between January and March 2010, and this increased to over 450 contacts in the following three months (April-June). This level of activity is in line with service targets.

Table 5: Contacts and registered clients seen, YPHS January-June 2010

<table>
<thead>
<tr>
<th></th>
<th>January – March 2010</th>
<th>April-June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of contacts</td>
<td>54</td>
<td>121</td>
</tr>
<tr>
<td>Total registered</td>
<td>56</td>
<td>121</td>
</tr>
<tr>
<td>clients seen</td>
<td>380</td>
<td>356</td>
</tr>
<tr>
<td>Number of contacts</td>
<td>356</td>
<td>356</td>
</tr>
</tbody>
</table>

Source: YPHS, Community and Women’s Health – Quarterly data return forms: Primary Health Report

Notes: PHS service activities are reported against funding sources. a) refers to the Community Health Program and b refers to the Innovative Health Services for Homeless Youth. In terms of nursing contacts, the majority of contacts are recorded against CHP (87% in Jan-Mar; 97% in April-June).
6.2 AOD-related services

Given the substantial changes in the recording of AOD-related activities over the reporting period, especially changes between 2006 and 2008 (for example, replacing ‘counselling/information/assessment’ with ‘A&D counselling’ and ‘A&D Assessment’) it is difficult to discern actual trends in service delivery. However, data over the five year period indicate that the most common AOD-related services provided to registered contacts were: counselling / information / assessment; A&D counselling; A&D Assessment. Together these activities accounted for approximately two thirds of contacts in 2005, 2006 and 2007, and approximately 50% of contacts in 2009. Referrals to other AOD services, namely a treatment service, and providing information and education related to injecting drug use were also common AOD-related services (see Table 6).

During the site visit interview, staff reported ‘little demand for pharmacotherapy’ among young people presenting to YPHS. Staff felt this was a combination of various factors including lower levels of heroin use among young people compared to adults, limited understanding among young people of the breadth of pharmacotherapy options (e.g. cannabis withdrawal), and young people’s substance use history. For young people seeking AOD treatment, YPHS typically refers young people to YSAS.

### Table 6: AOD related services provided to registered clients, YPHS, 2005-09

<table>
<thead>
<tr>
<th>Services</th>
<th>2005 (6 months)</th>
<th>2006 (9 months)</th>
<th>2007 (2 months)</th>
<th>2009 (4 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;D Counselling</td>
<td>10.6</td>
<td>0</td>
<td>23.4</td>
<td>35.9</td>
</tr>
<tr>
<td>Referral to GP / Specialist</td>
<td>0</td>
<td>0</td>
<td>4.3</td>
<td>15.4</td>
</tr>
<tr>
<td>A&amp;D Assessment</td>
<td>1.5</td>
<td>0</td>
<td>14.9</td>
<td>12.8</td>
</tr>
<tr>
<td>OBSOLETE - Counselling / information / assessment</td>
<td>54.5</td>
<td>62.7</td>
<td>23.4</td>
<td>0</td>
</tr>
<tr>
<td>Referral to drug treatment service</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12.8</td>
</tr>
<tr>
<td>IDU information / education (incl. BBV, safe use)</td>
<td>10.6</td>
<td>11.9</td>
<td>17</td>
<td>10.3</td>
</tr>
<tr>
<td>Management of drug withdrawal</td>
<td>1.5</td>
<td>1.7</td>
<td>0</td>
<td>7.7</td>
</tr>
<tr>
<td>Advocacy / Referral for pharmacotherapy elsewhere</td>
<td>1.5</td>
<td>0</td>
<td>6.4</td>
<td>5.1</td>
</tr>
<tr>
<td>OBSOLETE - Referral for other A&amp;D services</td>
<td>18.2</td>
<td>13.6</td>
<td>10.6</td>
<td>0</td>
</tr>
<tr>
<td>OBSOLETE - Medical complications (e.g. abscess due to injecting)</td>
<td>0</td>
<td>1.7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OBSOLETE - Referral for Buprenorphine elsewhere</td>
<td>0</td>
<td>1.7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OBSOLETE - Referral for deter (all drugs)</td>
<td>1.5</td>
<td>3.4</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Department of Health, ADIS, September 2010
Note: Items with no contacts reported in any of the four years have been deleted from the table. These activities include: OBSOLETE – Methadone or Buprenorphine assessment; OBSOLETE – Methadone or Buprenorphine review; Pharmacotherapy

**AOD services accessed by YPHS survey participants**

As part of the survey, participants were asked if they had accessed one or more (or none) of five specific AOD services. Of the five services listed, only one participant responded, and they had obtained information about safer injecting practices.
6.3 Counselling services

As Table 7 shows, general counselling has remained the most commonly provided counselling service between 2005 (50%) and 2009 (53.7%), with relatively consistent rates of provision within this period. Mental health issues accounted for the second most common counselling-related service in 2009 (18.5%), however this item was only introduced as a specific recording field post 2007. It is likely that counselling for mental health issues was recorded under ‘general’ or ‘other’ counselling prior to 2007. Referrals to mental health services reduced from 25% in 2005 to 13% in 2009, as did the provision of crisis counselling, which decreased from 20.8% in 2005 to 5.6% in 2009. Due to changes in the reporting fields, it is difficult to discern if the decrease in crisis counselling is a reflection on presentations or data recording practices.

