Australian National University

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SA Health

‘Y Health – Staying Deadly’

An Aboriginal Youth focussed Translational Action Research Project

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A C K N O W L E D G E M E N T S

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Background

DEFINITIONS AND TERMINOLOGY

a) Youth: This report defines youth as belonging to the age group 12-24 years. This is in line with the definition used by the University of Melbourne Centre for Adolescent Health and the NSW Centre for the Advancement of Adolescent Health(1)

b) Aboriginal and Indigenous: The word 'Indigenous' has been used interchangeably with Aboriginal & Torres Strait Islander. The word 'Aboriginal' has been used when it is in relation to communities in South Australia or New South Wales. It is not meant to be offensive to or excluding of Torres Strait Islander people.

CURRENT PRACTICE, POLICY & EVIDENCE GAP

Preventive activities – screening and early detection

The Australian Government advocates the use of Health Checks "to help ensure that Aboriginal and Torres Strait Islander people receive primary health care matched to their needs, by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality".(2)

The Medicare Benefits Schedule (MBS) item 715 provides funding for Aboriginal & Torres Strait Islander Health Checks. There are concerns regarding this MBS Item. Firstly, it has categories for Children (0 - 14 yrs.), Adults (15 - 54 yrs.) and Older Persons ≥55 yrs.). These categories do not capture the specific needs of youth, and their health issues are obscured by the overlapping age categories. Secondly, the evidence base for the specific preventive activities recommended in the current MBS Item 715 Health Checks is unclear. Indeed, one detailed research study has shown that the screening recommendations in the Adult Health Check align poorly to the needs of remote Aboriginal & Torres Strait Islander communities.(3)

In 2008 the Screening Subcommittee of the Australian Population Health Development Principal Committee (APHDPC) stated, *"Screening programs to establish the presence or risk of a disease aim to reduce the burden of the disease in the community, including the incidence of the disease, morbidity from the disease or mortality" (4).* While there is some research available regarding youth assessment, there is no comprehensive health screening tool available for Aboriginal & Torres Strait Islander Youth.

Research and translation in primary care

Most primary care research is conducted by tertiary educational or research institutions and translating evidence into practice is a well-known problem. The Aboriginal community for too long has endured the practice of being the subject of research with few demonstrated benefits and very little control over the research direction or process.(5) Rigney describes "Privileging Indigenous voices in Indigenous research management and practice" as one of the principles of "Indigenist Research".(6) Self-determination in research is both ethical and pragmatic and therefore an important governance issue.(7)

A Best Practice project can therefore be described as one that will have a positive impact on the health of the Aboriginal community, incorporates health needs that are important to both the community and policy makers, be practical enough to achieve outcomes, attempts to impact on a basic issue that has been identified as a problem by both the community and the available supporting evidence; and one that is community focussed and community led, not researcher focussed and researcher led.

WHY ABORIGINAL YOUTH?

Unique health needs

Aboriginal and Torres Strait Islander youth like all young people have specific developmental and health needs which make them unique and distinct from children or adults.(8) One such difference is that psychosocial causes are responsible for most illness in this age group.(1) Apart from the usual social and economic factors influencing health, the health status of young people is strongly influenced by family breakdown, physical/sexual abuse and neglect and homelessness. Adolescence is also a period of risk taking and experimentation, thereby providing greater potential for adverse health outcomes. Yet young people under-utilise health services, are reluctant to seek help for health problems, engage with services at later stages of illness and for shorter periods and seldom receive counselling about risky behaviours when they do.(9-12)

The imperative and opportunity for early intervention

According to the World Health Organisation, "Nearly two-thirds of premature deaths and one third of the total disease burden in adults are associated with conditions or behaviours that began in their youth, including: tobacco use, a lack of physical activity, unprotected sex, or exposure to violence. Promoting healthy practices during adolescence, and taking steps to better protect young people from health risks is critical to the future of countries' health and social infrastructure and to the prevention of health problems in adulthood".(13) In addition, young people are future parents. **Primary and secondary prevention activities in this group therefore have the potential for impacting on the next generation**.

Clinician training and charting tools are associated with increased screening rates and counselling of adolescents about risky behaviours.(14)

At-risk consumers

Aboriginal and Torres Strait Islander youth aged 12-24 years comprise 3.7% of all Australians of that age. They are over-represented in social and health disadvantage, the details of which are described below.(15) This becomes more significant since they comprise around 27% of the total Indigenous population, whilst their non-Indigenous counterparts comprise 18% of the population.(15) Colonisation and its resultant cataclysmic cultural disruption with accompanying disadvantage in education, employment, health literacy and healthcare is directly linked to the current state of poor health and wellbeing in the Aboriginal and Torres Strait Islander population.(16)

General Health

In 2008–09, young Aboriginal and Torres Strait Islander Australians aged 15–24 years were less likely to rate their health as excellent or very good, compared to young non-Indigenous Australians (58% compared to 67% respectively). Similarly, young Indigenous people were more likely than non-Indigenous young people to rate their health as fair or poor (10% compared to 7%). They are also more likely to experience health risk factors such as obesity, physical inactivity, poor nutrition, smoking, risky alcohol consumption, lower educational attainment, unemployment, lower socioeconomic status, and imprisonment.(15)

Sexual and Reproductive Health

In 2008, the fertility rate of Indigenous young women aged 15-19 years was 5.3 times higher when compared to their non-Indigenous counterparts (78 and 14 births per 1000 females respectively).(15) In 2008, 20% of Aboriginal and Torres Strait Islander mothers were teenagers compared to 3.5% of non-Indigenous mothers. The proportion of Indigenous women of all ages that give birth to low birth weight infants is three times higher than non-Indigenous women, and pre-term deliveries are more than twice as high. Congenital

abnormalities are more prevalent in Indigenous than in non-Indigenous babies, and particularly for babies born to teenage mothers.(17)

Sexually Transmitted Infections (STIs) are also more common in this group. In 2008 Indigenous young people 12-24 years were 10.6 times more likely than their non-Indigenous counterparts to have a notifiable STI. The incidence of chlamydia and gonorrhoea in the young Indigenous population is 7.1 and 81.1 times higher respectively than for non-Indigenous young people.(15)

Smoking and Substance Abuse

In 2007-08, Indigenous young people aged 15 – 24 years were more than twice as likely to be daily smokers compared with their non-Indigenous counterparts (39% and 16% respectively for males, and 40% and 14% respectively for females).(15)

Indigenous Australians are twice as likely to be recent users of illicit drugs (26.9% vs. 15%). In addition, Indigenous Australians who become involved in drug use typically begin that use from a younger age than other Australians. Risky use, poly-drug use and associated harm are more prevalent amongst Aboriginal and Torres Strait Islander youth. They are more likely than non-Indigenous youth to smoke tobacco and cannabis. In contrast to the decline in cannabis use in the general community in the last decade, there has been a recent rapid escalation and pervasiveness of cannabis use within some Indigenous communities. As per the National Aboriginal and Torres Strait Islander Health Survey (2004-05), 23% of non-remote Aboriginal persons aged over 17 years reported using cannabis in the previous 12 months.(17) In 2004-05, Indigenous young people aged 18-24 years were also more likely than their non-Indigenous counterparts to drink alcohol at high risk levels for short-term harm at least once a week (23% and 15% respectively).(15)

Mental Health

Indigenous young people 18-24 years old experience poorer emotional wellbeing and are 2.4 times as likely to report high or very high levels of psychological distress. In 2003, mental health disorders were the leading cause of disease burden for Indigenous young people 15-24 years (27% males, 29% females). Between 2003 and 2007, the suicide rate for Indigenous people 15-24 years was 4.1 times higher than their non-Indigenous counterparts. Hospital separations due to mental and behavioural disorders (including substance and alcohol abuse) are 2.7 times higher than non-Indigenous youth in several States.(15)

Chronic Conditions

Indigenous young people are twice as likely to suffer from disability or long-term conditions as their non-Indigenous peers (18) and chronic diseases account for about 80% of the mortality gap between Indigenous and non-Indigenous Australians.(19)

Mortality

The death rate is almost 2.5 times, and the injury death rate almost 2.6 times that for non-Indigenous young people. Between 2003-07 the death rates for injury and poisoning, road transport accidents and assault were all higher for Indigenous Australians aged 15-24 years compared with their non-Indigenous counterparts (2.6, 2.0, & 6.0 times respectively).(15)

THE ABORIGINAL PRIMARY CARE CLIMATE

Health workforce problems and solutions

Reliance on medical practitioners to deliver preventive care especially in Indigenous Health is impractical. This is due to an ongoing medical practitioner shortage in Australia with a disproportionate shortage of Indigenous doctors.(20) In 2011, there were 249 doctors who identified as Indigenous amounting to 0.3% of the medical workforce.(21) In addition, the proportion of the clinical workforce comprising general practitioners has declined from

44.8% of the clinical workforce in 1999 to 38.0% in 2009 and 33.9% in 2011.(21, 22) Aboriginal health services also face medical practitioner shortages with remote services being the worst off. Overall, 0.7% of medical practitioners work at an Aboriginal Health Service (22) and 69% of Aboriginal Community Controlled Health Services employed a doctor.(23)

In contrast to the employment of doctors, 85% of Aboriginal Community Controlled Health Services employed Aboriginal Health Workers (AHW) and nurses. In 2008-09, AHWs made 21% and nurses made 32% of health care related client contacts.(23) Culturally appropriate care is effective and highly recommended and an Indigenous workforce is central to culturally appropriate care.(15, 24) The health of rural Indigenous communities is strongly linked to access to culturally appropriate health services.(20) Therefore and with the necessary training, mentoring and tools, and appropriate systems in place to support them; competent Aboriginal Health Workers can play a crucial role in the delivery of targeted preventive services. In addition, many indigenous youth will receive care from non-indigenous health providers. Training to ensure culturally competent clinicians and culturally appropriate care is vital.

Youth friendly primary care services

In addition to problems with culturally appropriate care, mainstream primary health care services in general are for the most part not youth friendly. Unsuitable hours of operation, lack of flexible appointment systems and lack of staff that are trained in working with young people are significant barriers.(1) Aboriginal medical services also have the same issue in regard to youth friendliness.

SUMMARY OF RESEARCH AIMS

The ‘Y Health – Staying Deadly’ project primarily sought to address the identified practice and policy gaps by developing and implementing an evidence-informed, culturally valid Aboriginal and Torres Strait Islander Youth Health Check and an accompanying Youth Health Audit tool. In conducting the project within an Aboriginal Primary Care setting, it also sought to strengthen the research and clinical capacity within this environment by supporting young Aboriginal researchers and Aboriginal Clinical Health Workers.

The ‘Y Health – Staying Deadly’ project had the following aims:

1. Ensure significant and appropriate Aboriginal involvement in all aspects of the project to achieve credible and long-term sustainable outcomes
2. Develop and Implement an evidence based screening tool (a Youth Health Check) to enable appropriate screening leading to appropriate management and timely referrals
3. Promote Aboriginal Health Worker ownership of the Health Check, and support specific professional skill development and independence
4. Embed the Youth Health Check within a continuous quality improvement cycle by developing a Youth Health Audit tool
5. Strengthen research capacity within Aboriginal Primary Care through individual mentoring and meaningful participation
6. Promote and enhance community awareness regarding the benefits of Youth Health Checks through appropriate dissemination methods

Research Team Roles

The core working group consisted of staff members of Watto Purrunna Aboriginal Health Service in Adelaide, Professor Ngiare Brown from AIDA and based in southern NSW, and Assoc. Professor Smita Shah from University of Sydney and based in Sydney. Most of the project team members were based in Adelaide, which was also the locus of project activity.

Dr Brown provided vital cultural leadership and guidance, as well as academic input into the Youth Health Check and template development. Her ongoing clinical role with the AFL National Indigenous Youth Group also enabled her to provide additional commentary on the documents. Dr Shah provided valuable academic input into the Youth Health Check and template development.

The Adelaide based project team worked closely with local Aboriginal community members and collaborated informally with local youth and sexual health service providers, and NT Health; and more formally with the Menzies' School of Health Research through the ABCD National Research Partnership (Figure 1).

ETHICS APPROVAL

This project received Ethics Approval from the following:

a) Aboriginal Health Research Ethics Committee (South Australia), Reference No: 04-12-423, approval given 29/3/2012

b) South Australian Dept. of Health Human Research Ethics Committee protocol number 496/01/2015, approval given 22/2/2012

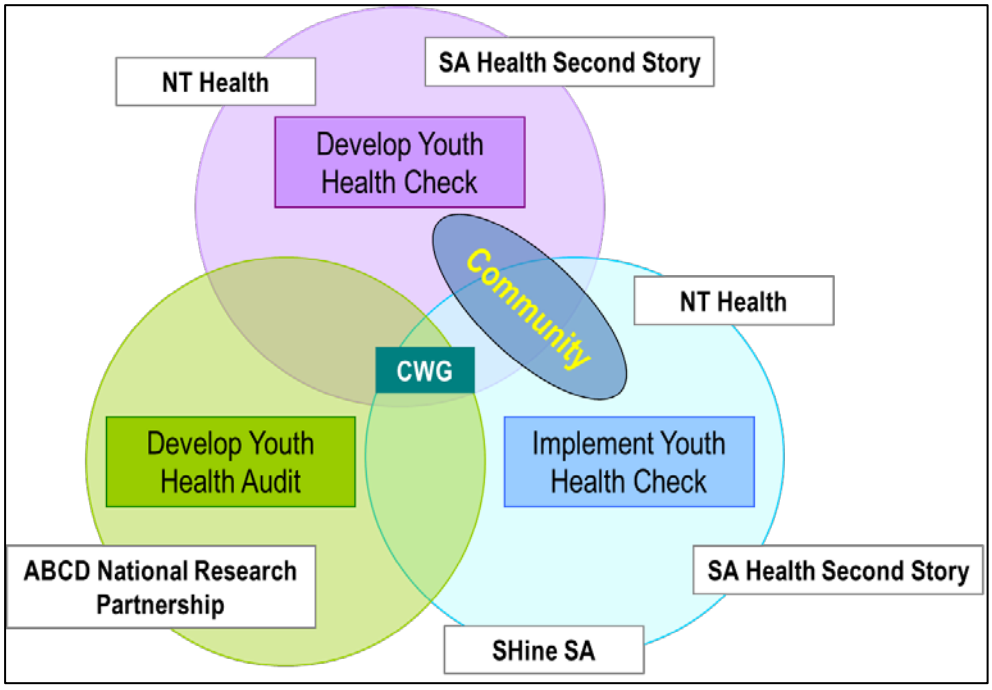

Figure 1: Research project partnership arrangements
CWG = Core Working Group

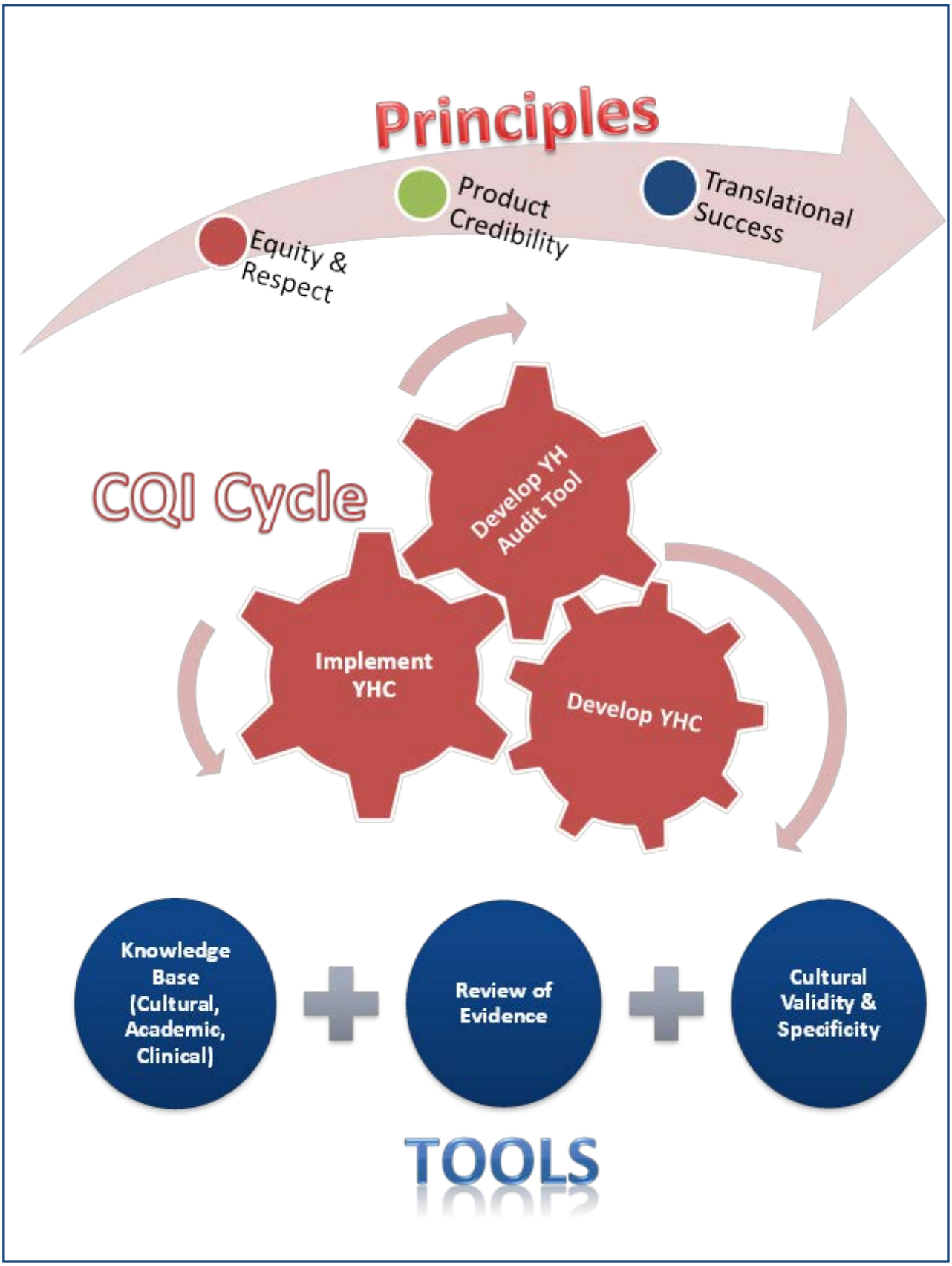

Figure 2: CBPAR Overview

YHC = Youth Health Check YH = Youth Health

Methods

This project utilised a Community Based Participatory Action Research approach (CBPAR) in the so-called T3 area of the Translational research paradigm where discoveries can flow in a bi-directional manner from bedside to bench to policy makers and organisations. Such discoveries or knowledge being initiated at “the bedside” or in this instance, in and with the concerned community is more likely to result in sustained Translation.(25) It also sat in the top part of McKenzie and Hanley’s Ladder of Community Participation.(26) (Appendix 5)

The Venn diagram (Figure 1) shows the three main aspects of the project and this was divided into four stages (Figure 3). Stage 1 was the set-up, including establishing Terms of Reference for the core working group, and confirmation of relevant Community representatives (e.g. Aboriginal youth, Aboriginal Health Workers). In Stage 2, we formulated the content for an evidence-informed Aboriginal Youth Health Check through review of evidence and legislation, youth and community focus groups, and expert group consensus. We then developed electronic and paper-based health check templates. In Stage 3 stage we partnered with the Menzies’ School of Health Research, to develop a youth health audit tool based on the evidence for the youth health check and expert group consensus. In Stage 4 we trained two Aboriginal Health Workers in conducting a youth health check and tested the template with young people associated with the project. The audit tool was also tested and further refined. Dissemination included traditional and innovative methods. Throughout the project, we supported basic research methods training for interested Aboriginal staff. Detailed description of the Methods follows.

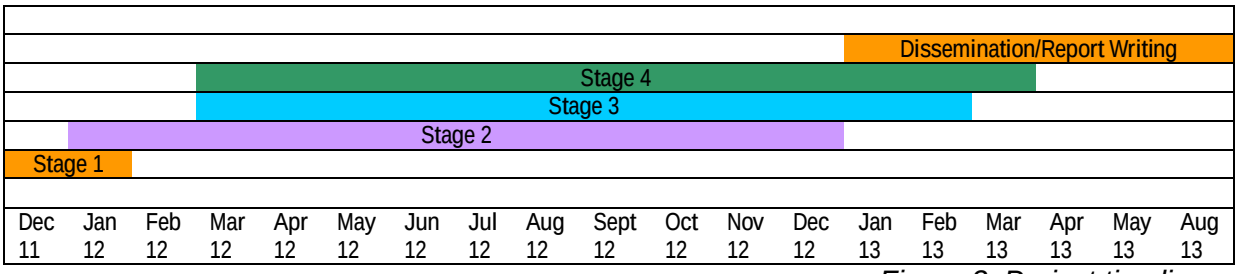

Figure 3: Project timelines

CBPAR IN THE ‘Y HEALTH’ CONTEXT

Community Based Participatory Action Research (CBPAR) was selected as the most appropriate approach as it permits engagement of multiple stakeholders who either affect, or are affected by a common concern. It is defined as collaboration among community groups, practitioners, policy-makers/decision makers, and researchers to create new knowledge or understanding about a practical issue in order to bring about change. It is a planned, systematic approach to issues relevant to the community of interest, requires community involvement, has a problem-solving focus, and makes a lasting contribution to the community. (10)

The CBPAR approach also supports the translation or uptake of research findings, and in this project, it also sought to strengthen self-determination within the Aboriginal community through meaningful participation and the enhancement of Aboriginal research capacity. Project governance structures ensured significant and appropriate Aboriginal participation at all stages of the project — identification of a need for a Youth Health Check, initial project planning and grant proposal submission, and project delivery. Aboriginal project members included health service management, Chief Investigators, Project Support Officer, Aboriginal Clinical Health Workers, Aboriginal youth and their family members. Additional support was provided by Aboriginal Educators and Aboriginal Wellbeing and Youth Workers.

Figure 2 shows an overview of the Methods. Under the umbrella of Community Based Participatory Action Research, there were three “Key Principles”; three “Tools” and three elements embedded in a Continuous Quality Improvement (CQI) cycle. The CBPAR was also underpinned by a Systematic and a Systems approach.

KEY PRINCIPLES

The ‘Y Health- Staying Deadly’ project amalgamated three overlapping and interacting key principles, with the ultimate goal being the uptake of a health check by Aboriginal youth and Aboriginal Primary Care providers. These principles were ‘Equity & Respect’, ‘Product credibility’ and ‘Translational success’.

TOOLS

The core project team had joint clinical and academic expertise. We conducted a Review of existing evidence, utilised Expert knowledge (cultural, clinical, and academic) to enhance and supplement the evidence, and examined the evidence using Cultural Validity and Cultural Specificity criteria. Cultural knowledge was provided by the Aboriginal membership of the project, led by Prof Brown.

Cultural validity and cultural specificity

The term ‘cultural appropriateness’ is often invoked in regard to ensuring that an approach, process, or output is appropriate to the needs of the Indigenous community. It is a broad term and varies greatly in interpretation and application. In the absence of Indigenous specific evidence or tools, mainstream evidence or tools can be utilised. However, the questions that should be asked are: do these mainstream theories or models adequately reflect or address the needs of a minority group, and are there any gaps? These questions are answered best by two approaches that were developed in the field of cross cultural research and in Ethnic Minority psychology.(27, 28) The first is a cross-cultural approach derived from Anthropology, referred to as the *etic* perspective. It looks at the *universality* of mainstream knowledge or the *generalisability* of majority group theories and norms to other cultural groups. The tool for this is Cultural Validity. The second approach is a cross-cultural cross-racial approach derived from Sociology, referred to as the *emic* perspective and it looks at aspects that are *specific* or particular to a culture. The tool for this is Cultural Specificity. In the ‘Y Health’ project, these two criteria were examined via the following: alignment with Aboriginal culture and knowledge, relevance of mainstream or non-youth health assessment areas to the health of Aboriginal and Torres Strait Islander youth, use of screening tools used with, designed for and/or validated with Aboriginal and Torres Strait Islander population, testing the product with the target group, and refining and/or noting future modifications.

CONTINUOUS QUALITY IMPROVEMENT CYCLE

The CBPAR approach sat alongside a Continuous Quality Improvement cycle (CQI). The core project team collaborated with the local Aboriginal community and with youth health service providers to develop and implement a culturally appropriate Aboriginal Youth Health Check. The team also collaborated with the Audit and Best Practice in Chronic Disease (ABCD) National Research Partnership to develop a Youth Health Audit Tool. There had already been discussion about the proposed project prior to the grant submission. Once funding was secured, preliminary project meetings were held with community members and Aboriginal primary care staff to confirm interest in the project, to clarify roles and to invite their participation.

Youth and community meetings

Meetings with Aboriginal young people aged between 12-24 years were conducted to assist with cultural validity, cultural specificity, youth friendliness of the Health Check, and to get information about how to promote its uptake by Aboriginal youth. Participants were recruited through existing networks and relationships with three community youth groups. Meetings were conducted at locations and times that were convenient to the young people and were facilitated by their usual Youth or Wellbeing worker. The young people shared their perceptions of health and illness, knowledge and understanding of health checks and their benefits. They provided suggestions for the format of the health check and how it could be completed, where health checks could be accessed, and what factors would make it easier to access them. They also provided detailed input into the wording for the psychosocial assessment in the Youth Health Check (YHC), including sensitive areas such as exploration of cultural connectedness, sexual health, mental health, and substance use. Guardians or carers of the young people also participated in many of these meetings and provided valuable input. This information was analysed and incorporated into the development of the Health Check template, and also informed the implementation or delivery of the YHC.

Other Aboriginal community members also provided critical input and reflections on the content of the health check and its user friendliness, how and where health checks can be delivered, and the utility of the current primary care services to Aboriginal youth. Concern had been raised by some staff members as to community acceptability of asking youth about taboo areas such as sexual health and substance use. Transparency of intent and process was paramount and we therefore had honest discussions with elders and guardians informing them exactly what a Youth Health Check would cover and why.

