Training and Information Resource Needs Analysis of Youth Workers and Allied Professionals

A Collaboration Between Brisbane Youth Service and Youth Link

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# ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ACOSS</td>
<td>Australian Council of Social Service</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>BBV</td>
<td>Blood Borne Virus</td>
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<td>BYS</td>
<td>Brisbane Youth Service</td>
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<tr>
<td>C&amp;LD</td>
<td>Culturally &amp; Linguistically Diverse</td>
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<tr>
<td>ECCQ</td>
<td>Ethnic Communities Council Queensland</td>
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<td>HAV</td>
<td>Hepatitis A Virus</td>
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<td>HBV</td>
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<td>Hepatitis C Virus</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<td>IDU</td>
<td>Injecting Drug Use</td>
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<td>IYHS</td>
<td>Indigenous Youth Health Service</td>
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<tr>
<td>NCHECR</td>
<td>National Centre in HIV Epidemiology and Clinical Research</td>
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<td>NCHSR</td>
<td>National Centre for HIV Social Research</td>
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<tr>
<td>NIROA</td>
<td>Non-Injecting Routes of Administration</td>
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<td>NYARS</td>
<td>National Youth Affairs Research Scheme</td>
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<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
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<td>QH</td>
<td>Queensland Health</td>
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<td>QLD</td>
<td>Queensland</td>
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<td>SNAP</td>
<td>Statewide Needs Analysis Project</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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EXECUTIVE SUMMARY

Since 1987 Brisbane Youth Service (BYS) and Youth Link have been funded by Queensland Health to deliver HIV prevention education to marginalised young people in Brisbane and Cairns. In 1999/2000 Queensland Health refocussed the service delivery model to the provision of training across the state to those working with marginalised young people around sexual health, including HIV/AIDS and Hepatitis C. Youth Link is to provide sexual health training in Northern zone, and BYS will train workers in Central and Southern Zone, as well as producing sexual health resources for distribution to marginalised young people state-wide. It was agreed that Brisbane Youth Service (BYS) and Youthlink Cairns would jointly undertake a State-wide Needs Analysis Project (SNAP) to identify the training and resource needs of these workers. This document is the final report of this research project and recommends an approach to guide training and resource development on sexual health.

This research is based on a literature review, a questionnaire of workers state-wide and focus group discussions. A database of 800 Queensland health and welfare service providers who undertake sexual health interventions with marginalised young people was developed. Two questionnaires were sent to all those on this database, one dealing with resource materials on sexual health, and the other focused on workers’ training needs. Only 51 resource questionnaires were returned (6% response rate) and while these findings are reported they cannot be generalised to workers across the state. As a result, further research is recommended in relation to resource needs. The response rate for the training needs survey was 28% (or 225 surveys returned from 800). Focus groups were also held in eighteen (18) areas across the state, each involving representatives from 10 – 12 services from the database in that area.

The report commences with a review of literature on sexual health and young people, identifying the range of social, cultural, environmental and behavioural issues that influence a young person’s sexual health choices. The review identifies that marginalised young people are at greater risk of ill-health due to issues of discrimination and lack of access to mainstream health services. Current research describes a broad range of factors which impact on young people’s sexual health. Across all these factors the evidence shows that while information on sexual health must be provided in a way that is culturally relevant to marginalised young people, information alone will not change behaviour. Effective sexual health interventions must take account of the social and cultural context within which risky behaviour occurs. It is also essential to raise and address the cultural beliefs and attitudes prevalent in both mainstream culture and the sub-cultures of target groups, in this education process. Finally the review identifies that sexual health issues cannot be treated or responded to in isolation of other health determinants.

Survey responses and focus group data reinforce this evidence. The report identifies influences on the sexual health risk behaviours of young people, both in terms of their personal ability to negotiate safe sex, and their access to accurate information on sexual health. Personal issues of self-esteem and confidence to ask for information, as well as the perceived lack of “youth friendly” services, limit young people’s access to sexual health information. This is exacerbated in rural and regional locations where services are more limited.
Workers also highlighted the complexity of issues facing marginalised young people, and the importance of dealing with issues such as homelessness, sexual abuse, unemployment and substance use in conjunction with sexual health, rather than in isolation.

In summary, all the evidence points to the importance of a holistic approach to sexual health interventions and the need for workers to have some understanding of the range of issues influencing marginalised young people’s options and choices. Sexual health training needs to be provided in a way that acknowledges this reality, along with the diversity of youth populations and risk behaviours.

The report finds that a broad range of workers need to have knowledge of sexual health, and sexual health specific workers need information on broader health and welfare matters which impact on sexual health. Additionally the data identifies that workers also require training in basic youth-work skills (eg communicating with young people, building relationships, cultural issues, etc.) to improve their existing sexual health interventions. This is particularly the case for sexual health specific workers who service a broad range of populations, including young people. Workers also identified organisational and community attitudes which impinged on their capacity to deliver effective sexual health education to young people, especially those under eighteen years.

Based on these findings the report recommends three ‘streams’ of training be developed in response to each category of workers’ training needs. Those workers who undertake sexual health education as their core duties require advanced training with detailed information on sexual health which is regularly updated, skills in working with marginalised young people, and a capacity to refer clients to other services for related needs. The second stream includes those who undertake sexual health interventions occasionally (non-core sexual health workers) and so require basic sexual health information. Workers in both these streams will also benefit in sharing their experience of sexual health interventions with young people. The third stream includes workers at a managerial-level who supervise sexual health workers. This stream focuses more on raising awareness of sexual health issues, community values and attitudes towards sexual health, and the broad range of factors which influence young people’s sexual health.

The research also identified a number of issues in relation to delivery of this training. Across the state workers emphasised the importance of training that could be sourced and delivered at the local level, not just for ease of access, but to ensure the specific issues in each area could be a focus. While the issues identified across the state were similar, clear regional variations were identified in the data. The report therefore recommends sexual health training coordinators be identified in a number of areas across the state, who are in turn resourced by BYS/Youth Link. While a training package may be developed for core sexual health workers across the state, the specific needs of workers in any particular area will determine which aspects of this package are used in training delivery. Finally, in acknowledgement of the decentralised nature of Queensland and digital delivery mechanisms (eg internet, video-conferencing) self-paced learning modules should also be considered.
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SECTION ONE: INTRODUCTION

1.1 BACKGROUND

This document is the final report of the Statewide Needs Analysis Project (SNAP) undertaken jointly by Brisbane Youth Service (BYS) and Youth Link, with funding from Queensland Health. Queensland Health has provided funds to BYS and Youth Link to undertake HIV/AIDS education and prevention with young homeless people in the inner-city of Brisbane and Cairns, respectively. Queensland Health reviewed these projects and in 1999/2000 negotiated with both community services to re-focus their HIV projects. In summary, the change in focus for these projects is twofold.

Firstly, the focus of the projects is now broader than just HIV/AIDS, and extends to all aspects of sexual health, including HIV, Hep C and other STI’s, as well as the many contextual factors which influence young people’s sexual health. The literature reviewed for this report documents the broad range of factors that impact on young people’s sexual health, and documents the existing evidence of the key influences on young people’s sexual health choices. The literature identifies how young people understand sexual health, and the priority of sexual health issues in the daily lives of marginalised and/or homeless young people.

Secondly, and more importantly, the projects have shifted from direct service delivery to marginalised young people, which in both agencies focused on working with young people in a health promotion framework to encourage healthy sexual practices. The new role is to provide information, training and support to health and welfare professionals across the state who undertake sexual health interventions with marginalised young people. YouthLink will provide training and support to workers in the Northern Zone of Queensland Health, and BYS will cover Central and Southern Zones. Finally it was agreed that BYS will continue to produce sexual health promotion resources targeted to marginalised young people for distribution across Queensland. There is no additional funds offered to undertake this role, and the recommendations of this report assume no additional funds will be available.