### Table 7: Counselling services provided to registered clients, YPHS, 2005-09

<table>
<thead>
<tr>
<th></th>
<th>2005 (6 months)</th>
<th>2006 (9 months)</th>
<th>2007 (2 months)</th>
<th>2009 (4 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=24</td>
<td>n=30</td>
<td>n=16</td>
<td>n=54</td>
</tr>
<tr>
<td>General counselling</td>
<td>50</td>
<td>56.7</td>
<td>62.5</td>
<td>53.7</td>
</tr>
<tr>
<td>Mental health issues</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>18.5</td>
</tr>
<tr>
<td>Referral to mental health service</td>
<td>25</td>
<td>16.7</td>
<td>12.5</td>
<td>13</td>
</tr>
<tr>
<td>Crisis counselling</td>
<td>20.8</td>
<td>13.3</td>
<td>12.5</td>
<td>5.6</td>
</tr>
<tr>
<td>Referral to GP / Specialist</td>
<td>0</td>
<td>0</td>
<td>6.3</td>
<td>3.7</td>
</tr>
<tr>
<td>Physical assault (incl. domestic violence)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>Sexual assault (&lt;16 yrs)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>Relationship counselling</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1.9</td>
</tr>
<tr>
<td>Child protection issues</td>
<td>4.2</td>
<td>0</td>
<td>6.3</td>
<td>0</td>
</tr>
<tr>
<td>OBSOLETE - Other counselling</td>
<td>0</td>
<td>13.3</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Department of Health, ADIS, September 2010

Note: Items with no contacts reported in any of the four years have been deleted from the table. These activities include: OBSOLETE - Referral to Child Protection Services; Referral to sexual assault service (e.g. CASA); Serious mental illness; Sexual assault (>16 yrs); Sexuality / Gender issues

The capacity of YPHS to provide a counselling service has increased over the past 18 months. According to staff, the service evaluated and revised the counselling care model, and a counselling service is now available three afternoons a week. The increased capacity is also associated with the recent employment of a counsellor/case co-ordinator. Staff reported that the revised model is beneficial, with an increase of referrals to the service, as well as overall contacts for counselling-related services. As staff noted,

> [The counsellor/case co-ordinator] has transformed that role and is actually over-performing in terms of stats and has been able to change the relationships with staff and so people look for her service and are really keen to engage and refer. And young people are coming back and so it’s obviously a way more responsive approach.

The new counselling model has also enhanced the service’s capacity to identify and respond to mental health concerns, and facilitate appropriate referrals.

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4 This role is primarily a care co-ordination role.
### 6.4 General health

The most common general health services provided to registered YPHS service users from 2005 to 2009 was ‘other general health’. This service accounted for close to half the general health contacts in 2005, and declined to approximately 25% in 2009. The second most common general health service provided in 2009 was referral to a GP or specialist (24.3%). Prior to 2009, referral to a GP or specialist accounted for less than 6% of contacts (see Table 8).

Within the context of providing general health services, staff emphasised the importance and benefit of working from a holistic health and harm reduction framework. Staffs’ ability to tailor interventions and approaches to young people was also highlighted. The following quote provides a good illustration of the approach taken at YPHS.

> I had a young person come in and say, ‘oh, I’ve got deranged LFTs, I don’t know what that means’. I said, ‘you’re drinking to a point where you’re causing liver damage’. They’re going, ‘what does that mean?’ It’s like, ‘here’s a picture book’. Then if you have a dialogue about it, for example, if you take GHB and alcohol and you’re at a nightclub and your friends disappear and you’re in the toilets, there’s a high risk of sexual assault. That seems more immediate to them than someone saying, ‘you’ve got raised LFTs, you need to think about fatty liver’ - it doesn’t register when you’re 19

