Final Project Report 2012

WHAT WOULD IT TAKE TO OPTIMISE YOUNG PEOPLE'S SEXUAL HEALTH?

A conversational journey with youth workers

Youth Affairs Network Queensland
Project funded by Communicable Diseases Branch, Queensland Health

Queensland Government

youth affairs network qld

Final Project Report: What would it take to optimise marginalised young people's sexual health? : A conversational journey with youth workers

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Report on a research project conducted for the Youth Affairs Network of Queensland and funded by the Commicable Diseases Branch, Queensland Health.

Subject: Sexual Health; Youth Health; HIV/AIDS Hepatitis C and Sexual Health; Marginalised Young people; young people; youth work; workforce development

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Cover Image: Good Sexual Health Guide, Brisbane Youth Service.

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Acknowledgements

YANQ conducted interviews with 34 key stakeholders across Queensland. This included: youth workers (both generalist and specialist), youth service managers, state wide youth organisations, youth and sexual health services, academics, teachers and trainers in the youth field. We thank the individuals and organisations who gave generously of their time to participate in face to face and phone interviews. Feedback will remain anonymous as this has enabled participants to be candid in the interviews.

Background

In early 2009, YANQ received funding from the Department of Education and Training (DET) to undertake a Youth Services Workforce Skills and Training Project. For some time, YANQ have been advocating for a systemic approach to the development and maintenance of the youth sector workforce to ensure quality services for young people. The project has gone some way towards this goal through the drafting of the Youth Sector Development Plan, creating a platform to support a vibrant and sustainable youth sector workforce that protects and promotes young people's rights.

In 2011, the Youth Affairs Network of Queensland (YANQ) received a small amount of funding from Queensland Health to undertake research into workforce issues impacting on the capacity of youth workers to engage in sexual health education with marginalised young people.

Marginalised young people have been consistently identified as a high risk group in relation to sexual health. YANQ received anecdotal feedback that in recent years that youth workers are not engaging with young people and providing them with information and support in relation to sexual health matters. This research seeks to explore what impacts on youth workers' ability to provide effective interventions around sexual health? What knowledge, skills, resources, value and ethics, training and support is available to youth workers? What do youth workers identify that they need and what workforce development strategies are recommended to enable the youth sector to respond more effectively?

Summary of themes

This project provides a very brief snapshot and introduction to the key themes raised by youth workers and other key stakeholders when asked "what would it take to optimise marginalised young people's sexual health?". It is not a comprehensive representation of all perspectives within the youth sector. All key themes have been included in this report, with particular emphasis on the key issues that were consistently repeated across the State. Of particular note,

- the central role of empowering young people to have agency over their sexual health and participate in the development of sexual health interventions
- the primary role of safe and trusting working relationships with young people when delivering interventions
- using a holistic, rights based and well being / strengths based approach to young people's sexuality, moving away from problem based approaches
- the development of a whole of government youth and youth health policy in Queensland underpinned by rights and well being approaches
- the establishment of a Centre for Excellence for youth health practice to research, disseminate and support practice development, workforce development, policy and advocacy for youth health in Queensland, it is suggested this centre is located within the youth sector
- support for comprehensive school based sexual health education for all young people that is mandatory, teacher supported and part of the school curriculum
- the expansion of the prevention and early intervention role for School Based Youth Health Nurses to deliver and improve access to sexual health services for young people in schools
- access for all young people to consent to confidential health services based on competency and context assessments not age specific benchmarks
- recognition of the specific needs of marginalised young people both within and outside the school environment
- maintainance and expansion of community based youth health services located within the youth sector (such as IHSHY programs, which include: prevention and early intervention, health promotion, clinical services from a range of service providers including: general practitioners, nurses, allied health, alternative health and youth health workers etc)
- in partnership with young people, the use of networked participatory action research inquiry based approaches to sexual health and youth health – local networks, centrally resourced and supported
- better coordination of existing resources and creative use of new resources, such as one off project and event based funding with a focus on culture, learning and inquiry
- funding for small projects in youth services across Queensland for the ongoing development of peer

based, culturally centred health promotion projects, resources and education tools. This could be centrally supported through the centre for youth health.

Summary of recommendations

In addition to effective education and training, workers supported the use of workforce development strategies to enable more effective responses around youth sexual health. The workforce development recommendations below are aimed at increasing the effectiveness and capacity of the youth sector to support marginalised young people's sexual health development and the prevention of blood borne viruses and Sexually Transmitted Infections.

The draft Queensland Blood Borne Viruses and Sexually Transmissible Infections Strategy 2012-15 identifies five strategic action areas. The categories for recommendations in this report have been aligned to this strategy as follows:

Strategic action area 1: Enabling environment

- build supportive public policy;
- create supportive environments;

Strategic action area 5: Research and surveillance

- research and practice leadership,

Strategic action area 2: Education and prevention

- strengthen community action;
- developing personal skills for young people;

Strategic action area 3: Early detection, care management and treatment

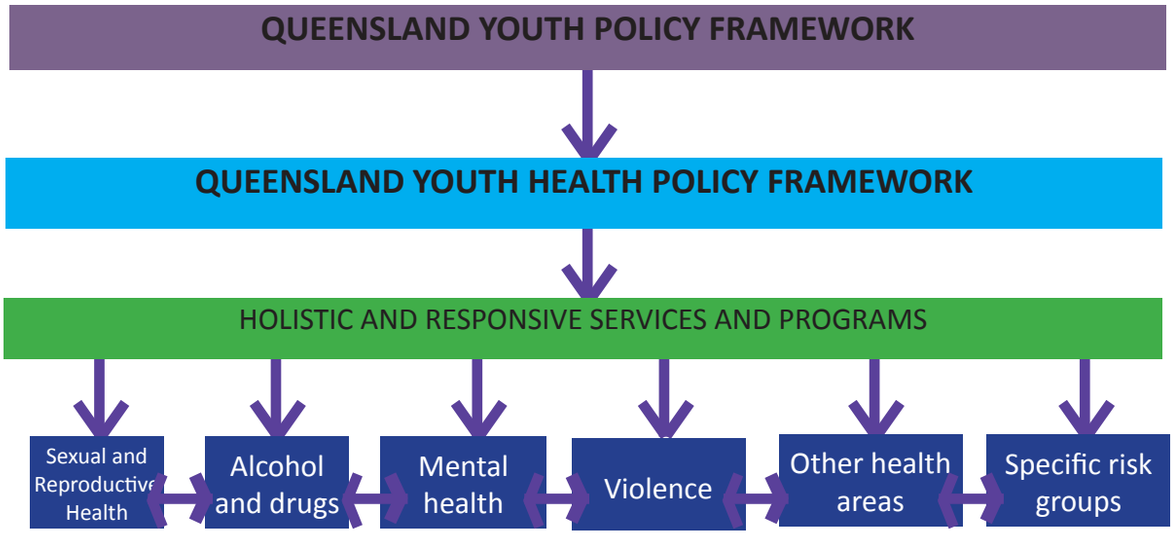
- making clinical health services accessible; and

Strategic action area 3: Training and Professional Development

- learning and skilling strategies.

BUILD SUPPORTIVE PUBLIC POLICY

The suggested policy framework is outlined in the diagram below:



- Development of a comprehensive Queensland Youth Policy Framework – this will be an overarching whole of government framework for social policy responses to 12-25, year old, it will include: youth participation, whole of government, including marginalised young people both within and outside school environment, holistic approach, broad range of issues, analysis of the context of young people's issues, principles, elements, goals, strategies, targets and resources, outline benefits, what will this policy drive? Links to other policies

- To recognise youth health as a major social investment and creative challenge.

- To recognise the specific needs and cultural context of young people (age 12-25) and the specific skills, information, resources and context required to optimise their health

- Development of a holistic, population based **Queensland youth health policy framework**, to advocate a clear political commitment to youth health and equity in all sectors. This holistic policy framework will be population rather than issue based, it will outline characteristics of effective youth health work that will then be applied to specific focus areas such as sexual health, alcohol and other drugs, violence, mental health, general health and wellbeing. It will also outline strategies for specific youth populations. The current policy environment has young people's issues scattered across a range of issue based health policies.

- This policy will include: a contextual analysis of young people's health including the social determinants of health, youth participation, whole of government, holistic approach, wellbeing, harm minimisation, health promotion, primary, secondary and tertiary services, key principles and strategies, goals, targets, coordination of resources, good practice principles, outline benefits and what will it drive, links to other policies.

- Reorientation of public policy, attitudes and organisation of health services to focus holistically on the needs of the young people with strengthened linkages to resources for specific issue based programs and services

- Review of the **youth health policy framework for school based health clinical services and health promotion**. Utilising Youth Support Coordinators, School Based Youth Health Nurses and other relevant stakeholders. Including the expansion of the prevention and early intervention role of School Based Youth Health Nurses in delivering sexual health services. Ensuring compulsory minimum requirements for the

delivery of sexual health education for all young people in Queensland.

- To respond to the health gap within Queensland and to tackle inequities based on social rules and practices relating to youth health and youth sexual health

- Establish **Youth Health Policy and Advocacy Roles** in the Centre for Excellence for youth health to maintain youth health policy expertise and advocate for youth health issues

Characteristics of effective policies, services and programs

- To acknowledge **young people and their communities** as the main health resource, to support them through financial and other means to optimise their health and to accept young people as an essential voice in their own health

- **Accountability** how does policy and decision in all areas of government impact on young people and youth health?

- **Definition of approach to youth health**, sexual health and marginalised young people, move to a strengths-based, wellbeing, social justice and rights based approach not just problem based and disease prevention

- **Key policy principles** – Culturally appropriate (both ethnicity and youth cultures), Accessibility, Evidence based approach, Youth Participation, Collaboration and partnerships, Professional development and Sustainability

- **Identify barriers** to the adoption of healthy public policy for young people and marginalised young people and address these barriers

Review legal framework for youth sexuality in the following areas:

- Consent law for 16 year olds – criminalising consensual peer based sexual activity for under 16s, suggested exploring a competency and context assessment model rather than chronological age based benchmarks

- Anal sex consent law for 18 year olds – seen as discriminatory for male same sex partners (eg consenting 17 year old male partners potentially being charged)

- Review of recording processes for young people under 18 being charged with these offences (eg having a criminal record as a sex offender, impact on employment, accessing blue cards, future opportunities etc)

- Clarification of termination law to enable young people to access terminations safely at the young woman's request. Removing the abortion law from the Queensland Criminal Code

- Consent to medical treatment – suggest this is clarified as competency and context based assessment of young people to consent to medical treatment (without parental permission)

- Confidentiality – move away from age based benchmarks to competency and context based assessment for the confidential delivery of health services to young people (such as Gillick competency)

- Removing civil liability exposure for youth health practitioners in providing youth health services when using competency and context based assessments to provide youth health services without parental consent

Infrastructure to support youth health practice, learning and development:

- Resource existing or (where needed) establish new regional infrastructure based in the youth sector to support youth health across Queensland. In order to coordinate this, it is recommended to establish a **Centre of Excellence for Youth Health Practice** which incorporates the range of specific youth health issues, and includes both research and workforce development initiatives for the youth sector and others who work with young people.

- It is suggested to research initiatives outside Queensland that could be good models for developing workforce responses eg Youth Substance Abuse Service in Victoria, YACWA Peer Education Project, NSW Youth Accommodation Association the HOT Project, etc.

- The Centre of Excellence in Youth Health would take a lead role in working with other key stakeholders to support learning and development in youth health practice. This would include a role in resourcing and supporting local and regional networking around youth health (including youth sexual health).

CREATE SUPPORTIVE ENVIRONMENTS

- Protection of natural and built environments and conservation of natural resources as part of youth health promotion

- Creating supportive environments that nurture young people's health and sexual development, including the social, emotional and attitudinal environment– recognise that sexuality is a part of every human being, (regardless of choices around sexuality)

- Address impact of social context and community attitudes on sexual health choices such as racism, sexism, homophobia, violence, cultural, religious and ethical context of young people's sexuality

- A broad based anti-discrimination campaign to challenge homophobia and promote positive responses to young people's sexual health development

A CULTURE OF INQUIRY: BUILDING THE EVIDENCE BASE, RESEARCH AND PRACTICE LEADERSHIP

- Recognition of the specific role of the community youth health sector in delivering youth health services and developing and maintaining practice expertise in youth health practice. Particularly Innovative Health Services for Homeless Youth (IHSHY) funded programs. Utilise this existing practice wisdom to inform evidence and research processes in youth health work, including the development of collaborative partnerships with a range of health providers

- Establishment of **Centre of Excellence in Youth Health Practice** located in the youth sector. This centre would resource the research, maintainance and dissemination of youth health practice skills, resource and support regional and local youth health networks, and oversee small grants funding for culturally appropriate sexual health promotion projects across Queensland for marginalised young people. This would include: youth work, inquiry based networked and evidence based approaches (including evidence from practice wisdom), peer based approaches, providing effective interventions, community cultural development and youth community development, primary secondary and tertiary youth health services including health promotion. Centre of excellence based within the youth sector in Queensland and works across a range of youth health areas including sexual health, drug and alcohol, mental health, violence and general health, with a focus of specific population groups. The centre would draw from a range of disciplines including youth work, health and allied health, alternative health and public health.

- Recognition of youth health as a specific focus of practice and the articulation of characteristics of good youth health practice. Including: frameworks, beliefs and values, youth participation, engagement, trust and relationship building, assessment, case planning, linking to specialist services etc

STRENGTHEN COMMUNITY ACTION

- Genuine Youth participation and empowerment on all levels of policy development and interventions – youth workers involved to facilitate involvement by marginalised young people

- Develop flexible systems for enabling a diversity of young people to participate in setting priorities, make decisions, plan strategies and implementing them. This can be enabled youth workers through community development approaches

- Invest in research that supports the optimising of youth health, this includes both qualitative and quantitative research methods that consider the needs of specific cultural groups

- In communities where there is not a community based youth health service, it is suggested to strengthen linkages and partnerships between youth service providers and primary health services. Focus on approaches with young people as a population, not just specialist health issue based funding

- Resources and support for youth sector organisations to hold local activities for significant events such as World AIDS Day etc (In 2002, 65 youth services in Southern and Central Qld voluntarily held activities for World AIDS Day resourced by the HIV/AIDS team at Brisbane Youth Service)

- Small seed projects for health promotion with a diversity of youth sub groups across Queensland. (similar to Tribes project at NUAA or Hep c Qld small grants) – support for these projects provided through the central centre of youth health promotion excellence

- Better coordination of existing human and material resources to enhance young people's sexual health through inquiry based local network approaches using participatory action research methods. Local level inquiry based networks – how are young people going in our local area? What would it take to optimise young people's health and sexual health in this local area?

- Identification of new resources required at both a local and statewide level to support regional and/or local based youth health networks across Queensland. Resource support for local partnerships and regional networks between youth service providers and specialist sexual health services and other key relevant stakeholders focusing on young people and sexual health

- Centralised resourcing and support for these youth health networks through the Centre for Excellence in Youth Health. (similar to the YANQ C Plan Networks or the Workforce Council's Integrated Skills Development Strategy).

DEVELOP PERSONAL SKILLS FOR YOUNG PEOPLE

- Maintain and enhance existing health promotion and primary health care responses with marginalised young people, including IHSHY funded youth health services
- Seed funding for small youth health projects in youth services across Queensland to develop culturally centred, peer based responses to young people's sexual health. This would enable resources to support project based learning, local inquiry and action based outcomes for young people. This might not just go to youth workers, but also to groups of young people themselves. This could be centrally supported through the centre for youth health. It might be small grants for resources development or to run activities such as World AIDS Day, Valentine's Day, Youth Week activities etc. Young people could be involved in the planning and implementation of these projects which could use community cultural development and participatory action research processes.
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be involved in the planning and implementation of these projects which could use community cultural development and participatory action research processes.

- Access to information, learning opportunities, skills development, resources and funding support in timely, culturally centred, developmentally responsive manner. Information, education and enhancing life skills aimed at increasing young people's agency and control over their own health and their environment, and to make choices conducive to health. Enabled through school, home, work and community settings.

- Examine factors that influence marginalised young people in the development of their sexuality and choices around sexual behaviour

- Articulation of characteristics of good youth health practice for primary, secondary and tertiary interventions with marginalised young people and general youth populations. This model would be based on research, practice wisdom and young people themselves

- Specific resources and inclusion of diverse sexualities in sexual health education programs, including specific information relating to sexual health practices

- Moral / ethical decision making skills education for young people

- development of culturally appropriate health promotion resources using culturally centred peer based inquiry processes

- Practice resources to support: ad hoc / brief interventions, case planning, education workshops, peer education processes,

- Training programs

- Information, skills development and resources for workers and young people

- Explore the possible use of **Youth Health Passports** (or similar concept) for marginalised young people (similar to those used for young people involved with statutory child protection), these would be non-mandatory, might be self assessed or done in conjunction with professional staff.

ACCESSIBLE YOUTH HEALTH SERVICES TO YOUNG PEOPLE

- Reorient the health care system to share power in partnership with young people and the youth sector to optimise youth health. This includes individuals, community groups, health professionals, health service institutions and governments.

- Recognition of the specific role of the community youth health sector in delivering youth health services and developing and maintaining practice expertise in youth health practice. Utilise this existing practice wisdom to inform evidence and research processes in youth health work.

- Enable access for all young people to consent to confidential youth health services based on competency and context assessments. These services to address access issues such as: travel, cost and other specific age related issues.

- Ensure clinical services are accessible to and accessed by young people. Eg auditing by young people of existing health services for "youth friendliness"

- Establish clear pathways for young women choosing to terminate a pregnancy in Queensland and in particular those under the age of 14. All young people to consent to confidential termination services based on competency and context assessments. These services need to be accessible to young people and remove issues such as: travel, cost, late presentation, and other specific age related issues. It is suggested that access is through both private and public clinics.

- Ensure the maintainance and further development of specialist youth health services as needed, (eg ISHYI funded youth health services).

- Co-location of health services with youth services (as appropriate).

- Strengthen links between youth workers, primary and specialist health services.

- Development of whole of school approaches to youth health promotion, prevention, early intervention and access to clinical services through key stakeholders including: Youth Support Coordinators, School Based Youth Health Nurses and other relevant stakeholders

LEARNING AND SKILLING STRATEGIES

The key groups for learning and skills development could include:

- pre-service youth workers
- induction for new youth workers
- more experienced youth workers
- senior youth workers and workplace mentors
- managers and supervisors
- others in secondary roles that support youth work practice, such as front line reception and administration staff
- other professionals who are working with young people, such as medical practitioners, sexual health workers, etc.

The content, strategies and processes that support workforce development might vary for different groups. Workers identified a range of strategies, in addition to training, that support learning and skills development about sexual health and youth health interventions. A range of strategies were suggested to enhance these learning processes, as displayed on the table on the table over the page.

Additional strategies include:

- establish a Centre for Excellence in Youth Health Practice in the youth sector that supports the development, maintenance and dissemination of practice skills in youth health and youth work;
- Learning and development would be informed by the documentation, articulation and dissemination of characteristics of good youth health practice; particularly drawing on the practice wisdom of existing community based youth health services (such as IHSHY funded programs)
- the development of a "culture of inquiry" in youth health work;
- Establish local and/or regional youth health inquiry based networks to support the development of capacity and responses to youth health and sexual health;
- Use of a "Learning exchange" model, rather than didactic training, to bring together youth workers, specialist sexual health workers and other key stakeholders to share knowledge and skills and improve local and regional responses to young people's health and sexual health;
- These learning exchanges could be a possible catalyst of regional/local sexual health networks. How do these networks get driven and receive ongoing resources and support as needed? These local networks would be inquiry based action focused networks to work in partnership with young people to understand what is happening locally and to formulate local responses around youth health and sexual health;
- A planned approach to skilling workers was suggested. This could involve relevant training providers in each region being involved in local youth health networks;
- the development of an accredited skills set in "youth health work";

TABLE 1: STRATEGIES TO ENHANCE LEARNING PROCESSES

Strategy	Formal	Informal	Suggested strategy
Pre-service education through University	*		Embed youth health practice skills
Pre-service education through TAFE or RTO	*		Embed youth health practice skills
Ongoing education through University whilst employed in youth sector	*		Embed youth health practice skills
Ongoing education through TAFE or RTO whilst employed in youth sector	*		Development of a "youth health practice" skills set
VET assessment only pathways, including Recognition of Prior Learning and Recognition of Current Competency	*		Access to grants and scholarships to support this – resources to support gap training
Workplace learning, accredited and non accredited, including in-service	*	*	Support for in-service skills development
Training outside the workplace – accredited and non accredited	*		Ensure that content and processes fit the learning and development needs of the participants.
Workplace based induction training	*	*	Development of resources to support this.
Interagency network meetings,	*	*	Discussion of current issues, sometimes formal learning activities linked to these meetings, developing better practice strategies, enabling better coordination of existing resources
Learning exchanges	*	*	Bringing together youth work, sexual health and other key stakeholders to share skills and resources, developing action plans
Youth work practice forums – facilitated peer education processes	*		Trouble shoot scenarios – how am i going to deal with it when these things come up?
Email lists and discussion forums online	*	*	Suggested to be established and expanded to support practice development across the youth sector in Qld.
Sexual health information updates		*	FPQ cd rom and information sessions
Further reading such as journals, research through the internet,		*	Identify and disseminate information about websites and other sources of information around sexual health practice
Learn from information resources that are designed for young people		*	The ongoing development of culturally centred, peer based resources using community cultural development processes
Practice supervision	*		Training and support for supervisors, particularly youth workers moving through the management roles. Foster workplace cultures that support and value this. Articulate framework and develop resources for peer support and peer supervision.
Mentoring	*		Training and support for the Senior Youth Worker role across the youth sector
Peer support and learning in the workplace	*	*	Foster workplace cultures that support and value this. Articulate framework and develop resources for peer support and peer supervision.
Workplace projects - action learning processes	*	*	Resources to support doing pieces of youth health work, problem solving and learning during the work process
Personal experiences		*	eg LGBT staff – "it meant that i prioritised the issues in my work role". Provide opportunities for youth workers to youth health work and document learning. Youth work forums at regional and state levels.
Learning from young people themselves		*	Provide opportunities for youth workers to youth health work and document learning Youth work forums at regional and state levels.