1.2 ABOUT THE ‘SNAP’ (statewide needs analysis project)

The first phase in re-focusing these HIV projects is to identify who in Queensland undertakes sexual health interventions with marginalised young people, and then to determine what information, training and support these workers need to maintain and enhance their work. This approach enables both services to take a leadership role in the development and/or implementation of training and education, based on a solid understanding of the needs of workers across Queensland.

The agreed objectives for the SNAP are:
- Map and develop networks within Government and non-government organisations and individuals involved in the delivery of sexual health information and education to marginalised young people;
- Enable these workers across the state consultation opportunities that will inform future project development;
• To identify gaps in information resources, highlight distribution difficulties and build on existing resources, particularly those specific to rural and regional cultural groups;
• To develop a framework for the provision of sexual health training to workers state-wide.

A steering committee was established to advise on project development which included staff of BYS, Youth Link and Queensland Health, and representatives of a number of agencies with expertise in sexual health. A list of Steering Committee members can be found at Appendix One. The role of the Steering Committee was to assist in the identification of key services and workers across the state, advise on the development of a methodology and to assist in the analysis of the data once collected. In addition to discussion at committee meetings, this report has been distributed to all members of the steering committee and the recommendations reflect their feedback and comments.

1.3 PURPOSE OF THIS REPORT

The purpose of this report is to:
• Describe the background to the development of a state-wide training needs analysis project undertaken by youth workers at BYS and Youth Link;
• Document the findings from a review of literature and research into sexual health issues for marginalised young people;
• Describe the methodology of the needs analysis;
• Report on and discuss the findings from the research; and
• Recommend an appropriate training model based on the literature review and research findings.

This report provides the direction for the development of a training and resource model for workers across Queensland providing sexual health information and resources to marginalised young people.
SECTION TWO: REVIEW OF LITERATURE ON SEXUAL HEALTH ISSUES FOR MARGINALISED YOUNG PEOPLE

2.1 INTRODUCTION

The aim of this review is to present the research evidence in relation to marginalised young people’s sexual health, particularly highlighting sexual health research on marginalised young people in Queensland. This evidence describes the complex and interrelated social, economic, cultural, environmental and behavioural issues that affect marginalised young people’s sexual health, and forms the basis for the development of the proposed training model.

Queensland evidence is cited throughout this review wherever possible, but in those areas where data is only available nationally or the only published research undertaken occurred overseas, national and international sources are included. National and international research is also used where there is a need to support limited Queensland specific information, or compare local trends with similar populations outside Queensland. A limited number of unpublished community-based and government reports are included where they contain more up-to-date information or confirm other research findings.

The literature review commences with definitions of the key terms in the research question, but the difficulties of how workers and young people interpret these terms is discussed in section four. Research on the general social and economic circumstances of marginalised young people is presented, including discussion of the impact of poverty and homelessness on sexual health. The social and cultural impacts of adolescence are then discussed, focusing on sexual health issues commonly encountered by marginalised young people during this stage of development, and the evidence on this target group’s access to health services. The next section then looks at young people’s relationships and their personal capacity to negotiate sexual health. The review concludes by identifying the types of behaviours (eg injecting drug use) and identities (eg gay/lesbian) which affect sexual health.

2.1.1 Definitions

This review uses the following definitions in order to clarify what is meant by sexual and injecting health for marginalised and at risk young people.

**Sexual Health**

The World Health Organisation (WHO 2000) defines the concept of sexual health to include three basic elements:

- A capacity to enjoy and guide sexual and reproductive behaviour in accordance with a social and personal ethic.
- Freedom from fear, shame, guilt, false beliefs and other impairing psychological factors which inhibit sexual response and affect social-sexual relationships.
- Freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions.
Queensland Health further adds:

A holistic approach to young people’s sexual health builds on this definition by considering sexuality within the context of lives and culture. It is difficult to isolate sexual health from other aspects of their lives, but as a minimum, needs to include sexuality and sexual well-being, reproductive health and pregnancy, and the effects of sexual violence. For the purpose of this review, sexual health is also extended to include matters related to blood-borne viruses such as hepatitis C (although sexual transmission is rare) because of the commonality in unsafe behaviours which can lead to infection.

(Queensland Health 1999)

This review has therefore an added emphasis on injecting health issues in keeping with Queensland Health’s direction to discuss injecting behaviours in a sexual health context.

Injecting Health
Injecting health is included to accommodate the emphasis in Queensland Health’s policy documents of the importance of blood borne viruses such as Hepatitis or HIV which can be transmitted through injecting as well as sexual contact. Within a harm reduction framework, injecting health is defined as the set of behaviours and practices which enable young people to engage in intravenous injection without risk of infection. Because of the close relationship between sexual and injecting health, particularly in terms of infection risk, this review will include issues of safe injecting.

Marginalised and at risk young people
The accepted definition of young people (found in policy documents from BYS, Youth Link, Queensland Health and most other agencies) is those aged from 12 to 25 years. However not all young people live in poverty, find themselves homeless or have regular experiences of being marginalised by mainstream services. Once again the Queensland Health (1999) report provides a definition of marginalised young people which is used throughout this report:

Research confirms that there are populations of young people who are at increased risk of poor sexual health because their circumstances, environment and behaviours compound and can lead them to becoming disenfranchised from mainstream support. Marginalisation can lead to risky sexual and injecting practices. Examples include those with emerging homosexual or bisexual identity, those young people who are homeless or at risk of being homeless, those who have or are experiencing violence, abuse, or non-consensual sex, young offenders, and those for whom foster care arrangements are not appropriate.

It is often argued that simply being within the ages of 12 to 25 years is itself a risk factor for transmission of HIV and STI’s. This is borne out by numerous studies showing a disproportionate rate of STI amongst young people (Moore et al 1998). The three most recent research reports into sexual health of marginalised young Queenslanders (QH 1999; Hillier, Matthews & Dempsey 1997; and Harrison and Dempsey 1997) agree that young people can be considered at greater risk of sexually transmitted infection than the general population. However all these reports also identify that the young population is not homogenous and a diversity of risk exists across specific identities and behaviours. These reports, and others (e.g. Barnes & Clements 2000; Williams 2000; and Davies 2001) also identify that marginalisation can lead to risky sexual and injecting practices.
This review acknowledges that sexual and injecting health is affected and influenced by numerous factors. Therefore, the review recognises that sexual and injecting behaviours should not be examined as disconnected from individual, situational, social, cultural, economic and political contexts. In addition, the response from mainstream health services and other institutions may further marginalise young people, and so the review includes evidence on service responses. Also, marginalised young people in Queensland are a heterogeneous group, diverse in sexual orientation, gender, age, race, experience, class, geographical location, knowledge, educational level, beliefs, attitudes, and cultural identities. All these factors will be considered in relation to the existing evidence.

2.2 IMPACTS OF POVERTY, HOMELESSNESS AND RELATED FACTORS

The low level of employment among marginalised and at risk young people, and their correspondingly low income, is also a concern in relation to their health and their access to health care. Since the 1970’s young people’s rates of unemployment have consistently remained at three times the rate of the general population (Kriesler 1997: 61), resulting in nearly one-third of young people being unemployed during periods of high general unemployment. As a result young people are over-represented amongst those living in poverty. Recent Australian Bureau of Statistics figures (ABS 1996; ABS 1997) show that 25% of young people nationally were living in after-housing poverty, twice the rate of the general population.

Of the participants in the Hillier (1997) study, only 5% were receiving wages, 65% were receiving government benefits, 14% were on Abstudy or Austudy and 9% had no dependable income source. Of alarm, was nearly a fifth (18%) of the group under 18 years, had no regular income at all. A recent study by Department of Families for its Youth At Risk Outreach Service (YAROS) Review (Queensland Department. of Families 2002) had similar figures, with 76% on Centrelink benefits or pensions, 7.5% in full or part–time employment and 9.5% having no income at all. It also reported that the introduction of the Common Youth Allowance, ‘mutual obligation’ and its system of breaches and penalties has had ‘a significant adverse impact on young people’s ability to access and maintain income support (p. 32).

