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‘The doctor just talks about it’
Sustainable health promotion and practice in schools

Docs and Teens program
Research evaluation report
August 2016

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Debbie Ollis
Gayle Savige

School of Education
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Written by

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Lyn Harrison, Debbie Ollis & Gayle Savige assert their moral rights to be identified as the authors of this work.
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EXECUTIVE SUMMARY

This research aimed to evaluate the effectiveness of the Docs & Teens program, which is a health access and literacy program delivered in Geelong schools and co-facilitated by local general practitioners and teachers. We were interested in whether students increased their knowledge of, and access to, local health services and if the program contributed to an improvement in their health literacy and help-seeking behaviours. We also mapped program content against current Victorian curriculum guidelines. Both quantitative and qualitative methods were used to gather data from students, teachers, doctors and relevant health professionals.

The findings indicate that:

- the program has the potential to make a valuable contribution to health access and literacy for young people in schools
- all involved in the program enjoyed their interactions in the program and valued the approachability of GPs and the interactive and frank teaching approaches used to deliver the program
- students and teachers valued the particular expertise of GPs
- teachers and schools were identified by students as important resources for obtaining health information and advice.

However, there were issues that related to the current provision, scope, content, outcomes and organisation of the program that raise concerns about its sustainability:

- The amount of content covered means that complex issues are covered in breadth rather than depth and rely on follow up from teachers post program.
- Related to the above, survey data indicates that there is very little improvement in student knowledge and behaviours post program.
- Apart from headspace there was little indication of knowledge about other community health services covered in the program content.
- There is some evidence to indicate that there is a mismatch between what teachers and other stakeholders see as important content for the program compared to what students would prefer to learn.
There is a need for GPs and teachers to consult prior to delivery of the program to make sure that the content meets the needs of individual schools.

Content needs to be up to date and closely aligned with any changes in Victorian school curriculum, and professional development for GPs and teachers needs to reflect these changes.

As the program stands, the content is suitable for Year 9 and Year 10 students and it is important that the program be modified if taught to Year 8, as was the case in one case study school.
INTRODUCTION

Access to health services remains an important determinant of wellbeing for young people. Although they value and trust the information they get from general practitioners (GPs) (Johnson et al., 2016) they do not readily access services or advice without parental approval (Mitchell et al., 2014). The current Victorian Labor government’s 2014 funding announcement of $46.2m for GPs to treat adolescents in disadvantaged schools is recognition of this contradiction and evidence that the government values increasing access to services for young people in schools.

Improving young people’s access to GPs is likely to occur if health programs are able to allay the concerns of young people and build their trust with these service providers. Promoting youth-friendly consulting environments and ensuring practitioners’ have sufficient training to develop the knowledge and skills needed to communicate effectively with young people can help establish trust. These steps will help to encourage young people to seek medical advice when needed (Bernard et al., 2004; Kefford et al., 2005). Further, strategies to reduce financial or other barriers may also improve access to general practice services, especially for young people from disadvantaged backgrounds (Trigger et al., 2008; AIHW, 2011).

There have been a number of GP access programs running in Victorian schools over the past decade. Despite anecdotal evidence that such programs are effective there is a paucity of evidence to support the efficacy and sustainability of school-based health literacy programs run by external agencies.

This study has evaluated a school-based health literacy program, co-facilitated by GPs or health professionals and teachers. The findings of this program (called Docs & Teens) have the potential to impact on the design and implementation of school-based health access and literacy programs in Australia that use outside agencies to support and provide links to services.

The Docs & Teens program was adapted from the Centre for Adolescent Health ‘Health Access Package’, developed in 1992, that was subsequently adapted by a Melbourne secondary school, which delivered the program using both teachers and local health care workers. The access program was eventually piloted and developed by the North East Division of General Practice and in 2001 the GP Association in Geelong commenced their involvement. The program has been
revised over the years by the Education Officer responsible, in response to emerging youth health issues and changes in Victorian curriculum frameworks.

This report documents the results of research undertaken to evaluate Docs & Teens, a health access and literacy program conducted by GPs and/or health professionals in Victorian secondary schools. In consultation with the steering group, data was collected using surveys, focus group and individual interviews from schools and the stakeholders who had been involved in the program. These data were then analysed to assess whether the aims of the Docs & Teens program had been met.

RESEARCH AIMS

The research aimed to:

- evaluate the effectiveness of the Docs & Teens program to increase youth knowledge of and access to local health services, to broaden young people’s definitions of health and ill health, to increase knowledge related to the content of the program and increase health literacy and help-seeking behaviours of young people
- evaluate the effectiveness of the Docs & Teens program to increase GP knowledge of adolescent health and overcome barriers between GPs and young people
- analyse the content of the program and map this against state and national curriculums.

YOUNG PEOPLE, HEALTH & ACCESS

Most young Australians experience relatively good health, but some (especially Aboriginal and Torres Strait Islanders) often have much poorer health outcomes than others in the population. Poor health can hamper a young person’s ability to develop to their full potential (AIHW, 2011). During adolescence there is an expectation that young people will acquire knowledge, develop a range of skills, and learn to manage emotions and relationships, as they become increasing independent. It is an important phase for establishing healthy social behaviours and lifestyles that promote positive health outcomes in the years that follow. Access to curriculum that improves health-seeking behaviours becomes important (ACARA, 2012).
Young people’s definitions of health and ill-health

The most widely accepted definition of health is ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (World Health Organization, 1946). An Australian study by Booth et al. (2004) found that younger adolescents characterised ‘health’ in terms of physical wellbeing only. Their descriptions of health included ‘fitness, your physical state and keeping your body in good condition’. Other aspects of health (sexual and mental health) were accepted by some young people but only after prompting. However, most could identify a wide range of circumstances or behaviours that might impinge on their health (Van Dyke et al., 2014). Older adolescents, unlike their younger counterparts, were able to recognise broader definitions of health, particularly female adolescents (Booth et al., 2004).

Young people’s knowledge of health services and their health-seeking behaviours

During adolescence, some young people will visit or make contact with health services independently of their parents. However, a sizeable proportion of young Australians do not seek health care when they have major health concerns, or if they do seek help, they may not receive the care needed to alleviate their concerns (Van Dyke et al., 2014). The major health issues faced by young people include sexual and mental health problems, injuries and bullying/exposure to violence and substance misuse. These problems and behavioural factors are partly preventable or may be treated. If adolescents are knowledgeable about the services available to them, and feel confident and able to locate and access the services they require, their ability to achieve and maintain good health will be improved not only through their adolescent phase but also into their adult life.

In general, the main barriers adolescents face when accessing health care include concerns relating to confidentiality, knowledge of services and embarrassment in disclosing health concerns, particularly in regard to emotional, mental and sexual health problems (Van Dyke et al., 2014). The accessibility and characteristics of a health service (e.g. whether or not it is youth friendly) are also important considerations. In addition, inconvenient or limited opening hours, and the cost and transport associated with visiting a GP, can also restrict adolescents from using health care services (Bernard et al., 2004; Trigger et al., 2008).

Moreover, access to health services is not always equitable, placing further obstacles detrimental to the health-seeking behaviours of some young people. Socioeconomic status, gender, sexuality, age, culture and geographic location are factors that can all impinge on a person’s access to health services.
services. Health services in rural and remote areas are often limited compared to those found in metropolitan and city areas, placing adolescents who live in these areas at a disadvantage. Some services may also be prohibitive if adolescents do not have the means to cover any costs associated with their use, especially if they wish to access such services independently of their parents.

**Young people’s access to GPs**

Young people with health or medical concerns will usually visit the health services of a GP before visiting other services. GPs play an important role in the care of their young patients by monitoring and managing their health issues, and often establishing ongoing relationships to help young people achieve and maintain good health. Therefore, it is vitally important that young people are able to access the services of GPs when required.

However, significant impediments (as previously indicated) often exist for young people when seeking appropriate and timely health care. In 2008–09, young Australians including adolescents were less likely than those aged 25 years and over to attend GP consultations (AIHW, 2011).

Lack of anonymity can be one of the impediments that some young people experience if wishing to consult a GP.

**GP knowledge of adolescent health**

Primary health care for young people in Australia occurs in youth-specific health services, community health centres, emergency departments and non-government organisations, but the bulk occurs in general practice.

There is sound evidence that GPs, who are often the first port of call for young people with health issues, often lack the confidence, knowledge and skills needed to deliver appropriate health care to adolescents (Sanci et al., 2000; Van Dyke et al., 2014). However, there is encouraging evidence that training GPs not only improves their confidence and skills in working with young people but also helps GPs to bring about changes to their actual practice. This is one reason why the GPs in Schools model is popular among Divisions of General Practice (Sanci et al., 2000).

**Health education in schools**

Violence and bullying within the school environment is a serious social problem both in Australia and globally (Gini & Pozzoli, 2009; Morrison, 2003; Hillier et al., 2010; Our Watch, 2015). Education programs can have a positive effect on the health and wellbeing of adolescents. Schools that
promote supportive environments and healthy social relationships have been shown to positively influence health, academic performance and sense of self (Springer et al., 2006; Frydenberg et al., 2009; Our Watch 2016).

In the US, it has been suggested that there is insufficient sexuality education in schools and that which does exist is very unsatisfactory (Weis & Carbonell-Medina, 2002; Levesque, 2000). In the UK, inadequate attention is devoted to sexuality education, which sits in a jam-packed curriculum of Personal, Social and Health Education and Citizenship (Goldman, 2011).

Although sexuality education is a common feature of Australian secondary school programs, approaches are often inconsistent and ad hoc, with some schools providing approaches consistent with the guidelines offered by Department of Education (2005), Department of Education and Early Childhood Development (DEECD, 2008), the Australian National Council for AIDS, Hepatitis C and Related Diseases (ANCAHRD, 1999), UNESCO (2009) and the American School Health Association (Future of Sex Education Initiative, 2012), while other schools provide little, if any, education to students (Ollis et al., 2013). The most recent research indicates that school-based sexuality and relationships education does not focus on the issues young people feel are important and relevant to them (Johnson et al., 2016).

Education about puberty, sexuality, relationships and reproductive health and safety is generally located in the Health and Physical Education (HPE) curriculum (Goldman, 2010). Despite this, sexuality education is often allocated only a few hours in secondary HPE courses, and is increasingly being integrated with more general content related to student health and wellbeing (Ollis et al., 2013).

Support for a cross-sector approach to health education may be viewed as desirable given that young people access such information from a range of sources in and outside of schools (Samdal & Rowling, 2010). A systematic review of peer-led sexual health education programs, for example, found limited evidence to support this type of approach (e.g. to improve sexual outcomes among adolescents in terms of condom use and the incidence of sexually transmitted infections). However, most of these types of interventions did bring about improvements in adolescent knowledge, attitudes and intentions (Kim & Free, 2008).

A review of school-based behavioural interventions programs (led by teachers or health educators) generally found a statistically significant effect on improving participants’ sexual health knowledge, but these interventions had a limited effect on behavioural outcomes. The ineffectiveness of these interventions programs was probably due to a number of factors, including imperfect delivery and
content relevance (Future of Sex Education Initiative, 2012). These factors could be overcome or minimised if the delivery of these programs complemented well-designed school curriculums.

One of the difficulties in evaluating the effects of external agencies (such as health care personnel and GPs) on health education programs in schools relates to the fact that most programs vary in the time of their delivery, the length and content of the intervention, the personnel involved and the characteristics of the students receiving the intervention (such as age and prior health education experience). Furthermore, there is research to show that sexual and reproductive health education is often more efficacious if it is delivered before sexual activity begins (Mueller et al., 2008; Baldo et al., 1993). This suggests the timing of interventions designed to promote healthy sexual behaviours requires careful consideration and, given that implementation is a crucial aspect of planning and delivering successful health education programs, it often receives insufficient attention (Durlak & DuPre, 2008; Schutte et al., 2014).

Health programs that are comprehensive, include student feedback and guidance and integrate all aspects of health in a well-designed curriculum in line with student wellbeing policies and practices, are likely to be the most effective (Our Watch, 2016). Involving external agencies to assist in the delivery of school-based health programs needs to be carefully evaluated to ensure these interventions are effective, sustainable and do in fact support and complement the school curriculum.

One Australian study that was effective in achieving sustainable and large improvements in knowledge, skill and self-perceived competency in GPs involved a multifaceted educational program that focused on the principles of adolescent health care. This program was run by the Divisions of General Practice and targeted at GPs only. Unlike the Docs & Teens program, this study did not involve schools. It used evidence-based education strategies and the workshops ran for 2.5 hours per week over six weeks (Sanci et al., 2000). The Docs & Teens program requires GPs and school staff to attend a three-hour upskilling session on facilitating the workshops to be implemented in schools. Once completed, the upskilled staff facilitate two 90-minute workshops with Year 8 or 9 classes in schools. GPs indicate the number of times they wish to deliver the program and to which schools.
THE DOCS & TEENS PROGRAM

The Docs & Teens program was developed by the Centre for Adolescent Health and modified by Divisions of General Practice for use by GP facilitators and school co-facilitators. It continues to be delivered to Year 8 or Year 9 students by Barwon Medicare Local (formerly the GP Association of Geelong).

According to its program manual (headspace Geelong & Barwon Medicare Local, 2015) the Docs & Teens program in schools has enabled GPs and other local health care workers to deliver the program in an adolescent-‘friendly’ environment. The program endeavours to support the current Victorian curriculum and provides support to teaching learning outcomes. The program’s co-facilitation between local community health workers and teachers also provides an opportunity to develop community partnership.

Anecdotally, the Docs & Teens program has:

- encouraged students to be more open with staff after participation in the workshops
- encouraged students to obtain their own Medicare cards
- encouraged students to visit their local community health centre
- received positive support from parents.

In summary, it is extremely important that the health needs of young people are adequately addressed by education programs run in schools given that schools have a direct influence on the education and development of adolescents.

CURRICULUM APPROACH

The Docs & Teens curriculum was designed to be an access program focusing on building relationships between local GPs and Year 9 students in 25 schools in Geelong.

According to the Docs & Teens Program Manual (headspace Geelong & Barwon Medicare Local, 2015, p. 4) the materials used are suitable for use with Level 9 students but can be adapted for use with Level 8 students. The content of the program is designed to address the Level 10 standards for the Health knowledge and promotion dimension of the AusVELS curriculum. According to the
manual, the program fits within the HPE domain under the Physical, Personal and Social Learning Strand. The program is typically delivered to students in two 90-minute sessions at least a week apart and can be run in any school term, according to the particular school’s requirements and the availability of GPs. What term the program runs in is also subject to these variables.

The program is discussion and activity based, with 18 activities included in the manual. Most of these are extension activities. There is not enough time to complete all of these activities in the sessions available, but teachers are invited to use these resources in follow-up sessions if they want to. Although the flexibility of the program to meet emerging needs or a change in circumstances is often stressed, what follows is the typical content covered in each session, as evidenced in our classroom observations from the two case study schools in this report, given the time allowed and the size of the student groups.

**Session 1**

**Activity 1: What is health? (10 minutes)**

**Aim**
- To develop a common understanding of the term ‘health’ in the group.

**Introduction**
‘What is health?’ is written on the board along with a circle with four quadrants and students are asked to volunteer labels for each. The idea is that they come up with the following labels: Physical, Social, Emotional and Spiritual. If they do not, the GP or facilitator will fill in the gaps. Students are then asked to provide examples under each of these headings.

**Activity 2: Musical chairs (10 minutes)**

**Aims**
- To gain student interest.
- To connect the program with known health knowledge.
- To create a gender balance and mixing of personalities in the final seating arrangement.

**Introduction**
Students are seated in a circle. A volunteer is asked to stand in the middle and their chair is removed. The person in the middle asks a question about a health-related issue – for example, ‘Stand up if you have ever had … a headache, a broken bone …’ All those who have experienced
Activity 3: **Who to go to? (Card game) (60 minutes)**

**Aim**
- To show students that there are at least two to three different services available that can help with each health issue they may encounter.

**Introduction**
Large laminated cards with the health-related services available to students are laid out on the floor in the middle of the room with students seated in a circle around them. The GP explains the purpose of the various services. The students are then each given a ‘problem’ card and asked which service would be the most suitable one for them to get advice for this problem.

Additionally, facilitators are urged to make sure they cover how students can apply for their own Medicare card, as this topic is considered a priority.

Activity 4: **Question box (5 minutes)**

**Introduction**
Each student is asked to write a question on a piece of paper on what they would like to ask the doctor, without anyone else knowing they are asking. They all have to write something on the piece of paper whether they have a question or not. These questions are collected to be answered in Session 2.

**Session 2**

**Recap (5 minutes)**
This session typically commences with a recap of the last session. Facilitators are directed to revisit issues of doctor–patient confidentiality, obtaining a Medicare card and bulk billing.

**Activity 2 revisited: Musical chairs (10 minutes)**
GPs are encouraged to revisit the musical chairs activity but focus this time on students’ personal choices; for example, ‘Stand up if you have ... eaten fruit in the last two days, had breakfast this morning, stayed up too late last night ...’
Activity 5: Mailbox questions (40 minutes)

The GP reads out the questions students wrote down in Session 1 and answers each one.

Activity 6: Contraception kit (20 minutes)

Forms of contraceptives are shown and explained. In small groups, students practise putting condoms on plastic bananas.

Information brochures on ‘All you need to know about visiting a doctor’ (covers the Medicare system) and ‘Who to go to?’ are given to the co-facilitator for distribution to students.

Optional activity: Harm ranking (20 minutes)

Aim

To help students discern the potential level of harm in a given situation.

