STRATEGIES FOR REDUCING BARRIERS TO REPRODUCTIVE HEALTH SERVICES FOR DIVERSE YOUTH

Summary of Site Monitoring
Key Findings

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Between November 1997 and early January 1998, staff conducted site visits to nine (9) reproductive health provider agencies. Four sites from Baltimore, MD, five sites in Houston, TX were selected. Sites reflected four types of clinic delivery settings: Community-based facility or clinic (e.g., private clinic or local health department), school-based or school-linked clinic, University/Hospital-based clinic, and managed care provider agency. The fifth site in Houston was a hybrid provider agency, school/community facility.

Agencies were assessed according four service delivery content areas -- Administrative/ Organizational Philosophy, Staffing Patterns, Staff Responsibility and Training; Program Content and Service Delivery Strategies, and Community Linkages and Service Delivery Outreach. Agencies were also assessed for their capacity to serve adolescents and diverse youth (developmental and cultural competency) according to the preliminary competency framework described in the previous section. Information regarding the four content areas and developmental/cultural competency was determined via interviews, observation and review of agency documents and educational materials.

In the following pages, we highlight key findings from data gathered during the site-monitoring phase of the project. Where appropriate, we note whether differences exist across content areas by provider type. However, we caution that since site visits were conducted among agencies only in two geographic regions, agency differences may also reflect regional differences in the nature of service delivery. Thus, differences across types of providers should be interpreted with caution.

Key Findings -- Summary Points

Administrative/Organizational Philosophy

Mission Statement & Assessment

- Six (6) out of nine (9) sites serve only adolescents and exist for the sole purpose of serving adolescents. The remaining three sites serve both adult and teen clients. The sites providing services to clients of all ages include the agencies with ties to managed care organizations and one community-based, reproductive-health provider.

- With respect to a mission statement about the importance of serving youth or a specific purpose of serving youth, we find that roughly half (4 out of 9) of the sites have such a mission statement. The

remaining sites have a more generic or institutional mission statement about the importance of providing services to clients in need of care, and ensuring quality care and equity of care to clients.

- Agencies generally have some type of process for regularly assessing their organizational mission and quality of services. Most sites report using client surveys and staff observations as the primary means for evaluating their services. Only three of the nine sites explicitly involve teens in their assessment process and only three sites (primarily University/Hospital-based agencies) have a formal youth advisory board.

Plans to Target Youth or Increase the Number of Youth Served

- Most sites reported having a desire to target youth or to increase the number of youth reached by their services, or to target specific sub-groups of teens (e.g., males or out-of-school youth). However, few had clear plans or strategies for how this outreach would take place. Only one site reported having a specific, long-range goal for increasing the number of youth served.

- Sites that served only teens demonstrated procedures and priorities that centered, naturally, around addressing adolescent needs. However, clinic documents and educational materials were not always found to be teen oriented, or teen friendly.

Funding, Staffing & Program Priorities to Serve Youth

- The existence of specific funding, staffing or program priorities seemed to depend on whether the site has an explicit mission or commitment to serving teens. However, many sites were a part of a larger umbrella organization. Thus, the individual site often had a desire or internal goal to serve teens, but the larger agency which determines funding, staffing and program priorities, did not always share the site's goals for serving teens or diverse youth.

- The majority of sites noted a lack of money as the primary reason for not providing a broader range of adolescent services, or the additional services they would like to provide. Staff resources were also reported as limited, particularly for psycho-social services. However, some sites noted the need for more clinicians or having clinical staff available at more times convenient for teens.

- Staffing diversity generally reflected the diversity of the client base (primarily European- or African-American). However, staff from Hispanic and Asian heritage were not well represented

- Seven (7) sites indicated either a desire to improve services specifically to ethnic minority youth, or that issues of culture and diversity were important factors in delivering care to ethnic minority youth. However, only two (2) of the seven (7) had a special service or program for young minority clients. The remaining two sites served a client population that was predominantly from one ethnic minority sub-group.

- There were no sites that demonstrated organizational policies or a mission statement that explicitly addressed the issue of culture, or that focussed on the provision of services to ethnic minority youth as an organizational priority.

- Efforts to serve diverse clients were often made on the basis of language. This was more prevalent among sites where the Hispanic population (or language minority clientele) was high or reasonably high. However, two (2) sites had made explicit attempts to develop and/or implement programs designed for particular ethnic sub-groups of teens

- All sites employed staff that were that were generally older (over 30), except for one community-based site that made an explicit effort to employ younger staff, with the belief that younger staff could relate better to teens, develop better relationships with teens, and thus increase teens' comfort with services.

- Staff members at all sites were primarily female. However, four sites had at least one male staff member that was actively involved in the delivery of services to adolescent clients.

Staff Training

- All sites expressed a need for more training in working with teens, although some sites believed the most important thing about working effectively with teens was "you have to like them, and like working with them". Furthermore, the best way to learn how to work effectively with teens is through hands-on experience.