- embedding the core knowledge and skills required for effective youth health and sexual health interventions with young people into pre-service youth worker training programs, both within tertiary institutions (TAFEs, RTOs and Universities) in formal qualifications and through 'on the job' training for youth workers;

- an emerging youth worker focus to assist in developing a "grounded practice framework" and youth health practice skills. This might start in formal training programs and evolve in first few years of work. This ongoing induction training could focus on developing key youth work skills;

- For experienced workers, the use of assessment only pathways by RTOs/TAFEs to recognise existing skills in youth health promotion is suggested;

- having accessible and culturally appropriate peer based resources for both workers and young people;

- youth work practice forums could particularly focus on complex practice issues and ethical decision making, such as:
    - Values and ethics, ethical literacy, ethical decision making models and ethical issues for youth workers;

- Ethical reporting of child protection matters;
- Confidentiality and service delivery for 12-16 yo;
- Sexual health promotion for young people with a history of sexual violence / trauma;
- Diversity and sexual health;
- Generic youth work;
- Youth health skills;
- Prevention, education, tertiary interventions;
- Developing "youth friendly" accessible clinical services;
- Networking and partnerships around youth health;
- Youth participation and youth engagement;
- Regulations, safe work practices;
- Complex practice skills;

SECTION 1

ABOUT THE PROJECT

Proposal

The aim of this project is to ensure the youth sector workforce development strategies are inclusive of the needs of youth workers and youth agencies working with marginalised young people around sexual health.

This project is aligned with the *Queensland HIV, Hepatitis C and Sexual Transmissible Infections Strategy 2005-2011: Implementation Action Plan 2009-11*. It specifically addresses Strategic Priority 4 in relation to Training and Professional Development.

Objective One (4A) of the strategy aims to create: A skilled workforce (paid and volunteer workers) that can assist in reducing the transmission and minimising the impact of HIV, HCV and Sexually Transmitted Infections (STI's) in Queensland.

The project will identify principles for suggested models of practice, identify strategies and models for skilling workers and broader workforce development strategies.

Methodology

The research will be conducted by identifying a small sample of generic youth agencies located in urban / suburban /regional, rural and isolated areas of Queensland. Youth workers from these agencies will engage in qualitative interviews. The process is described as a conversational journey, where the experiences, key themes and suggested strategies identified by youth workers are collated in this research report.

The methodology draws on Participatory Action Research Principles. The interviews started with key agencies, workers and networks, and followed a 'snowball method' to identify participants. The promotional flyer used for contacting youth services is included in Appendix 1. The key themes and recommendations from the participant interviews are collated in this draft report. The conversation starter questions used to guide the research are included in Appendix 2. The draft report was validated by interview participants to ensure that it represented their views and experiences. Permission was sought by agencies to publish any identifying information. The final report will be submitted to Qld Health and published by the Youth Affair Network of Queensland.

Research follow up

The findings from this project will help to inform both the Workforce Development strategies of the Youth Sector and future planning and implementation initiatives by Queensland Health. There is a real opportunity to integrate youth health and sexual health workforce development strategies for youth workers into the broader youth sector workforce development processes currently being undertaken by YANQ. Additionally the findings of this research will inform YANQ's advocacy and policy work in relation to youth health.

SECTION 2

THE CONTEXT OF MARGINALISED YOUNG PEOPLE'S SEXUAL HEALTH

Outlined in the remainder of this report are the key themes emerging from the research conversations. All feedback has been included with particular emphasis on the themes that were consistently repeated across the State. Direct quotes from research participants have been included in italics.

The role of young people

Workers stressed the critical role of young people to inform or implement responses around sexual health. They emphasised the lack of engagement with young people about their sexual health and what response they want. Youth participation is a key practice in youth work practice. Particularly developing young people's critical awareness and skills and empowering them to participate in decision making processes.

A range of examples of effective youth participation were presented during the interviews: for example: peer based interviewing, peer based education, young people auditing clinical health services for "youth friendliness", young people driven resource development and community projects, young people learning to facilitate their own case meetings.

Workers found it challenging at times to generate enough interest from young people to have these conversations. Sexuality can be a taboo subject, young people may be uncomfortable to participate, it's important to establish how young people want to be engaged with and participate. "How do we let young people take the lead in developing sexual health responses?"

Other workers emphasised that it was quite easy to engage young people in discussions around sexual health.

> *"Young people's reproductive health is our core business so sexual health is easy and natural to discuss in a context where you use a non judgemental, holistic and relationship based approach"*

Also emphasised were supporting young people's skills in negotiating systems and self advocating, particularly talking to health professionals.

The suggested use of the participatory action research inquiry process has a specific purpose that enables youth participation. Crane and O'Regan (2010:3) suggest :

> *"Participatory Action Research (PAR) is **emancipatory** to the extent that it includes as **active participants** those who are most affected by the issues under investigation, especially the least powerful. In human services this is typically the clients and target groups of service delivery. Social programs should benefit those vulnerable individuals, groups and communities who experience the issue being targeted by the intervention. PAR conceptualises the participation of service users and other target groups of intervention as important for philosophical reasons (respect, voice, rights), to ensure the most responsive strategies are developed and to achieve the best possible outcomes."*

History of HIV/AIDS, HEP C, Sexually Transmitted Infections (STIs) and Sexual Health Promotion for marginalised young people in the youth sector

Family Planning Qld, Queensland Health, primary care services and community based youth health services have a long history of providing prevention and clinical youth health and sexual health services in Queensland. The funding of School Based Youth Health Nurses (SBYHN) has enabled better health services for young people, including marginalised young people, in the school environment.

In 1987 peer based HIV/AIDS prevention and support organisations were funded in Queensland. This included

working with men who have sex with men, injecting drug users, sex workers and homeless / marginalised young people. The funding for the latter group was allocated to youth services in Brisbane, Townsville and Cairns. Whilst each project operated differently, the core foci were health promotion with young people, developing culturally appropriate resources and providing youth worker and health worker training. Each project was located in a youth health team (which included clinical health services) within a generic youth drop in service.

In 2000 these projects were reorientated to workforce development with a State wide focus. The first critical piece of work was a State wide training and development needs analysis of youth and sexual health workers (the SNAP report). The findings of this SNAP report are similar to the key themes that have been identified in this research, suggesting that key themes in this earlier, more extensive research remain relevant.

In 2003, the HIV/AIDS funding was re-orientated to target a broader youth population and moved to specialist sexual health services. Whilst training of youth workers is still undertaken, there is a broader focus on skills development for a wider group of professionals who work with young people, particularly teachers in schools. The focus on workforce development has remained. Workers identified a gap in the development of culturally appropriate peer based resources for marginalised young people.

Policy environment

"There is no overarching youth policy or youth health policy in Queensland, so these issues are dealt with in segmented ways. These policies need an holistic and generalist analysis of young people's issues. Include non-methodological methods for responses and engagement with young people as central."

"There is a disconnect between 'person centred approaches' and the institutional need to 'de-personalise young people'. This has included suspending or eroding young people's rights, for example through confidentiality where there are a range of legislative outs and focus on 'risk averseness'"

"how do we ensure that youth health policy doesn't get taken over by the medical model, it's really important to emphasise and support the role of the community based health sector"

"Young people having sex is a political hot potato! No one wants to touch it! The current policy seems to be all about preventing social problems, like unwanted pregnancy, not on supporting young people to develop healthy sexuality"

"We don't acknowledge young people as sexual beings. The portrayal of youth sexuality is aberrant, with them in need of protection"

"In the busy-ness of youth workers, with a focus on service delivery, they have limited capacity to engage in policy debates, we need to put include practical examples about how policy changes will affect them and their work practice."

"We need young people centred, holistic policy that is driven by practice wisdom in that it comes out of the work done between young people and youth workers. It's important to clearly identify the issue that you're trying to address and focus on the best interests of young people."

"the caution I have with the 'headspace' mental health service delivery model is that youth health is clinically driven, rather than being driven by a broader analysis of young people's issues."

Workers repeatedly identified the need for political leadership and the development of a policy environment that supports effective youth health and sexual health work with young people. They suggested a policy that outlines a response framework and plan for action that is holistic and population based rather than the current policy framework where young people's health issues are scattered across a range of specific issue based policies such as

mental health, drugs and alcohol, specific diseases etc.

In addition to centralised policy leadership, workers suggested networking, resources and processes to enable local action and ownership. Workers also discussed the need to outline the benefits of a youth and youth health policies. What does having a youth health policy drive or enable? What difference does it make? The policy would need to include an analysis of young people's issues, driven by youth participation and be tangible about resources and outcomes. What benefits it will bring and what systems need to be re-oriented to achieve these outcomes?

Others suggested that the absence of a policy may mean that workers have more flexibility in their work, but were concerned that lack of a supportive policy framework could increase the risk and potential liability for individual workers and agencies, particularly in practice areas that are more complex. In the absence of holistic, wellbeing and rights based youth health policy, workers felt that that were being "left in the lurch". They also suggested whole of government youth policy, which could incorporate a youth health policy. They suggested all government departments needed to be accountable for how their portfolio area impacted on young people.

> *"Lack of resources around youth health research, policy and advocacy means there is not a strong adolescent health sector in Queensland"*

It was noted that the absence of a youth policy and youth health policy framework in Queensland has meant there has not been an investment in youth health policy skills and practice. Workers noted that the adolescent health sector is less resourced and coordinated than their observations of other jurisdictions. They noted NSW, Victoria and South Australia as youth health policy leaders that enable the development of specialist policy frameworks for adolescent health. This has included youth health service delivery, research, policy and advocacy.

Centres such as the Centre for the Advancement of Adolescent Health (CAAH) have taken a lead role in the development of NSW youth health policy. Other examples include the NSW Adolescent Health Association (http://www.nayh.org.au/), Arts and Health Foundation (http://www.artshealthfoundation.org.au/), Australian and New Zealand Adolescent Health Association or internationally the International Association for Adolescent Health (http://www.iaah.org/) and Global Youth Coalition on HIV/AIDS (www.gyca.org).
Workers suggested the value in developing a similar specialist practice and research centre in Queensland.
Workers also suggested the need to have the "right youth health policy" based on youth work principles of holistic work, accessibility, empowerment and participation by young people, rights based work and well being approaches.
Concern was also raised that advocacy and policy can be single issue focused (such as mental health or alcohol and drugs) rather than holistic population based advocacy. Workers suggested establishing youth health policy position/s at the youth sector peak or within the lead government youth policy agencies.
Workers also identified the ongoing need for community based youth health policy to be a key part of ongoing health care and policy reform. Workers flagged the challenge of staying up to date with such reforms and the need to disseminate and be included in these reform processes, possibly through health policy advocacy roles located in the youth sector peaks or to explore other strategies.

> *"The emerging role of Medicare locals, how to ensure that young people's health issues are on the agenda and that it's not taken over by the medical model. How does the community health sector get involved in setting the agenda but not have it co-opted? What is the relationship between these new purchasing arrangements and the broader health policy agenda?"*

There are a range of legislative reforms identified by workers during this project, these included:

- consent law for 16 year olds – criminalising consensual peer based sexual activity for under 16s, suggested exploring a competency and context assessment model rather than chronological age based benchmarks

- anal sex consent law for 18 year olds – seen as discriminatory for male same sex partners (for example, consenting 17 year old male partners potentially being charged)

- Recording processes for young people under 18 being charged with these offenses (eg having a criminal record as a sex offender, impact on employment, accessing blue cards, future opportunities etc)

- Clarification of termination law to enable young people to access terminations safely at the young woman's request

- Consent to medical treatment – suggest this is clarified as competency and context based assessment of young people to consent to medical treatment (without parental permission)

- Confidentiality – clarity of providing confidential services based on competency and context based assessments (such as Gillick competency) not a specific age

- Clarification of civil liability exposure of youth health practitioners in providing youth health services, particularly when using competency and context based assessments to provide youth health services without parental consent

It was also suggested that human reproduction also be discussed and located within environmental sustainability and population polices. It was suggested that literacy and agency around sexual and reproductive health could be a strategy in such policies.

Community attitudes and values

> *"Ultimately, it comes down to the way that young people are perceived, are they poor decision makers, incapable, raving with hormones or capable and able to make good informed decisions? We need to start back at square one eg challenging negative images of young people in the media. We need positive images and positive media about young people, not just the elite young people but those who are not necessarily acknowledged."*

> *"Many people in our community still believe that if you teach young people about sex, they will become sexually active"*

> *"We work with conservative values in a conservative state"*

The policy environment and community attitudes and values were identified as the two main factors that impacted on effective sexual health and youth health work with young people. Community attitudes directly impacted on the work undertaken and the openness of workers in their community. Many talked about "flying under the radar" due to conservative attitudes.

> *"You do what you can get away with, sometimes it feels like your flying without a safety net"*

Others found a discrepancy between "perceived community attitudes" and the reality when they spoke directly with parents and others. They suggested that a vocal minority who were against homosexuality and termination belied the reality that the silent majority (75%) of parents and community members quietly support sexual health education for young people. (Quantum Market Research 2008 in McKee et al 2010:3)

Workers suggested that strategies need to be developed to challenge stereotypes, discrimination and promote positive values around youth sexuality. This was particularly emphasised for challenging homophobia.

Role of Non Government Organisations in contracted service delivery

"There is a changing relationship between Government and service providers. This has primarily been driven by neo-liberal paradigm, applying market principles to social policy and the purchasing of social services. NGOs may experience conflict where their contractual obligations to government differ from their social contract with young people and their communities."

"To get funding you have to establish that a problem exists, rather than just promoting the well being of a group of people."

"How do we do sector reform collectively?"

"Accountability processes have changed, including organisational acquittals – how was money used? What is considered the evidence base? Transparent measures of effectiveness, I think we don't measure outcomes in meaningful ways"

Workers identified significant changes in the youth and community services sector in the last decade. This included: changing relationship between NGOs and government, outcome based funding, erosion of rights based practice, challenge in process based work where they may not be clear pre-determined outcomes, funding and contractual arrangements changing, more focus on individual service delivery than systems advocacy and community development, specific issue based funding rather than holistic funding to work with youth populations, deficit approaches to health rather than rights and wellbeing approaches, central data collection systems, sharing of information, allocation of resources, allocation of resources and time to maintaining compliance arrangements rather than service delivery, particularly the implementation of new systems and time when extracting information from databases.

Youth workers work with a diversity of young people in a multitude of settings. This can focus on specific issues or there might be a more generalist and holistic approach. Generally not all services are located in the one place so youth work requires a range of interlinking networks and referral pathways to support young people to access multiple services.

Workers also discussed the changing role of youth workers, suggesting a move away from direct work with young people and rights based approaches, to case management and systems negotiation roles. This has particularly been through a particular focus on Juvenile Justice issues and the emergence of youth workers in schools and other funding types which emphasise institutional engagement, networking and negotiation skills. It was suggested that this required different skills sets for youth workers.

Many youth services are implementing quality systems and use continuous improvement in developing programs. Workers suggested an 80 / 20% split between time spent in service delivery and back end support. With increasing emphasis on accountability and compliance, workers suggested this can be challenging to achieve.

Workers suggested the implementation of these systems as being valuable when it supported more efficient and effective outcomes for young people but this was not always the case and presented cost challenges for smaller NGOs.

"As a housing service our overarching goal is related to housing, such as where do I go after this accommodation placement? However we work holistically and examine how does health assist with this goal? We have a focus on the here and now, what are the current resources and supports that the young person can access?"

Workers suggest the challenge in measuring client outcome and the benefit of the service as demonstrating movement towards the case plan goals may not be easily measurable. Whilst the work is holistic, it is often opportunistic and driven by young people. For example, if the working relationship is a critical component of the work, what are the measures or indicators of solid relationships, is it possible to measure trust, is it about disclosure? It's also about what the relationship enables in the young person's life. What is the role of practice wisdom, experiential, gut instinct?

"We need broader conversations about better practice, to dialogue, engage, understand, unpack. The work is being driven by risk aversion and the practice is becoming more prescriptive. Whilst the agency

policy can provide an overarching framework or guidelines but there is a core role of worker's judgement and ethical decision making."

"What worries me about youth workers being located in larger NGOs is that the decision making can more further and further away from practice and this can lead to more prescriptive agency policies around practice. It can also mean that advocacy for young people can be lost in other population groups that the agency represent"

Workers suggested coming together as a sector to develop more meaningful measures of the work. Being creative and challenging rigid ways of thinking about the work. One suggestion was to run "youth work practice forums" to discuss these kind of challenges and develop strategies for practice.

Workers highlighted the YSC support model using the centralised YSC Hub Coordinators to support the sector. Whilst centrally based, strategies were in place to support local ownership. The YANQ CPLAN model also supported local context, individual difference and a statewide focus to advocate at broader government level. Workers strongly supported networking models that had local input and centralised management or coordination to progress statewide issues. This enabled work across a range of issues for young people, youth sector issues and practice level.

Starting with the development of a shared vision and highlighting the principles that inform the work. Workers suggested supporting sector leadership, local input and ownership and good resources to enable quality outcomes.

Workers also suggested strengthening the link between service delivery, youth work practice and advocacy.

"young people are a specialised group with particular experiences, context and developmental differences, not only does this require specific practice skills, it also requires clarity around advocacy. In my experience, larger NGOs representing a broader range of target groups are less likely to have their higher level management (decision makers) involved in the sector peaks, it's much more likely to be CEOs of youth specific organisations who engage in these processes."

"When it comes to youth advocacy, there is a difference between youth organisations and "youth and family" organisations or mainstream services, often workers within mainstream services are internally advocating for youth work practice models whereas in youth services, advocacy and youth work practice is embedded across the whole organisation."

Whilst workers supported the idea of 'wrap around support' concerns were raised when information was shared with agencies who operated from different practice frameworks or practice strategies that might erode young people's right to access services. Workers also noted a shift in holistic 'population' based funding to funding for specific issues.

SECTION 3

MARGINALISED YOUNG PEOPLE'S EXPERIENCES

Sexual health experiences of marginalised young people

> *"Epidemiology shows the most 'at risk' young people are ATSI and children in Departmental Care, we already have youth health services that focus on homeless young people and these services work well"*

Marginalised young people have long been identified as a particular "at risk" group in relation to HIV/AIDS, Hepatitis C and STIs. This can be due to disengagement from mainstream education, their specific engagement in "high risk" behaviours, the social context of their sexual decisions and barriers to accessing mainstream health services. The Burdekin Report (Human Rights and Equal Opportunity Commission 1989) inquiry into youth homelessness was a seminal inquiry leading to (amongst other things) the establishment of Innovative Youth Health Services to respond to this population. Data suggests that marginalised young people (homeless young people in particular) have increased rate of certain STI's, pap smear abnormalities and pregnancies requiring antenatal care. (Gunn 1998 and Gunn, Harrison and Schrader 1998)

Specific issues that impact on sexual health and marginalisation include: lack of family or other supports; homelessness; imprisonment; injecting drug use; poverty; sex exchange and sex work; and sexual assault.

The following data relate to the incidence of STIs in the general youth population.

For Queensland males aged 15-19 years there were 11 new notifications of HIV between 2004 and 2006, representing a notification rate of 1.6 per 100,000 population. Among females aged 15-19 years there were 2 new cases between 2002-2004." (Commission for Children and Young People and Child Guardian 2009:43)

> "In 2008 in Queensland, there were 1.2 chlamydia notifications per 1000 females and 0.1 per 1000 males in those aged 10-14 years. These statistics possibly raise child safety concerns, but 94% of these notifications were in 13-14 year olds and infection in this age group may be linked to sex between same age peers."
>
> (Commission for Children and Young People and Child Guardian 2009:43)

What youth workers say...