Introduction

Students are asked to pair up. Each pair is given a situation card and asked to rank the situation from ‘least harmful’ to ‘most harmful’. Pairs discuss where this situation should be placed on the continuum. Then students form a group circle and, working around the circle, are asked to place their situation card where they feel it belongs on the continuum from least to most harmful. When all cards are placed students are invited to stand up and inspect the continuum and justify any changes that they may wish to propose.
METHODOLOGY

OVERVIEW

This project was conducted in two stages.¹

Stage 1

a. A review of literature to guide the development of the survey and contextualise the research.

b. A quantitative cross-sectional post-program survey of students from nine government secondary schools that received the Docs & Teens program in 2014/2015 in order to evaluate:
   - youth knowledge about and access to local health services (including GPs)
   - young people’s definitions of health and ill health
   - knowledge related to program content
   - health literacy and help-seeking behaviours.

c. A quantitative survey of stakeholders (GPs and health professionals including school nurses, school staff and steering group members).

d. A content analysis and mapping of curriculum documents against state and national curriculums.

Stage 2

In-depth case studies of two schools involving:

a. Pre-program and post-program surveys with students from one school.

b. Classroom observations of program delivery in both schools.

c. Focus groups with teachers and allied health professionals.

d. Three student focus groups in each case study school (four groups of mixed-sex and two groups of girls only; i.e. six groups in total).

e. Individual interviews with four GPs with longstanding experience in program delivery.

f. An interview with the Education Officer responsible for Docs & Teens program content and administration.

¹ For copies of all surveys and interview questions and additional data please contact Dr Debbie Ollis <debbie.ollis@deakin.edu.au>.
DATA COLLECTION

The Education Officer and steering group undertook to contact schools to:

- request they participate in the research project
- gain consent
- ensure links to all online surveys were accessible.

Sample

Student samples (for the post-program survey and case study surveys) were drawn from schools that were involved in the delivery of the Docs & Teens program.

The stakeholder sample was drawn from those involved in the organisation and/or the delivery of the Docs & Teens program (i.e. GPs and health professionals including school nurses, school staff and steering group members).

Both quantitative and qualitative methods were used to examine the success of this program.

Quantitative methods

Quantitative data were collected using online surveys that were developed and implemented using the online software Survey Monkey.

Cross-sectional surveys

In 2015, a cross-sectional online survey was administered to:

- a total of 568 students who had previously participated in the Docs & Teens program in 2014 and 2015. These students were drawn from nine schools out of a possible 27 secondary schools in the Barwon South Western region.
- a total of 31 stakeholders (teachers, doctors and other health professionals) involved in the program.

Characteristics of the students from the cross-sectional post-program survey are summarised under the section on Post-program survey of students from 2014/2015. A total of 280 (49.3%) boys, 276 (47.9%) girls and 16 (2.8%) students who declined to categorise themselves as either male or female undertook the post cross-sectional survey. The students ranged in age from 13 to 17 years, with the majority (61%) of students aged 15 years. The next largest age group was 14 years (22%), followed by 16 years (17%). Less than 1% of students were either 13 or 17 years of age.
Cohort surveys

A smaller sample of students was drawn from one case study school. These students undertook two online surveys. The first survey was undertaken prior to participating in the Docs & Teens program and the second survey was undertaken after participating in the program.

Each student in the pre-program survey was matched to their post-program survey. This pairing was used to determine if there were any significant changes in their pre-program responses compared to their post-program responses. For the purpose of matching students and maintaining anonymity, students were required to enter a code on each survey consisting of the first three letters of their mother’s name followed by their street number. This code was then used to match (pair) each student correctly.

Qualitative methods

Qualitative data were collected through focus groups and interviews. The focus groups were conducted with students from the case study schools and interviews were conducted with stakeholders. The two case study schools were chosen (after discussions with the steering group) in terms of their suitability with regard to each school’s geography, socioeconomic status and the size of the student populations. The case study schools participated in the Docs & Teens program during the second half of 2015.

Details of the focus groups and interviews conducted after the delivery of the Docs & Teens program included:

- post-program focus groups with 36 students (comprising four mixed-sex and two single-sex focus groups).
- post-program interviews with doctors, teachers and school personnel involved in the planning and organisation of the program. These interviews involved seven teachers, four GPs and one school nurse.

Prior to conducting the interviews, the researchers observed eight classroom sessions of the Docs & Teens program so they could familiarise themselves with the delivery of the program (in the case study schools).

All interviews were recorded and then transcribed and names were anonymised where necessary.
Aims

The aim of the cross-sectional post-program student survey was to examine students’ experience of the content and pedagogies of the Docs & Teens program and whether they believed it had provided health information, increased health literacy and access to health services and promoted help-seeking behaviours.

The aim of the student focus groups was to explore the key themes identified in the surveys and through classroom observations. Parental permission was gained for students involved in the focus groups.

The aim of the stakeholder survey was to examine the experiences of the GPs, health professionals and teachers who conducted the program. In particular, the survey asked questions to evaluate their knowledge and understanding of working with young people, concerns about the content, their experience of teaching the program, as well as their assessment of support, professional development, financial remuneration (paid to GPs) and other structural and contextual issues that impacted on teaching the program in schools. It was also designed to gather information about whether, in their view, the program had impacted on students’ health knowledge, literacy and access and their help-seeking behaviours.

The aim of post-program stakeholder interviews was to explore the key themes identified in the surveys and classroom observations. Each participating teacher / GP / stakeholder who was involved in the case study schools was asked to participate in interviews run by a Deakin researcher in a quiet and confidential location for between 30 and 60 minutes. All but one participating stakeholder was interviewed.

DATA ANALYSIS

The data has been analysed using a variety of methodologies including thematic, inductive, content and statistical analysis. A significant amount of data presented in this report was collected through interview-based research. Interview data was analysed thematically and inductively to determine what patterns, themes and categories emerged (Patton, 2002) in relation to the aims of the Docs & Teens program and in light of the key findings of the survey of students and stakeholders.

Patton (2002, p. 453) describes content analysis as the process of ‘identifying core consistencies and meanings’ from primary data. The data was read for patterns, similarities, differences,
inconsistencies and change over the research period where appropriate and then these were explored during interviews with student, teachers and stakeholders.

The case study surveys were analysed using the Wilcoxon signed-rank test, a non-parametric version of a paired samples t-test. This test was used to determine if there was a significant change (i.e. \( p\)-value is < 0.05) in student responses to a health literacy survey, administered before and after the Docs & Teens program.

Descriptive statistics were used to describe the data from all four surveys (the two case study surveys, the stakeholder survey and the large cross-sectional post-program survey). Descriptive statistics were obtained using frequencies to summarise and describe the characteristics of the student/stakeholder populations and the survey measures (i.e. how many students/stakeholders gave each response).

The chi-square test was also used to explore differences between males and females in the Post Docs & Teens Health Literacy Survey.

**STEERING GROUP**

Cath Mayes, Head of Strategy, Research and Policy: Sexual and Reproductive Health, Women’s Health and Wellbeing, Barwon South West Inc. and Malcolm Scott, Manager headspace Geelong, formed the steering group that guided this research. We met with them regularly throughout the project to discuss project planning and methodology and they were instrumental in assisting us to gain access to participating schools and health professionals. The Education Officer for Docs & Teens, Julie Arnall, provided valuable advice in the early planning stages.

**ETHICS APPROVAL**

Ethics approvals to conduct the research were obtained from the Deakin University Human Research Ethics Committee (reference HAE 2015-051, 24 March 2015) and the Victorian Department of Education and Training (reference 2015-002634, 22 April 2015) as per the research design. All participants were provided with a plain language statement describing the aims of the project and what would be required of participants and informed consent forms were obtained.
DOCS & TEENS PROGRAM: RELATIONSHIPS TO AUSVELS

AUSVELS CURRICULUM

The AusVELS Curriculum (VCAA, 2015b) is Victoria’s interpretation of the Australian Curriculum (ACARA, 2013). It builds on the same theoretical framework; however, it has a slightly different structure and focus. As with the Australian Curriculum, the AusVELS curriculum in Health and Physical Education (HPE) recognises the need to take a strengths-based approach, one that starts from students’ strengths in relation to their health and agency, rather than a disease orientated and deficient approach. Health education is part of the HPE learning area.

The Health and Physical Education domain provides students with knowledge, skills and behaviours to enable them to achieve a degree of autonomy in developing and maintaining their physical, mental, social and emotional health. (VCAA, 2015a)

According to the Victorian Curriculum and Assessment Authority, this domain ‘is unique in having the potential to impact on the physical, social, emotional and mental health of students’. Using health knowledge, it ‘develops an understanding of the importance of personal and community actions in promoting health and knowledge about the factors that promote and protect the physical, social, mental and emotional health of individuals, families and communities’. A key strategy involves students investigating the ‘provision of health services by both government and non-government bodies’ to develop ‘differing perspectives and develop informed positions’ (VCAA, 2015a).

The Docs & Teens program is a health access and literacy program and as such does have the potential to contribute to the learning focus and standards of the curriculum domain of HPE.

The AusVELS Curriculum is made up of domains. HPE is one domain, as is English, Mathematics, Science and so on. The curriculum uses an 11-level structure. Each level includes a learning focus statement (about its content) and standards (what students work towards to complete that level) organised by dimensions. In the HPE domain there are two dimensions: Movement and physical
activity and Health knowledge and promotion. Health knowledge and promotion is the dimension of relevance to this research.

As the Docs & Teens program has been used with Year 8 and Year 9 students in this research, it is against Level 8 and Level 9 that the program will be mapped to assess the potential of Docs & Teens to contribute to the standards.

**Learning focus and standards**

The following table outlines the learning focus and standards that the Docs & Teens program has the potential to contribute to. It is important to use ‘potential’, as observation of the program clearly demonstrated that different GPs concentrated on activities in differing length and breadth. Moreover, there were only two 90-minute sessions in the program and students were not required to undertake any assessment. Therefore, it is impossible to make any assessment of students’ ability to meet the AusVELS standards following the program. In addition, Docs & Teens content may only contribute to part of the learning focus included in the following table.
### Table 1  
AusVELS learning focus and standards mapping of the Docs & Teens program

(Table 1 spreads across two pages)

<table>
<thead>
<tr>
<th>Docs &amp; Teens activity</th>
<th>Learning focus</th>
<th>Level 8</th>
<th>Level 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is health?</td>
<td>Describe the health interests and needs of young people as a group, including those related to sexual health (e.g. safe sex, contraception, abstinence and prevention and cure of sexually transmitted infections) and drug issues (e.g. tobacco, alcohol, cannabis use).</td>
<td></td>
<td>Examine mental health issues relevant to young people and consider the importance of family and friends in supporting their mental health and emotional health needs.</td>
</tr>
<tr>
<td></td>
<td>Examine mental health issues relevant to young people and consider the importance of family and friends in supporting their mental health and emotional health needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musical chairs – identifying health issues amongst the group</td>
<td>Describe the health resources, products and services available for young people and consider how they could be used to improve health.</td>
<td>Examine mental health issues relevant to young people and consider the importance of family and friends in supporting their mental health and emotional health needs.</td>
<td></td>
</tr>
</tbody>
</table>
| Who to go to? (card game) |  **Describe the health resources, products and services available for young people and consider how they could be used to improve health:**  
**Describe the health interests and needs of young people as a group, including those related to sexual health (e.g. safe sex, contraception, abstinence and prevention and cure of sexually transmitted infections) and drug issues (e.g. tobacco, alcohol, cannabis use).**  
**At this stage, they use problem-solving strategies relevant to the health interests and needs of young people, such as issues associated with sexual health and drug use. They discuss and evaluate strategies to minimise harm and protect their own and others’ health.**  
**Begin to see themselves as members of larger communities and to consider factors that affect their own and others’ ability to access and use health information, products and services within their local area.**  
**Learn how to access reliable information about health issues affecting them and to identify barriers and enablers to accessing health services.**  
**Examine mental health issues relevant to young people and consider the importance of family and friends in supporting their mental health and emotional health needs.** | **Examine mental health issues relevant to young people and consider the importance of family and friends in supporting their mental health and emotional health needs.** | **Examine mental health issues relevant to young people and consider the importance of family and friends in supporting their mental health and emotional health needs.** |
| Contraception kit      | Students discuss relationships and how the different aspects of relationships vary between people and over time. They consider how the different roles and responsibilities in sexual relationships can affect their health and wellbeing. They explore a range of issues related to sexuality and sexual health such as safe sex practices, sexual negotiation, same sex attraction and the impact of alcohol on sexual and personal safety. Students explore assumptions, community attitudes and stereotypes about young people and sexuality.  
They learn strategies for supporting themselves and other young people experiencing difficulties in relationships or with their sexuality, and learn about the community services available to assist. |                                                                                                                                                      |                                                                                                                                                      |
<p>| Question box           |                                                                                                                                                                                                             |                                                                                                                                                      |                                                                                                                                                      |</p>
<table>
<thead>
<tr>
<th>Docs &amp; Teens activity</th>
<th>Standards</th>
<th>Docs &amp; Teens potential to contribute to standard (see key above)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is health?</strong></td>
<td>Describe the physical, emotional and social changes that occur as a result of the adolescent stage of the lifespan and the factors that influence their own development. Describe the effect of family and community expectations on the development of personal identity and values. Identify outcomes of risk-taking behaviours and evaluate harm minimisation strategies. They identify the health concerns of young people and the strategies that are designed to improve their health.</td>
<td>I in relation to health</td>
</tr>
<tr>
<td><strong>Musical chairs – identifying health issues amongst the group</strong></td>
<td>They identify the health concerns of young people and the strategies that are designed to improve their health.</td>
<td>I in relation to the health issues identified by students</td>
</tr>
<tr>
<td><strong>Who to go to? (card game)</strong></td>
<td>They describe the health resources, products and services available for young people and consider how they could be used to improve health. Identify and explain the rights and responsibilities associated with developing greater independence, including those related to sexual matters and sexual relationships. Analyse the positive and negative health outcomes of a range of personal behaviours and community actions. Identify the health services and products provided by government and non-government bodies and analyse how these can be used to support the health needs of young people.</td>
<td>M-S depending on depth of GP and the context of the school</td>
</tr>
<tr>
<td><strong>Contraception kit</strong></td>
<td>Identify and explain the rights and responsibilities associated with developing greater independence, including those related to sexual matters and sexual relationships. Demonstrate understanding of appropriate assertiveness and resilience strategies.</td>
<td>M depending on focus of GP and the context of the school</td>
</tr>
<tr>
<td><strong>Question box</strong></td>
<td>Totally dependent on questions from students</td>
<td></td>
</tr>
</tbody>
</table>
SUMMARY

- Year 9 and 10 are the most appropriate years to implement the Docs & Teens program.
- If Year 8 is to be included, work needs to be done to scaffold the content of the program so that it works towards the curriculum standards.
- GPs require some understanding of curriculum learning focus and standards and the way schools assess students in health education to ensure enhancement and scaffolding of school programs.
- Overall the content of the Docs & Teens program provides an Introductory level contribution to health learning standards at Year 8 and Year 9, with the exception of the following standards:
  - Demonstrate understanding of appropriate assertiveness and resilience strategies.
  - Identify the health services and products provided by government and non-government bodies and analyse how these can be used to support the health needs of young people.
POST-PROGRAM SURVEY OF STUDENTS FROM 2014/2015

Schools that implemented the Docs & Teens program in 2014 were asked to complete the online survey.

At the completion of the research in December 2015, nine government schools had participated, with 568 students completing a cross-sectional survey about their experiences of the two-session Docs & Teens program.

BACKGROUND CHARACTERISTICS

A total of 568 students undertook the post-program student survey. Three schools had more than 100 students participate and one school had seven students only participate.

The ratio of males and females was similar, with very few students (< 3%) identifying as neither male nor female.

The students ranged in age from 13 to 17 years with the majority (61%) of students aged 15 years. The next largest age group was 14 years (22%), followed by 16 years (17%). Less than 1% of students were either 13 or 17 years of age.

Less than 2% of students identified as having a disability or as being an Aboriginal or Torres Strait Islander; however, most students (70%) indicated they did not identify with any of the identities listed.

