Improving access to reproductive and sexual health services for young people

A service coordination guide for primary health care providers in Victoria

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References

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Executive summary

Family Planning Victoria is a leading, not for profit, state-wide provider of reproductive and sexual health care, education and advocacy.

Family Planning Victoria sought to develop the Improving access to reproductive and sexual health services for young people: A service coordination guide for primary health care providers in Victoria (the Guide).

The scope of work for the Guide was to focus on:
- improving the coordination of services for young people, by providing information that health and community service providers need to support the development of partnerships to respond to the reproductive and sexual health needs of young people.
- having the conversation with young people, by providing health and community service providers with guidance regarding the reproductive and sexual health conversation with young people.

The Guide was developed in metropolitan Melbourne, with a focus on the North and West Health Region for the purposes of engaging the Project Reference Group and consulting service providers and young people. This regional focus provided the opportunity to involve a broad range of stakeholders in developing the Guide, however it is intended as a state-wide resource (more details about these regions can be found in Part B of this Guide). The Guide, tools and appendices can be applied to any Victorian primary health care setting and adapted to the needs of local primary health care providers.

Following a review of the literature, the primary health care services in the region were mapped. Fifteen representative service providers were consulted as well as thirty six young people through seven focus groups across five locations in Melbourne. These groups included Same Sex Attracted & Sex/Gender Diverse (SSASGD) young people, young men, Aboriginal and Torres Strait Islander young people, and a general youth group. The final draft of the report was provided to stakeholders for final feedback and some edits were made before publication.

The literature found that:
- Young people are vulnerable when it comes to their reproductive and sexual health (R&SH) as they experience rapid physical, emotional and social growth and change, and often engage in risk taking behaviours that reflect adolescent developmental processes of experimentation and exploration. Their R&SH issues are broad and diverse, indicative of their social and biological development.
- Primary health care providers have a key role in supporting young people to navigate the physical, emotional and social changes that underpin reproductive and sexual well-being.
- Effective service coordination requires primary health care providers to place the needs of the young person at the centre of service delivery to ensure young people have access to appropriate, timely and ‘youth friendly’ services to improve their R&SH.

Twelve key themes emerged from the consultations and were further supported in the literature. These themes offer service providers insight into the R&SH issues of young people and the ways in which providers can better engage with young people through effective communication and youth friendly service delivery that is consistent with current R&SH policy and legislation.

The themes relate to:
- The need for youth friendly care
- Confidentiality and privacy
- Contraception awareness, access and support
- Pregnancy prevention
- Knowledge about sexually transmissible infections
- Acceptance and understanding relating to the individual’s sex and gender diversity
- Perceived and real cost of services
- Specific issues related to Aboriginality and cultural diversity
- Consent and respectful relationships
- Young people’s experience in engagement with service providers
- Awareness of services and referral pathways
- Availability of R&SH information and knowing the support resources used by young people

The Guide offers primary health care providers a service delivery and referral pathway to improve service delivery and service coordination to address the R&SH needs of young people, as identified in the literature and youth focus groups.
The Guide is divided into two parts:

**Part A** is a practical guide to implementing a service coordination approach to providing R&SH services for young people. It is built on a service delivery and referral pathway as reflected within the Victorian Service Coordination framework\(^1\). It provides an overview of the Guide and its development, and steps primary health care providers through a service delivery and referral pathway that is based on a service coordination methodology.

**Part B** describes the development of the Guide, the policy context and how service mapping contributes to service coordination. It describes the key themes that emerged from the analysis of the literature and consultations with service providers and young people.

Larter Consulting offers eight recommendations to FPV to improve R&SH service delivery to young people and to encourage collaboration between service providers to promote improved service coordination of R&SH services in Victoria. These are:

**Recommendation 1:** That primary health care providers who wish to integrate a service coordination approach to youth R&SH, consider collaborating with local partners and/or stakeholders to develop a localised service map.

**Recommendation 2:** That service providers establish youth friendly practices and processes, including policies and procedures.

**Recommendation 3:** That this Guide is widely disseminated to primary health care providers throughout Victoria, including but not limited to: General Practitioners GPs, nurses, counsellors, youth workers, Aboriginal Health Workers and allied health professionals working with young people in primary health care settings. The Guide should be made available through various platforms, e.g. online, electronic, hard copy, tablet or smart phone application versions.

**Recommendation 4:** That this Guide be forwarded to initiatives such as Respectful Relationships Education and the Safe Schools Coalition.

**Recommendation 5:** That this Guide is promoted and distributed to Victorian Primary Health Networks (PHNs) for distribution to their GP network. It should be included in key youth initiatives such as the Victorian Government’s ‘100 GPs in 100 schools’ initiative.

**Recommendation 6:** That this Guide be incorporated and referenced in programs that develop clinical and referral pathways such as Health Pathways or Maps of Medicine developed by the Primary Health Networks.

**Recommendation 7:** That primary health care providers are further supported through training that complements the use of this Guide.

**Recommendation 8:** That resources to support and assist young people with access to R&SH services and information be developed to complement this Guide and improve R&SH outcomes for young people in Victoria.

### 1. Using the Guide

The Guide has been divided into two parts – Part A and Part B.

**Part A** is a practical guide to implementing a service coordination approach to providing R&SH services for young people. Following a brief overview of the Guide and its development, it steps primary health care providers through a service delivery and referral pathway informed by a service coordination methodology. The service delivery and referral pathway is underpinned by the Victorian Service Coordination Framework. It is presented as a flowchart and then outlined in detail, offering considerations for effective service delivery, as evidenced in the literature and from consultations undertaken during the development of this Guide. These considerations include understanding the context of R&SH for young people, key R&SH issues that may affect young people, the barriers they may experience when accessing services and how youth friendly service delivery and effective communication can engage youth people.

**Part B** describes the development of the Guide in detail and how service mapping contributes to service coordination. It describes the key themes that emerged from a review of the literature and from consultations with service providers and young people. The similarities and differences between the themes that emerged from service providers and young people are discussed. Part B concludes with recommendations for improved R&SH service delivery, coordination and collaboration based on the work that was completed as a part of this project.
PART A
Service Delivery and Referral Pathway Tool
2. Introduction

2.1 Purpose of the Guide

Family Planning Victoria (FPV) has developed this Guide as part of their Integrated Health Promotion Plan 2013-17. The purpose of this Guide is to support Victorian primary health care providers to engage with young people in Victoria about Reproductive and Sexual Health (R&SH). The Guide is informed by evidence from the literature, consultations with service providers and focus groups with young people and encourages collaborative approaches to managing R&SH issues for young Victorians.

The aim of this Guide is to:

1. Improve R&SH care and referral pathways for young people in Victoria
2. Improve the capacity for primary health care providers in Victoria to provide R&SH services and support to young people in Victoria.

2.2 Why focus on young people?

There are about 1.2 billion adolescents aged 10-19 years in the world today, 89% of whom live in developing countries. Yet, young people are acknowledged as a vulnerable population, as they continue to experience higher rates of sexually transmissible infections (STIs) than other populations, experience pregnancy, and engage in risk taking behaviours that adversely affect their reproductive, sexual and mental health.

The health and well-being of young people is impacted by social and biological changes, and socially determined by individual, peer, family and cultural factors that influence the nature and extent of young people’s sexual behaviour and their knowledge and experience of sexuality. Young people often engage in health risk behaviours that reflect adolescent developmental processes of experimentation and exploration. They can be at risk of reproductive and sexual ill-health as they often lack knowledge about their bodies, sexuality and how to protect themselves, and may not appreciate the risks involved with sexual activity.

Young people require special attention as they navigate this time of biological and social transition and form their identity among peers, family and friends. They need support and care to understand and work through some of these changes, encouragement and empowerment to talk about their R&SH and to engage with primary health care providers for R&SH services.

2.3 Development of the Guide

The Guide was developed in metropolitan Melbourne, with a focus on the North and West Health Region, however it is intended as a state-wide resource.

Following a review of the literature, the primary health care services in the region were mapped. Fifteen representative service providers were identified and consulted between 24 November 2015 and 13 January 2016, on the basis that they either delivered R&SH services or worked with young people.

Seven focus group discussions were facilitated with young people across five locations in Melbourne. Thirty-six young people were consulted between 15 February and 2 March 2016. Guided by the literature and collaboration with FPV, four groups were targeted for consultation: Same Sex Attracted & Sex/Gender Diverse (SSASGD) young people, young men, Aboriginal and Torres Strait Islander young people, and a general youth group. Focus group sessions and interviews were noted and recorded to identify emergent themes.

See Part B for more information about the engagement processes and outcomes.
2.4 Definitions of Key Terms

Reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life, have the capability to reproduce and freedom to decide if, when and how often to do so. This includes the right of women and men to be informed and to have access to safe, effective, affordable and acceptable methods of family planning, as well as other methods of their choice for regulating fertility or the right to go safely through pregnancy and childbirth.⁷

Sexual Health is a state of physical, emotional, mental and social well-being in relation to sexuality; not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.⁸

Young people are defined in this guide as people aged 12-25 years, consistent with the age range serviced at Family Planning Victoria’s Action Centre.

Primary Health Care is the first level of contact that individuals, families and communities have with the health care system. In Australia, primary health care incorporates personal care with health promotion, the prevention of illness and community development. It includes the interconnected principles of equity, access, empowerment, community self-determination and inter-sectoral collaboration, and encompasses an understanding of the social, economic, cultural and political determinants of health.⁹

A Primary Health Care Provider is a health or community service provider who works in primary health care. This encompasses a broad range of roles including, but not limited to: general practitioners (GPs), nurses, counsellors, youth workers, psychologists, Aboriginal health workers, dieticians and physiotherapists.¹⁰

2.5 An overview of service mapping and recommendations

A service mapping exercise was completed for the North and West Metropolitan Health Region to develop this Guide. Service mapping involves collecting demographic data and information about local services in a designated health region and is useful for understanding the stakeholders who can support young people’s R&SH. It is recommended that primary health care providers who want to integrate a service coordination approach to youth R&SH, collaborate with local services to develop a service map for their region. See Appendix A for what information is collected for a service map and Part B, Section 2.2 ‘Service mapping’ which describes the service mapping process used for this project.
3. Service Delivery & Referral Pathway

3.1 Service Coordination

The Victorian Service Coordination Framework helps primary health care providers work together to align practices, processes and systems. This allows for people’s health and social needs to be identified early to prevent deterioration in health, and to ensure they have access to the services they need by providing appropriate and timely services. Service coordination enables organisations to remain independent of each other, while working together; to focus on the client, develop partnerships, exchange information as necessary and address client’s needs from a social model of health. Effective service coordination is achieved through appropriate communication, competent staff, consistent practice standards and the maintenance of a duty of care. Good referral pathways and linkages between GPs, other primary health care providers, sexual health services and secondary health services, are important for meeting young people’s R&SH needs.

The service coordination operational elements or stages related to the R&SH of young people are shown in Figure 1 and include:

- Context of R&SH of young people
- Initial contact
- Initial needs identification
- Assessment
- Care planning

Figure 1: Service Coordination Elements

Additional processes may include providing information, consenting to share information, referral, information exchange, service delivery and exiting. These processes can occur at any stage. Elements can also be implemented in a range of ways according to clients’ needs, the service provider and the context in which services are provided, such as undertaken and provided by one service provider, or by a number of providers, including those from other services.

3.2 The Service Delivery & Referral Pathway Tool

The Service Delivery and Referral Pathway Tool (the Tool) on the following page has been developed from the service delivery and referral approach reflected in the Victorian Service Coordination Framework. Although R&SH issues for young people are broad and encompass social determinants that can create various complexities, the Tool offers primary health care providers guidance for identifying, assessing and planning care for young people requiring access to R&SH services.

Each element of the Tool provides an opportunity for the primary care provider to consider relevant information regarding R&SH of young people. With a service coordination approach, Victorian primary health care providers should be able to utilise any element within the Tool to assist and engage a young person in regard to their R&SH.
Service Delivery & Referral Pathway Tool

Consideration

**CONTEXT OF R&SH OF YP**

Understanding the R&SH of Young People (YP)

**INITIAL CONTACT**

Beginning the conversation about reproductive and sexual health

Identity if it is a reproductive & sexual health issue

**INITIAL NEEDS IDENTIFICATION**

Extending the conversation. Is an interpreter required?

What does this young person need or want most?
An assess the urgency of the situation and prioritise needs:
- Counselling?
- Prescribing?
- Clinical intervention?
- Advice and education?
- Referral for medical/surgical intervention or other services?
- Further assessment?

**ASSESSMENT**

Assess the context of the R&SH issue
Consider the value & appropriateness of conducting a HEADSS Assessment

Assess what support is available to the young person

Discuss options & course of action to address the reproductive and sexual health issue

**CARE PLANNING**

Collaborate with the young person to assist and prepare them for referral

Develop a care plan in collaboration with the young person

Check the young person's understanding & provide take away information and resources

Implement a follow up process for review

**Supporting Information**

- Understanding the R&SH of young people - Part A
- Key themes in R&SH for young people and barriers to accessing services - Part A
- Creating a youth friendly service – Part A
- Youth friendly communication - Part A
- Duty of care and consent - Part A
- Statement of confidentiality - Part A
- Statement of inclusion - Part A
- Definitions of R&SH - Part A
- Understanding the R&SH of young people - Part A
- The consultation, extending the conversion - Part A
- Opportunistic screening - Appendix F
- Using interpreter services - Part A
- Using the right language - Part A
- Understanding the R&SH of young people - Part A
- Referring to other services - Part A
- Services, links and resources to support service providers and young people - Appendix G
- Assessment - Part A
- HEADSS Assessment - Appendix H
- Services, links and resources to support service providers and young people - Appendix G
- Services, links and resources to support service providers and young people - Appendix G
- Follow up and maintaining communication and engagement - Part A
- Services, links and resources to support service providers and young people - Appendix G
3.3 Context of R&SH of young people

Through discussions with Victorian young people and service providers, it is clear that understanding R&SH from the young person’s perspective has the potential to improve R&SH service provision. The following section highlights the key themes identified with respect to the youth context, brief information regarding the fostering of a youth friendly service, and some of the common barriers for young people engaging with R&SH services. Further information on these contextual factors are provided in Part B of the Guide.

3.3.1 Understanding the R&SH of young people

Given that most causes of ill-health in young people are psychosocial rather than biological, it is important to take a holistic approach to young people’s R&SH by considering psychosocial factors as well as biology and the burden of disease.

During the consultations, young people raised some R&SH themes relating to biological needs, however most R&SH concerns raised by young people were in the context of their relationships, sex/gender identity, and social and cultural background. The following section defines the key themes and issues in R&SH for young people, evidenced in current literature, as well as derived from consultations with service providers and focus groups with young people. A detailed analysis and the supporting literature for each theme is provided in Part B of the Guide.

Please note, the order of priority for these issues varies from one young person to the next, and despite the fact that some themes emerged more often than others during consultation, priorities for young people may differ and are therefore not representative of all young people in Victoria.

It is recommended that primary health care providers become familiar with these common themes and use the service coordination approach to develop an understanding of priorities in their local area/region.