> "*Most are drunk and don't use condoms at 1st sexual experience, Too many drinks or drugs and alcohol can impact on decision making, this can lead to a depression cycle involving more drinking, more sex"*

Workers observed a range of issues that impact on marginalised young people's sexual health. These issues have been well documented elsewhere, so are only briefly touched on here. These micro, mezzo and macro issues can include: poverty and social disadvantage such as homelessness; engaging in "high risk' behaviour such as injecting drug use, sex exchange behaviour; values and attitudes – "won't happen to me"; levels of empowerment and agency in their lives; confidence and self image; awareness; personal skills such as communication, ethical decision making processes; the nature and context of sexual activity for example unexpected or unplanned experiences, being intoxicated, not being able to have sex in an environment over which they can exercise control; access to resources such as condoms; family disengagement and lack of family support and mentors.

SECTION 4

EXISTING INTERVENTIONS AND RESPONSES

To young people...

Current frameworks

Sexual health wellbeing approaches view sexuality as a normal and healthy part of all human beings. Workers suggested holistic approaches, rights, wellbeing and strengths based approaches, a feminist gender based analysis and harm minimisation as well as the enabling of informed consent. This meant a pro-active and planned ongoing education process that addresses the broad range of factors that affect sexual health including: sexuality, identity, consent, communication, relationships with self and others (self esteem) etc.

Examples of existing responses around youth sexual health:

A range of responses to youth sexual health were identified during the interviews. Whist this is not an exhaustive list, those listed here were suggested by workers as examples of good practice. Learning from and expanding on these examples is recommended.

Response	Details	Contact
Youth Accessing Contraception and other Information (YACI) Regional Network in Cairns / Hinterland	Sexual health network involving Youth Link Cairns, YETI, FPQ, the regional HIV/AIDS, Hep C and Sexual Health Coordinators, School Based Youth Health Nurses and other key stakeholders– producing better geographical and regional responses to youth sexual health – focus on system engagement and network development solution (more information about this later in the report)	
Youth interagency networks	Existing geographic and issue based youth interagency networks	Listed on YANQ website www.yanq.org.au
YANQ - C Plan networks	Regional networks focusing on workforce development for the youth sector	YANQ www.yanq.org.au
FPQ – The Youth Project	Focus on workforce development in sexual health for a range of professionals who work with young people, particularly teacher focus, communities of practice	Family Planning Queensland
FPQ – 'Sexual Health Matters' Project	A partnership between Family Planning Queensland the Department of Communities (Child Safety Services). Project to support the sexual health needs of children and young people in and exiting foster care and Departmental Care. Involved production of resources for foster and kinship carers and delivery of workforce development for youth sector professionals	Family Planning Queensland
Create Foundation and FPQ - "Out of the box" Sexuality and relationships forum	A partnership between young people with a care experience, Create Foundation, and Family Planning Queensland. Young people developed innovative ways to promote existing sexuality and relationships education material to children and young people in and exiting foster care and Departmental Care. Development of web based resource to follow.	Family Planning Queensland
Information resources	www.istaysafe.com FPQ CD ROM of fact sheets, condoman facebook page, Commonwealth Government sexual health resources, ShineSA resources, ARCSHS (School based resources), “the Saucy Sex Scale” from Brisbane Youth Service YEAH – HIV prevention, national, “grooving the move”, info booths, safe sex, HIV, AOD / sexual health training – “sex, drugs and rock n roll”	Various
Youth Link in Cairns	Youth worker and peer based education and training in sexual health, youth heath clinic	
Sarah Larkin, General Practitioner at James Cook University, Townsville	Rural and remote young people’s needs and access to services, including ATSI young people, peer research surveying young people regarding access to health and other support services	

Regional HIV/AIDS Coordinators, Queensland Health	Townsville – responses to young people's sexual health in ATSI communities in the Townsville, Palm Island, Mt Isa and Gulf areas Cairns – involvement in the YACI network in Cairns / Hinterland	
Cape York initiatives	Young people's health check, young people's radio serial raised sexual health issues	
Brisbane CPLAN	trialling "can of worms" forums for youth workers to discuss ethics and practice values	YANQ www.yanq.org.au
Children by Choice– Healthy Living / Healthy Choices Program	Workshops and resources about making good choices in your life	
Local regional councils youth advisory committees	Various initiatives in local governments across Queensland	
ATSI health worker positions	Youth detention centres and prisons initiatives	
Rockhampton	Culturally appropriate workshop program for ATSI young people – 8 wks, 1 arvo, cultural stuff, self awareness, thinking ahead, indigenous students at school – 8 high schools, 2 running the program	
Access to free resources and condoms	Examples given by workers where condoms are better resourced and more freely available in other jurisdictions. eg through TAFE, NSP programs, schools, youth services, hospitals, General Practitioners	
YACWA peer based sexual health education project		
NSW Youth Accommodation Association the HOT Project		
ShineSA	Developed skill sets for youth workers in responding to sexual and reproductive health. This project employed young people as peer interviewers to identify what young people thought youth workers needed to work with them effectively around sexuality.	
Culturally appropriate peer based resources	Identified a gap as these were previously developed through the HIV/AIDS funded youth health services through peer based community cultural development processes	
Community based youth health services	Clinical services and youth health promotion with marginalised young people across Queensland	Various – a small number of locations, not available in many geographic areas
Sexual health services and outreach clinical services for young people	Clinical services with marginalised young people	Various – a small number of locations, not available in many geographic areas
Ethnic Communities Council of Queensland	Focus on sexual health and cultural diversity	Some work in youth health area

Access to sexual health information

"Where do young people go to get information about sexuality?"

"In lieu of sexual health education being done well, where are young people getting educated? Pornography, TV, the internet, peers?"

Workers suggested young people needed access to relevant, accurate, realistic and culturally appropriate information, skills and resources that is developed from young people's perspectives, experiences and needs. This could include focus around relationships, emotions and pleasure, not just biology, reproduction and disease. Workers suggested this be delivered in a timely, age and culturally appropriate manner. Education needed to be based on an understanding of where young people get their information from, including use of new technologies.

"Key informal sources (of sexual health information) are friends, parents and the media – including television, magazines, the Internet and pornography."

(McKee 2011:3)

This suggests:

Information source	Practice implication	Application for marginalised young people
Friends	a focus on peer based education	this is particularly recommended with marginalised young people
Parents	support for parents or guardians/carers as educators, parents are commonly uncomfortable in this role, they strongly support sexuality education in schools, recent research indicated that 75% if parents supported education in schools (Quantum Market Research 2008 in McKee et al 2010:3)	Marginalised young people may not have supportive relationships with parents and families, hence to need to support the people they do trust to talk with about sexuality, such as friends, youth workers, etc.
The media	working with the media that young people access as this is where they receive information about relationships and pleasure *"young people seek out relevant information from the media for themselves when the time comes. If exposed to information that is too advanced for them it goes over their heads."* (McKee 2010:3) - media projects such as magazines and soap operas, radio programs etc	What specific media do marginalised young people access?

How are we going in responding to marginalised young people's sexual health?

Most workers agreed that the response to marginalised young people's sexual health is variable. This is both within and outside the school context. Workers presented examples of innovative and pro-active sexual health work, but also identified many examples where young people's needs were not being met. Workers also suggested that responses can be ad hoc and in many regions lacked centralised planning and coordination of existing sexual health resources. They identified the benefit of coordinated local network based responses to inquire with young people about their sexual health and how to respond more effectively. They also suggested enhancing working relationships between youth and sexual health services (including General Practitioners, pharmacies etc). These ideas will be further discussed throughout this report.

SECTION 5

ISSUES AND CHALLENGES EXPERIENCED BY WORKERS

Values and Ethics

> *"Worker attitudes and values are critical, we try to guage a worker's values prior to referring a young person as a poor referral can be so damaging, we refer to individuals we know, not organisations generally."*

> *"Personal / professional values of the worker is critical, the relationship with young people creates an openness to talk about it."*

> *"We need to avoid confusing ideologies with values, as it is values that are important, what are the values of youth work?"*

Values and ethics were consistently raised as a critical factor in responding to young people's sexual health. Many workers saw them as fundamental in understanding and developing responses. These included: critical social analysis of young people, youth work practice, young people's sexuality and sexual development.

> *"I talk about myself as being non discriminatory rather than non judgemental, because I do make judgements all the time as a youth worker, I need to be transparent about this."*

Workers suggested it is impossible to be "value free" or "value neutral" as a youth worker, what workers do (or don't do) is underpinned by a system of values. They stressed the importance of identifying, articulating and being accountable for these values. What values does the youth sector hold and promote? Some examples include: cultural diversity, human rights, social justice, gender equality, challenging homophobia, non-violence, being pro-choice, providing access to information, skills and resources, empowering young people, etc.

In relation to sexual health the way data is gathered and utilised also stems from a values base. Sexuality and individual decision making and experiences are subjective. Workers suggested the use of phenomenological and participatory action research methods to inquire about young people's stories and experiences and develop culturally appropriate peer based responses.

At the YANQ conference 2011, the "hot topic" was Alan McKee's presentation on pornography, generating lively lunchtime discussion amongst youth workers. One worker asked "how do we as a sector come together to discuss ethical practice issues and values such as how we respond to young people's use of pornography?"

One suggestion was to run facilitated practice discussion forums to explore complex practice areas, values and ethical decision making. This might run like a community forum or panel type discussions for workers to discuss practice dilemmas and complexities of practice.

Some examples of the ethical challenges faced by youth workers include:

The context/s of young people having sex; places where young people are having sex control (or lack of control) over the physical environment, how does this impact on safety and choices? communal living environments? unable to have sex in their home environment?	Conflicting beliefs and value systems, value differences between young people, youth workers, organisations and the community
Cultural and religious differences	The Legal and ethical context for practice;
Responding to sexual activity, eg in a residential housing service where clients begin sexual relationships	Intoxication and sexuality
Pornography, eg young people request to access pornography in accommodation or detention centres	Young people under 16 who are sexually active
Identity and self esteem	Working with diverse sexualities being value positive
Pregnancy options (continuing the pregnancy, parenting or adoption, terminating the pregnancy)	Use of contraception or having unsafe sex
Consent , developing the skills to give informed consent and the contextual factors that influence decision making	Sexual violence – response as a child protection or sexual assault matter, involvement of criminal justice system, mandatory reporting
Relationship issues	Intimate partner violence, bullying based of sexuality or sexual identity
Impact of media and community attitudes on youth sexuality	Intimacy and pleasure

> *"what is needed to build ethical capacity? Decision making models, ethical literacy, approaches, values, paradigms,*

Rather than responses to specific ethical issues, it is suggested this skilling could focus on ethical literacy, or frameworks and models for decision making in complex environments.

Workers suggested the development and dissemination of youth work practice papers on key ethical dilemmas and practice forums to debate ethical dilemmas. A focus on practice development could include exploring key questions such as: Who are you? What is your value system? How does this impact on clients? What skills are needed to dialogue with other key stakeholders about different values? How to work effectively with people who have different value systems and contexts to achieve good outcomes in young people's lives?

The Youth Affairs Network of Queensland has had a specific focus on train the trainer to skill current youth workers to run values and ethics workshops and practice forums for youth workers across Queensland. There are a range of suggested models for ethical decision making, Chenoweth and McAuliffe (2005) outline an Inclusive Model of Ethical Decision-Making based on four key principles: accountability, critical reflection, cultural sensitivity and consultation.

Confidentiality and privacy

When asked further about the nature of youth work relationships, workers suggested trust, safety in accessing services and the role of confidentiality in this. This can include actual policies and practices and perceptions by young people of service confidentiality (eg parental consent or being seen and questioned when accessing a service in smaller communities).

Workers can be unsure about the standard of care in relation to confidentiality. They observed that young people may get poor or incorrect advice or they may observe breaches of confidentiality by other service providers and the negative impact of this. Also mentioned was an absence from the discussion about the dangers and possible damages to the young people for breaches of confidentiality. Examples were given where confidentiality about sexual activity was breached, parents were informed and the young person subject to physical violence as a punishment.

Particularly noted for marginalised young people are the significant barriers to disclosing their personal situation as this may only be disclosed over time in a safe and trusting relationship. Lack of confidentiality presents very real barriers for these young people in accessing services. Hence workers suggested providing confidential services based on competency and context assessments with exceptions (such as harm to self, harm to others, child protection concerns) as preferable to the young person having to establish their risk status prior to accessing confidential services.

Practices around confidentiality vary between services and across different age ranges. Particularly variable is the response to consensual peer based sexual activity for under 16s. Workers discussed the emergence of risk management frameworks and mandatory reporting as impacting on young people under 16 exercising their rights to education and services. Many youth and clinical health services rely on competence and context assessments to meet Gillick competence for service delivery.

Practices around seeking parental permission to provide services can vary as well. Generally youth services and youth sexual health clinical services articulate youth rights frameworks and competency and context assessments for confidential service delivery. However this can differ when young people access General Practitioners, pharmacists and other services. Some do mandatory reporting or parental consent for everyone under 16, others it is under 14, others it is competency and context based. Others will use a risk of harm framework for reporting.

> "what we see in risk verse organisations are blanket rules and policies where the trust and discretion are taken away from the workers and their professional judgement"
>
> "sometimes you're better to have no policy than bad policy"

There appears to be a greater emphasis on risk management and liability of workers and organisations. This has led to practices that have eroded young people's rights around confidential service access. Some workers raised concern that some youth services were requiring signed consent by parent / guardian to provide services to under 16 year olds.

In addition to the relationship being critical to practice, workers outlined the way in which policies and processes can be disempowering for young people. For example, lengthy consent documents being signed prior to contact, especially when young people are vulnerable and may not be providing informed consent. Workers all stressed a practical application and understanding of power dynamics within relationships, as a general rule, workers suggest re-seeking permission and consent when disclosing new information or information to new workers, ensuring that young people are central to this process.

It is of value to explore the interface between organisational, legal and ethical expectations, worker values and young people's values. Clarity regarding the interface dimensions of the law, policies and practices for confidentiality and it's limitations was suggested as valuable to both service providers and young people. In particular, to consider the impact of these policies and practices on the capacity of young people to exercise their rights.

Other areas mentioned included reporting of criminal behaviour and mandatory reporting of child abuse. Staff mentioned that they know young people won't talk about consensual peer based sexual activity for fear of

mandatory reporting or parents being informed. Workers suggested this could include a greater understanding about location and mandate and how this impacts on work practices.

Youth health research (Lehrer et al 2007 and Booth et al 2004) supports this youth work practice wisdom that the most "at risk" young people are more likely to not access health services based on confidentiality concerns. In relation to young women these risks included: having ever had sexual intercourse, birth control nonuse at last sex, prior sexually transmitted infection past-year alcohol use, high and moderate depressive symptoms, suicidal ideation, suicide attempt and unsatisfactory parental communication. (Lehrer et al 2007) This highlights the critical nature of confidential service delivery as a component of working with marginalised young people, combined with issues of trust and rapport to enable disclosure, providing confidentiality prior to disclosure of risk is recommended.

Sexually active 12-15 year olds

> *"People need to open their eyes that young people are having sex before the age of 16. How do we respond effectively to this? The problem is that we are criminalising this behaviour and sending it underground so young people are scared to talk about it. Also, they think if they do, we'll report them to child safety."*

> *The developmental challenge most mentioned by participants in the ARACY middle years project was physical development / puberty / sexuality. This included: onset and commencement of puberty; physical changes occurring at different rates which can impose expectations and limitations; young people going through puberty at an earlier age; and sexual identity.* (ARACY 2011:13)

Concern was raised (almost unanimously) about the adequacy of responses to sexually active 12-15 years olds who engaging in peer based consensual sex. There were differing comments about young people under 16 of different age groups, hence the different age groups mentioned in this section. Generally workers found it ethically more complex in working with sexually active 12-13 year olds than 14-15 year olds. Concern was expressed about the use of the criminal justice system to criminalise this behaviour. Workers suggested that young people matured at different ages and varying social, cultural and personal factors influenced this.

Young people sexually mature and are ready for sexual activity at different ages, the legislation does not reflect this. Workers strongly supported a competency and context assessment as being more appropriate that age related benchmarks and criminal sanctions.

In relation to service delivery, many services used competency and context assessments for under 16, including HEADSS assessment, FRASER guidelines. Workers negotiated (in simple accessible language) limited confidentiality with young people, that could be breached with the young person's permission , under legislation (such as mandatory reporting of child abuse) or for harm to self or others.

In the context where youth sexuality for 12-15 year olds was not considered legitimate, workers discussed the challenges of providing age appropriate, but relevant information and services. Workers discussed complex practice issues relating to conflicting ethics and values, ethical reporting of child protection concerns, empowerment and being client centre, possible power differences between young people and their partners.

They suggested a particular gap for accessing appropriate supports for sexually active 14-15 year olds.

Workers also discussed the challenges of working with the older age group (15+) when there were legitimate risks and child protection concerns. Concern was expressed about the adequacy of responses to this issue.

Workers suggested a possible area of practice support was for ethical decision making in relation to child protection concerns. This might include training, practice forums, case by case responses, supervision and reflected in agency policy and procedures.

"There are specific issues for women under 14 when they present with unplanned pregnancies. These are often complex situations involving child protection issues. Currently due to the licensing of private abortion clinics, women under 14 are excluded from these services. These young women must travel interstate to access terminations as the public system does not provide adequate responses to them."

Workers found responding to unwanted pregnancy in 12 and 13 year olds particularly complex issues. For many workers it was ethically easier to work with over 16's around sexuality and unwanted pregnancies. "If the young woman is over 16, I'd offer her counselling and take her to General Practitioner to discuss her options." Others identified values barriers to workers making referrals to discuss pregnancy options, particularly for young women under 16 and access to termination services for under 14.

Child protection and mandatory reporting of child abuse

"The capacity of practitioners to exercise good ethical judgement is impacted by organisational accountability and risk management approaches which may not empower or be of benefit to the young person. The critical issue for the young person is who can they trust and how can they be respected and empowered in the response to their situation?"

"Child protection, child abuse and risk dominate the discourse about young people and sex, normal healthy youth sexuality is seen as a problem or gets lost in the policy debates"

"The focus in policy in Queensland is on child protection and risk management not healthy youth sexuality – sex is fun and a normal part of a young person's development"

Concern was raised that the public discourse around healthy youth sexuality has been overwhelmed by child abuse and risk management concerns. Workers emphasised the need for comprehensive and effective education and clinical services to support young people's relationships and sexual development.

Clinicians discussed the complexity of mandatory reporting regimes in clinical practice as this may impact on the young person. Particularly in relation to consensual peer based sexual activity. Some suggested that the ability to "sit with risk", do assessments, use their ethical judgement, and the mandated response did not appreciate the complexities of young people's experiences.

Workers suggested variable response from child safety when doing reporting, identifying times when help was needed but it was not considered appropriate to the situation. An example was given of a 13 year old, with a 14 year old boyfriend. Police were sent around to the family home to discuss the matter with the parents. In another example, a 15 year old was highly vulnerable and at risk but was not provided support. Workers suggested there was a variable response to over 15s from child safety.

Workers were also concerned that mandatory reporting means that under 16 are not discussing peer based sexual activity. Workers suggested ethical decision making on a case by case basis based on competency and context assessments as preferable to blanket age based policies. Variation in reporting included: workers may report under 16 (if partner 5 years older), under 14 (any sexual activity at all) or seek parental permission to deliver services to anyone under 16, anyone under 16 who is pregnant.

Workers suggested more training for workers in ethical based reporting (for non mandatory reporting) and an understanding of the guidelines and legislation for mandatory reporting for child protection concerns, including assessment and response skills and processes. Workers raised concern about the variable response by mandatory reporters in what would be reported. Examples were given of 15 year old peer based consensual sexual activity that was reported by a medical practitioner to child safety. Assessment of competence and protecting young people's rights were seen as important within practice as well as risk management and protection.

Workers suggested that many marginalised young people are already reported to DOCS. Workers raised concern that mandatory reporting meant that talking about youth sexuality might be avoided.

Providing sexual health education to young people with a history of sexual abuse was a potentially complex practice area. Workers suggested sharing strategies for discussing healthy sexuality in a manner that was safe, they expressed fear they might re-trigger and re-traumatise young people. Workers supported providing better resources and support to foster carers and respite carers.

Workers also discussed information sharing between NGO services and Child Safety staff as needing clarification. Workers suggested times when more information would have been useful. They also suggested supporting the role of the young person, providing confidential services and empowerment of the young person to give or withhold permission for information sharing between agencies and workers.

Workers identified links between history of child abuse, current drug use, mental health, poverty and sex exchange behaviours. Workers suggested more skills and resources needed to work with these complex situations. Workers suggested that the relationship with the Child Safety Officer and other child safety staff as a key factor in responses to young people.

Many workers identified the health passport process by child safety as a valuable tool for young people when it was well implemented. It was suggested that there might be scope to use a similar tool with broader youth populations which included sexual health issues.

Workers stressed the need for any skilling to be grounded in work practice. Practice forums that engage key players (youth workers, Commission for Child Guardian and Young People, Department of Communities Child Safety Services, Child Safety Officer training, Create Foundation forum, young consultants) was suggested.