Almost 90% of the students completed the Docs & Teens program in 2014 with the remaining students undertaking the program in 2015.
Table 2  Background characteristics of students: post-program survey of schools involved in Docs & Teen across 2014/2015

<table>
<thead>
<tr>
<th></th>
<th>POST 2014</th>
<th>POST 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
<td>568</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>School</strong></td>
<td></td>
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<tr>
<td>1</td>
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</tr>
<tr>
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<td>103</td>
<td>18.1</td>
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<tr>
<td>3</td>
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</tr>
<tr>
<td>4</td>
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<td>3.3</td>
</tr>
<tr>
<td>8</td>
<td>37</td>
<td>6.5</td>
</tr>
<tr>
<td>9</td>
<td>28</td>
<td>4.9</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>280</td>
<td>49.3</td>
</tr>
<tr>
<td>Female</td>
<td>272</td>
<td>47.9</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>2.8</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>3</td>
<td>0.5</td>
</tr>
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<td>14</td>
<td>123</td>
<td>21.7</td>
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<td>15</td>
<td>345</td>
<td>60.7</td>
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<tr>
<td>16</td>
<td>95</td>
<td>16.7</td>
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<td>17</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Identification</strong></td>
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<td></td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Islander</td>
<td>11</td>
<td>1.9</td>
</tr>
<tr>
<td>Person with a disability</td>
<td>11</td>
<td>1.9</td>
</tr>
<tr>
<td>Person from a non-English speaking background</td>
<td>28</td>
<td>4.9</td>
</tr>
<tr>
<td>Person who identifies with a religion</td>
<td>39</td>
<td>6.9</td>
</tr>
<tr>
<td>Person from a rural area</td>
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<td>5.6</td>
</tr>
<tr>
<td>Gay/lesbian/bisexual/transgender/queer/intersex</td>
<td>33</td>
<td>5.8</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
<td>4.2</td>
</tr>
<tr>
<td>None of the above</td>
<td>401</td>
<td>70.6</td>
</tr>
<tr>
<td>I prefer not to say</td>
<td>29</td>
<td>5.1</td>
</tr>
<tr>
<td><strong>Participated in the Docs &amp; Teens program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>500</td>
<td>88.0</td>
</tr>
<tr>
<td>2015</td>
<td>68</td>
<td>12.0</td>
</tr>
</tbody>
</table>
STUDENTS’ EXPERIENCES OF THE DOCS & TEENS PROGRAM

Figure 1  Students’ perceptions of the ability of the Docs & Teens program to meet spiritual needs

Twenty-five per cent of the students felt that the Docs & Teens program met their spiritual needs and nearly 20% felt that it did not. Nearly 60% of students indicated that meeting ‘spiritual needs’ was not relevant to them.
The data in Figure 2 show that being healthy means being fit (93%), eating well (89%), having good relationships (88%) and feeling good about yourself (86%). It is less likely to be associated with having a faith.
One of the aims of the program was to increase health knowledge. As Figure 3 shows, 40–45% of the students agreed that the program had increased their knowledge in all areas. A further 25–30% strongly agreed in relation to most areas except violence in relationships. Very few students, approximately 10%, disagreed or strongly disagreed that the program had increased their knowledge.
Students clearly enjoyed the interactive teaching and learning activities provided in the Docs & Teens program. Close to 70% of the students enjoyed the discussion and games. Decision-making scenario type activities also featured as activities that students enjoyed (approximately 50%). A further 55% enjoyed the opportunity for posing anonymous questions. Least enjoyed activities were those that required students to read handouts or do ranking activities.
Students felt that a variety of health professionals should teach the program – 50% strongly agreed and another 30% strongly agreed a doctor should teach it. Approximately 80% of students either agreed or strongly agreed that a health educator, another health professional or school counsellor should teach the program. Students also indicated that the program should be taught by school nurses (60%) and health and physical education teachers (60%).
This graph shows that students saw equality as a key feature of respectful relationships, with 90% saying that a respectful relationship is one based on equal rights. Trust, listening to each other, letting your partner hang out with friends, and not putting each other down also featured as key elements of a respectful relationship by students.
Students were confident that they would know who to go to for help (78%) and know where to go for help (78%). They also indicated that if they had a health issue they would ask the doctor or another health professional (70%), ask a parent (75%) or ask another trusted adult (62%). They were less likely to ask a female friend, look up the internet or ask a school nurse. They were least likely to ask a male friend (40%), use social networking (less than 30%) or ask a teacher (31%).
A doctor (78%), mum (70%), a friend (68%) and dad (55%) were nominated the most often as someone students could talk to about a health issue. Other family members, online advice and religious leaders were nominated the least, with religious leaders the lowest at just over 10%. Approximately 19% of students said they could not talk to anybody.
Figure 9  Students’ responses to the statement ‘The Docs & Teens program has given me confidence to …’

Students agreed (between 50% and 70%) or strongly agreed (between 10% and 18%) with choices related to feeling confident. Disagree or strongly disagree responses were around 10% for each of these categories.
Students strongly agreed or agreed that the Docs & Teens program had helped them to take responsibility for their own health (around 74%) and see the importance of learning about health at school (around 75%). They were less likely to agree that the program helped them to visit a doctor (around 66%) or to get their own Medicare card (less than 50%).
DIFFERENCES BETWEEN GIRLS & BOYS

Research on young people’s views of health and health education programs have shown clear gender differences in what young people think about school-based approaches to health issues such as mental health, sexuality and drug education (Cave et al., 2015; Mitchell et al., 2014; Woolfson et al., 2009). The Docs & Teens program was no exception. The following section includes the results of the post-program survey analysed by the responses from girls and boys.

The Docs & Teens post-program survey was analysed using the non-parametric chi-square test to see if there were significant differences between the responses of girls and boys. The level of significance was set at $p < 0.05$. A value of $p < 0.001$ was considered very significant.

Figure 11  Girls’ and boys’ responses to ‘Being healthy means ...’

At least 90% of girls and boys agreed with all the statements about what being healthy meant, except for ‘having a faith’ and ‘belonging to a community’. Approximately two-thirds of both girls...
and boys considered ‘having a faith’ as being healthy. ‘Belonging to a community’ was considered healthy by a significantly greater proportion of girls (93%) compared to boys (86%).

A significantly greater proportion of girls compared to boys agreed that healthy means being physically fit, not worried or stressed and eating well.

**Figure 12** Girls’ and boys’ responses to trusting information from family and friends about health issues

When students were asked which family members or friends they trusted to give accurate information about health issues, girls and boys gave similar responses, except for mothers, uncles and female friends, where they differed significantly. A significantly greater proportion of girls trusted their mums and female friends compared to boys. However, a greater proportion of boys trusted their uncles compared to girls.
A significantly greater proportion of girls compared to boys indicated they would trust all the health professionals listed in the survey, with the most significant difference being shown for the youth worker (84% to 68%).
The majority of girls and boys (> 80%) indicated they would trust all school programs as a source of accurate information about health issues. However, a significantly greater proportion of girls would trust the Docs & Teens program compared to boys. The most significant difference between girls and boys related to pornography as a source of accurate information. In this instance, just 4% of girls would trust pornography compared to 30% of boys.

The following four graphs show the differences between girls and boys in their responses to a variety of health topics including health services, relationships and sexual activity topics.
The vast majority of students (> 80%) indicated they thought all the health topics listed should be included in a program conducted by doctors with teenagers. However, the proportion of girls who responded favourably to the topics ‘Illicit drugs’, ‘Mental illness’, ‘Safer sex’, ‘Sexually transmitted infections’, ‘Sexual health checks’ and ‘Contraception’ was significantly greater than the proportion of boys.
There were no significant differences between the proportion of girls and boys who responded to the topics about health services. Most students (88–97%) indicated these topics should be included in a program conducted by doctors with teenagers.
A significantly greater proportion of girls (96%) compared to boys (85%) indicated that ‘Violence in relationships’ should be included in a program conducted by doctors with teenagers. The only other significant difference related to ‘Gender and sexual diversity’, where 94% of girls wanted this topic included compared to 87% of boys.
The proportion of boys responding to topics to include in a program conducted by doctors with teenagers was significantly greater than girls in relation to three sexual activity topics: sexual pleasure, pornography and masturbation.
The most significant differences ($p < 0.001$) in help-seeking behaviours between girls and boys related to whether they would ‘ask someone else for advice’ or ‘ask a female friend’. A significantly greater percentage of girls would ‘ask someone else for advice’ (94%) or ‘ask a female friend’ (83%) compared to boys (82% and 61% respectively). There was also a significant difference ($p < 0.05$) between girls and boys in terms of asking a male friend. In this instance, 60% of boys would ‘ask a male friend’ compared to 47% of girls.
‘Dad’, ‘sister’, ‘uncle’ and ‘friend’ were the people that girls and boys showed the most significant differences in response to the question about whom they could talk to if a health issue was worrying them. The percentage of girls who could talk to their dad or uncle was significantly less than the percentage of boys who could talk to these family members. Around two-thirds of boys indicated they could not talk to their sister compared to 45% of girls. These findings may be expected; that is, each sex may prefer to talk to members of the same sex about health issues. Interestingly, the percentage of girls (85%) who could talk to a friend was significantly greater than the percentage of boys (61%). This finding would suggest boys were less comfortable discussing health issues with their friends.
There was little difference between girls and boys in terms of having the ‘correct’ knowledge around sexually transmitted infections (STIs). However, the proportion of girls who correctly responded to the statement that ‘A person can contract an STI from oral sex’ was significantly greater than the proportion of boys.
There was a very significant difference between the proportion of girls who correctly responded to the following two statements compared to boys: ‘It is not sexual assault if a drunk girl has sex with a boy and doesn’t remember’ and ‘It is legal for a 15-year-old to have sex with an 18-year-old’.

The proportion of boys who correctly responded to the statement, ‘It is legal for a 16-year-old to have sex with a 30-year-old male’ was significantly lower than their female counterparts. However, in this case the percentage of correct responses was poor for both girls and boys (42% and 31% respectively).
Figure 22 shows the correct and incorrect responses of girls and boys to statements about Medicare, confidentiality and bulk billing. Further, Table 3 illustrates where girls and boys significantly differed in their responses to statements about Medicare and confidentiality.

A significantly greater proportion of girls than boys responded correctly to the following statements:

- You can get your own Medicare card at 15 years.
- Your own Medicare card allows you to visit a doctor without an adult.
- Confidentiality cannot be broken if you are in danger of harming yourself/others.
- headspace is a free and confidential service.
There were no significant differences between girls and boys in their responses to the other statements.

Table 3  
Girls’ and boys’ correct/incorrect responses to statements about Medicare, confidentiality and bulk billing

<table>
<thead>
<tr>
<th>Correct/incorrect responses to statements about Medicare, confidentiality and bulk billing</th>
<th>Male</th>
<th>Female</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Correct</td>
<td>Incorrect</td>
<td>Correct</td>
</tr>
<tr>
<td>You can get your own Medicare card at 15 years</td>
<td>73%</td>
<td>27%</td>
<td>87%</td>
</tr>
<tr>
<td>You can get a Medicare card at 15 years without parental permission</td>
<td>65%</td>
<td>35%</td>
<td>70%</td>
</tr>
<tr>
<td>Your own Medicare card allows you to visit a doctor without an adult</td>
<td>73%</td>
<td>27%</td>
<td>85%</td>
</tr>
<tr>
<td>Visits to a GP / other health care professional are confidential</td>
<td>80%</td>
<td>20%</td>
<td>87%</td>
</tr>
<tr>
<td>Confidentiality cannot be broken if you are in danger of harming yourself/others</td>
<td>66%</td>
<td>34%</td>
<td>88%</td>
</tr>
<tr>
<td>Bulk billing allows you to visit a doctor without paying</td>
<td>67%</td>
<td>33%</td>
<td>73%</td>
</tr>
<tr>
<td>A doctor cannot bulk bill without a Medicare card number</td>
<td>56%</td>
<td>44%</td>
<td>58%</td>
</tr>
<tr>
<td>You need money to be able to visit a doctor</td>
<td>50%</td>
<td>50%</td>
<td>37%</td>
</tr>
<tr>
<td>headspace is a free and confidential service</td>
<td>82%</td>
<td>18%</td>
<td>90%</td>
</tr>
</tbody>
</table>
There were no differences in responses between girls and boys for the following statements around respectful relationships: ‘You trust each other’ and ‘You don’t do things for the other person to keep them happy even though you feel uncomfortable about how they will react’.

However, for all the other statements about respectful relationships there were significant differences. The most significant differences ($p < 0.001$) were for the following statements:

- You do things that you don’t want to keep the other person happy because you feel pressure to say yes.
- One person pays for meals etc. if they have more money.
- You want the other person to be happy even if you don’t really like what they are doing.
- You go places with your boy/girlfriend to make them happy even if you don’t want to.
- One person needs to have more power than the other.
The remaining statements also showed significant differences:

- Two people have equal power. \((p < 0.01)\)
- You don’t put each other down. \((p < 0.05)\)
- You don’t go places with your boy/girlfriend if you don’t want to even when you feel pressure to do so. \((p < 0.01)\)
- You let your partner hang out with their friends. \((p < 0.05)\)
- You listen to each other. \((p < 0.05)\)

Figure 24  Girls’ and boys’ responses regarding who should teach Docs & Teens

In general, the majority of girls and boys (80% or more) agreed that the content of the Docs & Teens program should be taught by ‘a health and PE teacher’, ‘a school nurse’, ‘another health professional’, ‘a doctor’ or ‘a health educator from outside the school’. However, girls’ responses were significantly different from boys’ responses in relation to ‘a science teacher’, ‘school counsellor’ or ‘a youth worker from outside the school’. The percentage of girls (90%) who
disagreed that ‘a science teacher’ should teach the content in the Docs & Teens program was significantly greater than the percentage of boys (77%). A significantly greater proportion of girls were in favour of ‘a school counsellor’ (76%) or ‘a youth worker’ (84%) compared to boys, where the percentages were 62% and 70% respectively.

Figure 25  Girls’ and boys’ perceptions of increased knowledge about health access and confidentiality in answer to the statement ‘The Docs & Teens program increased my knowledge about …’

For girls and boys, the vast majority (> 86%) indicated that the Docs & Teens program increased their knowledge in relation to 13 knowledge statements (shown in Figure 25 above and Figure 26 below). There were no significant differences in responses to statements that the Docs & Teens program increased their knowledge about health access and confidentiality issues (Figure 25).
For statements about health and relationships, only one significant difference was found between girls and boys; that is, a significantly greater percentage of girls (95%) indicated the Docs & Teens program increased their knowledge about ‘Contraception’ compared to boys (89%).
Figure 27  Girls’ and boys’ perceptions of increased confidence in health-seeking behaviours in answer to the statement ‘The Docs & Teens program has give me confidence to …’

Most students (85–93%) agreed that the Docs & Teens program gave them confidence in the areas listed in Figure 27. A significantly greater proportion of girls felt the Docs & Teens program gave them confidence to ‘Resist pressure to do something that didn’t feel right for me’ compared to boys.
The Docs & Teens program appeared to help girls and boys equally, in all areas listed in the Figure 28. The percentage of responses ranged from 86% to 92% except for ‘Getting my own Medicare card’, where responses were 74% and 72% for girls and boys respectively.
SUMMARY

- A focus on spiritual needs in the Docs & Teens program was seen as irrelevant for nearly 60% of the students.
- Most students agreed that the program had increased their health knowledge and help-seeking behaviours.
- Students preferred interactive teaching and learning activities.
- There was strong agreement that GPs, and to a lesser extent teachers, should teach the Docs & Teens program. Students strongly disagreed with having a school chaplain or counsellor teaching the program.
- Students saw equality, trust and communication as important features of respectful relationships.
- A significant proportion of females compared to males agreed that being healthy means being physically fit, not worried or stressed, and eating well.
- A significantly greater proportion of females trusted their mums and female friends compared to boys. However, a greater proportion of males trusted their uncles compared to girls.
- Significantly fewer boys (84% to 68%) would trust youth workers to provide accurate information.
- Significantly more girls would trust the Docs & Teens program for accurate information than boys.
- The most significant difference between girls and boys was that 30% of boys trusted pornography as an accurate source of information compared to just 4% of girls.
- A significantly greater proportion of girls (96% compared to 85% of boys) indicated that information about violence in relationships should be included in the program.
- A greater proportion of boys than girls felt that sexual pleasure, pornography and masturbation should be included in the program.
- Girls are more likely to seek advice or help than boys.
- Girls had a significantly greater knowledge than boys of sexual assault and the law. However, both girls and boys had a poor knowledge of the age of consent.
- Girls had a greater understanding of how Medicare and bulk billing worked.
- Less than 50% of students felt that the program helped them to either visit a doctor or get their own Medicare card. These were the lowest response rates in this category.
- Boys were less comfortable discussing health issues with their friends than girls.
The Docs & Teens program is designed to be facilitated by a GP, who is paid to run the sessions. If a GP is not available another health professional such as a nurse will teach the program and, failing that, a teacher. Neither health professionals nor teachers are paid. There is an expectation that a teacher will co-facilitate all sessions. There are 62 GPs who are registered, trained and have taught the program. Members of the steering group emailed all these GPs to request their involvement in the research. As Table 4 shows, only 14 GPs completed the survey.

**BACKGROUND CHARACTERISTICS**

<table>
<thead>
<tr>
<th><strong>Table 4</strong></th>
<th><strong>Background characteristics of stakeholders</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of stakeholders</strong></td>
<td>31</td>
</tr>
<tr>
<td><strong>Role</strong></td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td>14</td>
</tr>
<tr>
<td>Health professional</td>
<td>7</td>
</tr>
<tr>
<td>Teacher</td>
<td>10</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>25–35 years</td>
<td>3</td>
</tr>
<tr>
<td>36–45 years</td>
<td>11</td>
</tr>
<tr>
<td>Over 45 years</td>
<td>17</td>
</tr>
<tr>
<td><strong>Identification</strong></td>
<td></td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Islander</td>
<td></td>
</tr>
<tr>
<td>Person with a disability</td>
<td></td>
</tr>
<tr>
<td>Person from a non-English speaking background</td>
<td></td>
</tr>
<tr>
<td>Person who identifies with a religion</td>
<td>5</td>
</tr>
<tr>
<td>Person from a rural area</td>
<td>2</td>
</tr>
<tr>
<td>Gay/lesbian/bisexual/transgender/queer/intersex</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td>22</td>
</tr>
<tr>
<td>I prefer not to say</td>
<td>2</td>
</tr>
<tr>
<td><strong>Length of time involved in the Docs &amp; Teens program</strong></td>
<td></td>
</tr>
<tr>
<td>1 year</td>
<td>6</td>
</tr>
<tr>
<td>2–4 years</td>
<td>8</td>
</tr>
<tr>
<td>5 or more years</td>
<td>17</td>
</tr>
</tbody>
</table>
Most presenters were female, over 45 years of age and had been involved in the program for five or more years.
STAKEHOLDER EXPERIENCES OF TEACHING THE DOCS & TEENS PROGRAM

Figure 30  Positive experiences for stakeholders

<table>
<thead>
<tr>
<th>Key</th>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7_2</td>
<td>It was positive</td>
<td></td>
</tr>
<tr>
<td>Q7_3</td>
<td>I enjoyed delivering the program</td>
<td></td>
</tr>
<tr>
<td>Q7_4</td>
<td>I felt confident in my knowledge of the subject matter</td>
<td></td>
</tr>
<tr>
<td>Q7_5</td>
<td>I believe my participation in the program was helpful to the students</td>
<td></td>
</tr>
<tr>
<td>Q7_6</td>
<td>I felt that I empowered students to seek help for health issues</td>
<td></td>
</tr>
<tr>
<td>Q7_8</td>
<td>I would be happy to teach it again</td>
<td></td>
</tr>
<tr>
<td>Q7_20</td>
<td>I liked the teaching approaches</td>
<td></td>
</tr>
<tr>
<td>Q7_23</td>
<td>I was able to cover all the content</td>
<td></td>
</tr>
</tbody>
</table>

Figure 30 shows that the vast majority of those involved with the Docs & Teens program indicated that it was a very positive experience. The only area to receive less than 80% agreement was in relation to covering all the content. While all the teachers indicated they were able to cover all the content, approximately 20% of the GPs and other health professionals disagreed.
Figure 31  Negative experiences of stakeholders

