'YOU GET PEOPLE TO TALK TO AND THAT…'
A summary report on the evaluation of three youth health projects in Glasgow
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Introduction and context

Over the past few years in Greater Glasgow NHS Board area there have been a variety of attempts to address young people's need for health service access. This work has addressed issues relating to access to mainstream services and has included the development of discreet youth health services.

This report is concerned with three youth health projects in Glasgow; two of which are funded by the Primary Care Trust[1] whilst the other operates within the voluntary sector. The main question examined, and the issue that under-pins these projects, relates to how we can provide the most effective and comprehensive health care system for young people in Glasgow.

In the long-term the projects aim to change the behaviour of some of the most vulnerable young people in the city and to get health professionals to adopt a more youth friendly approach towards young service users.

Although the projects are organised differently, all combine information and educational functions with a clinical service and all have strong links with a range of partner agencies. The significant differences relate to the ways in which information and clinical functions are delivered.

Brief description of projects

Health Spot is a voluntary sector-led youth health project operating in the Castlemilk area of Glasgow.

YHS and H4U are both projects developed within the primary care structures (currently Local Health Care Co-operatives) as 'priority projects'.

YHS focuses its work on the Maryhill area of Glasgow whilst H4U has its focus on the Eastern LHCC area including the East End of Glasgow and Greater Easterhouse.

	Health Spot	YHS	H4U
Main source of funding	Voluntary Sector	Primary Care Trust	Primary Care Trust
Operating since	1998	2003	2002
Sessions per week	3	1	5
Number of sites	3	1	5
Number of full-time staff	2	0	3
Number of part-time staff	1	3	1
Number of sessional staff	7	7	12
Approx contacts pa	2,165	817	2,146
Average contacts per month	180	68	178
Average age	Unknown*	14.2	13.3
% males	54	49	36
Other activities	Education, training and research functions	Training of health workers	Health text service
Approx annual budget	£102k	£66k	£86k

*Unlike the other two projects, Health Spot collects in age bands

Research Aims

o To evaluate the effectiveness of the priority youth health projects within Maryhill/Woodside and Eastern LHCCs and Castlemilk Youth Health Spot in delivering services for young people in their areas.

o To reflect on and learn from the experiences of the three projects with a view to informing the future direction of youth health service provision in Greater Glasgow.

Research Methods

The study used the following approaches:

- Desk-top research looking at secondary data within each of the projects
- Interviews with staff (n = 25)
- One focus group at each project mainly involving management committee members
- Interviews with young users of the projects (n =21)

The evaluation was restricted by a decision by the Greater Glasgow NHS Ethics Committee to prohibit interviews with under-16 year-olds unless they provided written parental consent. Given that the majority of users were under-16 and many did not tell their parents about their involvement, this placed limits on the evaluation.

Results

Main themes emerging

- From the perspective of the service providers, the three priority issues in youth health to be addressed are sexual health, mental health and addictions. Each of these areas are inter-linked and are most effectively addressed by a general youth health service operating within the framework of a social model of health.

Young People's Involvement

- Young people participated in the youth health service for a variety of reasons with initial motives being linked more strongly to curiosity and sociability than to pre-identified health needs. Service users tended to be 'clubbable' and to be part of a peer group who also made use of the service.

'My friend was telling me like, "they're dead friendly", and I'm like that right, "you're just saying that to get me in there". And she was like, "no, honestly just go along, it's a drop-in service and you can pop your head in and pop back out". So, sort of I did do that, pop my head in and pop back out and then I knew somebody so that was good as well, that was a good start because they were like, "oh its really good to see you and is everything ok" and it was good that way'. (Female, Project 1)

Developing Trust

- Young women often took a considerable period of time (several months) building up trust before they were willing to discuss a health concern. The projects allowed them the space to build up relationships prior to presenting their concern. The workers were aware of the time needed to develop trust and understood young people's concerns.

'I waited a couple of months to talk to them about something, but then after that you just get used to them'. (Female, Project 3)

Confidentiality

- The issue of confidentiality is central to the need for a youth health service. Young people are concerned about GPs passing on information to parents and even of being seen in a doctor's waiting room by relatives or neighbours.