3.3.2 Key themes in R&SH for young people and barriers to accessing R&SH services

Theme 1 – The need for youth friendly care

- The literature shows that young people are concerned about the way that they are treated when accessing R&SH services. Fear of negative attitudes from providers: not being respected, feeling judged and having assumptions made about them are some of the barriers identified. This was also reflected in focus groups conducted to develop this Guide.

Theme 2 – Confidentiality and privacy

- Focus groups identified a greater need for explicit confidentiality and privacy statements, to inform young people of their legal rights, and legal obligations of the primary health care provider. Concerns about confidentiality are also raised in the literature. Refer to Part A, Section 3.4.1 and Appendices C & L of Part B.

Theme 3 - Contraception

- Accessing contraception is a common concern for young people and is a common reason for visiting a primary health care service. Most young people in the focus groups were familiar with condoms and oral contraceptives; however they were not as familiar with long acting reversible contraception (LARC).
Theme 4 - Pregnancy
• Service providers and young people reported that preventing unplanned pregnancy was a common concern for Victorian youth.

Theme 5 – STIs
• Young people consulted expressed concerns about contracting STIs and not knowing enough about STI risks and prevention. Primary health care providers reported that they often initiate conversations with young people about the possible risks for transmission.

Theme 6 - Sex and gender diversity
• Young people in the focus groups expressed concerns around their sexual orientation and/or gender. They also raised concerns around disclosing to primary health care providers, and feared experiencing stigma, discrimination, and having assumptions made around their R&SH.

Theme 7 – Cost of services
• Young people and service providers identified that young people avoid accessing services due to prohibitively high costs (also identified as a barrier in the literature\textsuperscript{18}), and are often not aware of their right to access their own Medicare card once aged 15 years. Family Medicare cards compromise young people’s confidentiality in the family context, and can impact upon their R&SH.

Theme 8 – Aboriginality and cultural diversity
• Cultural background is a significant contributor to social determinants of R&SH\textsuperscript{19}. The focus groups found that young people have concerns that assumptions are made about their cultural background and sexual practices, and fear the impact that disclosure of their R&SH issue may have on their family or cultural identity.

Theme 9 – Consent and respectful relationships
• Consent and respectful relationships were largely brought up by service providers consulted, and not by young people in the focus groups, possibly implying that issues of consent and respectful relationships may need to be initiated by service providers and young people may need further information and education.

Theme 10 – Engaging with service providers
• Youth focus groups identified that young people engage with providers in various ways with some feeling confident to be open and direct about their R&SH, while others are very embarrassed and can be fearful and reserved. Young men were identified by some service providers as being more resistant to conversations about R&SH but consultations with young men showed they can be either open and direct or reserved.

Theme 11 – Awareness of services and referral pathways
• R&SH is delivered by a variety of services in Victoria\textsuperscript{20}, yet most young people and many service providers were not aware of local R&SH services available to young people.

Theme 12 – R&SH information and support resources used by young people
• Focus groups identified that the internet is often the first source of information for young people with respect to their R&SH. Young people will commonly access general practice clinics for medical R&SH needs.
### 3.3.3 Creating a youth friendly service

Most service providers consulted identified being ‘youth friendly’ as important for engaging young people about their R&SH. Young people in the focus groups stated that they want service providers to: treat them with respect and understanding; use appropriate language and effective communication styles that minimise discomfort; and consider the individual’s level of knowledge of R&SH. It is important to be aware that young people have varying levels of R&SH literacy. Refer also to section 3.4.3 Youth friendly communication.

Overall, youth friendly services are those that:

- Provide a private consultation space that maintains confidentiality
- Ensure all staff communicate and engage with young people in a caring, non-judgemental manner
- Treat young people with respect for their gender, sexuality and cultural differences
- Understand the R&SH issues of young people
- Make young people feel safe in the knowledge that any consultation remains confidential and private
- Ensure young people will not experience discrimination
- Provide free or low-cost consultations
- Explain to young people about how to access their own Medicare card
- Make medically accurate age-appropriate health information available
- Make services accessible by addressing structural barriers - is it easy to make an appointment? Are there policies and procedures to support engaging young people?
- Consider the physical environment and whether it is welcoming to young people.

To ascertain whether your service is youth friendly, consider conducting a youth friendly checklist (Appendix B).

Engaging effectively with young people involves understanding the developmental stage of the young person and anticipating the types of questions or concerns they may have at that stage. See Appendix E: Adolescent developmental stages for more information.

### 3.4 Initial Contact

The first contact between a primary health care provider and a young person is the opportunity to establish trust for the effective management of the presenting R&SH issue and for any potential future R&SH needs where appropriate. This section outlines the Initial Contact element of the Service Delivery & Referral Pathway Tool, emphasising the issues around youth-friendly communication, duty of care, confidentiality and inclusion.
3.4.1 Duty of Care and Consent

Duty of care, a legal requirement, stipulates that a primary health care provider must take reasonable care to protect another person from a foreseeable risk of injury. Duty of care is a primary health care provider’s moral and ethical responsibility to ensure the safety of young people. Confidentiality and privacy are part of a duty of care. It is imperative that young people are made to feel that their information is safe and their confidentiality will be maintained with the exception of reporting laws (See Appendix C: Reporting laws of child abuse in Victoria).

Statement of confidentiality

It is recommended that primary health care providers have a formal confidentiality statement to discuss with young people. An example of a confidentiality statement is provided below:

Young people have the legal right to confidential health care just like adults do, unless the provider has concerns that the young person is at risk of harm to themselves, there is a risk of homicide or physical or sexual abuse; or the young person cannot be considered a mature minor. In these cases information may have to be shared according to reporting laws to ensure the young person remains safe.

Consent as a mature minor

Legislation in all Australian states and territories define a ‘minor’ as a person under 18 years of age. However, a young person under 18 years of age can consent to medical treatment or intervention if they are considered sufficiently mature enough by a qualified health professional to give informed consent. This is determined by the Gillick test of competence that is undertaken by a qualified health professional. See Appendix D for further information about the Mature Minor and the Gillick test.

3.4.2 Statement of inclusion

Although not part of a duty of care as such, it is recommended that service providers include a statement of inclusion in conversation with young people. For example:

Young people have the right to not have assumptions made about their gender and/or sexual identity and relationships or about their culture.

3.4.3 Youth friendly communication

A service’s physical and structural environment is important for improving access to R&SH services, however youth friendly services also provide a positive, non-judgemental experience for young people through effective communication. Effective communication in R&SH care for young people requires a willingness to ask sensitive questions and providing accurate information in a respectful and non-judgemental manner. This will include:

- Understanding the developmental stages of young people (Appendix E)
- Understanding the barriers for young people accessing services (sections 3.3.2 & 3.3.3)
- Acknowledging the courage it took for the young person to attend the appointment
- Adopting a friendly, sincere, informal, professional style of communication that is respectful and non-judgemental
- Using clear, simple language and supporting the use of medical terminology with clear explanations.
3.5 Initial Needs Identification

Initial Needs Identification (INI) is a broad screening process to uncover underlying and presenting issues to determine the best possible services, urgency and type of intervention required. It involves extending the conversation about the young person’s R&SH issue using clear, simple language, including whether the young person may benefit from the use of an interpreter. It involves determining the urgency of the young person’s R&SH need to prioritise any intervention and arrange a referral or further assessment, if necessary.

3.5.1 The consultation – extending the conversation

A youth friendly approach that adopts an effective communication style can reassure a young person that the provider understands or wants to understand their R&SH issue and that they want to assist them. The consultation involves:

- Getting to know the young person and who they have come in with. It is important to explain that the consult may involve time alone with the young person and time together with a parent or support person (if the young person consents)
- Being aware that the young person may be embarrassed, ashamed or nervous
- Initiating a wider discussion of R&SH opportunistically during consultations e.g. a young woman coming in for emergency contraception provides opportunities for the GP to ask about relationships, contraception, possible need for an STI screen and discussion about consensual sex. See Appendix F for opportunistic screening.
- Adopting a communication style that embodies a holistic, relaxed approach that encourages the young person to discuss their R&SH issue in order for the provider to prioritise their needs
- Considering the need for interpreter services (see www.dss.gov.au/free-interpreting or phone 1300 575 847)
- Establishing what this young person wants and needs right now
- Prioritising the needs of the young person

Consideration

Extending the conversation. Is an interpreter required?

What does this young person need or want most?
Assess the urgency of the situation and prioritise needs:
- Counselling?
- Prescribing?
- Clinical intervention?
- Advice and education?
- Referral for medical/surgical intervention or other services?
- Further assessment?

Supporting Information

- The consultation, extending the conversion - Part A
- Opportunistic screening - Appendix F
- Using interpreter services - Part A
- Using the right language - Part A
- Understanding the R&SH of young people - Part A
- Referring to other services - Part A
- Services, links and resources to support service providers and young people - Appendix G
3.5.2 Using the right language, at the right time and the right place

The following communication strategies are recommended for effectively engaging young people in conversations about the R&SH based on literature, and the suggestions made by service providers and young people themselves during consultations to develop this Guide.

- Ask permission, such as: ‘Is it ok if I ask you some personal questions?’
- Ensure there is sufficient time and privacy to allow the young person to respond
- Use clear simple language that ‘steps’ young people through what to expect, what will or may happen and why, especially for any tests or examination
- If parents are present, establish whether their presence might hinder open and honest communication. Perhaps parents should be asked to leave momentarily to maintain the young person’s privacy
  - E.g. ‘…before I have some time alone with [the young person] is there anything further you would like to add?’
- Frame reproduction, sex and sexuality as an everyday normal human activity – not a taboo or shameful topic. Positively framed conversations within the context of being safe and having fun can open up conversations. A punitive or negative approach can close down communication
  - E.g. ‘if you behave like this, there could be terrible consequences’
- Consider if a ‘third person’ approach might work well – ‘It’s not uncommon for young people your age…’
- Pick up on non-verbal and verbal cues to elicit more information – ‘I see that you are looking down at your feet a lot today… are you nervous or worried about telling me something?’
- Paraphrase to check understanding – ‘Have I got this right… do you mean….
- Offer feedback and share what you are thinking to invite the young person’s thoughts and encourage participation in decision making
- Provide reassurance, validate the young person’s feelings and establish your role as an advocate for them
- Allow young people time, as young people can take time to respond to direct questions and may even feel threatened when asked too many ‘why’ questions or too many questions at once
- Remember conversations about R&SH should consider the young person’s developmental stage, age and maturity as well as the social context of their relationships, environment, family, peers, culture, and school.

3.5.3 Referrals and awareness of other services

During the initial needs identification, a provider may determine that the young person wants or needs a referral. Making a referral requires awareness of other R&SH services. Creating a service map offers service providers the opportunity to collaborate with local services to effectively and holistically address and manage the R&SH needs of young people. For more information on service mapping see sections Part A 2.5, Part B 2.2 and Appendix A.

There are a broad range of services that can assist young people with their R&SH such as council run youth services, community health services and mental health services, however, GPs are the major providers of clinical R&SH services in Victoria.

The following websites and resources provide more information and options for referral:

- Health Direct Australia provides information about R&SH and services available
- National Health Services Directory provides information about general practice, hospitals, pharmacies and allied health providers across Australia www.nhsd.com.au
- Better Health Channel provides health information, services and support and medication information
- Family Planning Victoria provides health information and services and provider education, training and resources www.fpv.org.au
- Appendix G in this Guide for services, useful link and resources
- Appendix I in this Guide for Understanding Medicare and working with general practice
### 3.6 Assessment

#### Service Delivery & Referral Pathway Tool

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Supporting Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td><strong>Supporting Information</strong></td>
</tr>
<tr>
<td>Assess the context of the R&amp;SH issue</td>
<td>• Assessment - Part A</td>
</tr>
<tr>
<td>Consider the value &amp; appropriateness of conducting a HEADSS Assessment</td>
<td>• HEADSS Assessment - Appendix H</td>
</tr>
<tr>
<td>Assess what support is available to the young person</td>
<td>• Services, links and resources to support service providers and young people - Appendix G</td>
</tr>
<tr>
<td>Discuss options &amp; course of action to address the reproductive and sexual health issue</td>
<td>• Services, links and resources to support service providers and young people - Appendix G</td>
</tr>
<tr>
<td>OR</td>
<td><strong>Collaborate with the young person to assist and prepare them for referral</strong></td>
</tr>
</tbody>
</table>

Assessment is a systematic interactive process by which the primary health care provider uses critical thinking to collect, validate, analyse and synthesis information in order to make a judgment about the health of the young person. This involves collecting more detailed information about the presenting issue/s and interpreting relevant information to identify the support or intervention required. At this time the service provider will use effective interpersonal skills to discuss options and a course of action or collaborate with the young person to assist them to prepare for referral.

Considering the young person’s cultural background, gender and sexual orientation, social networks and relationships, assists in building a picture of the young person’s overall health and well-being. A psychosocial assessment of the young person will assist in contextualising the R&SH issue and the value and appropriateness of conducting a HEADSS assessment (see below) can be considered at this time.

#### 3.6.1 HEADSS Assessment

The HEADSS assessment is a developmentally appropriate psychosocial history-taking tool, which has been used successfully around the world in adolescent health and is widely accepted in Australia. A HEADSS assessment assesses a young person’s R&SH issue in the context of other aspects of their life and health, including their physical, emotional and social well-being.

The assessment is known as the acronym HEADSS, assessing: **H** – Home, **E** – Education/Employment, **A** – Activities, **D** – Drugs, **S** – Sexual activity and **S** – Suicide. The tool structures its questions to facilitate effective communication in an understanding, non-threatening manner. See Appendix H for more details about conducting a HEADSS assessment.
3.7 Care Planning

Care planning is the process of reviewing the assessment of the young person’s needs and collaborating with them to develop a plan for any required treatment or care. This may include coordinating and/or case management, referral, feedback, review, re-assessment, monitoring and developing an exit plan when the young person has achieved the identified goals.

Care planning involves ensuring the young person understands and agrees to the planned care and has the support they need to meet their goals. Additional information may need to be provided to the young person to help them to make a decision that is appropriate to their needs, wishes, values and circumstances.

A typical care plan includes:

- Identifying needs and priorities
- Clearly articulated goals
- Identifying services and interventions required to support the young person achieve the set goals
- Specific actions to be taken by the client
- A crisis management plan
- A monitoring and review process.

Service Delivery & Referral Pathway Tool

<table>
<thead>
<tr>
<th>consideration</th>
<th>Supporting Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a care plan in collaboration with the young person</td>
<td>Follow up and maintaining communication and engagement - Part A</td>
</tr>
<tr>
<td>Check the young person’s understanding &amp; provide take away information and resources</td>
<td>Services, links and resources to support service providers and young people - Appendix G</td>
</tr>
<tr>
<td>Implement a follow up process for review</td>
<td></td>
</tr>
</tbody>
</table>

Supporting Information

- Follow up and maintaining communication and engagement - Part A
- Services, links and resources to support service providers and young people - Appendix G
3.7.1 Follow up and maintaining communication and engagement

Care planning also requires follow up and continuing effective communication to ensure the young person engages with the agreed services to address their R&SH needs.