<table>
<thead>
<tr>
<th>Q7-7</th>
<th>Q7-16</th>
<th>Q7-17</th>
<th>Q7-18</th>
<th>Q7-19</th>
<th>Q7-21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GP</strong></td>
<td><strong>Hlth Prof</strong></td>
<td><strong>Teacher</strong></td>
<td><strong>GP</strong></td>
<td><strong>Hlth Prof</strong></td>
<td><strong>Teacher</strong></td>
</tr>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td>Disagree</td>
<td>Disagree</td>
<td>Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>Not Sure</td>
<td>Not Sure</td>
<td>Not Sure</td>
<td>Not Sure</td>
<td>Not Sure</td>
<td>Not Sure</td>
</tr>
<tr>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
</tr>
</tbody>
</table>

**Key**
- Q7_7: It was a very negative experience
- Q7_16: I felt under prepared
- Q7_17: I felt under skilled
- Q7_18: It was difficult to maintain classroom management
- Q7_19: I felt uncomfortable with some of the content
- Q7_21: I felt uncomfortable with some of the teaching approaches

Figure 31 tends to confirm the results of the previous graph in that the vast majority of those involved with the Docs & Teens program (i.e. 80% or more) disagreed with negative statements about the program.
Figure 32  Sense of support provided by headspace and schools for teaching the Docs & Teens program

![Bar chart showing support levels](chart.png)

**Key**

- Q7_12  I felt very supported by headspace Geelong
- Q7_15  I felt very supported by the school
- Q7_13  I felt very unsupported by headspace Geelong
- Q7_14  I felt unsupported by the school

Figure 32 indicates that around 80% or more of those involved with the Docs & Teens program felt very supported by headspace and schools.
Nearly 70% of the sample felt that they had learned a lot about adolescents from teaching the program. GPs were the group who felt that teaching the program had also contributed to learning about themselves. Nearly 50% of GPs and teachers found the teaching challenging. However, health professionals were less likely to find teaching the program personally and professionally challenging and were less reflective about whether it had impacted on learning about themselves.
In general, the majority of teachers indicated the program was too short, whereas 60% of the GPs and around 80% of the health professionals disagreed. However, the majority of presenters did not consider the program to be too long.
On the whole, at least 70% of GPs and teachers agreed that headspace Geelong had adequately prepared and built their confidence to cover the content of the program as well as increased their knowledge, skills, understanding and enthusiasm. A similar finding was reflected among the health professionals, except in relation to knowledge, skills and enthusiasm. In response to knowledge and skills, less than 30% of health professionals agreed that headspace had increased their knowledge of schools or skills to work with adolescents. Just over 40% of health professionals agreed that headspace had increased their enthusiasm.
The majority (> 70%) of GPs disagreed that the professional development provided by headspace was too short, inadequate, irrelevant or made them apprehensive about teaching the program. Around 55% of health professionals and around 70% of teachers disagreed that the professional development provided by headspace was inadequate in relation to the expectations and aims of the program. All GPs and health professionals disagreed that the professional development provided by headspace made them apprehensive about teaching the program, whereas only half the teachers disagreed.
Figure 37a  Responses to the question ‘What topics do you think are the most important to include in the Docs & Teens program? How important is …’
Figure 37b Responses to the question 'What topics do you think are the most important to include in the Docs & Teens program? How important is …'
Overall the topics considered most important to those teaching the program were *where to go for help*, *contraception*, *sexual consent*, *laws about sex*, *STIs* and *violence in relationships*. Those considered least important were *masturbation*, *sexual pleasure*, *puberty*, *reproduction*, *love* and *being close*.

The following four figures analyse the 27 responses\(^2\) in Figures 37a and 37b according to who taught the Docs & Teens programs – that is, GPs, teachers or health professionals – and their views on what topics are important to include. This deeper analysis is presented in four figures due to the large number of options in the question.

All professionals were unanimous in rating ‘*Where to go for help*’ as a very to extremely important topic. Out of the 27 possible topics shown in Figures 37a and 37b, the vast majority (80–100%) of teachers and GPs rated the same 10 topics as very to extremely important. These were:

- Where to go for help
- Safe and unsafe alcohol use
- Sexual consent
- Laws about sex and relationships
- Illicit drugs such as marijuana and ice
- Healthy relationships
- Contraception
- Rights and responsibilities in relationships
- Sexually transmitted infections
- Violence in relationships

This was in contrast to the health professionals group, where 80–100% of health professionals selected only one of these 10 topics, namely ‘*Where to go for help*’, as very to extremely important. The majority (80–100%) of the health professionals group considered ‘*Paying a visit to a doctor*’ as being a very to extremely important topic to teach in the Docs & Teens program.

\(^2\) The original survey question included 28 topics, but one option was ambiguously worded to combine two topics (*Safer sex* and *Mental illness*). This option has been excluded from the reported results.
Safe and unsafe alcohol use and illicit drugs were rated as the most importance issues by teachers and GPs, while health professionals rated paying a visit to the doctor as the most important. Another key difference was in relation to over-the-counter medication, which teachers rated as very important, while GPs and health professionals rated it as the least important of the top 10 topics.
Figure 38b  Importance of topics in the Docs & Teens program according to who was teaching the program (cont.)

<table>
<thead>
<tr>
<th>Key</th>
<th>Q16_8</th>
<th>Q16_9</th>
<th>Q16_10</th>
<th>Q16_11</th>
<th>Q16_12</th>
<th>Q16_13</th>
<th>Q16_14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When to get to a hospital</td>
<td>Healthy relationships</td>
<td>Puberty and sexual development</td>
<td>Reproduction issues, conception, assisted reproduction (IVF), pregnancy, birth</td>
<td>Love and being close</td>
<td>Contraception</td>
<td>Where to go for help</td>
</tr>
</tbody>
</table>

With the exception of ‘Where to go for help’, health professionals rated all topics in Figure 38b significantly lower than teachers and GPs, particularly in relation to puberty and reproductive issues.
Figure 38c  Importance of topics in the Docs & Teens program according to who was teaching the program (cont.)

Key
Q16_15  Sexual activity
Q16_16  Sexually transmitted infections (STIs)
Q16_17  Sexual health checks
Q16_18  Sex and social media
Q16_19  Violence in relationships
Q16_20  Negotiating sexual activity
Q16_21  Sexual consent

With the exception of sexual activity, health professionals rated all of the topics in Figure 38c lower than teachers and GPs, particularly in relation to violence in relationships, STIs and sexual consent.
Figure 38d  Importance of topics in the Docs & Teens program according to who was teaching the program (cont.)

Overall teachers rated the most sensitive topics as more important compared to the GPs or health professionals. Sexual pleasure remained the topic rated the lowest in regard to importance by all professionals, whereas all rated getting healthy as important. In addition, teachers and GPs considered legal issues of high importance.
SUMMARY

Teaching Docs & Teens was overall a positive experience for all professionals. For GPs it enabled a greater understanding of young people and themselves. This was not the case for other health professionals.

GPs and health professionals felt that there was adequate time to cover the content of the program, whereas teachers felt it was too short.

All stakeholders felt the level of support from headspace to teach the program was high. GPs felt satisfied with the level of professional development, and felt they didn’t need additional professional development.

Where to go for help, contraception, sexual consent, laws about sex, STIs and violence in relationships were considered the most important topics to include in the Docs & Teens program, whereas masturbation, sexual pleasure, puberty, reproduction, love and being close were considered the least important.

There were marked differences in what teachers and GPs rated as important and what health professionals rated as important. Teachers were more likely to rate the more sensitive issues in the Docs & Teens program as important to cover.
GPs’ VIEWS ON THE DOCS & TEENS PROGRAM

Four general practitioners with a longstanding involvement in delivering Docs & Teens were interviewed for this evaluation of GPs’ views on the program. The doctors were asked about their roles, the aims of the program, the quality of the professional development provided, their views on the program’s sustainability, curriculum content and the strengths and weaknesses of the program. Their views are summarised below.

AIMS OF THE PROGRAM

Kate\textsuperscript{3} has been involved in the Docs & Teens program since its inception and was very clear about this being an access program. In her view:

\begin{quote}
... it’s [the program’s] been mistaken over the years as being a health provider, which it is not.
\end{quote}

Rather, she thinks the idea was always to give young people information about where to go for various health issues. She said it has been:

\begin{quote}
... mistaken both by the schools and by the deliverers as being a sex ed program, which it was never, ever set out to be.
\end{quote}

Related to this, she said:

\begin{quote}
They shouldn’t be asking ‘Do you know about chlamydia?’; they should be asking ‘Do you know where to go if...?’
\end{quote}

In contrast, Linda came into the program with an interest in young people and sexual health, and had a slightly different view of the program:

\textsuperscript{3} Pseudonyms are used for all GP names to maintain anonymity.
... to show that we are approachable and you can talk about anything with us and we will listen ... it’s sort of an advertising role for a general practitioner but also an opportunity to teach them a little bit of the vocabulary and to be able to say this is a mental health problem that you’ve got ... or if it was a sexual health problem as well, just to allow them to realise that we do actually get it. I don’t expect them to retain a lot of knowledge but at least they get an introduction to some of the stuff we’re talking about.

Linda thinks the program is a good way to encourage students to look after themselves ‘more from a sexual health perspective and then a bit of mental health too’. Although she sees her role as making students feel they can approach a GP, she does not encourage students to come and see her because ‘I don’t think that’s what I should be doing’.

Zia sees the main aim of the program as ‘health literacy’. She also identified three key aims:

... teaching young people their right to access health care (Medicare cards); feeling comfortable going to a GP and doctor; and patient confidentiality.

She said that while health literacy is the main aim, ‘building a relationship of trust with young people’ was also very important.

For Kate, information and engagement are the main aims, as:

... anything beyond that is unrealistic. It’s a vignette ... to get them thinking about getting themselves organised along health lines, preventative but also just understanding the system.
GP PROFESSIONAL DEVELOPMENT

All of the doctors completed the training provided before they started teaching the program, but a long time has elapsed between then and now. One GP has been involved in the training sessions as a facilitator. All thought that they were useful as presenters regardless of the fact that they had done the training a long time ago. All mentioned attending current health issues updates organised by the program’s Education Officer that were available to them, other health professionals and teachers. Zia described the training as follows:

Two hours of training ... trying to step through the program. In the first session of the program, we tell them about throwing the contraception kit around and we tell them about the anonymous questions with that back-up support if needed. But generally, so it’s really just stepping through the intro, the game, what the role-playing is about and some kind of I guess – that’s where Julie’s [Education Officer’s] part is really crucial around just helping frame it for the doctors to understand that we want to get the young people to really speak up. So it’s very much directed at just that first part of the program. So the rest is really relying on the GP to have all the relevant knowledge and be a GP who’s up to date with your specific issues. One of the other benefits I was going to say is that I think for GPs who are doing Docs & Teens and teaching young people about confidentiality and Medicare and the fact that they are really entitled – we think as doctors that they’re entitled under 16 to have free health care and should be bulk billed and we teach them in the program to advocate for themselves in that regard and say, ‘Could I please be bulk billed?’
Working with schools

Kate pointed to the importance of the teacher or school nurse as a co-facilitator ‘so that they can follow up afterwards’ but was aware that some schools did this a lot better than others. In some schools, teachers see it as ‘a time to sit on their computer at the back while you’re delivering’. She stressed the important role that teachers play as they:

... know each child, they know the issues, they can contribute and help out in difficult situations and do it much better than we can as non-teachers.

Although Kate is not teaching in the program as much as she used to, she did take the time to chat to teachers before she delivered the program to see if there were any particular issues they wanted her to highlight, or something they did not want mentioned. She was the only doctor out of the four interviewed who did this. Others admitted that it would be a good idea to do this but that they simply did not have the time. As Andrew observed, ‘the catch is that we don’t know what the curriculum already involves so we’re flying blind’. Kate also pointed out that the program needed to be modified for teaching to Year 8 students and it was important to know this before delivery.

In her interview, Linda made the point that she follows up with teachers when she arrives for the second session, to see if there have been any disclosures resulting from the Question box activity. Even though the questions are meant to be anonymous, she makes the teacher aware that someone in the class has:

... asked this and can you keep an eye out for them, because I am going to encourage that person to seek help, so who are the resources you think I should suggest within the school?

Often the teachers are already aware of such situations. Linda also often has students stay back after class to talk with her.
SUSTAINABILITY

The doctors are paid for delivering the program, and although the amount is nominal compared to what they would get paid in their practices, they all agreed that many doctors would not do it if payment were withdrawn. This would apply more so to those GPs who deliver a lot of sessions than the ones who do only a few each year. Zia thought that ‘if it was voluntary, numbers would drop quite significantly’. Andrew feels that the payment serves two purposes: ‘to show appreciation but also to try and encourage people to come in’.

The interviewees agreed that the work of the Education Officer in coordinating the program was crucial to its success. If the program were supported by another organisation, the role would still need to be maintained. Linda commented that she ‘wouldn’t want a specific interest group taking over’. The interviewees could not imagine the schools taking over the role that the Education Officer fulfils, because teachers were too busy and the reason why doctors participate is because everything is organised for them: ‘all [we] have to do is turn up ready to teach.’ Linda thinks that Julie [the Education Officer] does an ‘amazing job’.

CURRICULUM

There were concerns about the variation in content and delivery across the range of schools. For example, Kate remarked that in some schools the nurse will deliver the first session, and someone else will deliver the second. Kate sees this as ‘the main problem’. She also emphasised the importance of ‘not creating norms’; for example, avoiding making prior assumptions that all of the students are sexually active.

Zia thinks that the program has remained ‘adaptable and flexible … and contextually relevant’. She talked about regular resource updates (e.g. to meet changing family planning guidelines around contraception) coupled with education nights for GPs and other health professionals organised by the Primary Health Network. These have not only allowed the GPs to keep abreast of changes, but also allowed others not involved in the delivery of Docs & Teens to keep up to date with youth health issues. As Zia said:

… it’s one thing to educate young people and advocate that they see a GP, but to then have a doctor say, ‘Oh well, no, you’re too young and you can’t have that …’
Zia admitted that she couldn’t really control what happened in other practices but acknowledged attempts to disseminate information and alert local ‘doctors to keep in line with current and contemporary recommendations’. She also mentioned that workshops on ice, pornography and social media had been organised and were well attended.

Zia remarked that one way the GP facilitators have attempted to keep resources up to date is by changing the scenarios on the ‘Who to go to?’ cards. Recently they included ‘You have watched pornography and are unsure if sex happens this way in real life’ and ‘You are concerned about you or your friend’s level of alcohol or other drug use’. She said these situations had replaced the ‘three or four questions around chlamydia’. For her, it was also important to review the cards so that they didn’t become too ‘weighty’; that is, if they added cards they might also need to exclude some.

Andrew suggested that there was too much focus on sexual health in the program. He said:

> I think that the focus on drugs is just as important and I think that there’s been a tendency to downplay that and that’s probably reflecting just individual differences.

**STRENGTHS OF THE PROGRAM**

All of the doctors were of the opinion that students found the program valuable. As a way of gauging this, Kate said:

> ... very often, more times, than not, they’ll come up and speak with you privately afterwards. Even if that is the only thing that happens, that is a good outcome.

Kate also sees students in her practice all the time:

> They’re fine about saying, ‘Oh, I saw you at Docs & Teens’.

Linda noted that the program has ‘been geared quite well to their issues’ and really likes the hands-on approach, the Contraceptive kit and the Question box activity. She also likes the flexibility to change the curriculum on the spot to meet the needs of students. The other thing that she liked about delivering the program is that it makes her feel ‘a little bit more in touch with that particular group’.
Zia also appreciated ‘seeing young people in their context in a place where they feel comfortable’. For her this helps to ‘calibrate what’s age appropriate at different ages’. As she said:

*I think being part of young people’s educational world is beneficial for us as doctors.*

Zia also appreciates making links with the school wellbeing teams. Making these connections helped her to particularly support early-career teachers in responding to students’ health issues. Unlike Linda, Zia tried wherever possible to visit local schools so that ‘*the young people can come and see me*’. Her ideal vision would be to case manage tricky situations with the school nurses and wellbeing workers.

**SUGGESTIONS FOR IMPROVEMENT**

As the program has grown Kate thinks that ‘*some have lost sight of the original goal*’. She expressed her concerns as follows:

*... one of my main concerns for the last five or six years, is that they’ve got more and more doctors involved. They have needed to because they’ve taken on more and more schools but not all of them are young people trained ...*  

Related to this, Kate said that it is incumbent on doctors to keep up with young people’s issues. headspace runs forums on youth issues throughout the year and it is important that the doctors in the program come to these. She thinks that regular attendance should be a prerequisite for delivering the program. Kate has also offered to do a parents’ session before the program starts but this offer has yet to be taken up. Further, Kate wondered how to attract younger GPs to the program, perhaps using registrars that volunteer for a placement at headspace, as she felt that as time goes on she is getting more and more distant from young people.

In regard to the deleterious effects of expansion, Kate expressed concerns about doctors not being from the local area. One of the original aims of the program was to match local schools with GPs that were within easy access. However, because of the scaling up of the program it was difficult to match local doctors to local schools. She said:
We’ve had examples when GPs are delivering and the students ask about local services and they’ve got absolutely no idea.

Linda feels there is too much information to cover in a short time:

A couple of the cards [in the Who to go to? activity] now they tried to put together two or three different scenarios into one. There was one about ‘are you feeling sad because you’ve been bullied because you’re gay’, and they used to be three separate things ... maybe they could put depression and anxiety back together. But the bullying is a big enough topic for that age group that warrants its own card.

Linda also questioned the usefulness of the What is health? activity and thought it should be condensed.

Zia, too, expressed some concerns about content overload. She sees her role as helping students ‘understand the pathways’ for assistance if they need it, but was unsure ‘whether a two-hour program can do this’. She ‘started to feel a little bit pressured by the amount of content that we were trying to put forward’.