Whilst there already existing training opportunities for understanding child sexual assault and trauma, practice skills in linking this to sexual health and broader youth health was suggested.

When making ethical decisions about child protection concerns, workers used a range of processes to do this. Many spoke of individualised responses on a case by case basis. They accessed supervision, organisation's policy and procedures, legislation and child safety online assessment materials (such as Structured Decision Making tools) to make these assessments.

Concern was raised about the impact of mandatory reporting policies for consensual peer sexual activity. For example mandatory reporting of consensual activity for under 14, workers felt this potentially eroded trust and create barriers to accessing sexual health services including contraception and late presentations for unwanted pregnancies.

Workers suggested the need within child protection policy to clearly distinguish age appropriate responses and practices for children and young people. The development of practice guidelines for 12-18 year olds was suggested, ensuring rights based and inclusive practice strategies for example skilling young people to facilitate their own case planning meetings etc.

"The emphasis on child protection seems like we can't talk about sexuality, especially for male workers"

Clinical youth health services

"Our clinic is an open accessible drop in service, non stigmatising access, trust and relationships are critical, generic holistic health approach."

"Our team not delivering clinical sexual health service such as contraception, pregnancy testing and STI screening, but clinical services need to be accessible and youth friendly. Young people need to know where to go. "

"Many young people we see won't go to doctor, because there may be awkward questions for under 16s such as "you shouldn't be having sex!"

"Finding a good family doctor who is youth friendly can be difficult, we've started a list of GPs and refer young women to them."

"In areas where there are youth health services, most health needs are being addressed. I'd be more concerned about areas where there are not accessible "youth friendly" health services"

Workers emphasised the need for more "genuinely youth friendly" health services. The service options in different geographic locations will vary, many area rely of GPs and hospitals, for example emergency contraception availability. Workers emphasised that the due to the social construction of young people and community attitudes, there were a number of youth health issues that were generally not dealt with well in the mainstream health system, these included sexual health, alcohol and other drugs, mental health and reproductive health for young parents.

Co-location of services is a useful strategy for example ISHYI funded services such as Brisbane Youth Service, Youth Link, Young Parents Program, Young Women's Place, and other interstate examples such as High Street and Cellblock. These services can include a range of holistic youth work responses, clinical health services, non stigmatising access, drop in centres, walk in services located in a youth space, flexible and responsive services, peer based education and support, pharmacy close by, bulk billing, no medicare card needed, non identifying access and coded results.

"we would fax the prescription to the pharmacy across the road, it was filled and the medication available for the young person by the time they left the appointment"

Workers suggested the value of non stigmatising service access, concern was raised about visibility, such as who sees you going into the clinic? There continue to be systems barriers to accessing mainstream health services. Workers suggested in some locations, young people won't access sexual health clinic or specialist sexual health services.

For school based young people, workers suggested more early morning, late afternoon and night time appointments (particularly Thursday night at the same time as late night shopping). Workers suggested for some young people it can be difficult to access clinical health services without parents knowing.

A strategy was to focus on building strong relationships and networking between youth workers and General Practitioners, particularly bulk-billing General Practitioners in locations where there are few youth and sexual health services. For example a partnership between professional peak bodies to host networking breakfasts or other events to meet each other, to develop skills in working with young people and being 'youth accessible', for young people to access doctors and referral to youth workers for follow up support. Youth workers can provide supported referrals and active follow up
Workers supported community clinical outreach, that istaking clinical health services out to youth services or schools. Strongly emphasised was expanding the role of School Based Youth Health Nurses to provide pregnancy and STI testing. Workers also suggested closer links with "youth friendly" General Practitioners for STI blood testing, contraception and unplanned pregnancy options.

Workers suggested ensuring that doctor's surgeries and pharmacies are more 'youth friendly' environments.

> *"Youth workers play an important linking role when young people don't know someone, feel isolated, are concerned about visibility in the community, workers can recommend "this person is ok when they know the name and face of doctor".*

Other projects were mentioned that enabled young people to define "Youth friendliness" and audit health services for this. "The youth advisory council (attached to the local regional council) gave feedback on this, this gave the youth tick of approval to health services FPQ conducted a prior project about what young people want for sexual health services, this included DVDs, interviews, excerpts "what young people know, want, say" collated in a project report and promotional flyer.

Also highlighted were experiences of young parents in accessing health services, such as "I'm judged", "They didn't listen to me".

Workers discussed the value of using interactive 'youth friendly" education processes and resources (where appropriate) in a clinical setting. This information, skills and resources could be presented through the internet, slide shows, very visual, high impact resources, demonstrations such as how to put on a condom. Workers suggested that education needs to be hands on, visual, interactive, not just read out or didactic. It needs to consider literacy and understanding of issues as well as being age appropriate.

In some regions, there were "unexpected" service providers delivering sexual health interventions, eg headspace services. In others there was a lack of sexual health options for young people.

> *"The community health didn't have priority for young people, let alone young people and sexual health"*

Young people and unplanned pregnancies:

> *"Women under the age of 20, represent 29% of our clients. (for women who disclosed their age), therefore as the only Queensland prochoice service providing counselling, information and education services on all unplanned pregnancy options we strongly value our relationship with the youth sector. It is the experience of Children by Choice that younger women are more likely to disclose their age when experiencing an unplanned pregnancy, in our experience young women are more likely to disclose their age because of age related issues. This can be an important factor in their information-gathering and decision-making processes and also for age specific referrals."*

There are significant barriers often experienced by young women to navigate their decision and access their preferred option. Our statistics (Children by Choice 2011) show that younger women are:

1. Slower to recognise a pregnancy or early signs and more likely to wait "head in the sand"
2. Slower to access or have limited access to services for support and information.
3. More likely to present later in their gestation
4. Tend to have limited financial resources

The above factors are exacerbated for young women living in regional and rural areas. We believe that the youth sector is in a critical place to support these women and assist them in timely referral pathways.

School based work – general and marginalised young people

> *"This is a highly political area so politicians don't want to touch it, however most people see and importance and value of it"*

"The young people who are really vulnerable are those who are on the edge, hanging in at school with no parent or adult support"

"There are pockets of things happening, however it is dependent on the school environment"

"In school environments it's important to respect boundaries, find the opportunities, what is possible? We need teacher champions, where we can highlight examples of really good practice. It's also about working with the organisational culture, and strategically challenging this culture."

"There is an assumption that services need to be provided in the school environment, whereas it is also useful to have good linkages to community based youth health services, we need support for these services."

"Sexual health education is often biology and reproduction focused, whereas young people might be more focused on relationships, intimacy and pleasure."

"A plausible explanation for this disconnect between knowledge and practice is a lack of relevance of formal sexuality education to young people's own experiences. Formal schooling provides largely 'technical' information (contraception, STIs, HIV/AIDS). Young people want 'practical' information (how to have relationships, how to have pleasurable intimate encounters). Schooling tells them that sex is bad, while their own experiences sugest that sexual exploration can be pleasureable." (McKee, 2011:3)

"We have very urbanised, metro centric policy, the context for addressing issues is very different in rural areas, it is not resourced, there is high worker turnover, salary packaging strategies may assist in some way. There is a greater population of marginalised yp in school environment , they can see YSCs outside school hours, eg school holidays, after school, however if in rural area where there is a 2 hour bus home, this is difficult. Outcome based funding may not take into account practical issues such as worker travel time."

Due to the education and training reforms of the last decade, the ETRF or "earning or learning" agenda has led to a greater number of marginalised young people are now staying in school making it an important point of access for sexual health education.

Whilst a state wide policy on sexuality, human and relationship education exists, in practice workers felt it was hit and miss or ad hoc as delivery on the ground was dependent on the principal, the teachers, who is teaching it, values, ethics and skills of those delivering it, the school and community environment and other key players such as parents and citizens associations etc.

There can be a difference in responses between the state schools, private schools and faith based schools, but the differences as so variable that it is difficult to generalise. Workers suggested that overall young people were fairly poorly educated about sexuality, some may get no sex education at all, others may have a talk in grade 12, others are starting earlier and getting more comprehensive sexuality education.

"The existence of the school based youth health program and youth support coordinator program is fantastic, visionary, about youth health in a youth focused way – excellent resource for young people. However there are limitations."

Workers suggested expanding the prevention and early intervention role of School Based Youth Health Nurses to utilise their skills more effectively. This could include: providing sexual health information, giving out condoms, pregnancy testing, STI urine testing, and linking with General Practitioners for STI blood tests, contraception, morning after pill, referral for unwanted pregnancies,pap smears, and other services. The primary relationship and interface with the young person may be with the nurse with GP support. It was suggested that this could be established with minimal resources and outreach clinics could be covered by existing resources such as Medicare. Such clinics have been established by General Practitioners at private high schools and could be implemented by Education Queensland through flexible and responsive policies. "In our experience, parents supported access for their children to confidential medical care in the school environment."

Others challenged the assumption that services are provided in the school environment, whereas it is useful to have good linkages to community based youth health services. It was mentioned that there is currently a School Based Youth Health Nurse pilot project looking at condom availability and pregnancy testing in schools

Support was reiterated for comprehensive sexual health education for all young people in Queensland schools, with the option for parents to opt their children out. It was suggested that sexual health education to start quite young. This sexuality education would normalise sexual development, it would be school based. There was feedback that current school based sexual health education was limited in schools. As a non-mandatory part of the curriculum, it was suggested that some schools were not providing sufficient sexual health education. Workers suggested that it often had a reproduction and biology focus with limited social development focus. Additionally there was limited support for parents to equip young people with skills to have those conversations.

"The principal can often set dynamic for school environment, or can have a key role in influencing it, who are the key allies in the school environment?"

"There are pockets of things happening but not systemically, it is dependent on the school environment and attitudes and values of key personnel in the school environment"

"It is varied for young people in school context, between different schools and classes, we need a consistent whole of school approach, they have to do something up to year 10, not specified what, how much etc"

"One of the barriers is ensuring that the education is culturally appropriate, we've developed our own program for indigenous students at school, including cultural stuff, self awareness, thinking ahead, etc"

"We are still dealing with it as a taboo item, when schools are doing it, it is often from an abstinence based policy and community attitudes that young people shouldn't be sexually active. There is still the fear from that if kids are informed they will be sexually active."

"we do most of our sexual health work one on one, for example the morning after pill, the worker might give information, or take the young person to the GP, we keep it fairly quiet, what are the implications of these decisions?"

Workers noted that sexual health is in the school curriculum but not mandatory, so the inclusion of sexual health education is up to the school. This can mean that schools are 'opting out', creating a 'hit and miss' response in different schools, it can depend on the principal, the teachers, the school environment and other key stakeholders to enable or inhibit comprehensive sexuality education. This was compared to other jurisdictions where sexuality education is mandatory and parents can opt young people out.

Workers suggested the need for political leadership to progress this issue. Particularly when there is a disconnect between the level of support that parents have for sexuality education and the policy response. For marginalised young people, where there may be a non-supportive home environment, school is the first point of call for sexuality education. It was suggested that there can also be benefits to part of this education being delivered by someone outside the school community, for some young people it can make it safer to ask questions. Workers suggested basic sexual health education from year 6, ongoing over school life, that it is age appropriate, very interactive, including group discussions and other participatory learning methods. Particularly that the content is relevant to the interests and needs of young people themselves.

The focus on disease prevention lacked a focus on broader sexual health and well being issues. Broader sexuality issues for education could include: sex and emotions; ethical decision making; self reliance; confidence; intimacy and comfort; relationships; communication and negotiation; sexuality; context and experiences of sex; relaxation; emotional literacy; stress and anxiety; coping skills; personal development; health; life skills; how to deal with stressful situations; conflict; anger; self esteem; desire and arousal. Workers also suggested that most sexual health education had a heterosexual focus, and the homosexuality needed to be included within the normal range of sexualities.

Pedagogies and education approaches mentioned included: adult education processes, "youth friendly" interactive education processes, popular education, peer based education, Friere and pedagogy of the oppressed, particularly the process of "conscientization", community cultural development, youth arts approaches, activity and participatory action learning, inquiry based approaches and project based learning.

Due to the social construction of young people and their individual and structural disadvantage, workers suggested an education process that enabled young people be aware of this disadvantage, allowed them to investigate and challenge this on both an individual level and collectively on a structural level. Workers suggested the role of key stakeholders and advocates to address structural disadvantage, such as access to services. It was suggested that consciousness raising could enable young people to challenge internalised messages about age, gender stereotypes, homophobia, capacity for making informed choices etc.

Workers also stressed that in addition to relevant and timely information, young people needs opportunities for skills development, resources, values clarification and personal development to be empowered to make decisions consistent with their personal ethic and well being.

"Scare tactics don't work when educating young people, because they don't address the factors that impact on decision making, such as being drunk, pressured, disempowered…"
"Critical consciousness focuses on achieving an in-depth understanding of the world, allowing for the perception and exposure of perceived social and political contradictions. Critical consciousness also includes taking action against the oppressive elements in one's life that are illuminated by that understanding." (http://www.onecountry.org/e152/e15216as_Review_Consciousness_story.htm)

Most workers suggested we could be doing sexual health education better. Some suggested more emphasis on safety, myths, realistic and honest information. Many discussed that young people get a lot of information from each other, this can be both positive and negative, as such many suggested peer education as an effective approach to utilise these existing relationships constructively and to challenge misinformation.

Another suggestion was developing a **youth health passport** type approach used by Child Safety Services to all young people in a school environment. The focus would be on fundamental universal youth health.

In rural and remote areas workers identified access issues and a disjunct between policy and practice. Workers supported early intervention for young people's development, including sexuality. Workers discussed the challenge of work role that is at times collegial or confidential, "*there can be role conflict, particularly when taking on role of advocate*". However they also highlighted the benefits of being an outside service delivery agency in a neutral role outside of the school and government employment.

Others highlighted the Youth Support Co-ordinator infrastructure through the Queensland Youth Housing Coalition Hub Coordinators as a good model to replicate in the broader youth sector. This includes: a sector advocacy role, working groups, hubs as statewide workers, regional hub role to prioritise regional issues, internet group, conferences, YSC practice manual, support for consistency of practice, programs, peer support, maintain workforce profile information, conducting exit interviews when workers are leaving jobs, highlighting workforce retention and sustainability issues, organising learning and skilling opportunities such as workshops and training, statewide induction of YSCs, articulating the models of youth work practice.

The new regional hubs are employed under an "interchange agreement", where they are employed by community organisations and sit in government, supervised by govt worker, role to identify gaps in service delivery, highlight priorities. This has been generally been the 'at risk' groups including Aboriginal and Torres Strait Islander, homeless , Child Protection and Youth Justice clients, Culturally and Linguistically Diverse and pregnant / parenting young people. Workers highlighted an inherent conflict between advocacy roles and supervision and possible lack of independence when locating these roles in government.

> *"The current service delivery arrangements have eroded the capacity of youth workers to provide confidential services to young people in school environments. It has been a move from young people's rights based approaches to minimising risk for institutions."*

There was a sense that *"DET is more strongly controlling the agenda"* which can present challenges for youth driven and rights based youth work practice.

"It's important for the youth sector to articulate youth work practice, identify who we are and where we fit. At it's core, some policies undermine the youth work practice process of building trust and relationship with young people and partnering with young people to set the agenda, rather than an externally imposed agenda."

Workers also expressed concern about the capacity to deliver confidential services in the school environment, that move towards a more "risk based approach" has meant diminished capacity for workers to provide confidentiality. Others expressed concern that mandatory reporting meant that young people presented a barrier to talking about consensual peer based sexual activity. This may be an area where clarity for young people and workers is required.

Workers also highlighted the power dynamics relating to confidentiality and consent, where forms and processes can be disempowering, eg signing a lengthy consent form when a young person is in crisis and needing an immediate response.

In the school environment youth workers need to be understood, valued, and promoted as ethical and professionally competent. When considering the standards professionalization, workers highlighted that there was often a disconnect between practice and reality.

The Youth Project through Family Planning Queensland has a particular focus on workforce development for teachers and others who deliver school based sexual health education. This has included developing communities of practice, highlighting practice champions and developing a media profile for good sexual health work. Creating supportive environments that act as enablers for the delivery of sexual health information is an important element of ensuring that young people receive relevant education. There is capacity for sharing workforce development skills with future youth sector initiatives.

In a recent survey of parents, the overwhelming majority of parents (98%) agreed that young people need to be provided with information about sexual decision making before they engage in sexual relationships. (Footprints Market Research, Commissioned by FPQ 2010)

There is a teacher resource centre on the Family Planning Queensland website. It is an online portal with information to help teachers prepare for and implement sexuality and relationships education (SRE) programs in their school. It provides teaching and learning strategies, research, curriculum links, resources and professional development.

There is scope for joint training and skilling between teachers, school based youth health nurses, youth workers, guidance officers and other key stakeholders around complex practice issues – for example discussions re behavioural issues, negotiating consent, communication, sexual ethics, decision making, skills, environment pressures, identity, self esteem, emotions etc.

Marginalised young people outside the school system

"Not all kids make it to high school or drop out whilst there"

"It's open street knowledge, peer based, couch surfing, not living at home, child safety clients – they may not have control over the environment in which they are having sex. They might be swapping sex for accommodation, drugs, safety etc"

There are a range of community based youth health services in some geographic locations. Generally they are located within generic youth services (often drop in centres) and they are effectively servicing young people in their local areas. Concern was expressed for young people who lived in areas without good local clinical youth health services available. In some areas, there are "youth friendly" sexual health clinics or "youth friendly doctor"

but there were gaps in other geographic locations. An audit of youth friendly health services and training for health service providers could assist addressing this issue. Also to promote youth friendly health services to young people.

Connectedness to community is important, rather than young people just dealing with it by themselves. Critical was engagement with young people. What issues are young people presenting with?

> *"We need more resources, I've just started, but what I can see is fear of change, fear of sex, we're more petrified of bad press, many workers fly under the radar, yet they are quietly and proficiently delivering services"*

There are a range of services in some geographic areas already delivering youth health and young parents support and case management. Some youth health services provide education only, others include clinical services, others have outreach clinical services at their youth services.

Many youth services include drop in and outreach services that focus on a range of specialist issues including health, housing, employment,

Accessible drop in spaces can include: kitchen facilities, showers, storage, resources, activities, computers, a safe place with no stigmatising access, although there are guidelines in place. Access is often opportunistic rather than planned, although planned work often follows out of initial engagement. Health interventions can be individually or group focused, often responding to presenting concerns, such as sexuality and identity etc. Generic support often takes an holistic health approach

Parents and legal guardians

> *"There's people you talk about that stuff with, but others you can't, many young people have a lack of guidance, some can talk to parents but others can't – it depends who you feel safe with, it might be mum, dad or bigger sister"*

> *"What is appropriate in delivery of services and follow up? What are the repercussions if having conversations without parental consent?"*

Workers suggested the need to effectively resource and skill parents, other adults and peers to discuss sexual health matters. Confidentiality between service providers and legal guardians emerged as a key them, particularly permission to deliver services for under 16 year olds. Previous research and projects have demonstrated that parents can be very supportive of sexual health education. Concern was expressed that sometimes policy makers and community leaders (such as school principals) may be out of step with this.

Rural communities

> *"The biggest thing is the impact of community attitudes on young people and youth workers, for example gay young people usually keep it to themselves"*

> *"I definitely agree with a positive versus a negative way to frame and approach young people's sexuality."*

> *"We work with over 16 one on one in clinical setting and because of the legal situation we have a lot more free to provide the services that are needed"*

> *"It's definitely an issue out here, you hear stories of kids talking, you'd be surprised about what goes on"*

"I'm not sure if they are getting enough info and advice, parents attitudes about this will vary, for some it is a very touchy subject, you need to make sure everything done is appropriate to the ages of the children"

"Our local community health centre ran women's and men's health days for over 50's, we thought they could include a session on how to talk with your young people about sex"

"We tend to keep it 'under the radar" when faced with hostile community attitudes, we do what we can get away with but in a sense that means that workers are taking on risk personally"

"You can run stuff if you want, but you need the support of the community if you want to get young people there, so it's not just working with the young people it's also about working with the community"

The culture and experiences for young people and youth workers can vary significantly between different rural communities. Key factors that influence the work are community attitudes and values/attitudes of key leaders in the community. Workers gave examples of a whole range of interventions from parent supported community health expos on sexual health through to very little happening in the local school or community.

Worker turnover was identified as a key issue, or difficulty in finding qualified and experienced staff to fill key work roles. Induction resources and training were suggested, as well as access to on the job training to gain qualifications, supervision and mentoring in work roles.

Workers suggested the need for 'on the job' training for workers who were new to the role and didn't know where to go for useful information when learning about role.