Youth Health Check development

Content of a Health Check (identifying screening recommendations for Indigenous Youth)

Review of Evidence

The 2nd edition of the NACCHO/RACGP publication ‘National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people’ was selected as the major source of information as it provides the “latest national and international evidence and good practice points” to maximise the opportunity for illness prevention for Aboriginal and Torres Strait Islanders accessing primary health care.(29) Two members of the research team separately and systematically reviewed all chapters of the Guide and extracted recommendations relating to the general health assessment and management of identified health risks or conditions for young people aged 12-24 years. The extracted information was checked several times against the source reference to ensure accuracy.

Where recommendations or their implications were not clear, further evidence was sought or the relevant NACCHO/RACGP Guide chapter author was contacted for clarification. Additional literature searches were conducted to identify psychosocial, mental health, nutrition and physical activity screening tools appropriate for Aboriginal and Torres Strait Islander youth. (Appendix 1)

Expert Group Recommendations

Other items for inclusion in the Youth Health Check were recommended by members of the project team and other Aboriginal and youth health service providers (referred to collectively as the ‘expert group’). These were based on cultural knowledge, clinical and academic expertise, experience in working with the target population, experience conducting health assessments, and consideration of best practice guidelines.

Health Check Evidence and Content Document (refining the recommendations)

The collated evidence from the NACCHO/RACGP Guide and literature reviews, along with the expert group recommendations were compiled into an exhaustive content document. Recommendations were then re-organised according to the structure and flow of a clinical consultation, with screening items, follow up items and corresponding levels of evidence listed in separate columns. (Appendix 2)

Creating a Screening Tool and Health Check Template from the Evidence and Content

The following processes identified the key elements of a youth health screening tool and the subsequent development of the YHC template.

The Evidence and Content document was subjected to cultural validity and cultural specificity inspection by the project team.

17 Health Check templates from Australia and New Zealand that were of possible or direct relevance to Indigenous youth aged 12-24 years were identified and reviewed. (Appendix 5) These templates were compared against each other and their content compared with the compiled evidence and recommendations. Items from these templates that were not supported by evidence but were considered useful to include in the YHC were tabled for detailed discussion within the expert group. Other observations were made about the length, language, structure and flow of the templates with regard to user friendliness (cultural appropriateness, youth friendliness, and ACHW friendliness).

Where the NACCHO Guide recommendations were naturally aligned to sections in the HEEADSSS psychosocial assessment, the relevant recommendations from the former were incorporated into the appropriate section of the latter. Examples include incorporating screening for gambling into the Activities section, and conducting a dietary and physical activity assessment in the Eating/Exercise section.

Aboriginal Clinical Health Workers within Watto Purrunna Aboriginal Health Service were specifically consulted and their input also informed the structure of the YHC template. The initial draft of the YHC template was reviewed by them before being tested through health checks with 30 Aboriginal youth between 12 and 24 years, from a range of urban, rural and remote settings. After conducting the Youth Health Checks, the two Aboriginal Clinical Health Workers gathered verbal client feedback and also provided their feedback. The draft template was also reviewed and commented on by Dr Brown, Dr Shah and The Second Story. Refinement to the Youth Health Check template occurred during and after the pilot.

Youth Health Check implementation

Factors impacting on the uptake of YHC by health providers

Existing Services and Service delivery

Meetings were held with local youth providers (SHine SA, The Second Story, Shopfront Youth Health and Information Service, and Adelaide Northern Headspace) to identify what services were being delivered, existing partnerships, gaps and barriers to service delivery, and opportunities for improved service coordination. Information regarding the YHC was provided and referral pathways were negotiated and established. This included procedures for making referrals, how clients then accessed services and methods for communicating client information. Existing referral pathways were clarified and some were newly established. These pathways were reviewed and refined during the YHC trial, and ongoing evaluation will occur with future delivery of the YHC. The nature of service coordination will need to be revisited in the coming six months following recent State-wide service reviews and the impending major restructure of SA Health youth primary health care services.

Health Worker Resources & Training Needs

Resources to support the Aboriginal Clinical Health Workers in conducting the YHC were identified and gathered concurrent with the YHC content development. Examples of these are mandatory reporting obligations under current legislation, the national immunisation program schedule, national dietary and physical activity guidelines, etc. Other resources were collected and provided to the ACHWs prior to the YHC pilot and include health education resources, information regarding local youth health and social services, and referral pathways.

Two Aboriginal Clinical Health Workers and the project Chief Investigator (Public Health Medical Officer for Watto Purrunna) jointly identified Health Worker training needs and these were addressed by the Chief Investigator at the time of identification. Further discussion occurred after the YHC pilot. The two youth health audits described below also provided information on health worker skills & training requirements.

Factors impacting on Uptake of YHC by Aboriginal youth

Youth Engagement with Preventative Care

The youth meetings discussed previously provided an opportunity to explore the factors influencing Aboriginal youth engagement with health services and preventative care. Topics of discussion included young people's understanding of health and illness, health seeking behaviours, acceptance of health checks, interactions with health services, and barriers and enablers to health service access and utilisation. A meeting was also conducted with three parents/guardians of the young Aboriginal participants to capture their perspective on these topics. These discussions provided preliminary identification of means to increase youth acceptance of health checks and engagement with health services.

A literature search was also conducted to explore whether there was a relationship between Indigenous youth mobility and utilisation of health services. (Appendix 1)

Quality improvement

Youth health audit tool development

This was led by the Menzies' School of Health Research through the ABCD National Research Partnership. Four members of the Watto Purrunna 'Y Health' project team were on the Partnership's Youth Health Audit Reference Group. The Youth Health Audit Tool was modelled on previous ABCD audit tools and designed to measure the quality of care provided by Primary Health Care services for Indigenous youth aged 12-24 years against best practice standards. The evidence base for the Audit tool was driven by the evidence base for the youth health check.

Youth Health Audits

Members of the project team less intimately involved in the YHC Content development conducted the Audit Tool Pilot at Watto Purrunna Aboriginal Health Service. This also served to provide baseline data regarding the quality of care being provided by the service prior to the Youth Health Check template pilot. 'Y Health' team members provided feedback and participated in a focus group evaluation, leading to refinement of the Youth Health Audit Tool. A second Youth Health Audit was conducted six months after the YHC pilot to monitor service delivery change within Watto Purrunna.

DISSEMINATION

Promoting the YHC

The dissemination focus for the 'Y Health' team was to promote the YHC amongst the Indigenous community, especially youth. A popular means of dissemination of health

information to Indigenous youth has been through comics and story books. This was confirmed and supported by local community members. We therefore contracted Inception Strategies (creator of the Condoman comic) to produce a 24-page social comic and accompanying posters to promote the Youth Health Check. The Y Health team held a two full-day creative workshop in November 2012, facilitated by Inception Strategies and attended by nine Aboriginal young people aged 12-24 years who had previously participated in the YHC meetings. The preliminary storyline and character development occurred during this workshop. The project team then worked with Inception Strategies to further develop and refine the storyline and script. Information previously provided in the YHC youth meetings regarding health, illness, and health seeking behaviours were incorporated into the storyline. Aboriginal youth workshop participants and a Senior Aboriginal Clinical Health Worker reviewed and approved of the final version of the script before production proceeded.

Other dissemination methods

These include conference presentations and journal publications. Official endorsements for the Youth Health Check will also be sought from the following significant bodies: National Aboriginal Community Controlled Health Organisation and State Affiliates, and the RACGP National Faculty of Aboriginal & Torres Strait Islander Health. Approval has already been indicated informally. Community events to launch the comic book and poster are also planned as are radio interviews for local Aboriginal radio programs.

The Y Health team found the mandatory Investigator meetings conducted by the funding body APHCRI to be of significant value since they were also attended by consumer group representatives and government policy makers. These meetings provided insights into decision making and means of dissemination of project information best suited to gain support from policy advisors for sound and sustainable translation of project findings and outputs.

Results and Outputs

YOUTH & COMMUNITY FOCUS GROUP MEETINGS

A total of eight youth meetings of two to three hour duration were held and a total of 23 individuals attended. Of these, 14 were female and 9 were male. There were 14 youth aged 12-17 years and 9 youth aged 18-24 years. Most young people attended more than one of the meetings. Some carers also usually attended these meetings.

Overall, there was unanimous and overwhelming support for the project goals. A youth specific health check was seen by carers as long overdue and by young people as important in acknowledging their status as a distinct group.

> “Bout time isn’t it? It don’t feel proper that my fifteen year old boy can be checked same way as my man for a health check. And my mister, he’s like forty. And like, we know our son is not, you know, he’s not like full grown up and all and young folk their bodies and brains are just not like us adults but it’s also silly to be treating them like they was little kids” [Quote from parent]
>
> “Thank you, thank you, for your project, for doing something about the fact that our young people need a different kind of assessment and different kind of help. Cos we know they think different and behave different don’t they?” [Quote from community member]
>
> “Are you going to talk to the Prime Minister and make sure this young health check gets recognised?” [Quote from grandmother]

"Of course this is important. We want our young people to be healthy, not like us, all full of diabetes and dyin' early and stuff. Half my family is gone, so many funerals, I want something better for my kids, I want them to get their checks and pick up problems before it's too late".[Quote from parent]

"Ya I remember one time we went to see the doctor and she said I should get a well health check and my mom said that was OK. It was real funny cos the doctor, she kept saying, oh this bit is not for you, this is for younger kids and you're twelve. And she kept crossing bits out because I was too old for those questions and I kept laughing and my mom kept telling me to stop it but she was laughing too. It was silly that most of the check up was not right for me and it was a child check up but it was like I wasn't a child but I wasn't an adult neither."[Quote from young person]

The following specific areas were discussed:

Concepts of health and illness

Discussions included what it means to be healthy and unhealthy. Self-confidence, healthy family and peer interactions and a stable environment were seen to be associated with good health. Being discriminated against, remains a reality for Aboriginal youth. It is of concern that diabetes was not seen to be a health problem, indicating that the prevalence of the condition may be leading to normalising pathology (see comment regarding diabetes).

Reflections on health (Being healthy means?)

"Looking after yourself, respecting your body"

"Being in a good stable environment", "being around positive people", "Having people around to motivate you, positive people"

"Being happy"

"Getting enough sleep", "not sleeping too much"

"Eating healthy", "having a proper meal", "Having money to afford the food to be healthy"

"Having a good routine", "get up early, get ready and get on with the day"; "Being organised"

"Catching up with friends", "good to get out there and socialise with family and friends"

"Keeping clean and fresh" (having clean clothes, having a shower)

"Going with the flow"…."bein chill and relaxed"

"Keeping fit", "try and get to the gym regularly", "Doing physical activity makes you a better person and helps you get a job"

"Having transport to get around"

"Socialising and going out on weekend and drinking is not necessarily alright but in moderation it's alright….sitting in your house every day without friends and being lonely is not good….it's unhealthy…socialising makes you happy"

Reflections on being unhealthy and illness ("Being unhealthy means?")

"It's like smoking", "overweight", "eating badly"

"Not socialising or getting out", "being bored", "not getting to know people", "Unhealthy people don't make as many friends" "less confidence"

"Sleeping non-stop", Being "gloomy", "hopeless", "depressed", "stressed", "tired", "achy"

"Working too much and not having time to be healthy"

"Unhealthy people do abuse…like with alcohol, drugs, cigarettes, eating too much"

"Diabetes is so common that it's not sick…everyone's got it so it's normal and probably every Aboriginal person is going to get it….but you do have to be unhealthy to get diabetes"

A bad environment is: "violence", "alcohol", "drugs", "unstable", "craziness", "not mentally stable", "when people aren't right"

"You can be high off of drugs and you're happy but you're not healthy"

"It gets passed down. If your father did that sort of stuff, like doing drugs then you end up doing drugs"

"Being drunk and happy is the pretend happy….why would they be drinking every day? When they're sober they're not happy"

"Confidence is really important. Boys/girls that have no self-confidence always need help, don't want to say things/speak out", "fear of shame"

"Self confidence is a big problem for young people our age. People might be drunk and put people down, get abused and think the worst of themselves. It's got to do with family mostly in the Aboriginal community"

"There are a lot of Aboriginal programs out there. But, we don't have the confidence to take the opportunity. We need to become stronger, and not keep comparing ourselves to others"

"Racism is still around. My brothers get picked on because of the colour of their skin"

Acceptability of the content of a Youth Health Check

All youth and community participants approved of the content of the YHC and found it to be acceptable and important. There was no disapproval of and indeed specific approval of discussions around cultural connections, safety, sexual health, emotional wellbeing, smoking and substance use. Carers and youth felt that health professionals should be up front about asking about these areas but they should do it in a respectful and confidential way and mindful of cultural taboos e.g. keeping sensitive health discussions gender appropriate.

"We know our young 'uns are doing it, so somebody should be talkin to them about these things you know. Glad it's you and the health workers that's gonna be doing it cos I'm not!" [Quote from a grandmother]

Format of the Youth Health Check template

Youth seemed puzzled by the idea of a paper based template. An electronic version was the unanimously preferred option, with web based format or smart phone "apps" that directly send results to the health service being especially popular amongst the males. In general, youth preferred options and tick boxes rather than having to write words.

"I dunno bout reading stuff on paper. It's like my brain takes longer to focus and I can't really understand. But when it's on the computer, it's real easy and I can understand the stuff more easily". [Quote from 12 year old]

What would make a young person want to have a health check?

There were widely varying responses and there were clear differences between the younger adolescents and the older youth. The older youth (>20 years) thought that they were ready to have health checks because it made sense to them to look after their health. What they needed was a health service they felt comfortable attending, and greater ownership of their health information and records. The younger members thought that peer promotion of health checks would make a difference to them. All of them thought that flexible delivery of health

checks e.g. being able to have them at schools; residential facilities or other educational institutions would be useful. Self-completion of parts of the health check was also suggested as a means of resolving any discomfort with bringing problems up verbally and had the potential for decreasing time spent in a consultation.

> "A one hour health check can give you an extra 10 years of life" [Quote from young person]

Engagement between Aboriginal youth and primary care services: enablers and barriers

Table 1 outlines the identified preliminary enablers and barriers. Overall, Aboriginal youth were seeking a youth friendly environment; features of which include guarantee of confidentiality, suitable hours of operation, flexible appointments of adequate duration, health professionals with appropriate communication skills and a physically inviting space.

LITERATURE SEARCH

Our literature searches were not able to find any health screening tools for psychosocial assessment, nutrition and physical activity designed and validated for Indigenous youth. In regard to the literature search on Indigenous youth mobility and utilisation of health services, though Indigenous youth are a highly mobile population(30) there were no studies that specifically examined a relationship with health service utilisation. Details of these literature searches are provided in Appendix 1.

EXAMPLES OF THE APPLICATION OF THE CULTURAL VALIDITY CRITERION

A strengths-based approach

An approach where individual strengths and concerns are identified, is recommended for youth assessment.(1, 31) An integrated focus on competency and pathology enhances our understandings of the developmental trajectory; the consideration of strengths allows professionals to see the potential for functional success and adaptability.(32, 33) The identification of protective factors that support resilience provides an indication of an individual's ability to cope with stressors.(1) Establishing individual strengths also presents an opportunity for health professionals to support continued effort in areas in which a young person is doing well and to encourage self-efficacy in health promoting behaviour.

The Indigenous world-view also embraces a strengths-based approach; this therefore meets the criterion of cultural validity.

The HEEADSSS tool

This is a widely recognised and well accepted comprehensive psychosocial assessment tool for young people(1, 34) and is recommended in the NACCHO Guide.(29) The acronym stands for the areas of Home, Education/Employment, Eating/Exercise, Activities, Drugs & other substances, Smoking, Self-Harm & Suicide, and Safety & Spirituality. The topics move from less sensitive to more sensitive areas. The HEEADSSS assessment "gives a profile of the overall balance of risk and protective factors in a young person's life".(1) Such an assessment is also aligned to the Indigenous view of health encompassing the physical, spiritual, cultural, social and environmental domains.

The Kessler 5 (K5) Psychological Distress Scale

This is a shortened version of the ten item scale (K10), which has been shown to identify levels of distress that are associated with a current diagnosis of anxiety or depression.(35-37) The K5 was selected as an appropriate tool for measuring the psychological distress of Indigenous people during a stakeholder workshop conducted to develop the social and

emotional wellbeing section of the 2004-2005 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS).(38) The K5 has since been used in the 2004-2005 and 2010-2011 NATSIHS and has been evaluated by the Australian Bureau of Statistics as being an accurate measure of psychological distress in the ATSI population.(38)

The recommendation to 'assess for overcrowding'

Overcrowding is considered a risk factor for ear disease, rheumatic heart disease and family violence.(29, 39) The definition given for overcrowding in the literature is from a Western perspective. Within Indigenous culture, the 'collective' is more important than the 'individual' and having an immediate supportive network of individuals has significant benefits. There is therefore a dichotomy between the benefits of good bonding social capital and the risks of a lack of personal space, which was taken into account.

EXAMPLES OF THE APPLICATION OF THE CULTURAL SPECIFICITY CRITERION

Modification of the HEEADSSS psychosocial assessment

Cultural integrity is intimately tied up with positive health outcomes for Aboriginal populations worldwide.(15, 40) Prof Brown has commenced a dialogue around Cultural determinants of health and in line with the UN Declaration on the Rights of Indigenous Peoples, describes the importance of reclaiming, promoting and preserving cultural integrity.(41) Racism is commonly experienced by the Aboriginal population and is closely linked to depression and other mental illness. Therefore, cultural connectedness and exposure to racism were integrated into this assessment. Other culture specific areas such as bush tucker, traditional dance, seeing a traditional healer were also incorporated. The D (drug use/ cigarettes/ alcohol) and second S (suicide/ self-harm/ depression/ mood) sections were combined to reflect the close relationship of mental health and substance use, and to incorporate existing validated tools such as the Indigenous Risk Impact Screen (IRIS) that assess risk in both areas. A question assessing current concerns was added to the end of the psychosocial section. The language of the original HEEADSSS assessment questions was adapted to be user friendly to AHWs. (Appendix 2)

Adaptation of the Stay Strong Plan (AIMHI)

The Stay Strong Plan was identified during the literature search on mental health screening tools. It was designed for Aboriginal & Torres Strait Islander adults to facilitate the management of mental health conditions, and begins with a self-identification of individual strengths and concerns. The plan also lends itself to adaptation and we sought and received permission to do so. The content and language of the Stay Strong Plan strengths and concerns items were adapted to reflect the areas covered by the modified HEEADSSS assessment without compromising cultural appropriateness. The process and outcome were checked and approved by Dr Tricia Nagel (AIMhi project Lead).

Adaptation of K5 mental health assessment

We also adapted the self-assessed K5 from the Stay Strong Plan. In addition to its simplicity and culturally appropriate language, the K5 Plus One also has a visual scoring scale and includes an additional question to determine if the young person would like assistance with any mental health issue.

ABORIGINAL & TORRES STRAIT ISLANDER YOUTH HEALTH CHECK EVIDENCE AND CONTENT DOCUMENT

This is a significant output of the project and is a comprehensive list of evidence informed recommendations for inclusion in a Youth Health Check (YHC). Expert group recommendations have been identified as 'best practice' or 'standard good care' in the 'level of evidence column' with accompanying justifications in the corresponding 'comments' column. This document can be used to view the evidence behind the YHC template or be used by Primary Care Services to develop a template designed for their local context. (Appendix 2)

ABORIGINAL & TORRES STRAIT ISLANDER YOUTH SCREENING TOOL AND TEMPLATE FOR AGES 12 – 24 YEARS

Screening tool components

We concluded that a comprehensive preventive health assessment for Aboriginal & Torres Strait Islander youth should consist of a cultural social emotional wellbeing assessment, a clinical assessment, and a summary of the health assessment. (Appendix 3)

Template structure

Development of an electronic template that could interface with an electronic health record system was beyond the scope of this project. A word processor version and a paper-based version have been developed.

There are four sections to the template and these may be completed at separate times or in one health encounter. (Appendix 3) The first two sections are for self-completion by the young person and may require assistance from a carer or health professional. The first section is basic health information. The second section is self-identification of factors contributing to a young person's wellbeing, any health concerns they have, and the K5 Plus One assessment.

The third section is the Health Professional's assessment and includes a cultural social emotional wellbeing assessment; other screening, physical examination, and clinical tests. The cultural social emotional wellbeing assessment (a culturally valid modified psychosocial assessment) builds on the young person's self-identified strengths and concerns from the second section.

The fourth and last section is the Health Plan. This client centred section is jointly discussed and completed by the young person and health professional as a partnership. It includes a summary of areas that are going well, problems that have been identified, action areas prioritised by the young person, advice provided by the health professional and referrals that have been made. The action plan then details the top three areas for action, including what will happen, who is involved, a date for review and a review of progress.

YHC paper based template pilot test

Health worker feedback

Health Workers found the various sections of the template easy to negotiate and especially endorsed the client-centred Health Plan. However, a paper-based template also presented difficulties in terms of having to copy the information into the electronic health record thus duplicating the effort. They largely did not require any specific skills in order to conduct a YHC. The identified training needs were: understanding the legislation around age of

consent to medical treatment; communicating well with a young person, and conducting a psychosocial or cultural social emotional wellbeing assessment.

Youth feedback

Overall, the young people had no difficulty with the areas covered by the YHC. The younger adolescents (12 – 14) needed assistance filling out aspects of the self-completed sections. Some youth found it difficult to answer the questions because this was a departure from their usual experience; they had never been asked to think about their health and others had always answered on their behalf. Youth from remote areas for whom English is a second language, struggled with following the questions in the self-completed section, and the youth worker who assisted them suggested that we replace words with pictures or visual representations and generally increase the pictorial content of the template. Translation into Aboriginal languages was also a recommendation. Another difference was that youth from remote areas immediately understood the question "what keeps you strong", whereas urban youth struggled with this and needed alternate wording such as "what's good in your life" or "what's going well for you".

The features of the Youth Health Check template are described in Table 1 (page 26).

HUNT FOR THE ZERO PHONE

An educational and entertaining 24 page comic and accompanying posters to promote and market Aboriginal & Torres Strait Islander Youth Health Checks have been produced through Inception Strategies. Titled "Hunt for the Zero Phone", the comic introduces the concept of a health check, what it involves, and where they can be accessed. It also promotes the benefits of engaging in health promoting and risk reducing behaviour. All the characters are based on 'Y Health' project youth participants and some Watto Purrunna staff members.

QUALITY IMPROVEMENT

In partnership with and led by the Menzies' School of Health Research, a Youth Health Audit tool has been developed, piloted, and refined. The National ABCD Research Partnership is currently testing the audit tool at other Aboriginal primary health care sites around the country and is establishing a web based tool. Once this work is complete and the tool is endorsed, it will become part of the One21seventy suite of audit tools.

Two audits (a baseline and subsequent audit) were conducted six months apart at Watto Purrunna during the course of this project. Analysis and audit comparison demonstrates that use of the Youth Health Check template has resulted in improvements in the screening of all domains of the psychosocial assessment and also many clinical areas. A screening rate of 100% was achieved in five of these areas. The audit results and further steps will be discussed with the Watto Purrunna clinical team as part of a quality improvement planning session in the coming months.

UPTAKE OF YOUTH HEALTH CHECKS BY HEALTH PROVIDERS

Competence and confidence of Aboriginal Health Workers to conduct Youth Health Checks

Feedback from the ACHWs and the audit results confirm that apart from cardiac auscultation which is beyond their scope of practice, Aboriginal Health Workers can competently conduct the entire Youth Health Check. They and their clinical line manager also identified the need for the service systems to support health checks including follow ups, recalls, and

opportunity to provide health education. A study conducted by the Inala Indigenous Health Service in Queensland had similar findings.(42)

Additional considerations

Anecdotal feedback from local and interstate health providers has identified the following three factors that will significantly influence the uptake of YHC by primary health care providers:

1) Endorsement and promotion of the YHC by the Australian Government Department of Health and Ageing, and national organisations such as NACCHO and RACGP
2) Inclusion of the YHC into the current MBS Aboriginal & Torres Strait Islander Health Check Item 715
3) Availability of electronic templates. In regard to this, informal communications from electronic health record software developers suggests that the above two factors would influence their willingness to develop such a template.

WHAT FACILITATES ENGAGEMENT BETWEEN YOUTH AND PRIMARY CARE SERVICES

Table 2 (page 26) summarises the preliminary findings of this discussion with youth and carers. Most of the enablers and barriers are well documented. Of note are the following enablers:

1) Strong relationships and credibility with the Aboriginal community
2) Space for social and cultural interaction in addition to the provision of health services and related programs
3) Good coordination and communication between various health service providers and collaborative partnership between health services and youth services (including schools)
4) Safe and secure sharing of health information
5) Better use of social media and community networks

In regard to the concern around a family member being employed at a service, it needs to be clarified that the young people felt uncomfortable about discussing concerns of a confidential or sensitive nature in this situation, they were not implying that staff members behave unprofessionally.

STRENGTHENING THE CAPACITY OF ABORIGINAL PRIMARY CARE RESEARCH

Supporting capacity of individuals

Whilst specific research methods knowledge and skills areas have been supported, the focus of capacity strengthening has been to enhance critical thinking skills. Three interested Aboriginal staff members received variable training in the following areas: conducting literature reviews, developing a research question and proposal, ethical considerations, facilitating meaningful community engagement in research, facilitating focus groups, organising and analysing qualitative data, and assisting with conference presentations and workshops. They were also involved in pilot testing the Youth Health Audit. Formal staff training included a two-day workshop on qualitative research methods and a two-day instruction on NVivo software.

Involvement in research networks

Four project researchers have joined the South Australian Health and Medical Research Institute (SAHMRI) Aboriginal Research Network to support and be supported in future Aboriginal Health Research in South Australia.

Ongoing research collaboration

The Y Health project has led to two research collaborations seeking to improve the quality of care provided for Aboriginal youth.

The team at Watto Purrunna is working with Dr Janet Kelly on a Lowitja Institute funded project to modify the patient journey mapping tool developed through the Flinders University 'Managing Two Worlds Together' (MTWT) project. The tool maps client journeys through the health system from the multiple perspectives of the client, their carers/guardians, and health professionals involved in their care. We will be modifying and using the MTWT journey mapping tools to provide further knowledge into current gaps in primary care service delivery for Aboriginal Youth.