The move from delivering the program at Year 9 to now delivering at Year 8 in some schools concerned Zia. She thought that this was driven by schools that were having ‘problems in Year 8’. For her, some students – particularly boys – were too immature and ‘dominated the conversations often using very inappropriate language’. She felt that Year 9s were more ready ‘for a skills based approach ... and role-playing’ and doubted whether many 13-year-olds ‘would actually make it to a GP’. She also resented being put in a classroom management role with Year 8s when co-facilitators were reluctant to step in.

Andrew expressed similar concerns about the move to Year 8, in particular referencing the developmental framework. He said:

... you have to accept frontal lobe development is important. Year 9 is a good year because the kids are more independent ... as a cohort and starting to think a little bit more critically. Year 8 is a bit of a risk, but as I understand it the schools felt they
should be getting in even earlier to prevent particularly sexual problems ... you can say that kids are maturing earlier ... but it’s a very dangerous thing to say that they’re maturing in a sophisticated, cognitive way.

Linda also pointed to the fact that sometimes the regular teacher is not present and if the replacement is not sure of the program ‘or where I am going with it ... sometimes I am not sure if they even need to be there’. Related to content, she commented that:

If you are going to talk about depression and mental health, you need to discuss suicidal thoughts because they need to access some help. I don’t tend to go beyond that but it’s meant that there will be people in the room who actually get upset when you start talking about it.

Linda’s main aim is for young people to access help either for themselves or for their friends. Further, she said that the GP facilitators get very little feedback from the students on what they thought of the program and it would be useful to know ‘what they wanted to know more about; were there things that I haven’t explained well enough?’ One girl said to her once, ‘I’m never having sex again’, which gave Linda pause for thought as this was not the message she was trying to give.

Andrew sees a weakness of the program as being reliant on ‘non-professionals in that we’re not educationalists. I think at times we get left to do it too much ourselves’. However, he did qualify this by saying:

I’ve had teachers who really do understand the curriculum and drive it so that they use us more as a resource, which I would have thought is a logical way of doing it because we’re not educationalists.
SUMMARY

The main take-home messages culminating from the doctors’ interviews can be summarised as follows:

- All thought the Education Officer had done a great job and the role would need to be retained for the successful implementation of the program.
- All appreciated contact with students as it helped them to keep up to date and they had fun teaching the program.
- Doctors were able to establish a good rapport with students. For example, students would often approach them after the sessions and some would contact them outside of class.
- The program contained too much content and not enough time for delivery.
- All see the Docs & Teens program primarily as an access program.
- All see a mismatch between the program aims and the current content.
- There are differences of opinion about the content focus (e.g. sexual health versus drug education).
- All agreed they needed to know what health content had been taught before the program.
- They emphasised that co-facilitation with teachers/nurses was a good model, but in practice it often didn’t work this way.
- None had undertaken any ‘refresher’ training in recent years.
- To move the Docs & Teens program from Year 9 to Year 8 was questioned in terms of appropriateness; that is, in terms of younger students’ immaturity.
- Lack of consistency in delivering the two sessions often occurs when the same doctor does not deliver both sessions. This is also a problem when the teacher is away for one of the sessions, making it difficult to follow up students’ questions.
CASE STUDIES

The follow case studies provide an in-depth look at how two schools have implemented the Docs & Teens program.

CASE STUDY 1: BARWON HIGH SCHOOL

Barwon High School is a relatively new 7–12 secondary school with a current enrolment of 534 students and 37 staff. It is situated in a growing population belt with predictions that the school will continue to grow until 2036. The majority of the students (96%) come from families that have English as their first language. The school is situated in the middle quartile of the Index of Community Socio-Educational Advantage (ICSEA) at 61%. A larger proportion of boys (57%) are enrolled compared to girls (43%). The school prides itself on providing students with the knowledge, life skills and technical prowess required to succeed in a rapidly changing 21st century. A key focus of the principal and his team is the promotion and facilitation of independent and active learning. The teaching staff believe in the premise that the more actively a student participates, the more they will enjoy their studies, which often translates into higher grades and greater depth of learning.

_We are a school that values the development of skills and attributes within our students that will prepare them extremely well to be independent, creative and critical thinkers._

_(Barwon High School Principal)_

Context

The Docs & Teens program has been running at the school for the past four years as an extracurricular activity initiated by the health and wellbeing staff. It forms part of a home-room program called ‘Connect’, rather than being integrated into the existing HPE curriculum. ‘It was initially through Connect, and that was a wellbeing program, Connect is like our home group,

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4 ‘Barwon High School’ is a pseudonym.
where they have half an hour every day after recess ... it’s a great wellbeing type introductory session’ (HPE Coordinator).

At the end of 2014 a decision was made to integrate the two sessions of the Docs & Teens program into the health education curriculum. In 2015, the program was thus used to introduce a Year 9 health education unit called ‘Sex, Drugs and Rock ‘n’ Roll’. This was undertaken according to the HPE coordinator because, ‘it was a new CAT [common assessment task]. Then when the emails came through about Docs & Teens ... it was perfect to start off our health unit.’

The school planned to run the program as documented in the Docs & Teens Program Manual (see pp. 8–11). At the time of this research, the school was planning to develop the ‘Sex, Drugs and Rock ‘n’ Roll’ CAT based on the Docs & Teens introduction.

The ‘Sex, Drugs and Rock ‘n’ Roll’ CAT and has two parts to it. ‘The first part we’ve changed to a reflection on Docs & Teens ... going back over what organisations are available to them, and how do they contact them. Part two [is] ... about things they brought up, the questions, and are there any further questions that need answering that weren’t brought up or discussed.’

At Barwon High School, the Docs & Teens program was taught between 24 August and 4 September 2015. The two sessions for each class were spread over two weeks and each session went for 90 minutes. Two GPs conducted the sessions, with three Year 9 groups. The same GP did not necessarily conduct consecutive sessions.

The school has an HPE program from Years 7 to 9, although the focus is overwhelmingly on physical education. Health Education is an elective in Year 10. The school sees Docs & Teens as becoming an important introduction to their Year 9 health program. Teachers do not play an active role as co-facilitators.

Classroom observations of curriculum and teaching

Session 1

Observation of a sample of two classes at Barwon High School provided some insight into the planned program in operation. Much of the first session was spent defining health using the categories listed in Table 5. The four components of health listed in this table were used to introduce the activity. The GP asked the students what would fit under each topic. Overall, students were able to identify a number of physical health issues but they struggled with the other areas and the GP identified most.
During the focus group interview, two of the three teachers raised questions about why the spiritual dimension had so much prominence whereas other areas of health, such as sexual health, were not mentioned: ‘It just didn’t really stick with me, so … like the spiritual part of it?’

In Session 2, another GP repeated this activity as a means of recapping Session 1, but didn’t focus on spiritual health. The GP included the word ‘ethics’ in the spiritual quadrant with no explanation.

The What is health? activity was followed with the Musical chairs activity, designed to get students to identify a range of health issues they may have had. The GP started by asking students to stand up if they had had an argument with someone in their family in the last week. Students then ran around to find another seat. The student without a seat was required to ask a further question. Questions covered by the students included someone they knew who:

- had the flu this winter?
- had an allergy?
- had broken a bone?
- had an OCD?
- ate vegetables last night?
- had contracted chickenpox?
- had diabetes?
- had autism?
The remainder of the session explored a range of health issues and services that students might need to access in their local area. The GP introduced the next activity by asking students if they had their own doctor, and emphasised the importance of having their own doctor and that the doctor should be someone they felt comfortable with. This activity used a set of large flash cards that listed a range of health services students could access in the Geelong area. The GP laid these cards out on the floor, briefly explaining the focus of each.

This was followed by a set of scenario cards from which students had to decide which service was suitable for which health-related issue. The scenarios included:

- Having your own Medicare card
- Thinking about having sex
- Worrying a lot
- Getting picked on at school
- A friend with suicidal thoughts
- Sexual assault
- Chlamydia
- Alcohol
- Eating disorders
- Condoms
- Unconscious situation
- Pornography
- Pregnancy
- Twisted testes

The two GPs who conducted this activity concentrated on different issues, were inclusive in some areas and not others and sent particular messages to students. For example, while discussing the health issues and services for same-sex attracted young people one of the GPs used the phrase ‘those sort of people’ – not a very inclusive approach for students who may identify as same-sex attracted or gender diverse. There was also a heavy concentration by one of the GPs on sexual consent, pornography and suicide – issues that all require follow-up, which was not available in this program unless students actually accessed the services. In addition, a number of students were frustrated that the GP concentrated on issues they already knew rather than what they wanted to know.

*The things we didn’t know she skipped over, and the things we did know she talked about for a while.*
Overall students engaged with the scenario activity because:

... it went into like deeper medical issues ... it was a much deeper sort of experience.

It also provided advice about where to go:

Places you can go in Geelong. I knew Geelong had headspace but I now know there’s so many more places and just lots of information.

However, a number of students commented that the ‘activity dragged on, went on for too long’. The GP also covered getting a Medicare card and its use for these services. Students subsequently struggled to remember how to get their own card beyond applying online. Not one of the 15 students involved in the focus group interviews said they would apply for their own Medicare card.

The final activity in the first session required students to write down questions they wanted the GP to answer in the following session. These were to be put in an anonymous question box. However, there was no real time for students to reflect on or develop their questions.

Session 2

In Session 2, the GP spent over half the time redoing the health defining activity, the musical chairs game and the services activities. Students expressed frustration that they had already undertaken these activities in the first session. This was then followed by a contraception information session. The GP began this activity by asking students, ‘What do you need to think about before having sex?’, which the students struggled to answer. A range of contraceptive options was canvassed. Most emphasis was placed on the IUD implant, and the pill. There was a condom demonstration and students all had a go at putting a condom on a plastic banana. In addition, the GP spent time lecturing the students about negative aspects of pornography.

Students in this session were very engaged in the topics on sexual activity, pornography and contraceptives. The GP said there were a lot of reasons why people have sex, but didn’t cover them. The GP had set the students homework, which was to talk to their parents about pornography, but no student completed it. The GP spent a lot of time on pornography and its role in sex education. This involved telling students her opinion, but very little discussion with or by the students.
This second session involved far more talking by the doctor than had taken place in Session 1. Students wanted to cover how to have sex; however, the GP skipped over this request, saying there wasn’t time. She also said that she was ‘not going to tell you about that part’.

Another key observation from this session was a tendency by the GP to feed into gendered discourses about sexual activity and desire, saying men ‘may not be awesome at foreplay’. There was no time left in this session for the students’ questions to be answered.

**Teachers’ and students’ views on the program**

Teachers felt the Docs & Teens program had been a success because it was ‘informative’, students were ‘really engaged’ and ‘there was some great discussion’. They did however think that it could be longer, as ‘there was a lot introduced’ but not covered in the required depth.

Students also talked about the importance of the way the program was structured for engagement and the activities they participated in.

> It was hands-on. We all sort of had our opinion and we could all have a say and when we did the scenario situation we all got involved and it was good because it wasn’t just like a class where you just sit there and listen. It was more of a discussion so we could jump in and ask any question about anything and she could answer pretty much everything ... the best part of this program was doing hands-on activities I reckon.

The teachers also felt that although they could have covered this content (two of the three teachers had in the past) ‘they really liked that the doctors introduced it and had some of those difficult topics and discussions’. It prevented the students feeling embarrassed and feeling as though they had to ‘snigger’. According to one teacher:

> I think those sessions were very honest. I think some of the issues they bring up would be harder for us to talk about in that same sort of environment.

Students also liked the doctor covering the content because the information was presented, as they put it, without a message:
The doctor just talks about it like it was any other thing. They didn’t make it seem like a big deal or make it feel awkward so we didn’t feel awkward and that was definitely much better.

The students also valued their anonymity in the class, as well as being able to work with their friends. ‘I felt like it was comfortable because we were with our friends.’ It was something they felt they didn’t have with teachers who knew them.

The doctor doesn’t actually know who you are; they just know your face because you’re in their class. They don’t even know your name. Whereas the teacher would be able to pick up your handwriting or the wording because they pick up your English essays. They’d work it out.

It would have been really weird and awkward if they split us up. Teachers like to put you in groups with people that you’re not very comfortable with like when you’re doing group projects and stuff. If that were to have happened, it wouldn’t have been a pleasant experience. It would have been kind of awkward, but I find that because we had our friends there to support us we were able to gain some knowledge and just have a little laugh along the way.

The students also felt that the teachers were embarrassed and uncomfortable, which impacted on their contribution in class:

You can tell they’re all awkward and embarrassed about it, as much as we are.

Students also questioned the teachers’ professional expertise:

*Our health and PE teachers just – they don’t seem like they specialise in it as much as her. She’s a doctor. She’s actually treated this stuff. Our health and PE teachers definitely haven’t helped any patients with anything.*
Teachers and students felt that the program could be improved by including more relevant content. Teachers felt that part of the problem was that the program had not been updated in the years they had been involved and therefore had not kept pace with issues relevant to young people, particularly the impact of technology. However, they also acknowledged that perhaps the school should be following up on a number of these issues.

*Everything’s the same, got the same folder. So yeah perhaps the technology side of it, and yeah pornography and ‘sexting’ and all that, which is I think far – a lot more prevalent and bigger issues for the kids today. Maybe more of a focus on that. Maybe that’s for us to follow up with, I don’t know.*

In addition, a number of students were frustrated that the GP concentrated on issues they already knew about that they had covered in primary school, rather than what they wanted to know. For example, students wanted greater concentration on the topic about experimenting with alcohol consumption.

Teachers and students felt the content was rushed and perhaps the program should either have longer sessions or additional sessions. Teachers were concerned the content lacked depth and the program lacked flexibility.

*Kids can get quite inquisitive and ask a question, and another question comes off that. Then the docs are willing to answer these questions, but they miss out on some of that other stuff, or they have to rush through it, so maybe that extra time, that extra day.*

Students felt that the program needed one more session. However, if the school had to pay for the program and do all the organisation that is currently undertaken by the Docs & Teens coordinator, it is unlikely that the school would continue to offer the program: *‘It probably depends how much we’ve got in the budget and what we can get approved to use ... I’d say probably not in all reality’.*
SUMMARY

Teachers were pleased with the program overall. They felt that although they could teach the content (one teacher had in the past), the doctor provided a link to outside the school.

"I’d feel comfortable doing it. I wouldn’t have a problem, but ... the fact that there’s an outsider ... that’s coming in, (the doctor) might deliver a little bit more punch. They (the students) see us every day."

Students at Barwon High School found the program informative and engaging overall. They were engaged in the health defining activity, which was reinforced using an interactive game of musical chairs. Students explored the range of services available in their local area in relation to a number of health issues facing young people. They expressed some frustration because, rather than covering the set program in Session 2, the first few activities were repeated, which left no time to answer students’ questions.

In addition, there was an over concentration on sexual health issues, including pornography, which meant that other issues were glossed over. Students felt there was repetition and the issues they wanted to cover (e.g. depression and other areas of sexual health) did not get covered.

Although there was a discussion on how to obtain your own Medicare card and why you would do this, none of the students in the case study focus groups had actually done this or indicated they would in the near future. There were also illustrations of language that was not inclusive of same-sex attracted students.

Teachers were very clear about the aims of the program.

"... the services ... protecting themselves, and knowing where to go ... where to get help."

For the students, their greatest recollection about the program was ‘when we put a condom on the banana’. They also recalled a focus on ‘STDs and stuff and depression and anxiety and all that’.

However, drilling further into their understanding of why they were involved in the program, students clearly understood what the program involved.

"... how you can get help and what people you can see and what professionals you can seek out to, I don’t know, help with"
something ... like, lots of the different places you can visit if you need help ... how to help others ... Medicare cards so we can go to the doctors by ourselves without a parent.

A number of students thought they had participated because it ‘kind of made up for all the health that we don’t really do that much of’. They also maintained that the program involved information that they needed to know.

... stuff that we actually needed to know, not just stuff they were just telling us about ... stuff about your beliefs and what other people believe in and it was like spiritual stuff ... depression ... we don’t really do anything else like that about it.
CASE STUDY 2: RIVER COLLEGE

The second case study school, River College\(^5\), is a 7–12 state secondary college situated in a semi-rural setting in the Barwon Health region of Victoria. It has an enrolment of 823 students, made up of 505 boys and 318 girls. The school’s Index of Community Socio-Educational Advantage (ICSEA) is 977, with 1000 being the current average. The proportion of students in the bottom quarter, middle quarters and top quarter are 38%, 56% and 6% respectively. Students with a language background other than English comprise 4% of the student populations, while 3% identify as Indigenous.

In 2014, 344 students were enrolled in Vocational Education and Training (VET) pathways. Of the 165 students that completed secondary school in 2015, 32% went to university, 35% to TAFE or other vocational study and 24% were in employment.

The College offers a strong academic environment and a wide range of subjects at VCE and VET levels. The College also has a sports academy and fitness centre. It offers both academic courses and specialist coaching in AFL, netball and fitness through to VCE.

Context

The College has a comprehensive HPE program from Years 7 to 9 and Health Education is elective in Year 10. The school sees Docs & Teens as an important part of its health program and teachers play an active role as co-facilitators.

The Docs & Teens program was taught between 22 October and 27 November 2015. The two sessions for each class were spread over two weeks during this time. Each session went for between one hour and 45 minutes and one hour and 50 minutes. Six GPs volunteered to conduct sessions but they did not make all of the sessions nominated due to unforeseen circumstances. The school nurse stood in for one of the first sessions and replacement GPs took two other sessions.

Docs & Teens was taught at Year 9 for a number of years but has been taught at Year 8 for the last two years as teachers felt that some of the Year 8 students would benefit from the program. There is however some debate about this change as discussed below.

\(^5\) ‘River College’ is a pseudonym.
Classroom observations of curriculum and teaching

Classroom observations were conducted in four different Year 8 classes. Four observations (one in each of these four classes) were conducted for Session 1, but only two observations were conducted for Session 2 (one observation was cancelled due to a teacher illness, and another because an observer was not available). All of these observations were completed between 3 November and 24 November 2015. Four doctors were involved in the program’s delivery. As one of the doctors scheduled for one of the first sessions was unable to attend, a replacement doctor attended.