This may include:

- Checking the young person’s contact details are up-to-date as contact details can change
- Explaining to the young person the importance of maintaining contact and follow up so the provider can monitor progress of outcomes and continue to support the young person to meet their goals
- Helping the young person to make follow up appointments to ensure they are not told ‘we are fully booked for 6 weeks’
- Ensuring appointments are long enough so that the consultation is not rushed
- Using SMS text messaging to remind young people about appointments or to check how things are going. Informal, friendly text messaging such as: “Are you ok? We missed seeing you at your appointment” will keep communication open
  - Please note: some young people share mobile phones with parents or friends, so please check with the young person if SMS text messaging will be private
- Providing positive feedback for the things that are going well or offering further help and support to continue building a positive, trusting relationship
- Collaborating with the young person to assist with and prepare them for referral to other services
- Communicating, sharing and exchanging information with other service providers as required and with the young person’s consent
- Expressing concern and interest in wanting to help the young person address health risk behaviours, to set short and medium term goals and to continue planning care to meet set goals
- Encouraging and empowering the young person to talk to their parents or a trusted adult if this helps
- Providing the young person with sufficient information and resources to support them to remain engaged in their health care. See Appendix G for services, links and resources that may support a young person.
PART B

Development of the Guide
1. Introduction

Part B of the Service Coordination Guide (Guide) provides a comprehensive overview of the reproductive and sexual health (R&SH) of young people. It outlines the development of this Guide, the policy context of R&SH, and describes in detail the themes that emerged from current literature and from the service providers and young people who were consulted to develop this Guide. It concludes with recommendations for improved R&SH service delivery, coordination and collaboration based on the work that was completed as a part of this project.

2. Development of this Guide

2.1 Project background

Family Planning Victoria (FPV) commissioned Larter Consulting (Larter) from November 2015 until April 2016 to develop the Guide. The methodology included service mapping, consulting with service providers and young people and liaising with a Project Reference Group (PRG).

The Guide is a state-wide resource, however its development was strategically focussed to metropolitan Melbourne, with a focus on the North and West Health Region which included the Local Government Areas (LGAs) of Banyule, Darebin, Hume, Nillumbik, Whittlesea and Moreland (see figure below). This regional focus provided the opportunity to involve a broad range of stakeholders in developing the Guide.

Figure 2: LGAs involved in the project

FPV established a PRG to oversee the project plan and its deliverables. The Guide was tested with the PRG prior to dissemination to ensure usability and relevance for Victorian primary health care providers engaging with young people about their R&SH.
2.2 Service Mapping

A service mapping exercise was undertaken to collect demographic data and service provision information about the health region selected for this project. This provided information about the available services for young people with respect to R&SH and highlighted potential collaboration opportunities and referral pathways. The mapping exercise collated data on services that offer R&SH care for young people, as well as services that work with young people generally, where R&SH issues may arise.

Service information such as location, hours of operation, contact details and billing procedures (free, bulk-billed or cost involved), and the type of service provided (e.g. STI testing, pregnancy counselling, relationships counselling) were collated into an Excel database. This service map built on previous data collected by Women’s Health in the North (WHIN).

Service mapping information was collected in three ways: through website searches, telephone or direct interview with providers or through a survey (Appendix A).

Ninety services were identified in the service map, which included the specified LGAs, as well as the LGA of Yarra and State/catchment-wide services. These services included: community health services, local council youth and other services, GP super clinics, hospital outpatient clinics, mental health services and termination services.

Less than half of these services (10 of 26 services) predominantly delivered ‘clinical’ services. Clinical services were those identified as delivering: contraception, pregnancy options counselling/pregnancy testing, maternal health, termination services, STI testing, immunisation, pap screening, HIV clinic, Female Genital Mutilation/Cutting (FGM/C) services, sexual violence services and provision of condoms.

Approximately 62% of services delivered education and support services in R&SH. Education and support services were those offering: counselling, support and education in alcohol and drugs, puberty, body image, relationships, safe sex, sexuality/gender, teen pregnancy, peer support and provision of condoms.

The service mapping exercise provided a useful picture of the R&SH services available to young people in the selected project area, highlighting collaboration opportunities and potential referral pathways. Appendix A describes how to develop a local service map and provides a survey template that services may wish to use to perform a local service mapping exercise.
2.3 Service provider consultations

Fifteen service providers were consulted between 24 November 2015 and 13 January 2016. Services were selected to represent a broad range of service types. The individuals consulted held roles including nursing, allied health, health promotion and youth worker. Table 1 below outlines the services consulted by type and by LGA.

Table 1: Service consulted by type and by LGA

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number Of Services</th>
<th>LGAs Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health services</td>
<td>4</td>
<td>Whittlesea; Nillumbik; Moreland; Banyule</td>
</tr>
<tr>
<td>Council youth services</td>
<td>4</td>
<td>Hume; Whittlesea; Banyule</td>
</tr>
<tr>
<td>Mental health services</td>
<td>2</td>
<td>Moreland; Yarra</td>
</tr>
<tr>
<td>Specialised SRH services</td>
<td>2</td>
<td>Banyule, Melbourne CBD</td>
</tr>
<tr>
<td>GP Super Clinic</td>
<td>1</td>
<td>Whittlesea</td>
</tr>
<tr>
<td>School Nurses</td>
<td>1</td>
<td>Moreland</td>
</tr>
<tr>
<td>Aboriginal Medical Service</td>
<td>1</td>
<td>Yarra (Catchment/State-wide)</td>
</tr>
</tbody>
</table>

Service providers were interviewed either face to face or via telephone using a consultation guide (see Appendix J) to ensure consistency in questioning. Interviews were thirty minutes to one hour in duration and were recorded with permission as well as transcribed in real time against the consultation guide questions. The consultations aimed to elicit information about existing services, gaps in service delivery and referral pathways, and to identify best practice strategies for effective engagement and communication with young people about their R&SH.
2.4 Youth consultations

Young people were consulted between 15 February and 2 March 2016 through seven focus groups across five locations, with thirty-six young people consulted. The literature review, FPV and the PRG informed the priority groups for consultation including: a general youth population group, young people who identify as Same Sex Attracted and Gender and Sexually Diverse (SSAGSD), Aboriginal young people and young men (as a neglected cohort). Accessing youth by focused population segment allowed discussion to focus on the specific R&SH issues and barriers to service provision for each priority group.

The focus groups aimed to determine young people’s knowledge of, and access to, available services, and their preferences for how providers engage them in conversations about their R&SH. A focus group question guide (See Appendix K) was tailored for each group to elicit information regarding:

- Their primary R&SH needs and concerns
- What creates a positive interaction with a service provider
- How they would like providers to raise and discuss R&SH
- Whether they are aware of R&SH services available to them

Young people were recruited through existing youth networks and hosted by organisations and at venues familiar to each youth group. The methodology used pre-existing groups and sources to recruit participants, rather than random sampling. Focus groups continued to be recruited until saturation was reached, where no new themes were emerging, which occurred after seven groups were completed. Despite the small sample size, the key themes from discussions were well supported by the existing literature, and were triangulated against the consultations with service providers.

It must be noted that the sample of young people participating in the focus groups was not representative of all Victorian young people, and this is acknowledged as a limitation of the findings. It was particularly difficult to prioritise only four sub-populations given the multiple and diverse needs of young people in Victoria.

Two consultants with experience consulting young people facilitated the focus groups. Drawing on best practice, the focus groups began with an overview of the project and by establishing a safe and confidential environment for discussion. Given the potentially sensitive nature of the subject matter and the vulnerability of the target group, focus groups were carefully facilitated to avoid raising any topic that could potentially distress participants or result in inadvertent personal disclosure. Discussions lasted for 1.5 - 2 hours, were recorded with permission from participants and were notated in real time. All young people consulted received a gift voucher in recognition of their participation.

Demographic details for each participant were collected. Table 2 identifies the location, host and target group consulted, number of participants and the age range in each group.

Table 2: Focus groups with young people

<table>
<thead>
<tr>
<th>Location/LGA</th>
<th>Host Organisation</th>
<th>Target Group</th>
<th>No. of Participants</th>
<th>Age Range (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosanna (Banyule)</td>
<td>Banyule Youth Services – Queer Sphere</td>
<td>SSAGSD</td>
<td>3</td>
<td>15 - 22</td>
</tr>
<tr>
<td>Mill Park (Whittlesea)</td>
<td>Whittlesea Youth Services</td>
<td>SSAGSD &amp; non-specific</td>
<td>9, 7</td>
<td>14 - 19</td>
</tr>
<tr>
<td>Sunbury (Hume)</td>
<td>Sunbury Youth Centre</td>
<td>Young men</td>
<td>5</td>
<td>16 - 18</td>
</tr>
<tr>
<td>Craigieburn (Hume)</td>
<td>Craigieburn Youth Centre</td>
<td>Young men</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Preston (Darebin)</td>
<td>Victorian Aboriginal Health Services</td>
<td>Aboriginal</td>
<td>10</td>
<td>18 - 22</td>
</tr>
</tbody>
</table>
3. Policy Context

Understanding the policy context of R&SH contextualises the importance of appropriate service delivery. Federal, state and territory governments have policies on individual aspects of R&SH, but there is no coordinated approach, policy or strategy that addresses R&SH as a whole. Federal, state and territory governments have policies on individual aspects of R&SH, but there is no coordinated approach, policy or strategy that addresses R&SH as a whole. Victorian Context

Victorian Context

Improving R&SH is identified as a health and well-being priority in the Victorian Public Health and Well-being Plan 2015-2019 with strategic directions to:

• Promote and support positive, respectful, non-coercive and safe sexual relationships and reproductive choice (including planned, safe and healthy pregnancy and childbirth).
• Reduce sexually transmissible infections and blood-borne viruses with a focus on prevention, testing, management, care and support, surveillance, research and evaluation, in line with national strategies.
• Work towards eliminating HIV and viral hepatitis transmission and significantly increase treatment rates.

Although there is no state-wide R&SH policy, FPV progress R&SH strategies within the Victorian Health Priorities Framework Metropolitan Health Plan 2012-2022, together with organisations such as the Women's Health Association of Victoria (WHAV).

Australian Context

Australian Context

Although there is no national policy, the Australian Government has implemented policies for specific R&SH areas including the:

• Third Sexually Transmissible Infections Strategy 2014-2017
• Second National Hepatitis B Strategy 2014-2017
• Fourth National Hepatitis C Virus Strategy 2014-2017
• Seventh National HIV Strategy 2014-2017

National organisations such as the Australian Medical Association (AMA) and the Royal Australasian College of Physicians (RACP) advocate for national policy leadership and the RACP recently published a position statement recommending that Governments, health professionals and health providers specifically address the R&SH needs of young people.

International Context

International Context

Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. The World Health Organisation identifies that these include the right of all persons, free of coercion, discrimination and violence to:

• The highest attainable standard of sexual health, including access to reproductive and sexual health care services
• Seek and receive sexuality education, and health information related to sexuality
• Receive respect for bodily integrity
• Choose their partner
• Decide to be sexually active or not
• Have consensual sexual relations
• Have consensual marriage
• Decide whether or not, and when, to have children
• Pursue a satisfying, safe and pleasurable sexual life.
4. Themes from the literature and consultations

Young people are at risk of contracting STIs and having unplanned pregnancies as a result of inexperience, lack of knowledge regarding risks involved with unprotected sex, social pressure, substance use and reluctance to talk with parents or a doctor about their concerns\(^\text{36}\). A recent Australian survey of over 2,000 school students in years 10, 11 and 12, identified that:

- 69% of students had experienced some form of sexual activity, yet only 43% of those identifying as sexually active reported ‘always’ using a condom
- 13% of sexually active students reported using no contraception the last time they had sex, 15% used withdrawal and 5% had had sex that resulted in pregnancy
- Knowledge of STIs is generally poor\(^\text{37}\)

Young people are concerned about contraception, pregnancy and STIs however their R&SH concerns extend beyond these issues and are socially contextualised in their relationships, sex, gender and cultural identity and impacted by their experience with service providers. Some R&SH issues are common to most young people, while some are specific for particular groups. However, most young people in the focus groups expressed concern about how to access supportive services that will meet their needs.

The following themes were identified from the literature, consultations with service providers, and focus groups with young people during the development of this Guide.

4.1 Emergent Themes

Theme 1 – Youth-Friendly, Respectful and Non-Judgemental Care

What the literature tells us:

- Young people are more concerned about the way they are treated when they attend a service for R&SH than anything else\(^\text{38, 39}\)
- Optimal R&SH care is age, developmentally and culturally appropriate and delivered from a youth-friendly perspective\(^\text{40}\)
- Youth-friendly approaches improve access for young people to R&SH services and can have beneficial health outcomes for young people\(^\text{41, 42, 43}\)
- Interpersonal relations that promote youth-friendly service provision and effective communication enable providers to interact and engage with young people on a personal level about their R&SH\(^\text{44}\)

What service providers told us:

- Being ‘youth-friendly’ is a key enabler for young people accessing services. This means making young people feel welcome, respecting their differences and not judging them
- Young people will not access services if they feel uncomfortable or have had a bad experience with a service provider who has judged them or made them feel unwelcome

What young people told us:

- Respectful, caring and non-judgemental attitudes from service providers and a youth-friendly approach that understands the needs of young people is a key enabler for young people to access services.
- Fear of being disrespected, disregarded or being judged is viewed by many young people as a key barrier for accessing services.
Theme 2 – Confidentiality and Privacy

What the literature tells us:
- Confidentiality and privacy are part of a duty of care\textsuperscript{45}
- Assurance of confidentiality and privacy are critical for young people to feel confident and comfortable to access health services and to discuss personal information\textsuperscript{46}

What service providers told us:
- Most service providers identified and supported the notion that maintaining confidentiality and privacy when dealing with young people is a high priority

What young people told us:
- Most young people raised concerns about confidentiality and privacy, with particular concerns raised about disclosure to parents without their consent and fear of abuse or shaming from family, friends or their community
- Most young people stressed the need for service providers to assure confidentiality and privacy upfront, at the beginning of any consultation

Theme 3 - Contraception

What the literature tells us:
- The Fifth National Survey of Secondary Students and Sexual Health found that of those students who were sexually active (identified as having had either vaginal or anal sex):
  - The most commonly used form of contraception was the condom (58%) and / or the contraceptive pill (39%).
  - Only 7.5% of students reported use of Long Acting Reversible Contraceptives (LARCs e.g. Implanon – a soft rod-shaped implant).
  - 13% of sexually active students reported using no contraception the last time they had sex, 15% used withdrawal and 5% had had sex that resulted in pregnancy
  - Only 4% of students had accessed emergency contraception, suggesting that emergency contraception is significantly underutilised as back-up after unprotected sex\textsuperscript{47}
- Although contraceptive use was reported as high from women attending Family Planning Clinics in Victoria, nearly 40% of women were found to be at risk for unintended pregnancy, primarily due to inconsistent contraceptive use and use of ineffective contraception. Strategies for improving consistent use of contraception or a greater emphasis on long-acting contraception could benefit some young people\textsuperscript{48}
- Some young women may want access to emergency contraception (Emergency Contraceptive Pill (ECP) or Morning After Pill (MAP)), which is most effective if taken within 24 hours of unprotected sex\textsuperscript{49}
- Young people under 18 years are able to be prescribed contraception, if a doctor determines the young person is mature enough to understand the implications and the correct use of the contraception\textsuperscript{50}