The collaboration with Menzies' School of Health Research on the Youth Health Audit Tool project led to a successful research grant proposal to Beyond Blue (on which Dr Annapurna Nori is a Senior Investigator). Funds are being utilised to support two Indigenous researchers within Watto Purrunna for a 12 month period. One of them is being supported to undertake the accredited Certificate IV in Indigenous Research Capacity Building (delivered through Aboriginal Health Council of SA); and will also finalise a Health Worker training package and train local ACHWs in conducting Youth Health Checks. Another was supported for an Honours research project in Psychology that explored psychologists' perspectives on the enablers and barriers to the delivery of mental health care to Aboriginal youth.

DISSEMINATION OF PROJECT FINDINGS AND OUTPUTS

We focussed our knowledge dissemination efforts at the coal face. We specifically targeted discussion and promotion of the Youth Health Check within the Aboriginal community, including young people, health professionals, leaders and elders. This involved transparent discussions on the YHC content, why it is important, how it can be delivered, where it can be accessed, and the benefits of a health promotion and illness prevention approach. We have planned for a community launch of the comic book and poster. Three thousand copies of the comic book and two thousand copies of the poster will be distributed among Aboriginal Health Services around Australia.

The 'Y Health' team has presented at four national conferences (Appendix 4). Conferences were strategically selected to ensure a variety of audiences and themes ranging from Quality Improvement, Population Health, Social Inclusion, and Primary Care.

Conclusions and Recommendations

The 'Y Health' project has been an example of a culturally credible and inclusive research partnership. It has strengthened research capacity within Aboriginal Primary Care at the individual and organisational levels. The project has established a governance structure for research to occur within an Aboriginal Primary Health Care setting and in so doing, will enable staff members to engage with research in a culturally sound and safe way. Senior Aboriginal clinician researchers such as Prof Brown are invaluable due to their academic and cultural input and are a vital role model for younger aspiring Aboriginal clinician researchers.

The Youth Health Check is a culturally valid and culturally specific tool, developed with meaningful participation of community members. The involvement of Aboriginal primary care

staff and community members has enabled successful project development and implementation. This has included increasing health worker and community understanding of the importance of the health check content, and building skills and capacity of the health worker to conduct a youth health check. The result has been increased ownership of and commitment to the Youth Health Check. The learning from this project is being developed into a practical framework to support Aboriginal primary care organisations and communities in engaging with research.

In summary, the project meets the criteria for best practice research by meeting cultural, academic and clinical standards in developing an Aboriginal & Torres Strait Islander Youth Health Check. We have tested it in primary health care to ensure its credibility. With appropriate support and resources we expect a good uptake of the Youth Health Check in primary care services around Australia. Effective knowledge translation is likely to result from the tool being developed in the context in which it is applied.

We recommend that the following steps be taken by policy advisors and decision makers to close the current gaps in preventive services to Aboriginal & Torres Strait Islander youth.

I. Endorse an Aboriginal & Torres Strait Islander Youth Health Check

The changes necessary to support and sustain uptake by health providers are:

Adjustment of the current MBS Aboriginal & Torres Strait Islander Health Check Item 715 to incorporate a Youth Health Check for ages 12-24 years

This would address the lack of equity in regard to Indigenous Youth in the current MBS Item 715. It has no onerous administrative implications for the Australian Government since the MBS Item number already exists. The following changes will need to be made to the existing Health Check age ranges:

a) Child Health Check to be changed to 0 -11 years

b) Adult Health Check to be changed to 25-54 years

Development of a Youth Health Check electronic template

This will need to be incorporated within current leading Patient Information Management Systems e.g. Communicare, Medical Director, Genie, Zedmed, Best Practice, and MMEX.

II. Endorse and support Aboriginal Clinical Health Workers/Aboriginal Clinical Health Practitioners to deliver preventive care

Competent Aboriginal Clinical Health Workers can play a crucial role in the delivery of Youth Health Checks. The necessary tools have been developed through this project. ACHWs do not need any additional training apart from those in common with any clinician working with young people.(1) Such training and mentoring can be addressed through changes in their training curriculum via the Aboriginal & Torres Strait Islander Health Registered Training Organisation National Network (ATSHRTONN).

III. Endorse the incorporation of Cultural Validity and Cultural Specificity into Indigenous research methodology

IV. Promote an Aboriginal Primary Health Care research model through

- Supporting local Aboriginal primary care research networks
- Supporting Aboriginal Primary Care organisations to take ownership of research through an appropriate skill mix of cultural, academic and clinical expertise
- Funding dedicated to research officer positions within either Aboriginal Primary Care organisations or Aboriginal primary care research networks.

Further Research

This project's many facets highlight the complexity of preventative health for Aboriginal and Torres Strait Islander youth. Research in the following areas is necessary to unravel some of this complexity and to assist young people in engaging with their health.

1) *Utilisation and utility of the non-health sector in health engagement*

   Low health service utilisation by Aboriginal and Torres Strait Islander youth is a well-recognised barrier to the uptake of preventive and other services. A possible solution to increasing the uptake of preventive services can be to partner with the non-health sector. According to the Closing the Gap Clearinghouse Resource Sheet 12, *"Schools are uniquely placed to teach the knowledge, skills and attitudes that underpin healthy living",* and *"Positive health outcomes can be achieved when health education programs are... provided by trained and well-resourced classroom teachers… underpinned by positive partnerships with parents, community members and health professionals…and designed and evaluated according to sound health and educational theory and practice."*(18) The 'Y Health – Staying Deadly' project has been approached by schools and youth groups, requesting involvement in a partnership around health checks. A study investigating this would be the natural next step to the current project.

2) *Health Literacy and Resilience*

   The single most important psychosocial task of adolescence is the development of resilience. Health literacy is both aided by and aids self-management efficacy. Yet very little is known about the development of or resilience among Indigenous young people or about uniquely Indigenous approaches to the development of health literacy.(18)

3) *The impact of preventive health self-management efficacy on health literacy, health engagement and health outcomes*

   Self-management efficacy has been strongly promoted in the management of long term or chronic conditions. Applying this to the area of disease prevention and health promotion may be beneficial in terms of health literacy, health engagement and health outcomes.

YHC FEATURES	METHOD
Evidence Informed	Based on NACCHO/RACGP Guide recommendations, other empirical evidence and clinical expertise
Culturally Valid & Specific	All YHC content items and YHC template subjected to bidirectional cultural scrutiny using sources of knowledge of Aboriginal & Torres Strait Islander culture
Strengths Based	Identifies and acknowledges practices or factors that contribute positively to health
Acceptable to Aboriginal Youth	Language and format is appropriate for and understood by the target group YHC template aligned to youth needs
User Friendly (Acceptable to Aboriginal Health Workers)	Aboriginal Health Workers involved in the development and refining of the YHC template: • Assisting with converting evidence-informed content into a template format • Testing and evaluating the YHC template; auditing preventive practice
Potential for electronic versatility	The YHC templates are available in print and word processor versions and can easily be incorporated into electronic health software

Table 1: Features of the Aboriginal & Torres Strait Islander Youth Health Check

ENABLERS	BARRIERS
• Availability of gender appropriate and culturally aware health care staff • Flexible appointments • Drop-in centre enabling peer cultural connection • Family support • Promotion of health services and programs via social media • Relaxed setting • Transport available or easily accessible location • Good communication and relationships with staff	• Frustration of having to repeat one's 'health story' • Lack of 'drop-in' capacity • Concept of 'shame' around health concerns • Lack of information regarding health concerns or available programs/services • Poor communication ➢ use of jargon or information not pitched at young people's level ➢ judgmental attitudes ➢ not listening or in a hurry • Cumbersome intake system and indirect access to the person you want to see • Discomfort around revealing sensitive information if family member is working in the service (see explanation on page 22)

Table 2: Factors impacting on engagement between Youth and Health Services

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Appendix 1: Literature Review

Psychosocial Screening Tools

A literature review was conducted to ascertain the most appropriate general psychosocial screening tools for use with Aboriginal and Torres Strait Islander youth. The Cochrane Library, Australian Indigenous HealthInfoNet, PubMed, PsycInfo and CINAHL databases were consulted using the search terms '(psychosocial) AND (screening OR assessment) AND (youth OR adolescent)'. Inclusion criteria included screening tools for psychosocial risk and/or protective factors or general psychological distress of relevance to 12 – 24 year-olds, and publications in English language. Exclusion criteria included publications that were not in the English language, relating exclusively to populations under 12 or over 25 years old, and tools that were developed for use with clinical populations, those with chronic conditions or those in acute settings. The additional qualifiers of 'Indigenous' and 'Aboriginal' were added to each search for comparison. The addition of these extra terms restricted search results significantly. Almost all of the results returned involved the use of diagnostic mental health tools with clinical populations rather than the use of tools screening for more general psychosocial risk factors (i.e. home environment, occupation, alcohol and other drug use, social factors, sexuality etc).

The HEEADSSS assessment (early and more recent versions), was the only tool identified that covered a broad range of environmental, social and mental health factors, as well as risk-taking behaviour. Although the assessment is not standardised and as such has not been validated with Aboriginal and Torres Strait Islander youth, it is congruent with the holistic Indigenous view of health. This assessment covers a range of domains that may influence a young person's wellbeing, such as: Home, Education/Employment, Eating/Exercise, Activities/Peer relationships, Drug use, Cigarettes & Alcohol, Sexuality, Suicide/Self-harm/Mood and Safety/Spirituality.

References:

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Mental Health Assessment Tools

Utilising the results of the psychosocial screening tool searches, as well as the background knowledge of the project team, a list of mental health assessment tools was compiled. Some addressed multiple domains, while others focused on specific areas such as depression, anxiety, emotional regulation and conduct problems.

The identified tools that have been used with Aboriginal and Torres Strait Islander populations included:

Kessler Psychological Distress Scale – Revised (5-question subset)

The Kessler Psychological Distress Scale was originally formulated as a 10-item scale. It was first used with Aboriginal and Torres Strait Islander respondents as a 5-question subset in the 2004/2005 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and has been considered appropriate for use with Aboriginal and Torres Strait Islander people aged 16 and above. Stakeholders involved in the development of the SEW section of the 2004/2005 NATSIHS made two changes to the language used to improve understanding – 'hopeless' changed to 'without hope' & 'restless or fidgety' changed to 'restless or jumpy'. The K5 was found to be internally valid & results were consistent with other population study findings measuring Aboriginal and Torres Strait Islander Social and Emotional Wellbeing. Stakeholders in a 2006 NATSIHS workshop supported continued use of the K5 in the next 2010-2011 NATSIHS.

References:

Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. 2009, Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People, Discussion Paper No. 10, Cooperative Research Centre for Aboriginal Health, Darwin.

Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, Normand S-LT, Walters EE, Zaslavsky A. Short screening scales to monitor population prevalences and trends in nonspecific psychological distress. Psychological Medicine 2002; 32(6), 959-976.

Australian Institute of Health and Welfare 2009. Measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. Cat. no. IHW 24. Canberra: AIHW.

Strengths and Difficulties Questionnaire (SDQ)

This is a 25-item self-report questionnaire that can also be administered with external raters. It has been validated with Aboriginal & Torres Strait Islanders aged 4 – 17 years in urban and remote settings. Domains covered include Emotional Symptoms; Conduct Problems; Hyperactivity; Peer Problems; Prosocial Behaviour. There is also an optional 'Impact Supplement' that assesses overall distress and social impairment.

References:

Goodman, R., Meltzer, H. & Bailey, V. (1998). The Strengths and Difficulties Questionnaire: a pilot study on the validity of the self-report version. European Child and Adolescent Psychiatry, 7, 125 -130.

Sawyer, M.G., Guidolin, M., Schulz, K.L., McGinnes, B., Zubrick, S.R., & Baghurst, P.A. (2010). The mental health and wellbeing of adolescents on remand in Australia. The Australian and New Zealand Journal of Psychiatry 44(6), pp. 551-559.

Turner, K., & Sanders, M. (2007). Family intervention in Indigenous communities: emergent issues in conducting outcome research. Australasian Psychiatry 15, pp. 39-43.

Williamson, A., Redman, S., Dadds, M., Daniels, J., D'Este, C., Raphael, B., Eades, S., & Skinner, T. (2010). Acceptability of an emotional and behavioural screening tool for child in Aboriginal Community Controlled Health Services in urban NSW. Australian and New Zealand Journal of Psychiatry 44, pp. 894-900.

Zubrick S, Silburn S, Lawrence D et al. (2005). Chapter 2: The Western Australian Aboriginal Child Health Survey: The Emotional and Behavioural Health of Aboriginal Children and Young People. Perth: Curtin University of Technology and Telethon Institute for Child Health Research. Retrieved from http://aboriginal.childhealthresearch.org.au/kulunga-research-network/waachs/waachs-volume-2.aspx, 28 June 2013.

Indigenous Risk Impact Screen (IRIS)

A 13-item, health professional completed tool that screens for alcohol and other drug risk, including: Tolerance, Withdrawal, Impulse Control, Addiction and Drug Importance. The tool includes Emotional Wellbeing (Mental Health) risk items including: Depression, Anxiety and Stress related to past experiences. The tool has been validated for use with Aboriginal and Torres Strait Islander people aged 18 years and over. It has not yet been validated for people younger than 18.

The IRIS was validated against the Severity of Dependence Scale (SDS), the Alcohol Use Disorders Identification Test (AUDIT) and the Leeds Dependence Questionnaire (LDQ). Additional Mental Health measures included the Depression Anxiety and Stress Scale (DASS-21) and the Self-Report Questionnaire (SRQ). IRIS demonstrated good convergent validity.

References:

Queensland Health. (2004). Indigenous Risk Impact Screen and Brief Intervention Project: Tool Kit.

Schlesinger, C., Ober, C., McCarthy, M., Watson, J., & Seinen, A. (2007). The development and validation of the Indigenous Risk Impact Screen (IRIS): a 13-item screening instrument for alcohol and drug and mental health risk. Drug and Alcohol Review 26, pp. 109 – 117.

Strong Souls

A 25-item, self-report measure that covers the domains of Depression, Anxiety, Suicide risk and Resilience. The Resilience domain includes culturally-oriented items. The tool has been validated for use with Aboriginal and Torres Strait Islander 16 – 21 year-olds, however, it has not been validated in clinical settings.

Reference:

Thomas, A., Cairney, S., Gunthorpe, W., Paradies, Y., and Sayers, S. (2010). Strong Souls: development and validation of a culturally appropriate tool for assessment of social and emotional well-being in Indigenous youth. Australian and New Zealand Journal of Psychiatry 44, pp. 40 – 48.

Westerman Aboriginal Symptoms Checklist (WASC-Y)

A 53 item self-report measure, which screens for risk of depression, anxiety, suicide, alcohol/drug use, impulsivity and resilience. The WASC-Y has been validated for use with 12 – 17 year-old Aboriginal Australians.

References:

Stathis, S.L., Doolan, I., Letters, P., Arnett, A., Cory, S., & Quinlan, L. (2012). Use of the Westerman Aboriginal Symptoms Checklist – Youth (WASC-Y) to screen for mental health problems in Indigenous youth in custody. Advances in Mental Health 10(3), pp. 235-239.

Westerman, T.G (2003) The development of the Westerman Aboriginal Symptom Checklist for Youth: A measure to assess the Moderating Effects of Cultural Resilience with Aboriginal Youth at Risk of Depression, Anxiety and Suicidal Behaviours. Abstract of Doctor of Philosophy Thesis. Curtin University.

Nutrition Screening Tools

A literature review was conducted to identify appropriate nutrition screening tools for use with Aboriginal and Torres Strait Islander (ATSI) youth in a primary health care setting. The following search terms were used on the Cochrane Library, Pubmed and CINAHL databases: diet OR dietary OR nutrition, AND screening OR assessment OR history OR recall, AND adolescent/s OR adolescence OR youth OR young people, AND Aboriginal. From the total 353 listed articles, 10 were short listed for review. Inclusion criteria included:

English language, countries with similar western or indigenous diets, target age 12-24 years, brief dietary screening/assessment enabling comparison with the Australian dietary guidelines, appropriate for use in a primary health care setting, reliable and validated tools, and tools validated for use with ATSI populations. An internet search also identified the following three web pages which provided useful information regarding nutrition screening and assessment tools: the Australasian Child and Adolescent Obesity Research Network (ACAORN) - http://www.acaorn.org.au/streams/nutrition/tools-validation/index.php, the UK Medical Research Council -http://dapa-toolkit.mrc.ac.uk/dietary-assessment/methods/index.html, and the U.S. National Cancer Institute http://riskfactor.cancer.gov/diet/shortreg/register.php. A total of 116 tools were found on these three websites and an additional 6 were short listed for review. Further information and an additional 3 tools were found by searching the references of appropriate journal articles, through recommendations of experts in the fields of nutrition promotion and research, and reviewing the development of the SA Health 'Do It For Life' program Lifestyle and Risk Factor Assessment Tool.

No brief screening tools were found that enabled comparison with the Australian dietary guidelines and had also been validated for use with ATSI peoples aged between 12-24 years in a primary health care setting. Most of the tools identified were food frequency questionnaires or dietary recall surveys designed for use in large population health surveys in Western countries, where dietary practices may differ from Australian populations. In addition, some tools assessed specific components of diet (e.g. fruit and vegetables or only fats) and few screened for total food and drink intake. Four tools were designed as brief nutrition screeners for use with adults in a primary health care setting (Block et al 2000, Gans et al 2006, Rifas-Shiman et al 2000, Roe et al 1994). However, none of these tools were designed for, or validated with Australian participants and their suitability for use with ATSI populations in unknown.

References:

Block G, Gillespie C, Rosenbaum EH, Jenson C (2000), A rapid food screener to assess fat and fruit and vegetable intake, American Journal of Preventive Medicine, vol. 18, no. 4, pp. 284-8

Gans K, Risica PM, Wylie-Rosett J, Ross EM, Strolla LO, McMurray J, Eaton CB (2006), Development and evaluation of the nutrition component of the Rapid Eating and Activity Assessment for Patients (REAP): a new tool for primary care providers, Journal of Nutrition Education and Behavior, vol. 38, no. 5, pp. 286-92

Rifas-Shiman S, Willett W, Lobb R, Kotch J, Dart C, Gillman M. (2000), PrimeScreen, a brief dietary screening tool: reproducibility and comparability with both a longer food frequency questionnaire and biomarkers, Public Health Nutrition, vol. 4, no. 2, pp. 249-254

Roe L, Strong C, Whiteside C, Neil A, Mant D (1994), Dietary intervention in primary care: validity of the DINE method for diet assessment, Family Practice, 11(4):375-81

Physical Activity Screening Tools

A literature review was conducted to identify appropriate physical activity screening tools for use with Aboriginal and Torres Strait Islander (ATSI) youth in primary health care settings. The following search terms were used on the Cochrane Library, Pubmed and CINAHL databases: physical activity OR exercise, AND screening OR assessment, AND adolescent/s OR adolescence OR youth OR young people. From the total 1204 listed articles, 12 were short listed for review. Inclusion criteria included: English language, target age 12-24 years, brief physical activity screening/assessment enabling comparison with the Australian physical activity guidelines, appropriate for use in a primary health care setting, reliable and validated tools, and tools validated for use with ATSI populations. An internet search also identified the following two web pages which provided useful information regarding physical activity screening and assessment tools: the Australasian Child and

Adolescent Obesity Research Network (ACAORN) - http://www.acaorn.org.au/streams/activity/tools-validation/index.php and the UK Medical Research Council - http://dapa-toolkit.mrc.ac.uk/physical-activity-assessment/methods/index.html. A total of 34 tools were found on these two websites and an additional 7 were short listed for review. Further information and an additional 5 tools were found by searching the references of appropriate journal articles, reviewing the development of the SA Health 'Do It For Life' program Lifestyle and Risk Factor Assessment Tool, and reports and publications on the Australian Government Department of Health and Ageing website.

None of the screening tools reviewed met all of the inclusion criteria listed above and only five met some of the criteria. Most tools found were designed for use in population health surveys and may not translate well to a primary health care setting where the aim of screening is to compare physical activity levels with the national guidelines. Three brief tools designed for use in primary health care settings were identified: PACE + Adolescent Physical Activity Measure (Prochaska, Sallis & Long 2001), General Practice Physical Activity Questionnaire (UK Department of Health 2013), and the Brief Physical Activity Assessment (Marshall et al 2005). The PACE + Adolescent Physical Activity Measure is useful for comparison with the national physical activity guidelines for young people up to 18 years of age but since it has only been validated for this age group of American adolescents, its effectiveness with the ATSI population is unknown. The General Practice Physical Activity Questionnaire assesses physical activity based on guidelines for adults, but has only been validated for this sample in the UK. Likewise, the Brief Physical Activity Assessment can be used as a comparison with national guidelines for those over 18 years and has been validated with an Australian population but not an ATSI sample. The Previous Day Physical Activity Recall (PDPAR-24) was the only tool found that has been validated for use with ATSI adolescents (Trost et al 2007). However, it is not widely available on the web and its suitability for use in a primary health care setting is unknown. The Active Australia Survey is the only tool adapted for, and tested with ATSI adults but was found to be invalid with this population sample (Marshall & Miller 2004). No appropriate measures were identified that enabled comparison of activity level with the Australian physical activity guidelines and had also been validated for use with Aboriginal and Torres Strait Islander peoples aged between 12-24 years in a primary health care setting.

References:

Marshall AL & Miller R (2004), Measuring Physical Activity in Urban Indigenous Australians: Final Report April 2004, The University of Queensland and Queensland Health. Viewed (23/05/12) at http://www.health.gov.au/internet/main/publishing.nsf/Content/8A93EA8534A4CFB7CA25760000082C0B/$File/indigenous.pdf

Marshall AL, Smith BJ, Bauman AE, Kaur S (2005), Reliability and validity of a brief physical activity assessment for use by family doctors, British Journal of Sports Medicine, 39:294–297

Prochaska M, Sallis J & Long B (2001), A Physical Activity Screening Measure for Use With Adolescents in Primary Care, Archives of Pediatric Adolescent Medicine, vol. 155, no. 5, pp. 554-559

Trost S et al (2007), Validation of a 24-h physical activity recall in indigenous and non-indigenous Australian adolescents, Journal of Science and Medicine in Sport, vol. 10, no. 6, pp.428-35

UK Department of Health 2013, General Practice Physical Activity Questionnaire (GPPAQ). Viewed (30/05/2013) at https://www.gov.uk/government/publications/general-practice-physical-activity-questionnaire-gppaq, http://www.patient.co.uk/doctor/General-Practice-Physical-Activity-Questionnaire-(GPPAQ).htm,

http://onlinelibrary.wiley.com/doi/10.1002/9781118702758.app8/summary, https://www.ncbi.nlm.nih.gov/books/NBK51962/

Youth Mobility & Health Service Utilisation

A database search was conducted to answer the question "Does the mobility of Aboriginal and Torres Strait Islander youth affect their usage of health services?"

Databases included CINAHL and Edith Cowan University's Indigenous Health InfoNet; Australian Bureau of Statistics website, University of Tasmania's Australian Clearinghouse for Youth Studies and the Australian Institute of Health and Welfare's Closing the Gap Clearinghouse. Search terms included "transient", "transience", "mobility", "health service usage", "health service utilisation", "multiple health service utilisation", "Aboriginal", "Indigenous", and were limited with "youth" where possible.

Studies that addressed the relationship between mobility (as a predictor) and health service usage (as an outcome) were not identified. However, some studies reported and discussed data relating to:

- Patterns of movement within Indigenous populations by age (ABS 2008, Biddle & Prout 2009)
- Reasons for Indigenous population movement (Birdsall-Jones et al 2010)
- Incompatibility of indigenous mobility patterns with health and social service delivery (Kainz et al 2010)

According to 2001 and 2006 census data (ABS 2008), Aboriginal and Torres Strait Islander people aged 5–19 years accounted for 43% of net movement from remote areas and were most likely to move to inner regional areas. This age group were also most likely to leave remote and very remote areas, commonly to pursue education opportunities. Aboriginal and Torres Strait Islander people aged 20–39 years were most likely to move to major cities. An overall pattern of migration from more remote areas to less remote areas was observed between 2001 and 2006 which has implications for service delivery.

Using some of the same data, Biddle and Prout (2009) reported that on the night of the 2006 Australian Census, 17 – 25 year-olds represented the highest proportion of Indigenous people away from their place of usual residence. They noted that life-stage seems to affect the reasons people relocate, not only the frequency with which they do so. Prout (2008) notes a peak of temporary mobility amongst young adults and describes 'existential mobility', which involves a 'floating' young Indigenous population who seek shelter and resources from extended family. Existential mobility is posited as arising from boredom, lack of economic participation and meaningful social roles. Other suggested reasons behind Indigenous mobility include exploration of identity in the context of state, culture and social norms.

Biddle and Prout (2009) also distinguishes between 'service' and 'resident' populations (characterised by place of usual residence). Three conceptualisations of mobility are described: Circulation (one home-base; frequent journeys away); Multi-Local Residence (two or more home-bases that are usually linked and considered extensions of one another) and Perpetual Movement (no home-bases; people move between family locales, where 'home' is embedded in network of family members).

Temporary mobility is described as 'endosocial'; that is attributable to family reasons and resistant to external influence. Alternatively, it may also be based around the person's engagement with mainstream services and economy. Other influences on mobility may be weather and large cultural/social events. According to Birdsall-Jones et al (2010), the drivers of Indigenous mobility may be 'culturally' (i.e. to attend a funeral or travel to fulfil traditional customs) or 'socially' (i.e. escaping abuse or being unable to afford rent) legitimated; or, non-legitimated (i.e. inability to maintain own residence due to substance misuse, then

staying with family members). Clearly, contributing factors to Indigenous mobility vary, and the remedies to homelessness and overcrowding are complex due to the interplay between the factors and broader societal pressures.