### Table 8: General health services provided to registered clients, YPHS, 2005-09

<table>
<thead>
<tr>
<th>Service</th>
<th>2005 (6 months)</th>
<th>2006 (9 months)</th>
<th>2007 (2 months)</th>
<th>2009 (4 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=49</td>
<td>n=49</td>
<td>n=34</td>
<td>n=148</td>
</tr>
<tr>
<td>Other general health</td>
<td>42.9</td>
<td>51</td>
<td>29.4</td>
<td>25.7</td>
</tr>
<tr>
<td>Referral to GP / Specialist</td>
<td>4.1</td>
<td>0</td>
<td>5.9</td>
<td>24.3</td>
</tr>
<tr>
<td>Pathology collection</td>
<td>0</td>
<td>0</td>
<td>2.9</td>
<td>12.8</td>
</tr>
<tr>
<td>Physical assault – acute</td>
<td>10.2</td>
<td>4.1</td>
<td>8.8</td>
<td>10.1</td>
</tr>
<tr>
<td>Skin disorder (incl. scabies / lice)</td>
<td>8.2</td>
<td>4.1</td>
<td>11.8</td>
<td>6.8</td>
</tr>
<tr>
<td>Respiratory Issues</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6.1</td>
</tr>
<tr>
<td>Wound dressing / tissue trauma</td>
<td>6.1</td>
<td>10.2</td>
<td>5.9</td>
<td>5.4</td>
</tr>
<tr>
<td>Podiatry</td>
<td>0</td>
<td>0</td>
<td>2.9</td>
<td>2.7</td>
</tr>
<tr>
<td>Vaccination</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2.7</td>
</tr>
<tr>
<td>Dental problems / referral</td>
<td>8.2</td>
<td>10.2</td>
<td>11.8</td>
<td>1.4</td>
</tr>
<tr>
<td>Serious mental illness</td>
<td>8.2</td>
<td>8.2</td>
<td>11.8</td>
<td>0</td>
</tr>
<tr>
<td>Mental health assessment</td>
<td>0</td>
<td>0</td>
<td>2.9</td>
<td>0.7</td>
</tr>
<tr>
<td>Prescription (not pharmacotherapy)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.7</td>
</tr>
<tr>
<td>Referral to allied health</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.7</td>
</tr>
<tr>
<td>OBSOLETE - Asthma</td>
<td>4.1</td>
<td>0</td>
<td>2.9</td>
<td>0</td>
</tr>
<tr>
<td>OBSOLETE - Gastrointestinal (not)</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OBSOLETE – Respiratory tract infection</td>
<td>6.1</td>
<td>4.1</td>
<td>2.9</td>
<td>0</td>
</tr>
<tr>
<td>Sexual assault – acute</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vein Care</td>
<td>0</td>
<td>6.1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Department of Health, ADIS, September 2010

Note: The following variables became obsolete in 2008, and were recorded as different variables: Asthma; Gastrointestinal (not hepatitis); Respiratory tract infection
**Allied health in-reach services**

Despite the low number of registered contacts reported via ADIS for dental health (e.g. 1.4% in 2009), staff indicated that dental care is one aspect of health that young people require, but do not readily present for. As a way to promote and increase young people’s access to dental services, YPHS established a link with the dental program provided and funded by Inner South Community Health Services (ISCHS). At the time of the site visit, an ISCHS dentist conducted dental assessments at YPHS once a fortnight. Following the assessment, an appointment is made for the young person to visit the dentist at ISCHS for any further assessments and dental treatment. According to staff, having the same practitioner conduct the assessment and treatment enhances the continuity of care and likelihood of the young person attending ISCHS for dental work. This example illustrates the ability of YPHS to create health care opportunities for young people by utilising external services, and tailoring practices to increase engagement.

Similarly, YPHS, staff has established links with external services to facilitate young peoples’ access to podiatry and dietary services via Doutta Galla Community Health Service. Staff indicated that while access to Doutta Galla Community Health Service’s (DGCHS) podiatrist and dietician extends the health service opportunities for young people presenting to YPHS, the DGCHS team is quite stretched and access is often limited. YPHS is currently advocating for the podiatry service to become ‘a more regular option’ for YPHS service users.

> You can imagine the need for podiatry. That’s difficult too because we’re not doing treatments here for podiatry where they could be.

**General health services accessed by YPHS survey participants**

As part of the survey, participants were asked if they had accessed one or more (or none) of three specific general health services. All five participants had seen a nurse or a health worker and three participants had spoken to a YPHS staff member about their mental health. One participant had seen a counsellor while at the YPHS, and one participant they had wounds dressed or treated at YPHS.
6.5 Sexual health

The current ADIS structure for sexual health includes activities previously recorded under the following sections: gynae; transgender; sexually transmitted infection (STI) diagnosis, and sexual health. The 2009 ADIS table for sexual health included 35 items; however these have been grouped into 11 sexual health service activities to aid reporting.

STI-related health and pregnancy and/or contraception were the two most common sexual health services delivered to registered contacts in 2009. STI-related services accounted for approximately a third of the sexual health service delivered to registered contacts in 2009, rising from 19.7% in 2005. Registered contacts for pregnancy and/or contraction-related health services gradually increased from 9.8% in 2005 to 23.4% in 2009. Sexual health information/education was the third most commonly provided service in 2009 (35.1%) whereas, in 2005 to 2007 it was the most common service (51%, 48.6% and respectively) (see Table 9).

| Table 9: Sexual health services provided to registered clients, YPHS, 2005-09 |
|---|---|---|---|---|
|  | 2005 (6 months) | 2006 (9 months) | 2007 (2 months) | 2009 (4 months) |
|  | n=51 | n=74 | n=37 | n=60 |
| STI-related screen /treatment/follow-up | 19.7 | 0 | 32.4 | 36.7 |
| Pregnancy/contraception | 9.8 | 17.6 | 16.2 | 23.4 |
| Sexual health information / education (incl. HIV and reproduction) | 51 | 48.6 | 35.1 | 18.3 |
| Referral to GP / Specialist | 0 | 0 | 2.7 | 15 |
| Ante/post natal care | 7.8 | 2.7 | 5.4 | 5 |
| Gynae problems | 5.9 | 6.8 | 5.4 | 1.7 |
| OBSOLETE - Asymptomatic screen (swabs) | 3.9 | 21.6 | 0 | 0 |
| Pap smear / breast check | 2 | 0 | 2.7 | 0 |
| OBSOLETE - Worker screen | 0 | 2.7 | 0 | 0 |

