Youth clinic model for youth sexual health

Promising solution to ensure access to care

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Abstract

Objective To understand the services offered at a youth clinic as a site specializing in youth sexual health services, and the implications of this model for young people's well-being.

Design Qualitative research plan that follows the principles of grounded theory.

Setting A youth clinic located in an urban neighbourhood in Montréal, Que.

Participants The participants in this study were young patients, aged 18 to 23, accessing the clinic and the health care providers supporting them at the clinic. The clinic's interdisciplinary team consisted of family physicians, nurses, a sexologist, a social worker, and a receptionist. All members of the clinic team (n=8) and 8 youth patients were interviewed.

Methods Semistructured interview methods were used with the youth participants and health care providers. Youth participants were recruited using convenience sampling.

Main findings The primary results are divided into 3 components: the composition of the interdisciplinary team, with particular attention to the co-location of the team members; particular conditions at youth clinics, notably the presence of a receptionist on the team, financial coverage for certain prescriptions, and longer consultation times allowing for an educational component; and young people's positive perceptions of these services.

Conclusion Considered together, the characteristics of a youth clinic promote access to youth sexual health services on several levels. The findings encourage general practitioners to collaborate with services connected to family medicine when supporting young people's sexual health.

Editor's key points

- Including sexual health care tailored to young people as part of services provided at youth clinics presents an opportunity to enhance access to care and respond to this population's diverse needs.
- In interviews, providers often highlighted the benefits of their complementary specialties and their proximity to one another, and their important relationships with other connected external services. Certain medications, such as contraceptives, are covered financially in the youth clinic. Providers discussed the benefit of working with young people at a more flexible pace with respect to time and content of a consultation, which is rarely possible within regular services. Young people reported feeling at ease upon entering the clinic and shared that they appreciated that all services were in the same location.
- It may be necessary to rethink models of care for young people to encourage them to use sexual health services. The first important step would be to incorporate interdisciplinary specialties into existing services and clinics, particularly at family practices, and to promote partnerships among services. Equipping family medicine professionals with connections to community services and sexual health services is a possible means to better respond to youth sexual health needs.

Sexual health services at youth clinics may be more effective at responding to the diverse needs of young people[1,2] and encouraging changes in sexual behaviour[3] compared with regular or nonspecialized services. Yet there are few youth-centred services in Canada and many young people instead resort to using regular family practices to meet their sexual health needs.[4-6] Several studies have reported that general practitioners feel ill equipped to support young people's sexual health needs,[7,8] and that young people feel embarrassed and uncomfortable when accessing that model of care for their sexual health.[9-11]

The objective of this study was to understand the services offered at a youth clinic, as a site specializing in youth sexual health services, and the implications of this model for young people's well-being. The characteristics of this youth clinic can be divided into 3 components: the composition and co-location of the health care team; particular aspects of the youth clinic, notably a qualified receptionist, coverage of certain prescriptions, and an educational component included within its programming; and the acceptability of this model for young people. Combined, the findings of this study demonstrate the capacity of this model to ensure access to sexual health services for young people at several levels.

Methods

My qualitative research plan was inspired by the principles of grounded theory, which require the analysis of contextual factors experienced by research participants.[12,13] The context of this study was a youth clinic located in downtown Montréal, Que, that offers sexual health services to patients aged 15 to 25. This clinic is located within a CLSC (local community service centre), which is a larger centre that houses family medicine services.

I interviewed 2 groups at the youth clinic: health care providers from the clinic and youth patients. Speaking with these 2 groups allowed me to better understand consultations taking place in the clinical setting and to learn about the young peoples' experiences at the clinic. I interviewed the 8 health care providers from the clinic and 8 youth patients, consisting of 7 young women and 1 young man. I use female pronouns when referring to the health care providers because they were all women. There were 2 selection criteria used for the youth participants: age 18 to 25 years and previous use of the youth clinic's services. When using the term *young people,* I am referring to the population group classified as *youth,* meaning persons aged 15 to 24 years of age, as defined by the World Health Organization (WHO). The term *adolescent*, instead, refers to young people aged 10 to 19 years.[14] Since I focused on one segment of these 2 groups, namely young people aged 18 to 25 years, I also drew inspiration from the WHO's definition of *emerging adulthood*. This term describes the period spanning the late teenage years to the late 20s.[15] The period designated *emerging adulthood* characterizes youth as a pivotal period in transitioning toward adult life, marked by the end of one's studies, leaving the family home, obtaining employment, and forming one's own family.