The complexity of Indigenous mobility is often seen as problematic by health and social service providers. Kainz et al (2010) report that from a service provider's perspective, mobility negatively impacts on service delivery. Health records located elsewhere intra- or interstate can be difficult to access in short periods of time. Patterns of movement are seen as unpredictable, and populations are seen as fluctuating not only due to individuals who travel for health or family reasons, but also due to their accompanying family members. Many services are simply not established in a manner that allows staff to plan and provide services and evaluate their work with Indigenous clients in a dynamic manner. The reactive nature of service delivery to a changing client group may in turn lead to unmet needs and pressure on organisations.

The implications for mobile Indigenous youth, who wish to access health and social services are unclear. Further research in this area is justified by the lack of evidence demonstrating connections between this group's movement and their health service usage. However, it seems that this segment of the population commonly move from remote to less remote areas, and often to pursue education or employment opportunities. The services available during these transitions may be ineffective due to limited forward-planning, capacity and adaptability.

References

Australian Bureau of Statistics 2008, ' The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, Oct 2010', cat. no. 4704.0, ABS, Canberra, <www.abs.gov.au>.

Biddle, N. & Prout, S. (2009). Indigenous temporary mobility: an analysis of the 2006 census snapshot. Report: Centre for Aboriginal Economic Policy Research, Canberra. CAEPR Working Paper No. 55/2009.

Birdsall-Jones, C et al. (2010) Indigenous homelessness. AHURI Final Report No. 143. Melbourne: Australian Housing and Urban Research Institute, Western Australia Research Centre.

Kainz, T., Carson, D.A., Carson, D.B. (2012). Temporary Indigenous Mobility in Remote South Australia: Understanding the Challenges for Urban Based Health and Social Service Delivery. Journal of Rural and Community Development 7(1), 16 – 36.

Prout, S. (2008). On the move? Indigenous temporary mobility practices in Australia. Report: Centre for Aboriginal Economic Policy Research, Canberra. CAEPR Working Paper Series, no. 48/2008

Appendix 2: Youth Health Check Resource Documents

ABORIGINAL & TORRES STRAIT ISLANDER YOUTH HEALTH CHECK: 'Y HEALTH' RESOURCE DOCUMENT NO. 1

Authors

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Introduction

This evidence informed document outlines what preventive activities are recommended for Aboriginal & Torres Strait Islander youth aged 12 – 24 years. It is part of a Suite of resources to assist with the delivery of Aboriginal & Torres Strait Islander Youth Health Check. These have been developed with the main target audience being Aboriginal Health Services. Mainstream Primary Care Services can also utilise these resources bearing in mind the caveats that we have identified and explicitly stated.

Content document development process

The NACCHO – RACGP National Guide to a Preventive Health Assessment in Aboriginal & Torres Strait Peoples 2nd Edition was the primary evidence base for identifying preventive activities relevant to young people aged 12 – 24 years. This was supplemented by literature reviews in the areas of psychosocial, mental health, nutrition and physical activity screening tools for Aboriginal & Torres Strait Islander youth; the Centre for the Advancement of Adolescent Health GP Resource Kit, and mandatory considerations such as legislation.

All chapters of the NACCHO – RACGP National Guide were systematically reviewed to identify recommendations relating to the general health assessment and management of identified health risks or conditions for young people aged 12-24 years. Where recommendations or their implications were not clear, further evidence was sought or the relevant chapter author was contacted to request clarification.

Other items for inclusion in the Youth Health Check were recommended by members of the project team and other Aboriginal and youth health service providers (referred to collectively as the 'expert group'). These were based on cultural knowledge, clinical and academic expertise, experience in working with the target population, experience conducting health assessments, and consideration of best practice guidelines.

The evidence gathered, along with the expert group suggestions have been compiled into this exhaustive content document which informed the creation of the YHC template. Recommendations have been organised according to the flow or structure of a health check, with screening items, follow up items and corresponding levels of evidence listed in separate columns. Expert group recommendations have been identified as 'best practice' or 'standard good care' in the 'level of evidence column' with accompanying justifications in the corresponding 'comments' column.

<u>Cultural Validity and Cultural Specificity</u>

The term 'cultural appropriateness' describes an approach, process, or output that meets the needs of the Indigenous community. It is a broad term and varies greatly in interpretation and application. In the absence of Indigenous specific evidence or tools, mainstream evidence or tools can be utilised. However, two questions should be asked: do these mainstream theories or models adequately reflect or address the needs of a minority group, and are there any gaps? These questions are answered best by two tools that were developed in the field of Ethnic and Minority Psychology.(1) The first is Cultural Validity, a cross-cultural approach derived from Anthropology. It

looks at the universality of mainstream knowledge or the generalisability of majority group theories and norms to other cultural groups. The second tool is Cultural Specificity, a cross-cultural cross-racial approach derived from Sociology. It looks at aspects that are specific or particular to a culture. In the 'Y Health' project development of this content document, these two criteria were examined via the following: alignment with Aboriginal culture and knowledge, relevance of mainstream or non-youth health assessment areas to the health of Aboriginal and Torres Strait Islander youth, and use of screening tools used with, designed for and/or validated with Aboriginal and Torres Strait Islander population.

Examples of application of these criteria are: inclusion of a strengths based approach, ensuring cultural connectedness is incorporated, and examining the concept of overcrowding.

Sections

1. General Information: This should be done the first time a young person attends a clinical service and updated appropriately. It therefore can or may be done outside of conducting a Health Check. Discussion of specific legislation is beyond the scope of this document.
2. History
3. General Health Assessment
4. Examination
5. Tests
6. General Health Advice
7. Attachments: Additional information such as risk factors for various conditions, is provided in the attachments for the convenience of the health professional.

How to read the document

The content document flows from top to bottom. Each row in the table describes the recommendation, comments, the applicable age group, the level of evidence supporting the recommendation, relevant follow up actions, comments and the level of evidence for the follow up action.

Levels of Evidence

The levels of evidence correspond to the levels in the NACCHO/RACGP National Guide to a Preventive Health Assessment in Aboriginal & Torres Strait Peoples 2nd Edition. Other sources have been assigned "Best Practice" level of evidence, and expert group recommendations have been assigned "Standard good care" level of evidence.

References and resources

The National Guide as mentioned above is the standard reference for this document and is notated as NG. The Level of Evidence is provided with the relevant chapter in brackets. Other evidence sources are referenced in the bibliography using standard format.

Useful resource links such as Medicare information etc. are provided as hyperlinks denoted by a letter of the alphabet. These can be accessed when viewing this document electronically.

Frequency of recommendations

The frequency of screening or follow up recommendations is annual unless otherwise stated.

Glossary of abbreviations and acronyms

CKD	Chronic Kidney Disease
CVD	Cardiovascular Disease
ECG	Echocardiography
EG	Expert Group
ETS	Environmental Tobacco Smoke
GP	General Practitioner
IFG	Impaired Fasting Glucose
IGT	Impaired Glucose Tolerance
NG	The National Guide to a Preventive Health Assessment in Aboriginal & Torres Strait Peoples 2nd Edition
NIPS	National Immunisation Program Schedule
MSM	Men who have sex with men
PHC	Primary Health Care

GENERAL INFORMATION						
RECOMMENDATION	**COMMENTS regarding Recommendation**	**AGE GROUP (years)**	**LEVEL OF EVIDENCE for Recommendation**	**FOLLOW UP**	**COMMENTS regarding Follow Up**	**LEVEL OF EVIDENCE for Follow Up**
Basic Information: Name; DOB; Address; Medicare Card; Centrelink concession; Parent/Guardian details		12 - 24	Standard good care	Provide information regarding access to a Medicare Card	Individual Medicare cards can be issued for young people aged 15 years and above (A)	Standard good care
Registered for PIP IHI		12 - 24	Standard good care			
Contact details of usual health service; and list of health or youth services the young person attends		12 - 24	Standard good care, to enable coordination of care if appropriate and relevant			
Consider whether the young person is able to consent to medical care	Refer to State legislation regarding age of consent to medical care (B)	12 - 17	Medico-legal imperative	Depending on the age of the young person, a mature minor assessment may need to be done		Medico-legal imperative
Provide confidentiality information	Refer to State & Territory legislation regarding: • Age of consent (C) • Mandatory reporting of child abuse and neglect (D)	12 - 24	Best Practice(2)			

GENERAL INFORMATION						
RECOMMENDATION	**COMMENTS regarding Recommendation**	**AGE GROUP (years)**	**LEVEL OF EVIDENCE for Recommendation**	**FOLLOW UP**	**COMMENTS regarding Follow Up**	**LEVEL OF EVIDENCE for Follow Up**
Ensure informed consent is given for the Health Check		12 - 24	Standard good care	Consent to provide a copy of the health check to usual health provider		Standard good care

HISTORY						
RECOMMENDATION	**COMMENTS regarding Recommendation**	**AGE GROUP (years)**	**LEVEL OF EVIDENCE for Recommendation**	**FOLLOW UP**	**COMMENTS regarding Follow Up**	**LEVEL OF EVIDENCE for Follow Up**
PAST CLINICAL HISTORY						
History of IGT or IFG, gestational diabetes mellitus, polycystic ovary syndrome, cardiovascular disease, and current antipsychotic medication use	To assess Diabetes risk	18 +	II B (NG Ch 14)			
History of diabetes	To assess Cardiovascular Disease risk	18 +	GPP (NG Ch 12)			
	To assess Chronic Kidney Disease risk		III B (NG Ch 13)			
Other past history including hospitalisation for serious conditions; surgeries/operations performed		12 - 24	Standard good care			
Ask if receiving clinical care or other support for any existing chronic conditions		12 - 24	Standard good care			

HISTORY						
RECOMMENDATION	**COMMENTS regarding Recommendation**	**AGE GROUP (years)**	**LEVEL OF EVIDENCE for Recommendation**	**FOLLOW UP**	**COMMENTS regarding Follow Up**	**LEVEL OF EVIDENCE for Follow Up**
MEDICATION HISTORY						
Allergies to medications	To prevent prescription errors	12 - 24	Standard good care			
Current Medications	Find out current medications, whether taken as prescribed and affordability	12 - 24	Standard good care			
FAMILY HISTORY						
Premature cardiovascular disease, chronic kidney disease	To assess Cardiovascular risk To assess Chronic Kidney Disease risk	18 +	GPP (NG Ch 12) III B (NG Ch 13)			
Mental Illness	Recommended as part of a psychosocial assessment	12 - 24	Best practice (2)			
IMMUNISATIONS						
Immunisation status as per the NIPS	Evidence only in NG for - Children (age group not defined) - Prevention of bronchiectasis - Prevention of hearing loss in <15yrs	12 – 24	Best practice (3)	Provide immunisations as appropriate		Best practice

HISTORY						
RECOMMENDATION	**COMMENTS regarding Recommendation**	**AGE GROUP (years)**	**LEVEL OF EVIDENCE for Recommendation**	**FOLLOW UP**	**COMMENTS regarding Follow Up**	**LEVEL OF EVIDENCE for Follow Up**
History of vaccine preventable illness, evidence of vaccination, serology		12 – 24	Best practice (3)			
Annual **Influenza** vaccination	< 15 yrs, evidence only for those with chronic conditions [NIPS covers those who are medically at risk, including chronic conditions (E)]	12 – 14 with a chronic condition	II C (NG Ch 11)			
	Covered by NIPS (E)	15+	GPP (NG Ch 11)			
	May reduce incidence of acute Otitis Media as a secondary complication of influenza [Not on NIPS <15 yrs of age unless considered medically at risk]	≥6 months	I C (NG Ch 7)			

HISTORY						
RECOMMENDATION	**COMMENTS regarding Recommendation**	**AGE GROUP (years)**	**LEVEL OF EVIDENCE for Recommendation**	**FOLLOW UP**	**COMMENTS regarding Follow Up**	**LEVEL OF EVIDENCE for Follow Up**
Pneumococcal Polysaccharide (23vPPV) vaccination	For those with underlying high-risk conditions (F) Covered by NIPS	15+	II C (NG Ch 11)	A second vaccination is required 5 years later. A third vaccination is required 5 years later or at 50 years of age (whichever is later)		II C (NG Ch 11)
Human Papilloma Virus (HPV) Vaccination	For the prevention of cervical cancer, ideally prior to the onset of sexual activity Provided in schools by the NIPS	12-13 females	I A (NG Ch 8) II B (NG Ch 15)			
	For the prevention of cervical cancer ideally prior to the onset of sexual activity Provided in schools by the NIPS	12-13 males (and 14-15 males to the end of 2014)	Best Practice, NIPS (G)			
	Promote human papilloma-virus (HPV) vaccination Not on NIPS. Check for State funded opportunities	14-18 females	II B (NG Ch 15)			

HISTORY						
RECOMMENDATION	**COMMENTS regarding Recommendation**	**AGE GROUP (years)**	**LEVEL OF EVIDENCE for Recommendation**	**FOLLOW UP**	**COMMENTS regarding Follow Up**	**LEVEL OF EVIDENCE for Follow Up**
	Promote HPV vaccination for the prevention of cervical cancer for health benefit, but likely to be less effective Not on NIPS, private prescription required (cost implication)	19-24 females	II B (NG Ch 15)			
Hepatitis B vaccination	NIPS covers those in Yr 8 (12-14 yrs), others will need private prescription (cost implication)	12-24 especially those at high risk of STI/BBV	GPP (NG Ch 8)			
Hep A vaccination	For men who have sex with men (MSM), injecting drug users, chronic Hepatitis B & Hepatitis C infection Given once only Not on NIPS, private prescription required (cost implication)	12 – 24	GPP (NG Ch 8)			

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Current concerns or worries		12-24	Standard good care			
Conduct a psychosocial assessment [Useful tools include the HEEADSSS assessment]	A strengths based approach is recommended, including the identification of factors that support resilience(2, 4) See 'Y Health' Staying Deadly Questionnaire, 'Y Health' Cultural Social Emotional Wellbeing Assessment; and the Menzies Stay Strong Plan]	12 – 24	GPP (NG Ch 3, Ch 12 for 18+ yrs)			
Assess for overcrowding (Attachment 1)	Prevention of hearing loss	< 15 yrs	III C (NG Ch 7)	Refer for housing assistance if indicated		III C (NG Ch 7)
	Prevention of rheumatic heart disease	Age unspecified	III B (NG Ch 5)			III B (NG Ch 5)
	Risk factor for child abuse and neglect	Age unspecified	Best Practice(5, 6)			Best Practice
	The expert group recommends ages 12-24 for practical reasons *Caution with interpreting overcrowding as a risk factor*					
Assess nutrition	No validated screening tool available for Aboriginal & Torres Strait Islander Youth	12 – 24	GPP (NG Ch 12)	Provide dietary advice to promote healthy eating		GPP (NG Ch 1 for 18 +) I A (NG Ch 12) I A (NG Ch 14)

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
	[24 hour food and drink recall is a simple tool]			Perform a more in-depth dietary assessment if required		Standard good care
				Refer if eating disorder suspected		Standard good care
Explore food security (whether the young person has enough to eat)	Food insecurity is recognised as a determinant of poor health in the Aboriginal and Torres Strait Islander population (7, 8) The One21seventy child health audit includes enquiry regarding food security	12 – 24	Standard good care	Refer to appropriate agencies or support services		Standard good care
Assess current level of physical activity including type/intensity, duration, & frequency of physical activity	Enables comparison to National Physical Activity Guidelines No validated screening tool for Aboriginal & Torres Strait Islander youth for use in the PHC setting	12-24	I B (NG Ch 1) GPP (NG Ch 12)	Provide physical activity brief intervention		I A (NG Ch 12, Ch 14)
				Give targeted advice to those who are insufficiently active		I B (NG Ch 1)

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
				Refer all to appropriate community based physical activity programs and encourage use of public facilities that promote activity		I B (NG Ch 1)
Ask about gambling		12+	GPP (NG Ch 1)	If gambling is identified, screen for problems by asking "have you ever had an issue with your gambling?"		GPP (NG Ch 1)
				Refer for intervention (CBT, gambling services)		

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Assess for risk factors of illicit drug use	See Attachment 2 for risk factors	12 – 24	GPP (NG Ch 3)	Where risk factors are present, administer one of the following validated screening tools - CRAFFT (≤ 21 years), IRIS (≥ 18 years), Substances & Choice Scale (13-18 years)	The IRIS tool combines substance use and mental health and is currently the only validated tool for this use within the Aboriginal & Torres Strait Islander population [Practical tip: EG suggests use of screening tools during a Health Check if time allows or during a follow up assessment]	III B (NG Ch 3)
				Where multiple risk factors are present refer for preventative case management		I B (NG Ch 3)
Provide brief interventions for illicit drug users		12 – 24	III B (NG Ch 3)			

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Refer illicit drug users to: a) drug education programs based on social learning theories b) parent education programs and family therapy c) needle exchange services	Expert Group suggestion: *For those < 18 years intervention is required for any amount of substance use. For those 18 years and over intervention is dependent upon individual circumstances and whether substance use is an issue.* *Where an Aboriginal Health Worker identifies a concern, a GP should sign off on the Health Check to ensure that appropriate action has taken place or is planned.*		a) II B (NG Ch 3) b) II B (NG Ch 3) c) I B (NG Ch 3)	Provide brief intervention for harmful/hazardous drinking		I A (NG Ch 1)
Enquire about alcohol use	One21seventy child health audit includes an enquiry or discussion of alcohol use for children 5+ in NT, 11+ in Qld	12 – 14	III B (NG Ch 1)			

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Assess quantity and frequency of alcohol consumption	Consider enquiring about alcohol consumption for all youth as assuming alcohol consumption in 15+ years may be offensive for some members of the community	15+	I B (NG Ch 1)			
Assess smoking status	One21seventy child health audit includes an enquiry or discussion of smoking for children 5+	12+	I A (NG Ch 1) GPP (NG Ch 12) III B (NG Ch 13 18+)			
<u>In Smokers:</u> 1) Assess level of nicotine dependence to help predict relapse to smoking and guide intervention choice e.g. Fagerstrom test 2) Deliver brief intervention: a) non specific b) using 5 A's (Assess, Advise, Agree, Assist, Arrange)		12 - 24 12 - 24	GPP (NG Ch 1) a) I A (NG Ch 11 & Ch 12) III B (NG Ch 13 18+) b) I A (NG Ch 1)			

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
3) Offer referral for smoking cessation counselling		12 - 24	I A (NG Ch 1)			
4) Offer follow up visits for those attempting to quit		12 - 24	II C (NG Ch 1)			
5) Recommend smoking cessation pharmacotherapies to patients interested in quitting	First line treatments are NRT, bupropion and varenicline	Check MIMS for NRT as age varies according to product, bupropion - 18+, varenicline >18 (H)	I A (NG Ch 1)			
6) Screen for symptoms of asthma	Symptoms include shortness of breath, chest tightness, wheeze & cough	12 – 24	Best Practice (9)	If asthma symptoms are present, do Spirometry		Best practice (9)
7) Screen for COPD symptoms	Symptoms include persistent cough/sputum production, wheezing, dyspnoea	12 – 24	II B (NG Ch 11)	If COPD symptoms are present, do Spirometry		I A (NG Ch 11)
8) See Tests for serum lipids		12 – 24				

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Assess exposure to environmental tobacco smoke (ETS)	One21seventy child health audit includes a screen for exposure to ETS for all children (except <2 in NT)	12+	Best Practice(5, 9, 10)	Advise avoidance of exposure to ETS & provide parents with information of effects		III C (NG Ch 1), III A & III C (NG Ch 11)
Provide anticipatory guidance and sexual health education		12 – 24	GPP (NG Ch 3)	If sexually active, take a sexual history		Standard good care
Ask if sexually active and identify at-risk sexual behaviours		12 – 24	GPP (NG Ch 3)			
For all sexually active clients or those considering initiating sexual activity, promote the use of and/or provide condoms and discuss proper methods of use		12 - 24	III C (NG Ch 3) III B (NG Ch 8)			
For all sexually active clients, provide sexual health counselling including a proactive discussion of issues of sexuality		12 - 24	II B (NG Ch 8)			

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
For sexually active females, consider possibility of pregnancy		12 - 24	Standard good care			
For sexually active females or females considering initiating sexual activity, assess suitability for and offer hormonal contraception		12 - 24	III C (NG Ch 3)			
In young people engaging in risky sexual behaviour: a) Use individual behaviour change techniques such as motivational interviewing and cognitive behavioural therapy b) Offer or refer to pregnancy prevention/ education programs to improve knowledge and increase contraceptive use		12 - 24	a) GPP (NG Ch 3) b) I A (NG Ch 3)			

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Screening for depression is not routinely recommended unless comprehensive support services are available	One21seventy child health clinical audit includes enquiry about social emotional wellbeing in children 6+ in NSW, Vic, SA, TAS, ACT & NT, and all children in Qld & WA See Attachment 3 for a definition of comprehensive support services and mental health screening tools used with Aboriginal & Torres Strait Islander populations	15+	I B (NG Ch 10)			
Assess for risk factors of depression	See Attachment 2 for risk factors	15+	GPP (NG Ch 10)	If mental health problems are identified, refer for appropriate support services (e.g. mental health professional, GP)		Standard good care

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Screen for depression in those at greater risk	See Attachment 2 for risk factors The expert group has taken a strengths based approach and included factors that support resilience. See the 'Y Health –Staying Deadly' Youth Health Check template and associated documents The expert group suggests that screening for mental illness should be part of a comprehensive Youth Health Check due to the high prevalence of psychological distress and adverse psychosocial events in the Aboriginal & Torres Strait Islander community (5, 11)	15+ as per NG [12-24 as per Expert Group]	I B (NG Ch 10)			

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Screening for suicide risk is not routinely recommended		12-24	I C (NG Ch 10)	If at risk of suicide refer for appropriate support services, especially Aboriginal mental health workers		III C (NG Ch 10)
Consider screening for suicide risk (past and current suicidal ideation and intent) in the presence of risk factors	See Attachment 2 for suicide risk factors	12-24	GPP (NG Ch 10)			
Ask about hearing difficulties	The One21seventy Child health audit includes hearing screening for all children (except Tas, ACT & children <6months in NT) The preventative services clinical audit includes a hearing screening for 15+	15+	GPP (NG Ch 7)	Refer for audiology if concerns are identified		Standard good care

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
In low prevalence areas (<5%): a) screen for diabetes b) screen for diabetes using the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)	National prevalence data not available Higher prevalence noted in remote communities (11, 12)	18+	a) GPP (NG Ch 12), III B (NG Ch 13) b) III B (NG Ch 14)	If AUSDRISK ≥12 See Tests		III B (NG Ch 14)
Ask about visual difficulties	The One21seventy child audit protocol recommends enquiring about parental concern regarding vision	[12- 24]	Expert group suggestion			
Assess oral hygiene, teeth, gums and oral mucosa annually	The One21seventy child health protocol recommends: • Yearly oral exam for all children 6+months • Discussion of oral health for children 6months+ in all States except <5 yrs in the NT	12-18	IV C (NG Ch 4)	Annual review with a dental health professional	The Child Dental Benefits Schedule (CDBS) provides access to dental services for children aged 2-17 years (I)	IV C (NG Ch 4)

GENERAL HEALTH ASSESSMENT						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
IF oral health is good, assess teeth, gums and oral mucosa every 2 years	The expert group suggests an annual assessment due to the high prevalence of poor oral health and risk factors for the same (5, 11)	18+	IV C (NG Ch4)	Two yearly review with a dental health professional	The expert group suggests an annual review due to reasons as stated previously	IV C (NG Ch4)
IF poor oral health or risk factors for dental disease, assess teeth, gums and oral mucosa annually	See Attachment 2 for dental disease risk factors	18+	IV C (NG Ch 4)	Annual review with a dental health professional		IV C (NG Ch 4)
Ask if visited a dentist in the last 12 months		12-24	Standard good care			

EXAMINATION						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP (YEARS)**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
BMI using age and gender specific centile charts	BMI-for-age percentiles link [J]	12-17	I A (NG Ch 14), GPP (NG Ch 1, Ch 12)	1. Provide brief interventions on nutrition 2. Provide brief interventions on physical activity		1. I A (NG Ch 12, Ch 14), GPP (NG Ch 1) 2. I A (NG Ch 12, Ch 14), GPP (NG Ch 1)
BMI		18+	I A (NG Ch 14) III B (NG Ch 13) GPP (NG Ch 1, Ch 12)			
Waist circumference	The preventative services clinical audit includes waist circumference measurement for 15+	18+	I A (NG Ch 14) GPP (NG Ch 1, Ch 12)			

EXAMINATION						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP (YEARS)**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
<u>If overweight/ obese:</u>		12 - 24		1. Provide brief interventions on weight loss 2. Provide brief interventions on nutrition 3. Provide brief interventions on physical activity 4. Develop a weight management plan 5. Refer to dietician, exercise physiologist, if available 6. Encourage regular self weighing 7. Encourage a net energy deficit through combined dietary and physical activity interventions as per Australian dietary and physical activity guidelines 8. Individual or group based psychological interventions are recommended in combination with dietary and physical activity advice 9. See Tests		1., 18+yrs I B (NG Ch 13) 2. 18+yrs III B (NG Ch 13) 3. 18+yrs II B (NG Ch 13) 4. I B (NG Ch 1) 5. GPP (NG Ch 1) 6. I C (NG Ch 1) 7. I B (NG Ch 1) 8. I A (NG Ch 1)

EXAMINATION						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP (YEARS)**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Examine skin for scabies and impetigo	NG states this is for children living in areas with high rates of infectious skin disease. NG does not define age group for 'children' The One21seventy child audit protocol recommends a skin check for all children 0-15 years. The One21seventy preventative services clinical audit protocol includes a skin check for 15-54 years	[12 – 24]	GPP (NG Ch 2)	Treat according to management guidelines	GPP (NG Ch 2)	
	The expert group suggests examining skin for general skin conditions including scabies and impetigo due to the increased prevalence of other skin conditions and possible secondary infection (11, 13, 14)					
Check for tattoos and/or piercings	Check skin for tattoos, body piercings and any sores. If there are tattoos, ask where they got this done e.g. home, friend's garage, etc (assess risk of BBV)	12-24	Standard good care	Discuss risk of BBV and offer testing	Standard good care	