- Formal training on how to work with adolescents was rare. Staff at the majority of sites reports hands-on experience as the primary source of their training on how to work with teens. However, clinical staff, particularly clinicians at the University/Hospital sites had some training on adolescent issues through the agencies department of adolescent medicine. However, no site indicated this training was fully sufficient for what was needed to work with effectively with teens. Staff at all sites expressed a need to understand the developmental and emotional stages of adolescence and the need to know how to communicate with teens more effectively.

- Four (4) sites had some formal, organized in-service training on adolescent issues. These same sites also supported and encouraged continuing education for staff on adolescent issues. However, more common across sites was the use of staff meetings to present specific topics on either adolescence or issues relevant to serving adolescent clients.

- With respect to staff training on issues of culture and diversity, only two sites expressed a desire for staff training on how to work effectively with clients from different cultures or ethnic minority sub-groups. In both instances, this training was referred to as training in "cultural sensitivity", rather than training in issues of cultural competency.

Program Content, Service Delivery Strategies & Outreach

- Seven (7) sites provided comprehensive services to teens. The remaining two sites offer either exclusively Ob/Gyn and/or reproductive health services.

- All sites offered clinical as well as educational services. However, six (6) sites also offered psycho-social services either though a social worker or psychologist (on site or through referral) ;

- The range of educational materials targeting teens was quite modest across all sites. Much of the information disseminated to youth is generic and targeted primarily towards an adult audience.

- Only one (1) community-based site used peer educators. Although several other sites have explored using peer educators, most have decided against it at this time. Sites who did not use peer educators cite two reasons for not using them: 1) the findings about the effectiveness of peer educators is mixed. Specifically, the impact of peer educators on behavior may be greater for the

peer educators than the teen clients exposed to peer educators; 2) teen clients are often more concerned about issues of confidentiality when peer educators, or youth clinic workers are involved.

- All sites provide one-on-one educational and counseling services. Only one site (school-based agency) reports using group education as part of their services.

- Community outreach varies across sites, but is generally limited. University/hospital-based agencies demonstrated the greatest amount of community outreach, networking and coordination with other community agencies. The efforts of one, community-based site stood out among all sites we visited. However, this probably reflects the fact that this site recently received a grant to hire a staff person specifically to do community outreach.

Barriers to Service Delivery

Potential barriers for teen clients

- Staff may not be representative enough across gender, race/ethnicity, or age

- Issues of payment for services may be important at some sites, particularly those that may have recently undergone administrative changes (to managed care or other HMO-type structure)

- Hours of operation may be a problem at 6 of the nine sites, as most are only open during school hours.

- The majority of sites have a lack of written or video information available in waiting areas; most materials are not teen oriented or written for a teen audience.

Barriers for staff in providing services

- Each site has distinct barriers depending on the type of provider system. Sites that are subsumed under a larger health system or health organization have unique barriers. Specifically, the larger agency mission or philosophy to service delivery did not acknowledge the importance of developmental issues unique to teens, or stated the need to work with all clients, without any distinctions for age, gender or race. Thus, most sites did not receive sufficient support or resources for adequate staff training or the development of special services or outreach activities to teens.

- Financial resources were a key issue for all sites, which limited staffing resources and the ability to develop special or additional service delivery strategies or programs.

- The majority of sites expressed a concern that teens they generally serve present a host of psychosocial and family problems that go beyond the expertise or capacity of existing staff and resources. Thus, teens in need of such services may not be adequately served.

- Only a few sites had formal in-service training on adolescent issues, with the majority of staff getting training on the job. Sites mentioned challenges working with parents and how to work with teens to encourage parental involvement, while maintaining confidentiality of services.

- No sites had any formal training on cultural diversity, cultural competency, or how to work

effectively with ethnic minority clients, although two sites expressed a desire for some type of cultural sensitivity training. The majority of sites indicated that learning how to work with diverse youth was important, but only two sites had made an explicit attempt to develop more tailored programs or services to ethnic minority youth.

Developmental and Cultural Competency

According to the developmental and cultural competency framework, we found the following capacities among provider sites:

Developmental Competence (Figure 1)

- Two sites demonstrated policies, priorities and practices that were consistent with advanced (proficient) developmental competency. Both of these sites were University/Hospital based provider agencies. These sites were strong advocates for youth and the provision of services to youth, had clear organizational policies and practices in place that addressed serving youth, along with supports for staff to acquire training and skills to work effectively with youth.

- Three (3) sites were categorized as being developmentally competent, two (2) as developmentally pre-competent, two (2) as being at the stage of developmental blindness.

There were no further distinctions across sites as to their level of developmental competence.

Cultural Competence (Figure 2)

- No sites emerged as being at the advanced stage of cultural competency, as sites did not have explicit organizational policies or practices that formalized either the importance of cultural competency or formalized systems of service delivery to address issues of cultural and diverse teen clients.