All of the doctors followed the recommended format in the Docs & Teens Program Manual (see pp. 8–11), but each doctor exhibited differences in terms of time devoted to particular activities, emphasis on particular health issues and their approach to classroom organisation and management. There were a number of students who left the session or were late for a session across all of the groups.

Session 1

All but one session began with the What is health? activity. In one class, the doctor asked the teacher to conduct this session, and she took 30 minutes to complete it, which was 20 minutes over the recommended duration for this activity. The other two classes completed this activity in just over 10 minutes. One doctor started with the Musical chairs activity and then moved into the four aspects of health.

Discussions on the physical, social and emotional aspects of health covered familiar territory. There was a strong emphasis on mental health in the emotional quadrant and the identification of risk factors related to anxiety, depression and suicide. Doctor 4, when discussing suicide, made the observation that ‘Boys get angry and girls get moody’. Doctor 2, who had a special interest in drug-related issues, discussed major psychosis and drug-induced psychosis.

The spiritual quadrant was the last to be discussed. Doctor 1 explained this by saying that in a few years, students will start to ask ‘Why am I here?’, ‘Where do I belong?’, ‘Who am I?’ and ‘How do I fit?’ Doctor 2, in response to a student mentioning ‘Halloween’ discussed All Saints Day, followed by a very brief reference to yoga and meditation. Doctor 3 described this category as ‘a bit special and off-beat’ and then related the category to religion and ended with the following written on the board for this quadrant: ‘church’, ‘mosques’, ‘religions’, ‘cults’, ‘yoga’, ‘meditation’. The teacher that co-facilitated this session talked about values and referred to the fact that her class had talked a lot about these this year. She too referred to the question ‘Who am I?’
Students enjoyed the *Musical chairs* activity and teachers invariably stepped in before the start to make sure that students were aware of the need to be careful when changing chairs. In the game, students focused almost solely on the physical quadrant with statements such as ‘*Stand up if you have ever had a cold ... a broken arm ... etc.*’ Doctor 3 told students at the end of the game about the *Question box* activity to be completed at the end of the session. She gave the class some examples of previous questions asked by students, and stressed that the questions were anonymous and that they would all be answered at the beginning of the next session. She was the only doctor to do this.

Activity 3 was the *Who to go to?* card game. This gave students a chance to get to know available services and what service was the most appropriate for a variety of scenarios printed on cards, one of which was distributed to each student. Sometimes there were not enough cards to go around depending on the size of each class. A boy in one class put his hand up and asked ‘*What is a GP?*’ It became apparent during discussions that the doctors were unfamiliar with some of the local health services.

Doctor 2 initiated a discussion on getting a Medicare card during this third activity and also discussed bulk billing. (Bulk bill was discussed by all doctors, but at different points in the program.) On several occasions during this discussion the doctor emphasised the importance of always ‘*keeping your parents in the picture*’. This included if you found yourself pregnant. This doctor also gave a CPR demonstration in response to the card ‘*You are at a party and your friend has become unconscious*’ (Doctor 4 also did this). The card ‘*You have noticed one of your testicles is really sore or swollen*’ led to a long discussion on testicular torsion, including the information that a male testicle can die within six to eight hours without treatment. This condition occurs in 2% of the male population. Three of the four doctors observed initiated this conversation.

In response to a card about unprotected sex, Doctor 2 observed that ‘*Girls are in a bargaining position – you have the power – no sex without a condom – unless it is forced sex. You should carry one and make sure you can use it*’. In this class the card activity took 40 minutes. When discussing the card related to thinking about having sex for the first time, Doctor 4 asked students what did they thought the percentage of kids having sex was. The responses ranged from 40% to 90%. Doctor 4 said that 25% of Year 10s were having sex.

In the class taken by Doctor 1, some time was spent on the card ‘*You have noticed some discharge on your jocks*’, as the doctor took the opportunity to talk about common STIs focusing on chlamydia. The teacher took the opportunity to remind students that they had gone through these
using the STI wheel in a previous lesson. The doctor then introduced anal sex and pornography in order to discuss changing sexual norms.

Doctor 3 took the opportunity during this activity to talk about doctor–patient confidentiality and made sure students knew what ‘confidentiality’ meant. The doctor outlined the only three situations where confidentiality would not apply: when someone is suicidal, if someone is being abused, and if you are in danger of hurting someone else.

Doctor 2 was the only one to use the optional ‘Least to most harmful’ continuum activity (see pp. 8–11) as a whole-class discussion rather than as the paired discussion suggested in the manual. This activity was rushed as time in the session ran out.

**Session 2**

Each doctor started with a recap of Session 1. Doctor 1 did the *Question box* activity at the end of her session and Doctor 4 did it after the recap, as suggested in the *Docs & Teens Program Manual*. The school nurse attended the session run by Doctor 1 as she had taken Session 1 with this class in the doctor’s absence. Also, the normal health teacher for this group was absent and another teacher was standing in for her. The doctor for this class then proceeded to go over all of the content from Session 1 for the bulk of the lesson. She then discussed contraception and demonstrated CPR. The students were very fidgety by the time it got to this stage, but were interested in the different contraceptive devices shown. The doctor then did the *Question box* activity towards the end of this session. Two of the questions were ‘What do you do if you are getting beat up at home?’ and ‘What do you do if one family member is giving another death threats?’ These questions were handled sensitively and the message that we all have a right to feel safe was reiterated. Appropriate support services were mentioned. The nurse mentioned that they could help connect students to the right service without having to know the full story. In this session the doctor ran out of time to do the condom demonstration.

In the session run by Doctor 4, one of the boys in the revision of testicular torsion asked how common this condition was. The doctor replied that she had only seen three cases since she began to practice. The boy then asked if girls’ vaginas twisted and the doctor replied, ‘It can happen with ovaries but is really uncommon and I don’t need to tell you about that’. In this session the following questions were asked and answered in detail:

- How old are you when you get your period?
- Is it supposed to hurt to use tampons?
- Are there vaginal condoms?
Can men have babies?
Why do boys get erections all the time?
What are pearly penile capsules?
Can you get STIs from oral sex?
Do you have to tell your mother if you are pregnant and want an abortion?
I have a heart murmur. Should I continue to have this checked?

In addition, there were four questions related to mental health, and a question about a pornographic YouTube cartoon of Shrek (for which the doctor steered the discussion to gender-based violence).

The next activity used was the Contraception kit (see pp. 8–11). The doctors also interwove issues around respectful relationships throughout both second sessions. Doctor 4 went through the various forms of contraception including the female condom. After a question and answer session, the doctor explained how condoms worked, where to get them, how to use them and how to dispose of them safely. The students then practised putting a condom on the ‘magic banana’ and things got a bit chaotic. The doctor then finished with the following take-home message: ‘condoms, coma position, chlamydia, confidentiality and Medicare card.’

Teachers’, students’ and the nurse’s views on the program

The teachers interviewed were very positive about the Docs & Teens program. Some had been involved in the program at several schools over a number of years and commented that the biggest challenge now is the influence of social media. When asked what they thought the aims of the program were, one teacher commented:

I’ve always seen the goal of the program to be breaking down the barriers, to show the young people that, OK, here’s someone you can go to if you need to. That alone I think is really powerful. If that is all they get out of it I think, well, job done really ... I think, making them aware that they’re not alone. I think just seeing a normal person who is actually a doctor come into the room and have a conversation is a very positive thing.

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The doctor made this question up in order to discuss doctor–patient confidentiality. An animated discussion ensued which included age of consent, disclosure to police etc.
In the second year of delivery to Year 8s, one teacher thought that they had done ‘a few things better than last year with a little bit of preparation before the program to give the students an awareness of some of the things that were going to be discussed over the two days’. The teachers were experienced HPE teachers. One, who had recently completed the training workshop, felt that the training was worthwhile as it ‘did remind (me) of some of those important cues and things to pick up on’. Those who had been involved as co-facilitators for a long time had not done the training for a number of years.

The school nurse, a co-facilitator, saw the program as a:

... prime opportunity to be involved in the classroom and a really good opportunity to get to know the health staff.

Having the staff trained meant that if the nurse was not there ‘it’s not the end of the world’. This time around the nurse also stepped in to run a session when a GP did not turn up. She commented that the way the sessions ran was dictated by the GPs: ‘some run the show themselves and we just add bits and pieces but some rely a bit more on co-facilitating ... or just throw to you to run certain activities yourself’.

One of the teachers commented that her biggest challenge was ‘reading the GP and trying to work out where I should jump in, how much of a lead I should take. I find I really have to work on that for the first 15 minutes’.

Another teacher commented that as he got to know particular GPs he was happy to steer them ‘in a certain direction that [he] thought the kids needed to know more about’. This teacher identified that up-to-date research focused on Geelong was lacking in the program and felt this was one area where ‘teachers had trouble keeping up’. He added that having a ‘fact sheet’ to hand around would add value to the program and be a point of difference to what was taught in the school’s health program. He felt that a lot of the information that GPs delivered ‘the kids could look up on the internet anyway’. He was of the view that contextualising statistics to the local area would make the program ‘feel more real’ for his students.

Another teacher, who conducted a reflection lesson after the program, said that her students were of the opinion that they had ‘learnt that in class already’. She did not see this as necessarily a bad thing as it reinforced their learning. What it did highlight for her was the need for GPs to know what schools are doing in their health education programs, and the need for GPs to contextualise the learning. Otherwise, she thought, perhaps she should:
... change what I’m running in the class because I know that’s what they’re running in Docs & Teens – or should we run Docs & Teens a bit different?

The school nurse felt that there was ‘information overload’. As she said:

The scenarios are awesome and the topics are awesome. But I just think it’s too much ... [and] they are getting the information in their health classes.

One teacher in a similar vein said:

... we need less words and more interaction.

The move from delivering the program to Year 8 students instead of Year 9s did present issues for student engagement. Some activities went for too long (e.g. the Who to go to? scenario activity – recommended time 60 minutes) and having a double session, when students were used to single sessions for health, presented challenges. As one teacher commented, ‘even the good ones were starting to lose it a bit’. As teachers, they are mindful of mixing it up and keeping students moving in order to keep them focused. This teacher questioned the decision to change delivery from Year 9 to Year 8:

I like Year 9. I don’t know why it’s changed. You can say that the kids need it a bit earlier but this group that I had this year – and talking to B. as well – her group probably didn’t need it. I reckon you could just grab a few kids that do need it and do it earlier on. I’ve got a Year 7 group this year and I don’t know how they’re going to go next year. I had a kid that fell off the ... fainted off a chair because we were looking at the female reproductive system on a cartoon on the TV of a vagina. It’s such a big transition between 7 and 8 already.

Another teacher thought that they already had a good Year 8 program and that because of this:
Another solution offered was to split the difference and have the Docs & Teens program running for Year 9 at the beginning of the year. Still another idea was to pare the program right back and concentrate just on services for the Year 8s. One other teacher would like to see the emphasis on ‘relationships’ rather than the ‘hard-core risk-taking stuff’.

In relation to timing one teacher expressed concern that in Term 3 they were juggling assessment tasks and then report writing. One solution was to try and incorporate the learning from Docs & Teens into an assessment task when they are doing their planning. They had run the program after report writing this year, which was an improvement.

The first session of the program finishes with students writing a question for the GPs asking for more information about an issue of concern to them. The GPs then begin Session 2 by answering these questions. The teachers thought this activity was valuable in ‘prompting a lot of discussion with students still coming up after class and saying things’. As well, these questions often alert teachers to issues they should be following up with students. Often teachers can guess which student has asked a particular question because they are already addressing issues with them through the school welfare team. If they can’t identify a student then teachers make sure they follow-up in a general sense in the next health class, making sure to remind students whom they can go to for assistance. There is a problem however, when a student may attend one session and not the other, which happens quite frequently.

Teachers expressed their gratitude for the level of organisation implemented by the program’s Education Officer. They did not feel that they would be able to take on this role if organisational tasks were devolved to the school.

There appeared to be some differences in content cover and focus between GPs. One teacher mentioned that he had to cover putting on a condom in the next health class because the GP did not cover this.

One concern raised in this focus group was the increase in doctors who were not local to the area and did not have a good idea about local services available to students. As well, some doctors had asked teachers *not* to point out they practice in the local area as they are not taking any more clients. The school nurse, while acknowledging how hard it would be to always have local doctors deliver the program, did think that this defeated the purpose of connecting students to local GPs.
and other services. One of the main aims of the program is for students to gain knowledge of how to apply for their own Medicare card if needed. One teacher talked about a conversation she had with her students on this topic:

... the kids were asking me about the Medicare forms. They said, ‘Well, how would I do it Miss? How would I get one?’ I said, ‘Oh, a really good question.’ So I put it on the screen how to google Medicare and brought it up. I found it interesting myself because then on the site it talked about if they want one at 15, they actually have to fill in and go to DHS to get a transfer form to get a separate one. I’m like well that sounds a bit more complicated than just getting their own. So I said just go down to Centrelink, walk in and just say I want my own Medicare card.

The nurse indicated that this process was a change as you ‘used to just download the form’. One teacher suggested obtaining forms to bring in to show students what needs to be filled in. The nurse suggested that she could keep some forms in her office for those who needed them, rather than sending Medicare forms home with all students.

**Student focus groups**

Three student focus groups were held at River College. Two were mixed-sex groups (8A and 8C) and one was a girls’ group (8B). All students interviewed said they largely enjoyed the Docs & Teens program and that the doctors that facilitated were friendly, knowledgeable and approachable.

Asked about what they remembered from the program the following topics were cited: contraception; things that you should know about sexual health; where you should go for help; if you have a friend who is mentally ill you should tell someone; how to get a Medicare card; STIs; social, mental, physical and spiritual health; what to do if you are at a party and a friend drinks too much; it doesn’t matter what sexuality you are.

When asked about available health services, all the students knew of headspace and where it was. They also knew a range of other health services and where they were located, although some had trouble with working out what the various acronyms stood for. The students had little knowledge of services other than ‘headspace and Kids Helpline’ (8A) before the Docs & Teens program. As one
boy said, ‘I knew a couple but didn’t know how much variety there was and all the different specific ones’ (8A). All said they had easy access to these services via public transport.

Students were asked their opinions on why the school hosted the program and most answers had a ‘futures’ orientation. For example, one boy replied, ‘To give us an insight of what we need later when we grow up and stuff’ (8A). This was a common response and the students did not indicate that they thought they would need to access services any time soon unless they needed to help a friend.

All students remembered the What is health? activity that started the first session, although they were less sure what the spiritual quadrant was about, citing ‘religion’, ‘culture’, ‘beliefs’, ‘values’ and ‘morals’. They had covered the physical, mental and social aspects in health education previously.

We asked how comfortable the students felt about the content covered and one boy said that he thought:

... some people in our class felt a little awkward but most of us are mature enough to understand and to take it in.

(8A Focus Group)

One girl commented that some of the mental health stuff was ‘hard to hear and intense’ and made them feel awkward but that ‘it was most of the things you have to hear’ (8B). Some of the girls did not like ‘people making stupid jokes’ (8B), although others found this funny. One girl said:

... the boys don’t always ask stupid questions. They do ask interesting ones that maybe you want to know as well secretly.

(8B Focus Group)

Doctors were seen as experts in the content material presented, even though their teachers in health education had taught them about some of it previously. It was clear that teachers often followed up issues raised in the program. Referring to his teacher, one boy commented, ‘We could ask her stuff as well if we were unsure and she’d ask the doctor and get back to us’ (8A). This year group had already engaged in a unit on healthy relationships and they found that the Docs & Teens program built on some of the knowledge previously gained. Students liked the way the doctors went into some detail when answering students’ questions.
Although most students felt comfortable enough to talk to their own GPs, some were more reticent. A girl who said ‘sometimes’ said she would not feel comfortable talking to a GP ‘when it’s something that some people don’t know about, so it’s very, very, very, very, private’ (8B). She would prefer to talk to a friend if this was the case.

All students liked the Question box activity with one girl saying ‘I was excited to get the questions answered’ (8B). Another said ‘I had a question that I needed answered and it was answered well’. The session on contraception was also popular and students were able to name the various forms of contraception they had been introduced to. They also liked the various activities and games they played, particularly the Musical chairs activity from Session 1. All stressed the importance of having fun and appreciated the sense of humour displayed by the doctors.

One of the main aims of the program is to inform students about applying for their own Medicare card. All seemed aware of how they could do this, but some would only think about doing this when they were 18 because this is when ‘things get like more hectic’. One girl said:

You’d probably start thinking about it when you’re about to get to the age of 15 like to see if you actually need it. Like what’s going on in your life to see if it would be good to get it. But then wait to see like do I really need it at this moment or can I wait a couple more years when I’m more comfortable to talk.

(8B Focus Group)

Some students did not like the session on how to put on a condom, although they did concede that it ‘was good to know how to do it though’. The girls (in 8B) thought that it would be probably less awkward in a same-sex group.

When asked about how the program might be improved, students volunteered the following comments:

I didn’t like recapping things we already knew.

Learning about depression, anxiety and all the mental health issues just made us not feel happy.
We did a whole unit on depression, anxiety and mental health so we already know everything but she still recapped and covered it.

There was a lot of information ... I don’t remember it all.

They could have covered eating better food in more depth. That’s one of the things these days because lots of people are having so much sugar.

I think it could have been less talking.

... hands-on sort of stuff.

Maybe a bit more in-depth with mental health issues because they are getting more popular.
SUMMARY

All of the GPs observed were friendly, approachable and very knowledgeable about STIs, forms of contraception and who to go to for help. The following is a summary of some of the issues that were identified during classroom observations of the two case study schools.