Source: Department of Health, ADIS, September 2010

Notes:

a) Subtotal for STI-related screen /treatment/follow-up includes 13 items: OBSOLETE - Recurrent NSU; OBSOLETE - First diagnosis of Herpes Simplex Virus (HSV) at the Centre (whether primary or recurrent) OBSOLETE - Further episodes or treatment of genital warts after previous episode/s recorded at the Centre; OBSOLETE - HSV recurrence after previous episode already noted at the Centre; Chlamydia; Gonorrhoea; OBSOLETE - First diagnosis of genital warts at the Centre; Other infection / condition (Incl. STIs); OBSOLETE Trichomonas OBSOLETE - Vaginal candida Review / follow up of STI; STI SCREEN; STI screen

b) Subtotal for pregnancy/contraception includes three items: contraception advice/prescription; pregnancy & contraceptive advice / prescription (obsolete post 2007); pregnancy testing/counselling

c) Subtotal for sexual health information / education (incl. HIV and reproduction) includes one item: Sexual health information / education (incl. HIV and reproduction)

d) Subtotal for Referral to GP / Specialist includes two items: Referral to GP / Specialist; OBSOLETE - Referral to GP / Specialist

e) Subtotal for Ante/post natal care includes four items: antenatal care; referral to antenatal care; antenatal care / referral (obsolete post 2007) and post natal care

f) Subtotal for gynae problems includes five items: All other gynae problems; Menstrual irregularity (obsolete post 2007); Pelvic pain (not PID) (obsolete post 2006); PID (obsolete post 2007); and TOP referral (obsolete post 2007).

g) Subtotal for Pap smear / breast check includes three items: Pap smear / breast check; repeat pap for abnormality (obsolete post 2006) ;routine pap / breast check (obsolete post 2007)
Staff indicated that young people seem to be more willing to discuss sexual health issues with staff, and undergo tests for STIs at YPHS as there is less stigma attached to presenting to a primary health service as opposed to a specific sexual health service.

_We’re not a drug specific agency and we’re not a sexual health specific agency, so we actually have people coming to us to have their sexual health screen because we’re not a sexual health agency. So there’s no stigmatism, we just do it._

Furthermore, staff considered the large number of screening tests conducted for STI is an indicator that clinicians are discussing sexual health with young people and young people have given informed consent for the tests to be performed.

_The fact that we’re being able to screen means that the people are being informed. You can’t screen unless you’re informed. If you’re happy to be screened, that means that we’ve obviously given you enough information._

In addition to the STI tests, staff also indicated that a number of the nursing staff are authorised to provide medication such as Azithromycin® for chlamydia. This means that young people receive immediate access to treatment as opposed to accessing a GP.

**Sexual health services accessed by YPHS survey participants**

Three of the five survey participants had discussed their sexual health with a YPHS staff member.
6.6 **Blood borne virus-related services**

This section covers hepatitis-related services, and HIV-related services. Hepatitis vaccination, as well as Hepatitis C testing, treatment and support, were identified as priority areas to explore within the review and are discussed in this section.

### 6.6.1 Hepatitis-related services

As Table 10 shows, information and/or education was the most common hepatitis–related service provided to registered contacts from 2005 to 2009. Pre-test counselling was the second most common hepatitis-related service (22.2%) in 2009 followed by referral to GP/Specialist, hepatitis testing and vaccination (11.1%).

In 2005 and 2006, testing for hepatitis C was among the most common hepatitis-related services provided at YPHS, however post 2007, this item became obsolete. While the number of contacts post 2006 for hepatitis C testing cannot be discerned from the available ADIS data, staff reported that a similar number of hepatitis screening tests were conducted in 2009 compared to 2006. Hepatitis C testing and post-counselling is also considered an important part of the YPHS health service response. While very few young people were engaged in hepatitis C treatment, the YPHS staff provided ongoing management and monitoring services to service users who returned to the clinic.

![Table 10: Hepatitis-related services provided to registered clients, YPHS, 2005-09](image)

As part of the interview, staff were specifically asked about the provision of hepatitis B vaccinations. Staff indicated that hepatitis B vaccinations are administered, however providing young people with the recommended three vaccinations within the required period of time is a challenge given the high level of mobility among this client group. Staff also highlighted the importance of viewing each contact as an opportunity to offer and provide information and different interventions to improve the health outcomes for service users. As one staff member reported,

*It's part of every clinical contact potentially, but you've just got to make it easy for them. So if they are here, they've got all this stuff going on, if they are offered a vaccination, a lot of them will take it up.*

Staff made the point that on one level health promotion activities such as hepatitis B vaccinations, while a valuable preventative measure, may not be an immediate priority for presenting young people.
6.6.2 HIV-related services

From 2005 to 2009, pre and post-test HIV/AIDS counselling was the most common HIV-related service provided to registered service users attending YPHS. The proportion of registered contacts for this service fluctuated over time. Information and/or education, and HIV/AIDS counselling (not including pre and post counselling) were also common HIV-related services. It is important to note however, the low number of overall contacts for HIV-related services (i.e. less than 25 registered contacts each year) and the changes in the reporting of service activities within this domain over time (e.g. ‘pre & post test HIV/AIDS counselling’ became obsolete post 2007, and was replaced by two reporting items: pre-test counselling and post-test counselling) (see Table 11).