A large-scale survey of Queensland youth undertaken in 1998 found that three to four percent of 15-19-year-olds, representing approximately 34,000 teenagers, were not in the workforce and were not studying (McClelland et al 1989). A report titled Ethnic Youth Needs Analysis by the Ethnic Communities Council of Queensland (ECCQ, 1995) conducted focus groups with young people from various ethnic backgrounds as well as some service providers. The young people reported finding it “very difficult to obtain employment, especially those who cannot speak English and have no formal qualifications” (Sartori 1995: 14). Lucashenko & Terare (1994) also report that both male and female Indigenous young people between the ages of 15-19 are the most vulnerable in terms of unemployment and lack of any income support. Independent financial resources are crucial for young marginalised people who typically no longer live at home, and often have no family support.
As a result of low income and disconnection from family, many young people will also find themselves without appropriate housing. Data from the Commonwealth Department of Family and Community Services program of Rent Assistance identifies that 60% of young households pay more than 30% of their income on rent, and 23% pay more than half their income on rent. The result is a high number of young people living in after-housing poverty, or simply not being able to pay rent and meet the costs of ordinary living. The data set on the Supported Accommodation Assistance Program (AIHW 1999) highlights the high rate of homelessness amongst young people. In 1997/98 36% of all SAAP clients nationally were aged between 15 and 25 years, with 18–19 year olds being the highest users of refuges and shelters than any other population group.

The Hillier (1997) study primarily focused on homelessness and by definition, “young people living in unsettled housing” (16). The findings showed that in the preceding three months, one fifth still spent time in the parent household and one third stated supported housing. Remaining options for an individual, were friends’ housing and what was described as ‘couch hopping’. This is where the young person moves on once they felt they were imposing. Smaller numbers were living on the streets, in squats, rooming houses, and foster care or in prison. The study surmised that supported accommodation was “by far the best option” (15). These young people were more likely to have employment or have remained in schooling, as within this type of accommodation, young people were often given the opportunity to develop life skills and observe stable, healthy patterns.

In terms of gender, young women were more often in supported housing, while young men were more likely to be living on the streets. Moreover, anecdotal evidence suggests that even in the private rental market, real estate agents are often apprehensive and unhelpful in leasing rental accommodation to people under 25 years of age (Moody 2001). A further report ‘Speeding Around Slow Bends – i2i Project – Final Report’ studied young people’s initiation into injecting drug use and issues for HCV education. It also identified lower levels of employment and higher levels of government income support, particularly for the 13 to 17 year age group, as well as the transience of the group (Williams 2000). These impacts are summarised:

“It is not difficult to imagine the extreme hardship for these young people living away from home and having no secure income. This lack of economic independence also highlights the plight of younger people who need to leave home for reasons of abuse or persecution but have no financial support available if they do” (Hillier et al 1997: 20)

Research also indicates a strong correlation between unemployment, poverty and homelessness, and early school leaving (Brooks et al, 1997; Williams, 2000). An additional document for National Youth Affairs Research Scheme (NYARS) outlined a range of negative impacts of early school leaving as reported in two Parliamentary inquiries ([Senate Standing Committee on Employment, Education, and Training 1992; House of Representatives Standing Committee on Employment, Education and Training 1996] in Brooks et al 1997). These negative impacts included poor physical and mental health due to dependence on welfare and unemployment, homelessness, poverty, and the breakdown of family support. Young people of school age who cannot maintain their study due to poverty and/or homelessness become further marginalised from mainstream services.
Another NYARS report identified that young people who do fit into foster care arrangements or those leaving care and protection are at higher risk. This is due to the greater likelihood that they “are more likely to experience homelessness, unemployment, early parenthood, loneliness and despair” (Maunders, et al 1999: vii).

The Hillier study (1997) also found that homeless youth leave school earlier than their home-based peers. It found that 84% of participants were not at school at the time of the research. The study also found that overall, girls had more years of schooling than boys, and that Queenslanders, on average, left school earlier than Victorians. Lucashenko & Terare (1994), found that the young Indigenous people in their study were likely to leave school before the age of 15 or at least 17. Moreover, they would have moved house in the last year and have very little disposable income. This is also consistent with the i2i study were there was also “higher instance of early school leaving”, again predominantly for the 13 to 17 age bracket (Williams 2000: 140).

On young people, poverty and long-term unemployment, NYARS identified social and economic costs of sustained unemployment and poverty (Crooks, et al 1996). Barnes and Clements (2000) state that due to the current government’s income support policy, numbers of marginalised young people are on the increase, with many engaged in high risk activities. The impact of Social Security policy which mandates income support “breaches” is currently being studied by Australian Council of Social Service (ACOSS), although results are not yet available to back up anecdotal evidence. Impacts and consequences discussed in the NYARS study included questions of subsistence living and the shrinkage of social networks, hardship, misery, low self-esteem, social isolation, poor personal health, and limited access to necessary goods and services.

2.3 GENERAL HEALTH, SEXUALITY AND SEXUAL VIOLENCE

For all young people adolescence is an inherently difficult time. For the disadvantaged young person, this period can be an extremely traumatic and often violent experience (Terrell, 1996; Moore et al 1996). Sexual and injecting health does not occur in a vacuum. As found in a number of research studies (QH, 1999a; Hillier, et al, 1997; Gunn, et al, 1998; Harrison & Dempsey, 1998), sexual health is commonly given a low priority by marginalised young people as they are more focused on dealing with poverty and homelessness. Despite the low priority of sexual health, sexuality remains an essential concern for young people.

Adolescence marks the onset of many changes and challenges. These include identity development and complex body changes such as the development of the adult shape, genital development, capacity for reproductive functioning, and vast hormonal changes. The fact that “...Sexuality is by nature a very sensitive, personal and potentially embarrassing facet of individual experience” (Warr & Hillier 1997: 138) means that health services and others dealing with adolescents need to assure them of confidentiality when discussing sexuality and providing sexual health services, contraceptive advice or condoms.
The incidents and experiences that occur during puberty are directly linked to adolescent sexual behaviour. In comparison to young people living at home, homeless young people become sexually active at a younger age and have more sexual partners (Rosenthal et al 1994 in Harrison and Dempsey 1998). A study by Louie (in Moore et al 1996:19) of young injectors showed that they had their first experience of sexual intercourse at a much earlier age (mean age 14 years) than their peers who didn’t inject. Young homeless people in Australia are also more likely than other young people to engage in anal sex - an indicator of diverse sexual practice (Moore et al 1996:21).

This difference in sexual practice and experience of ‘at risk’ young people needs to be taken into account in education and program development, and in the delivery of health services as do issues of sexual identity. Issues of sexual identity development also occur at this age, and young people exploring their sexuality or confirming a gay or lesbian identity may face issues that further marginalise them.

Experiences of discrimination, unemployment, homelessness, poverty, rejection, abuse by and mistrust of adults, all create a resistance and fear to access health services that are not sensitive to the context of their lives, culture, and histories (Harrison and Dempsey 1998). Included in this is a reluctance to present for treatment of STI’s when they suspect infection (Moore 1996: 14). Bureaucratic environments and application processes which reflect government policies leave marginalised or disadvantaged young people dealing with services they do not trust (Barnes & Clements 2000). This often leads young people to give up on mainstream health and welfare services, or to perceive such services as creating more problems for the young person and not dealing with the original issue. This marginalisation in turn can lead to increased risk behaviours (QH 1999a; Harrison and Dempsey 1998). The impact of Centrelink breach policy (discussed above) can exacerbate this mistrust of mainstream services.