- Variability in content delivery and pedagogical approaches – some GPs used overlong explanations of some aspects and, because of lack of time, were forced to skip over important content. Some GPs relied on teachers to undertake ‘crowd control’ and others were happy to intervene.
- Most did not devote enough time to setting the ground rules for behaviour with the class and some did not mention these at all.
- Up-to-date research information was referred to by some, but only in a general sense.
- Spirituality in the health diagram was not handled in any depth and terms such as ‘morals’ and ‘values’ went unexplained. One doctor described this category as ‘a bit special and off-beat’ and morals and beliefs as ‘airy fairy’. Far too much time was spent on this activity, in some cases 30 minutes (and in one case an hour) when 10 minutes is suggested by the Docs & Teen Program Manual.
- Some GPs were not local and did not know what services were available in the community.
- Sexual health formed a large focus in the sessions. This focus appeared to play to some doctors’ strengths but was covered at the detriment of other issues. In a program that is about access and building relationships with GPs and other health service providers this may be an inappropriate emphasis.
- Running over time means that little time is allowed at the end of the first session for students to think about the questions they might like to ask the doctors.
- Both students and doctors were often absent for one of the sessions. This makes it difficult for students who have missed out on important information and puts a burden on replacement GPs, who were forced to spend time at the beginning of the next session trying to work out what had been covered previously.
- There is a heavy emphasis on risky practices in the sessions, which needs to be examined given the focus on a strengths-based approach in the new Australian Curriculum. As one example, when discussing the emotional side of the health quadrant the GP mentioned that one in 10 people suffers from depression and used words and phrases such as ‘dark’, ‘hopeless’, ‘in pain’ and ‘can’t get out of bed’ to describe the condition.
- A strong emphasis on telling your parents you are applying for a Medicare card in one session seems at odds with some of the very good reasons why a young person would not want to.
Several doctors gave first aid demonstrations in the sessions, which is not in the program manual but was enthusiastically received by the students.

Testicular torsion was a focus in the sessions observed and quite a deal of time was taken in explaining what this is. Given the low percentage of young men suffering from this condition its inclusion in an already crowded curriculum was puzzling.
BACKGROUND CHARACTERISTICS

Table 6 shows the characteristics of the students involved in the case study at River College. There were 47 students who completed the pre-program and post-program surveys. The majority of students were female (60%) and before the program 62% of students were 14 years of age. One student identified as Indigenous, one as a person with a disability and one indicated they came from a non-English speaking background. No one identified as gay, lesbian, bisexual, transgender, queer or intersex. A small number of students (four) came from a rural area and three identified with a religion. All students bar one participated in the Docs & Teens program in 2015.

Table 6  Background characteristics: pre- and post-program responses

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<th>PRE</th>
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Table 6  Background characteristics: pre- and post-program responses
Students were asked how much they agreed with statements about health in terms of physical, mental and social health. After the Docs & Teens program, student responses to all areas of health changed significantly. Students were more likely to agree that all areas contributed to health.

The data shows that for each statement, students moved their responses in a more positive direction in the post-program survey compared to the pre-program survey. For example, prior to the program, 74% of students agreed that being healthy meant ‘being physically fit and keeping your body in good condition’ whereas after the program, 98% of students agreed with this statement.
Prior to the program the majority of boys (89%) nominated other school programs as their sources of information about health issues. About two-thirds of boys selected parents as their source of information. After the program, 95% of boys indicated the Docs & Teens program provided them with information about health issues and less than 50% nominated parents as a source.
The majority of girls (more than 80%) indicated their mothers were their source of information about health issues, with a smaller percentage selecting other school programs (64%) or their fathers (50%). After the program, more than 80% selected their mothers and the Docs & Teens program as sources of information about health issues.
Seeking health advice

There was no significant change in whether students looked for health advice; that is, students’ responses after the Docs & Teens program were similar to pre-program responses. Around 50% of the students surveyed indicated they had looked for or asked for health advice, while around one-third indicated they had not sought advice.
Figure 43  Case study 2: All students’ pre- and post-program reasons for not seeking health advice

The main reason that students selected for not seeking health advice was that they didn’t have any health issues.
Trusted sources: differences between girls and boys

In the post-program survey, all students were less likely to trust their dad, aunties, uncles, female friends or TV and movies as accurate sources of information about health issues compared to the pre-program survey. An analysis by gender illustrated some differences between girls and boys.

Figure 44  Case study 2: Girls’ pre- and post-program responses to trusting information from family and friends about health issues

Except in relation to their sisters, girls’ responses to family and friends as trusted sources of information about health issues declined post program. The responses, however, were not statistically significant.
Although not statistically significant, girls were more likely to nominate health workers as a trusted source of information post program. Results for school nurses and counsellors stayed the same and all other categories declined slightly.
After participating in the Docs & Teens Program, girls were less likely to trust the internet and pornography to provide accurate information about health issues.
There was no significant change in the responses of boys from the pre-program to the post-program survey.

With regard to family and friends as trusted information sources, although the differences were not statistically significant, mums and dads (higher for boys than girls) were still regarded as trusted sources, whereas uncles were less so post program. The ‘Not sure’ response was higher for all categories other than ‘Mum’ and ‘Dad’ post program.
Figure 48  Case study 2: Boys’ pre- and post-program responses to trusting information from health professionals about health issues

All categories in this question were higher post program, except for ‘Doctor’, which declined from nearly 100% pre program to around 85% post program.
Again, although not statistically significant, just over 60% of boys nominated the internet as a trusted source post program compared to 40% pre program. Around 90% of boys nominated the Docs & Teens program as a trusted source of information post program.

**Students’ views on topics that should be included in a program conducted by doctors with teenagers**

Students did not change their responses to this question post the Docs & Teens program, except for the option around paying to visit a doctor (i.e. the Medicare system). In the post-program survey, significantly more girls wanted this topic included in an education program conducted by doctors with teenagers, compared to the pre-program survey. When the analyses were done for boys only, masturbation became less important as a topic after the Docs & Teens program (i.e. fewer boys considered it important to include in an education program).
Table 7  Case study 2: Students’ pre- and post-program views about topics that should be included in a program conducted by doctors with teenagers

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<th>GIRLS</th>
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<td>Looking after our health</td>
<td>100</td>
<td>95</td>
<td>No change</td>
</tr>
<tr>
<td>Safe and unsafe alcohol use</td>
<td>94</td>
<td>100</td>
<td>No change</td>
</tr>
<tr>
<td>Over the counter drugs (i.e. Panadol, coffee)</td>
<td>100</td>
<td>90</td>
<td>No change</td>
</tr>
<tr>
<td>Illicit drugs such as marijuana, ice</td>
<td>84</td>
<td>100</td>
<td>No change</td>
</tr>
<tr>
<td>Safer sex</td>
<td>100</td>
<td>100</td>
<td>No change</td>
</tr>
<tr>
<td>Mental illness like anxiety &amp; depression</td>
<td>88</td>
<td>90</td>
<td>No change</td>
</tr>
<tr>
<td>Paying to visit a doctor (i.e. Medicare system)</td>
<td>59</td>
<td>78</td>
<td>Significantly more students wanted to include this topic</td>
</tr>
<tr>
<td>When to call an ambulance</td>
<td>82</td>
<td>74</td>
<td>No change</td>
</tr>
<tr>
<td>When to get to a hospital</td>
<td>81</td>
<td>79</td>
<td>No change</td>
</tr>
<tr>
<td>Healthy relationships</td>
<td>94</td>
<td>95</td>
<td>No change</td>
</tr>
<tr>
<td>Puberty and sexual development</td>
<td>100</td>
<td>100</td>
<td>No change</td>
</tr>
<tr>
<td>Reproduction issues – conception, assisted reproduction (IVF), pregnancy, birth</td>
<td>94</td>
<td>90</td>
<td>No change</td>
</tr>
<tr>
<td>Love and being close</td>
<td>59</td>
<td>58</td>
<td>No change</td>
</tr>
<tr>
<td>Contraception</td>
<td>95</td>
<td>86</td>
<td>No change</td>
</tr>
<tr>
<td>Reality of parenthood</td>
<td>63</td>
<td>77</td>
<td>No change</td>
</tr>
<tr>
<td>Where to go for help</td>
<td>100</td>
<td>95</td>
<td>No change</td>
</tr>
<tr>
<td>Sexual activity</td>
<td>95</td>
<td>77</td>
<td>No change</td>
</tr>
<tr>
<td>STIs</td>
<td>94</td>
<td>100</td>
<td>No change</td>
</tr>
<tr>
<td>Sexual health checks</td>
<td>82</td>
<td>100</td>
<td>No change</td>
</tr>
<tr>
<td>Sex and social media</td>
<td>88</td>
<td>79</td>
<td>No change</td>
</tr>
<tr>
<td>Violence in relationships</td>
<td>100</td>
<td>95</td>
<td>No change</td>
</tr>
<tr>
<td>Negotiating sexual activity</td>
<td>81</td>
<td>84</td>
<td>No change</td>
</tr>
<tr>
<td>Sexual consent</td>
<td>88</td>
<td>90</td>
<td>No change</td>
</tr>
<tr>
<td>Rights and responsibilities in relationships</td>
<td>100</td>
<td>90</td>
<td>No change</td>
</tr>
<tr>
<td>Gender and sexual diversity – gay, lesbian, bisexual, transgendered, queer, intersex</td>
<td>94</td>
<td>90</td>
<td>No change</td>
</tr>
<tr>
<td>Sexual pleasure</td>
<td>65</td>
<td>56</td>
<td>No change</td>
</tr>
<tr>
<td>Pornography</td>
<td>47</td>
<td>47</td>
<td>No change</td>
</tr>
<tr>
<td>Getting help about sexual issues</td>
<td>94</td>
<td>94</td>
<td>No change</td>
</tr>
<tr>
<td>Masturbation</td>
<td>71</td>
<td>32</td>
<td>Significantly fewer boys wanted to include this topic</td>
</tr>
<tr>
<td>Health services in your local area</td>
<td>82</td>
<td>77</td>
<td>No change</td>
</tr>
</tbody>
</table>


Table 7  Case study 2: Students’ pre- and post-program views about topics that should be included in a program conducted by doctors with teenagers (cont.)

<table>
<thead>
<tr>
<th>Which of these health topics should be included in a program conducted by doctors with teenagers?</th>
<th>BOYS</th>
<th>GIRLS</th>
<th>Change from pre to post (p &lt; 0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression and anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual health information, such as contraceptive options, availability and use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safer sex issues, such how to use condoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dealing with homophobia</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Help-seeking behaviours

There was no change in how students responded to the question about their help-seeking behaviours after the Docs & Teens program.

In their post-program survey responses, students were less likely to nominate another family member or an uncle to discuss a health issue that was of concern to them compared to the pre-program survey.

Table 8  Case study 2: All students’ pre- and post-program responses about whom they could talk to if something were worrying them

<table>
<thead>
<tr>
<th>If a health issue were worrying you, could you talk to any of the following?</th>
<th>Change from pre to post (p &lt; 0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor (GP)</td>
<td>No change</td>
</tr>
<tr>
<td>Mum</td>
<td>No change</td>
</tr>
<tr>
<td>Dad</td>
<td>No change</td>
</tr>
<tr>
<td>Sister</td>
<td>No change</td>
</tr>
<tr>
<td>Brother</td>
<td>No change</td>
</tr>
<tr>
<td>Another family member</td>
<td>Significantly less likely after the program</td>
</tr>
<tr>
<td>Aunt</td>
<td>No change</td>
</tr>
<tr>
<td>Uncle</td>
<td>Significantly less likely after the program</td>
</tr>
<tr>
<td>Friend</td>
<td>No change</td>
</tr>
<tr>
<td>Another trusted adult or a religious leader</td>
<td>No change</td>
</tr>
<tr>
<td>Seek advice online</td>
<td>No change</td>
</tr>
<tr>
<td>Nobody</td>
<td>No change</td>
</tr>
</tbody>
</table>
Improved knowledge

In general, the Docs & Teens program failed to improve the knowledge of students in relation to statements about sexual health or legal matters about sexual consent.

Figure 50  Case study 2: Students’ pre- and post-program responses to statements about sexual health
There were no significant improvements in responses to statements about sexual health after students completed the Docs & Teens program, except for the statement that ‘HPV is the virus that causes genital warts’. Prior to the program, 39% of students gave a correct response to this statement (i.e. HPV is the virus) and after the program this increased to 53%. However, a large proportion of students (47%) were still unable to respond correctly to this statement after the Docs & Teens program.

Most students (i.e. more than 70%) knew that ‘Someone can have an STI without any obvious symptom’ and ‘A person can contract an STI from having oral sex with another person’. For all other statements, correct responses ranged between 30% and 56%, suggesting student knowledge in these areas was poor and did not improve with the Docs & Teens program.
There were no significant changes to student responses to statements about legal issues around sexual consent after completing the Docs & Teens program.
Improvements in knowledge about Medicare, confidentiality and bulk billing

The Docs & Teens program lead to a significant improvement in knowledge in five of the nine statements about Medicare, bulk billing and visits to the GP. Knowledge improved in all statements about Medicare.

Figure 52  Case study 2: Comparison between students’ pre- and post-program responses about Medicare

After the Docs & Teens program, students’ knowledge about Medicare improved significantly. Initially, just over 50% of students indicated they were not sure about the age at which they could obtain their own Medicare card and 45% were not sure that having their own Medicare card allowed them to visit a doctor without an adult. After the program, this uncertainty dropped to 21% and 16% respectively, with the majority of students (~80%) responding correctly to these two statements. Prior to the program, around 60% of students were not sure about needing their parents’ permission to secure a Medicare card. After the program, the ‘Not sure’ responses almost halved, with correct responses increasing twofold.
Students’ knowledge about confidentiality did not change significantly after participating in the Docs & Teens program, except in relation to headspace. Prior to the program, around two-thirds of students knew that headspace was a free and confidential service and this increased to almost 90% after the program.
After completing the Docs & Teens program, students’ knowledge about bulk billing did not improve significantly, except for a significant increase in the number of students who were able to respond correctly to the statement ‘Bulk billing allows you to visit a doctor without having to pay for this service’.
Improved confidence

Table 9  Case study 2: Students’ pre- and post-program perceptions of confidence and help-seeking behaviours

<table>
<thead>
<tr>
<th>PRE</th>
<th>POST</th>
<th>Change from pre to post (p &lt; 0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have the confidence to ...</td>
<td>The Docs &amp; Teens program has given me confidence to ...</td>
<td>No change</td>
</tr>
<tr>
<td>Respond to different health situations</td>
<td></td>
<td>No change</td>
</tr>
<tr>
<td>Access/use different health services</td>
<td></td>
<td>No change</td>
</tr>
<tr>
<td>Know where to go for health resources (e.g. contraception)</td>
<td></td>
<td>No change</td>
</tr>
<tr>
<td>Manage my health</td>
<td></td>
<td>No change</td>
</tr>
<tr>
<td>Resist pressure to do something that doesn’t feel right for me</td>
<td></td>
<td>No change</td>
</tr>
<tr>
<td>Find trustworthy information on health issues</td>
<td></td>
<td>No change</td>
</tr>
</tbody>
</table>

The Docs & Teens program did not appear to alter student confidence in relation to the situations listed in Table 9, although the context of the pre-program survey question differs slightly in wording from the context of the post-program survey question.

The post-program survey asked students if the Docs & Teens program helped them to ‘Take responsibility for their health’, ‘Seek advice from a local health service’ and ‘Get their own Medicare card’, which differs from the pre-program survey, where students were asked if they could ‘Take responsibility for their health’, ‘Seek advice from a local health service’ and ‘Get their own Medicare card’. 
SUMMARY

- All students increased their positive responses to the range of statements beginning ‘Being healthy means ...’
- A large number of students agreed that the Docs & Teens program was a good source of health information, although for girls the program competed with their mums, who were also seen as the most trusted source of accurate information.
- For girls, dads as a trusted source of information declined post program (from 82% to 58%). Boys saw dads as a highly trusted source of information both pre and post program (85%).
- Significantly more girls than boys agreed that understanding the Medicare system should be included in the Docs & Teens program and fewer boys than girls thought that masturbation should be included.
- There were no significant changes in students’ responses to statements about sexual health and laws around sexual consent.
- Students’ knowledge about Medicare improved significantly after the Docs & Teens program. Their knowledge about confidentiality improved, but this was not statistically significant.
- At the end of the program students were aware that they had access to bulk billing and that this meant they did not have to pay to visit a GP.
- The program did not increase students’ confidence related to help-seeking behaviours.
HELP-SEEKING SCENARIOS

STUDENT SURVEY ‘WORD CLOUDS’

In addition to traditional survey questions that looked at changes in knowledge and experience, students were required to read a series of help-seeking scenarios that reflected the issues covered in the Docs & Teens program. These included issues covering cyber sexual harassment, the decision to have sex, sexual consent, gender-based violence, depression, STIs and homophobia. Students were required to identify where they could go, whom they could talk to and what they could do in the situation to help.

The data is presented as a textual analysis, as there were far too many responses to tabulate in any other way. It is presented as a series of ‘word clouds’ of the key words identified in the students’ answers to questions. The size of the word indicates how relatively often it was mentioned in the students’ answers. Some of the word clouds are specifically from the case study schools, while others were generated from the full cohort of students’ responses.

Sam: Online harassment

Scenario

Your friend Sam gets at least one SMS message a day from a boy in her PE class asking her to have sex with him. You know it makes her feel sick and she has stopped coming to school on the day she has PE. The boy never speaks to her at school. What would you do in this situation? What advice would you give Sam?

Where could Sam go and whom could she talk to for help?