I recruited the youth participants using convenience sampling. I used semistructured interviews to collect data because of the method's flexibility. This allowed me to use themes based on previous research, while also allowing the respondents the freedom to add other elements they deemed pertinent.[16,17] The interviews were 45 to 60 minutes long and occurred between February and June 2015. I recorded and transcribed the interviews. Using a 3-step coding process—open, axial, and selective—I sorted the data according to overarching themes. I stopped collecting and analyzing data once saturation of themes was achieved. Participants' names have been changed to respect their confidentiality.

Findings

The average age of the youth participants was 20.8 years. Most respondents were cégep students; 2 respondents were finishing high school. The characteristics of these young people are provided in **Table 1**.

Interdisciplinary team under the same roof

As a health service centred on youth sexual health needs and problems,[18] this youth clinic houses an interdisciplinary team (ie, physicians, nurses, sexologists, social workers, and a receptionist). Responding to young people's needs by offering curative and preventive services, a youth clinic is a place that focuses on a specific aspect of health or a particular demographic group, in this case youth sexual health. At first glance, this youth clinic is a service specializing in sexual health. However, by adopting a holistic approach, as promoted by the WHO,[19] and by having a variety of health care professionals on the team, the clinic's providers can offer consultations for other health or psychosocial concerns upstream of the young people's sexual health problems, as needed.

Table 1. Characteristics of youth participants

CHARACTERISTIC	n
Gender	
• Women	7
• Men	1
Age, y	
• Average	20.8
• Range	18-23
Occupation	
• Secondary school student	2
• College (cégep) student	6

The clinical team is *interdisciplinary,* not multidisciplinary, because team members function in collaboration with one another rather than in silos[20,21]: the diverse range of specialties grouped together at the same site work collaboratively and share tasks during consultations. Covering both medical and psychosocial domains, the team of 8 providers included family physicians, nurses, a sexologist, a social worker, and a receptionist. Without exception, all providers touted the importance of this cohesion between complementary specialties in providing services: on the importance of "interactions" between providers (Micheline, family physician), of a "collaborative" team spirit (Linda, social worker), and of a team that "is not hierarchical" (Lysandre, nurse) in sharing tasks and responsibilities when supporting young people. This team also works in a shared space, meaning it is a co-located service. A young person could, therefore, consult one or several professionals during a single appointment.

The providers often highlighted the benefits of their complementary specialties and their proximity to one another when providing care. For example, the sexologist illustrated how her presence on site complemented clinical services. She suggested that a youth patient "in a state of crisis" following a clinical diagnosis of herpes would need immediate practical advice on the daily management and treatment of herpes, a service frequently provided by a sexologist (Maryse, sexologist). Similarly, a family physician found that, by receiving support from an interdisciplinary team, she is better equipped to provide more in-depth care according to the problems experienced by the young person: "If, during the consultation, I suspect sexual violence or psychological abuse at the root of the young person's problem, I can immediately send them to the social worker" (Micheline, family physician). In short, the complementary nature of these services, adapted to the clinical and psychosocial characteristics of sexual health, allows providers to offer appropriate, timely care to young people.

Beyond the interactions between complementary specialties at the same clinic, the interdisciplinary team share important relationships with other connected external services. Since the clinic is located at a CLSC, it benefits from mental health and substance use services for young people, in addition to regular family medicine services. The youth clinic providers can, therefore, easily ensure external follow-ups addressing the particular needs of young people are conducted, and support the transition toward adult care.