What service providers told us:
- The need to access contraception is a high priority for most young people, particularly condoms and the oral contraceptive pill
- Young people are less aware of contraceptive options such as LARCs (e.g. Implanon), Intra Uterine Devices (e.g. Mirena) or injection options
- Finding service providers who can offer implant contraceptive options can be difficult for providers and young people alike
- The cost of contraception can be a barrier for some young people. Writing a script for the oral contraceptive for example is not useful if the young person is unlikely to fill the script because they don’t have the money, or if they have to ask a parent for the money
What young people told us:
- The need to access contraception is a high priority for most young people
- Options for contraception are not always provided to young people and they are generally not aware of LARCs or other options
- Cultural underpinnings, beliefs and values about contraception should be considered during discussions about contraception, as explained by young Aboriginal people who identified that they often feel ‘pushed’ to take a particular contraception instead of being offered options or indeed asked if they even want to be on contraception
- The need for sensitivity, privacy, confidentiality and to consider the young person’s age was raised in some youth consultations as important when discussing contraception

Theme 4 – Pregnancy

What the literature tells us:
- Although fewer young women are giving birth (15.6 births per 1,000 young women in 2011), this is most likely due to improved availability of contraception, access to abortion and sex education
- Even before having sex, many young people and particularly young women, have concerns about potential unplanned pregnancy
- The majority (78%) of Australian secondary students surveyed in 2013 expressed a desire to have children at some stage of their life with the preferred age to have a child being between 25 and 29 years
- The national study on the sexual health and well-being of same sex attracted and gender questioning (SSAGQ) young people showed that same sex attracted women had higher pregnancy rates than heterosexual women:
  ‘When we compared the pregnancy rate of the 15-18 year olds with the SSASH study (Smith et al, 2009) we found that double the percentage of SSAGQ young women had been pregnant (10%) compared with 5% of their heterosexual peers’,
- Some young women want to access emergency contraception such as ‘the morning after pill’

What service providers told us:
- Fear of potential unplanned pregnancy is a concern for most young people
- Some young women want access to information and options for a termination of pregnancy
- Some young women want to become pregnant and want to discuss fertility issues
- Some young women have been refused a referral for a termination because of the doctor’s personal beliefs

What young people told us:
- Most young people expressed concerns about unplanned pregnancy, including some young women in same sex relationships. Young men are also concerned about potential unplanned pregnancy
Theme 5 – (STIs) Sexually Transmissible Infections

What the literature tells us:

• 75% of all STI diagnoses in Australia occur within the 15-29 year old age group

• Blood borne and sexually transmissible infections such as HIV, HPV, Hepatitis C and Chlamydia disproportionately affect young people

• There were 12,607 notifications for sexually transmissible infections for 15–24 year olds, of which 90% were for Chlamydia in 2014

• Knowledge of STIs among Australian secondary students is generally poor, including knowledge of Chlamydia (despite Chlamydia being the most common STI among young people), HPV and hepatitis; but knowledge of HIV is relatively high

• 80% of HIV diagnoses are in men who have sex with men

• Many teenage men who have sex with men are at risk for a STI, often have sex with older men and do not consistently use condoms

• Less than 10% of young people aged 15-29 years are screened each year in general practice

• Young men may be less likely to be offered STI testing

• Young people value and trust the expertise of health workers and doctors and think it is appropriate for them to raise STIs as an issue for discussion

• Barriers to Chlamydia screening for GPs (which may apply to other STIs) include: time, lack of awareness or knowledge about Chlamydia, lack of support for partner notification, and concern about embarrassing their patient

• Barriers to Chlamydia screening for young people include: the cost of the consultation and the Chlamydia test, availability of transport to the clinic, lack of knowledge about the need for testing, the location of the pathology collection site, embarrassment or unease about providing a specimen, and, for those living in rural and remote areas of Australia, fears about confidentiality, the lack of female GPs, and health care availability

What service providers told us:

• Most young people do not appear to know much about STIs and although they might be concerned about getting an STI, they are often unaware of the risks

• Most young people need service providers to initiate conversations about STIs and the possible risks for transmission

• Few young people understand that STIs can be transmitted through oral sex

• Positive ‘safe sex’ messages can engage young people more effectively, than negatively framed language that may scare or deter young people from presenting. For example:

  ‘Conversations about safe sex and STIs should encourage enthusiastic consent. e.g. Agreeing to be ‘safe’ increases the fun and pleasure of sex and sexuality so that concerns about STIs (and pregnancy) don’t have to ruin the fun, but they are often framed in negative or punitive ways like ‘if you don’t do this or that there will be terrible consequences’

• It is a good idea for service providers to offer opportunistic testing so that young people can be engaged there and then, rather than expecting them to come back again

What young people told us:

• They are concerned about getting an STI but are not always aware of the symptoms

• ‘The whole topic is embarrassing, especially if you had to tell someone about a discharge, it can make you feel ashamed’

• Some young people might just be afraid to know the truth (e.g. don’t want to know about Chlamydia)

• Some young men reported that they would raise any S&RH concerns with a doctor by saying something like:

  ‘I’ve got some issue in my pants’ or ‘hey, I went out had sex and there’s a problem downstairs’
Theme 6 - Sex and Gender Diversity

What the literature tells us:

- In the Australian secondary students survey in 2013, 8% of young men and 4% of young women reported sexual attraction only to people of the same sex and 5% of young men and 15% of young women were attracted to people of both sexes. 67
- A national study of 3134 same sex attracted and gender questioning (SSAGQ) young people, showed that most young men identified as exclusively same sex attracted, but half of the young women were attracted to both sexes. 68
- Many young people realise their sexual differences before puberty and SSAGQ young people can suffer high levels of verbal and physical abuse in the community and especially at school. 69
- Many sex and gender diverse young people feel discriminated against, can be particularly vulnerable when seeing a doctor, and may be at increased risk of isolation, depression, suicide, substance abuse and injury through violence. 70
- Young SSAGQ people may delay seeking treatment due to concerns about perceived or real discrimination or judgement of their sexuality and consequently, may be under screened for a number of health conditions. 71
- Young people should not be pushed to ‘come out’, as disclosing sexuality only enhances a young person’s well-being if the people they choose to come out to are supportive. 72

What service providers told us:

- Many young people have concerns related to their gender and sexual identity or may be questioning their identity.
- ‘Coming out’ or disclosing gender and sexual diversity can be difficult for many young people, who fear discrimination or repercussions from family or cultural community.
- Assumptions cannot be made about young people’s sexual relationships.
- Transgendered (‘trans’) young people may want access to hormones, clinical intervention, counselling, or support to assist their social transition. For example, support with school, changing ID documents and support for, or with, family.
- For some young people who find discussing their body, biology or gender assigned at birth particularly distressing, it might be appropriate to refer them to the Royal Children’s Hospital Gender Dysphoria Service. 73
What young people told us:

- Young people can have concerns around their sexual orientation and/or gender and can be fearful about disclosing same sex attraction, sex and gender diversity due to stigma, discrimination and perceived assumptions made about:
  - Their gender or sexual identity
  - The sex of a partner/s
  - Relationship characteristics (monogamous, single, partner, polyamorous)
  - Sexual practices (e.g. that all gay-identified men for example engage in anal sex)
  - Sexual desire (not acknowledging asexuality)
  - An example of a heterosexist assumptions:
    ‘Some doctors just assume you are heterosexual – One doctor persisted in asking “are you sure you’re not pregnant, are you sure you haven’t had sex with a man?” despite me telling her repeatedly that I was gay and my partner was in the waiting room’

- Some young people did not know there are SSASGD friendly doctors or where or how you would go about finding them. They assumed all doctors have to be friendly, but their negative experiences told them otherwise

- Some same sex attracted females identified that their gay (female) friends in their 20’s were not getting Pap tests because they didn’t think they need to, as was the case with some of their straight friends too

- The use of a preferred pronoun (‘she’, ‘he’ or ‘them’) is important to some SSASGD young people. Some young people prefer use of a pronoun that may not match the gender they were assigned at birth. For example, female assigned at birth may identify as male, in which case their preferred pronoun may be ‘he’ or ‘him’. An example of the binary assumptions made about gender identity:
    ‘I prefer to be referred to as “they” or “them”… in health and human development at school they divided the class into guys and girls…but there was no ‘middle ground’…which is where I wanted to stand…’

- For some young people, discussions about the gender they were assigned at birth can be difficult and cause distress. An example where the service provider was not sensitive in the discussion:
    ‘Don’t make assumptions about what I need or want – the doctor’s attitude when I got my second puberty blocker needle...just kept going on about children in the future when all I want is to get on with my transition…I don’t like my body…I didn’t want to talk about babies!’

Theme 7 – Cost of Services

What the literature tells us:

- The cost involved in accessing services is a common barrier for young people.
- Making services affordable encourages youth-friendly service delivery, as does supporting young people (at 15 years) to get their own Medicare card.

What both service providers and young people told us:

- Costs involved in accessing R&SH services are a concern for most young people who may not have money to independently pay for services.
- Young people are not always aware they can access their own Medicare card (at 15 years) and can be worried about confidentiality when using a family Medicare card.
Theme 8 – Aboriginality and Cultural Diversity

What the literature tells us:

- Culture plays a central role in shaping people’s identity, values, beliefs, social roles and behaviours.\(^8^0\)
- Aboriginal young people are far more likely to be disadvantaged across a broad range of health, community and socioeconomic indicators compared with non-indigenous young people, and may suffer significant cumulative historic trauma.\(^8^1\)
- A recent survey of Aboriginal young people showed that overall knowledge of STIs and BBVs was generally good, however only 37% of participants reported ‘always’ using a condom in the last year.\(^8^2\)
- Aboriginal health services are identified as the most common place for young Aboriginal people to be tested for an STI, followed by private general practice clinics.\(^8^3\)
- Young Aboriginal people’s beliefs and attitudes about contraception, pregnancy and parenting are often significantly influenced by the opinions of peers and family.\(^8^4\)
- Contraception use can be perceived negatively among community members and peers. There can be negative connotations regarding the use of Implanon, with stigma associated with sexual behaviour and that a young woman may be promiscuous.\(^8^5\). Note that the previous two points can also be applicable to all young people in general.
- ‘Shame’ can be a powerful barrier for many young Aboriginal people. Shame is more than embarrassment; it can be associated with deep-seated feelings of inadequacy and disempowerment and may also involve feeling outcast and ostracised from friends and family, which is particularly relevant to the high value placed on group belonging in Aboriginal cultures. For example, a young person may experience shame when describing symptoms or when examined, requiring strict privacy and confidentiality from health providers.\(^8^6\)
- R&SH literacy can be a particular problem for young people from culturally and linguistically diverse (CALD) backgrounds, including international students who report access issues and less than optimal sexual health outcomes and experiences.\(^8^7\)
- 70% of international students who make a claim on health insurance within the first 12 months of arrival, do so for pregnancy related treatment.\(^8^8\)
- Unplanned pregnancy, abortion, STIs and violence affect female international students in Australia; often symptomatic of limited sexual health literacy, poor access to health services and the dynamics of the immigration experience.\(^8^9\)
What service providers told us:

- Privacy and confidentiality are very important to Aboriginal young people.
- Young Aboriginal people are very diverse just as the rest of the population. There is diversity in how young Aboriginal people live their lives. Taking time to understand an individual's cultural identity and how this may influence their perception is important to engaging young Aboriginal people.
- Aboriginal young people should be offered the same reproductive health care as everyone else and a GP should learn how to follow each individual's responses and enquire as to how each individual feels or believes about each issue.
- People’s attitude should not be assumed by the way they look; if someone looks Aboriginal you can’t assume what they think or believe, just as not all of one cultural group will think one same thing, or a certain way someone dresses does not reflect what health care they may want offered.
- Aboriginal young women can want advice about becoming pregnant which seems to speak about cultural underpinnings and the importance of ‘family’.
- Targeting young Aboriginal people for R&SH can be difficult due to broader implications of disclosing abuse, or fear of family or peers finding out about sexual activity.
- Opportunistic testing is useful to reduce ‘shame’.
- The age of the Aboriginal Health Worker (AHW) can impact service delivery, as the AHW may be confident raising R&SH with a younger person, but may not be confident raising R&SH with an older person as this can be perceived as disrespectful.
- The sex of the provider can also be important, as young men may want a male provider and females may prefer females.
- Knowledge of HPV vaccine and its link with cervical cancer is not well known among many Aboriginal young people.
- There are high rates of HPV vaccination in male and female young people through the school immunisation programs with a few referring to come to VAHS.
- Young people from CALD backgrounds can be worried about parents finding out about their R&SH issue and the repercussions they may experience from family including physical retribution for breaking cultural taboos around sexual activity.
- Young people from CALD backgrounds and international students can be very concerned about disclosing same sex attraction or ‘coming out’ for fear of the cultural impact and repercussions from family.
- Contraception can be a difficult topic to raise with some young people from CALD backgrounds due to conflict with cultural expectations.
- Refugee CALD young women often want to see a female provider for cultural reasons.
- Cost of services can be a barrier to services for both Aboriginal and CALD young people.

What young Aboriginal people told us:

- Aboriginal young people report similar R&SH concerns and information sources (internet and Google followed by a doctor’s opinion) to non-indigenous young people.
- Young people may choose a doctor working at an Aboriginal health service for cultural and familiarity reasons, however convenience and location to a doctor, bulk billing and trusting the doctor will maintain confidentiality are important considerations.
- Some young people feel they are ‘pushed’ constantly about contraception, without being asked what they would like to do e.g. they may wish to become parents at a young age.
- Random questioning about R&SH can produce ‘shame’. Some young people suggested a ‘list’ or form that can be filled in about R&SH prior to a consultation could make discussions easier and lessen shame.
- Aboriginal young people do not want assumptions made about them or their culture, such as comments like ‘your people’ or ‘you don’t look Aboriginal’ or asking questions that assume sexual abuse has taken place.
Theme 9 – Consent and Respectful Relationships

What the literature tells us:

- There are age limits around young people’s capacity to consent (give permission) to any aspect of sex (having sex, being touched or letting another person perform a sexual act in front of the young person) which protect young people by law.\(^{90}\)
- Pornography can be accessed on smartphones, computer screens and is present in popular culture, shaping the desires and imagination of young people. Internet porn depicting aggression against women can be normalised, shared and imitated.\(^{91}\)
- ‘Sexting’ is sending nude, sexual or indecent photos (or ‘selfies’) using a computer, mobile phone or other mobile device. It is a crime in some circumstances, particularly if an image of a person is distributed without their knowledge or consent.\(^{92}\)
- Young people should be reminded that ‘sexting’ creates a digital footprint that could have implications for them in the future and that criminal charges, including those related to child pornography can be made against them.\(^{93}\) See Appendix C: Reporting laws of child abuse in Victoria: Child Pornography Law Victoria
- Respectful Relationships Education has been included in Australian curriculum to prevent gender-based violence.\(^{94}\)

What service providers told us:

- Young people do not always understand what ‘consent’ actually means, that it must always be given and that it is ok to ‘change your mind’
- Young people often need service providers to raise the topic and provide information and education about the ethical and legal implications of consent
- Young people may not be aware of what an unsafe relationship looks like or what unsafe sexual practices are, requiring service providers to intervene and provide information and support
- Young people may not know the legal age for sex or the laws around age differences. See Appendix M: Laws and changes in R&SH
- Some young people may be confused about sexual decision making or what constitutes coercion or unwanted touching
- Disrespectful language and power imbalances can be evident in the language used by some young people, particularly some young men who refer to some girls as ‘sluts’, but see themselves as a ‘hero’ for having multiple sexual partners
- Access to pornography seems to have had a negative impact on some young people’s perceptions of consent and healthy, respectful relationships
- Sexual assault can be inadvertently disclosed by a young person who does not understand consent or what constitutes a healthy respectful relationship
- Some providers will receive referrals from Child Protection Services requiring appropriate counselling, clinical support and possible forensic intervention

What young people told us:

- Overall the topic of consent and respectful relationships did not come up in the youth focus groups, but was indirectly raised through comments such as:
  - ‘Some guys make a joke about rape, but rape is never funny’
  - ‘Slut shaming happens’
Theme 10 – Engaging with Service Providers

What the literature tells us:

• Access to someone for advice, and appropriate service delivery are significant protective factors for adolescent health and well-being.