EXAMINATION						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP (YEARS)**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Examine teeth/gums/ oral mucosa annually	The One21seventy child health protocol recommends: • Yearly oral exam for all children 6+months • Discussion of oral health for children 6months+ in all States except <5 in the NT The One21seventy preventative services clinical audit includes an oral health check for 15+	12 – 18 [12-24]	IV C (NG Ch 4)	1. Provide dental hygiene advice 2. Annual review with dental health professional	1. Expert Group 2. IV C (NG Ch 4) 2. The Child Dental Benefits Schedule (CDBS) provides access to dental services for children aged 2-17 years (K)	
IF oral health is good, examine teeth, gums and oral mucosa every 2 years	The expert group suggests an annual assessment due to the high prevalence of poor oral health and risk factors for the same (5, 11)	18 +	IV C (NG Ch 4)	Two yearly review with a dental health professional	The expert group suggests an annual review due to reasons as stated previously	IV C (NG Ch 4)

EXAMINATION						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP (YEARS)**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Cardiac auscultation to assess for previously undiagnosed RHD	The One21seventy child audit protocol recommends cardiac auscultation for all 0-15 The One21seventy preventative services clinical audit protocol does not include cardiac auscultation	12-24	GPP (NG Ch 5)	If heart murmur is present refer for ECG		GPP (NG Ch 5)
In trachoma endemic areas (>5% prevalence of active trachoma in young children), screen for trachoma according to national guidelines[3]	Trachoma prevalence areas are available from the National Indigenous Eye Health Survey Report (L) - See Attachment 5 The One21seventy child health audit protocol recommends a trachoma screen for children 4+ in the NT, and where indicated in other States The One21seventy preventative services clinical audit protocol includes a trichiasis assessment for 15+	12 - 24	GPP (NG Ch 6)	Refer to GP or optometrist if a problem is identified	Guidelines for the public health management of trachoma in Australia (2006)[3]	Best Practice

<table>
<tr><th colspan="7">EXAMINATION</th></tr>
<tr><th>RECOMMENDATION</th><th>COMMENTS REGARDING RECOMMENDATION</th><th>AGE GROUP (YEARS)</th><th>LEVEL OF EVIDENCE FOR RECOMMENDATION</th><th>FOLLOW UP</th><th>COMMENTS REGARDING FOLLOW UP</th><th>LEVEL OF EVIDENCE FOR FOLLOW UP</th></tr>
<tr><td rowspan="2">Assess visual acuity</td><td>The One21seventy child audit protocol recommends:
Eye exam for all children 0-15 but only children 4+ in NT
Near & distant visual acuity & movement check for children 6+months in Qld & NT, all children in NSW & WA, but not for children in Vic, SA, Tas or ACT
The One21seventy preventative services clinical audit protocol includes visual acuity 40+yrs</td><td>[12-24]</td><td>Standard good care</td><td rowspan="2">Refer to GP or optometrist if a problem is identified</td><td rowspan="2">All Australian residents are eligible for a self referred, Medicare funded vision assessment with a registered optometrist every 24 months[4]
Department of Health and Ageing has
a list of national eye health and spectacle subsidy schemes[5]
Visiting Optometrists Scheme (VOS) providing access to optometric services for people living in remote communities[6]</td><td rowspan="2">Standard good care</td></tr>
<tr><td colspan="3">The Expert Group recommends a visual acuity check for all youth since it cannot be assumed that assessment has been performed in early childhood</td></tr>
</table>

EXAMINATION						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP (YEARS)**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Otoscopy to detect acute or chronic otitis media (glue ear)	One21seventy child audit protocol recommends otoscopy for all children and hearing screening for all school aged children One21seventy preventative services clinical audit includes an ear and hearing assessment for 15+	12- 14	GPP (NG Ch 7)	1. If detected, refer to clinical practice guidelines for Management: of otitis media (M) 2. Refer to GP if a problem is identified		1. GPP (NG Ch 7) 2. Standard good care
Pulse	Assess rate and rhythm	12-24	Standard good care	Refer to GP if a problem is identified		Standard good care
BP	The One21seventy preventative services clinical audit includes a BP assessment for 15+	18 +	III B (NG Ch 13) GPP (NG Ch 12)	1. If elevated, refer to GP 2. If elevated, see Tests		1. Standard good care 2. III C (NG Ch 13) GPP (NG Ch 12)

TESTS (STI & BBV)						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP (YEARS)**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
For all people with risk factors, screen for STI (according to local prevalence guidelines) or BBV	See Attachment 2 for risk factors for STIs and BBVs Testing to be done annually and repeated 3 months after a positive test	12-24	GPP (NG Ch 8)	GP to follow up on abnormal tests	Post-test counselling for BBV is essential	Best Practice(15-17)
Screen all sexually active 15-24 year olds for Chlamydia and Gonorrhoea	The One21seventy preventative services clinical audit includes PCR for chlamydia and gonorrhoea from 15+	15-24	I A (NG Ch 8)			
Where local prevalence rates are high, screen all sexually active 12-24 yr olds for Trichomonas vaginalis	National prevalence rates unavailable	12-24	III B (NG Ch 8)			
Screen men who have sex with men & others at high risk of STIs for syphilis	One21seventy preventative services clinical audit includes syphilis serology from 15+ See Attachment 6 for risk factors for STIs	12-24	II B (NG Ch 8)			

TESTS (STI & BBV)						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP (YEARS)**	**LEVEL OF EVIDENCE FOR RECOMMENDATION**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Screen those at high risk of BBV a) for HBV where non-vaccinated or vaccination status is unknown b) for HCV c) including MSM for HIV	See Attachment 2 for risk factors for BBVs	12-24	a) GPP (NG Ch 8) b) III A (NG Ch 8) c) II B (NG Ch 8)	GP to follow up on abnormal tests	Post-test counselling for BBV is essential	Best Practice (15-17)
If sexually active female, offer Pap test every two years 1-2 yrs after initiation of sexual activity OR at age 18 yrs (whichever is LATER) regardless of whether HPV vaccination has been given	The One21seventy preventative services clinical audit includes a pap smear check for 15+	As relevant	II A (NG Ch 15)	GP to follow up on abnormal tests		Standard good care

TESTS (Diabetes)						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP (YEARS)**	**LEVEL OF EVIDENCE FOR SCREENING**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
In low prevalence populations (<5%), measure fasting plasma glucose or random venous blood glucose if a) AUSDRISK score ≥12 b) any of the following are present:: previous IGT or IFG, history of gestational diabetes mellitus, history of polycystic ovary syndrome, history of cardiovascular disease, current antipsychotic medication use	National prevalence data is not available Higher prevalence noted in remote communities (11, 12) The One21seventy preventative services clinical audit includes a fasting or random capillary or venous blood glucose check for all 15+ If fasting test not practical, measure random glucose HbA1C is an alternative screening test	18 +	a) III B (NG Ch 14) b) II B (NG Ch 14)	Order OGTT if fasting glucose is 5.5 - 6.9 mmol/L, or random glucose is 5.5 - 11.0 mmol/L		II B (NG Ch 14)
In high prevalence populations (≥5%), measure fasting plasma glucose or random venous blood glucose			II B (NG Ch 14)			

TESTS (Lipids, Urine ACR, Spirometry)						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP (YEARS)**	**LEVEL OF EVIDENCE FOR SCREENING**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Measure serum lipids if: smoker, history of diabetes, overweight/obese, elevated BP, positive FH of CKD or premature CVD	The One21seventy preventative services clinical audit includes a lipid profile check for all 15+	18 +	GPP (NG Ch 12)	GP to follow up abnormal result		Standard good care
Measure urine ACR (first void preferable) if CKD or CVD risk factors are present	See Attachment 2 for CKD and CVD risk factors	18 +	III C (NG Ch 13)	GP to follow up abnormal result		Standard good care
Do Spirometry if COPD symptoms present in a smoker	Symptoms include persistent cough/sputum production, wheezing, & dyspnoea	12- 24	I A (NG Ch 11)	GP to follow up abnormal result		Standard good care

GENERAL HEALTH ADVICE						
RECOMMENDATION	**COMMENTS REGARDING RECOMMENDATION**	**AGE GROUP (YEARS)**	**LEVEL OF EVIDENCE FOR SCREENING**	**FOLLOW UP**	**COMMENTS REGARDING FOLLOW UP**	**LEVEL OF EVIDENCE FOR FOLLOW UP**
Advise on the use of sunglasses to prevent UV-B exposure & risk of developing cataracts		12 – 24	III C (NG Ch 6)			
Inform all families of impact of noise exposure		12 – 24	GPP (NG Ch 7)			
In trachoma endemic areas, provide education to families relating to the prevention of trachoma		Not specified [12 – 24]	II B (NG Ch 6)			

Attachment 1: Definitions

Overcrowding: The nationally accepted definition of overcrowding in Australia is based on the following household occupancy standard:

- single adult - 1 bedroom
- single adult group - 1 bedroom per adult
- couple with no children - 2 bedrooms
- sole parent or couple with 1 child - 2 bedrooms
- sole parent or couple with 2 or 3 children - 3 bedrooms
- sole parent or couple with 4 or more children - 4 bedrooms

Households that require two or more additional bedrooms to meet the standard are considered to be overcrowded.

References:

Australian Bureau of Statistics (2005), 4704.0 - The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, Chapter 4 – Housing Circumstances, viewed 12/06/12, http://www.abs.gov.au/ausstats/abs@.nsf/0/681D58F329F204EDCA2570980083C798?opendocument

Australian Bureau of Statistics (August2011), 2050.0.55.002 - Position Paper - ABS Review of Counting the Homeless Methodology, viewed 12/06/12

http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/D27107E6A3B6EAF3CA2578E20019328F?opendocument

Attachment 2: Risk Factors

Risk factors for Illicit Drug Use

Individual influences

- Not completing secondary school
- Unemployment
- Delinquency
- Residing in remote and very remote areas
- Favourable attitudes to drug use
- Sensation seeking and adventurous personality
- Relationships with peers involved in drug use
- Low involvement in activities with adults

Family Influences

- Parental conflict
- Parent-adolescent conflict
- Parental attitudes to drug use and rules around drug use
- Alcohol and drug problems in the family

Community influences

- Perceived and actual level of community drug use
- Community disadvantage and disorganisation
- Availability of drugs within the community

Positive media portrayal of drug use

Reference: NACCHO/RACGP (2012), National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people. 2nd edn. South Melbourne: The RACGP, Chapter 3, Table 3.2, pg. 85.

Risk Factors for Depression

• Exposure to adverse psychosocial events, such as unemployment, divorce or poverty

• A previous history of depression or suicide attempts

• A history of physical or sexual abuse

• A history of substance abuse

• Presence of other chronic diseases, including chronic pain

• Multiple presentations to health services may also be an indicator of depression.

Factors that make it more likely that depression will be missed include:

- limited consultation time
- presentations of mostly physical or atypical symptoms
- health professional attitudes – eg. the belief that nothing can be done, or that depression is a normal response to stress
- communication difficulties

Reference: NACCHO/RACGP (2012), National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people. 2nd edn. South Melbourne: The RACGP, Chapter 10, Table 10.4, pg. 182 From National Collaborating Centre for Mental Health and the Royal College of Psychiatrists. Depression: the treatment and management of depression in adults. London: Royal College of Psychiatrists, 2010.

Risk Factors for Suicide

- Past history of intentional self-harm
- History of mood disorders
- Hazardous alcohol consumption or use of other recreational drugs

Reference: NACCHO/RACGP (2012), National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people. 2nd edn. South Melbourne: The RACGP, Chapter 10, pg. 186.

Risk factors for Dental Disease

- Poor oral hygiene practices (eg. no/irregular toothbrushing, use of hard toothbrush, no use of fluoride toothpaste, incorrect brushing technique)
- Poor diet and nutrition (eg. high and regular consumption of sucrose and carbohydrate containing foods and drinks, especially black cola, sweetened fizzy drinks)
- Salivary composition and flow: if poor then there is less protective effect from saliva
- Low exposure to fluoride
- Xerostomia or dry mouth can also contribute to development of dental caries. Risk factors for xerostomia include use of common medications, particularly antidepressants, antihistamines and antihypertensives; radiotherapy and chemotherapy for cancers of the head and neck; Sjogren syndrome; HIV infection; and diabetes, particularly in people with poor glycaemic control
- High consumption of acidic foods and drinks such as sports drinks and juices can contribute to tooth erosion; bulimia is also an erosion risk factor
- General risk factors for periodontal disease include smoking, diabetes, advancing age, stress and poor oral hygiene
- Tobacco smoking and alcohol consumption are risk factors for the development of oral cancer
- HIV infection can also contribute to a greater risk of periodontal disease, oral ulceration and cancer
- Other modifying risk factors can include age, socioeconomic status and access to oral health services

Reference: NACCHO/RACGP (2012), National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people. 2nd edn. South Melbourne: The RACGP, Chapter 8, table 4.2, pg. 100.

Risk Factors for STIs and BBVs

Risk Factors for STIs	Risk Factors for BBVs
• Age < 30 years • Age < 35 years and sexual network relates to a remote community • Multiple current partners • Engaging in group sex • New partner • Using condoms inconsistently • Live in areas with a high incidence of STIs • Having sex while under the influence of drugs and alcohol • Having sex in exchange for money or drugs • Prison incarceration • Victims of sexual assault • Men who have sex with men where any of the above risk factors are also present	• Prison incarceration • Blood transfusion prior to 1990 • Tattoos or piercings not performed professionally • Cultural practices i.e. initiation ceremonies • Current or past injecting drug use • Household member with HBV or HCV • Sexual partner with HBV or HCV • Infants of infected mothers

Reference: NACCHO/RACGP (2012), National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people. 2nd edn. South Melbourne: The RACGP, Chapter 8, Table 8.1, pg. 152. Adapted from Bradford D, Hoy J, Matthews G. HIV, Viral Hepatitis and STI's: A Guide for Primary Care. Sydney: Australasian Society for HIV Medicine; 2008 [cited 2011 October

10]. Available from: http://www.ashm.org.au/images/publications/monographs/HIV_viral_hepatitis_and_STIs_a_guide_for_primary_care/hiv_viral_hepatitis_and_stis_whole.pdf.

Risk Factors for Cardiovascular Disease and Chronic Kidney Disease

- Family history of CKD or premature CVD
- Overweight/obesity
- Smoking
- Diabetes
- Elevated blood pressure

Reference: NACCHO/RACGP (2012), National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people. 2nd edn. South Melbourne: The RACGP, Chapters 12 (pg. 216) 13 (pg. 225)

Attachment 3: Mental Health

Features of comprehensive support services associated with improved outcomes from depression screening

• An initial visit with a nurse specialist for assessment, education and discussion of patient preferences and goals

• A follow up visit with a trained nurse specialist and ongoing support for adherence to medication for those prescribed antidepressant medications

• A visit with a trained therapist for cognitive behavioural therapy

• A reduced copayment for patients referred for psychotherapy

• Professional support including the following:

– staff and clinician training (1 or 2 day workshops)

– availability of clinician manuals

– monthly training lectures

– academic detailing

– resource materials for clinicians, staff, and patients

• Institutional financial commitment

Reference: NACCHO/RACGP (2012), National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people. 2nd edn. South Melbourne: The RACGP, Chapter 10, Table 10.3, pg. 181. From O'Connor EA, Whitlock EP, Beil TL, Gaynes BN. Screening for depression in adult patients in primary care settings: a systematic evidence review. Ann Intern Med 2009;151(11):793–803.

Mental Health Screening Tools

The following mental health screening tools are recommended for use with Aboriginal and Torres Strait Islander peoples.

Kessler Psychological Distress Scale – Revised (5-question subset)

The Kessler Psychological Distress Scale was originally formulated as a 10-item scale. It was first used with Aboriginal and Torres Strait Islander respondents as a 5-question subset in the 2004/2005 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and has been considered appropriate for use with Aboriginal and Torres Strait Islander people aged 16 and above. Stakeholders involved in the development of the SEW section of the 2004/2005 NATSIHS made two changes to the language used to improve understanding – 'hopeless' changed to 'without hope' & 'restless or fidgety' changed to 'restless or jumpy'. The K5 was found to be internally valid & results were consistent with other population study findings measuring Aboriginal and Torres Strait Islander Social and Emotional Wellbeing. Stakeholders in a 2006 NATSIHS workshop supported continued use of the K5 in the next 2010-2011 NATSIHS.

References:

Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. 2009, Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People, Discussion Paper No. 10, Cooperative Research Centre for Aboriginal Health, Darwin.

Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, Normand S-LT, Walters EE, Zaslavsky A. Short screening scales to monitor population prevalences and trends in nonspecific psychological distress. Psychological Medicine 2002; 32(6), 959-976.

Australian Institute of Health and Welfare 2009. Measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. Cat. no. IHW 24. Canberra: AIHW.

Strengths and Difficulties Questionnaire (SDQ)

This is a 25-item self-report questionnaire that can also be administered with external raters. It has been validated with Aboriginal & Torres Strait Islanders aged 4 – 17 years in urban and remote settings. Domains covered include Emotional Symptoms; Conduct Problems; Hyperactivity; Peer Problems; Prosocial Behaviour. There is also an optional 'Impact Supplement' that assesses overall distress and social impairment.

References:

Goodman, R., Meltzer, H. & Bailey, V. (1998). The Strengths and Difficulties Questionnaire: a pilot study on the validity of the self-report version. European Child and Adolescent Psychiatry, 7, 125 - 130.

Sawyer, M.G., Guidolin, M., Schulz, K.L., McGinnes, B., Zubrick, S.R., & Baghurst, P.A. (2010). The mental health and wellbeing of adolescents on remand in Australia. The Australian and New Zealand Journal of Psychiatry 44(6), pp. 551-559.

Turner, K., & Sanders, M. (2007). Family intervention in Indigenous communities: emergent issues in conducting outcome research. Australasian Psychiatry 15, pp. 39-43.

Williamson, A., Redman, S., Dadds, M., Daniels, J., D'Este, C., Raphael, B., Eades, S., & Skinner, T. (2010). Acceptability of an emotional and behavioural screening tool for child in Aboriginal Community Controlled Health Services in urban NSW. Australian and New Zealand Journal of Psychiatry 44, pp. 894-900.

Zubrick S, Silburn S, Lawrence D et al. (2005). Chapter 2: The Western Australian Aboriginal Child Health Survey: The Emotional and Behavioural Health of Aboriginal Children and Young People. Perth: Curtin University of Technology and Telethon Institute for Child Health Research. Retrieved from http://aboriginal.childhealthresearch.org.au/kulunga-research-network/waachs/waachs-volume-2.aspx, 28 June 2013.

Indigenous Risk Impact Screen (IRIS)

A 13-item, health professional completed tool that screens for alcohol and other drug risk, including: Tolerance, Withdrawal, Impulse Control, Addiction and Drug Importance. The tool includes Emotional Wellbeing (Mental Health) risk items including: Depression, Anxiety and Stress related to past experiences. The tool has been validated for use with Aboriginal and Torres Strait Islander people aged 18 years and over. It has not yet been validated for people younger than 18.

The IRIS was validated against the Severity of Dependence Scale (SDS), the Alcohol Use Disorders Identification Test (AUDIT) and the Leeds Dependence Questionnaire (LDQ). Additional Mental Health measures included the Depression Anxiety and Stress Scale (DASS-21) and the Self-Report Questionnaire (SRQ). IRIS demonstrated good convergent validity.

References:

Queensland Health. (2004). Indigenous Risk Impact Screen and Brief Intervention Project: Tool Kit.

Schlesinger, C., Ober, C., McCarthy, M., Watson, J., & Seinen, A. (2007). The development and validation of the Indigenous Risk Impact Screen (IRIS): a 13-item screening instrument for alcohol and drug and mental health risk. Drug and Alcohol Review 26, pp. 109 – 117.

Strong Souls

A 25-item, self-report measure that covers the domains of Depression, Anxiety, Suicide risk and Resilience. The Resilience domain includes culturally-oriented items. The tool has been validated for use with Aboriginal and Torres Strait Islander 16 – 21 year-olds, however, it has not been validated in clinical settings.

Reference:

Thomas, A., Cairney, S., Gunthorpe, W., Paradies, Y., and Sayers, S. (2010). Strong Souls: development and validation of a culturally appropriate tool for assessment of social and emotional well-being in Indigenous youth. Australian and New Zealand Journal of Psychiatry 44, pp. 40 – 48.

Westerman Aboriginal Symptoms Checklist (WASC-Y)

A 53 item self-report measure, which screens for risk of depression, anxiety, suicide, alcohol/drug use, impulsivity and resilience. The WASC-Y has been validated for use with 12 – 17 year-old Aboriginal Australians.

References:

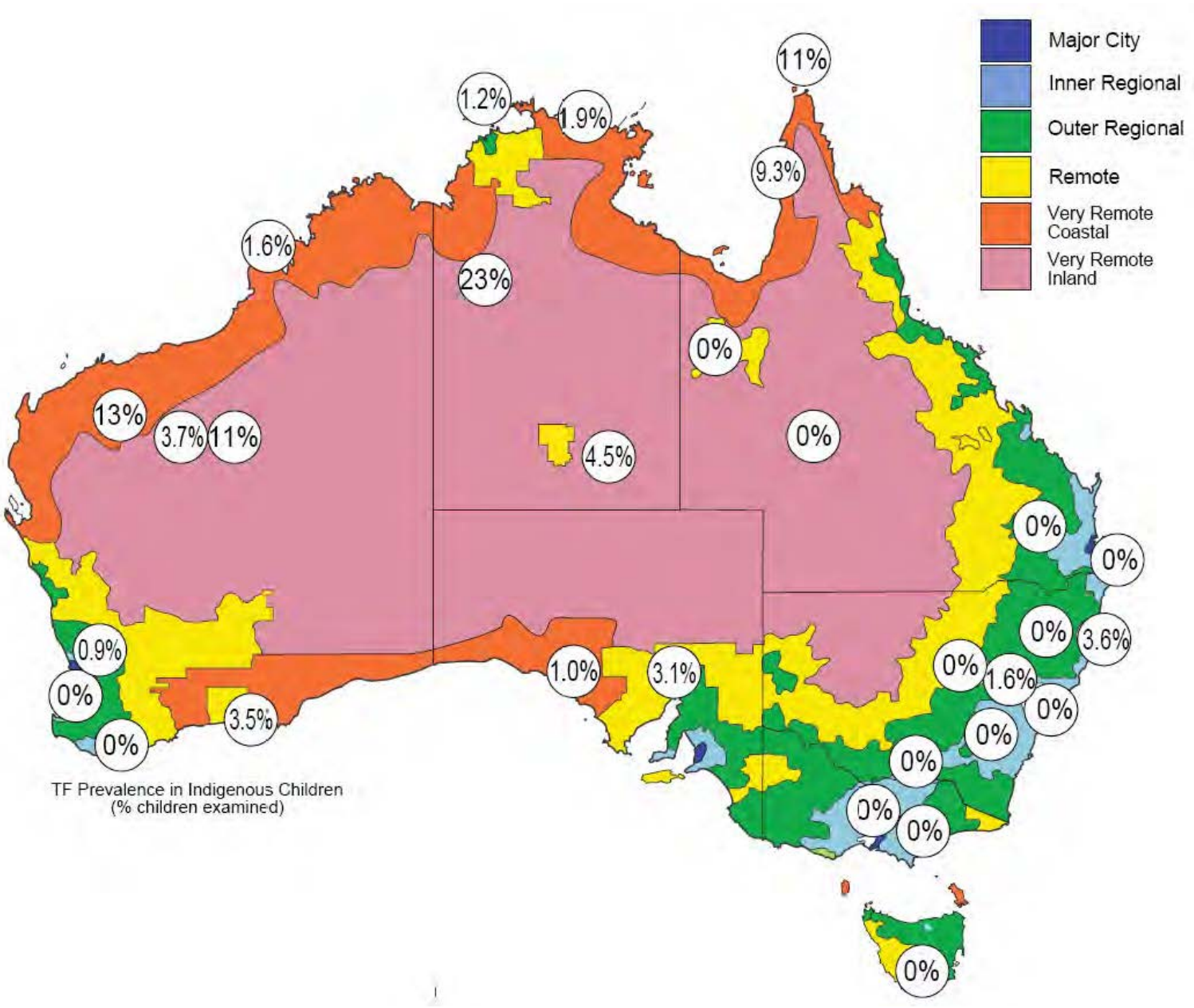
Stathis, S.L., Doolan, I., Letters, P., Arnett, A., Cory, S., & Quinlan, L. (2012). Use of the Westerman Aboriginal Symptoms Checklist – Youth (WASC-Y) to screen for mental health problems in Indigenous youth in custody. Advances in Mental Health 10(3), pp. 235-239.

Westerman, T.G (2003) The development of the Westerman Aboriginal Symptom Checklist for Youth: A measure to assess the Moderating Effects of Cultural Resilience with Aboriginal Youth at Risk of Depression, Anxiety and Suicidal Behaviours. Abstract of Doctor of Philosophy Thesis. Curtin University.

Attachment 4: Trachoma Prevalence Map

From the National Indigenous Eye Health Survey Report

Reference: Taylor, HR (& members of the National Indigenous Eye Health Survey Team) (2009), National Indigenous Eye Health Survey, Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne in collaboration with the Centre for Eye Research Australia and the Vision CRC. ISBN 978-0-7340-4109-8



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3. Australian Government National Health and Medical Research Council. The Australian Immunisation Handbook 10th Edition2013.
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11. Australian Institute of Health and Welfare. Young Australians: Their Health and Wellbeing 2011 Cat. no. PHE 140, Australian Institute of Health and Welfare, Canberra. 2011.
12. Minges KE ZP, Magliano DJ, Dunstan DW, Brown A, Shaw JE,. Diabetes prevalence & determinants in Indigenous Australian populations: A systematic review. Diabetes Research & Clinical Practice. 2011;93:139-49.
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14. MacRae A TN, Anomie, Burns J, Catto M, Gray C, Levitan L, McLoughlin N, Potter C, Ride K, Stumpers S, Trzesinski A, Urquhart B, . Overview of Australian Indigenous health status. Retrieved [20/05/2013] from http://www.healthinfonet.ecu.edu.au/overview_2013.pdf. 2012.
15. National Hepatitis B Virus (HBV) Testing Policy Expert Reference Committee. National Hepatitis B Tesing Policy. Commonwealth of Australia, 2012.
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A CULTURAL SOCIAL EMOTIONAL WELLBEING ASSESSMENT (BASED ON HEEADSSS ASSESSMENT)

ABORIGINAL & TORRES STRAIT ISLANDER YOUTH HEALTH CHECK: 'Y HEALTH' RESOURCE DOCUMENT NO. 2

Authors: Dr Annapurna Nori, Ms Rebecca Piovesan, Ms Joanne O'Connor, Assoc Professor Smita Shah, Professor Ngiare Brown

Introduction and tool development

A psychosocial assessment is an integral part of a health related consultation with a young person. The 'Y Health' Cultural Social Emotional Wellbeing Assessment (CSEW) is derived from the mainstream HEEADSSS Assessment(2) with modifications to incorporate culture specific norms or behaviours. Culture has been placed foremost. The language has been altered to suit the Aboriginal & Torres Strait Islander health workforce and community. See also the 'Y Health' Resource document No 3 (Question Guide to a Cultural Social Emotional Wellbeing Assessment). This table consists of the original HEEADSSS Domains, the equivalent CSEW Topics and any relevant comments.