Table 11: HIV-related services provided to registered service users, YPHS, 2005-09

<table>
<thead>
<tr>
<th>Services</th>
<th>2005 (6 months)</th>
<th>2006 (9 months)</th>
<th>2007 (2 months)</th>
<th>2009 (4 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-test counselling</td>
<td>0.00</td>
<td>0.00</td>
<td>25.00</td>
<td>53.33</td>
</tr>
<tr>
<td>Information / Education</td>
<td>16.70</td>
<td>0.00</td>
<td>37.50</td>
<td>33.33</td>
</tr>
<tr>
<td>Post-test counselling</td>
<td>0.00</td>
<td>0.00</td>
<td>12.50</td>
<td>6.70</td>
</tr>
<tr>
<td>Referral to GP / Specialist</td>
<td>0.00</td>
<td>4.80</td>
<td>0.00</td>
<td>6.70</td>
</tr>
<tr>
<td>Counselling re HIV/AIDS (not including pre/post-test counselling)</td>
<td>41.70</td>
<td>19.00</td>
<td>18.80</td>
<td>0.00</td>
</tr>
<tr>
<td>OBSOLETE - Pre &amp; post-test HIV / AIDS counselling*</td>
<td>41.70</td>
<td>76.20</td>
<td>6.30</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Source: Department of Health, ADIS, September 2010
Note: Items with no contacts reported in any of the four years have been deleted from the table. These activities include: Medical monitoring (e.g. blood tests); First HIV diagnosis; Treatment of HIV-related illness

6.7 Practical services

Table 12 (registered contacts) shows that material and/or financial assistance and practical assistance and/or supported referral were the most common practical support services provided at the YPHS over the years. Registered contacts for practical assistance/supported referrals increased from 15.4% in 2005 to 40.0% in 2009, and contacts for material/financial assistance fluctuated. Other common practical support services provided via YPHS (permanent or in-reach services) include assistance with legal issues, accommodation referrals and alternative therapy.

Table 12: Practical support and natural therapy services provided to registered clients, YPHS, 2005-09

<table>
<thead>
<tr>
<th>Services</th>
<th>2005 (6 months)</th>
<th>2006 (9 months)</th>
<th>2007 (2 months)</th>
<th>2009 (4 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical assistance/supported referral</td>
<td>15.40</td>
<td>18.20</td>
<td>30.80</td>
<td>40.00</td>
</tr>
<tr>
<td>Material / financial assistance</td>
<td>23.10</td>
<td>45.50</td>
<td>7.70</td>
<td>30.00</td>
</tr>
<tr>
<td>Food and nutrition</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Alternative therapy (eg naturopathy, massage, acupuncture)</td>
<td>15.40</td>
<td>0.00</td>
<td>15.40</td>
<td>0.00</td>
</tr>
<tr>
<td>Assistance with housing</td>
<td>0.00</td>
<td>0.00</td>
<td>7.70</td>
<td>0.00</td>
</tr>
<tr>
<td>Assistance with legal issues</td>
<td>15.40</td>
<td>9.10</td>
<td>23.10</td>
<td>0.00</td>
</tr>
<tr>
<td>OBSOLETE - Referral re accommodation</td>
<td>15.40</td>
<td>9.10</td>
<td>15.40</td>
<td>0.00</td>
</tr>
<tr>
<td>OBSOLETE - Referral re education / training / employment</td>
<td>7.70</td>
<td>18.20</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>OBSOLETE – Showers</td>
<td>7.70</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Source: Department of Health, ADIS, September 2010
Note: Items with no contacts reported in any of the four years have been deleted from the table.
Consistent with previous years, information was the most common practical service provided to unregistered service users in 2009 (37.8%). Other (unspecified) was the second most common practical service in 2009 (21.7%), followed by education (17.4%), and general nursing (13%) (see Table 13).

Practical services are considered as important as health services within the holistic approach to healthcare. As one staff noted,

*It's not just physical health it's about spiritual and emotional health. You're going to feel disempowered if you can't get a job. You can't get a job if you can't write a CV.*

| Table 13: Services provided to unregistered clients, YPHS, 2005-09 |
|---------------------------------------------|----------------|----------------|----------------|----------------|
|                                           | 2005 (6 months) | 2006 (9 months) | 2007 (2 months) | 2009 (6 months) |
|                                           | n=246          | n=322          | n=142          | n=252          |
| Information                               | 35             | 29.2           | 35.8           | 37.8           |
| Other                                     | 1.5            | 10             | 0              | 21.7           |
| Education                                 | 15.3           | 19.6           | 10.8           | 17.4           |
| General Nursing                           | 16.8           | 8.8            | 6.7            | 13             |
| Supported Referral                        | 2.2            | 3.8            | 15             | 5.7            |
| Wound Care                                | 2.2            | 0              | 0              | 1.7            |
| Advocacy                                  | 0              | 9.2            | 4.2            | 1.7            |
| Counselling                               | 2.9            | 0.4            | 0              | 0              |
| Drug Treatment Referral                   | 0.7            | 2.7            | 0              | 0              |
| Food / Nutrition                          | 0              | 0.4            | 13.3           | 0              |
| NSP                                       | 0              | 0              | 4.2            | 0              |
| Secondary Consultation                    | 4.4            | 2.3            | 0.8            | 0              |
| Social Interaction                        | 16.1           | 12.3           | 9.2            | 0              |