"SWYN addresses youth worker turnover by giving a USB with "youth work 101" information, particularly for workers who are not trained or experienced in youth work "

"sexual health keeps coming up at our regional youth network, issues around service access, not hospital, in rural areas it varies, there is also varying feedback about school based sexual health education, some say it is less informative, not getting info they need, patchy, it can vary according to values and skills of teachers, principals and school environments. The school based youth health nurse and the youth support coordinators are important for this as well"

Workers identified the value of networking and conferences, face to face and online networking to support rural youth workers. There a long standing networks across many rural areas, such as the SWYN network across the South West Region. A novice worker gave an example of an induction USB that had been put together by this network to support induction for new youth workers in the region. Workers suggested a very real need to resource and support these networks for the critical role they play for isolated rural youth workers.

"In our community high school sex ed is happening, they're more open about it than they used to be"

One worker who is new to work (a couple of months) mentioned that she has not touched sexual health yet, but was acquainting herself with the local referral systems and resources. *"We have a good local service providers network in our area."*

In some towns it can be hard to get a General Practitioner appointment and going to the hospital can be stigmatising. A number of workers mentioned the "growing respect" and "love bites" program focusing on decision making and consent around sexuality. Workers suggested the values of key players in the school environments can make a big difference in the type of sex education that occurs. This can include the principal, teachers, School Based Youth Health Nurses and others.

Many youth services engage young people through running activities and education workshops, support young people being involved in the local youth council (if there is one). The starting point can be to engage young people and find out what they need to know or are interested in.

"In our small community, many people are homophobic, but young people are more open about it. I'm not sure how to support LGBT young people, some might be supported in the school environment, part of my role might be to give permission to talk about it."

Workers suggested the need for values and ethics clarification, skills in youth health promotion and being able to work with community values and attitudes. Some workers suggested there were good resources and programs in their town, whilst others identified a lack of these resources.

Many local regional councils have youth development officers who work with a youth development focus and often some service delivery. Workers identified these workers as a useful resource for the regional youth sector.

"Sexual health comes up in conversations between young people, sometimes during games or informal conversations."

Youth workers in rural communities often work with the whole youth population in a particular area, they identified the shift for YARI funding to more "at risk" young people as being problematic in a rural service delivery context as it was difficult to isolate "at risk" young people from the whole youth population as it could be stigmatising for them. Additionally concern was raised about how YARI program logic could incorporate such a broad range of diverse services.

"Most of young people with unwanted pregnancies, STIs are going to our local youth mental health service headspace, we've had really mixed feedback about this, some young people find headspace very accessible, others report that it's not that confidential, others report excellent results."

"Access to free condoms, especially in rural areas, is really difficult"

"In rural areas there are a limited numbers of services for example the GP, being known in a rural area there is a lack on anonymity"

"Young people who identify as gay, particularly in rural areas, float to the city, attitude of the community around that, frightened of doing thorough assessments"

"I'm not seeing much unwanted pregnancy and STIs, isolation is a big issue, not being able to go anyway, transport is difficult, our young people travel to next town for high school (25 high schoolers), job opportunities and employment are key issues"

Many youth workers in rural areas are providing sexual health interventions in a range of different ways. Sometimes this is through confidential individual service delivery, education workshops or community forums.

PRACTICE EXAMPLE – YOUTH HEALTH FORUMS

We ran a session on sexual health at youth engagement forum (outside school context) in our local community. All the young people and their parents were invited (but no parents attended). We had mental health, alcohol and drugs and sexual health sessions. We had local mental health service providers, general practitioners and the school based youth health nurse ran the sexual health session. It was an open discussion, we didn't individualise issues and then there were small groups where young people could ask questions. Young people who were scared to ask questions in the big group could follow up privately with worker afterwards.

Another youth service ran a youth health day, this involved session by the police (one punch can kill), Qld Health (Alcohol and other drugs), School based youth health nurse (sexual health for young people and hygiene). We observed what young people needed and set up the day based on what the young people wanted to know. There were 3 different age appropriate delivery (gr 11-12, gr 10 and gr 8-9). This included personal stories about alcohol and violence.

What helped make it a success? We had good relationships with the young people, and we were able to bring in specialists. Some young people wanted their parents there and others didn't. We had existing good relationships with parents. We went through the school and p&c, we went through what was going to be discussed and it was approved first. We made sure it was age appropriate (yr8-9 had slightly less info than 11-12, for the older group the info given on assumption that they were going to be sexually active). We had quite a few meetings beforehand, one of the the school principals wanted to know how deep we would go, what is going to be covered, the other school principal just left it with us. We ran a community forum before the youth event to raise awareness, this info night for parents was about discussing the content prior to the youth health session.

The worker suggested that because of her personal and professional values she prioritised the issue and saw it as part of her work role. It was also a priority with the young people, the initiative was developed through good networks, good links with young people, parents and other key stakeholders, and bringing in specialist skills for the sessions.

Workers identified "unexpected allies" in the community, such as "the matron at the hospital, she has great values and is very open about sexual health, but the challenge can be in getting the young people there."

Workers suggested better networking to make good use of existing resources and additional resources, such as funding small buckets of money for one off events for youth health.

Aboriginal and Torres Strait Islander (ATSI) communities (rural and remote)

> *"Sexuality - when I bring up the topic, it's a no go zone, young people cringe, they're embarrassed, it's a shame thing. They may not be open enough to say 'i've got an itch'"*

There were a small number of ATSI respondents in this research, so represented here are some of the key themes that were highlighted rather than a comprehensive representation of the diversity of views and experiences of ATSI workers young people and communities. We recommend a more comprehensive examination of the specific issues for ATSI young people and service providers.

The research work of Sarah Larkins in Townsville at James Cook University was highlighted. This was peer based research by ATSI young people over four intensive interview sites. This research is a more comprehensive account of issues and experiences for ATSI young people and their communities.

There is great variation between different ATSI communities so each community needs an individualised response taking into account the local factors. The suggested focus be on prevention and improvement of general health services, then within this young people's health and sexual health services.

> *"Health and health access generally can be very difficult, sometimes in the absence of good primary health care, sexual health can be overlooked"*

> *"Sexual health work happens in a community context where there can be bigger challenges, such as isolation, transport, cultural barriers, language and literacy. Getting things done in communities, particularly as an outside worker / agency can be challenging, a local contact person is critical"*

Workers identified a need for programs that go into communities, and the challenges of providing services by agencies external to communities. These challenges included: communication, need for better linkages, coordination and networking between key agencies who are working in the same communities eg youth services, headspace, PCYC, NGOs and Government service providers. This included strengthening relationships with Child Safety staff.

Workers suggested the value of piggy backing resources and the need for a central coordination point, especially a local contact person on the ground in the community.

"The challenge is getting the right links with the right people. Getting things coordinated in communities can be very difficult"

"Networking, communicate more effectively with all stakeholders working within a community"

"Wider strategic networking is needed"

Community attitudes and values to young people and sexual health were highlighted as well as the stigma that can exist for service access around sexual health

"ATSI health staff can be targeted, eg they may be unable to bring someone in around sexual health, client perceptions around confidentiality can impact on service access, don't know when you're being picked up, visibility of accessing a health service"

"People could be aggressive with us, perception, assumptions, shame around sexual health, school has resources, trying to do education, education having to be delivered ATSI curriculum, sexual health staff, one off sessions, most schools are supportive, education / support for parents to educate young people, Mornington request – developed flyer encouraging parents/carers to talk to young people, not just about STIs, seen as shame, talk to parents/carers, they are usually supportive, actively supportive"

"Not talked about, but understood that many young people are having sex, they (the parents) want help with it"

"It can be a challenge in getting sexual health on the agenda in some communities"

"We some 12 year olds with STIs, but that is fairly rare, the majority are older than that, usually 15 plus"

Improving the responses to LGBTI young people were suggested, there were anecdotal reports of LGBT young people being prescribed anti depressants in response to bullying.

"Services on the ground needing more support and resources, eg DVDs"

Workers identified that running general youth events can present challenges as young people of all ages can attend, including the younger age group, so getting appropriate messages to the right age group can be a challenge. "The really young ones often attend the youth events"

School based programs may not be as effective in ATSI communities where school attendance is low or where young people are away from communities to attend school. Whilst young people may get education when they're away, workers emphasised the need for need for follow up with these young people when they are back in communities

Ongoing programs that were identified as effective included outreach clinics at ATSI high schools, ATSI health workers doing health education and clinical service delivery,

"We need people on the ground in communities doing sexual health outreach work, there can be a lack of information flow between agencies working in the same communities. Better coordination needed for limited resources, who, how and what? For networking"

"Reliant on ATSI health workers (who are often elders) can present challenges, especially where sexual health work is stigmatised and worker or community attitudes may not support sexual health work with young people."

Other available resources included: hospitals, PCYC, sexual health outreach, doctor, nurses – RFDS fly in fly out, NGOs and outreach services, Qld Health sexual health promotion roles in the Gulf communities.

"There's lots of work being done in Cape York, young people's health check, young people's radio serial raised sexual health issues"

"It's important any responses involve young people through peer education processes, not using social marketing – community empowerment is needed – not just community engagement – community development, community identify the issue, sustainability, community ownership"

Increasing access to condoms is needed, eg the condom tree, family on border, over the heads of the campfire site, location of condom tree is critical

"It can be shameful, private issue, sexuality, who would you talk to about sexuality? Generally they would talk to someone they felt comfortable with"

"Generally primary health care is missing, no accommodation, nowhere for outsiders to stay"

Workers identified a disparity of resource allocation between different ATSI communities and the need for more consistency in resource allocation and responses across ATSI communities

Workers identified the IMT – Instant management teams as a coordinated approach within health, whilst there were ongoing challenges eg workers with the right skills, accommodation, coordination with people on the ground etc.

The role of ATSI health services was highlighted in addressing youth health and youth sexual health issues.

Lesbian, Gay, Bisexual, Transgender and Intersex young people

"LGBT young people can go through a really rough time, especially if they are in a family who doesn't support being gay or if community or school attitudes are hostile, many young people get bullied at school because of assumptions about their sexuality"

It was suggested that the current youth policy environment does not effectively address homophobia and other core issues, values, tolerance, promoting diversity, bullying etc.

"The main problem is not with the young people, it's the homophobic community attitudes and messages they receive. Once young people work this out and can accept themselves for who they are, they're usually ok!"

Concern was raised about the way young people could internalise negative messages about their sexuality.

"This is a taboo subject for many young people, that's why the relationship, trust, rapport, confidentiality and time are so important. You also need an awareness of the negative messages young people may have absorbed about their sexuality and find safe ways to discuss this."

Workers identified an increasing number of young people presenting with gender issues. Young people have varying journeys and experiences around this. The Jellybeans transgender support group for young people was identified as an effective resource.

A gap was identified in young people's access to gender clinics. Public clinics were at high capacity, were difficult to access and had lengthy waiting times. This area of clinical health and mental health practice was considered specialised and not well addressed by generic youth mental health services. Workers suggested the need for a statewide resource list of "youth and transgender friendly" psychologists, psychiatrists and other clinicians with specialist skills and value base to address transgender young people's concerns. This included the provision of assessment, referral, management of HRT, counselling component, experience in gender related issues, ongoing support during lengthy hormones treatment and faster responses for new appointments and flexibility to be responsive to young people's experiences.

Resources and campaigns:

- soften the fuck up, beyond blue, one in three (dv site), Rip n roll campaign, NSW,
- Lyn HILLIER – writing themselves in 1, 2 & 3, Transnation, Vivienne CASS Identity Model 1986, John HOWARDS work
- "it get's better campaign" – yp may not relate to this as they want it better now – 21 can seem like a long way away
- FCKH8 campaign – real, better now
- Drysdale Campaign, Lady Gaga does it better, Bligh – it gets better

Practice strategies:

> *"Within standards of youth work practice, it needs to be clear that homophobia is not acceptable – inclusive service, creating dialogue, values awareness, how it comes across – conscious and unconscious messages"*

Workers identified attitudes and values as a critical component of quality services. Workers suggested being "values positive" not just values neutral in working with LGBTI young people. They suggested removing the assumption of heterosexuality, to strive towards this, eg discussion of new partner etc. The "coming out" period of first disclosure was seen as a critical time for support, and concern about the impact of negative responses on young people.

They stressed the importance of young people's participation and ownership of services, a number of existing youth health services were highlighted as good practice examples.

A number of youth services provide counselling and peer support groups, community education and advocacy with LGBTI young people. Workers identified the lack of role models in both the media and in personal relationship with young people. Worker comfort levels can vary in responding.

Again the importance of trusting relationships and specialised skills (as needed) was emphasised. Interventions needed to be mindful of youth development. Young people may be curious, inquisitive, confused, not have access to proper info or a safe place to ask questions. Workers identified that they had to be discrete, and needed the skills in how to navigate a homophobic community.

Another response to address the lack of role models to normalise diverse sexualities was the use of peer mentoring and adult members paired with young people, "one of the biggest things young people have to learn is coping

with the bullshit". Responses from families were variable, supportive families were a critical part of young people's positive development. PFLAG was suggested as a useful resource to assist families.

> *"Young people are often Isolated, lack information and support, face hostile environments. The support helps young people to move through the process a lot faster, parental and/or family support is critical."*

> *"Young people need supportive environments and services that are more accepting and inclusive."*

> *"I tell young people 'Don't take it on', labels isolated them, who is the one person you love dearly who accepts you? A trusting relationship is critical and developing coping skills, what is something that helps with finding peace, eg sport, ride on city cat, talking to chickens, whatever. They have to learn to be comfortable with themselves"*

A number of workers suggested that they would "suss out" worker values around sexuality prior to referral and that they would refer to individuals not organisations generally.

Be visible, actively and subtly raising the issue can be important as there may be significant barriers to the young person raising it.

> *"I put posters above my desk in the youth service, young men may treat as a joke, but it is a good conversation starter, young people may ask "why do you have that above your desk?". It provides an opportunity to discuss the topic. I think workers need to actively raise the issue as there are so many barriers for young people to raising it, so it may never get discussed."*

> *"You need to be careful of answers given in a peer group, and challenging homophobic comments or jokes, cause there is sure to be someone in the group who is questioning their sexuality and they will take note of your responses – are you safe to talk to or not?"*

> *"Young people get lots of heterosexual messages, there is a lack of visible role models and this can impact on self esteem. Our community is reasonably tolerant, but young people are not getting the info they need in schools."*

Responses in school environments can vary between schools. Workers suggested that ongoing whole of school approaches were needed to address homophobia and homophobic bullying and to support young people developing confidence in their identity. Concern was raised that focusing on generic anti-discrimination and inclusiveness did not address specific homophobia issues. Teacher, principal and other key stakeholder attitudes to youth sexuality, young people and diverse sexuality were suggested as key elements in school responses. They also suggested ongoing education processes not just "one off" sessions, however single workshops were considered better than nothing.

> *"Most sexual health education is based on an assumption of heterosexuality. There needs to be gay specific sexual health information available more broadly, such as through health nurses in schools."*

> *"There is a need for safe environments, free from bullying and harassment. Often education for mental health issues can ignore the sexuality and gender identity component. The core issue is support."*

Workers suggested that sexual health education needed to be inclusive of diverse sexualities, not just heterosexuality. Safe sex education, workshops and outreach services were also suggested.

There were differing viewpoints about group based processes to address diverse sexuality.

One worker suggested caution and clear boundaries as "Raising this issue in school environment can lead to violence or verbal abuse if a young person self identifies during the education session, you need to be aware of

how safe the environment is for the young person."

> *"one strategy we use is that every young person gets the same handouts, so we are not targeting individuals"*

> *"When you're challenging homophobia you need to be strategic, there can be a 'pack mentality' in groups, i suggest challenging respectfully, sometimes it's better one to one, if you have time, seek to understand, use humour, picking your timing is the key"*

Others thought the "Best space for peers to discuss things is among themselves – values, group skills, challenging behaviours, referral, advice, information"

Workers were concerned about ongoing myths around diverse sexuality education "I'd say, they're often scared of it, like you're teaching them to be gay, however opinions among adults can be really diverse as well!" "I want to blow up the notion that being gay is a "lifestyle choice", for most people it's not a choice it's a fact of their reality"

Workers discussed the differences for young people in urban, regional and rural areas. "The community in Brisbane can be safer than regional areas. In regional areas young people can be more isolated, it also depends on the community and their family. In small communities, everyone knows everyone, especially if public opinion is dominated by homophobia."

> *"Support equals outcomes, it can increase confidence levels, the relationship with family, friends, family of choice, especially having a family member who is an LGBTI role model can make all the difference for young people"*

Use of language, put up visuals, use of language is gender neutral (eg partner) – young people know who to talk to – safety, visibility.

Skilling Strategies

Workers suggested values forums, facilitated discussions to discuss ethics, values and practice issues.

Workers suggested clear leadership was needed to challenge homophobia. A focus on rights, and a stronger legal framework ensuring equality was noted.

> *"We need a broad based anti-discrimination campaign against homophobia. The main issue for LGBTI young people is stigma from mainstream community and internalised homophobia, once they learn to accept themselves, they are usually fine!"*

> *"We need advertising to keep the issue visible, a broad based anti discrimination campaign, similar the current mental health one or the one challenging HIV discrimination"*

As well as presenting diversity, simple messages, how to address publicly, openly gay people in media, realistic role models, men who have sex with men and don't identify as LGBT.

Youth development roles and youth support networks were key resources to enable networking, training, presentation and identifying service gaps. Internal staff training and external training were suggested, including QAHC, Relationships Australia .

Generic LGBTI, sexual diversity and gender identity training in pre-service courses for youth workers, both at Universities and TAFEs / RTOs as well as 'on the job' induction training – particularly values clarification and practice strategies were suggested.

Workers suggested skilling for staff and young people, perhaps even joint education sessions.

> *"More LGBT supports are needed throughout Qld, particularly support for young people in regional areas"*

Workers also suggested the value of community education to inform parents and having a diversity of positive gay role models. "One of the problems with a lack of a range of role models can be that young people don't see being gay as normal, or they don't see that gay people can lead "normal lives", so they can try living to stereotypes rather than being authentic to themselves."

Negotiation skills, comfortable saying no

Support needs for HIV and Hep C positive young people were highlighted. "young people are often ignored and isolated, they may not fit the criteria for support or have "youth friendly" services, perhaps training in how to work with young people or work in partnership with youth services"

The issue of unsafe sex between people living with HIV/AIDS was also raised. "Guys are dating others with HIV, having unsafe sex and may not be aware of risks and dangers, seroconversion, viral load and stigma around HIV."

> *"Protecting young people, keeping them naive about sex is actually putting them in danger."*

> *"we suggest that schools to give out condoms, to make them accessible, perhaps through the school nurse or vending machines. Private and free access is important."*

A range of legislative reform suggestions included:

- Changing the age of consent laws for anal sex from 18 to the same as vaginal sex
- Reviewing the sex work and sex exchange responses for young people under 18, unsafe, sex exchange, safe, economic reasons, poverty
- Reviewing the termination laws for under 16s – parental consent
- 12-15 year old peer based consensual sexual activity
- Impact of criminal charges for young people under 18 having peer based consensual sex – concern re criminal record for sexual offences, eligibility for blue cards.

It is recommended the all youth health work is "culture centred" in practice, further examination of the specific needs and recommendations for CALD young people is suggested.

Culturally and Linguistically Diverse young people

Many workers were seeing a greater number of CALD young people than ATSI clients. In addition to a range of cultural barriers, workers identified particular issues for young people of refugee background. Refugees can have significant sexual health issues, such as unwanted pregnancy, STIs, fistulas etc

Often a lack of education or significant gaps in education meant that young people were not aware of sexual

health practices, such as contraception, condoms, pap smears, STIs etc. Additionally parents may not be educated around sexual health and knowledge of contraception may not be good. Cultural values and practices can also impact on sexual health education. Workers identified that young people were often torn between cultures. The youth health promotion officer at ECCQ was identified as a valuable resource for youth workers.

Other specific risk groups and issues

It is noted that other specific risk groups and risk behaviours have not been included in this report as they were not touched in the conversations. This included: young people with disabilities and learning difficulties; specific issues for young women and young men; imprisonment and detention, homelessness, poverty, injecting drug use, sex work and sex exchange behaviour, body piercing and tattooing and other risk behaviours and sexual assault.

These could be further areas of exploration and research as failure to include them does not mean they are not significant and important to young people and youth workers, it was simply beyond the limited scope of this research. They are significant practice areas and require specific skills to work effectively.

SECTION 6

CHARACTERISTICS OF GOOD SEXUAL HEALTH INTERVENTIONS WITH MARGINALISED YOUNG PEOPLE

General principles of intervention

It is not within the scope of this report to outline at a micro level good practice with young people around disease prevention, youth sexuality and youth health. This has been outlined in a range of previous publications. Also noted by workers is that not all marginalised young people will want or need to access youth workers or other professionals in order to achieve and maintain good sexual health.

The interviews did reinforce components of good sexual health practice with marginalised young people as outlined below.