Part one of a two part research project - Report from the Sexuality, Homelessness and Young People Project conducted in Queensland and Victoria (Hillier et al 1997), found general health problems related to poverty included poor nutrition, respiratory ailments, lethargy, tiredness and dental and skin problems. Poor oral health can leave people vulnerable to a range of infections. Gum disease can lead to cuts and sores in the mouth which can lead to an increased likelihood of HIV and other STI’s being transmitted during oral sex, as well as increasing the risk for transmission of HCV from shared personal items such as toothbrushes (Jones 2001: 68). This study concluded, "poverty changes the risk factors in regard to health in general, and sexual health in particular" (Hillier et al 1997:53).

General health problems are frequently over represented within marginalised populations of young people in Queensland. The Hillier (1997) study found many health problems are more common amongst marginalised young people compared to the general population. Depression was also an issue of concern for many young people, and mental health issues, including ‘dual diagnosis’ are seen as a priority by many workers in the field. Of significant importance, particularly for the homeless, is the often dominating priority of the meeting of basic needs (Hillier 1997; Rotheram-Borus 1991). Hillier asserts, “young people’s worries often centered around survival itself” (1997: 21). As the report concludes (Hillier 1997: 24)
Overall, the circumstances of being homeless, in some instances complicated by the use of drugs, posed difficulties for most [of the homeless young people interviewed] in terms of general health and wellbeing, although they appeared to have reasonable health care and diet related knowledge.

Another major issue of concern is the apparent high incidence of childhood sexual and physical abuse indicated for marginalised young people. While the Hillier study did not specifically examine these issues, it concluded that “sexual abuse lingered like a shadow behind the research process” (1997: 6).

The companion report to Hillier, “Keeping Sexual Health on the Agenda: Challenges for Service Provision to Young Homeless People in Australia” by Harrison and Dempsey (1997) interviewed service providers about their clients in relation to sexual abuse. It noted that they agreed that “experiences of sexual abuse were a significant sexual health barrier for their young homeless clients”. This contributes to a number of issues relating to sexual health, specifically in relation to control of their bodies. Roberts and McLachlan, in an unpublished paper for BYS state, “The little research that has been done in this area supports the observations of workers and survivors that the experience of sexual violence has an enormous negative impact on individuals ability to make self-protective choices”. (Roberts and McLachlan, BYS 1997) identifies this and other issues stemming from sexual abuse as having direct and indirect impacts on condom use and other safe sex behaviours.

The Lucasenko & Terare report also acknowledged that within Indigenous communities, levels of sexual and physical abuse were highly marked and that “sexual attacks and abuse of our people have been endemic since colonisation” (1994; 1). Additionally this study reported that for young Indigenous women, high rates of rape and sexual assault meant “that choices about safe sex are not always an option” (1994; 3). This research identifies various high-risk behaviours within the context of homelessness reported, and particularly for the inner city population of marginalised young people, include street sex work, sex exchange behaviours and high rates of injecting drug use (Davies, 2001; Barnes and Clements, 2000).

The young people in the Hillier study (1997) were asked to identify what they felt their three main worries were. Many categories were identified, of which included violence and abuse. Other studies clearly show that the streets are a hostile place. Issues include the high risk of victimisation and violence, and sexual assault and abuse, (Green, et al 1999: Rotheram-Borus 1991) as well as exposure to life threatening situations (Terrell, 1996). Street drug cultures can lead to greater risks for homeless drug users than for others who have regular dealers and who don’t use in public. These risks include violence, robbery, police attention, sharing and re-use of syringes, unsterile injections and overdose (Maher et al, 1997 in Weatherburn et al 1999).
2.4 PERSONAL NETWORKS AND SEXUAL HEALTH SKILLS

While mainstream cultural and social factors exert a strong influence on the expression of a young person’s sexuality (Moore and Rosenthal, in Coleman and Roker [eds] 1998), the existing peer norms within a young person’s immediate social or identity group also have significant effect. Theories as to the possible factors influencing unsafe sexual and injecting practice are varied. Social learning theories posit that when significant role models sanction deviant behaviours that are perceived as ‘deviant’ by the young person, then the young person is more likely to engage in such behaviours (e.g. Akers, et al 1979).

The effect of peer influence and pressure is also marked during adolescence (Booth, et al 1999: Morrow 1999: Berger 1994). Some American research (eg King et al 1989 in Moore 1996) has identified the homeless as being well informed about HIV risks, whilst an Australian study by Hillier (1997) disagrees, with their sample of homeless young people having a poorer knowledge than an at school sample. Regardless, it is apparent that level of knowledge alone does not affect behaviour change (Booth, et al, 1999; Berger, 1994; Rotheram-Borus, et al, 1991). The Hillier (1997) study looked at homeless young people’s knowledge around safe and unsafe sexual activities and found that a significant majority (83%) scored on the lower end of the rating instruments used. It may be of significance to note that this study also found that their knowledge around ‘unsafe’ sexual activities was very low and knowledge in relation to ‘safe’ activities was even lower (1997:49).

Preliminary results of recent research conducted by QUT and BYS into Amphetamine use and HCV showed young amphetamine users to have a relatively high knowledge of HIV and HCV risk practices. Yet this knowledge did not necessarily translate into safe injecting practices (Davey, Davies, Hunter 2002. unpublished). This concurs with the research around knowledge and sexual practices cited above. The fact that knowledge does not directly translate into behaviour change is key to developing effective strategies for HIV, HCV and STI programmes for young people at risk.

Negotiating safe sexual and injecting practices is an area of difficulty for many marginalised young people. Research undertaken on Year 8-10 secondary school students across rural Australia found that young people have discomfort in managing many facets of sexual safety (Warr & Hillier, 1997). ‘Normative expectations’ of sexual behaviour influence cultural representations of the masculine and the feminine (Warr & Hillier, 1997). This creates and perpetuates a gendered asymmetry which encourages young men to pursue sexual experience, whilst young women are stigmatised and labelled as ‘sluts’ if they are sexually active or are perceived to have known sexual histories. Additionally they found common anticipation that once a relationship was established, engagement in sexual activity was expected.

Exposing and challenging assumptions and expectations around sex and gender for young people is essential if young people are to put their knowledge into practice. The development of negotiation skills and support for decisions about sex and relationships is also crucial. For marginalised and at risk young people this support will often come from youth workers, understanding health workers or teachers. Peer education and peer support groups are another strategy that has been successful and should be encouraged. (Harrison and Dempsey, 1997).
Hillier (1997) suggests that existing safe sex messages don’t meet the needs of young women in particular, in that contraception is often omitted from the discourse. A report on the sexual health of young people at risk prepared for Queensland Health (QH 1999: 13) states: “For young women biological issues such as contraception and unwanted pregnancy are as important as avoiding STI’s”. Hillier (1997) refers to studies which indicate that contraception needs to be distinguished from safe sex, for young people to understand differences between STIs and pregnancy. Condoms are generally more effective at preventing HIV and STI’s than their contraceptive effectiveness. For this reason concomitant use of condoms with another contraceptive such as spermicides, contraceptive pills or diaphragm should be encouraged (Moore et al 1996:88).

A Queensland Health report (1998) found that “the expectation that girls would take care of things is at odds with the finding that it is the girls who have most difficulty in dealing with condoms.” This is exacerbated in rural and remote areas where condom purchasing is rarely confidential and where girls’ reputations are public and important. (Warr and Hillier 1997). Given the above, it is important to emphasise the important role of sex education for young people in relation to both HIV/STI’s and pregnancy/contraception. Comprehensive sex education is regarded as essential for developing good general sexual health for all young people (QH 1999a, Moore et al 1996).