Source: Department of Health, ADIS, September 2010
Note: Items with no contacts reported in any of the four years have been deleted from the table. These activities include: computer use; emergency response/first aid; GP; massage; material aid e.g. money; mental health assessment; monitoring/recovery space; pathology collection; recreation; shower/washing machine; vein care;

### 6.8 Health promotion

In line with other SAPHS, YPHS acknowledge that health promotion activities can provide opportunities to engage, transfer knowledge and prompt service utilisation and healthy behaviours. For example, via contact with the Cancer Council, YPHS provided free moisturiser and sunscreen to young people. While cancer prevention was not a primarily focus of YPHS, staff noted that access to such items ‘value adds to the service’ especially if young people have limited access to basic skin care resources. Staff also noted during periods of organisation and staff changes, health promotion work was given a lower priority compared to direct clinical care, however staff were committed to increasing the focus of health promotion. With this said, staff also indicated that health promotion at an individual level occurs through dialogue with young people within the clinic environment as well as during outreach. This activity is largely funded via the Community Health Program.
7. WORKFORCE AND GOVERNANCE

7.1 Staff arrangements

A multi-disciplinary team of staff work within the YPHS. The health care team (HCT) includes a manager, nurse unit manager (NUM)/health promotion co-ordinator, nurse practitioner, clinical nurse consultant (CNC), clinical support nurse, a counsellor/care co-ordinator, sessional private GP, CAH adolescent fellow, and dentist therapist from ISCHS. The formal qualifications held by staff are diverse and included: social work; nursing; adolescent health, business and management, occupational and family therapy, and medicine.

As Table 14 shows, many of the staff work on a part-time or sessional basis. A mix of funding sources is used to support employment and access to a range of clinicians. Exploring various funding sources to supplement funds provided by MDS to support service delivery was a reality for YPHS, along with other SAPHS. As one YPHS staff noted,

"Look if we only ran our service on the drug and alcohol money alone, we'd maybe have one nurse. That would be it. There'd be nothing else."

In the time between the current and the previous evaluation in 2006, YPHS had experienced some staff turnover, as well as organisational and funding changes. According to staff, YPHS was currently adequately staffed and stability has been maintained to a degree.

<table>
<thead>
<tr>
<th>Position</th>
<th>EFT</th>
<th>Funding source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>0.2</td>
<td>RCH</td>
</tr>
<tr>
<td>Nurse Unit Manager/Health Promotion Coordinator</td>
<td>0.9</td>
<td>DoH</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>1.0</td>
<td>DoH</td>
</tr>
<tr>
<td>Clinical Nurse Consultant</td>
<td>0.8</td>
<td>DoH</td>
</tr>
<tr>
<td>Clinical Support Nurse</td>
<td>1.0</td>
<td>DoH</td>
</tr>
<tr>
<td>Counsellor/Care Coordinator</td>
<td>0.4</td>
<td>DoH</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>0.1</td>
<td>Private Practitioner (Medicare)</td>
</tr>
<tr>
<td>Adolescent fellow</td>
<td>0.1</td>
<td>RCH</td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>2-4 hrs per fortnight</td>
<td>ISCHS and Medicare</td>
</tr>
</tbody>
</table>

Source: Young People’s Health Service, April 2006, and revised in October 2010

Experience and attitudes

Having highly skilled staff was considered to be vital for effective service delivery within a primary health service. The mix of clinical expertise, together with non-judgemental attitudes and research capabilities was considered one of YPHS' strengths.

"These guys are all skilled clinicians with real skill subsets and a little bit of academia behind them and a lot of clinical practice."

Staff emphasised the benefit of having a nurse practitioner within the team especially given access to GPs was limited. For example, the nurse practitioner is authorised to prescribe medications and refer young people to specialists, which enhances the scope, and timeliness of service delivery. As indicated previously, the recent recruitment of a counsellor/care co-ordinator and nurse unit manager/health promotion co-ordinator brings a wealth of expertise to the service, and complements the nursing and medical team. Staff also noted that access to staff with clinical experience is
considered beneficial both in terms of working directly with young people, and facilitating appropriate referrals.

_We actually deal with quite a lot of stuff. So other services have started to actually recognise our competency again and therefore be more responsive when we call them, because there's an acknowledgement that is actually - we're seeking peer skill. It's not that we're freaking out at the first point of contact._

### 7.2 Supervision and support
YPHS is in the process of establishing regular supervision for members of staff. At the time of the site visit, staff reported that informal supervision via feedback and interaction with staff occurs on a daily basis. The frequency of formal supervision varies by staff. For example, the clinical support nurse receives weekly supervision and the CNC receives supervision fortnightly. Staff are matched with an appropriate clinical supervisor from their discipline area. Access to offsite/external supervision remains a preferred option according to staff. Via RCH, staff are also able to anonymously contact the Employment Assistance Program (EAP) for support outside the direct management structure.