> *"We need to put forward the case as to why particular ways of working with young people are important and necessary."*

> *"Social change is an iterative process whereby it jump starts lots of little processes. We need to hear about the good stuff that is happening for young people in their lives. We need to engage in dialogue with young people and the skills to engage in values discussions."*

One of the most consistent responses from workers was the values, ethics and principles that informed work with young people. The key issue highlighted was the attitude to young people and their sexuality, and this flowed on to policy, legislative and service delivery responses. All workers suggested moving from "problem based or disease prevention" construction of young people and their sexuality, to rights based and wellbeing approaches that understands sexuality as a normal and healthy part of young people's lives.

Disease prevention approaches conceptualise young people's sexual health as preventing negative social problems, such as unwanted pregnancy, STIs etc. This means the planning, implementation and evaluation of program effectiveness is based on prevention of disease, such as HIV/AIDS, Hep C, STIs and unwanted pregnancy. It can also be seen as a problem to be managed rather than empowering young people. This suggests the value of investing in early intervention and prevention approaches. It was not unusual for workers to have first contacts with young people about sexual health at points of crisis such as possible pregnancy or STI.

> *"Harm minimisation (not risk averse approach) and operates well in the youth space"*

Inherent in this were concepts around empowerment, sexual health rights and social justice. The Centre for the Advancement of Adolescent Health (CAAH) suggests the following principles to inform youth health work: accessibility, evidence based approaches, youth participation, collaboration and partnerships, professional development and sustainability

Workers suggested a process to identify resource and development needs, and frameworks and processes to support this. Some suggested measures of the work included emotional wellbeing. Health promotion approaches involving networking, change within institutions, values and attitudes, policy level and community attitudes.

> *"Even at a basic level, the accessibility and cost of condoms, are they privately accessible condoms so young people don't have to ask for them?"*

> **The relationship with young person and young people**

> *"We have very adult centric views about young people, they engage with people who they trust and feel safe with"*

> *"Central to the work is relationship with young people and then what happens with the young person as a result of the relationship"*

> *"It's a conversation with a human being, talking about life experiences"*

"There is stigma, shame and taboo related to sexuality, if the youth worker is comfortable to talk about it, it can help remove some of the stigma."

Within this relationship, youth workers discussed the need to understand power dynamics, boundaries, and a practical understanding how young people can be disempowered and their rights diminished through systems policies and practices. This was particularly noted as necessary when working with young people with complex needs.

Additionally workers discussed the challenge of engaging in "process" based work and the pressure of starting with pre-determined outcomes as inconsistent with practices designed to empower and "journey with" young people. There were also challenges in providing evidence, indicators or measures of good relationships, pure numbers and statistical data didn't capture the qualitative experience of young people and youth workers .

"The starting point is acknowledging young people as sexual beings and building healthy relationships. This involves being truly present, listening, remembering details, working holistically, engaging with young people as a whole person from an early age."

"It's important to understand the impact of trauma in relation to trust, safety, power dynamics, communication, conflict, difference, moving beyond labels, not making assumptions and sitting with complexity."

"It's about asking questions, listening, how sexuality impact on the young person's life, what is their relationship with it? What is important to the young person eg infertility in the long term."

It's also about the young person's relationship with themself – identity, self esteem, their body, being grounded in body, sensuality and being able to relax. Being self aware, aware of their own values, ethics, decision making, consent.

"Young people are going to engage with youth workers who have already built the relationship where there is trust"

Mitchell (2011) suggests there is clear evidence supporting client focused models and approaches with young people. Gronda's (2009) meta-analysis of case work effectiveness with homeless people, empathises that achieving the outcome of increasing a person's self care capacity is enabled by the relationship between the client and their case manager. The role of relationship is central to the effectiveness of the work.

Holistic approaches

Youth workers discussed starting with the young person, developing trust and a good working relationship, and working with a range of issues presented, including sexual health.

Working with complexity – for example if a young person has been sexually assaulted as a child, this can impact on intimacy. The work can be about planting seeds, gentle and honest, opportunistic interventions, grounding experiences into current reality, natural conversation, "aha" moments over coffee, informal, flexible, "meeting people where they're at" normalising, in normal setting,

Age specific focus – being developmentally responsive

"Young people can choose to say no or choose to say yes, take safe risks and hopefully enjoy the process of development"

Develop responses that recognise the distinct developmental and cultural experiences of young people. This is particularly in relation to empowering young people to manage their own health. The focus on emerging

sensuality and sexuality, which includes understanding of hormones, feelings, arousal, attraction, middle years education and normalising young people's experiences.

> *"Not just about physical act, relationships, transition to adulthood, especially for disengaged young people" Normalising sex, natural part of life, harm minimisation, respect for body, self esteem, nurturing, looking after body. Can give condoms, info etc We need to be building on confidence."*

Non-stigmatising service access

Consistently presented were examples where young people would not access services due to stigma, perceived or actual lack of confidentiality. Particularly having clinics with flexible opening hours, after school hours and at times when young people can access them. Transport, signage, having a welcoming and friendly atmosphere, and youth friendly staff assist young people in accessing services. Workers emphasised confidential and discreet access to information and resources, such as condoms and lubrication.

Youth health research (Booth et al 2004) found that one-third of young women and two thirds of young men said they would not seek help for their health concerns, and when they did, were most likely to seek help from family, friends or others they trusted. When professional help was sought, young people preferred someone they knew and trusted. The three groups of barriers to accessing health care were: concerns about confidentiality, knowledge of services and discomfort in disclosing health concerns, and accessibility and characteristics of services. Factors related to use of health care services were associated with age, gender, and location, but rarely with socioeconomic status (Booth et al 2004).

Confidentiality

Sexual health can be a stigmatised issue and some consensual sexual behaviour of young people is illegal. Workers discussed the critical role of trust and privacy in enabling young people to access services and talk honestly about sexual health matters. There are a range of differing policies and practices between organisations in relation to confidentiality. Many workers discussed a conditional confidentiality in service provision, informed by the young person's competence (Gillick competence), legislation (such as mandatory reporting), harm to self and harm to others, and permission from the young person.

Workers also discussed the influence of perceptions by young people and the community around confidentiality and the need to actively promote confidential services in order to encourage young people's access. This included: who will be informed about service access (including parents), mandatory reporting; responses to specific issues (such as consensual peer based sexual activity for under 16s)

Culturally centred practice

Workers suggested approaches that viewed sexuality as a normal and healthy part of young people's development. The workers aimed to empower young people to make informed decisions within their own personal values, their community and cultural context. These cultures included: race and ethnicity; religious and spiritual beliefs; and youth based sub-cultures. Workers suggested the work needed to be informed by young person's context (including peers) and education methods be culturally responsive, such as use of technology – internet, computer games, phone applications.

> *"The mass media and social media have thoroughly infiltrated the Microsystems. They now shape family, peer and school relationships. They also have more direct and pervasive effects, as both medium and message, as technologies that affect cognitive development, sleep and sedentariness, and as powerful vehicles of cultural messages."* (Eckersley in ARACY 2009:46).

Youth workers and other health promotion workers including community artists have a long track record of working in partnership with young people to deliver culturally centred interventions and informed by community cultural development frameworks. This process is started with dialogue and partnership with affected groups and from their cultural perspective "identifying problems and accompanying solutions from within the culture" (Dutta 2008 in McKee et al 2010:5).

Empowerment – development of agency

> *"The level of empowerment in other areas of life, directly relates to level of empowerment around their sexuality"*

Others suggested providing opportunities for young people to explore and clarify their ethics and values, and empowerment or agency, that is the capacity for young people to make choices and enforce them according to their own personal ethic. This is also informed by the culture and circumstances of young people's lives that impact on the capacity to make informed choices. Workers felt there were social pressures for young people from partners, peers and family.

> *"How do I safely say no?"*

> *"The challenge of these complex case panels is the power dynamics and genuine consent for young people to participate. The statutory or legal obligations of participants can vary in relation to information presented, they may be operating from different values and frameworks and power dynamics, how do these get negotiated? One strategy is to skill young people to facilitate their own case meetings, set the agenda and nominate who can be present at different parts of the meeting."*

Multi-level responses

Workers discussed the need for population based holistic youth health approaches, which considered primary, secondary and tertiary interventions for young people around their overall health first, followed by specific sub issues, such as sexual health, drugs and alcohol, mental health, violence prevention etc.

Primary prevention approaches being universal prevention approaches for all young people – through schools etc

Secondary prevention approaches targeted to "at risk" young people. This is currently provided by a range of stakeholders including youth workers, school based youth health nurses, FPQ, etc.

Tertiary service delivery once a sexual health issue has emerged. Workers discussed the need to proactively raise the issue and visibility of sexual health as many young people presented to them at points of crisis, such as unplanned pregnancy or an STI. Workers discussed the need for accessibility, availability and cultural appropriateness of clinical health services, including non stigmatising access. Youth workers play a role in referral and support for young people into clinical health services. These services include: youth health services, GPs, School Based Youth Health Nurses, FPQ, sexual health clinics. Particularly effective, are co-located of clinical health and youth services, outreach clinics and generic services where young people don't have to identify as having a sexual health issue prior to accessing the service. This is particularly important in small communities such as rural and ATSI communities. Workers also discussed the value of coded non-identifying STI testing.

Key effective interventions

> *"We have problem based funding measures, focusing on biological aspects, reproduction, STIs and pregnancy. What about the social aspects of sex?"*

Workers suggested there is value in defining what is meant by an "intervention". The following key interventions for sexual health work with young people were identified: embedding sexual health into existing work practices, one to one education, formal and informal interventions, active referral and follow up; opportunistic and brief interventions; embedded in case planning processes; applied interactive workshops; provision of sexual health specific resources (Needle and Syringe Program, condoms and lubrication, contraception, etc); producing and/or using culturally appropriate education resources; peer education and support; community education, community development and community events such as festivals etc; and accessible clinical health services.

Network approaches – coordination of existing resources

> *"Whilst we may be clear about our values, youth workers are often the least powerful people at the table, so we need to make alliances with people who can progress the shared vision."*

> *"When we do community consultations, where we bring together people with very different values, we use Bob Dick's work, where we start with developing a shared vision, visioning a long way out, like 30 years, if we start with discussion about values then we get stuck in conflict. Once we have the vision, we then talk about how we could get there."*

Overwhelmingly workers discussed the values of networked based approaches to coordinate responses, identify gaps and respond more effectively to young people in local areas. This also reflects the 'joined up' or 'no wrong door' approaches in current social policy. The community services sector and the youth sector have a long history of networks to achieve better outcomes for young people. There is great variation between local areas across Queensland in networked responses to sexual health.

One of the key challenges of networks, was key stakeholders operating from different values bases, roles and contexts. As identified above, Dick (in Crane and O'Reagan 2010 and Crane 2011) suggests that not agreeing on value and ideologies does not preclude doing effective work for the best outcomes for young people. Focus initially on the goals of the work, long term goals are suggested. Values will underpin characteristics of good practice and key practice principles.

The challenge lay in finding common ground and developing effective responses. Workers suggested using non deficit based models to better coordinate and mobilise existing resources. Other workers suggested initial discussions around values can be a "red herring" and suggested starting with developing a shared vision, often a long term vision, such as 30 years ahead.

> *"We don't have to look the same to be effective. It is useful to see what you're doing as contributing rather than conflicting"*

Others suggested simultaneously building partnerships and using inquiry based local networks based on participatory action research methods. This would focus on both providing responses and gathering the evidence of effectiveness. An example of a starting question might be "what would it take to optimise the sexual health of young people in our local area?". This exploratory process would enable development of creative local responses. Young people might be involved as peer researchers or participate in other ways to develop local responses.

Also suggested was the use of local networks, centrally resourced to support the development of specialised youth health practice skills. Similar models include the Workforce Council's Integrated Skills Development Strategy, the Youth Support Coordinator Hub Program and the YANQ C Plan networks.

Networks could be online, face to face or through other means.

Defining the nature of the service network can assist with coordination, articulation and partnership, use of resources, developing shared expectations, communication and coordination of activities. Lennie (2008) in Crane and Kaighn (2011: 118) outlines a continuum of integration to understand agency collaboration and networking. These five approaches are outlined in the table below.

The continuum of integration (Lennie 2008)

Autonomy	Cooperation	Coordination	Collaboration	Integration
Agencies act without reference to each other, although the actions of one may affect the other(s)	Agencies establish ongoing ties and provide limited support to an activity undertaken by the other agency. Communication and sharing information is emphasised. Requires a willingness to work together for common goals, goodwill and some mutual understanding.	Separate partners plan the alignment of their activities. Duplication of activities and resources is minimised. Requires agreed plans and protocols or the appointment of a coordinator or manager.	Partners put their resources into a pool for a common purpose, but remain separate. Responsibility for using the pooled resources is shared by each of them. Requires common goals and philosophy and agreed plans and governance and administrative arrangements.	Links between separate agencies draw them into a single system. Boundaries between the agencies dissolve as they merge some or all of their activities, processes or assets.
	Examples include learning and information sharing networks and open access to each others facilities and services.	**Examples** include the appointment of a hub coordinator to provide strong links between existing child care services, or developing joint funding proposals for new coordinated programs.	**Examples** include the establishment of shared service centres or developing joint management structures.	**Examples** include preventative or community-based place management programs. It can also involve the merger of similar agencies to form a single larger organisation.

Table 1: The continuum of integration
(adapted from Cairns et al., 2003; Fine et al., 2005, p.4 and the SNGO Fact Sheet on Shared and Collaborative Arrangements)

Jones et al (2007: 28-38) discuss some key frameworks and issues for service integration in the social housing context. The recurring themes included: leadership; trust and commitment; planning, monitoring and evaluation; allocation of responsibility; multi-level interventions; shared infrastructure; and adequate time and resources for change management.

Workers discussed the value in having an existing link with specialist staff to enable supported referrals and active follow up with young people. The final networking / skills development strategy suggested is use of "facilitated learning exchanges" which bring together youth workers, sexual health workers, medical practitioners and other key stakeholders to share information and skills, enhance working relationships, identify opportunities and plan local action around young people and sexual health. Young people could also be involved in this process.

> *"Having the existing relationship, knowing their value base and work practice cuts through red tape, you can speak to someone directly to access a service"*

Service accessibility

> *"We put in place a whole lot of barriers to young people accessing services, for service providers to jump through hoops eg limited access to emergency contraception, misinformation about it etc"*

Workers suggested the need for sexual health services to be "youth friendly". This included having friendly staff, ensuring 'non stigmatising' access, flexible service delivery. Quite practical strategies can enable service access, such as: location, opening times, transport options, signage and service visibility. Workers suggested that generic health services located in youth services mean young people can access services for any reason, so it is not assumed it is for sexual health.

There are a range of publications and checklists for clinical health services to assess their "youth friendliness". One such example is the New England Area Health Service (2001) "Youth Friendliness Assessment Tool" Tamworth, NSW.

Youth work Practice

Sexual health is often one aspect of a broader range of issues or there might be a different focus for youth workers. This may lead to a perception or reality that youth workers are not talking to young people about sexual health. This may be for a range of reasons, including values, work priority, etc. They may have contact with young people at crisis points of intervention (such as possible pregnancy etc) rather than being pro-active. It is suggested that sexual health is embedded into existing youth work practice.

> *"My primary focus is VSM, stopping young people from sniffing not doing sexual health work. "*

YANQ received anecdotal information that some youth workers are not providing information and referral around sexual health. The feedback in this research suggests that responses across the sector vary. Examples were given of observing workers who will not offer referral for pregnancy options and choice counselling. Beyond talking about their work, what is the actual practice when the young person is in the room?

Sexual health interventions can be planned through formalised processes such as health plans, case management, workshop, formal education but youth workers talked about many interventions being ad hoc and opportunistic in nature, for example overhearing a discussion in a group setting or young people telling story and responding to this. It appears to be influenced by the worker's interests, values and skills, work context and role, workload, network linkages and support available to access more information and resources.

Whilst youth workers do participate in some training and provide interventions, it was suggested that there could be better coordinated approaches in all regions to sexual health and young people.

> *"Strategic coordination is needed, at a basic level, all youth workers and volunteers could be providing service referral, information and access to condoms. They could also do projects to raise sexual health awareness such as health events, world aids day, valentines' day."*

> *"Youth workers generally have good knowledge and skills about sexual health, they just have such a wide range of issues they need to respond to, they often crisis point access eg pregnancy tests, MAP, etc) – smooth, no judgement, big personal topic, trust, relationship"*

> *"Barriers can include – attitudes / values, knowledge, skills, confidence, priority given to sexual health, role clarity, other pressing demands in a busy work schedule. A suggested strategy is to embed sexual health into existing work practice."*

Youth work training – one suggested approach is the use of "facilitated learning exchanges". To bring together

youth workers, sexual health workers and clinical staff and other key stakeholders to share ideas, network and learn from each other and develop action plans to respond to young people and their sexual health in the local area. This could be part of an ongoing networking process.

> *"In our area the local youth services are doing a great job! Eg we have two youth services who work very closely together and participate in our local sexual health network. Other youth services don't participate as well, but there's a whole range of reasons for this. We need to focus on building their comfort and confidence to build sexual health into work already being done"*

> *"Youth workers can be a jack or jill of all trades". Often their primary role is support, linkages, providing supported referrals and active follow up. This can require developing good linkages and partnerships with other services, knowing who to access, availability, capacity and criteria for access.*

> *"how do issues for young people get resolved? The focus is not about youth work but about young people. What resources are needed for facilitative inquiry to expose injustice and respond? The facilitative role of youth workers can bring in context analysis, understanding of power dynamics, models of practice."*

> *"Senior practitioners need a systems or institutional understanding, process based and facilitative skills as well as solid youth work practice skills"*

> *"The inquiry is how do we understand this situation and what can we do to improve it? We are inquiring together with young people. Are we game to get critical, where we don't care about the questions we ask? The focus is always on, how do we improve the situation for young people?"*

In respect to youth health work, workers commented:

> *"Young people may ask us certain questions because they trust us, but we're not trained to give clinical advice. There is a need for youth workers to have a specific youth health knowledge and skills base"*

Youth health practice can be layered over existing youth work practice skills. Areas of practice identified include: How to engage with topic as a safe and supportive adult with appropriate role boundaries and practice strategies; development and maintainance of youth work practice skills

Case meeting – teach young people to run them (when skilled or wanting to) – 25% of clients did it, lots of work to prepare agenda, who will be present for which discussions? Etc – mental health, education, carers, youth workers etc. Ask what young people are looking for.

Workers stressed the importance of peer based approaches when working with young people.

> *"information spreads among young people like wildfire, this can be both positive and negative, as misinformation and myths can spread as quickly as fact, but we need to harness these existing relationships using peer education"*

One on one, program delivery (can't do topic in group / community setting)

An area of practice is specialist youth work skills in health promotion, this could be supported by senior youth work roles, which could also support the development, maintainance and dissemination of specific youth work practice skills.

Examples of good youth health practice

YOUTH HEALTH PRACTICE EXAMPLE 1

The Youth Accessing Contraception and Information (YACI) network in Cairns was presented as an example of an effective network responding to young people's sexual health. This network brought together: sexual health educators and clinical staff, youth workers, school based youth health nurses, the youth development worker from the local regional council, and other key stakeholders in the Cairns region to develop responses to local issues. An inquiry process: What action do we want to take to improve work with young people?A write up of the YACI network was presented at the YANQ conference in July 2011. YACI developed in 2009. During this time there was national media attention focused on a legal case with a young woman around accessing pregnancy termination options as well as the 21st anniversary of sexuality education in schools. Workers found that due to media reporting, young women were stating beliefs that it was illegal to get abortions, others observed that young women were not getting emergency contraception from pharmacies.

The YACI project surveyed pharmacy practices in dispensing emergency contraception (it found that only two did not dispense this). The network sought to ensure pharmacies were accessible and youth friendly. The survey looked at organisational culture, values and attitudes of pharmacists and pharmacy assistants. Achievements included: developing closer relationships between key stakeholders, enabling referral to general practitioners and pharmacies who are youth friendly, including work towards establishing a Thursday night youth health clinic, getting sexual health on the agenda for National Youth Week activities. Through connecting back with pharmacies, a fact sheet and wallet card were developed. The network also strove to improve access to screening for STIs in the southern Cairns region where network members established pilot youth clinics. The pilot clinic at a community health centre didn't take off and was discontinued but the clinic at a Aboriginal and Torres Strait Islander college went well and is continuing weekly.

Some key factors that made this network successful included: having key players motivated to actively drive the network; identifying and responding to issues that are a priority and where there is interest and energy, finding commonality, collaborating effectively, utilise existing networking processes, having action based networks, achieving goals, having similar values base and frameworks for responses. Maintaining momentum continues to be a challenge as with most networks, specific network resources may assist with this. However, in February 2012 the YACI network helped to organise a very successful professional development day called "Sexessentials" attended by more than one hundred youth workers, health promotion staff, nurses, teachers, non-government and government health and community sector workers from the Cairns region as part of Sexual Health Awareness Week.