Likewise, the influence of relationships is noted in the injecting drug use experience. Crofts (1996) found that the first injecting experience was often unplanned, happened within a small group of people and commonly carried out by an acquaintance, a friend or sexual partner, Williams defined an ‘initiate’, as anytime from the first injection to an 18-month period since. She argues that, “Those involved in young people’s first and subsequent injecting experiences play a crucial educational role and must be resourced to increase this where possible because of the opportunities they may have to influence injecting practice” (Williams 2000:139). The role of sexual transmission amongst injecting drug users is often overlooked. That injectors can and do have an active sex life is often overlooked. As noted above young injectors are more sexually active than their non-using peers. The higher HIV incidence for gay male injectors in comparison to non-gay injectors is probably linked to sexual transmission (NCHECR 2001).

By their nature, adolescents are risk takers and some aspects of current youth cultures, also increase risk, such as high rates and episodic use of alcohol and drugs, (QH 1999a: Williams 2000: Barnes & Clements 2000).The impact of drug and alcohol use in relation to choosing, and maintaining safe sexual and injecting practices is often overlooked. Intoxication can affect ones ability to make decisions, or to stick to decisions already made (Williams, 2000). The i2i study found that more than three-quarters of participants were intoxicated to some degree when they had their first injection. The study reported that the young people were under the influence of various drugs including “marijuana, alcohol, amphetamines, pills, ecstasy, inhalants, cocaine, LSD, and heroin” when they had their initial injection (Williams 2000; 143). This may have impacted on their decision to try injecting. It also raises the concern of adverse drug interactions (Williams, 2000).
2.5 ISSUES FOR SPECIFIC BEHAVIOURS AND IDENTITY GROUPS

2.5.1 Sex Exchange Behaviour
Sex exchange behaviour, or the trading of sex to meet subsistence needs such as shelter, food, drugs or money, is a strategy undertaken by significant numbers of marginalised young people (Davie 2001). Sex exchange behaviour includes formal sex work, ‘survival sex’, sex for favours and opportunistic prostitution (BYS 2000: Green, et al 1999: Anderson, et al 1994). Explanations of sex exchange behaviour chiefly center on the young person’s use of this tactic as an economic survival strategy to meet basic needs (Green, et al 1999). One common assumption in the literature is that survival sex occurs outside of a young person’s personal social network (Ennett, et al 1999; Rotheram-Borus, et al 1991: Green, et al 1999: Ferguson 1993). Although one study undertaken in Brisbane did identify survival sex as fulfilling a need for emotional security for some individuals (Ferguson 1993, p. 46).

Sex exchange behaviour alters the negotiating position of marginalised young people in relation to protecting their sexual health. As shown above negotiating condom use is an issue for marginalised young people as a whole. The additional issues of negotiating with (usually) older and more powerful men in an area that is stigmatised and often illegal, ie the sex industry in its broadest sense, make those involved in sex exchange even more marginal and at risk. Discourses developed for sex workers in the commercial sex industry may not be appropriate for those involved in sex exchange as the transaction is not obviously based around cash and the young person is not an employee. In order to deal with the complex issues faced by marginalised young people involved in sex exchange Queensland Department of Families funds the Youth At Risk Outreach Service. These programs are holistic youth services that deal with broad issues facing these young people. A detailed report of this program has recently been produced (Queensland Department of Families 2001). There is also an extensive and informative literature review (Davies 2001) available.

The recognition of the role of sex exchange behaviour in initiating or maintaining personal relationships for survival purposes and the complex issues involved when exchanging sex for (injectable) drugs have not been explored. These are areas for further investigation.

2.5.2 Injecting Drug Use
Along with marginalised young people’s exploration into the labyrinth of sexual identity and experimentation, injecting drug use is an activity into which, significantly high numbers of this population initiate (Hillier et al 1997: 35; Barnes and Clements 2000). Injecting drug use leaves marginalised and disadvantaged young people at risk of BBV’s such as HIV/AIDS and HCV (QH 1999; Fitzgerald et al 1999; Hillier et al 1997; Barnes and Clements 2000; Williams 2000; QH 1997). The moment of initiation into injecting is one of importance for the young injector and the broader community (Fitzgerald et al 1999). The meaning of the rush for initiates to injecting drug use impacts on risk of transmission of BBV’s, such as HIV, HCV & HBV (Crofts et al 1996). Risk to the community as suggested by Crofts is by the “reproduction of an injecting drug using population” (Crofts et al 1996: 481). The individual’s experience at the first injecting was found to create a ‘social role transformation’. The narrative spoke of injecting behaviour by some participants, as it being “wrong” and meant a move away from having a current social identity to one in which she was “not normal … because no normal person takes drugs” (1996: 489). The research argues that this narrative “establishes a social distance between normal people and the injecting drug user” (489).
The i2i report speaks of initiation as transitional phenomenon, whereby two thirds of participants had prior experience with the injected substance through non-injecting routes of administration Non-Injecting Routes of Administration (NIROA) (Williams 2000). The research postulated, that viewing the injecting experience as a transition from non-injecting concedes that it is “not an isolated experience … that people move to and from injecting … [and that not all first time injectors] … make injecting their primary drug use method” (1996: 141).

The ‘rush’ for initiates to injecting has been found to have a significant influence on injecting behaviour. Research shows that 34% of participants cited “the rush” as being the reason for injecting (Crofts 1996: 483). Little attention has been given to injecting as a fun, pleasurable, risky, and attractive experience in the research. According to a further study: “In not attending to the social significance of the rush, interventions may be missing out on a significant component of the thrill of initiation into injecting drug use” (Fitzgerald 1999: 502).

The Annual Report on Behaviour on Initiation and Transition to Injecting Among Young People, included data on the drug most injected by location. The Brisbane findings reveal that while there was “little variation in frequency of injecting,” 59% mostly injected amphetamines and 34% mostly injected heroin. Sydney reported 33% for amphetamines and 58% for heroin use (NCHSR, 2001).

A number of recent studies have noted an increase in injecting behaviour in Queensland and other changes to injecting drug use patterns which affect young people at risk. Davey and Davies (1999) show a number of key changes which are supported by further research both published and unpublished (eg Queensland Department of Families 2001: Davey, Davies and Hunter 2002: Roberts and Williams 2001: Barnes and Clements 2000). In summary these include:

• Earlier initiation into drug use
• Earlier initiation into drug injecting
• A large increase in the use and injection of ‘base’ amphetamine (later identified as methamphetamine) and a consequent increase in methamphetamine related health problems such as psychosis, violent episodes and a discrete methamphetamine withdrawal syndrome.
• Injecting drug use being spread throughout the state.

The Youth At Risk Outreach Service Evaluation Report (Queensland Department of Families 2001) cites further evidence to confirm these changes such as the National Drug Strategy household Survey (NDSHS 2000) which shows the numbers of Queenslanders who had ever injected an illicit drug trebled between 1995 and 1998 alone (AIHW, 2000). This same study also confirmed a ‘marked increase inamphetamine use in Queensland’ (AIHW, 2000 quoted in Queensland Department of Families 2001). The YAROS review also points out that the Queensland crime Commission argues in 2000 that ‘amphetamines now pose a greater risk to the Queensland community than heroin.’
These changing patterns of use will have a continuous impact on the injecting and sexual health needs of at risk young people in Queensland. Figures from the US show that stimulant use ‘epidemics’ in general and methamphetamine ‘epidemics’ in particular often lead to high rates of HIV and Hepatitis infection amongst users and their sexual and injecting partners. Sexual transmission of HIV is a particular issue amongst methamphetamine users due to the higher level of unsafe sexual practices associated with the use of these drugs.

Amphetamine use is one of the most significant issues to recently arise in Queensland as supported by the above figures. High rates of amphetamine production and use in Queensland can have a large impact on marginalised young people. The link to community violence and the ‘double link’ between amphetamines and violent crime in Australia is an emerging social issue (Turnbull 1993). Implications for the mental health of marginalised young people, from amphetamine addiction and ‘speed psychosis’, is a developing concern. A number of relevant research projects are currently underway at both state and national levels.