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2 The word clouds in this research were generated using Wordle, an online tool that creates clouds from user-supplied text. See <www.wordle.net>.
Figure 55  Sam: pre-program word cloud (data from case study schools)

Trusted Adult Care School
Ask Police Family Parents
Situation Stop Advice headspace
Delete Block his Number

Figure 56  Sam: post-program word cloud (data from case study schools)

Place Shut Stop Answer Block Punch
headspace Face Doctor
Teacher Seek Help
Parents Sex Trusted Adult
Save the Messages Police
Someone Mum OK Principal
Prior to the program parents, school, trusted adults, police and headspace featured as the key resources students said they would access to deal with the online harassment. Looking for advice and acting to block the perpetrator were key strategies identified. There were similar patterns in both the case study school and the large 2014 cohort of students post Docs & Teens program. Following the program, teachers also featured alongside headspace, parents and trusted adults. To a much lesser extent mum, doctor and school principals were identified. Seeking help, blocking and confronting the perpetrator and Sam’s agency were identified as strategies.
Katie & Vincent: Sexual decision-making

Scenario

Katie and Vincent have been dating for four months. Katie confides in you that she is thinking about having sexual intercourse with Vincent. What would you do in this situation? What advice would you give her? Where could she go and whom could she talk to for help to decide?

Figure 58  Katie & Vincent: pre-program word cloud (data from case study schools)
Figure 59  Katie & Vincent: post-program word cloud (data from case study schools)

Trusted Adult  Ahead  Feels  Months  Married
Condom  Not to have  Sex  Safe  Mum
Parents  Age  Protection  Outcomes
Think  Dating for a Short Amount  Ask  Confident
Say  Place  Doctor  Consult  headspace

Figure 60  Katie & Vincent: post-program word cloud (data from all schools in 2014)

Advise  Doesn't  Feels  Comfortable  Teacher
Careful  Bit  Early  Doctor  Idea  Think
Long as  She is Comfortable  Ask  Check
Safe  Life  Protection  Business
Ready  Legal  headspace  Happy  Bit
Longer  Condom  Mum  Trusted Adult  Member
Sexual Intercourse  Family
Prior to the Docs & Teens program the key issues identified by the students were being ready to have sex and being safe. Students suggested that protection, overwhelmingly condoms, was important as a key strategy, as was asking for advice. Parents were the main human resource suggested to help in this scenario, followed by friends, the doctor and trusted adults.

Following the Docs & Teens program students identified the additional resources of headspace and greater use of the doctor. A key difference following the program was that there was no mention of friends as part of a solution. In addition, confidence and comfort emerged as important considerations.

**Angie & Tom: Respectful relationships**

**Scenario**

A week after your friend Angie started dating Tom, she started to withdraw from your friendship group. It has been three months now and you rarely see her. When you ask her to hang out she says that Tom doesn’t like it. Yesterday you noticed that she had bitten her nails down to the quick and she had some bruising on her arms. When you ask her what is going on, she breaks down and says Tom has been hitting her. What would you do in this situation? What advice would you give Angie? Where could Angie go and whom could she talk to for help with the violence?

![Word Cloud](image)
Stop Seeing Report Relationship
Care Trusted Adult School Nurse
headspace Somebody Parents
Doctor Police Family Place Cops Needs
Violence Ask Mum or Dad

Deal Suggest Advise Hard Comfort
Involved Break OK Dump
Authority Police Ask for Help
Parents Stop Dating
headspace Principle
Trusted Adult
Hug Seek Help Mum and Dad Family
As the word clouds show, police and parents are the key resources identified by students when asked what they would do and whom they would go to for help if they were helping someone in a suspected violent relationship. As with the other scenarios, students identified headspace and adults. Strategies centred on trying to stop the violence and getting Angie to end the relationship. The school nurse was also identified as a resource in this situation.

Following the program, police, headspace, parents and trusted adults remained the key human resources identified in both the case study schools and the 2014 survey of 568 students. To a lesser extent, doctors and school nurses are mentioned by the case study students post program by only about 2% of the sample. Students did not mention any other service identified during the Docs & Teens program. Strategies that students identified related to getting help, stopping the violence and ending the relationship.

**Jeremy: Homophobic violence**

**Scenario**

Whenever Jeremy, a boy in the year level below yours, goes to the toilet a group of boys in his year level who hang out in the corridor outside make comments about his sexuality, saying things like ‘Hey Jeremy, where did you get your “gay” haircut?’ or ‘Where are your “poofer” buddies?’ **What would you do in this situation? What advice would you give Jeremy? Where could Jeremy go for help and whom could he talk to about the bullying and homophobia?**

![Word cloud](image)
Figure 65  Jeremy: post-program word cloud (data from case study schools)

Police Call Trusted Adult Care
School Toilet Parents Worry
OK Teacher Principal Ignore
Stop Bullying Stand
Problems Listen Say

Figure 66  Jeremy: post-program word cloud (data from all schools in 2014)

Walk Bored Guys Principal Grow
Trusted Adult Confront Friends
Homophobic headspace Haircut
Not Listen Teacher Worse
Ignore Mean School
Fight Gay Mum Police GASP
Principle Therapist Punch
Parents again featured as the key resource in this homophobic violence scenario. Students’
identified the contradictory strategies of ignoring the situation and standing up for oneself.

Following the program, teachers became the most identified resource, closely followed by parents
and other trusted adults. Students in the case study schools also identify the need to support, care,
listen and make sure Jeremy was OK, whereas the large 2014 post-program cohort identified
actions such as fighting, therapy and GASP, an organisation designed to improve the health and
wellbeing of same-sex attracted and sex and gender diverse young people. (GASP was one of the
20 possible services and resources identified by GPs in one of the activities.)

Kim-lee: Depression

Scenario

Kim-lee has been really sad the last few months. She never wants
to hang out or play netball, which she loves, and says things like
‘I’m no good to anyone, nobody likes me’. What would you do in
this situation? What advice would you give Kim-lee? Where could
Kim-lee go for help and whom could she talk to about feeling
sad?

Figure 67 Kim-lee: pre-program word cloud (data from case study schools)
Figure 68  Kim-lee: post-program word cloud (data from case study schools)

Coach Professional Welfare Princess Cheer OK Mum Councillor Seek Help Self Ask School Chaplain Parents Think headspace Good at Netball Friends Counsellor Doctor Dad Life Encourage Play Positive Confidence

Figure 69  Kim-lee: post-program word cloud (data from all schools in 2014)

Cheer Therapist Problems Somebody Teacher Professional Care Depressed Counsellor Positive Friends Encourage headspace Welfare Parents Stop Ask True Trusted Adult Life Netball Mum Seek Help Say
The key resources identified by students prior to the Docs & Teens program in this case study were headspace, parents and friends. Issues and strategies raised included the need to comfort, be happy, encourage and ask for help. Following the Docs & Teens program, students appeared to have a greater sense of the need to seek help and identified parents (mums in particular), headspace, friends and the doctor as resources. The importance of trust emerged as a key issue with the 2014 cohort, while confidence and the need to be positive were key features of the case study schools. This result is perhaps the most significant, as students have clearly learned that headspace deals with depression.

**Chris: STIs**

**Scenario**

*Chris has told you he had unprotected sex when in was on holidays in Queensland. He also told you that he has a very smelly discharge coming from his penis and it burns when he goes to the toilet. You think he might have a sexually transmitted infection (STI). What would you do in this situation? What advice would you give Chris? Where could Chris go for help if he had an STI?*
The doctor and getting a medical check were the key resources and strategies identified in this situation, although parents and getting advice were also identified.

There was little change following the program. Similar resources were identified, mainly related to getting the doctor or GP and having a check. Students also identified headspace and Medicare.
## SUMMARY

- Parents and trusted adults remain the most identified resources to assist young people with health issues before and after the Docs & Teens program. These were followed by police, friends and doctors.

- The Docs & Teens program had very little impact on students being able to recognise the key community health service providers that could help address sexuality, sexual decision, violence in relationships and STIs when asked to apply them to a potential situation. Of the 20 services and people identified in the Docs & Teens program as part of the *Who to go to?* activity, headspace was the only community health service featured as a resource pre and post the program. GASP emerged in one scenario post program.

- Teachers and schools emerged as additional resources following the program in a number of scenarios.

- Doctors emerged overwhelmingly in situations relating to physical health issues such as STIs, and police in situations involving violence and harassment.

- Students in the case study schools were more likely to identify the need to support, care and listen, whereas the large 2014 post-program cohort identified more concrete actions such as fighting, therapy and service organisations.
CONCLUSION AND RECOMMENDATIONS

The Docs & Teens program has the potential to make a valuable contribution to health access and literacy for young people in schools. However, it requires some modification and procedural change.

Students, teachers and GPs value the program and enjoy teaching or learning the content through the interactive pedagogies used. They feel that students gain relevant and important information and an understanding of how to access community resources if they have a health issue.

Both students and teachers feel that the GP provides a non-judgemental ‘tell it like it is’ resource to support the work that teachers currently do in their health education programs. Teachers felt that the GPs provided additional information related to sexuality in particular, in a way that reduced embarrassment to students and maintained confidentiality.

Students valued the expertise of the GPs, their frank discussion of issues and their fun approach to providing information. GPs felt that the program increased their understanding of young people’s health needs and issues and how they could work with them.

GPs and teachers alike agreed that Docs & Teens was a health access program designed to increase health literacy in students, to make them feel comfortable accessing a range of health services inside and outside of schools, including accessing GPs, and to inform students of access options and the process to get their own Medicare card.

However, there were a number of issues raised in relation to the current provision, scope, content, outcomes and organisation of the Docs & Teens program that make it currently unsustainable.

The scope of the program and the range of health issues it attempts to cover is ambitious. In just two 90-minute sessions it was impossible to do justice to the range of complex sexual and mental health issues touched upon, and this is particularly problematic in schools that do not have a comprehensive health program where there may be little opportunity for following up on issues that might be raised for and by students.

The gender differences in relation to students’ views of what is important to include in the Docs & Teens program is consistent with other recent research (Mitchell et al., 2014; Johnson et al., 2016; Our Watch, 2016), namely the importance of violence in relationships by girls and the inclusion of
sexual pleasure, masturbation and pornography by boys. This, combined with boys’ reluctance to talk to friends and seek help, indicates that the Docs & Teens program needs be updated to ensure that issues around improving students’ knowledge and discussion of trusted sources of information are a clear aim of the program. However, it also points to the need or ensure pre- and post-planning approaches with schools. As current curriculum policy states (VCAA, 2015b) a focus on pornography, respectful relationships and violence in relationships should be covered in health education with teachers who have adequate background and professional development in sexuality education.

In its current form the Docs & Teens program does not meet its aims. Post-program survey data shows very little improvement in student knowledge, help-seeking behaviour, and the ability or desire to apply for a Medicare card. Very little recall or understanding was evident in relation to knowledge of potential use of community health services covered in the program. The help-seeking scenarios identified that headspace was the exception to this. In addition, the doctor and a couple of other services were mentioned in both surveys. This is despite students being able to recall a range of services in post-program focus groups. What did change in the help-seeking scenarios was the identification of teachers and schools as important resources for obtaining health information and seeking advice.

As well, students’ confidence levels did not change after the program in relation to responding to different health situations, accessing and using different health services, knowing where to go for health resources, managing their health, resisting peer pressure or finding trustworthy information on health issues. It is clear that acquiring knowledge, while a necessary first step, does not mean students feel confident in acting on this knowledge.

There is some evidence that, in the short term, Docs & Teens broadened notions of health to include the importance of faith and community, possibility because of the large focus on spiritual health in the introductory activity; however, this effect was not evident 12 months after the program. We were unable to ascertain why spiritual health had such a prominent focus in this activity considering that the World Health Organization definition of health (see p. 3) does not include ‘spiritual’ as a distinct component. It would have seemed more logical to include sexual health.

For stakeholders, where to go for help, contraception, sexual consent, laws about sex, STIs and violence in relationships were considered the most important topics to include in the Docs & Teens program, whereas masturbation, sexual pleasure, puberty, reproduction, love and being close were considered the least important. This finding is at odds with recent research on what young people
want to learn in sexuality and relationships education. For example, in Johnson et al. (2016), topics such as puberty, reproductive systems, STIs and contraception did not appear in the top 10 topics that students wanted to learn in more depth.

Neither the GPs nor the coordinator of the program had consulted teachers or students about the each school’s needs in relation to the program, and what health education had been covered or would be covered to contextualise Docs & Teens. Best practice has clearly demonstrated the need to consult with students in the development of programs for them (Ollis et al., 2013; Johnson et al., 2016; Ollis, 2014). In many schools, Docs & Teens was a one-off program, and this runs contrary to current research that shows that such an approach does not work (Our Watch, 2016; Formby et al., 2010). The two case study schools did provide workable models (with some modification) of how the program could add value to the school-based health education curriculum and connect young people to services, including the GP. All teachers felt that the program needed to be updated.

The series of activities in the program has remained unchanged for 15 years. Although professional development on current issues such as pornography and drug use has been offered to GPs in the region, the two to three hours training received is inadequate to equip GPs with the knowledge, content and teaching skills needed to implement the program in schools. Many of the GPs involved have been working in the program for more than five years, with their only professional development being a two to three hour workshop in the first year they started working in schools. Teachers who attended the professional development felt that it met their needs and acted as a refresher and reminder of current health issues for young people. However, students were often concerned about teachers knowing of their personal health concerns, especially in relation to questions they might ask about sexuality and drug taking. This seemed contradictory, as the teachers were present in all of our classroom observations. Emphasising the need to maintain students’ privacy, confidentiality and anonymity – and having teachers communicate this to their students – may go some way towards alleviating some student concerns.

Docs & Teens appeared to reinforce traditional notions of what health is; that is, being fit and eating well. These findings are not surprising given the way ‘health’ is marketed in the media and health and allied professions.

Schools differ enormously in their demographics, structure and context. The current Docs & Teens program is designed as a one-program-fits-all. It has been developed for Year 9 students, however some schools include the program at Year 8 and Year 10. Mapping the program against the Australian Curriculum and the Victorian AusVELS Curriculum confirms that Year 9 and Year 10 are the appropriate levels to include this content. However, some curriculum learning standards that
are relevant to Year 8 – such as ‘Identify the health concerns of young people and the strategies that are designed to improve their health’ and ‘Describe the health resources, products and services available for young people and consider how they could be used to improve health’ (VCAA, 2015b) – could also work to scaffold the content. This confirms the need to ensure the program is flexible enough to ensure that the content is working towards these standards if it is to be included in Year 8. Moreover, GPs need to have some understanding of the way schools assess students in health education to ensure enhancement and scaffolding of school programs.

Consistent with other research (Johnson et al., 2016; Our Watch, 2016), students clearly enjoyed the interactive teaching and learning activities provided in the Docs & Teens program. Close to 70% of the students enjoyed the discussion and games. Decision-making scenario-type activities also featured as activities that approximately 50% of the students enjoyed, while 55% enjoyed the opportunity to ask anonymous questions. Least enjoyed activities were those that required students to read handouts or do ranking activities.

In the help-seeking scenarios, parents, headspace, teachers and police featured as key resources. Very few students identified the doctor or the services identified during the program, regardless of whether they had just completed the program, which was true for the case study schools and the schools that had been part of Docs & Teens in 2014.

LIMITATIONS

When this research project commenced it was envisaged that all schools in the Barwon South West Region that had undertaken the Docs & Teens program in 2014 would be involved. This included public and private schools. The ethics requirements to gain access to the private schools ended up as a barrier and, as a result, only Victorian government schools were invited to be involved. In addition, the time taken to obtain ethics approval from two ethics committees was far longer than planned. The case study schools elected to take the Docs & Teens program very late in 2015, which caused further delays and narrowed the opportunity to take full advantage of the post-program surveys in adequate time. At the first case study school, numbers were too low to include in the post-program analysis because the logistics of gaining parental consent were difficult to achieve in the time available.

Some questions were worded differently in the post-program survey compared to the pre-program survey, as these questions focused on student perceptions of the Docs & Teens program. This may have impacted on student responses in these instances. In addition, it is important to acknowledge
that although students had covered the content of the survey in the Docs & Teens program and their health education curriculum more broadly there was no way to know if the students understood all the language. Focus group interviews seemed to indicate they had, but this sample was only 36 students and cannot be generalised for the entire research cohort.

A number of factors made it impossible for all students to participate in the pre-program and post-program surveys. The timing of the program, and difficulties with the logistics of parental consent resulted in only one case study school being involved. As well, the post-program survey at the same school was confused with a survey that the school’s Docs & Teens team routinely administers each year following their program implementation. As a result, students did not complete the post-program survey for this study when they were scheduled to and the survey had to be rescheduled for early 2016, further impacting on project timelines.
RECOMMENDATIONS

1. That the Docs & Teens program continues in Barwon South West Region secondary schools, with clear boundaries and processes for its implementation.

2. That GPs and/or the Docs & Teens Education Officer undertake a needs analysis for individual schools to tailor the program to the needs of schools and students. This would involve a short survey, interview or mapping to determine:

   a. The health education context prior to the program such as year level, previous content, when covered, teacher expectations, student consultation and how the Docs & Teens program will be followed up.

      i. Ideally the program should be conducted once students have covered information about sexual health, relationships, mental health and drug education. This contextualises the services mentioned in the program and prevents unnecessary time being spent on content.

      ii. Teachers must take an active role in the program. This could take a number of forms depending on the school context. This should be discussed prior to implementation.

      iii. Withdrawal of support should be considered if schools cannot provide this information or do not have an appropriate curriculum context that Docs & Teens can enhance in relation to health access.

3. That the Docs & Teens curriculum should be updated:

   a. In line with the learning focus and standards in the AusVELS HPE curriculum, and current Department of Education policy and initiatives in the health education field such as respectful relationships and Safe Schools.

   b. To reflect current research on school/community health interventions, young people’s health needs and education.

   c. To reflect current best practice in whole school (Health Promoting School) approaches that includes health access components.

   d. To provide more adequate resources to those young people who wish to apply for a Medicare card.
4. That the Docs & Teens professional development workshop is updated to reflect the issues in recommendation 3. In addition:
   
a. Include information on school assessment, working with teachers and schools and how to conduct a needs analysis with teachers and students prior to working with schools.

5. GPs and other health professionals should be required to undertake yearly professional learning to be eligible to deliver the Docs & Teens program.
REFERENCES


‘The doctor just talks about it’
Sustainable health promotion and practice in schools
Docs and Teens program
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