YOUTH SEXUAL HEALTH PRACTICE EXAMPLE 2

Networking to support Lesbian, Gay, Bisexual and Transgender young people in a rural community

This is an anonymous underground informal network in a rural area where gay and lesbian community members come together to support not only each other but young people who are gay and lesbian and/or questioning their sexuality or gender identity. This includes a gay and lesbian support group, who are proactive in finding and providing support through peer mentoring, partnering and collaboration with local service providers. The group has had regular 'family' catch ups including meals for the members of the group who have been isolated from their families due to sexual preference. The group is malleable and support is provided where needed as the group changes. It is member driven, with no set process of scheduled activities, it works informally. Some community attitudes are hostile to LGBT concerns, so the work was described as "flying under the radar" to develop the mentors program and letting people know by "word of mouth". It is open to community members of all ages.

YOUTH SEXUAL HEALTH PRACTICE EXAMPLE 3 – Waiting permission to publish

A third example of networked responses to sexual health is the FPQ "we've got what it takes" program. This brought together a range of people who work with young people in different capacities, including: sexual health workers; education staff (guidance officers and teachers); health staff; carers and respite carers; counselling staff; youth and disability services; and senior practitioners from Child Safety services.

This aimed to develop networks and linkages within the community who work with young people. Within a given geographic proximity, who is it that can resource you and how can members of the network support each other? This networking opportunity enabled participants to explore a framework for understanding and responding to sexual behaviours, and providing resources to take away to support conversations about sexual health and relationships with young people. Workers observed that internally focused networks can build worker confidence in working with sexual health issues, whilst externally systems focused networks make take on advocacy and systems change roles. "You don't need 'special training' to support young people's sexual health, rather access to other services and resources, and the confidence to respond effectively."

YOUTH SEXUAL HEALTH PRACTICE EXAMPLE 4 –

"Learning exchange" model used to skill worker and facilitate local area action on sexual health

The use of a "Learning Exchange" model in a regional area involved engaging a facilitator to organise a two day workshop in a regional community. This brought together youth workers, sexual health workers and other key stakeholders in the local community to exchange ideas and learn from each other about youth sexual health practice. The focus was on good practice, identifying issues in the local area, getting to know each other's work areas, exchanging knowledge, skills and practice strategies, and finally a focus on action planning. The interaction between youth workers and clinical staff identified the need for a youth sexual health clinic, so one afternoon per month was set aside for young people to access the local sexual health clinic. Youth workers took an active role in referring and facilitating young people's access to this clinic. Other workers brainstormed scenarios and education strategies for skilling young people to negotiate consent and communication in a sexual context.

SECTION 7

STRATEGIES FOR ENHANCING SEXUAL HEALTH PRACTICE

Workforce development responses in the youth sector

There are a few workforce development initiatives that support skills development for youth workers. Workers identified these as possible models for responses that could support more effective responses for youth health generally and sexual health more specifically. Some are generic workforce development responses to the community services sector, others are funding or specific issue based responses.

Workforce development initiative	Comments
Youth Affairs Network of Queensland workforce development research and action plan for the Youth Sector and the Murri (ATSI) youth sector in Queensland	A copy of the first report is available at: http://www.yanq.org.au/images/stories/Documents/youth_sector_report_2010.pdf
Youth Affairs Network of Queensland C PLAN regional networks to support workforce development in the youth sector throughout Queensland	Inquiry based networks using participatory action research to progress local and regional workforce development priorities for the youth sector
Other funding and issue based networks within the youth sector and other sectors in Queensland	A comprehensive list of networks and interagencies for the youth sector across Queensland is available at: http://www.yanq.org.au/workforce/networks
Dovetail – an NGO and Qld Health consortium to support learning and skilling in youth alcohol and other drugs work in Queensland	This reflects components of workforce development focusing on alcohol and other drugs work and a broader range of professional who work with young people
Family Planning Queensland youth project	Learning and skilling strategies for a range of workers who work with young people around sexual health
The workforce council – integrated workforce development strategy and other initiatives	Strategies to support workforce development across a broad range of the community services sector in Queensland, regionally based, not a specific youth sector focus
Queensland Youth Housing Coalition, Youth Support Coordinator Hub Program,	Broad range of issues for one area of funding, for youth workers in schools programs
The reconnect network	Skills development, other program issues

Workforce solutions: learning and skilling processes for youth workers

"How do youth workers prioritise the issue in busy work schedules, putting it on the worker's agenda and owning it as part of my job? How do workers advocate for themselves?"

"We need an inquiry based approach to skills development for youth workers. What do you (as a worker) need to feel confident and supported? What are the consequences of not doing it?"

"How does the sector empower itself to undertake action and develop effective responses around sexual health? How does youth sector leadership support this?"

"I suggest system engagement and regional/local network development solutions, leading to better coordination of existing resources and identifying gaps in resources"

"Developing communities of practice, provide mentors / support, networking, focus on youth health skills"

"Updated advanced training modules, focus on context, several different levels, context / political, organisation, individual practice"

"*Further training for youth workers needs to be subsidised. i cannot afford the training and I won't qualify for austudy! my lack of current skills and training is what is keeping me out of the field."*

In addition to the dissemination of practice wisdom and focus on practice discussions, it is useful to highlight the enablers and strategies for the sector empower itself in responding to sexual health. Through well networked

processes, roles, resources and boundaries of practice can be clarified.

Many workers are already providing sexual health interventions with marginalised young people. It was suggested that in addition to knowledge and skills, workers needed opportunities to build strong networks and partnerships, build confidence and make youth health and sexual health a priority in busy work schedules. For existing workers, it was suggested to provide opportunities to keep current with sexual health issues and better coordination of existing resources, so as not to recreate the wheel. Workers also suggested the value in having accessible and culturally appropriate resources for both themselves and young people.

The key groups for learning and skills development could include:

- pre-service youth workers
- induction for new youth workers
- more experienced youth workers
- senior youth workers and workplace mentors
- managers and supervisors
- others in secondary roles that support youth work practice, such as front line reception and administration staff
- other professionals who are working with young people, such as medical practitioners, sexual health workers, etc.

The content, strategies and processes that support workforce development might vary for different groups. Workers identified a range of strategies, in addition to training, that support learning and skills development about sexual health and youth health interventions. A range of strategies were suggested to enhance these learning processes, as displayed in the table below:

Strategy	Formal	Informal	Suggested strategy
Pre-service education through University	*		Embed youth health practice skills
Pre-service education through TAFE or RTO	*		Embed youth health practice skills
Ongoing education through University whilst employed in youth sector	*		Embed youth health practice skills
Ongoing education through TAFE or RTO whilst employed in youth sector	*		Development of a "youth health practice" skills set
VET assessment only pathways, including Recognition of Prior Learning and Recognition of Current Competency	*		Access to grants and scholarships to support this – resources to support gap training
Workplace learning, accredited and non accredited, including in-service	*	*	Support for in-service skills development
Training outside the workplace – accredited and non accredited	*		Ensure that content and processes fit the learning and development needs of the participants.
Workplace based induction training	*	*	Development of resources to support this.
Interagency network meetings,	*	*	Discussion of current issues, sometimes formal learning activities linked to these meetings, developing better practice strategies, enabling better coordination of existing resources
Learning exchanges	*	*	Bringing together youth work, sexual health and other key stakeholders to share skills and resources, developing action plans
Youth work practice forums – facilitated peer education processes	*		Trouble shoot scenarios – how am i going to deal with it when these things come up?
Email lists and discussion forums online	*	*	Suggested to be established and expanded to support practice development across the youth sector in Qld.
Sexual health information updates		*	FPQ cd rom and information sessions
Further reading such as journals, research through the internet,		*	Identify and disseminate information about websites and other sources of information around sexual health practice
Learn from information resources that are designed for young people		*	The ongoing development of culturally centred, peer based resources using community cultural development processes
Practice supervision	*		Training and support for supervisors, particularly youth workers moving through the management roles
Mentoring	*		Training and support for the Senior Youth Worker role across the youth sector
Peer support and learning in the workplace	*	*	Foster workplace cultures that support and value this Articulate framework and develop resources for peer support and peer supervision.
Workplace projects - action learning processes	*	*	Resources to support doing pieces of youth health work, problem solving and learning during the work process
Personal experiences		*	eg LGBT staff – "it meant that i prioritised the issues in my work role"

Strategy	Formal	Informal	Suggested strategy
Learning from young people themselves		*	Provide opportunities for youth workers to do youth health work and documentation of this learning.Provide opportunities for youth workers to youth health work and document learning. Youth work forums at regional and state levels

Learning and development would be informed by the documentation, articulation and dissemination of characteristics of good youth health health practice, particularly the practice expertise of community based youth health services such as IHSHY funded programs. This would include articulation of generic youth health skills that can be adapted to a range of specific health areas, including sexual health, injecting drug use, alcohol and drug use, violence. This would be informed by practice wisdom, research, evidence and the development of a "culture of inquiry" in youth health work.

A planned approach to skilling workers was suggested. This could involve relevant training providers in each region being involved in local youth health networks. These could include: existing regional networks, the workforce council, Universities, TAFEs, (including the lead centre), DET, state wide youth sector peaks, key stakeholders in the youth and sexual health sectors and non accredited training providers.

A suggestion was to have a centre or locate specialist skills within an existing centre that supported the development, maintenance and dissemination of practice skills in youth health and youth work. This centre would be an open door between research, practice and policy makers. This centre could take on a role to support the regional networks and disseminate practice skills in youth health prevention, resource development and tertiary services.

Workers suggest the development of an accredited skills set in "youth health work" including health promotion incorporating characteristics of good practice in youth health work, rights and wellbeing approaches, culture centred peer based strategies (community cultural development) and networked inquiry responses in partnership with young people (using participatory action research processes)

The value of training in generic youth health skills would be valuable in pre-service and workplace based delivery. Workers suggested a holistic approach, using generic youth health framework and skills that could apply to each specific youth health area (eg sexual health, drugs and alcohol, mental health etc).

> *"I have a degree in social science specialising in youth work. I am not currently working as a youth worker, how if i did decide to look at a career in youth work again i would need to undertake more training. I never received any training in sexual health and youth health practice"*

Worker suggest embedding the core knowledge and skills required for effective youth health and sexual health interventions with young people in youth worker training programs, both within tertiary institutions (TAFEs, RTOs and Universities) in formal qualifications and through 'on the job' training for youth workers.

Workers suggested an emerging youth worker focus to assist in developing a "grounded practice framework" where values are grounded into the realities of practice and youth health practice skills. This might start in formal training programs and evolve in first few years of work. This ongoing induction training could focus on developing key youth work skills.

For experienced workers, the use of assessment only pathways by RTOs/TAFEs to recognise existing skills in youth health promotion is suggested.

> *"Skills for creating dialogue with different stakeholders around values"*

> *"We find online, self paced learning resources, this can include web streaming, expert on line – possible RPL / assessment only for qualification outcome."*

It is suggested that youth work practice forums could particularly focus on complex practice issues and ethical decision making, such as:

- Values and ethics, ethical literacy, ethical decision making models and ethical issues for youth workers
- Ethical reporting of child protection matters
- Confidentiality and service delivery for 12-16 yo
- Sexual health promotion for young people with a history of sexual violence / trauma
- diversity and sexual health
- generic youth work,
- youth health skills,
- prevention, education, tertiary interventions,
- developing "youth friendly" accessible clinical services,
- networking and partnerships around youth health,
- youth participation and youth engagement,
- regulations, safe work practices,
- complex practice skills

The "Learning exchange model", rather than didactic training, would bring together youth workers, specialist sexual health workers and other key stakeholders to share knowledge and skills and improve local and regional responses to young people's sexual health. These learning exchanges could be a possible catalyst of regional/local sexual health networks. How do these networks get driven and receive ongoing resources and support as needed? These local networks would be inquiry based action focused networks to work in partnership with young people to understand what is happening locally and to formulate local responses around youth sexual health.

Infrastructure to support youth health practice, learning and development

Resource existing or (where needed) establish new regional infrastructure based in the youth sector to support youth health across Queensland. In order to coordinate this, it is recommended to establish a **Centre of Excellence for Youth Health Practice** which incorporates the range of specific youth health issues, and includes both research and workforce development initiatives for the youth sector and others who work with young people.

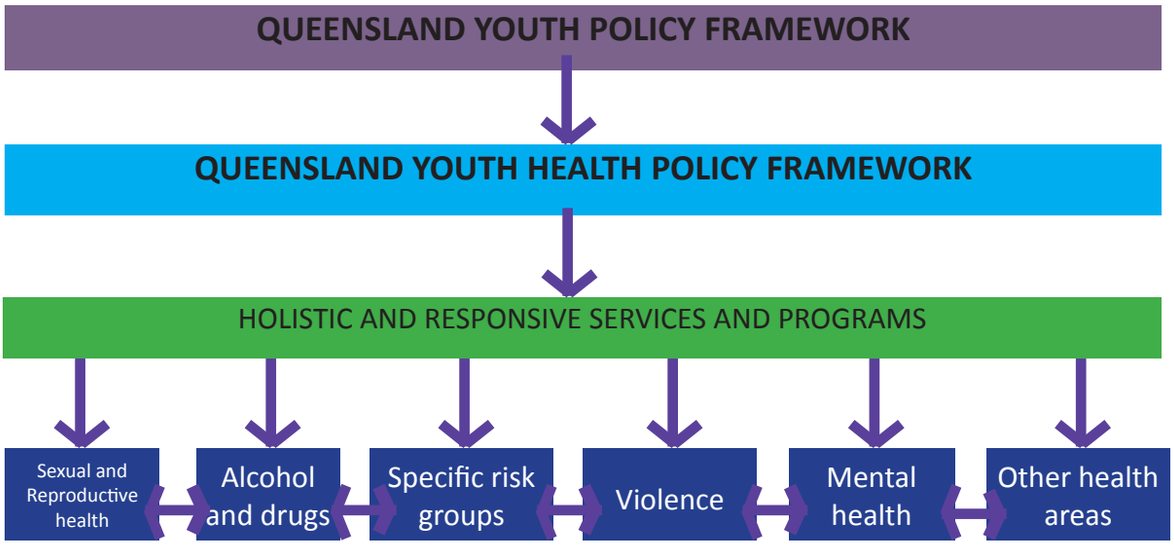
It is suggested to research initiatives outside Queensland that could be good models for developing workforce responses eg Youth Substance Abuse Service in Victoria, YACWA Peer Education Project, NSW Youth Accommodation Association the HOT Project, etc.

The Centre of Excellence in Youth Health would take a lead role in working with other key stakeholders to support learning and development in youth health practice. This would include a role in resourcing and supporting local and regional networking around youth health (including youth sexual health).

Youth Health Policy which reflects and supports good practice

BUILD SUPPORTIVE PUBLIC POLICY

– The suggested policy framework is outlined in the diagram below:



- Development of a comprehensive **Queensland Youth Policy Framework** – this will be an overarching whole of government framework for social policy responses to 12-25, year old, it will include: youth participation, whole of govt, including marginalised young people both within and outside school environment, holistic approach, broad range of issues, analysis of the context of young people's issues, principles, elements, goals, strategies, targets and resources, outline benefits, what will this policy drive? Links to other policies

- To recognise youth health as a major social investment and creative challenge. To recognise the specific needs and cultural context of young people (age 12-25) and the specific skills, information, resources and context required to optimise their health

- Development of a holistic, population based **Queensland youth health policy framework**, to advocate a clear political commitment to youth health and equity in all sectors. This holistic policy framework will be population rather than issue based, it will outline characteristics of effective youth health work that will then be applied to specific focus areas such as sexual health, alcohol and other drugs, violence, mental health, general health and wellbeing. It will also outline strategies for specific youth populations. The current policy environment has young people's issues scattered across a range of issue based health policies.

- This policy will include: a contextual analysis of young people's health including the social determinants of health, youth participation, whole of government, holistic approach, wellbeing, harm minimisation, health promotion, primary secondary and tertiary services, key principles and strategies, goals, targets, coordination of resources, good practice principles, outline benefits and what will it drive, links to other policies.

- Reorientation of public policy, attitudes and organisation of health services to focus holistically on the needs of the young people with strengthened linkages to resources for specific issue based programs and services

- Review of the youth health policy framework for school based health clinical services and health promotion. Utilising Youth Support Coordinators, School Based Youth Health Nurses and other relevant stakeholders Including the expansion of the prevention and early intervention role of School Based Youth

Health Nurses in delivering sexual health services. Ensuring compulsory minimum requirements for the delivery of sexual health education for all young people in Queensland.

- To respond to the health gap within Queensland and to tackle inequities based on social rules and practices relating to youth health and youth sexual health, particularly for Aboriginal and Torres Strait Islander young people and their communities.

- Establish **Youth Health Policy Roles** in the Centre for Excellence for youth health to maintain youth health policy expertise and advocate for youth health issues

Characteristics of effective policies, services and programs

- To acknowledge **young people and their communities** as the main health resource, to support them through financial and other means to optimise their health and to accept young people as an essential voice in their own health

- **Accountability** how does policy and decision in all areas of government impact on young people and youth health?

- **Definition of approach to youth health**, sexual health and marginalised young people, move to a strengths based, wellbeing, social justice and rights based approach not just problem based and disease prevention

- **Key policy principles** – Culturally appropriate (both ethnicity and youth cultures), Accessibility, Evidence based approach, Youth Participation, Collaboration and partnerships, Professional development and Sustainability

- **Identify barriers** to the adoption of healthy public policy for young people and marginalised young people and address these barriers

- Review legal framework for youth sexuality in the following areas:

    - Consent law for 16 year olds – criminalising consensual peer based sexual activity for under 16s, suggested exploring a competency and context assessment model rather than chronological age based benchmarks

    - Anal sex consent law for 18 year olds – seen as discriminatory for male same sex partners (eg consenting 17 year old male partners potentially being charged)

    - Review of recording processes for young people under 18 being charged with these offenses (eg having a criminal record as a sex offender, impact on employment, accessing blue cards, future opportunities etc)

    - Clarification of termination law to enable young people to access terminations safely at the young woman's request

    - Consent to medical treatment – suggest this is clarified as competency and context based assessment of young people to consent to medical treatment (without parental permission)

    - Confidentiality – move away from age based benchmarks to competency and context based assessment for the confidential delivery of health services to young people (such as Gillick competency)

- Clarify liability exposure for youth health practitioners in providing youth health services when using competency and context based assessments to provide youth health services without parental consent

CREATE SUPPORTIVE ENVIRONMENTS

- Protection of natural and built environments and conservation of natural resources as part of youth health promotion

- Creating supportive environments that nurture young people's health and sexual development, including the social, emotional and attitudinal environment– recognise that sexuality is a part of every human being, (regardless of choices around sexuality)

- Address impact of social context and community attitudes on sexual health choices such as racism, sexism, homophobia, violence, cultural, religious and ethical context of young people's sexuality

- A broad based anti-discrimination campaign to challenge homophobia and promote positive responses to young people's sexual health development

STRENGTHEN COMMUNITY ACTION

- Genuine Youth participation and empowerment on all levels of policy development and interventions – youth workers involved to facilitate involvement by marginalised young people

- Develop flexible systems for enabling a diversity of young people to participate in setting priorities, make decisions, plan strategies and implementing them. This can be enabled youth workers through community development approaches.

- Invest in research that supports the optimising of youth health, this includes both qualitative and quantitative research methods that consider the needs of specific cultural groups.

- In communities where there is not a community based youth health service, it is suggested to strengthen linkages and partnership between youth service providers and primary health services. Focus on young people as a population, not just specialist health issue based funding.

- Resources and support for youth sector organisations to hold local activities for significant events such as World AIDS Day etc (In 2002, 65 youth services in Southern and Central Qld voluntarily held activities for World AIDS Day resourced by the HIV/AIDS team at Brisbane Youth Service.)

- Small seed projects for health promotion with a diversity of youth sub groups across Queensland. (similar to Tribes project at NUAA or Hep c Qld small grants) – support for these projects provided through the central centre of youth health promotion excellence

- Better coordination of existing human and material resources to enhance young people's sexual health through inquiry based local network approaches using participatory action research methods. Local level inquiry based networks – how are young people going in our local area? What would it take to optimise young people's health and sexual health in this local area?

- Identification of new resources required at both a local and statewide level to support regional and/ or local based youth health networks across Queensland. Resource support for local partnerships and

regional networks between youth service providers and specialist sexual health services and other key relevant stakeholders focusing on young people and sexual health.

- Centralised resourcing and support for these youth health networks through the Centre for Excellence in Youth Health. (similar to the YANQ C Plan Networks or the Workforce Council's Integrated Skills Development Strategy)

A CULTURE OF INQUIRY: building the evidence base, research and practice leadership

"I suggest we need to build a culture of inquiry, using participatory action research. This enables collaboration with young people as co-inquirers, provides responses, evaluates the response and builds the evidence base"

"The youth sector needs to be skilled with the capacity to inquire into what is happening and the effects of this. We need to move away from being 'problem responders' to inquirers into how to make things better, not being stuck in reflective angst"

"Participatory action research is an inquiry based action focused research approach, it enables the production of evidence. Emancipatory action research, the work of Friere, enables the exposure of oppression and creates transparency."