Particular functions of a youth clinic

A youth clinic maintains certain specific functions of its programming owing to its mandate to work with young people. First, a central reception area with a qualified receptionist is used for initial triaging. During her interview, the receptionist informed me that she is considered the "first point of contact" with a young person and that her role consists of "filtering requests, rapidly assessing the degree of urgency, seeing who the best person [provider] for the young person would be, and determining whether the situation can wait until the next week" (Carole, receptionist). The fact that the receptionist is considered part of the team of providers renders direct communication with other providers possible, allowing a suitable rate of service provision for providers and young people alike.

Next, certain medications, such as contraceptives, are covered financially in a youth clinic. The providers shared that this particular function allows young people to access certain prescriptions that would, otherwise, be inaccessible because they do not have money or private insurance. They also added that they often seek less costly therapies (eg, generic prescriptions) or free samples to avoid high costs to young people (Sandra, family physician). One provider added that financial coverage for a prescription ensures the confidentiality of young people's choices by concealing their choices from parents who are the primary holders of private insurance (Lysandre, nurse).

Finally, providers have the benefit of working with young people at a more flexible pace with respect to time and content of a consultation, which is rarely possible within regular services. With the ability to provide consultations ranging from 15 to 60 minutes, the providers can go beyond the young person's initial request to explain certain concepts in a more in-depth manner. According to the providers, following several cuts to sexual health curriculum in Quebec, they have observed a knowledge decline in this area: "Young people no longer know the words for STBBIs [sexually transmitted and blood-borne infections], nor for naming body parts" (Micheline, family physician). According to providers, providing young people with correct information is urgently needed to remedy a critical situation. Marguerite (family physician) explained how she finished each consultation by offering pertinent sexual health information. "The spiel is in line with the goal of the consultation, for example, the morning-after pill, forgetting to take a contraceptive pill, or pleasure and pain during sexual activities." As such, the providers try to fill these knowledge gaps during their longer consultations, offering more in-depth explanations.

Young participants' responses to these services

The youth participants were unanimous in feeling at ease about accessing the youth clinic. They appreciated having the reception space reserved for them. By avoiding the risk of "running into neighbours or parents" (Léa, age 22), young people said they felt "less stressed" and safer at this clinic when visiting for a consultation on subjects that are often new, sensitive, or difficult. The providers observed this appreciation from youth patients. According to Sandra (family physician), the entire consultation occurs in a less intimidating environment when reception is conducted by a familiar person demonstrating a sincere understanding of their needs.

Youth participants also shared that they appreciated that all services were in the same location. For example, when explaining why they return to the clinic, several young participants shared that access to services was "easy and simple" (Julie, age 22), and that they had all their "medical and mental health [psychosocial] stuff addressed during the same appointment" (Laurence, age 18). The youth patients added that advice received at the youth clinic allowed them to better understand the sources of their sexual health problems. For example, the educational components of the consultations allowed young people to break free of their feelings of guilt. "She [provider] took the time to help me stop feeling guilty by telling me that sexual education in schools is currently weak, and that my boyfriend at the time was also responsible" (Mélanie, age 20). The youth patients felt at ease, safe, and supported at the clinic.

Discussion

The high number of students in the sample is explained by the fact that the clinic is located downtown, in proximity to colleges and universities. In addition, the higher number of young women participating in the study reflects the widespread tendency for young women to seek sexual health services more often than young men owing to gender norms related to accessing health services and the fear of stigmatization.[22]

In light of the results, I believe the youth clinic model may ensure access to care for young people. According to Penchansky and Thomas,[23] there are 5 complementary dimensions that define access to care. First is *availability,* referring to the relationship between the provision of a service and the need of a target community (eg, volume of nurses according to need); *accessibility* refers to the geographic location of the services (eg, whether the service is accessible via public transit); *accommodation* refers to the way resources and service components are organized (eg, interdisciplinary team makeup, hours of operation); *affordability* refers to the cost of care; and *acceptability* indicates the target community's response to the services (eg, level of trust in the services). The work of Penchansky and Thomas allows me to illustrate how the youth clinic model ensures access to health care for young people on several levels.