• Young people can be reluctant consumers of health services.

• Young people can be fearful, embarrassed and reluctant to discuss sensitive issues around R&SH.

• ‘Shame’ can be a powerful barrier for many young Aboriginal people.

• Negative attitudes of service providers toward young people can be a barrier for young people engaging with service providers.

• The interpersonal communication skills of a service provider can enable improved engagement with young people about their R&SH.

• Young men tend to visit a doctor less frequently than young women and rarely present with sexual health issues making it difficult for GPs to offer opportunistic education and screening.

• Self-imposed views on masculinity, privacy and embarrassment can be barriers for young men accessing sexual health care.

What service providers told us:

• Being ‘youth-friendly’ is a key enabler for young people to engage with service providers.

• A positive, non-judgemental welcoming attitude improves engagement with young people.

• Some providers identified young men as ‘difficult to reach’ and ‘reluctant’ when it comes to discussing issues around R&SH.

• Opportunistic discussions about R&SH can be useful when engaging young people.

• Interventions such as testing should be undertaken as soon as possible, as it may be difficult to get a young person to return for follow up.

What young people told us:

• Their engagement with service providers depends very much on how youth-friendly the provider is, how sensitive and caring they are, and whether they feel judged or not.

• They will not return to a service provider who judges or makes assumptions about them.

• Most young people identified GPs as their primary ‘go to’ person for R&SH.

• Young men differed in their engagement styles with providers. Some expressed reluctance and ideals of masculinity:

  ‘I definitely have mates who are awkward and struggle with these issues…awkward about their bodies. They [other young men] can talk about sex and sexual experiences but not about sexual worries [in reference to masculinity].’

• Other young men identified they can engage directly and openly with providers:

  ‘I’m happy to be straight up and blunt. I just want them to tell me what the problem is, tell me what the solution is. Be straight with me - like when a doctor said “what’s up with your acne?”’
Theme 11 – Awareness of Services and Referral Pathways

What the literature tells us:

It is difficult to find literature or evidence that identifies service providers’ or young peoples’ levels of awareness of the services available for R&SH. However, R&SH care for young people is delivered in settings including primary care, community and hospital-based adolescent health services, Aboriginal medical services, sexual health centres and family planning clinics, school-based services and justice health services.\(^\text{103}\)

What service providers told us:

- Most service providers had little knowledge of other R&SH providers in their local area, likely due to the fact there were not many R&SH services in the identified LGAs.
- Most providers reported referring internally to other health professionals and counsellors or to known youth friendly local GPs, but reported that finding such GPs can be difficult.
- Referrals were often made to local youth services, community health services or to state-wide services such as public hospitals and the FPV Action Centre. Referrals were occasionally made to child protective services or specialised services dealing with gender identity or gender re-alignment.
- Almost all providers stated there were no formal referral pathways and that it is difficult to find and access services.
- Two providers identified they had referral pathways between public health services (e.g. Royal Women’s Hospital, Royal Children’s Hospital, Mercy Hospital for Women), but this is dependent on visiting specialists on-site or ongoing relationships between their health providers and the health service.
- One provider stated they often struggle to find good, youth-friendly services for young people who have travelled in from rural or regional areas.

What young people told us:

- Overall young people were not aware of specific R&SH services.
- Most young people reported they would go to a GP for R&SH issues.
- Some young people made references to ‘that place in the city’ but could not name the place (they were referring to the Action Centre).
- A small number of young people consulted had heard of FPV and Melbourne Sexual Health Clinic.
Theme 12 – How Young People Access R&SH Information and Resources

What the literature tells us:

• Schools, parents, peers, and community and health professionals all contribute to young people’s reproductive and sexual health

• Google, family, friends, a friend-of-a-friend and partners are where young people go for R&SH information. A recent study showed young men also use pornography as a source of information

• GPs remain the first point of call for specific support for R&SH as well as other adolescent health problems

• Health messages sent by text message to young people may offer a discreet way for adolescents to receive health information on sensitive topics like sexual health

• Technologies such as the internet and SMS can assist in influencing behaviours such as condom use and STI testing

What service providers told us:

• The internet is popular for young people seeking R&SH information

• Young people will call providers on the phone or make an appointment for a face to face consultation for more information

• Information is often provided to young people opportunistically, when they are visiting a service provider for a R&SH issue or when R&SH arises when discussing another issue

• Many providers (particularly those working in youth services) reported successfully using SMS to remind young people about appointments or to check how things are going using informal, friendly text messaging such as: ‘Are you ok? We missed seeing you at your appointment’. Young people will often respond back to providers via SMS

• Facebook is used by some providers to send health information out to young people

What young people told us:

• Young people tend to seek information first from the internet, and then either go to a doctor, or are referred to a GP for further support

  ‘The internet. The answer to everything is the internet’

  ‘I would go to a service for spots on the penis, unexpected rash after sex, lumpy balls, but for other stuff - go to the internet’

• Many young people rely on information from their friends and peers

• Some young people rely on support and information from parents or older siblings
4.2 Similarities and differences between service providers’ and young people’s perceptions of R&SH

The findings from the literature review and consultations were, for the most part, consistent with the issues faced by young people when accessing services for the R&SH. The following points are a summary of the key similarities and differences between service providers and young people’s perceptions of R&SH as derived from the findings of consultations with each group.

**Similarities:**
- Contraception, pregnancy and STIs are priority concerns for young people
- Many young people want to discuss sex and gender identity and diversity issues with service providers, but find it difficult due to perceived fear of discrimination or judgement
- Young people want to know about how to have sex safely
- Issues of masculinity can arise for young men when discussing R&SH or accessing services
- Power imbalances between males and females can be evident in conversations about sex and relationships and disrespectful language (e.g. ‘slut shaming’) is sometimes used by some young men
- Positive communication is important. Being treated with respect in a non-judgemental and youth-friendly manner is a priority for young people and a negative attitude from a service provider can be a major barrier
- Confidentiality and privacy is important to young people, particularly reassurance that parents do not necessarily need to find out
- Low cost services are important to young people
- Young people can be embarrassed, lack knowledge or feel afraid or ashamed to access R&SH services
- Both service providers and young people have very little knowledge of local services available or the breadth of services that can support R&SH

**Differences:**
- Issues around consent were not raised by young people. Consent and respectful relationships were usually raised as a topic by service providers
- Pornography and sexting did not come up in conversations with young people, yet were raised by service providers as having negative impacts on young people’s perceptions of healthy sexual relationships
- The young men we spoke with were not as ‘difficult to reach’ or reluctant to discuss R&SH as some providers suggested, but this is biased by the intent of the discussions
- Refusal by some providers to refer young women for termination services did not come up as an issue for the young people we spoke with, but was raised by some service providers
5. Recommendations

FPV makes the following recommendations for improving R&SH service delivery to young people and to encourage between service providers to promote improved service coordination of R&SH services in Victoria.

**Recommendation 1:**

It is recommended that primary health care providers who are looking to integrate a service coordination approach to youth R&SH, consider collaborating with local partners and/or stakeholders to develop a localised service map.

**Recommendation 2:**

It is recommended that service providers establish youth friendly practices and processes, including policies and procedures.

**Recommendation 3:**

That this Guide is widely disseminated to primary health care providers throughout Victoria, including but not limited to: GPs, nurses, counsellors, youth workers, Aboriginal Health Workers and allied health professionals working with young people in primary health care settings. The Guide should be made available through various platforms, e.g. online, electronic, hard copy, tablet or smart phone application versions.

**Recommendation 4:**

It is recommended that this Guide be forwarded to key providers of initiatives which support youth health and youth access such as Respectful Relationships Education, Safe Schools Coalition and 100 GPs in 100 Schools to maximise uptake.

**Recommendation 5:**

It is recommended that this Guide is promoted and distributed to Victorian Primary Health Networks (PHNs), and through these organisations, distributed to GPs and included in key youth initiatives such as the Victorian Government’s 100 GPs in 100 schools’ initiative.

**Recommendation 6:**

It is recommended that this Guide be incorporated and referenced in programs that develop clinical and referral pathways such as HealthPathways or Maps of Medicine through the Primary Health Networks.

**Recommendation 7:**

It is recommended that primary health care providers are further supported through training and the use of this Guide.

**Recommendation 8:**

It is recommended that resources to support and assist young people with access to R&SH services and information be developed to complement this Guide and improve R&SH outcomes for young people in Victoria.

6. Conclusion

The Service Delivery and Referral Pathway Tool offers primary health care providers guidance for identifying, assessing and planning care for young people requiring access to R&SH services.

By understanding the R&SH needs of young people and their preferred language when having a conversation, we hope providers will feel more confident to work with and support young people throughout their R&SH needs as the traverse adulthood.
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Appendix A: Developing a service map

A service map can identify local and/or state-wide services and documents key demographic and service provision details. Information collected about each service enables service providers to identify what services are available to support young people with their R&SH and supports service collaboration and referral pathways.

Collecting information for a service map can occur during liaison with other services or more formally through accessing organisation websites or directories such as the Human Services Directory. The map can be created in an Excel database using the following headings across the top of the page and listing the services along the left side of the page:

**General Information**

- Location
- Organisation name
- Physical address, Postal address, Suburb, State, Postcode
- Phone contact
- Website address
- Hours of operation
- Available transportation / access - Bus / Train / Tram, other
- Target group - Who is this service aimed at?
- If a referral required
- If an appointment required
- Billing - Bulk billed? Free? Fee involved?

**Clinical Services Provided**

- Contraception Type e.g. Implanon, Mirena, Injections, Condoms, Emergency contraception?
- Immunisation
- Pap screening
- Pregnancy options – Counselling? Testing?
- Mental health
- Termination services
- STI testing
- HIV clinic
- Sexual violence
- FGM/C
- Counselling

**Education & psychosocial support**

- Alcohol and drugs
- Puberty
- Body image
- Relationships
- Safe sex
- Sexuality / gender
- Teen pregnancy
- Peer support
- FGM/C
- Pap screen
- Contraception
- Mental health
- STIs and HIV
Reproductive and sexual health – service mapping questionnaire

Please complete as much information relating to your organisation and the services it provides relating to sexual and reproductive health

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### Clinical Services Offered

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<th>STI testing</th>
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<th>HIV clinic</th>
<th>Pregnancy testing</th>
<th>Sexual violence</th>
<th>Pregnancy counselling</th>
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## 1. Accessibility

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<td>Does your service have a promotional strategy targeting young people?</td>
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<td>Is the confidentiality policy widely publicised to young people, their parents and carers?</td>
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<td>Does your service use creative, innovative strategies including technology and activity based approaches to improve young people’s engagement with health services?</td>
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<td>Are services provided free, or at a cost affordable to young people?</td>
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<td>Can young people access the service easily?</td>
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<td>Is the service open when young people can access it?</td>
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<td>Is the service sensitive to the cultural and language needs of young people?</td>
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<td>Is it possible for young people to drop in and use the service without having to make an appointment?</td>
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<td>Is there capacity to offer longer sessions to deal with complex issues that may arise?</td>
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**Recommended actions**

**Please describe**

## 2. Evidence-based approach

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<tr>
<td>Does your service regularly look at the latest research evidence to make sure your practice is up to date? For example, are youth health checks (including HEADSS assessments) routinely used with young people?</td>
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**Recommended actions**

**Please describe**

## 3. Youth participation

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<td>Does your service involve young people in service planning and review?</td>
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**Recommended actions**

**Please describe**
### 4. Collaboration and partnerships

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Does your service work collaboratively with others to help young people navigate the health system? For example, by providing co-location, outreach, referral facilitation?

Please describe

Recommended actions

### 5. Professional development

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Do staff receive training, supervision and support in working with young people aged 12-24 and youth health issues?

Please describe

Recommended actions

### 6. Sustainability

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Does your service develop sustainability strategies? For example starting with small initiatives or changes, and gradually building on success, and networking with other providers?

Please describe

Recommended actions

### 7. Evaluation

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Does your organisation evaluate its services, including seeking feedback from young people?

Please describe

Recommended actions
Appendix C: Reporting Laws of Child Abuse in Victoria

Mandatory Reporting of Child Abuse - Victoria

Mandatory reporting is a term used to describe the legislative requirement imposed on selected classes of people to report suspected cases of child abuse and neglect to government authorities. Some professionals such as doctors, nurses, police and school teachers are legally obliged to report suspected child abuse. In addition, any person who believes on reasonable grounds that a child needs protection can make a report to the Victorian Child Protection Service. It is the Child Protection worker's job to assess and, where necessary, further investigate if a child or young person is at risk of harm.

Child Sexual Abuse – New Laws to protect against

Three new criminal offences have been introduced to improve responses within organisations and the community to child sexual abuse. The offences form part of the Victorian Government's response to the recommendations of Betrayal of Trust, the report of the Parliamentary Inquiry into the Handling of Child Abuse by Religious and other Non-Government Organisations.

‘Failure to disclose’ offence requires adults to report to police a reasonable belief that a sexual offence was committed against a child (unless they have a reasonable excuse for not doing so). The new offence applies to all adults, not just professionals who work with children.

‘Failure to protect’ offence applies to people within organisations who knew of a risk of child sexual abuse by someone in the organisation and had the authority to reduce or remove the risk, but negligently failed to do so.

‘Grooming offence’ targets communication, including online communication, with a child or their parents with the intent of committing child sexual abuse.

All allegations of child abuse are investigated by the Sexual Offences and Child Abuse Investigation Teams (SOCITs) at Victoria Police, who are specialist detectives trained to investigate the complex crimes of sexual assault and child abuse.

Child Pornography Law – Victoria

Under Victorian law a person can be charged with possessing or producing child pornography if they have or make a film, photograph, publication or computer game that shows a person under 18 (or appears to be under 18) involved in sexual activity and/or posing in an indecent sexual manner.