Fortnightly team meetings are held with YPHS staff, and communication, reflections and support occurs as part of day-to-day practice. Fortnightly clinical practice discussions are also held. YPHS staff reflected that collectively ‘celebrating milestones and achievements’ and having a shared vision contributed to developing and fostering a supportive environment.

### 7.3 Training and professional development activities and priority areas
Professional development and access to training opportunities was acknowledged by staff at YPHS as critical to cultivating and supporting an effective working environment. Training and professional training opportunities are offered internally via CAH, and RCH, as well as external providers. For example, staff have access to a range of in-house training opportunities such as weekly training session via the RCH adolescent medicine unit. Staff are also encouraged to attend conferences and engage in ongoing education. The cost of core competency training is covered by RCH, and staff can apply for study leave for additional work-related training.

Key learning priorities areas are identified during supervision and performance development appraisals, and training options sought.

YPHS is in the process of establishing cross-agency staff exchanges whereby staff have the opportunity to work at another service for a short period of time. Staff exchanges aim to improve staffs’ skill set, increase their knowledge of the sector and enhance networks. Potential organisations include: Living Room; YSAS; and the Melbourne Sexual Health Clinic.

### 7.4 Recruitment and orientation
Recruitment and orientation is largely managed via RCH. Orientation for new staff encompasses RCH, Frontyard and YPHS. Policies and procedures have been established to guide and inform the process.
7.5 Governance structure

As noted, YPHS is auspiced by RCH. According to one staff member, being attached to the ‘RCH brand’ was beneficial as it provides the service with an additional level of credibility and influence, which was often useful when negotiating with other services and applying for grants.

Other benefits associated with being auspiced by a large organisation include access to technologies such as a pathology department. In this case, costs of pathology tests are met by the organisation, rather than transferred to the client. Greater access to academic and professional development resources which can be harnessed to improve practice, and access to medical staff via RCH were also viewed as a positive of the auspice arrangement. On a more practical level, access to well developed policies and procedures, which can be transferred to individual services such as YPHS was also an advantage.

A number of challenges were also identified and these mainly centred on the multiple processes and duration of time associated with seeking authorisation from various departments and stakeholders.

In respect to both the benefits and challenges of the auspice arrangement, staff recognised the importance of having a good awareness of the hierarchy helped staff navigate the system and achieve required outcomes for young people,

> But you understand the hierarchy of the system and you use the hierarchy of the system to get what’s needed for that young person.

7.6 Consumer involvement and representation

Staff indicated that increasing consumer participation is part of the YPHS’ strategic plan for the coming year. Staff acknowledged the importance of ensuring that future mechanisms to facilitate consumer involvement at a strategic and service level were cultural appropriate and sufficiently supported.

At an individual level, staff were committed to involving young people in decisions affecting their health, and working with young people on client-driven goals. As one staff member indicated,

> The practice of all the clinicians here is that they will do things by informed consent and ask about what they need and work with the priorities of the young person.

7.7 Quality improvement activities

Quality improvement activities are conducted within RCH as part of the EQUIP process. At the service level, YPHS has participated in a number of evaluation activities, focused on the service as a whole, and individual aspects of the service such as the outreach component. These activities have provided YPHS with an opportunity to reflect on service delivery and develop strategies to improve the service. Furthermore, YPHS was involved in the FY strategic planning activity and a number of initiatives are being undertaken as a result of this.
7.8 Risk management

Risk management policies and procedures are well established at YPHS, and are supported by clear lines of accountability.

YPHS’ risk management response is guided by policies and procedure established by RCH, Frontyard and Department of Health. Similar to other SAPHS, YPHS use RiskMan to record information concerning incidents. While staff reported they only had one category one incident, which occurred approximately seven years ago, managing behaviours is part of day-to-day practice.

7.9 Staff and clinician input

Staff at YPHS reported that the service has recently developed a strategic plan, and all members of the team contributed to the plan. Staff were given the opportunity to participate both on group and individual levels, and via fortnightly service planning meetings. As part of the process, staff have been encouraged to develop an individual work plan, which outlines their role and how their role will contribute to the broader plan. Staff noted that strategic plan will encompass goals of the team as well as the organisation overall.

*Because we are small, we're lucky in a way because we're able to build it together. That's obviously within. Then there's the broader hierarchy that we're engaging with to ensure that we're meeting the hospital's direction…*

8. DATA COLLECTION AND REPORTING

8.1 Data collection activities and systems

Staff indicated that ADIS is used to record service activities. The inability of ADIS to capture the breadth of services provided by YPHS, along with other SAPHS was a consistent theme.

Staff reported that, via funding from RCH, YPHS is in the process of revising its service specific database that has the capacity to capture both detailed and general information relating to service provision. It is also envisaged that the in-house database will be aligned with assessments tools used during clinical practice and its functionality will be improved to better capture outreach activities. Therefore, it will be used both as a reporting and information recording system. As one staff member noted, particulars related to a referral will be captured such as point of referral, time from referral to access, who they have been referred to, and outcome of referral. Access to detailed information will be used to monitor and improve practices.