First, the availability of this model responds to the specific needs of young people. The Public Health Agency of Canada indicated that, in 2015, young people aged 15 to 24 were reporting the highest rates of STBBIs. Notably, this age group reports 56.8% of chlamydia cases, despite accounting for only 12.6% of the Canadian population.[5] The model of care is also accessible because it is located in an area that young people access daily, close to schools and colleges in downtown Montréal. Combined, availability and accessibility ensure physical access to care.

Also, regarding the accommodation dimension, the interdisciplinary nature of the youth clinic will only further facilitate access to health care for youth patients. The complementary specialties found at the clinic, ranging from the medical to psychosocial domains, and the inclusion of a receptionist allows the clinic to offer services addressing a variety of needs linked to sexual health and sexuality.[19] Furthermore, with respect to accommodation, the services are affordable in response to the financial realities of young people. Young people need services adapted to the major changes that occur during adolescence. For example, it is often while making the decision to seek out sexual health services that young people interact with the health care system without guidance from their parents. This phenomenon, coupled with the fact that young people lack sexual health knowledge, increases their vulnerability to sexual health problems. The accommodation of services principle is, therefore, essential for youth populations.

Finally, the acceptability of the youth clinic among young people has also been observed. A study by the Institut national de la santé publique du Québec noted that barriers to STBBI screening services reported by young people included feelings of fear, guilt, and embarrassment while discussing their sexual activities.[5] Within the framework of this study, young people reported feeling at ease upon entering this model of services, especially given the presence of the receptionist, which also explains why they continued to return to these services.

While the 5 dimensions of access to care are observed within the context of this youth clinic, and while this type of care model is supported by Canadian provincial and international authorities,[24,25] such an approach to serving young people is rarely seen in Canada. Other sectors of the health care system and segments of the population are prioritized within provincial health budgets, often promoting curative care instead of preventive care and prioritizing older population groups. At the time my study was conducted, only 5.4% of the Canadian health budget was dedicated to public health, with an expected increase for long-term care and mental health. In addition, older people and infants represented the populations with the highest health costs per person. In 2017, spending per person increased to $2076 for people aged 20 to 24 and $11,438 for people aged 65 and older.[26]

Furthermore, it has been observed that young Canadians aged 15 to 29 years old seek out sexual health services and information in a variety of locations within the health care system, most of which do not specialize in sexual health or youth health care. According to 11 service sites, young Québécois women aged 17 to 29 years obtained their contraceptive prescriptions at nonspecialized medical clinics (36.0% of women aged 17 to 20 and 36.2% of women aged 21 to 29).[5] In Ontario, it was reported that, from a sampling of young people seeking care, 16% sought care from a family physician while only 6% went to a youth clinic.[4,6] A lack of

awareness among young people regarding existing services, the shortage of sexual health services for young people, as well as the embarrassment felt by young people, are the reasons behind these findings.

It is therefore necessary to rethink models of care for young people, in terms of content and form, to encourage young people to use these services. I believe that the first important step would be to incorporate interdisciplinary specialties into existing services and clinics, particularly at family practices, and to promote partnerships between services. Equipping family medicine professionals with community services and connections to the sexual health discipline are conceivable as means to better respond to youth sexual health needs.

Limitations

I note that my research has 2 important limitations. First, the study is descriptive and could therefore not establish a relationship of causality between the clinic's services and the improvement of young people's sexual health. Second, the findings may not be generalizable to other populations, given that the sample was small and based on convenience sampling.

Conclusion

This qualitative research conducted at a youth clinic in Montréal sought to describe the components of this model of care. I describe the key characteristics found, namely an interdisciplinary team and particular conditions according to their mandate. I also describe the acceptability of this model of care among young people. Together, these characteristics ensure access to care for young people at several levels. The results encourage family medicine professionals to collaborate with related specialists to support youth populations in matters of sexual health.

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Competing interests
None declared

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