Exceptions to child pornography offences:

From 2 November 2014 a person cannot be prosecuted for child pornography offences if they take, store or send indecent images of themselves. It is also not a child pornography offence if the person is under 18 years old and:

- No person in the photo is more than two years younger than the person producing the image
- The photo does not show an act that is serious criminal offence.
Appendix D: Assessment of the Mature Minor

The British landmark case of Gillick v West Norfolk and Wisbech Area Health Authority (1986) established a legal precedent that an adolescent under the age of 18 years is capable of giving informed consent when he or she “achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed” (The mature minor principle)\(^{118}\).

The ‘Gillick test’ of competence to consent is determined by a qualified health professional to ascertain a young person’s level of maturity to consent through consideration of:

- The young person’s age
- Level of independence and maturity
- Level of schooling
- Ability to express own wishes
- The gravity of the presenting illness, condition or treatment
- Family issues\(^{119, 120}\)

In recent times, the Fraser Guidelines have substituted the Gillick test of competence for consent related to contraception\(^{7}\).

The Fraser Guidelines identify contraception may be offered to a young person if:

- The young person understands the advice being given
- The young person cannot be convinced to involve parents/carers or allow a health professional to do so on their behalf
- It is likely that the young person will begin or continue having intercourse with or without treatment/contraception
- The physical and/or mental health of the young person is likely to suffer, unless he or she receives treatment/contraception
- The young person’s best interests require contraceptive advice, treatment or supplies to be given without parental consent\(^{121}\).

Gillick competence and the Fraser Guidelines are not designed to replace involvement by a parent/guardian.
## Appendix E: Adolescent Developmental Stages

This table has been sourced and adapted from Adolescent Developmental Stages p.35 in Adolescent Health: Enhancing the skills of General Practitioners in caring for young people from culturally diverse backgrounds, GP Resource Kit 2nd Edition[^122]

<table>
<thead>
<tr>
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<th>Early (10 – 14 years)</th>
<th>Middle (15 – 17 years)</th>
<th>Late (&gt;17 years)</th>
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<tr>
<td>Central Question</td>
<td>“Am I normal?”</td>
<td>“Who am I?”</td>
<td>“Where am I going?”</td>
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| Major Developmental Issues | • coming to terms with puberty  
• struggle for autonomy commences  
• same sex peer relationships all important  
• mood swings                      | • new intellectual powers  
• new sexual drives  
• experimentation and risk taking  
• relationships have self-centred quality  
• need for peer group acceptance  
• emergence of sexual identity               | • independence from parents  
• realistic body image  
• acceptance of sexual identity  
• clear educational and vocational goals, own value system  
• developing mutually caring and responsible relationships |
| Cognitive development | • still fairly concrete thinkers  
• less able to understand subtlety  
• daydreaming common  
• difficulty identifying how their immediate behaviour impacts the future | • able to think more rationally  
• concerned about individual freedom and rights  
• able to accept more responsibility for consequences of own behaviour  
• begins to take on greater responsibility within family | • longer attention span  
• ability to think more abstractly  
• more able to synthesise information and apply it to themselves  
• able to think into the future and anticipate consequences |
| Recommendations for what to do | • Reassure about normality  
• Ask more direct than open-ended questions  
• Make explanations short and simple  
• Base interventions need immediate or short-term outcomes  
• Help identify possible adverse outcomes if they continue | • Address confidentiality concerns  
• Always assess for health risk behaviour  
• Focus interventions on short to medium term outcomes  
• Relate behaviours to immediate physical and social concerns – e.g. effects on appearance, relationships | • Ask more open-ended questions  
• Focus interventions on short and long term goals  
• Address prevention more broadly |

[^122]: Adolescent Health: Enhancing the skills of General Practitioners in caring for young people from culturally diverse backgrounds, GP Resource Kit 2nd Edition.
## Appendix F: Opportunistic Screening

Opportunistic screening should be considered during extended conversations with young people about their R&SH. The Australian STI Management Guidelines for Use in Primary Care provide a succinct summary of screening guidelines and prompts for conducting a R&SH check. NSW Health STI Testing Tool - Clinical Guidelines for the management of STIs among Priority populations. 

www.can.org.au/File.axd?id=45fa685b-084c-4c6d-bbb3-8d584a1c66b

### STI Testing Tool

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<td>A sexually active young person under 25 years</td>
<td>This population is at higher risk for Chlamydia</td>
<td>Chlamydia</td>
<td>First pass urine OR Self-collected vaginal swab OR Endocervical swab</td>
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<td></td>
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<td>HBV</td>
<td>Consider vaccination for HBV &amp; HPV</td>
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<tr>
<td>A sexually active Aboriginal young person under 25 years</td>
<td>This population is at higher risk for Chlamydia *Can also be conducted as part of the Aboriginal health check - Medicare item 710</td>
<td>Chlamydia Gonorrhoea</td>
<td>First pass urine OR Self-collected vaginal swab OR Endocervical swab</td>
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<td>HBV</td>
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<td>Consider vaccination for HBV &amp; HPV</td>
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<td>HBcAb</td>
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<td>An (asymptomatic) person of any age requesting &quot;An STI checkup&quot;</td>
<td>The patient has requested it, so may be at risk. Ideally, take a sexual history to ascertain: a) if they fall into one of the groups below b) help you decide on sites for specimen collection</td>
<td>Chlamydia</td>
<td>First pass urine OR Self-collected vaginal swab OR Endocervical swab</td>
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<td>HIV Syphilis HBV</td>
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<td>Consider vaccination for HBV</td>
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<td>HIV Ab Syphilis EIA</td>
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<td>HBcAb</td>
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<tr>
<td>A man who has sex with men (MSM)</td>
<td>This population group is at higher risk for Chlamydia, Gonorrhoea, Syphilis, HIV, HAV, HBV</td>
<td>Chlamydia</td>
<td>First pass urine &amp; anal swab</td>
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<td>Gonorrhoea</td>
<td>Throat swab Anal swab</td>
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<td></td>
<td></td>
<td>HIV Syphilis HBV</td>
<td>Blood</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Vaccinate for HAV &amp; HBV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HIV Ab Syphilis EIA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HAV Ab (total)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HBcAb</td>
</tr>
<tr>
<td>A sex worker</td>
<td>This population group is at higher risk for Chlamydia, Gonorrhoea, Syphilis, HIV, HBV See above for MSM sex workers</td>
<td>Chlamydia Gonorrhoea</td>
<td>First pass urine OR Self-collected vaginal swab OR Endocervical swab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV Syphilis HBV</td>
<td>Blood</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Vaccinate for HBV</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>HIV Ab Syphilis EIA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HBcAb</td>
</tr>
<tr>
<td>A person who injects drugs</td>
<td>This population group is at higher risk for Chlamydia, Gonorrhoea, Syphilis, HIV, HBV and HCV* *HCV is not an STI but is included due to risks associated with injecting drugs</td>
<td>Chlamydia Gonorrhoea</td>
<td>First pass urine OR Self-collected vaginal swab OR Endocervical swab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV Syphilis HBV</td>
<td>Blood</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Vaccinate for HBV</td>
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<tr>
<td></td>
<td></td>
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<td>HIV Ab Syphilis EIA</td>
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<td></td>
<td>HBcAb</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>HCVAb</td>
</tr>
</tbody>
</table>

HAV = Hepatitis A  
HBV = Hepatitis B  
HCV = Hepatitis C  
HPV = Human Papilloma Virus  
NAAT = Nucleic Acid Amplification Test (eg: PCR)  
Information on vaccination www.immunise.health.gov.au  
Other risk behaviours

“I’d now like to ask about some other activities that could increase a person’s risk of certain infections, is that OK?”

☐ Have you had any tattoos?
  - If yes, was that here in Australia or overseas?

☐ Have you ever injected drugs?

☐ Have you ever shared needles or injecting equipment?

☐ Have you ever been in jail?

Consent

“I suggest that we test for…” eg: Chlamydia

☐ This will involve a urine test. Can you tell me what you understand about Chlamydia?

☐ If the result is positive, we can also talk about recent partners you’ve had being tested as well.

Contact tracing

Contact tracing aims to reduce the transmission of infections through early detection and treatment of STIs. It is the diagnosing clinician’s responsibility to initiate a discussion about contact tracing.

From what you have told me today we now know there are a few people who need to be informed. Would you like some tips about how to do this?

Explain different methods and offer choice:
Different methods might be needed for each partner.
(In person, phone, SMS, email or letter)

These sites can support your patients to tell their partners:
www.letthemknow.org.au
www.thedramadownder.info (MSM)
www.bettertoknow.org.au (Aboriginal People)

Contact Tracing resources

Manual ctm.ashm.org.au

Support

General Practitioners, Health Care Workers and patients can ask for support from their local Sexual Health Clinic


Getting started with an STI discussion

Bringing the subject up opportunistically

“We are offering Chlamydia testing to all sexually active people under the age of 25, would you like to have a test while you’re here or find out more about Chlamydia?”

Using a ‘hook’

“What have you heard about HBV or HPV vaccination? They protect against infections that can be sexually transmitted, perhaps we could discuss these while you’re here?”

As part of a reproductive health consultation

“Since you’re here today for a pap smear/to discuss contraception could we also talk about some other aspects of sexual health, such as an STI check up?”

Because the patient requests a “checkup” for STIs

“I’d like to ask you some questions about your sexual activity so that we can decide what tests to do, is that OK?” (See Brief Sexual History)

Consent

“I suggest that we test for…” eg: Chlamydia

☐ This will involve a urine test. Can you tell me what you understand about Chlamydia?

☐ If the result is positive, we can also talk about recent partners you’ve had being tested as well.

Brief Sexual History

“I’d like to ask you some questions about your sexual activity so we can decide what tests to do, is that OK?”

☐ Are you currently in a relationship?

☐ In the last 3 months, how many sexual partners have you had? How many partners have you had in the past 12 months?

☐ Were these casual or regular partners?

☐ Were your sexual partners male, female or both?

☐ From today, when was the last time you had vaginal sex*/oral sex/anal sex without a condom?

☐ In the past year were you ever paid for sex?

☐ Have you previously been diagnosed with an STI?

☐ Is there anything else that is concerning you?
Appendix G: Services, links & resources to support service providers and young people

<table>
<thead>
<tr>
<th>Community Services</th>
<th>Contact details</th>
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</thead>
<tbody>
<tr>
<td><strong>Action (Youth) Centre - (Family Planning Victoria)</strong></td>
<td>Appointments 9am - 12pm, then drop in till 5pm Monday to Friday&lt;br&gt;Level 1, 94 Elizabeth Street&lt;br&gt;Melbourne 3000&lt;br&gt;Ph: 03 9654 4766, 1800 013 952&lt;br&gt;www.fpv.org.au/health-care/action-centre</td>
</tr>
<tr>
<td>For youth under 25 (free for under 18s)</td>
<td></td>
</tr>
<tr>
<td>Information about STI treatment and testing, safer sex, contraception, HIV/AIDS, hepatitis, pregnancy advice, any other sexual health issue, support groups for those with gender identity issues</td>
<td></td>
</tr>
<tr>
<td><strong>Young People’s Health Service (FRONT YARD)</strong></td>
<td>Monday to Friday 12pm - 5pm.&lt;br&gt;No appointment required, for people aged 12-22 years.&lt;br&gt;19 King Street (near Flinders Street)&lt;br&gt;Melbourne 3000&lt;br&gt;Ph: 03 9611 2411, 1800 800 531&lt;br&gt;www.frontyard.org</td>
</tr>
<tr>
<td>Free service, that focuses on the needs of the homeless or disadvantaged</td>
<td></td>
</tr>
<tr>
<td>Confidential Youth Services (Accommodation, Centrelink, Counselling, Dental Health Services, Legal Service, self employment, Victorian Ombudsman)</td>
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<tr>
<td>‘Reconnect’ (Personal support and family mediation)</td>
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</tr>
<tr>
<td>Computer access</td>
<td></td>
</tr>
<tr>
<td><strong>Melbourne Sexual Health Centre</strong></td>
<td>Monday-Friday, best to arrive between 8.40am and 1.10pm&lt;br&gt;580 Swanston Street,&lt;br&gt;Carlton VIC 3053.&lt;br&gt;Ph: 03 93470244, free call 1800 032 017&lt;br&gt;www.mshc.org.au</td>
</tr>
<tr>
<td>Free, confidential, anonymous, sexual health service</td>
<td></td>
</tr>
<tr>
<td>Walk-in system</td>
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</tr>
<tr>
<td>Fact sheets for patients and National Management Guidelines for STIs available at <a href="http://www.mshc.org.au">www.mshc.org.au</a></td>
<td></td>
</tr>
<tr>
<td><strong>Child &amp; Adolescent Mental Health Services (CAMHS)</strong></td>
<td>Business hours: RCH Mental Health Service Intake provides initial triage, referral, case management first appointment and an information service. 9am - 5pm weekdays&lt;br&gt;After-hours: Nurse-on-call (triage/advise) or closest emergency department (crisis)&lt;br&gt;Urgent referrals from RCH ED to Psychiatry Consultation and Liaison:&lt;br&gt;Monday to Friday, 9am-5pm:&lt;br&gt;Speed dial 84444, or&lt;br&gt;After hours Psych CL Nurse (when available in ED), ext 4786 or page 4488, or&lt;br&gt;After hours, call Switch and ask for RCH Psychiatry Registrar on call&lt;br&gt;Less-urgent/intake/external referrals:&lt;br&gt;RCH Mental Health service Intake:&lt;br&gt;Ph: 1800 445 511 (under 15 years), or&lt;br&gt;Orygen Youth Health (15-24 years):&lt;br&gt;Ph: 1800 888 320&lt;br&gt;YAT Paging Service: 03 9483 4556</td>
</tr>
<tr>
<td>RCH covers Western and North Western metropolitan region of CAMHS</td>
<td></td>
</tr>
<tr>
<td>State government mental health services in Victoria are region-based</td>
<td></td>
</tr>
<tr>
<td>To correctly identify CAMHS region and regional contact details: <a href="http://www.health.vic.gov.au/mentalhealth/services/index.htm">www.health.vic.gov.au/mentalhealth/services/index.htm</a></td>
<td></td>
</tr>
<tr>
<td>Northern &amp; Western metropolitan region is the exception with children 0-15 years managed by CAMHS and 15-24 years old managed by Orygen Youth Health</td>
<td></td>
</tr>
<tr>
<td>Community Services</td>
<td>Contact details</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Eating Disorders Victoria**                          | Level 2  
Collingwood Football Club Community Centre  
cnr Lulie and Abbot Streets  
Abbotsford Vic 3067  
Ph: 1300 550 236  
www.eatingdisorders.org.au                                                                 |
| • Support, information, community education and        |                                                                                                                                                  |
|   advocacy for people with eating disorders and their  |                                                                                                                                                  |
|   families in Victoria.                                |                                                                                                                                                  |
| **YSAS (Youth Support and Advocacy Service)**          | 14-18 Brunswick Street,  
Fitzroy VIC 3065  
Ph: 03 9415 8860  
YSASline 1800 014 446  
www.ysas.org.au                                                                 |
| • Outreach teams are based at eight sites across       |                                                                                                                                                  |
|   Melbourne and regional Victoria for young people    |                                                                                                                                                  |
|   experiencing significant problems with alcohol      |                                                                                                                                                  |
|   and/or drug use.                                     |                                                                                                                                                  |
| • Service for young people between the ages            |                                                                                                                                                  |
|   of 12 - 21 years                                     |                                                                                                                                                  |
| **Youth Beyond Blue**                                  | www.youthbeyondblue.com                                                                                                                          |
| • Information for young people on anxiety, depression,|                                                                                                                                                  |
|   being bullied, dealing with stress etc.             |                                                                                                                                                  |
| **Infoxchange Service Seeker**                         | www.serviceseeker.com.au                                                                                                                          |
| • To find more local community support services        |                                                                                                                                                  |
|   e.g. local doctor, dentist, counselling services,    |                                                                                                                                                  |
|   drug and alcohol services                            |                                                                                                                                                  |
| **Reachout**                                           | www.reachout.com.au                                                                                                                               |
| • Australian website funded under the national        |                                                                                                                                                  |
|   suicide prevention strategy.                         |                                                                                                                                                  |
| • Information for young people, carers & professionals |                                                                                                                                                  |
| **24 hour telephone help lines:**                      | 1800 551 800  
131114  
1300 651 251                                                                                   |
| • Kids Help Line (Free call for those under 18 years)  |                                                                                                                                                  |
| • Lifeline: Counselling, support and Referral          |                                                                                                                                                  |
| • Suicide HelpLine                                     |                                                                                                                                                  |
Practice Resources