Cultural Validity & Specificity

The term 'cultural appropriateness' describes an approach, a process, or an output that meets the needs of the Indigenous community. It is a broad term and varies greatly in interpretation and application. When we do not have Indigenous specific evidence or tools, mainstream evidence or tools can be utilised. However, two questions should be asked: do these mainstream theories or models adequately reflect or address the needs of a minority group, and are there any gaps? These questions are answered best by two tools.(1) The first is Cultural Validity, a cross-cultural approach derived from Anthropology. It looks at the universality of mainstream knowledge or the generalisability of majority group theories and norms to other cultural groups. The second tool is Cultural Specificity, a cross-cultural cross-racial approach derived from Sociology. It looks at aspects that are specific or particular to a culture. In the 'Y Health' project development of this document, these two criteria were examined via the following: alignment with Aboriginal culture and knowledge, relevance of mainstream or non-youth health assessment areas to the health of Aboriginal and Torres Strait Islander youth, and use of screening tools used with, designed for and/or validated with Aboriginal and Torres Strait Islander population.

Examples of application of these criteria are: inclusion of a strengths based approach and ensuring cultural connectedness is incorporated.

Original HEEADSSS 'Domain' and Description	New 'Y Health' CSEW 'Topic' and Description	COMMENTS
	General: We want to find out about the young person's background, beliefs, experiences and connection to culture	**Non Indigenous health professionals must NOT engage in this discussion unless they have good local Aboriginal and/or Torres Strait Islander knowledge and connections AND excellent rapport with the young person**
Home Explore the home situation, family life, relationships and stability	**Home** We want to find out about where the young person is living and with whom; family life, relationships and stability We want to know if the young person feels safe in her/his environment We also want to identify any overcrowding that is causing problems	Note about overcrowding: There are social and wellbeing benefits to living with a supportive network of people. Therefore it is important to ask about overcrowding that is causing problems, not just a strict adherence to the definition.
Education/Employment Explore sense of belonging at school/work and relationships with teachers/peers/workmates; changes in performance	**Learning/Work** We want to find out about: • How the young person is going at school and/or work • Relationships with teachers/peers/workmates • Whether there have been big changes in how they are going at school or work • Whether they feel safe at school/work • Whether they have any plans for when they finish school or for their career	
Eating/Exercise Explore how they look after themselves; eating and	**Eating/Exercise** We want to find out about:	Food insecurity is recognised as a determinant of poor health in the Aboriginal and Torres Strait Islander population(7, 8)

Original HEEADSSS 'Domain' and Description	New 'Y Health' CSEW 'Topic' and Description	COMMENTS
sleeping patterns	• Food and eating habits, whether they eat bush tucker, whether they are getting enough to eat • Who does the food shopping and cooking • What kind of exercise they get during a week, how often and how much. This can include playing sports, going to a gym, walking to the shops or bus stop, walking/riding bicycle to school or work • Whether there has been any recent change in weight and if this is something the young person had planned or not	The One21seventy child health audit includes evidence of concern regarding food security
Activities/Peer Relationships Explore their social and interpersonal relationships, risk taking behaviour, as well as their attitudes about themselves	**Hobbies, Interests and Friendships** We want to find out about: • How the young person gets along with other young people • How she/he is socialising • What kind of interests she/he has • Whether she/he does things safely e.g. wears a bicycle helmet, puts on a seat belt; uses sunscreen and wears sunglasses • Whether she/he is taking part in any high risk behaviours, including gambling	If there are risk taking behaviours/activities, we need to: 1. Check whether the young person has broken the law or been involved with the juvenile justice system 2. Refer for youth specific counselling If the young person seems to be socially isolated, we need to do a mental health assessment
Drug Use/Cigarettes/Alcohol Explore the context of substance use (if any) and risk taking behaviours	**Substance Use including cigarettes, alcohol and other drugs** We want to find out if the young person is smoking, drinking alcohol or using other drugs If so, we want to find out about:	

Original HEEADSSS 'Domain' and Description	New 'Y Health' CSEW 'Topic' and Description	COMMENTS
	• Whether they are being pressured into it • What they are using, how and when they use, how much they are smoking/drinking/using, how often, if there have been any problems • If the people they spend time with smoke, drink or use substances	
Suicide/ Self Harm/ Depression/ Mood Explore risk of mental health problems, strategies for coping and available support	**Mental Health** We want to find out about the young person's mood, whether there is ongoing stress in their life, whether there has been anything hurtful or traumatic happen to them recently or in the past If the young person has a mood problem, you must assess if she/he is at risk of self-harm or suicide	
Sexuality Explore their knowledge, understanding, experience, sexual orientation and sexual practices. Look for risk taking behaviour/abuse	**Sexual Health & Sexuality** In this part, we discuss the young person's sexual health, whether she/he has had or is having sex, what her/his sexual orientation is and how she/he feel about themselves If the young person has had or is having sex, we want to know if: • She/he is using any kind of protection or contraception • She/he is consenting to it or being pressured	
Safety & Spirituality Sun screen protection; immunisation; bullying; abuse; traumatic experiences; risky behaviours.		Safety issues have been considered across all areas and not as a separate topic Spirituality has been considered as part of cultural

Original HEEADSSS 'Domain' and Description	New 'Y Health' CSEW 'Topic' and Description	COMMENTS
Beliefs; religion; What helps them relax, escape? What gives them a sense of meaning?		connectedness
	Finishing off We complete this assessment by checking with the young person if they have any other concerns or worries or if there is anything else they wish to talk about	

QUESTION GUIDE FOR A CULTURAL SOCIAL EMOTIONAL WELLBEING ASSESSMENT

ABORIGINAL & TORRES STRAIT ISLANDER YOUTH HEALTH CHECK: "Y HEALTH" RESOURCE DOCUMENT NO. 3

Authors: Dr Annapurna Nori, Rebecca Piovesan, Joanne O'Connor, Tauondi College Community Services Class 2012, Watto Purrunna Aboriginal Health Service Thursday for Kids Group, Mari Yerta Aboriginal Youth Group, Assoc Professor Smita Shah, Professor Ngiare Brown.

This guide provides examples of questions that are useful when discussing the various aspects of a young Aboriginal and/or Torres Strait Islander's current life situation.

This is not a checklist of questions and we advise health professionals not to ask each and every question as this is likely to disengage a young person. Go through this assessment in a relaxed way and don't rush through it. Let the young person feel comfortable about telling her/his story.

There are specific questions about cultural connectedness throughout the guide, but most of these are in the first section. Safety has also been considered across all topic areas and not separately.

WARNING: If you are a non-Indigenous person, and are not familiar with Aboriginal & Torres Strait Islander communities, you need to be extremely cautious asking the questions around culture. We strongly recommend that you do NOT explore this area these questions.

Resources:

1. NSW Centre for the Advancement of Adolescent Health GP Resource Kit

'Y HEALTH' QUESTION GUIDE FOR A CULTURAL SOCIAL EMOTIONAL WELLBEING ASSESSMENT

TOPIC AREA	POSSIBLE QUESTIONS
GENERAL: Explore background, beliefs, experiences and connection to culture	Tell me about yourself • Where's country for you? Where are you from? Where is your family from? • Do you visit country or your family's country? • Do you like where you are from? Do you feel connected with your culture? How close do you feel to your culture? • Do you feel connected with your community? How close do you feel to your community? • Do you take part in any cultural and/or community activities (e.g. NAIDOC events, ceremonies, hunting, art and crafts)? If so how often? Do you speak any Aboriginal and/or Torres Strait Islander languages? Do you have any beliefs that are important to you (religious or spiritual)? Have you been through ceremony? (**do not ask this question unless you have good local Aboriginal and/or Torres Strait Islander knowledge and connections AND excellent rapport with the young person**) Have you or do you face prejudice or racism? (if yes, explore details)
HOME Explore the home situation, family life, relationships and stability. We also want to identify any overcrowding that is causing problems	Tell me about where you live • Where do you live? (what type of place, how many rooms, is this where you live all the time; is there any chance you will need to move) • Do you stay at more than one place? If yes, what is it like for you moving around? • Do you have your own room? Tell me about your family (OR) the people you are living with • How many people live with you at the moment? • How are things going at home or where you live? • Who are you closest to in your family? • Do you get along with your family? Do your family members get along with each other? • Do you have any worries about your family or friends? • Do you have children? (What age?) Do you feel safe at home or where you are staying? Are there ever times you feel like leaving home? Have there been any changes at home lately (moves, departures, travelling to and from home/ community etc)

'Y HEALTH' QUESTION GUIDE FOR A CULTURAL SOCIAL EMOTIONAL WELLBEING ASSESSMENT

TOPIC AREA	POSSIBLE QUESTIONS
LEARNING/WORK Explore how the young person is going at school/work and relationships with teachers/peers/workmates; whether there have been significant changes	Do you go to school/study or work? • What year are you in/what job do you do? How are you going at school/work? OR Are you happy at school/work? (explore) If not, why? • Have you been missing or not going to school/work or often turning up late? • Are you keeping up with your school work? Do you need any help? How are your grades? OR What are your school reports like? • Do you get along with your teachers/boss and other students/work mates? (explore) • How are your friends or other students or work mates treating you? OR Do you have any problems at school/work, like getting bullied? Do you feel safe at school/work? Does your family encourage or help you with your studies/sport/work? What would you like to do when you leave school/you're older? OR what job/career plans do you have?
EATING/EXERCISE Explore food and eating habits and physical activity	What do you usually eat & drink over a whole day? OR Tell me what you ate yesterday? (explore type of food and amount, bush tucker) • What do you like to eat? • Do you get enough to eat? Who shops for the food/groceries? Who does the cooking? Has your weight or diet changed lately? • How do you feel about the way you look? (explore the possibility of eating disorders) During a usual or typical week, what kind of exercise do you do? • Do you play sport or do any exercise? (explore what kind including traditional dance, how often & for how long) • Do you ride your bike or walk to get around? (explore informal physical activity)
HOBBIES, INTERESTS AND FRIENDSHIPS Explore relationships with other young people, how they are socialising, whether they are engaging in any high risk behaviours	Who do you hang around with? (brothers, sisters, cousins, aunties, uncles or friends from school?) (explore for social isolation) • Do you like your friends and how much time do you hang out with them? • Have you ever been pressured into anything by your peers? What do you (and your friends) do in your free/spare time? What do you do on the weekend? Do you wear bike helmets, seat belts? Do you use sunglasses and sunscreen? Do you do anything that gets you into trouble, or could get you into trouble? Have you ever been in trouble with the police? Do you play the pokies, cards or bet online? If yes, How do you pay for it? OR What do you spend your money on?

'Y HEALTH' QUESTION GUIDE FOR A CULTURAL SOCIAL EMOTIONAL WELLBEING ASSESSMENT

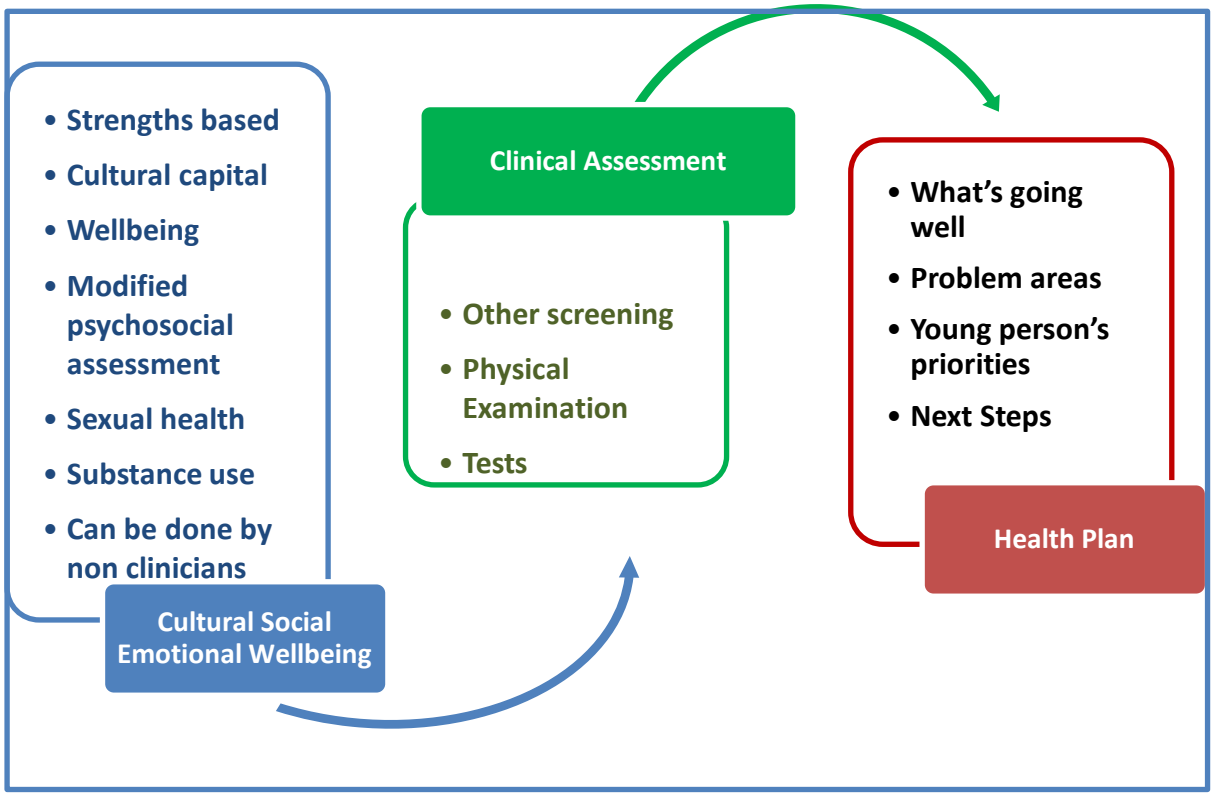
TOPIC AREA	POSSIBLE QUESTIONS
SUBSTANCE USE INCLUDING CIGARETTES Explore use, type, amount, frequency, consequences. Explore if the people they spend time with smoke, drink or use substances	Do people around you smoke or drink? • Do you smoke or drink? How much & how often? What about drugs? • Are people around you doing drugs? What type and how often? • Have you tried drugs before? (If yes, are you still taking them? What type and how often?) • (If currently using) Does this affect relationships, school, work or other responsibilities? How are you paying for it? Has this ever got you into trouble (getting into fights or in trouble with the police)? • Are you or have you been pressured into it?
MENTAL HEALTH Explore mood, stress, and trauma. Assess suicide risk if there are mood problems	How have you been feeling lately? • Have you been feeling sad, stressed, nervous or worried? (this question is not necessary if the young person has filled out a mental health tool such as the K5) • Are you still enjoying things as much as usual? How have you been sleeping? How much sleep do you get each night? Has your eating been OK? Has anything traumatic or hurtful happened to you lately or in the past? Do you have thoughts about hurting yourself? Have you ever tried to hurt yourself? If yes, explore how serious the injury was. Have you had any thoughts about suicide? If yes, Have you tried to end your own life? (try and find out if this is a current problem). [**Do not ask this question routinely. This is to be asked if the young person has risk factors for suicide. See Footnote below** [1]]
SEXUAL HEALTH & SEXUALITY	Have you noticed any body changes? (ask this question only if the young person appears not to have not gone through puberty) (For females) Are you having periods? Is everything going okay with your monthly or period? Do you have a boyfriend or girlfriend? • Have you ever slept with them or had sexual intercourse? How about with other people (boys/girls or males/females)? • What do you use for protection? • (For females)Do you take anything to stop you from getting pregnant (e.g. pill or Implanon)? Are you attracted to boys/males or girls/ females, or are you unsure? Do you feel comfortable with your sexuality or feelings? Has anyone ever taken advantage of you or used you? Have you ever felt uncomfortable or pressured about having sexual intercourse?
FINISHING OFF	Do you have any other concerns? OR Is there anything else you want to talk about? OR Is there anything else that is worrying you that we have not talked about?

[1] **RISK FACTORS FOR SUICIDE**:

1. Past history of intentional self-harm. 2. History of mood or mental health problems. 3. Hazardous alcohol consumption or use of other recreational drugs

Appendix 3: Youth Health Check Screening Tool and Template

Figure 4: The basic elements of a Youth Health Screening Tool



YOUTH HEALTH CHECK TEMPLATE

The first two sections can be completed by the young person, with assistance if necessary from a carer, youth worker, or health professional. The third is to be completed by a health professional and the fourth section is for the young person and the health professional to complete together.

Medico-legal considerations:

Please refer to State & Territory legislation for details regarding age of consent to medical treatment and mandatory reporting responsibility.

In brief, a young person below the age of consent to medical treatment cannot be seen alone without having an assessment of maturity ("mature minor" assessment). Such assessments can ONLY be done by medical practitioners.

A young person above the age of consent to medical treatment as well as a mature minor is entitled to the same levels of confidentiality and privacy as adults. Confidentiality can only be breached if there is harm or risk of harm to the young person, or the young person is at risk of harming another person.

Section 1: Client Health Information

This section is meant to be completed by the young person, but she/he may need help to complete it. Even if the young person completes this section without the health professional's help, the health professional should go through it with the young person to make sure all the information is correct. This section includes informed consent, contact details, usual health provider details, services attended, allergies, medical history, medications, and family history.

Section 2: Staying Deadly Questionnaire

The Staying Deadly Questionnaire is where young people can identify the factors that help to keep them strong and healthy, in addition to any health concerns. There is also a mental health screening tool (the K5 Plus One) that they fill out.

Section 3: Assessment by Health Professional

This section is performed by the health professional and includes a cultural, social, emotional wellbeing assessment; additional assessment, physical examination, and tests.

Section 4: Staying Deadly Plan

The Staying Deadly Plan is completed by both the client and health professional and has a client centred focus. It includes a summary of areas that are going well, problems that have been identified, action areas as prioritised by the young person, advice provided by the health professional and referrals that have been made. The action plan then details the top three areas for action, including what will happen, who is involved, a date for review and a review of progress.

Aboriginal & Torres Strait Islander
FEMALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

SECTION 1: My General Information

Date: ___/__/__

Consent

I agree to having a health check ☐ OR I agree to the young person in my care having a health check ☐

I would like SMS reminders for appointments ☐

Contact Details

Current address: _____

Current phone no: _____

Medicare no.:_____ Reference number: _____ Expiry date: _____

Centrelink concession no.: _____

Parent/Guardian Details (if this applies):

Name: _____Relationship to you: _____

Address (if this is different to yours): _____

Phone number: _____

Usual Health Provider/Service (do not fill in if we are your usual health service)

Name: _____

Address: _____

Contact number/fax: _____

I would like a copy of my health check report to be given to my usual health provider ☐

Youth groups or other Health Services that you attend (if this applies to you):

Do you also get help from a traditional healer e.g. Ngangakari? ☐ Yes ☐ No

Aboriginal & Torres Strait Islander
FEMALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

Basic Health Information

ALLERGIES:

Are you allergic to anything? ☐ Yes ☐ No ☐ Don't know

If yes, what are you allergic to? _____

HEALTH CONDITIONS OR PROBLEMS

Have you had or do you have any of the following health problems?

☐ Diabetes ☐ Asthma ☐ Heart disease ☐ High blood sugars ☐ Mental health problems

☐ Diabetes during pregnancy ☐ Hormonal problems ☐ Women's business problems

☐ Other _____

Have you ever had any operations or had to go to hospital? ☐ Yes ☐ No

If yes, what for? _____

MEDICINES / MEDICATIONS

Are you on any medications? ☐ Yes ☐ No

Please write the name and dose of the medications you are on:

Name	Dose
_____	_____
_____	_____
_____	_____

Are you able to get cheaper medicines through your doctor or clinic? ☐ Yes ☐ No ☐ Don't know

Are you or your family able to pay for your medications? ☐ Yes ☐ No ☐ Sometimes

Do you take your medicines as recommended? ☐ Yes ☐ No ☐ Sometimes

If your answer is no or sometimes, please tell us why:

☐ Keep forgetting ☐ Not important to me ☐ Don't like being on them ☐ Other _____

FAMILY'S HEALTH PROBLEMS

Does anyone in your family have any of the following problems?:

☐ Smoker ☐ Diabetes or high blood sugar ☐ Heart disease ☐ Kidney disease

☐ Mental illness ☐ Other _____

Health Professional Actions

☐ Allergy alert ☐ Refer to GP if there are any existing health conditions

☐ Test BGL (if 18+ AND any of these risk factors: heart disease, high blood sugars, diabetes during pregnancy, hormonal problems, women's business problems, antipsychotic medication use)

☐ Test Serum lipids & Urine ACR (if 18+ AND has diabetes or positive FH of CKD or premature CVD)

Aboriginal & Torres Strait Islander
FEMALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

SECTION 2: Staying Deadly Questionnaire

Date: ___/__/__

People that keep me strong: (family, friends, elders, community members)

The person whom I trust ,to give advice about my treatment or health concerns is: _____

Things that are helping to keep me strong: (tick all the boxes that apply to you and circle the 3 biggest strengths)

☐	Culture, language, heritage, spiritual belief	☐	Friends or supportive person to yarn with
☐	Going to country	☐	Having a safe place to go to
☐	Religion	☐	Art and craft
☐	Family and/or relationship	☐	Dance
☐	Health centre, health worker, doctor	☐	Music
☐	Traditional healer (e.g. Ngangakari)	☐	Hunting and fishing
☐	Good diet	☐	Positive thinking
☐	Sport / Exercise	☐	Making my own choices
☐	School / Learning new things	☐	Sleeping well / A good night's sleep
☐	Work / Community involvement	☐	Good Health
		☐	Other _____

You can use this space to write more about things that keep you strong:

Some worries I have are: (tick all the boxes that apply to you and circle your 3 biggest worries)

☐	Cultural or spiritual worries	☐	Losing family / friends
☐	Family and relationship worries	☐	Racism
☐	Where and how I am living	☐	Feeling alone / Feeling left out – not mixing much with others
☐	Ongoing health issues	☐	Feeling sad inside, no interest in doing things
☐	Hearing trouble	☐	Feeling anxious or nervous or jumpy
☐	Not eating well	☐	Sleep worry / Sleeping problems
☐	Not enough exercise	☐	Problem with my behaviour
☐	Missing school or trouble at school	☐	Not caring for self: trouble shopping, cooking, cleaning
☐	Getting picked on or feeling pressured to do things	☐	Mixed up thoughts, paranoid thinking or silly thoughts
☐	Nothing to do / Bored	☐	Hearing voices or seeing things
☐	Not working or trouble at work	☐	Self-harm behaviour or thoughts of suicide
☐	Money worries	☐	Too much energy, cant slow down, thinking too fast
☐	Marijuana, alcohol, cigarettes, other drugs	☐	How I look / My appearance
☐	Gambling worries	☐	Not being able to make my own choices
☐	Violence / Harm towards me	☐	Language barrier
☐	Difficulty reading and writing	☐	Other worry_____

You can use this space to write more about things that worry you:

Aboriginal & Torres Strait Islander YOUTH K 5 plus ONE (12 -24 years)

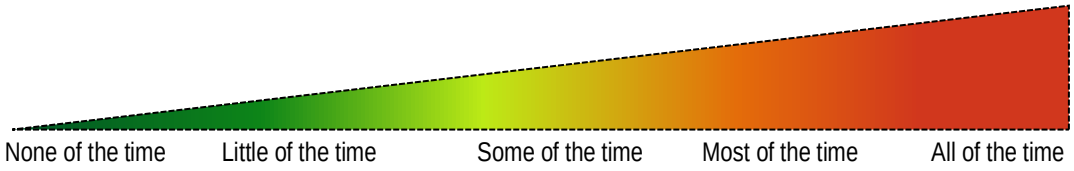
Name:	Other Names:	DOB: ___/__/__

DATE OF ASSESSMENT: ___/___/___

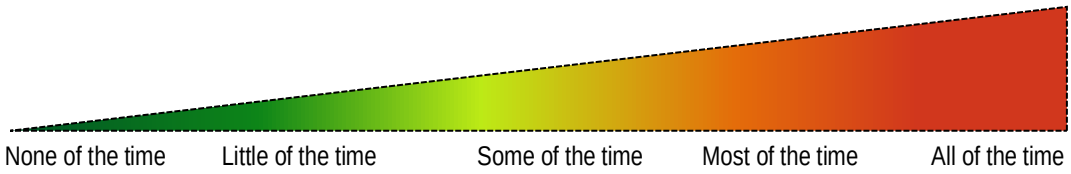
(Put a circle around the answer to each question)

In the last four weeks how often did you feel?

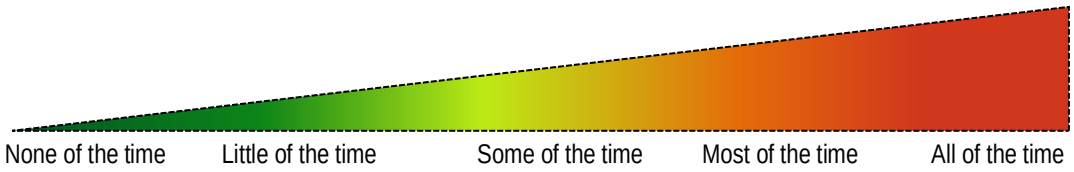
Nervous or Anxious?