8.2 Key performance indicators and reporting requirements

In respect to KPIs and reporting requirements associated with MDS funding, staff reported that they consisted of registered contacts per annum and quarterly reports. However, staff indicated that the requirements of quarterly reports had recently been altered.

Staff also indicated that for each funding body they are required to submit varying reports aligned with funding agreements.
9. **STRENGTHS AND OPPORTUNITIES**

9.1 **Strengths**

YPHS operates within a complex, integrated primary health environment and has consolidated on the primary health service model documented in 2006 evaluation (Norman, 2006). Key strengths of YPHS centre on:

- A dedicated and skilled workforce which is responsive to clients’ needs
- Ongoing commitment to reflective practice and continuous service improvement
- A strong commitment to tailoring interventions and service responses to the needs of young people
- Proactive approach to extending the service’s reach via fostering partnerships with other SAPHS and engaging in research and project work
- Effectively utilising resources via RCH

9.2 **Areas for improvement and future opportunities**

During the interview staff identified aspects of service provision that they wanted to address, adapt and improve. These include:

- Increased integration between the co-located services. One possible strategy included establishing regular cross-agency meetings with Frontyard staff. Benefits included enhancing awareness and knowledge of different services and continuity of care
- Extending the upper age criteria from 22 to 25 years. This will bring YPHS in line with other co-located services at Frontyard. This change would ideally align with policy requirements
- Explore opportunity to enhance access to medical staff, and direct access to allied health services, and increase capacity for care coordination as a way to further improve the health outcomes for clients. One possible strategy included seeking grants
- Increase YPHS consultancy role in terms of working with homeless services (for example) and helping them build their capacity to respond to the health needs of young people
- Continue to develop a relationship with the key FY staff to strength the referral pathway and identification of health-related needs.

10. **CONCLUSION**

The Young People’s Primary Health Service (YPHS) provides harm reduction, secondary prevention and counselling services for homeless and marginalised young people aged 12 to 22 years. The main clinic is located at Frontyard in the Melbourne CBD, however young people living outside the City of Melbourne also engage with the service. The diversity of services provided by YPHS is strongly aligned with harm reduction principles underpinning the SAPHS model and demonstrates the service’s commitment to addressing health needs of young people. YPHS also conduct a significant amount of outreach.

Better health outcomes for YPHS service users are difficult to measure, however YPHS provide services on a non-appointment basis and from a suitable location. While the sample is small, all of the service user survey participants (n=5) reported that they thought their health was improving, and access to general health, AOD and counselling-related services was common. Service users also valued the helpful, friendly and non-judgmental approach of staff.
YPHS is operated by a highly skilled and multi-disciplinary staff team that is respectful, non-judgmental and supportive. It is a complex environment and staff supervision and support arrangements help to maintain quality service delivery and address emerging concerns. Despite moderate staff turnover between 2006 and 2010, stability was maintained to a degree and strategies to sustain an effective and proactive workforce are in place. This re-building phase needs to be supported and monitored in the context of improving future capacity and strengthening the AOD sector and the primary health system.

YPHS’s commitment and vision to develop partnership arrangements with local service providers further enhances the provision of general and specialist health services to its target group. This approach creates a platform for a holistic model of care and links need to be regarded as mutually beneficial and supported to ensure the longevity of the integrated model.

The limited availability of service contact data (via ADIS, DH) across the reporting period (2005 to 2009) is a constraint of this review. Trends on the volume of contacts and service provision presented are suggestive at best. The usefulness of ADIS to capture the complex and varied work undertaken within the SAPHS environment presents a challenge not only for YPHS, but SAPHS in general. At the time of the evaluation YPHS, via RCH, is in the process of developing an in-house database to align assessment and reporting practices with data collection and monitoring processes. This infrastructure has the potential to provide useful information for service improvement and the identification of client outcomes.

Despite the central location of YPHS and the benefits of its co-location with other youth services, the design and structure of Frontyard presents a number of challenges. Most notably, the centralised duty and triage system staff by young workers and the placement of YPHS on the lower ground level of Frontyard means the separation of access and engagement points. Evaluating the impact of these factors on access is complicated, however YPHS staff continue to build relationships with the duty staff and co-located services ensure appropriate referrals are made, and improve continuity of care. Recent partnership arrangements with other city-based SAPHS present a further opportunity for YPHS to engage with young people and increase the service’s visibility and contact base. In addition, YPHS seeks to increase its outreach capacity, however at present outreach activities are supported via sources other than MDS funding.

In summary, the findings of this evaluation corroborate previous evaluations and show that YPHS continues to engage with the target group and provides services that lead to better health outcomes for marginalised young people, although contact numbers have dropped in recent years. Findings highlight the critical importance of ongoing effort to maintain and enhance a well-supported workforce and effective practices for engaging and delivery services to young people. While recent efforts to enhance cross-agency communication as a way to counter structural barriers to access should be acknowledged, increasing the uptake of health services warrants ongoing attention.
11. REFERENCES