- Reachout sexual health resources: [au.reachout.com/Wellbeing/Sex-and-relationships/?gclid=CMPA9LHjt8oCFRWTvQodd0YAgg](au.reachout.com/Wellbeing/Sex-and-relationships/?gclid=CMPA9LHjt8oCFRWTvQodd0YAgg)

Useful websites for information

- Information for health professionals and consumers to access health services. [www.nhsd.com.au](www.nhsd.com.au)
- Information to support the prevention, testing, diagnosis, management and treatment of STIs. [www.sti.guidelines.org.au](www.sti.guidelines.org.au)
- RACGP article on improving access to primary health care [www.racgp.org.au/afp/2012/may/youth-health-services](www.racgp.org.au/afp/2012/may/youth-health-services)
- Legal information for young people [youthlaw.asn.au](youthlaw.asn.au)
• Gay and Lesbian Health Victoria www.glhv.org.au
• National counselling and referral service for LGBTI people www.qlife.org.au
• STI and service information for Aboriginal clients www.bettertoknow.org.au/Clinics/Victoria
• Youth Affairs Council Victoria www.yacvic.org.au
• Family Planning NSW www.fpnsw.org.au/index_under25s.html
• Sexual health information www.playsafe.health.nsw.gov.au/
• Sex education and resources – United States www.scarleteen.com
• Resources Same Sex Attracted, Intersex, Transgendered and Gender Diverse (SSATGD) young people www.rainbownetwork.com.au/index.php/resources
• Support, training and resources for SSATGD people in Victoria www.zbgc.com.au

YouTube resources
• Issues of Consent (Cup of tea analogy) www.youtube.com/watch?v=Gp6allALDHA
• Emergency Contraception (Louna’s Lowdown from Royal Women’s Hospital) www.youtube.com/watch?v=N5yNDIrlq1Rk
• Getting a sexual health check www.youtube.com/watch?v=BePlDKsbHIs

Training for service providers
• Clinical education in sexual and reproductive health www.fpv.org.au/education-training
• Gender identity and SSA training www.glhv.org.au/training
• Training for schools to deliver sexual and reproductive health education www.fpv.org.au/assets/Safe-LandingCH.pdf
• Expressions of Interest for advanced sexual health nursing subjects www.ashm.org.au/international-programs/nursing/nursing-policy-advocacy
Appendix H: HEADSS Assessment tool: A Psychosocial Interview For Adolescents

The following information was sourced and adapted from a HEADSS Assessment tool available from the British Columbia Children's Hospital in Canada.  

Background

The major cause of morbidity and mortality in adolescents is unintentional injuries, including motor vehicle accidents with more than half related to drug or alcohol use. Next in importance are other causes of morbidity including unwanted pregnancy, sexually transmitted infection (STI), eating disorders, and mood disorders. These situations may not be apparent during a standard interview.

The primary health care provider who sees adolescents must be willing to take a developmentally-appropriate psychosocial history. A system for organising a psychosocial history taking was developed in 1972 by Dr. Harvey Berman of Seattle, and has since been successfully used around the world. This method structures questions so as to facilitate communication and to create a sympathetic, confidential, respectful environment for youth to attain adequate health care. The approach is known as the acronym HEADSS (Home, Education/employment, peer group Activities, Drugs, Sexuality, and Suicide/depression).

Preparing for the Interview

The way in which the primary health care provider undertakes an assessment can impact on health outcomes. Parents, family members, or other adults should not be present during the HEADSS assessment unless the adolescent specifically gives permission, or asks for it.

Confidentiality

It is not reasonable to expect an adolescent to discuss sensitive and personal information unless confidentiality can be assured. All adolescents and families, including caregivers (most commonly a parent or both parents), should be assured about confidentiality at the beginning of the interview. Each health care provider must determine the nature of his/her own confidentiality statement.

Belief Systems

As a primary health care provider, your own set of beliefs, based on your knowledge, experience, and level of tolerance in dealing with particular situations, will set the standard in providing developmentally-appropriate health care to youth and their families. Health care providers working with young people may be confronted with difficult situations where this particular belief system may be “tested”, if not challenged. Particular examples relate to health risk-taking behaviours that the provider may find difficult to accept and when a provider is confronted with a particularly challenging situation it causes him/her to be in a ‘dilemma’, i.e. a youth is seeking options counselling due to unwanted pregnancy and the providers own personal or religious beliefs impact the interaction, but must be put aside in the best interests of the young person.

Assumptions

Based on particular individual belief systems, these are some “assumptions” that many people hold about young people:

- Young people live in a home with two parents
- Young people go to school and get along with peers and teachers
- All young people are heterosexual

It is of significant importance not to “assume”, but rather to ask non-judgemental questions in a respectful, caring manner.
Starting the Interview

Introduction: Set the stage by introducing yourself to the young person, their parents or other significant person.

Suggestion: If the parents are present before the interview, always introduce yourself to the young person first. In fact, ask the young person to introduce you to the other people in the room. This gives the young person a clear message that you are interested in him/her/them.

1. Understanding of Confidentiality: Ask either the parents or the young person to explain their understanding of confidentiality or confidential health care.

2. Confidentiality Statement: After the young person and family have given you their views (from step 1), acknowledge their responses and add your views accordingly (confidentiality statement), based on the particular situation.

Home

Opening Lines: (Less/More) Developmentally-Appropriate

<table>
<thead>
<tr>
<th>Less</th>
<th>More</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tell me about your family.</td>
<td>Where do you live, and who lives there with you?</td>
<td>Open-ended question enables the collection of environmental as well as personal history.</td>
</tr>
</tbody>
</table>

Examples of Questions

- Who lives at home with you? Where do you live? How long? Do you have your own room?
- How many brothers and sisters do you have? How old are they?
- Are your parents healthy? What do your parents do for a living?
- What are the rules like at home? How do you get along with your parents, your siblings? What kinds of things do you and your family argue about the most? What happens in the house when there is a disagreement?
- Is there anything you would like to change about your family?

Asking about parental abuse or substance use (also see Drugs section) may be difficult. Using a scenario may facilitate this line of questioning, i.e. “Working with young people I have learned from some “kids” that their relationship with their parents is a difficult one; by this I mean they argue and fight. Some young people have told me that they wish their parents did not drink so much or use drugs. Is this a situation in your household? Has anything like it happened to you?”


**Education & Employment**

*Opening Lines: (Less/More) Developmentally-Appropriate*

<table>
<thead>
<tr>
<th>Less</th>
<th>More</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are you doing in school?</td>
<td>Are you in school?</td>
<td>Poor questions can be answered “okay”. Open-ended questions ask for information about strengths and weaknesses and allow further understanding.</td>
</tr>
<tr>
<td></td>
<td>What are you good at in school?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What is hard for you?</td>
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</tr>
</tbody>
</table>

**Examples of Questions**

- What do you like best and least about school? Favourite subjects? Worst subjects?
- Do you miss much school? Do you skip classes? Have you ever been suspended?
- What do you want to do when you finish school? Any future plans/goals?
- Do you work now? How much? Have you worked in the past?
- How do you get along with teachers, employers?
- How do you get along with your peers? Inquire about “bullying”.

**Activities**

*Opening Lines: (Less/More) Developmentally-Appropriate*

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<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you do any activities?</td>
<td>What do you do for fun?</td>
<td>Good questions are open-ended and allow young people to express themselves.</td>
</tr>
<tr>
<td></td>
<td>What things do you do with friends?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What do you do with your free time?</td>
<td></td>
</tr>
</tbody>
</table>

**Examples of Questions**

- Are most of your friends from school or somewhere else? Are they the same age as you?
- Do you hang out with mainly people of your same sex or a mixed crowd?
- Do you have one best friend or a few friends? Do you have a lot of friends?
- Do you spend time with your family? What do you do with your family?
- Do you see your friends at school and on weekends, too? Are there a lot of parties?
- Do you do any regular sport or exercise? Hobbies or interests?
- Do you have a religious affiliation, belong to a church, or practice some kind of spiritual belief?
- How much TV do you watch? What are your favourite shows?
- Do you read for fun? What do you read?
- What is your favourite music?
- Do you have a car?
- Have you ever been involved with the police? Have you ever been charged? Do you belong to a group/gang?
Drugs

Opening Lines: (Less/More) Developmentally-Appropriate

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<thead>
<tr>
<th>Less</th>
<th>More</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you do drugs?</td>
<td>Many young people experiment with drugs, alcohol, or cigarettes.</td>
<td>Good question is an expression of concern with specific follow-up. With younger teens, it is best to begin by asking about friends.</td>
</tr>
<tr>
<td></td>
<td>Have you or your friends ever tried them?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What have you tried?</td>
<td></td>
</tr>
</tbody>
</table>

Examples of Questions

- When you go out with your friends or to party, do most of the people that you hang out with drink or smoke? Do you? How much and how often?
- Do any of your family members drink, smoke or use other drugs? If so, how do you feel about this – is it a problem for you?
- Have you or your friends ever tried any other drugs? Specifically, what? Have you ever used a needle?
- Do you regularly use other drugs? How much and how often?
- Do you or your friends drive when you have been drinking?
- Have you ever been in a car accident or in trouble with the law, and were any of these related to drinking or drugs?
- How do you pay for your cigarettes, alcohol or drugs?
Sexuality

Opening Lines: (Less/More) Developmentally-Appropriate

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<th>Less</th>
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<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had sex?</td>
<td>Are you or have you been involved in a relationship?</td>
<td>What does the term “have sex” really mean to teenagers?</td>
</tr>
<tr>
<td>Tell me about your sexual relationships.</td>
<td>How was that experience for you?</td>
<td>Asking only about heterosexual relationships closes doors at once.</td>
</tr>
<tr>
<td></td>
<td>How would you describe your feeling towards sex and sexual relationships?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How do you see yourself in terms of sexual preference, i.e. gay, straight, or bisexual?</td>
<td></td>
</tr>
</tbody>
</table>

Examples of Questions

- Have you ever been in a relationship? When? How was it? How long did it last?
- Have you had sex? Was it a good experience? Are you comfortable with sexual activity? Number of partners?
- Using contraception? Type and how often (10, 50 or 70% of the time).
- Have you ever been pregnant or had an abortion?
- Have you ever had a discharge or sore that you are concerned about? Have you ever been checked for a sexually transmitted disease? Knowledge about STIs and prevention?
- Have you ever had a pap test?
- Do you have any concerns about Hepatitis or HIV?
- Have you had an experience in the past where someone did something to you that you did not feel comfortable with or that made you feel disrespected?
- If someone abused you, who would you talk to about this? How do you think you would react to this?
- For females: Ask about last menstrual period (LMP), and menstrual cycles. Also inquire about breast self examination (BSE) practices.
- For males: Ask about testicular self-examination (TSE) practices.
Suicide / Depression

It is suggested that every psychosocial interview seek to identify elements that correlate with anxiety or depression, a common precursor to suicide. Many of the items in the suicide screen (see box below) have already been determined in the psychosocial history:

- Severe family problems
- Changes in school performance
- Changes in friendship patterns
- Preoccupation with death
- Acting-out behaviour and health risk behaviours, including drug, alcohol and substance abuse

### Suicide Risk / Depression Screening

1. Sleep disorders (usually induction problems, also early/frequent waking or greatly increased sleep and complaints of increasing fatigue).
2. Appetite/eating behaviour change.
3. Feelings of “boredom”.
4. Emotional outbursts and highly impulsive behaviour.
5. History of withdrawal/isolation.
6. Hopeless/helpless feelings; two significant predictors of depression and suicide risk.
8. History of No. 7 in family or peers.
10. History of recurrent serious “accidents”.
11. Psychosomatic symptomatology.
12. Suicidal ideation (including significant current and past losses).
13. Decreased affect on interview, avoidance of eye contact – depression posturing.
14. Preoccupation with death (clothing, music, media, art).
15. History of psychosocial/emotional trauma.

Other items seek to include a family history of psychological problems or suicide, or a history of similar behaviour in close friends or relatives. There is also a high correlation between psychological disturbances and a family history of substance abuse. It is suggested that two other areas are also asked about as they are often forgotten:

1. **Sleeping Habits**
   
   Teenagers who are anxious or depressed have difficulty falling asleep. Generally, it takes them more than 30 minutes to fall asleep, and often more than one hour. Though many adolescents have occasional sleep problems, difficulties occurring more than once or twice a month are significant. Adolescents are often willing to discuss a sleep disturbance. Sleep problems tend to make adolescents feel miserable in the morning and are a considerable nuisance to otherwise healthy and active young people.