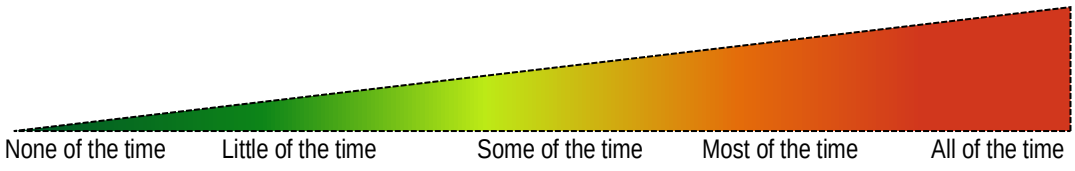
Hopeless (without hope)?



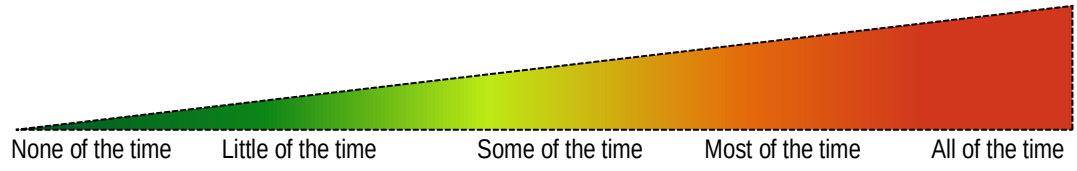
Restless or Jumpy?



Everything was an effort?



So sad that nothing could cheer you up?



SCORES	1	2	3	4	5

Would you like help with this?

☐ Yes ☐ Yes, but not today ☐ No

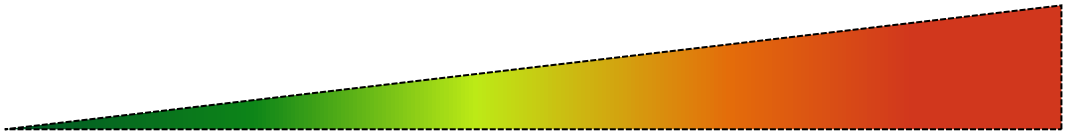
Aboriginal & Torres Strait Islander YOUTH K 5 plus ONE (12 -24 years)

Name:	Other Names:	DOB: ___/__/__

DATE OF ASSESSMENT: ___/___/___

THIS SECTION TO BE FILLED IN BY HEALTH PROFESSIONAL ONLY

K 5 SCORE = _____



None of the time 1 | Little of the time 2 | Some of the time 3 | Most of the time 4 | All of the time 5

Circle the relevant section:

Total Score	Risk of Depression or Anxiety	Ask about Self Harm/ Suicidal ideas	Follow Up
5 – 11	No risk or Low risk	May be necessary if other psychosocial risk factors are present	May be necessary
12 - 25	Medium to High Risk	YES	Necessary

Aboriginal & Torres Strait Islander
FEMALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

SECTION 3: Assessment by Health Professional

Date: ___/__/__

Confidentiality discussed ☐

CULTURAL SOCIAL EMOTIONAL WELLBEING ASSESSMENT (modified HEEADSSS)

(Begin with the answers on the Stay Deadly questionnaire. It is good to use open ended questions and probe or clarify as needed. You can refer to the question guide, but please do not ask every single question in it)

General (Begin by asking if the young person has any concerns. Then ask about the person's connection to culture, country, and language. Also ask about exposure to racism and prejudice.)	
	Actions ☐ Refer to Youth group ☐ Refer to Community group ☐ Refer to GP ☐ Other _____

Home (Ask about the home situation, family life, relationships and stability. We also want to identify any overcrowding)	
	Actions ☐ Refer to GP ☐ Housing assistance needed ☐ Refer to counsellor/ wellbeing worker ☐ Other _____

Learning/Work (Check how the young person is going at school/work and relationships with teachers/peers/workmates; whether there have been changes recently; whether there is bullying etc)	
	Actions Referral: ☐ Aboriginal education officer/ youth counsellor/ school counsellor ☐ GP

Aboriginal & Torres Strait Islander
FEMALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

Eating/Exercise (Ask about the young person's food and eating habits, including bush tucker; whether they are getting enough to eat. Also ask about physical activity including traditional dance)

Assessment:

Eating enough fruit ☐ Yes ☐ No Eating enough veggies ☐ Yes ☐ No

Drinking enough water ☐ Yes ☐ No Having dairy ☐ Yes ☐ No

Type of Physical Activity:

For how long:

How often:

Issues:

☐ Not having enough to eat ☐ Too many sugary foods ☐ High fat foods

☐ Low physical activity ☐ Possible eating disorder

☐ Other

Actions

Brief intervention:

☐ Food & diet

☐ Physical activity

Referral:

☐ GP

☐ Financial counselling/ support

Follow up:

☐ Dietary assessment

Hobbies/Interests/Friendships (Ask about the young person's hobbies and interests and relationships with other young people, how they are socialising, and whether they are engaging in any high risk behaviours. Ask about use of seat belts helmets, sunglasses, sun screen etc. Ask about gambling, including online gambling)

High risk behaviours ☐ Yes ☐ No

Gambling ☐ Yes ☐ No

Actions

Referral:

☐ GP

☐ Counselling

☐ Other _____

☐ Gambling assistance

Brief intervention:

☐ Safety advice

Substance Use including cigarettes (Ask about use, what type, how much and how often. If they are taking drugs or alcohol, find out if this has become a problem. Also find out if the people they live with smoke, drink or use drugs)

Smoking tobacco: ☐ No ☐ Occasionally ☐ Yes (How many per day:)

Exposed to other people smoking: ☐ No ☐ Yes

If smoker or exposed to smoke, ask about symptoms of:

Asthma (shortness of breath, chest tightness, wheeze, cough) ☐ Yes ☐ No

COPD (shortness of breath, chronic cough/sputum production, wheeze) ☐ Yes ☐ No

Smoking yarndi/ marijuana ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No How much: How often:

Other drugs ☐ Yes ☐ No

If yes, is it ☐ Eating ☐ Sniffing ☐ Injecting ☐ Smoking ☐ Other

When/ Where/ Who with: How much: How often:

If injecting, sharing needles ☐ Yes ☐ No

Actions

Brief intervention:

☐ Smoking/passive smoking/ alcohol/ drugs *(circle)*

Referral:

☐ Drug & alcohol service

☐ GP

☐ Needle exchange service

☐ Quit smoking program/ service

Follow up:

☐ Fagerstrom test for nicotine dependence

☐ Spirometry (symptoms of asthma/ COPD)

Aboriginal & Torres Strait Islander
FEMALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

Mental Health (Refer to the K5 plus one filled out by the young person. If the score indicates moderate to high risk, must ask about self-harm or suicidal thoughts. If no-low risk, consider asking about self harm if other risks present)

Enter the K5 score:

Is this score ☐ No - Low risk ☐ Moderate – High risk

Is there risk of self harm or suicide ☐ Yes ☐ No

Enjoying things as usual ☐ Yes…☐ No

Sleep Normal ☐ Yes…☐ No Appetite Normal ☐ Yes…☐ No

Affected by traumatic experience ☐ Yes…☐ No

Actions

Referral:

☐ Mental health service
☐ GP
☐ Counsellor
☐ Self-harm prevention/intervention
☐ Hospital

Sexual Health (Ask about sexual activity, contraception/protection, safe sex practices, sexual orientation, pressure to have sex, STIs)

Has been sexually active ☐ Yes ☐ No Age first started:

(If yes, offer STI testing)

Using protection (condoms) ☐ Yes, all the time ☐ Yes, sometimes ☐ No ☐ N/A

On contraception ☐ Pill ☐ Depo ☐ Implanon ☐ Other ☐ No ☐ N/A

Is your monthly period regular ☐ Yes ☐ No ☐ There's problems ☐ N/A

When was your last period

Has anyone ever taken advantage of you or used you? Have you ever felt uncomfortable or pressured about having sexual intercourse ☐ Yes ☐ No

Are you attracted to ☐ Boys/males ☐ Girls/ females ☐ Both ☐ Unsure

Do you feel comfortable with your sexuality ☐ Yes ☐ No ☐ Unsure

Have you had an STI (eg Gonorrhoea, Chlamydia) ☐ Yes ☐ No ☐ Unsure ☐ N/A

Have you had a pap smear ☐ Yes ☐ No ☐ Unsure ☐ N/A

If yes:

a) Was it in the last two years ☐ Yes ☐ No ☐ Unsure

b) Was the result ☐ Normal ☐ Had to go for more check ups ☐ Had treatment

Consents to STI test: ☐

Actions

Brief intervention:

☐ Safe sex & condom use

Referral:

☐ Sexual health service
☐ GP
☐ Antenatal care

STI screen (see Tests):

☐ Chlamydia
☐ Gonorrhea
☐ Trichomonas vaginalis
☐ Syphilis
☐ Blood Borne Virus screen (see Tests)

Follow up:

☐ Appt for pap smear

Immunisations (Check whether up to date as per National Immunisation Schedule)

Yearly Influenza	☐ Yes	☐ No	☐ Unsure	
dT or dTpa	☐ Yes	☐ No	☐ Unsure	
Hepatitis B	☐ Started	☐ Completed	☐ No	☐ Unsure
Hepatitis A	☐ Started	☐ Completed	☐ No	☐ Unsure
HPV girls 12–13 yrs	☐ Started	☐ Completed	☐ No	☐ Unsure
Varicella	☐ Started	☐ Completed	☐ No	☐ Unsure
Pneumococcal (for chronic illness)		☐ Yes	☐ No	☐ Unsure

Status:

Immunisations up to date as per National Immunisation Schedule ☐

Actions

☐ Check ACIR for immunisations given up to 7 years of age

☐ Check school or local council records

☐ RN/ GP/ Immunisation clinic

Aboriginal & Torres Strait Islander
FEMALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

EXAMINATION AND OTHER SCREENING

Pulse rate: Pulse rhythm: ☐ Regular ☐ Irregular Blood Pressure reading (18+yrs): Refer to GP if the systolic BP (the upper reading) > 120	Actions ☐ Refer to GP
Height: Weight: BMI: weight (kg)/height (m)^2 Waist circumference measurement (recommended 18 yrs +): If BMI > 25 or > 85th percentile, do brief interventions and make necessary referrals If BMI < 18.5 or < 5th percentile, refer to GP	Actions Brief intervention: ☐ Food & diet ☐ Physical activity Referral: ☐ Dietician ☐ GP ☐ Exercise physiologist Follow up: ☐ Weight management
Dental Do you have any problems with your teeth or gums ☐ Yes ☐ No If yes, describe the problems Have you seen a dentist in the last 12 months ☐ Yes ☐ No If yes, what has this been for Oral Exam Check teeth, gums and inside mouth: ☐ Normal ☐ Abnormal	Actions Brief intervention: ☐ Dental hygiene Referral: ☐ GP ☐ Dental Care
Ears Hearing Do you have any problems hearing ☐ Yes ☐ No If yes, has the client been referred to or seen an audiologist ☐ Yes ☐ No Otoscopy (12-14 yrs): L Ear: R Ear: ☐ Normal ☐ Abnormal	Actions Referral: ☐ GP ☐ Audiologist Brief intervention: ☐ Risk of noise exposure
Eyes Do you have any problems/difficulties with your vision or eyes ☐ Yes ☐ No Do you have any problems with your glasses or contact lenses ☐ Yes ☐ No ☐ N/A Vision check: L eye: R eye: Eye check (for trachoma endemic areas): THINK, THUMB, TORCH L eye: ☐ Trichiasis ☐ Pterygium ☐ Scarring R eye: ☐ Trichiasis ☐ Pterygium ☐ Scarring	Actions Brief intervention: ☐ Trachoma prevention Referral: ☐ GP ☐ Optometrist
Heart examination (HAS TO BE DONE BY A GP) Cardiac murmur ☐ Present ☐ Absent If present, give details	Actions ☐ ECG
Skin Do you have any problems with your skin ☐ Yes ☐ No If yes, describe them Do you have any tattoos or piercings ☐ Yes ☐ No If yes, where this was done Examine skin for following: Normal ☐ Rashes ☐ Eczema ☐ Scabies ☐ Head Lice ☐ Acne ☐ School sores ☐ Bruises ☐ Insect bites ☐ Other ☐	Actions Referral: ☐ GP Brief intervention: ☐ Risks of unsterilised tattoo equipment ☐ BBV screening (see Tests)

Aboriginal & Torres Strait Islander
FEMALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

TESTS (as required)

Symptoms of asthma or COPD OR exposed to tobacco smoke	☐ Spirometry
Age 18+ years, do finger prick test if • Areas where diabetes prevalence ≥ 5% • Had or has any of the following: impaired glucose tolerance, impaired fasting glucose, diabetes in pregnancy, polycystic ovary syndrome, cardiovascular disease, current antipsychotic medication use • AUSDRISK score ≥ 12 Finger prick blood sugar result: ☐ Random ☐ Fasting If random finger prick is above 5.5mmol, do fasting blood sugar	Actions ☐ Refer to GP
Age 18+ years and in areas where diabetes prevalence is < 5%: *AUSDRISK Score: Low (5 or less) ☐ Medium (6-11) ☐ High (12 or more) ☐ (do finger prick test) Finger prick blood sugar result: ☐ Random ☐ Fasting If random finger prick is above 5.5mmol, do fasting blood sugar	
For 18 yrs + AND any of the following risk factors: smoker, diabetes, overweight/obese, elevated BP, family history of chronic kidney disease or cardiovascular disease: Ask if the client has had a Urine ACR or Lipid test in the past 12months ☐ Yes ☐ No If no, these tests should be done. Urine ACR ☐ If ACR is more than 2.5, client needs appointment with GP Serum Lipids ☐	Actions ☐ Refer to GP
Pap Smear: 1st Pap test to be done > 18 yrs of age OR 2 years after first sexual intercourse (whichever is later) Ongoing Pap smears at 2 yearly intervals	Actions ☐ Refer to GP or RN for Pap smear
If h/o unsafe sex, offer STI screening including BBV (see BBV section below for more detailed information)	☐ Chlamydia ☐ Gonorrhoea ☐ Trichomonas ☐ Syphilis
If at risk of BBV and vaccinated against Hepatitis B, do pre-test counselling and order the following tests: HIV serology, Hepatitis B surface antibody, Hepatitis C antibody If at risk of BBV and not vaccinated against Hepatitis B or unsure of vaccination, do pre-test counselling and order the following tests: HIV serology, Hepatitis B surface antigen and surface antibody, Hepatitis C antibody	Actions ☐ Refer to GP BBV screening: ☐ Consent for BBV screening ☐ Pre-test counselling ☐ HIV serology ☐ Hep B surface antibody ☐ Hep B surface antigen ☐ Hep C antibody

Aboriginal & Torres Strait Islander
FEMALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

NOTES

- AUSDRISK. All the items on the AUSDRISK will have been done as part of the health check. Health professionals will therefore only have to do the scoring in order to complete this tool. Electronic health record software programs can make this process easier.

- Risk factors for Blood Borne Viruses = Current or past injecting drug use, Tattoos or piercings not performed professionally, Cultural practices i.e. initiation ceremonies, Prison incarceration, Blood transfusion prior to 1990, Household member with HBV or HCV, Sexual partner with HIV or HBV or HCV

Aboriginal & Torres Strait Islander

FEMALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

SECTION 4: My Staying Deadly HEALTH PLAN

Date: ___/__/__

Things that are going well

Problems identified

Young person's priorities (which things I want to tackle first)

Advice offered by Health Professional	Referrals

This Health Plan has been created by:

_____ _____

(My Name) (Name and position of Health Professional)

Aboriginal & Torres Strait Islander FEMALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

SECTION 4: My Staying Deadly ACTION PLAN

Date: ___/__/__

Top 3 Action Items	What's going to happen	Who's involved	Date for checking on action item	How things are going
1.				☐ Not started ☐ Started ☐ A little way ☐ Half way ☐ Almost there ☐ Stalled ☐ Done
2.				☐ Not started ☐ Started ☐ A little way ☐ Half way ☐ Almost there ☐ Stalled ☐ Done
3.				☐ Not started ☐ Started ☐ A little way ☐ Half way ☐ Almost there ☐ Stalled ☐ Done

If applicable:

☐ I give permission for this Health and Action Plan to be shared with my usual health provider or clinic

Updated on:

Aboriginal & Torres Strait Islander
MALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

SECTION 1: My General Information

Date: ___/__/__

Consent

I agree to having a health check ☐ OR I agree to the young person in my care having a health check ☐

I would like SMS reminders for appointments ☐

Contact Details

Current address: _____

Current phone no: _____

Medicare no.:_____ Reference number: _____ Expiry date: _____

Centrelink concession no.: _____

Parent/Guardian Details (if this applies):

Name: _____Relationship to you: _____

Address (if this is different to yours): _____

Phone number: _____

Usual Health Provider/Service (do not fill in if we are your usual health service)

Name: _____

Address: _____

Contact number/fax: _____

I would like a copy of my health check report to be given to my usual health provider ☐

Youth groups or other Health Services that you attend (if this applies to you):

Do you also get help from a traditional healer e.g. Ngangakari? ☐ Yes ☐ No

Aboriginal & Torres Strait Islander
MALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

Basic Health Information

ALLERGIES:

Are you allergic to anything? ☐ Yes ☐ No ☐ Don't know

If yes, what are you allergic to? _____

HEALTH CONDITIONS OR PROBLEMS

Have you had or do you have any of the following health problems?

☐ Diabetes ☐ Asthma ☐ Heart disease ☐ High blood sugars ☐ Mental health problems

☐ Hormonal problems ☐ Other _____

Have you ever had any operations or had to go to hospital? ☐ Yes ☐ No

If yes, what for? _____

MEDICINES / MEDICATIONS

Are you on any medications? ☐ Yes ☐ No

Please write the name and dose of the medications you are on:

Name	Dose
_____	_____
_____	_____
_____	_____

Are you able to get cheaper medicines through your doctor or clinic? ☐ Yes ☐ No ☐ Don't know

Are you or your family able to pay for your medications? ☐ Yes ☐ No ☐ Sometimes

Do you take your medicines as recommended? ☐ Yes ☐ No ☐ Sometimes

If your answer is no or sometimes, please tell us why:

☐ Keep forgetting ☐ Not important to me ☐ Don't like being on them ☐ Other _____

FAMILY'S HEALTH PROBLEMS

Does anyone in your family have any of the following problems?:

☐ Smoker ☐ Diabetes or high blood sugar ☐ Heart disease ☐ Kidney disease

☐ Mental illness ☐ Other _____

Health Professional Actions

☐ Allergy alert ☐ Refer to GP if there are any existing health conditions

☐ Test BGL (if 18+ AND any of these risk factors: heart disease, high blood sugars, hormonal problems, antipsychotic medication use)

☐ Test Serum lipids & Urine ACR (if 18+ AND has diabetes or positive FH of CKD or premature CVD)

Aboriginal & Torres Strait Islander
MALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

SECTION 2: Staying Deadly Questionnaire

Date: ___/__/__

People that keep me strong: (family, friends, elders, community members)

The person whom I trust ,to give advice about my treatment or health concerns is: _____

Things that are helping to keep me strong: (tick all the boxes that apply to you and circle the 3 biggest strengths)

☐	Culture, language, heritage, spiritual belief	☐	Friends or supportive person to yarn with
☐	Going to country	☐	Having a safe place to go to
☐	Religion	☐	Art and craft
☐	Family and/or relationship	☐	Dance
☐	Health centre, health worker, doctor	☐	Music
☐	Traditional healer (e.g. Ngangakari)	☐	Hunting and fishing
☐	Good diet	☐	Positive thinking
☐	Sport / Exercise	☐	Making my own choices
☐	School / Learning new things	☐	Sleeping well / A good nights sleep
☐	Work / Community involvement	☐	Good Health
		☐	Other _____

You can use this space to write more about things that keep you strong:

Some worries I have are: (tick all the boxes that apply to you and circle your 3 biggest worries)

☐	Cultural or spiritual worries	☐	Losing family / friends
☐	Family and relationship worries	☐	Racism
☐	Where and how I am living	☐	Feeling alone / Feeling left out – not mixing much with others
☐	Ongoing health issues	☐	Feeling sad inside, no interest in doing things
☐	Hearing trouble	☐	Feeling anxious or nervous or jumpy
☐	Not eating well	☐	Sleep worry / Sleeping problems
☐	Not enough exercise	☐	Problem with my behaviour
☐	Missing school or trouble at school	☐	Not caring for self: trouble shopping, cooking, cleaning
☐	Getting picked on or feeling pressured to do things	☐	Mixed up thoughts, paranoid thinking or silly thoughts
☐	Nothing to do / Bored	☐	Hearing voices or seeing things
☐	Not working or trouble at work	☐	Self harm behaviour or thoughts of suicide
☐	Money worries	☐	Too much energy, cant slow down, thinking too fast
☐	Marijuana, alcohol, cigarettes, other drugs	☐	How I look / My appearance
☐	Gambling worries	☐	Not being able to make my own choices
☐	Violence / Harm towards me	☐	Language barrier
☐	Difficulty reading and writing	☐	Other worry_____

You can use this space to write more about things that worry you:

Aboriginal & Torres Strait Islander YOUTH K 5 plus ONE (12-24 years)

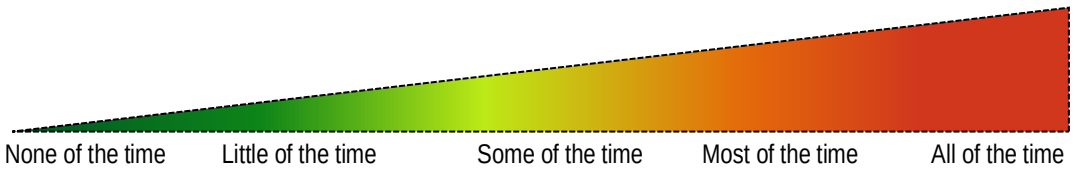
Name:	Other Names:	DOB: ___/__/__

DATE OF ASSESSMENT: ___/___/___

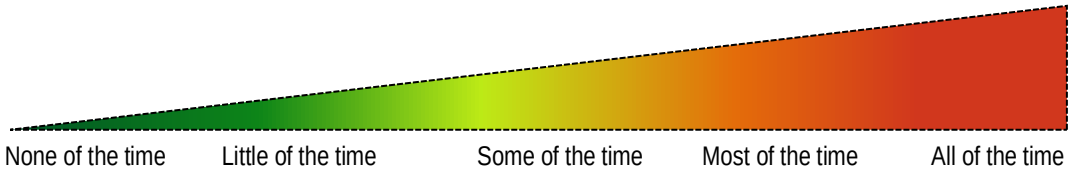
(Put a circle around the answer to each question)

In the last four weeks how often did you feel?

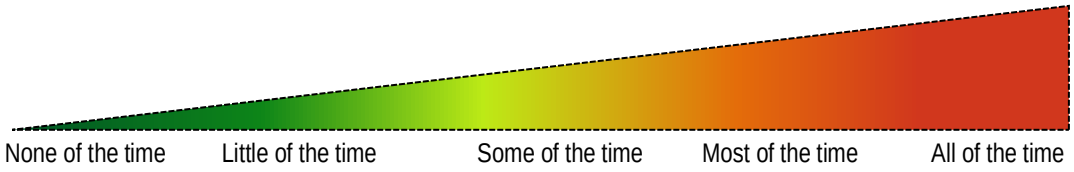
Nervous or Anxious?



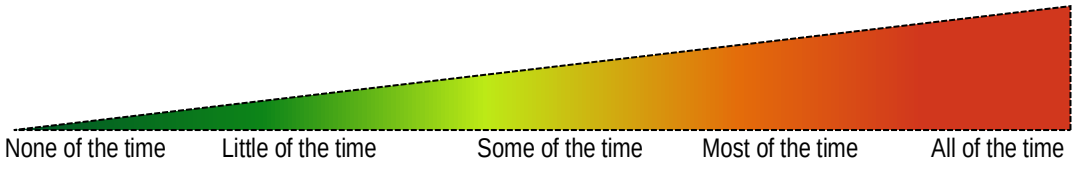
Hopeless (without hope)?



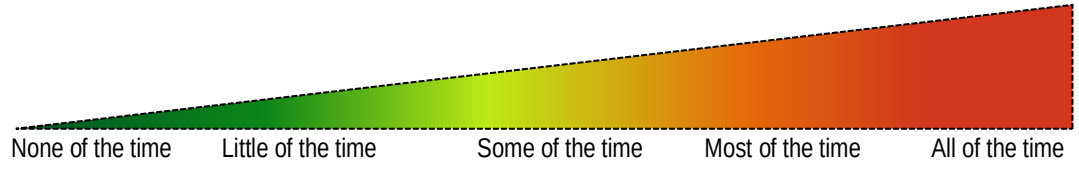
Restless or Jumpy?



Everything was an effort?



So sad that nothing could cheer you up?



SCORES	1	2	3	4	5

Would you like help with this?