"We've moved to an inquiry framework where we are naming and trying real things. What's working? What's not working? How can we do things differently? We need to create alliances with whoever supports the agenda, rather than only working with people like us."

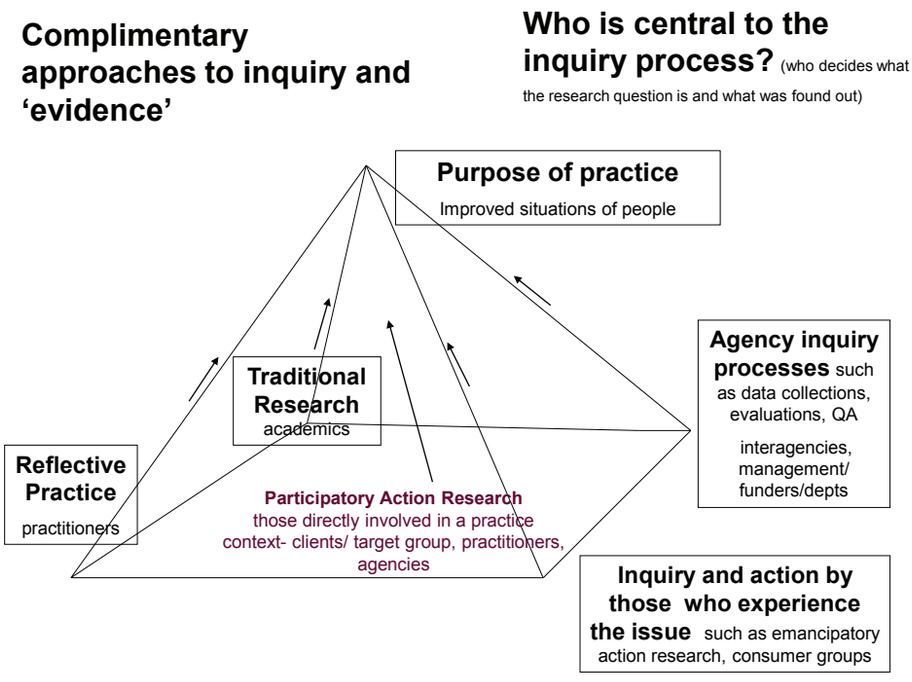
Workers discussed the need to have better access to good research information around youth health, particularly relating to effective practice strategies. They stressed that much current epidemiological data is problem and disease based and statistical data often fails to capture the complexity of the issues and young people's well being.

"The numbers don't dig deep enough, rarely are the experiences and aspirations of young people documented."

"We need to re-examine what we mean by evidence, as there is currently a disconnect between policy and practice. We also need to examine what is needed to develop good, well resourced youth work practice. We need to break free of routines and work to maintain community support for good youth work"

Workers also discussed a gap between evidence based practice and practice wisdom, being that that which is observed to be effective in practice. Workers expressed concern about the way in which evidence is collected or not collected, what is prioritised as significant, the values and frameworks which inform the evidence base and the impact on resources. Mitchell (2011) examines the integration between evidence based approaches and practice wisdom. Suggesting the two are not incompatible and suggests a model where practice wisdom informs what we understand as evidence.

Further Crane and O'Reagan (2010) outline a model of different way of knowing that impact on youth work practice. They suggest the Participatory Action Research approach as complimentary to inquiry, action and evidence gathering. It locates young people as central to the inquiry process, in that they are involved in deciding what the research question is and what is found out. They may also have a role in how the research information is used to inform responses. The diagram (Crane 2011) below outlines this model, which includes traditional academic research, agency inquiry processes, reflective practice and inquiry and action by those who experience the issue.



Further, workers discussed the need to work from a good evidence base, however the limited way in which evidence was defined and captured. Additionally exploring ways to capture this data so that is doesn't negatively impact on the work itself, but is embedded in work practice such as participatory action research methodologies. Discussion included complexity in defining what is a client outcome, how to represent the richness of relationships, content of the work and the value of scenario based data. There are inherent challenges in achieving "predetermined planned outcomes" when the nature of the work is process driven, relationship based, young people directed and often opportunistic in nature.

Wadsworth (2011) outlines a range of evidence gathering and evaluative processes that incorporate inquiry and research into practice. Crane and Richardson's (2000) Participatory Action Research Kit and Crane and O'Reagan (2010) On PAR manual are resources used by the youth sector to support inquiry based approaches. See also Crane (2011) for further discussion of these processes for the youth sector.

Recommendations:

Recognition of the specific role of the community youth health sector in developing and maintaining practice expertise in youth health. in youth health, particularly IHSHY funded programs. Utilise existing practice wisdom to inform evidence and research processes in youth health work.

Establishment of **Centre of Excellence in Youth Health Practice** located in the youth sector. This centre would resource the research, maintainance and dissemination of youth health practice skills, resource and support regional and local youth health networks, and oversee small grants funding for culturally appropriate sexual health promotion projects across Queensland for marginalised young people. This would include: youth work, evidence based approaches, peer based approaches, providing effective interventions, community cultural development and youth community development, primary, secondary and tertiary health services including health promotion. Centre of excellence based within the youth sector in Queensland and works across a range of youth health areas including sexual health, reproductive health, drug and alcohol, mental health, violence and general health, with a focus of specific population groups. This would be multi-disciplinary – drawing from youth work, health, allied health, alternative health and other disciplines.

Recognition of youth health as a specific focus of practice and the articulation of characteristics of good youth health practice. Including: frameworks, beliefs and values, youth participation, engagement, trust and relationship building, assessment, case planning, linking to specialist services etc

Workers suggested the use of collaborative inquiry approaches to support young people's sexual health development.

Shared language and definitions

"the environment of youth service delivery is a 'paradigm war' – the clinical language used to discuss young people can diminish their personhood, it's often a "done to" paradigm"

"there is a dichotomy between the medical model and the social welfare model"

Youth workers consistently mentioned the value of developing a shared common language across disciplines and communities around youth health work. Whilst similar language might be used, it can mean quite different things. Some of the suggested terminology includes: health promotion, young people and sexuality, workforce development, marginalised or 'at risk' young people, youth sector, youth workers, sexual health rights. These terms are discussed further below.

Health Promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, (Ottawa Charter) Political, economic, social, cultural, environmental, behavioural and biological factors need to be included as they can all favour health or be harmful to it.

Young people and sexuality

How young people and their sexuality are conceptualised directly influences policy responses, interventions and the evaluation of these responses.

1. One paradigm is the disease prevention approach, which is problem based, where young people's sexuality is a "problem to be managed" to prevent negative social outcomes, such as unwanted pregnancy, HIV/AIDS and sexually transmitted infections (STIs) and other negative outcomes

2. Another approach is strengths based and holistic, focusing on rights, health and wellbeing of young people not just absence of disease. This approach recognises young people as sexual beings (regardless of whether they are sexually active) and focuses on supporting their agency, sexual development and sexual health rights within a personal and social ethic.

3. Community based approaches – openness, inclusivity, for the "common good", liberating potential not regulating it, trust in people (Ball 2011) – healthy communities framework

In his keynote address to the YANQ Conference in 2011, Alan McKee outlined some definitions of "normal sexual behaviour" which is consistent with key benchmarks that workers identified for 'healthy youth sexuality'. Kanuga and Rosenfeld (in McKee 2011) suggest 'it may not be possible to precisely define what constitutes normal sexual behaviour' – but they find it relatively easy to say what it is not.

Some of the benchmarks identified (in McKee 2011) for healthy sexual development include:

1. Freedom from unwanted activity.

2. An understanding of consent and ethical conduct more generally.

3. Education about biological aspects of sexual practice

4. An understanding of safety.

5. Relationship skills.
6. Agency.
7. Lifelong learning.
8. Resilience.
9. Open communication.
10. Sexual development should not be 'aggressive, coercive or joyless'.
11. Self-acceptance.
12. Awareness and acceptance that sex is pleasurable.
13. Understanding of parental and societal values.
14. Awareness of public/private boundaries.
15. Competence in mediated sexuality.

"Our account is insistently non-hetero normative." (McKee 2011)

"The core features of emotional development include the ability to identify and understand one's feelings, to accurately read and comprehend emotional states in others, to manage strong emotions and their expression in a constructive manner, to regulate one's own behaviour, to develop empathy for others, and to establish and sustain relationships..."

(National Scientific Council on the Developing Child 2004:1)

Workforce development

"there is a whole lot of discussion about what this is, it's so new"

Workforce development is a fairly recent emerging paradigm in the community services sector. Workforce development encompasses a broad range of interventions that enable a workforce to be more effective. This can include strategies for the attraction and retention of workers, such as remuneration and workforce conditions, the policy environment and other contextual issues that impact of workforce effectiveness. In the area of education and training, it is more than training as it seeks to identify the range of knowledge, skills and resources that support sexual health work by youth workers. This could include such strategies as supervision, mentoring, project based learning, inquiry based approaches, informal and formal learning, etc.

This research identified varying levels of understanding and literacy among youth workers around workforce development. Workers suggested that *"the focus on immediate service delivery often means that youth workers may not have a broader systems perspective."* In this research this is borne out in the amount of direct service delivery content rather than broader systems discussion in the conversations.

Marginalised or vulnerable or disadvantaged or "at risk" young people

There are a range of terms used to describe young people who experience disadvantage. This includes: disadvantaged, marginalised, "at risk", disengaged, specific "at risk" groups such as ATSI, CALD, gender based risk etc. The use of this language primarily distinguishes an individualised causal definition of risk or a socially

constructed definition of being disadvantaged or marginalised.

> "We used to commonly refer to *disadvantaged* or *marginalised* young people. This implied that these young people had been treated unfairly, and that their situation was impacted by social factors. More recently, the terms *at risk* and *vulnerable* young people have become more common. These suggest that individual young people are responsible for their situation or, at the very least, imply that their situation is a matter of individual need rather than a consequence of their social circumstances." (Quixley 2011:2)

Many workers suggested the Victorian Policy Framework for Supporting Vulnerable Youth (2010) as a good way to conceptualise working with young people. Other suggested that whilst this model was a good start, it didn't go far enough. It is important to identify who are the workers and services that marginalised young people are most likely to be accessing, particularly young people who are disconnected from family and schools.

Specific groups of young people identified include: ATSI young people; Lesbian, gay, bisexual and transgender young people; young people from culturally diverse backgrounds and young refugees; young people in rural and remote areas; young people with disabilities and learning difficulties; young women; and young men

Youth work

Responses by youth workers to both youth health and youth sexual health can be embedded into existing programs and practices which is informed by good youth work practice. There are different ways of doing youth work and no shared understanding about what the work is, who does it and what it can be expected to achieve. As part of it's broader workforce development agenda, the Youth Affairs Network of Queensland has sought to start debate and develop a shared understanding within the youth sector about what youth work is. This aligns with similar debates happening in other states and internationally about the nature of youth work. This has particularly focused on discussion about codes of ethics and the professionalization of the youth sector, particularly the development of professional associations.

The Youth Affairs Network of Queensland has taken a leadership role in facilitating debate about these issues in the youth sector in Queensland. A number of papers on this topics have been released:

What is youth work? http://www.yanq.org.au/what-is-youth-work
Conservatising youth work: the dangers of adopting a code of ethics. http://www.yanq.org.au/our-work/413-conservatising-youth-work-dangers-of-adopting-a-code-of-ethics

Many workers identified the changing role of youth workers in the last decade and to a large extent this being influenced by the changes in young people's lives and policy approaches.

> *"We need clearer definitions of youth work and youth work practice. Young people have a fundamentally changed relationship to the labour market. This impacts on how young people are understood and constructed and their institutional location. Young people are staying in educational institutions longer and/or employed on a casual basis. This in turn has meant that youth work itself has moved into "relational work" where youth workers are more strongly engaged in social institutions such as families, schools, etc. This has led to a fundamental shift in the context of youth work." (Crane 2011 and personal communication)*

Youth sector and youth workers

There is also discussion about who are youth workers and the youth sector. Whilst there can be utility, caution is also needed in defining who is and who is not a youth worker or doing youth work. Whilst it is understood that this doesn't broadly include anyone who is working with young people (such as teachers, nurses etc), there is a very broad range of people and organisations who engage in youth work. The youth sector also includes roles that may not directly work with young people but whose strategic role is to benefit young people (such as policy, education and training, research and youth service managers and supervisors).

Previous research has suggested the learning and development needs of direct service youth workers, specialist

sexual health workers and youth service coordinators and managers differ, and different approaches are needed. (Brisbane Youth Service and Youthlink 2001)

Sexual health rights and wellbeing approaches

A clearer definition of these approaches could inform policy development and approaches to youth sexual health. There are a range of charters and definitions for this, including the World Health Organisation, SIECUS and other frameworks.

The World Health Organization defines reproductive rights as follows:

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.

Most charters or discussion about sexual health rights includes a broader range of rights for all people including rights to: information, resources, health care, agency and choice about their sexuality, freedom from exploitation and abuse, to live in accordance with their sexual orientation, etc.

An increased focus on values and ethics

Workers consistently identified the importance of values and ethics in youth health practice. This has been highlighted throughout the recommendations, particularly relating to policy, community education and awareness raising campaigns, and practice development and learning strategies.

Develop personal skills for young people

- Maintain and enhance existing health promotion and primary health care responses with marginalised young people such as IHSHY funded programs.

- Workers suggested seed funding for small projects in regional areas to respond to young people's sexual health. (Similar to the Tribes project at NUAA or the small grants through the Hep C Council of Queensland). This would enable small resources to support project based learning, local inquiry and action based outcomes for young people. This could be centrally supported through the centre for youth health. It might be small grants for resource development or to run activities such as World AIDS Day, Valentine's day, youth week activities etc. Young people could be involved in the planning and implementation of these projects which could use community cultural development and participatory action research processes.

- Access to information, learning opportunities, skills development, resources and funding support in timely, culturally centred, developmentally responsive manner. Information, education and enhancing life skills aimed at increasing young people's agency and control over their own health and their environment, and to make choices conducive to health. Enabled through school, home, work and community settings.

- Examine factors that influence marginalised young people in the development of their sexuality and choices around sexual behaviour

- Articulation of characteristics of good youth health practice for primary, secondary and tertiary interventions with marginalised young people and general youth populations. This model would be based on research, practice wisdom and young people themselves

- Specific resources and inclusion of diverse sexualities in sexual health education programs, including

specific information relating to sexual health practices

- Moral / ethical decision making skills education for young people

- development of culturally appropriate health promotion resources using culturally centred peer based inquiry processes

- Practice resources to support: ad hoc / brief interventions, case planning, education workshops, peer education processes,

- Training programs

- Information, skills development and resources for workers and young people

- Explore the possible use of **Youth Health Passports** (or similar concept) for marginalised young people (similar to those used for young people involved with statutory child protection), these would be non-mandatory, might be self assessed or done in conjunction with professional staff

Accessible youth health services for young people

- Reorient the health care system to share power in partnership with young people and the youth sector, to optimise youth health. This includes individuals, community groups, health professionals, health service institutions and governments.

- Ensure clinical services are accessible to and accessed by young people. Eg auditing by young people of existing health services for "youth friendliness"

- Ensure the maintainance and further development of specialist youth health services as needed, (eg ISHYI funded youth health services).

- Co-location of health services with youth services (as appropriate).

- Strengthen links between youth workers, primary and specialist health services.

- Development of specific school based approaches to clinical services and youth health promotion through youth support coordinators, School Based Youth Health Nurses and other relevant stakeholders.

Culturally responsive peer based resources

Workers suggested that there is a gap in the availability of "youth friendly" sexual health resources and they identified the need to continue to develop and share good resources. Others discussed the value in using community cultural development processes to develop peer based resources. Others suggested often the process of projects is as important as the specific resource outcome. Another suggestion was the use of participatory action research inquiry to find out what is useful for young people and to facilitate their involvement in developing responses. Many suggested that projects with both an participatory action and inquiry approach enabled learning and effective responses.

Workers suggested the need to continue running projects with different group of young people to continue the production of culturally relevant "youth friendly" resources, particularly the use of community arts processes. These projects could utilise new technologies, such as Multimedia / social networking tools, mobile phones, facebook etc

Workers suggested the allocation of small grants to run small projects with a diversity of youth cultural groups around youth sexual health. This could include developing locally culturally relevant sexual health resources for wider distribution.

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Appendix 1 – Promotional Flyer

youth affairs network qld

What would it take to optimise marginalised young people's sexual health?

A conversational journey with youth workers

The Youth Affairs Network of Queensland has received a small grant from Queensland Health to identify youth sector workforce strategies to respond effectively to marginalised young people around HIV/AIDS, Hepatitis C and Sexually Transmitted Diseases.

The project will seek to answer the following questions utilising qualitative interviews with youth workers:

- What are the education, training and support needs of youth workers to address HIV/AIDS and STI issues with marginalised young people?

- What is needed to ensure the ongoing review and development of accredited training programs for youth workers is informed by the latest research and complementary to QH action plans?

- What do youth workers need to facilitate the initiatives and outcomes of the Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy?

The process will involve a series of interviews with youth workers across Queensland to identify key themes, examples of good practice, principles of practice, the policy and community environment, service gaps and suggested workforce strategies.

The information gathered will be collated into a project report and published through YANQ. Participants will be sent a copy of the draft report for feedback prior to the finalisation of the publication. All information will be gathered confidentially and identifying information only published with the permission of relevant participants and youth work agencies.

If you are interested in participating in this project, please call

Sarah Roberts 0413 175 710

Youth Affairs Network of Queensland (YANQ) 2011

Appendix 2 - Suggested discussion starter questions

Focus on young people:

What would it take to optimise marginalised young people's sexual health?

What would it take to prevent HIV/AIDS, HCV, STIs and unwanted pregnancy among young people you work with?

What is optimal sexual health?

What are the sexual health experiences of young people you work with?

How do young people's experiences present in your work?

Where do young people access info about sexual health?

Discussion about Injecting, blood borne viruses...

What resources, knowledge and skills do young people need?

Do you have access to culturally appropriate, "youth friendly" sexual health resources for young people?

Do young people have easy access to condoms, contraception, clinical testing and treatment etc?

How could young people be engaged to act collectively around youth health concerns? Eg peer education etc

Are clinical health services in your local area "youth friendly"? Can you give more detail about this?

Focus on youth workers:

What values and ethics and practice approaches inform your work with young people and sexual health?

What interventions do you provide around sexual health?

What interventions do you have access to?

What are the gaps in service delivery?

How could interventions be improved?

What are some of the ethical dilemmas or practice complexities you experience as a youth worker regarding young people and sexual health?

What are your learning needs in relation to sexual health?

How do you access information, skills development and resources for youth health promotion?

What resources, knowledge or skills would you find useful in your work? Any suggestions for possible new resource / funding suggestions?

Are there good models of support you have observed in other areas such as Housing, AOD etc?

Focus on the Youth Sector / Workforce issues:

How does the current policy and legal environment impact on youth sexual health?

How well does the community environment support sexual health development for young people?

How well does the youth sector respond to young people's sexual health? Can you give examples or stories?

How could the youth sector be more effective in responding to young people's sexuality and sexual development?

Are there any sector wide strategies, education and training, resources or models of practice that you could suggest or recommend?

How could workers come together to improve their practice around young people's sexual health?

Can you give any examples where this work is being done well? Eg networking partnerships, peer education programs etc

What barriers might prevent workers from doing effective work in this area?

What would you like to see change in relation to young people's sexual health?

Appendix 3: The YEP Project, the Youth Affairs Council of Western Australia (YACWA) – Abstract for the Australian Youth Affairs Conference, 2011

Abstract for Australian Youth Affairs Coalitions Conference (2011).

Good practice example re application of action research to sexual health capacity building of the West Australian Youth Sector.

Youth sexual health peer education: an action research project

Organisation: Youth Affairs Council of Western Australia

Facilitator: Rebecca Walker

The sexual and reproductive health of young people is a global issue and one that requires an integrated, holistic response. So what is the youth sector's role in this response? When Chlamydia rates in Australia are at an all time high, along with other issues such as unwanted sex and unplanned pregnancies on the rise, what can the youth sector be doing to support young people making informed, mutually respectful choices in their sexual lives?

The YEP Project is a two-year action research project that aims to increase the WA youth sector's capacity to respond to young people's sexual health and BBV needs. Born out of a state-wide youth consultation in 2007 (Sorenson & Brown), and founded on a strong international evidence-base for youth peer education, the YEP Project is working with six youth sector agencies to investigate the value and effectiveness of peer-based programs in terms of their ability to positively impact on protective factors for STI and BBV transmission.

At the heart of the project are young people and facilitating their participation and ownership over issues that affect them, as well as creating safe, non-judgemental spaces where they can learn with their peers and develop skills both personally and as peer educators/role-models.

The research will be completed and available in July 2011. This presentation will discuss the emerging critical factors for achieving success with sexual health and BBV peer-based programs, the key challenges faced, as well as the preliminary outcomes with youth workers and young people.

http://www.yacwa.org.au/content.php?CID=57