2.5.3 Indigenous Young People

A recent report on Indigenous injecting drug use found that while injecting drug use is still fairly low in rural and regional areas of Queensland within Indigenous communities, alcohol, marijuana, and inhalant abuse remain major concerns (Cahill 2001). Further specific issues relevant to young Indigenous people are that they are generally “disadvantaged in their health status” (Moon, et al, 2000; 3). This report (Moon, et al, 2000: xi) cites that the death rate in proportion to the non-Indigenous community is 2.8 times higher for young Indigenous men and two times higher for Indigenous young women.

In addition to general health issues, the sexual health impacts of colonisation are identified. “With the advent of European control over Indigenous lives, and the enforced breakdown of Aboriginal Law and (traditional) social mores, sexual behaviour in urban communities has often lost its traditional sanctions and controls” (Lucashenko & Terare 1994). This study also reported poverty as an important significant concern, not only for indigenous young people but for Australia’s Indigenous population as a whole. Also significant is that “Indigenous households will have more children and more young children than corresponding non-Indigenous families” (Lucashenko & Terare 1994: 1).

Cultural difference has also been identified by Queensland Health to create increased risk if there are “cultural approaches to sexuality which create barriers, or there are sensitivities about acknowledging and addressing poor sexual health because of concerns about stigmatisation” (Queensland Health 1999).

Although many indigenous young people in Queensland can access Indigenous services in larger centres, some choose to access mainstream rather than culturally specific health services. This means that all youth services need an understanding of indigenous issues and be able to work with indigenous young people.

The ‘Indigenous Injecting Drug Use Consultation Report’ cited above provides detailed information and recommendations in relation to injecting drug use amongst indigenous people, and appropriate service responses. Most significantly this document identifies that the majority of Indigenous injectors are young people, and that service providers reported that injecting drug use was increasing amongst this group (Cahill 2001: 4-5).
2.5.4 Young people from Linguistically & Culturally Diverse backgrounds

Young people from Linguistically and Culturally Diverse (L&CD) backgrounds, living in Queensland, also face cultural barriers that affect their sexual health. The ECCQ (1995) reported the major issue from young people were the conflicts between parents’ expectations for their children to adhere to cultural attitudes and behaviours of ethnicity, versus the young person needing to find a place of belonging with peers. In effect this often meant many young people from culturally & linguistically diverse backgrounds felt no sense of belonging with either ‘mainstream’ Australian culture or their ethnic background (Sartori, 1995).

Additional concerns were the often-traditional cultural attitudes that restrict young people’s movements and independence. The study posited that this can “lead to stress and depression” (Sartori, 1995; 10). Information and education that takes cultural and linguistic differences into account is essential. Health services need to be able to deal with the specific needs of this group, for example by developing skills in working with interpreters.

2.5.5 Young People in Rural and Remote Areas

Rural and remote communities also have specific environmental influences which impact on a young person’s ability to have freedom of choice over sexual health. A study by Warr and Hillier (1997) titled ‘That's the Problem with Living in Small Town: Privacy and Sexual Health Issues for Young Rural People’, investigates how young people view themselves in relation to sexual health and the problems and barriers they face. Young people in rural and remote areas of Queensland have particular difficulties accessing services. Lack of public transport, issues of privacy and anonymity, confined opportunities in terms of education, employment and personal development, as well as conservative community attitudes can all make rural living particularly difficult. On the other hand, country living can also provide a sense of familiarity and security. Warr and Hillier postulate that in a small town, there may be consequences for personal attitudes (1997). An example is the fact that communities unaccustomed to diverse lifestyles and attitudes may furnish a sense of intolerance toward difference (1997: 133). This is seen in “rigid sex role expectations and conspicuous homophobic attitudes” (1997: 133).

Rural young people have high visibility, and in terms of their sexual safety, accessing safe sex materials such as condoms can be difficult under the watchful eye of parents and others (Warr & Hillier 1997). This is of significant concern for young women in smaller towns, due to the perception, whether based in fact or not, that behaviour such as purchasing condoms may gain her a ‘bad reputation’ as a ‘slut’. She often then finds herself either targeted for sexual favours or alienated from peers. Additionally fears around disclosure to parents and the expectations rural communities’ place on young women in terms of their behaviour can compromise the management of sexual safety.

The study identified that decisions around the use of condoms were influenced by a young person’s perception of a sexual partner’s infection risk. Many young people gauged sexual health by stories of sexual histories and reputations regarding a young person’s behaviour (Warr & Hillier 1997) rather than evidence. Here again, young people are basing decisions about sexual health on information from peers and cultural assumptions that promiscuity will automatically result in sexual infection. This does not provide an information base upon which young people can make informed sexual health choices.
2.5.6 Gay, lesbian and bisexual young people

Young lesbian and gay people are another sub-group of young people who have specific issues in relation to sexual and injecting health. Young gay men are a priority group within the National HIV/AIDS Strategy (2000), through the inclusion of gay men and young people as priority groups. Gay injecting drug users are the group with the second highest sero-prevalence of HIV in Australia, after gay men taken as a whole group. As such lesbians and gay men who also inject should be a priority group for health promotion interventions amongst homeless populations.

Coming to terms with ones sexuality is a difficult part of adolescence generally, for young lesbians and gay men the prospect of ‘being different’ can be overwhelming. The development of specific service responses to suicide in recent years also prompted research into the level of suicide risk and sexuality. Emslie (quoted in Ogilvie and Brough 2000) states that ‘suicide risk for gay youth appears to be related to the social consequences of being gay, not being gay itself.’ This can be linked to the impact of homophobic violence on young lesbian and gay people and from the heterosexism they experience in the family and the broader culture.

2.6 CONCLUSION

The evidence demonstrates the numerous factors affecting the sexual and injecting health of marginalised and at risk young people. The sexual health issues for adolescents are complex enough. Dealing with additional issues such as violence, abuse, homelessness and poverty makes these problems more complex and more difficult to resolve. These factors also tend to compound each other, and are both produced by and result in, further marginalisation from mainstream health services.

A key finding across the four main Queensland studies cited in this review is that provision of information and changes in young people’s knowledge about safe sexual and injecting health practices, while necessary does not in itself result in changed behaviour. Youth workers and health workers need to do more than provide information, condoms and clean equipment. They need to ensure that their services are accessible and confidential, and welcoming of a diversity of young people. Young people also need support with self-esteem, confidence and the development of negotiation skills in relation to sex, sexuality, condom use and contraception. In addition, young people may very well require support around poverty, abuse, homelessness and a range of other factors, before they are willing or able to discuss their personal problems with sexual health.

The evidence presented shows that in addition to these issues, there are a number of specific behaviours and identity groups, which are at greater risk of infection. Drug use, injecting health and its impact on sexual health have been mentioned above. Changing patterns of drug use, injecting drug use itself, and the exchange of sex for money or other gain can also introduce new risks for the marginalised young person, as well as compounding existing risks to their sexual health.
SECTION THREE: RESEARCH METHODOLOGY

3.1 A FRAMEWORK FOR TRAINING NEEDS ASSESSMENT

A needs assessment is generally the first phase towards informing government on the direction of a policy or strategy regarding a particular issue or group (Neuman 1991). In order for Queensland Health to determine the direction of training initiatives for workers throughout Queensland who undertake both formal and informal sexual health interventions with marginalised young people an assessment of the training requirements needed to be established. The most effective way of investigating these requirements was deemed to be via a needs assessment.