☐ Yes ☐ Yes, but not today ☐ No

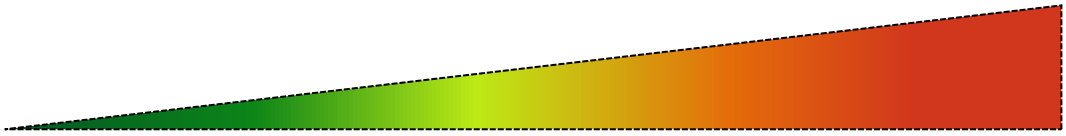
Aboriginal & Torres Strait Islander YOUTH K 5 plus ONE (12-24 years)

Name:	Other Names:	DOB: ___/__/__

DATE OF ASSESSMENT: ___/___/___

THIS SECTION TO BE FILLED IN BY HEALTH PROFESSIONAL ONLY

K 5 SCORE = _____



None of the time	Little of the time	Some of the time	Most of the time	All of the time
1	2	3	4	5

Circle the relevant section:

Total Score	Risk of Depression or Anxiety	Ask about Self Harm/ Suicidal ideas	Follow Up
5 – 11	No risk or Low risk	May be necessary if other psychosocial risk factors are present	May be necessary
12 - 25	Medium to High Risk	YES	Necessary

Aboriginal & Torres Strait Islander
MALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

SECTION 3: Assessment by Health Professional

Date: ___/__/__

Confidentiality discussed ☐

CULTURAL SOCIAL EMOTIONAL WELLBEING ASSESSMENT (modified HEEADSSS)

(Begin with the answers on the Stay Deadly questionnaire. It is good to use open ended questions and probe or clarify as needed. You can refer to the question guide, but please do not ask every single question in it)

General (Begin by asking if the young person has any concerns. Then ask about the person's connection to culture, country, and language. Also ask about exposure to racism and prejudice.)	
	Actions ☐ Refer to Youth group ☐ Refer to Community group ☐ Refer to GP ☐ Other _____

Home (Ask about the home situation, family life, relationships and stability. We also want to identify any overcrowding)	
	Actions ☐ Refer to GP ☐ Housing assistance needed ☐ Refer to counsellor/ wellbeing worker ☐ Other _____

Learning/Work (Check how the young person is going at school/work and relationships with teachers/peers/workmates; whether there have been changes recently; whether there is bullying etc)	
	Actions Referral: ☐ Aboriginal education officer/ youth counsellor/ school counsellor ☐ GP

Aboriginal & Torres Strait Islander
MALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

Eating/Exercise (Ask about the young person's food and eating habits, including bush tucker; whether they are getting enough to eat. Also ask about physical activity including traditional dance)

Assessment:

Eating enough fruit ☐ Yes ☐ No Eating enough veggies ☐ Yes ☐ No

Drinking enough water ☐ Yes ☐ No Having dairy ☐ Yes ☐ No

Type of Physical Activity:

For how long:

How often:

Issues:

☐ Not having enough to eat ☐ Too many sugary foods ☐ High fat foods

☐ Low physical activity ☐ Possible eating disorder

☐ Other

Actions

Brief intervention:

☐ Food & diet

☐ Physical activity

Referral:

☐ GP

☐ Financial counselling/ support

Follow up:

☐ Dietary assessment

Hobbies/Interests/Friendships (Ask about the young person's hobbies and interests and relationships with other young people, how they are socialising, and whether they are engaging in any high risk behaviours. Ask about use of seat belts helmets, sunglasses, sun screen etc. Ask about gambling, including online gambling)

High risk behaviours ☐ Yes ☐ No

Gambling ☐ Yes ☐ No

Actions

Referral:

☐ GP

☐ Counselling

☐ Other _____

☐ Gambling assistance

Brief intervention:

☐ Safety advice

Substance Use including cigarettes (Ask about use, what type, how much and how often. If they are taking drugs or alcohol, find out if this has become a problem. Also find out if the people they live with smoke, drink or use drugs)

Smoking tobacco: ☐ No ☐ Occasionally ☐ Yes (How many per day:)

Exposed to other people smoking: ☐ No ☐ Yes

If smoker or exposed to smoke, ask about symptoms of:

Asthma (shortness of breath, chest tightness, wheeze, cough) ☐ Yes ☐ No

COPD (shortness of breath, chronic cough/sputum production, wheeze) ☐ Yes ☐ No

Smoking yarndi/ marijuana ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No How much: How often:

Other drugs ☐ Yes ☐ No

If yes, is it ☐ Eating ☐ Sniffing ☐ Injecting ☐ Smoking ☐ Other

When/ Where/ Who with: How much: How often:

If injecting, sharing needles ☐ Yes ☐ No

Actions

Brief intervention:

☐ Smoking/passive smoking/ alcohol/ drugs *(circle)*

Referral:

☐ Drug & alcohol service

☐ GP

☐ Needle exchange service

☐ Quit smoking program/ service

Follow up:

☐ Fagerstrom test for nicotine dependence

☐ Spirometry (symptoms of asthma/ COPD)

Aboriginal & Torres Strait Islander
MALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

Mental Health (Refer to the K5 plus one filled out by the young person. If the score indicates moderate to high risk, must ask about self-harm or suicidal thoughts. If no-low risk, consider asking about self harm if other risks present)

Enter the K5 score:

Is this score ☐ No - Low risk ☐ Moderate – High risk

Is there risk of self harm or suicide ☐ Yes ☐ No

Enjoying things as usual ☐ Yes…☐ No

Sleep Normal ☐ Yes…☐ No Appetite Normal ☐ Yes…☐ No

Affected by traumatic experience ☐ Yes…☐ No

Actions

Referral:

☐ Mental health service
☐ GP
☐ Counsellor
☐ Self-harm prevention/intervention
☐ Hospital

Sexual Health (Ask about sexual activity, contraception/protection, safe sex practices, sexual orientation, pressure to have sex, STIs)

Has been sexually active ☐ Yes ☐ No Age first started:

(If yes, offer STI testing)

Using protection (condoms) ☐ Yes, all the time ☐ Yes, sometimes ☐ No ☐ N/A

Partner on contraception ☐ Yes ☐ No

Has anyone ever taken advantage of you or used you? Have you ever felt uncomfortable or pressured about having sexual intercourse ☐ Yes ☐ No

Are you attracted to ☐ Boys/males ☐ Girls/ females ☐ Both ☐ Unsure

Do you feel comfortable with your sexuality ☐ Yes ☐ No ☐ Unsure

Have you had an STI (eg Gonorrhoea, Chlamydia) ☐ Yes ☐ No ☐ Unsure ☐ N/A

Was the result ☐ Normal ☐ Had to go for more check ups ☐ Had treatment

Consents to STI test: ☐

Actions

Brief intervention:

☐ Safe sex & condom use

Referral:

☐ Sexual health service
☐ GP

STI test (see Tests):

☐ Chlamydia
☐ Gonorrhea
☐ Syphilis
☐ Blood Borne Virus screen (see Tests)

Immunisations (Check whether up to date as per National Immunisation Schedule)

Yearly Influenza	☐ Yes	☐ No	☐ Unsure	
dT or dTpa	☐ Yes	☐ No	☐ Unsure	
Hepatitis B	☐ Started	☐ Completed	☐ No	☐ Unsure
Hepatitis A	☐ Started	☐ Completed	☐ No	☐ Unsure
HPV boys 12–13 yrs	☐ Started	☐ Completed	☐ No	☐ Unsure
Varicella	☐ Started	☐ Completed	☐ No	☐ Unsure
Pneumococcal (for chronic illness)	☐ Yes	☐ No	☐ Unsure	

Status:

Immunisations up to date as per National Immunisation Schedule ☐

Actions

☐ Check ACIR for immunisations given up to 7 years of age

☐ Check school or local council records

☐ RN/ GP/ Immunisation clinic

Aboriginal & Torres Strait Islander
MALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

EXAMINATION AND OTHER SCREENING

Pulse rate: Pulse rhythm: ☐ Regular ☐ Irregular Blood Pressure reading (18+yrs): Refer to GP if the systolic BP (the upper reading) > 120	Actions ☐ Refer to GP
Height: Weight: BMI: weight (kg)/height (m)^2 Waist circumference measurement (recommended 18 yrs +): If BMI > 25 or > 85th percentile, do brief interventions and make necessary referrals If BMI < 18.5 or < 5th percentile, refer to GP	Actions Brief intervention: ☐ Food & diet ☐ Physical activity Referral: ☐ Dietician ☐ GP ☐ Exercise physiologist Follow up: ☐ Weight management
Dental Do you have any problems with your teeth or gums ☐ Yes ☐ No If yes, describe the problems Have you seen a dentist in the last 12 months ☐ Yes ☐ No If yes, what has this been for Oral Exam Check teeth, gums and inside mouth: ☐ Normal ☐ Abnormal	Actions Brief intervention: ☐ Dental hygiene Referral: ☐ GP ☐ Dental Care
Ears Hearing Do you have any problems hearing ☐ Yes ☐ No If yes, has the client been referred to or seen an audiologist ☐ Yes ☐ No Otoscopy (12-14 yrs): L Ear: R Ear: ☐ Normal ☐ Abnormal	Actions Referral: ☐ GP ☐ Audiologist Brief intervention: ☐ Risk of noise exposure
Eyes Do you have any problems/difficulties with your vision or eyes ☐ Yes ☐ No Do you have any problems with your glasses or contact lenses ☐ Yes ☐ No ☐ N/A Vision check: L eye: R eye: Eye check (for trachoma endemic areas): THINK, THUMB, TORCH L eye: ☐ Trichiasis ☐ Pterygium ☐ Scarring R eye: ☐ Trichiasis ☐ Pterygium ☐ Scarring	Actions Brief intervention: ☐ Trachoma prevention Referral: ☐ GP ☐ Optometrist
Heart examination (HAS TO BE DONE BY A GP) Cardiac murmur ☐ Present ☐ Absent If present, give details	Actions ☐ ECG
Skin Do you have any problems with your skin ☐ Yes ☐ No If yes, describe them Do you have any tattoos or piercings ☐ Yes ☐ No If yes, where this was done Examine skin for following: Normal ☐ Rashes ☐ Eczema ☐ Scabies ☐ Head Lice ☐ Acne ☐ School sores ☐ Bruises ☐ Insect bites ☐ Other ☐	Actions Referral: ☐ GP Brief intervention: ☐ Risks of unsterilised tattoo equipment ☐ BBV screening (see Tests)

Aboriginal & Torres Strait Islander
MALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

TESTS (as required)

Symptoms of asthma or COPD OR exposed to tobacco smoke	☐ Spirometry
Age 18+ years, do finger prick test if • Areas where diabetes prevalence ≥ 5% • Had or has any of the following: impaired glucose tolerance, impaired fasting glucose, diabetes in pregnancy, polycystic ovary syndrome, cardiovascular disease, current antipsychotic medication use • AUSDRISK score ≥ 12 Finger prick blood sugar result: ☐ Random ☐ Fasting If random finger prick is above 5.5mmol, do fasting blood sugar	Actions ☐ Refer to GP
Age 18+ years and in areas where diabetes prevalence is < 5%: *AUSDRISK Score: Low (5 or less) ☐ Medium (6-11) ☐ High (12 or more) ☐ (do finger prick test) Finger prick blood sugar result: ☐ Random ☐ Fasting If random finger prick is above 5.5mmol, do fasting blood sugar	
For 18 yrs + AND any of the following risk factors: smoker, diabetes, overweight/obese, elevated BP, family history of chronic kidney disease or cardiovascular disease: Ask if the client has had a Urine ACR or Lipid test in the past 12months ☐ Yes ☐ No If no, these tests should be done. Urine ACR ☐ If ACR is more than 2.5, client needs appointment with GP Serum Lipids ☐	Actions ☐ Refer to GP
If h/o unsafe sex, offer STI screening including BBV (see BBV section below for more detailed information)	☐ Chlamydia ☐ Gonorrhoea ☐ Trichomonas ☐ Syphilis
If at risk of BBV and vaccinated against Hepatitis B, do pre-test counselling and order the following tests: HIV serology, Hepatitis B surface antibody, Hepatitis C antibody If at risk of BBV and not vaccinated against Hepatitis B or unsure of vaccination, do pre-test counselling and order the following tests: HIV serology, Hepatitis B surface antigen and surface antibody, Hepatitis C antibody	Actions ☐ Refer to GP BBV screening: ☐ Consent for BBV screening ☐ Pre-test counselling ☐ HIV serology ☐ Hep B surface antibody ☐ Hep B surface antigen ☐ Hep C antibody

Aboriginal & Torres Strait Islander
MALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

NOTES

- AUSDRISK. All the items on the AUSDRISK will have been done as part of the health check. Health professionals will therefore only have to do the scoring in order to complete this tool. Electronic health record software programs can make this process easier.

- Risk factors for Blood Borne Viruses = Current or past injecting drug use, Tattoos or piercings not performed professionally, Cultural practices i.e. initiation ceremonies, Prison incarceration, Blood transfusion prior to 1990, Household member with HBV or HCV, Sexual partner with HIV or HBV or HCV

Aboriginal & Torres Strait Islander

MALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

SECTION 4: My Staying Deadly HEALTH PLAN

Date: ___/__/__

Things that are going well

Problems identified

Young person's priorities (which things I want to tackle first)

Advice offered by Health Professional	Referrals

This Health Plan has been created by:

_____ _____

(My Name) (Name and position of Health Professional)

Aboriginal & Torres Strait Islander

MALE YOUTH HEALTH CHECK (12-24 years)

Name:	Other Names:	DOB: ___/__/__

SECTION 4: My Staying Deadly HEALTH PLAN

Date: ___/__/__

Top 3 Action Items	What's going to happen	Who's involved	Date for checking on action item	How things are going
4.				☐ Not started ☐ Started ☐ A little way ☐ Half way ☐ Almost there ☐ Stalled ☐ Done
5.				☐ Not started ☐ Started ☐ A little way ☐ Half way ☐ Almost there ☐ Stalled ☐ Done
6.				☐ Not started ☐ Started ☐ A little way ☐ Half way ☐ Almost there ☐ Stalled ☐ Done

If applicable:

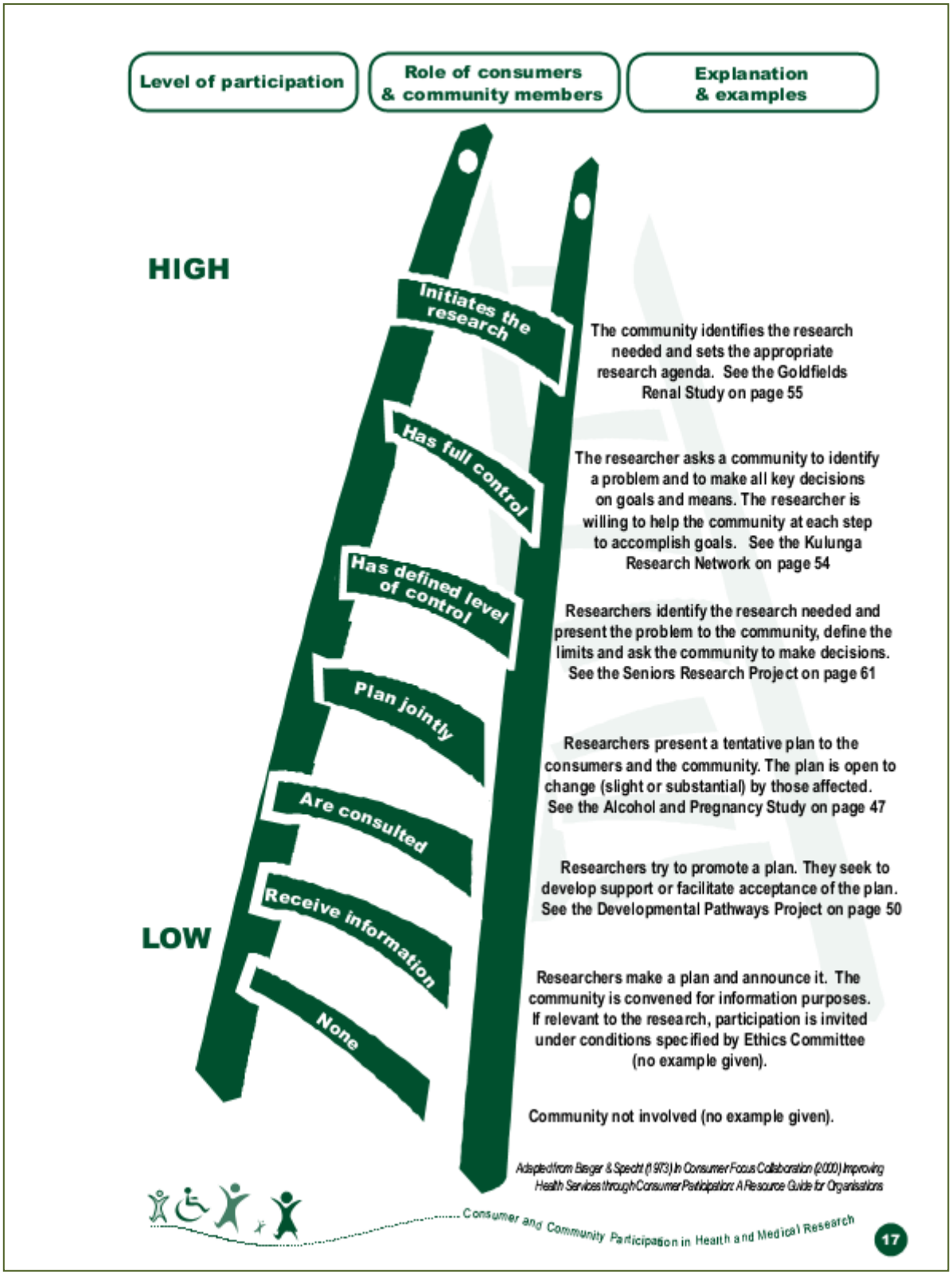
☐ I give permission for this Health and Action Plan to be shared with my usual health provider or clinic

Updated on:

Appendix 4: Y Health Project Conference Presentations and Workshops

Name of Conference	National Conference on Continuous Quality Improvement in Aboriginal & Torres Strait Islander Primary Health Care	Population Health Congress	National Social Inclusion & Complex Needs Conference	Primary Health Care Research Conference
Host Organisation	Lowitja Institute	PHAA, Australian Health Promotion Association, Australasian Faculty of Public Health Medicine, Australasian Epidemiological Association	Public Health Association of Australia (PHAA)	Primary Health Care Research & Information Service
When & Where	15th May 2012, Alice Springs	12th Sept 2012, Adelaide	15th April 2013, Canberra	10th July 2013, Sydney
Presentation/ Workshop Title	More than just data: challenges in quality primary health care for Indigenous youth	'Y Health – Staying Deadly' – Youth focused Community-Based Action Research in an Aboriginal Primary Care setting	Aboriginal Youth no longer forgotten – the "Y Health – Staying Deadly" Project	Honouring self-determination - taking control of the Aboriginal research platform
Author	Stefanie Puszyka	Dr. Annapurna Nori	Dr. Annapurna Nori	Dr. Annapurna Nori
Co-authors	Dr. Annapurna Nori, Rebecca Piovesan	Tabitha Lean, Dr. Ngiare Brown, Dr. Smita Shah, Mark McMillan, Jo Newham, Rebecca Piovesan	Ngiare Brown, Rebecca Piovesan , Joanne O'Connor, Smita Shah, Mark McMillan, Jo Newham	Damian Rigney, Amy Graham, Ngiare Brown, Smita Shah, Rebecca Piovesan, Joanne O'Connor, Mark McMillan, Jo Newham

Appendix 5: Further resources



Ladder of consumer and community participation in research (from McKenzie & Hanley "Consumer and Community Participation in Health and Medical Research: A practical guide for health and medical research organisations", 2007)

Health check templates reviewed

Source	Template Reviewed
AIMhi, Menzies' School of Health Research	Stay Strong Plan
Counties Manukau AIMHI Healthy Community Schools program, NZ	AIMHI Assessment
Ngartuitya Parenting Service, Relationships Australia, SA	Strong Family Action Plan
	Strong Family Interview
NSW Centre for the Advancement of Adolescent Health	Adolescent Health Check
NT Health	Youth Health Check 12-25 years
Pormpuraaw Primary Health Care Centre, Cape Yorke	Young Person's Check
The Second Story Youth Health Service, SA Health	Advanced HEEADSSS Assessment
	Adolescent Health Assessment
Royal Australian College of General Practice	Child Health Check 9-14 years
	Female Adult Health Check 15-19 years
	Male Adult Health Check 15-19 years
	Female Adult Health Check 20-54 years
	Male Adult Health Check 20-54 years
Watto Purrunna Aboriginal Health Service, SA Health	Child Health Check 5-14 years
	Male Adult Health Check 15-54 years
	Female Adult Health Check 15-54 years

HRN

Stay Strong Plan

DATE:...../...../.....

PRINCIPAL NAME (AKA)	OTHER NAMES	DOB:...../...../.....

People that help to keep me strong: (family, friends, elders, carers)

I trust this person to give advice about my treatment_____

Things that help to keep me strong: (spiritual, cultural, physical, family, social, mental and emotional) **(Tick or circle)**

☐	Culture, language, heritage, spiritual belief	☐	Work
☐	Art and craft	☐	Music
☐	Dance	☐	Teaching children
☐	Going to country	☐	Hunting and fishing
☐	Health centre, health worker, doctor,	☐	Knowing about illness and treatment
☐	Medication	☐	Support
☐	Good diet	☐	Family
☐	Exerise	☐	Positive thinking
☐	Other_____	☐	Other_____

Some of the worries I have are: **(Tick or circle)**

☐	Culture or spiritual worries	☐	Family or relationship worries
☐	Not many activites eg music, hunting, fishing, art and craft	☐	Feeling alone – not mixing much with others
☐	Not enough exercising	☐	Not working or trouble at work
☐	Not taking medication or treatment	☐	Gambling worries
☐	Physical Illness _____	☐	Not knowing enough about illness and treatment
☐	Hearing trouble	☐	Feeling anxious or nervous or jumpy
☐	Not eating well	☐	Violence or other problem behaviour
☐	Memory worry	☐	Not caring for self: trouble shopping, cooking, cleaning
☐	Sleep worry	☐	Feeling sad inside, no interest in doing things
☐	Marijuana, alcohol, cigarettes, other drugs	☐	Mixed up thoughts, paranoid thinking, silly thoughts
☐	Side effects of medicine: sleepiness, tight muscles, other	☐	Hearing voices or seeing things
☐	Too much energy, can't slow down, thinking too fast	☐	Self harm behaviour or thoughts of suicide
☐	Other worry_____	☐	Other worry_____

Detail of worries / current issues

Past worries: relevant family, medical, psychiatric and forensic history (trouble with the police or the law)

Early warning signs of me getting sick are:

1.	3.
2.	4.

If I know I am getting sick I will do these things to get help quickly:

1.
2.
3.

Progress toward previous goals: Previous care plan completed? ☐ ___ Previous care plan reviewed ? ☐ ___

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HRN

Stay Strong Plan

DATE:...../...../.....

Goals I have today for changing worries – step by step:	
Goals are things that we want to do differently. The steps to the goal help us to check how we are going. They should be do-able and measurable. Follow up with review and feedback. **Goal:** _____ Step 1. Step 2. Step 3. What would be good about making this change:	Think about: What will help? And who? And what has helped before? Change is your own choice. Everyone can make changes. Small steps can lead to big changes. **Goal:** _____ Step 1. Step 2. Step 3. What would be good about making this change:

Treatment goals for other Problems:		
Other Problem (Diagnosis)	**Goal and steps**	**Who will help**

Other treatments that I am trying :	**Who will help:**
1. Compliance strategies (Webster pack, dosette, depot) **2. Life style changes (substance use, diet, exercise, smoking, time-out, go bush, job training)** **3. Cultural or spiritual activity or treatment (going to country, healer, church)** **4. Other services (counselling, other treatments, treatment for physical illness, investigations)**	

5. Medication plan (Dose, Frequency and route): see prescription for details

I sometimes get worries that I call _____

The diagnosis today is _____

Signed (Client)_____Signed (Practitioner)_____

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The following measures can be useful well being screening tools. The first is an abbreviated version of the Kessler K-10 scale

In the last four weeks how often did you feel?

Nervous or anxious?

None of the time Little of the time Some of the time Most of the time All of the time

Hopeless (without hope)?

None of the time Little of the time Some of the time Most of the time All of the time

Restless or jumpy?

None of the time Little of the time Some of the time Most of the time All of the time

Everything was an effort?

None of the time Little of the time Some of the time Most of the time All of the time

So sad nothing could cheer you up?

None of the time Little of the time Some of the time Most of the time All of the time

Scores	1	2	3	4	5

Total Score ☐

Risk of anxiety or depressive disorder	
5 – 11	Low or no risk
12 – 25	Medium to High risk

Follow up indicated ☐

Follow up arranged ☐

(5 item Kessler K10 well being scale)

Alternative three item outcome measure and screening tool for depression

1. During the past month have you often been bothered by feeling down, depressed or hopeless?

   Yes ☐ No ☐

2. During the past month, have you often been bothered by having little interest or pleasure in doing things?

   Yes ☐ No ☐

3. Is this something with which you would like help?

   Yes ☐ Yes, but not today ☐ No ☐

If client scores yes to either 1 or 2 AND yes to 3 follow up for possible depression is indicated
(Whooley version of PHQ 2) This care plan meets requirements for Medicare items 2710, 2712, 2713 and Team Care arrangements

HRN

Stay Strong Plan

DATE...../...../.....

This page for practitioner use only

Mental state examination	
Appearance (Dishevelled? Well kempt?)	**Affect** (Happy? Sad?)
Behaviour (Agitated? Relaxed?)	**Perception** (Voices? Spirits?)
Conversation (Sensible? Confused?)	**Cogntion** (Attention? Memory?)

Risk Assessment **1 = no apparent risk** **2 = low risk** **3 = some risk** **4 = big risk** **5 = very big risk**

Self Harm or suicide risk	Harm to Others	Vulnerability – cannot look after self
1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Circle the number that matches your assessment of level of risk. Risk issues addressed by following actions:

Outcome measures scores				
Kessler 10 or 5	HoNOS	LSP	Other	Other

Tick or circle other care planning interventions

- ☐ Dosette or Webster pack offered today
- ☐ Carer psycho education given today
- ☐ Adult Health Check in last 12 months (BP, Weight, urine check)
- ☐ Liver/Renal/Thyroid/BP/Weight/Lipid check in last 6 -12 months
- ☐ Mood stabiliser check in last 3 months or circle 'not applicable'
- ☐ Client psycho education / illness information given today
- ☐ Referral for counselling or further support organised today

OR

- ☐ Adult Health Check arranged today
- ☐ New tests ordered today
- ☐ New tests ordered today

Mental Health Care Team	Name
Carer	
Aboriginal Mental Health Worker/Health Worker	
General Practitioner	
Registered Nurse	
Allied Health	
Traditional Healer	
Registered Psychiatric Nurse	

Care Plan completed at Hospital ☐ Health Centre ☐ _____Recorded on recall list ☐

Date of next review_____...../...../.....

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