'If I was to go to the health centre that was in Ballieston there might be people there that I know or that my mum knows or something so I wouldn't really have wanted to go in …this is somewhere for young people to come and it's only like your pals who know if you're going in to see the nurse or if you're asking them a question, so it's only them that know'. (Female, Project 3).

Youth Work versus Clinic?

- There was something of a tension between the provision of a youth work and a clinical facility. These were manifest in different types of acceptable behaviour, difficulties relating to confidentiality and in the need to prevent a strong 'ownership' of the project developing that might deter new service users.

'I think the service for a long while didn't know whether it was a youth service or a health service and we had difficulties over that. We're here to deal with young people and with that comes a certain level of behaviour, not that you condone certain behaviour but you expect it with young people. There is in the health service a zero tolerance of that kind of stuff, so for a long time there was a difficulty in reconciling that. We didn't know whether we were a youth service or a health service and it took some staff meetings to work through that. I still don't know whether that has been entirely resolved.' (Staff Member Project 2)

Inclusiveness

- Some groups of young people were clearly being missed by the projects. Ethnic minorities, asylum seekers and disabled young people tended not to participate and we suspect that the less clubbable, more socially isolated, young people who may have to deal with serious health related issues are not benefiting.

'We have no ethnic minorities here, none at all, not a sausage'. (Project 3)

'We have problems accessing asylum seekers. There are thirteen different languages spoken in the community and we don't have the resources for translation'. (Project 1)

Constraints on services

- Two of the projects were operating on relatively tight budgets and uncertainty over funding inhibited long-term planning, with staff being forced to spend time pursuing additional funds that could have been better spent on project management. In the three projects, physical spaces were not ideally suited to purpose and funding for additional sessions was required.

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Recommendations

1. This evaluation is a first stage in a process that should see dedicated youth health services made available to greater numbers of young people in Glasgow. Our first recommendation concerns the urgent need to develop and expand youth health services in Glasgow.

2. The three projects examined are all in their infancy and are experimenting with novel approaches to youth health provision. Inevitably experimentation will lead to some failed initiatives but a process of learning through experience and learning how to tailor services to local needs will be beneficial in the long-term. It is in this context that we advise against trying to impose uniform modes of delivery and recommend that new projects are given the scope to innovate.

3. The projects evaluated are all providing an excellent service on budgets that impose tight constraints on the sorts of service they are able to provide. There is no evidence of wasted resources but there is a keen sense that they are being prevented from developing work with under-represented groups due to the lack of funds. We recommend that a thorough review of finance is conducted with the aim of providing more stability and scope for expansion.

4. An effective youth health service must have a localised delivery. Young people will be reluctant to move far from their own neighbourhood to access a service.

5. It is important to deliver youth health services in premises that are fit for purpose. In this context we recommend that, where practical, information services and issue based youth work are not delivered on the same premises as the clinical service. While it is desirable to have youth centred facilities made available in health centres, when one physical space is used exclusively for the delivery of clinical and information services, confidentiality can be jeopardised and some young people (particularly those who do not belong to local peer groups) may be reluctant to access the service.

6. It is essential that provision is tailored to the needs of groups that are currently under-represented on existing projects, such as asylum seekers, ethnic minorities and those with disabilities.

7. The leaflets produced by the projects clearly provided relevant information in an accessible format. A strategy should be developed for making these leaflets widely available to all young people within the city.

8. Youth workers and clinical staff working on youth health projects have complementary skills, yet it is clear that lines of communication are not as open as they might be. We recommend setting up a small working party that has a remit to explore difficulties and suggest ways in which these may be overcome.

9. For the purposes of further evaluations, it is important that statistics relating to patterns of use are retained in a uniform manner. We also recommend that discussion with the Ethics Committee are held with the aim of ensuring that future research is able to solicit the views of under-16 year-olds.

10. Finally, we recommend building a process of evaluation into the 'rolled out' provision. It is important that each project has the opportunity to learn from others and that the Primary Care Division remains confident that its youth health strategy is effective and provides value for money.

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