- Most sites (6) were at the stage of cultural pre-competence, of which two seemed to be moving closer to the stage of cultural competence. Specifically, most sites spoke of the importance of culture and understanding diversity, but did not have formal approaches in place to address these issues. Two sites that attempted to refine their program or services to be more appropriate to ethnic minority clients still had no formal mechanism for keeping such service delivery practices on-going. However, it was these two sites we perceived as moving closer to cultural competence because of site efforts to implement activities to address the issue of culture.

- Two (2) sites could be defined as being at the stage of cultural competence, although the lack of staff training places them at the very early stages of this continuum. Although no formal organizational mission or policy was in place to institutionalize staff training or the development of certain approaches, these two sites were actively involved in working closely with ethnic minority youth, addressed the issue of language differences, and were seeking ways to increase staff capacity in this area.

- One (1) site was defined as being at the stage of cultural blindness. Staff and administrative policies at this site viewed clients and worked to serve clients in the same manner. Thus, equity in service delivery was viewed as most important for quality of care to clients.

Figure 1:
Stage of Developmental Competence Among Participating Sites

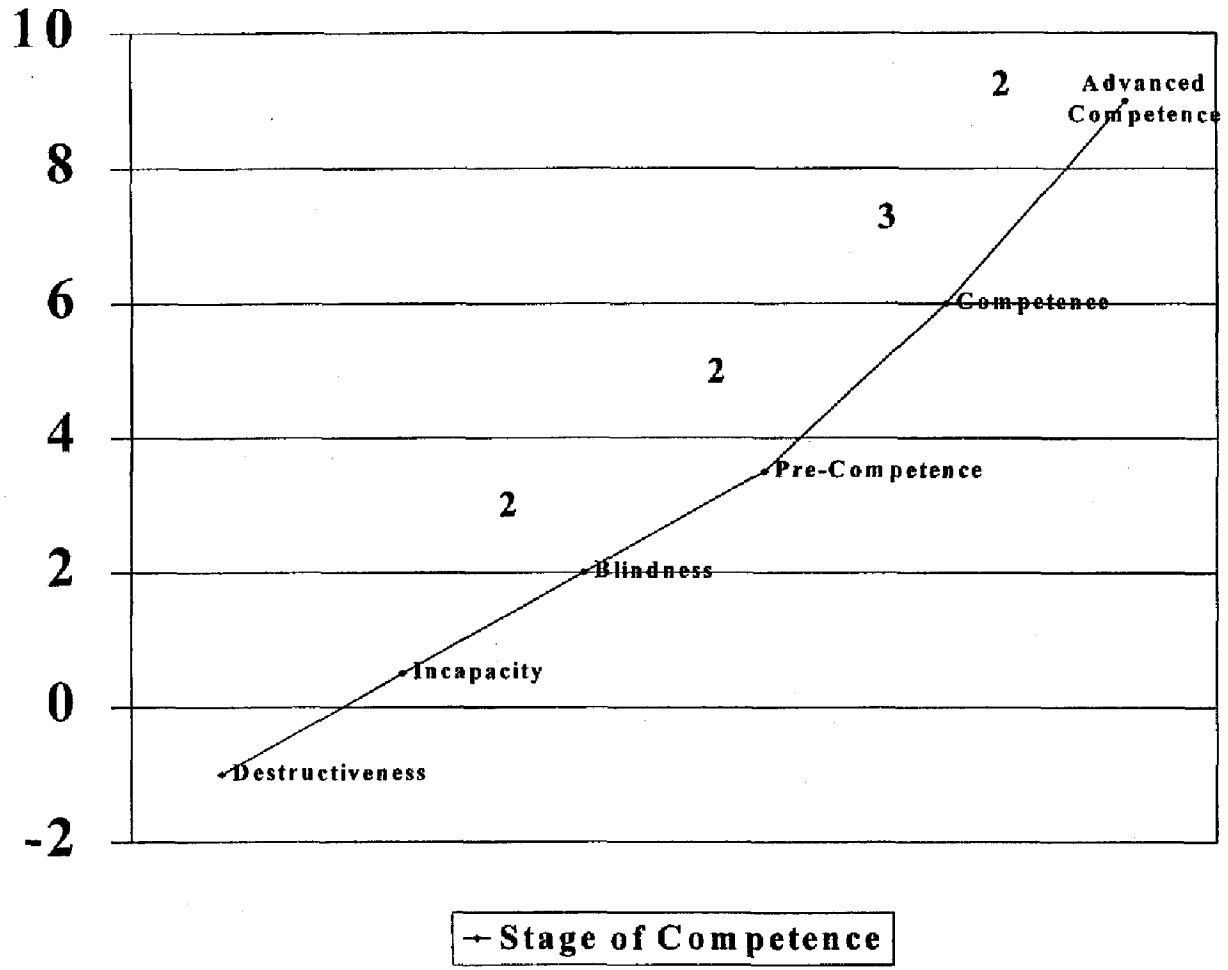

Figure 2:
Stage Of Cultural Competence
Among Participating Sites