2. **Eating Habits**
   
   Frequent fad dieting, crash diets, anorexic or bulimic behaviour, and obesity with significant overeating or bingeing are all indicators of significant psychological distress. Enquiring about a young person’s body image perceptions and whether or not they pursue thinness, fear being fat, or have poor dietary and/or abnormal eating habits or compensatory behaviour, may lead to identified disordered eating habits and, ultimately, eating disorders.
Wrapping Up The Interview

Suggestions for ending interviews with young people:

- Ask them to sum up their life in one word or to give the overall “weather report” for their life (sunny with a few clouds, very sunny with highs all the time, cloudy with rain likely, etc.).
- Ask them to tell you what they see when they look in the mirror each day. Specifically, look for teenagers who tell you that they are “bored”. Boredom in adolescents may indicate that the youth is depressed.
- Ask them to tell you whom they can trust and confide in if there are problems in their lives, and why they trust that person. This is especially important if you have not already identified a trusted adult in the family. This is an opportunity to let the young person know that you – the primary health care provider can be trusted to help with problems and to answer questions. Let them know you are interested in them as a whole person and that you are someone who wants to help them lead a fuller, healthier life.
- Give them an opportunity to express any concerns you have not covered, and ask for feedback about the interview. If they later remember anything they have forgotten to tell you, remind them that they are welcome to call at any time or to come back in to talk about it.
- For young people who demonstrate significant risk factors, relate your concerns. Ask if they are willing to change their lives or are interested in learning more about ways to deal with their problems. This leads to a discussion of potential follow-up and therapeutic interventions. Many adolescents do not recognise dangerous life-style patterns because they see their activities not as problems but as solutions. Your challenge lies in helping the young person see health risk-taking behaviours as problems and helping to develop better strategies for dealing with them.
- If the young person’s life is going well, say so. In most cases, you can identify strengths and potential or real weaknesses, and discuss both in order to offer a balanced view.
- Ask if there is any information you can provide on any of the topics you have discussed, especially health promotion in the areas of reproductive and sexual health, substance use and mental health. Try to provide whatever educational materials young people are interested in.
Appendix I: Understanding Medicare and working with general practice

Using Medicare

Not all providers who support young people with their reproductive and sexual health are able to access Medicare funding. For example providers in community health services or youth services may be State funded or provide services under local government funding arrangements. However, GPs, nurses who work in general practice and Aboriginal Health Workers can use Medicare funding to support service delivery.

Paying for health care can be an obstacle for young people. Some doctors ‘bulk bill’ under Medicare, but in other cases young people may have to pay an upfront fee and redeem a refund from Medicare. Whichever is the case, a young person should be advised to have a Medicare card.

- It is recommended that young people are advised that if they are over 15 years old they can apply for their own Medicare card (or 14 if they are living in a foster care or ‘out of home care’ arrangement.
- They do not need their parent’s permission to get their own Medicare card.
- Young people should be made aware that presenting the family’s Medicare card could potentially notify their parents of the consultation
- A Medicare card does not necessarily have to be sighted as Medicare details can be retrieved from records, or if the person is new to the health service, details of their name, address and date of birth can be taken and Medicare number details can be verified with Medicare. This will prevent services turning young people away because they do not have their card with them.

Why is it important for young people to have their own Medicare card?

- Young people may be at an age where they go away with friends, school and organisations and should carry their own card to make medical access easier
- It allows young people to practise using the health system before they leave school or home.

Working with general practice

GPs are the key primary health care provider of clinical R&SH services in Victoria. Understanding and working with general practice is critical for effective service delivery to meet young people’s needs.

- General practice provides the first point of contact for investigations, diagnostics and referral
- General practice is the gateway for most people into the broader health system, the contact point for accessing acute and secondary care and for managing patients’ needs on discharge.
- General practice is the gateway to the Medicare Benefits Schedule to enable access to various providers through Medicare funded services e.g. psychologists for counselling.
- GPs typically hold the most comprehensive patient health record and this information provides a foundation for continuity of care
- Effective partnerships with general practice help ensure patient safety, continuity of care, integration and quality health outcomes
- Integrated, collaborative, service coordination requires services to work with general practice to:
  - Ensure a cooperative, combined approach to planning and coordinating services
  - Focus on young people and their experience at the centre of the collaboration
  - Standardise approaches, with teams using shared protocols, defined roles and responsibilities and agreed and efficient communication channels
  - Ensure efficient information exchange, using shared electronic health records or secure messaging wherever possible
  - Promote and support the role of nurses in providing care to young people in general practice
  - Utilise the Medicare Benefits Schedule to provide care for young people
  - Utilise allied health, other disciplines and specialist care services
- Strengthen referral pathways between services
Appendix J: Service Provider Consultation Questions

Questions were tailored according to the type of provider and semi-structured to allow for flexibility in questioning. Given some services provided clinical R&SH and others worked with youth in other capacities (youth services, mental health), different questions were chosen to suit the service environment e.g. ‘Have you ever had to support a young person with a R&SH issue?’ Rather than ‘what types of R&SH issues have you dealt with?’

The following questions were used to prompt discussions.

<table>
<thead>
<tr>
<th>Key theme</th>
<th>Questions/Prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are some of the key R&amp;SH issues for young people?</td>
<td>Have you ever had to support a young person with a R&amp;SH issue?</td>
</tr>
<tr>
<td>What are the enablers and barriers for young people accessing R&amp;SH services?</td>
<td>What types of R&amp;SH issues have you dealt with?</td>
</tr>
<tr>
<td>How do service providers raise R&amp;SH in conversations and how best do they engage young people?</td>
<td>What did the young person want? Information?</td>
</tr>
<tr>
<td>Awareness and knowledge of local R&amp;SH services and referral pathways</td>
<td>Referral? Intervention?</td>
</tr>
<tr>
<td></td>
<td>How do young people approach you?</td>
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<tr>
<td></td>
<td>What makes your service youth-friendly?</td>
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<td></td>
<td>What are the barriers for young people/what stops them from using services?</td>
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<tr>
<td></td>
<td>How do you begin a conversation with a young person about their R&amp;SH?</td>
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<tr>
<td></td>
<td>How do you find out more to discuss options with a young person?</td>
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<tr>
<td></td>
<td>Are there particular conversations you find difficult?</td>
</tr>
<tr>
<td></td>
<td>Is there particular language or words that appear to work well?</td>
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<tr>
<td></td>
<td>What terms have you heard young people use in relation to their R&amp;SH?</td>
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<tr>
<td></td>
<td>What role do parents play in these conversations?</td>
</tr>
<tr>
<td></td>
<td>What are the barriers to having these conversations?</td>
</tr>
<tr>
<td></td>
<td>What R&amp;SH services are you aware of?</td>
</tr>
<tr>
<td></td>
<td>Which local services do you work with?</td>
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<tr>
<td></td>
<td>Do you feel you have enough information to support/advise/refer a young person – what would help you?</td>
</tr>
</tbody>
</table>
Appendix K: Youth Focus Group Questions

A focus group question guide was used with each group of young people to ensure consistent information was elicited from each discussion group. Specific probing questions were also added to guide discussions with different youth cohorts to ensure concerns or issues for particular groups of young people could be discussed to inform the Guide.

The following is a summary of the kinds of discussions that were prompted for, both through questions and interactive activities. Note, questioning was semi-structured for responsive facilitation.
<table>
<thead>
<tr>
<th>Key theme</th>
<th>Questions/Prompts</th>
<th>Engaging with difference &amp; diversity (Aboriginal, SSASGD youth, young men)</th>
</tr>
</thead>
</table>
| **What are some of the key R&SH issues for young people?**  
**How do young people like service providers to raise and discuss R&SH?**  
**Are young people aware of R&SH services available for them** | When you think about people your age, what do you think are the biggest needs they have when it comes to their R&SH?  
‘Needs’ could include information, advice, health care services, access to interventions or treatment  
• Pap testing? Vax?  
• HIV as part of other STIs?  
• New forms of PEP and PREP?  
• Safer sex? Porn? Sexting? Dating?  
• Any specific issues for the group GBLT, young men, Aboriginal?  
How do you know you want to access a service?  
What is the trigger? At what age?  
Ideally, who would you most want to talk to/where would you go if you had a question about R&SH? (GP or sexual health service?)  
Do you know any R&SH services?  
How do you know about these services?  
How is it different to knowing about other services? Internet?  
How do you know what you need to do? - e.g Medicare card/bulk billing, making an appointment, negotiating parent/family involvement  
• Would you like to book online  
• Willing to put some of your information online for service provider?  
How far would you travel?  
When do you go? (appointment/opportunistic)  
• Part of usual check-up? Routine/intentional  
• Alone or with friend?  
• (Parents/carers?)  
How do you raise R&SH issues with providers?  
How should doctors/counsellors/youth workers start conversations about some of these issues?  
• What info do you think they will ask you about?  
• How do you start the conversation?  
• Examples of ways not to start a conversation  
Think about a good or bad experience with a service (what made you want to go back)…  
Think about a bad experience in a service – think about the things that have/would cause you to feel uncertain or uncomfortable about accessing services. | How could service providers better support you?  
e.g what are some strategies for overcoming young men’s reluctance to access R&SH support?  
How can we better normalise sex and provide sex-positive messages for service providers?  
Do you know about specialised services? When would you choose to go to a specialist service over a generalist service?  
Definition of a safe provider?  
(How do you find/choose safe providers?)  
• Language  
• Correct names and pronouns  
• Comfort with types of sexual practices & relationships  
• Contraceptive info for women  
• Knowledge of transissues  
• Beyond disease  
3 priorities for a youth-friendly service/good service:  
Activity: Piece of paper – 3 things you would want a provider to do to support you with a R&SH issue or make you feel comfortable to talk about it?  
ON BACK OF PAPER: - 3 things that would put you off talking to a provider or using a service for a R&SH issue  
Activity: Any good stories of service provision experience?  
Any bad experience stories of R&SH service provision?  
CARE WITH DISCLOSURE |
Appendix L:  Glossary of terms related to sexual and gender diversity

The following definitions have been sourced from the publication ‘Writing themselves in 3’^128

Bisexual: A person who is sexually and emotionally attracted to people of both sexes.

Coming out: The process through which individuals come to recognise and acknowledge, both privately and publicly, their sexual orientation, gender identity or intersex status.

Gay: A person whose primary emotional and sexual attraction is toward people of the same sex. The term is most commonly applied to men, although some women use this term.

Gender identity: A person’s deeply felt sense of being male, female, both, in between, or something other. Everyone has a gender identity.

Gender questioning: Refers to the process whereby an individual comes to question the usefulness or validity of their current biological sex and/or assigned gender. This includes people who see the binary categories of male and female/masculine and feminine as meaningless or unduly restrictive, and those who feel that their gender does not align with the sex assigned to them at birth.

Heterosexism: The belief that everyone is, or should be, heterosexual and that other types of sexualities or gender identities are unhealthy, unnatural and a threat to society. Heterosexism includes both homophobia and transphobia (see below) and a fear of intersex people who challenge the heterosexist assumption that there are only two sexes.

Homophobia: The fear and hatred of lesbians and gay men and of their sexual desires and practices that often leads to discriminatory behaviour or abuse.

Lesbian: A woman whose primary emotional and sexual attraction is towards other women.

Pansexual: “Pan” is a prefix referring to “all” or “whole” so encompassing all kinds of sexuality and expressing the full spectrum of desire.

Queer: An umbrella term to include a range of alternative sexual and gender identities including gay, lesbian, bisexual and transgender or gender questioning.

Same sex attracted: An umbrella term applied to young people to describe individuals who experience feelings of sexual attraction to others of their own sex. This includes young people who are exclusively homosexual in their orientation, bisexual, undecided young people, and heterosexual young people who have these feelings at some time.

SSAGQ: Same sex attracted and gender questioning.

Transgender: An umbrella term and, for some people, an identity term used to describe all kinds of people who sit outside the gender binary or whose gender identity is different from the sex assigned to them at birth. Transgender people may or may not feel the need to access hormone therapy and/or surgery.

Transphobia: A fear and hatred of people who are transgender that often leads to discriminatory behaviour or abuse.
Appendix M: Laws and changes in R&SH

Sex and the Law

Sex, according to the law applies to sexual penetration, which includes anything that involves a penis touching a vagina, anus or mouth. It also includes putting an object or a part of the body into contact with a vagina or anus or touching a person in a sexual way, such as touching another person’s vagina, penis, anus or breasts. For further information see Am I old enough? Common legal issues for young people.

Age limits for having sex

<table>
<thead>
<tr>
<th>Age</th>
<th>What the law says</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 12 years old</td>
<td>A person cannot consent (agree) to any aspect of sex (having sex, being touched or letting another person perform a sexual act in front of them)</td>
</tr>
<tr>
<td>12 to under 16 years old</td>
<td>If someone is 24 months older then the young person cannot consent to any aspect of sex (as described above). It may not be a crime, if the older person is less than 24 months older than the young person</td>
</tr>
<tr>
<td>16 to 17 years old</td>
<td>A person cannot consent to any aspect of sex with anyone who is caring for or supervising them (e.g. teacher or foster carer).</td>
</tr>
<tr>
<td>18 years old and over</td>
<td>A person of 18 can consent to have sex with anyone else over 18 years</td>
</tr>
</tbody>
</table>

(Adapted from ‘What are the age limits for having sex?’ p.35-36, Victorian Legal Aid Am I old enough? Common legal issues for young people)

Mandatory Reporting of Child Abuse

See Appendix C

Discrimination Law– Victoria

The Sex Discrimination Act 1984 gives effect to Australia’s international human rights obligations to protect people from unfair treatment on the basis of their sex, sexual orientation, gender identity, intersex status, marital or relationship status, pregnancy and breastfeeding. The Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Bill Act 2013 (Cth) amended the Sex Discrimination Act 1984 (Cth) to introduce changes from 1 August 2013 to make it unlawful to discriminate against a person on the basis of sexual orientation, gender identity and intersex status under federal law. Same-sex couples are now also protected from discrimination under the definition of ‘marital or relationship status’.

Abortion Law - Victoria

Abortion became law in Victoria in 2008 through the Victorian Abortion Law Reform Act 2008. Under the Act, a woman is able to access abortion up to a gestational limit of 24 weeks. After 24 weeks, a medical practitioner is able to provide an abortion if another practitioner agrees that an abortion is appropriate with consideration of the current and future physical, psychological and social circumstances of the individual woman. The act also allows medical practitioners and nurses who have a conscientious objection to abortion to refuse to undertake or assist in the procedure, but they must inform the patient of their position, and the patient must be supplied with information about a medical practitioner who does not have any such objection.

There are two types of abortion – medical or surgical abortion that can be carried out by private abortion providers listed in the Yellow Pages under ‘Abortion’ or in public hospitals that provide limited free abortions. For more information see Family Planning Victoria’s Abortion procedures fact sheet.
Changes to the National Cervical Screening Program

Since the introduction of the National Cervical Screening Program (NCSP) in 1991, new evidence has emerged about the optimal screening age range and interval, the HPV vaccine has become available and there have been developments in new technologies for the early detection of cervical cancer.\(^{134}\).

**Changes to the NCSP will be introduced from May 2017**

- Pap smears will be replaced with human papillomavirus (HPV) testing of cervical samples. Entry age will increase from 18 to 25 years, and the screening interval extended from 2 to 5 years.

**Alternative sample collection option for under-screened or never-screened women**

- To improve participation, self-collection of a cervical sample for HPV testing will also be available for under-screened or never-screened women.

**A national register will be established**

- A national register for cervical screening will be established, replacing the current State- and Territory-based registries. Invitation and recall letters will be sent out to encourage participation.

**New tests will be available on the Medical Benefits Schedule from May 2017 onwards**

- The new tests are not currently available on the MBS, but MBS subsidy will be in effect from May 2017 onwards.

**Do not delay screening women under the current screening arrangements**

- For now, it is business as usual – do not delay the 2-yearly Pap smear test for women aged 18–69.

**HPV-vaccinated women should be screened for cervical cancer**

- Remind HPV-vaccinated women of the importance of cervical screening, because the current HPV vaccine only protects against two HPV types that cause about 70% of cervical cancers.
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