To assess the sexual health training requirements of people who work with marginalised young people a needs assessment was undertaken throughout Queensland. A thorough needs assessment seeks to identify “…both the expressed and the less visible needs of a target group as well as the more serious or widespread needs…[and] must trace links among related needs to identify those of highest priority” (Neuman 1991: 25). In this instance the primary target group was workers in the field. The literature suggests that asking workers directly what their training needs are is not necessarily an effective means of identifying training requirements, as the researcher can end up with a ‘wish list’ (Holton, Bates and Naquin 2001), rather than an exploration of the issues. Furthermore, this investigation sought to establish the deficits in sexual health knowledge as a way of identifying the training needs that are not necessarily recognized by the workers themselves.

3.1.1 Needs Framework for SNAP

This needs assessment attempted to incorporate the three main levels of analysis that are typical of this type of investigation. These levels are organisational, operational and individual (in Holton, Bates and Naquin 2001). Additionally, the assessment endeavored to explore regionally based issues, both at the level of service delivery and through identifying the sexual health issues faced by marginalised young people in the various health zones. This framework is depicted in Figure 1 below.

Figure 1: Breakdown of Needs Assessment
3.1.2 Limitations of this Framework

There was a range of difficulties encountered in undertaking a needs assessment of this type. These difficulties arose because Queensland is such a large geographical area and there are also broad ranging and diverse services that undertake both formal and informal sexual health interventions in the State. Both the difficulties and benefits that informed the research design of this needs assessment are outlined in Table 1.

Table 1: Difficulties and Benefits of Needs Assessment

<table>
<thead>
<tr>
<th>Difficulties</th>
<th>Benefits</th>
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<tr>
<td>Very large geographical area</td>
<td>Most effective means of identifying training needs</td>
</tr>
<tr>
<td>Diversity of services undertaking formal and informal sexual health interventions with marginalised young people</td>
<td>Research being carried out by two youth services</td>
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<tr>
<td>‘Marginalised’ can be interpreted differently depending on the geographic and cultural environment</td>
<td>Research informing development of training package</td>
</tr>
<tr>
<td>Training needs will differ according to the priority given to sexual health in particular organisations</td>
<td>A range of diverse services have input into training package</td>
</tr>
<tr>
<td>No way of obtaining a representative sample</td>
<td>Develop a data base of organizations throughout Queensland who work with / have contact with marginalised young people</td>
</tr>
<tr>
<td>Queensland Health definition of Sexual Health is not universal</td>
<td>Complimentary data collection methods – quantitative and qualitative</td>
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A number of these difficulties are relevant to the interpretation of data that has been obtained for the needs assessment and these difficulties will be referred to below where relevant.

3.2 RESEARCH METHODS

3.2.1 Development of database

In consultation with the steering committee, it was decided that a database of services whose clientele included marginalised young people throughout Queensland be established. Selection of services for the database was not restricted to youth or health specific services. It was acknowledged by the steering committee that there is a range of diverse services, for example housing and accommodation services, neighbourhood centres and in some rural and regional centres PCYC’s (Police Citizens Youth Clubs), which undertake informal sexual health interventions in the course of their service delivery. It was felt that eliciting information from the more marginalised services would be a key component in developing an effective sexual health training package for Queensland, particularly for those regions that have limited access to specialised youth services and/or sexual health workers.
Initial searches for the database were carried out using existing databases in the youth sector. These were obtained through Kids Help Line and Queensland Health. A number of additional databases were obtained from community sector organisations such as QUAC (Queensland AIDS Council), SQWISI (Self-Health for Queensland Workers in the Sex Industry), Multi-Cultural services, Community Health Services and YANQ (Youth Advocacy Network Queensland). Key youth organisations in the various regions were also contacted to obtain local directories. The final database consisted of 806 organisations.

3.2.2 Sampling Issues and the database

The database formed the basis of the sample of respondents for the survey. Attempts were made to obtain the name and position of the sexual health worker and/or key worker in each organisation. This was undertaken in order to verify that the organisation had contact with marginalised young people and undertook formal or informal sexual health interventions with marginalised young people. Furthermore, targeting individual workers by name within an organisation was seen as a means of maximising the survey response rate. However, successful contact with all organisations listed on the database was not achieved in all instances.

The database sample was a non-probability sample and was obtained through a purposive sampling technique. Whilst this technique is not ideal in that it does not achieve a representative sample, it is acceptable for exploratory research (Neuman, 1991) of this type.

Quantitative data collected through this method of sampling does not allow for generalisations across all people who carry out sexual health interventions with marginalised young people in Queensland. This sampling method was, however, perceived to be an effective means of being broadly inclusive, by gaining access to, and retrieving information from, a large number of respondents who are frequently overlooked in this type of research.

3.2.3 Sampling and Focus Group Participants

To complement the statistical data collected eighteen focus groups were conducted in various cities and towns across Queensland (see Table 2).

The focus groups were conducted in order to provide some qualitative depth and intensify the results of the survey data. Youth workers from Brisbane Youth Service and Youth Link facilitated the focus groups. Ten questions drawn from the survey were explored in each focus group.

Participants in the focus groups were also obtained via purposive sampling techniques. The criterion for participation in the focus groups was organisations that carry out sexual health interventions with marginalised young people as part of their core service delivery. The majority of organisations were chosen according to this criterion, however for a number of the rural and regional centres where fewer organisations undertake direct sexual health service delivery the criterion was expanded. In these locations the criterion was expanded to accord with the make up of services. These organisations were all drawn from the database. Ten to twelve participants were invited from each site.
The criteria used to identify potential focus groups participants included:
- Those working directly with the sexual health needs of marginalised young people
- By regional standards, i.e. having the greatest focus on sexual/ injecting health issues
- A mixture of government and non-government organisations
- Time and cost restraints in terms of travel

The focus groups were undertaken in a range of locations in order to explore the way in which sexual health training needs vary regionally. The selection of focus group participants varied based upon location. This was an inevitable consequence of locational differences in the numbers and expertise of workers with some responsibility for sexual health matters. Accordingly, participant selection was flexible enough to cater to the idiosyncrasies of particular sites. Therefore, in some sites focus groups were made up of both core sexual health workers and those who undertake sexual health interventions on the basis of necessity or at least on a more informal basis.

This was not seen to be problematic in terms of data collection as it was perceived that workers who undertake sexual health interventions as periphery to their core duties could bring a wealth of information regarding sexual health training needs in a number of the more isolated and less resourced areas in Queensland. Table 2 outlines the focus group sites and the health zones. Generally, ten to twelve organisations were invited from each location. It should be noted that there were variations in participation rates. Overall, focus groups carried out in the Southern and Central Health Zones had a higher level of participation than those carried out in the Northern Health Zone. This has been considered in the data interpretation.

Table 2: Focus Group Locations

<table>
<thead>
<tr>
<th>Location</th>
<th>Health Zone</th>
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<tr>
<td>Brisbane South</td>
<td>Southern</td>
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<td>Gold Coast</td>
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<td>Toowoomba</td>
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<td>Dalby</td>
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<td>Roma</td>
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<td>Brisbane North</td>
<td>Central</td>
</tr>
<tr>
<td>Sunshine Coast</td>
<td></td>
</tr>
<tr>
<td>Gympie</td>
<td></td>
</tr>
<tr>
<td>Maryborough</td>
<td></td>
</tr>
<tr>
<td>Rockhampton</td>
<td></td>
</tr>
<tr>
<td>Emerald</td>
<td></td>
</tr>
<tr>
<td>Gladstone</td>
<td></td>
</tr>
<tr>
<td>Cairns</td>
<td>Northern</td>
</tr>
<tr>
<td>Townsville</td>
<td></td>
</tr>
<tr>
<td>Mt Isa</td>
<td></td>
</tr>
<tr>
<td>Tablelands</td>
<td></td>
</tr>
<tr>
<td>Cooktown</td>
<td></td>
</tr>
<tr>
<td>Innisfail</td>
<td></td>
</tr>
</tbody>
</table>
Attention has been given to ensuring that the focus group data referred to throughout this report is reflective of the perspectives of a range of the participants and consistent across several of the localities. Responses from the focus groups have been categorised based on the principles of content analysis, however frequencies have not been tabulated into the identified categories. As the cost of transcription of audio tape recordings of the focus groups was prohibitive, this analysis has relied on the extensive notes taken by the facilitators.

3.2.4 Questionnaire Development and Distribution
The questionnaire was divided into the following sections:
- Demographics
- Organisational profile and service provision
- About your clients
- Sexual health interventions and barriers to sexual health
- Skills and training

The questionnaire was predominantly made up of fixed response questions and a few open ended questions. The questionnaire was informed by a questionnaire developed for the Sexuality, Homelessness and Young People Project (1997) carried out by the Centre for the Study of Sexually Transmissible Disease, La Trobe University. The development of the questionnaire was also informed by consultations with the steering committee, including Queensland Health representatives. A range of issues, including time constraints impacted on the development of the questionnaire and the capacity of the youth services to pre-test it. In the final analysis, these issues impacted on the quality of the questionnaire.

Eight hundred and four (N=804) questionnaires were distributed throughout Queensland to individual workers identified through the database. Included with the questionnaires was a letter from Brisbane Youth Service and Youth Link informing prospective respondents about the project as well as a self-addressed postage paid return envelope. Respondents were given five weeks to return the questionnaire and a reminder letter was sent to the entire sample two weeks after the questionnaires were distributed. In total 225 completed questionnaires were returned and the response rate was approximately 28%. This is a satisfactory response rate for this type of survey.
SECTION FOUR: SEXUAL HEALTH WORKFORCE

4.1 ABOUT THE SEXUAL HEALTH WORKFORCE

As described previously, 225 completed questionnaires were received or approximately 28% of those who received the questionnaire. Three quarters of those who were surveyed were female (n=165) (75%), 53 were male and 1 transgender. Forty percent (n=86) of those surveyed were from the Central Health Zone, 30% (n=66) were from Southern Health Zone and 30% (n=64) were from the Northern Health Zone, and 6 did not indicate zone. Eighty percent of people surveyed were full-time workers and 20% part-time and the average length of experience working in current position with marginalised young people was 5.65 years (range 1-30 years).

4.1.1 Organisation Type and Location

Table 3 outlines the types of organisations included in the survey.

A number of respondents who did not specify their specific organisation nominated the their organisation as ‘Queensland Health’. This does not however mean that there were not a range of other organisations that are funded by Queensland Health included in the survey. Tables 4, 5 and 6 outlines the organisations by Health Zone. There was a relatively even distribution of respondents throughout all three zones, however it should be noted that there are metropolitan, regional and rural centres in each of the zones.

Table 3: Categories of Organisation - frequency and percentage

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Frequency</th>
<th>Valid Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health</td>
<td>20</td>
<td>8.9</td>
</tr>
<tr>
<td>Community Youth Organisations</td>
<td>47</td>
<td>20.9</td>
</tr>
<tr>
<td>Queensland Health</td>
<td>61</td>
<td>27.1</td>
</tr>
<tr>
<td>Community Services</td>
<td>50</td>
<td>22.2</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>40</td>
<td>17.8</td>
</tr>
<tr>
<td>Total</td>
<td>218</td>
<td>96.9</td>
</tr>
<tr>
<td>Missing</td>
<td>7</td>
<td>3.1</td>
</tr>
<tr>
<td>Total</td>
<td>225</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### Table 4: Categories of Organisations by Central Health Zone – frequency and percentage

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Frequency</th>
<th>Valid Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health</td>
<td>7</td>
<td>8.4</td>
</tr>
<tr>
<td>Community Youth Organisations</td>
<td>18</td>
<td>21.7</td>
</tr>
<tr>
<td>Queensland Health</td>
<td>24</td>
<td>28.9</td>
</tr>
<tr>
<td>Community Services</td>
<td>16</td>
<td>19.3</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>18</td>
<td>21.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>83</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>86</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Table 5: Categories of Organisations by Southern Health Zone – frequency and percentage

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Frequency</th>
<th>Valid Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health</td>
<td>7</td>
<td>10.9</td>
</tr>
<tr>
<td>Community Youth Organisations</td>
<td>17</td>
<td>26.6</td>
</tr>
<tr>
<td>Queensland Health</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>Community Services</td>
<td>13</td>
<td>20.3</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>11</td>
<td>17.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>66</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Table 6: Categories of Organisations by Northern Health Zone – frequency and percentage

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Frequency</th>
<th>Valid Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health</td>
<td>6</td>
<td>9.5</td>
</tr>
<tr>
<td>Community Youth Organisations</td>
<td>10</td>
<td>15.9</td>
</tr>
<tr>
<td>Queensland Health</td>
<td>19</td>
<td>30.2</td>
</tr>
<tr>
<td>Community Services</td>
<td>18</td>
<td>28.6</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>10</td>
<td>15.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>63</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64</strong></td>
<td></td>
</tr>
</tbody>
</table>
4.1.2 Occupational Categories

Table 7 reports the breakdowns of those surveyed by occupational categories. The majority of those surveyed were nurses (27%) followed by those who held managerial positions such as co-ordinators, managers and director (25%) and those who held positions as health and training education officers and youth workers (7%).

Table 7: Occupation by Frequency and Percentage

<table>
<thead>
<tr>
<th>Position</th>
<th>Frequency</th>
<th>Valid Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>7</td>
<td>3.2</td>
</tr>
<tr>
<td>Nurse</td>
<td>58</td>
<td>26.5</td>
</tr>
<tr>
<td>Doctor</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>Health and Training Education Officers</td>
<td>16</td>
<td>7.3</td>
</tr>
<tr>
<td>Psychologists/ Counsellors/ Social Workers</td>
<td>15</td>
<td>6.8</td>
</tr>
<tr>
<td>Youth Workers</td>
<td>16</td>
<td>7.3</td>
</tr>
<tr>
<td>Co-Ordinators/Managers/ Directors</td>
<td>54</td>
<td>24.7</td>
</tr>
<tr>
<td>Guidance Officers</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>Artistic Director</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Tutor</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Welfare Project Officers</td>
<td>13</td>
<td>5.9</td>
</tr>
<tr>
<td>Housing Support Workers</td>
<td>10</td>
<td>4.6</td>
</tr>
<tr>
<td>Sexual Health Workers</td>
<td>5</td>
<td>2.3</td>
</tr>
<tr>
<td>Family Support Officers</td>
<td>6</td>
<td>2.7</td>
</tr>
<tr>
<td>Team Leader</td>
<td>6</td>
<td>2.7</td>
</tr>
<tr>
<td>Alcohol and Drug Workers</td>
<td>4</td>
<td>1.8</td>
</tr>
<tr>
<td>Volunteer</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Total</td>
<td>219</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>225</td>
<td></td>
</tr>
</tbody>
</table>

4.1.3 Organisation of the data

Overall, respondents have been identified as belonging to groups within two central categories. These two central categories are Health Zones – “Central”, “Northern” and “Southern” - and priority given to sexual health and injecting drug needs of marginalised young people within an organisation - “high to moderate” and “low to not”. The high to moderate priority organisations assign a 51% and above priority to sexual health and injecting drug needs of young people, while the low to not priority organisations assign a priority of 50% and below.

The survey results have generally been reported using these two groupings. Focus group data has been drawn upon throughout this report as a means of intensifying themes evident in the survey or by presenting issues that are situated in contrast to the survey results.
4.2 DATA DEFINITIONS AND INTERPRETATIVE DILEMMAS

The intention of the current research is to identify the training needs of people (referred to here as ‘workers’) who undertake formal and informal sexual health interventions with marginalised and at risk young people. Throughout the research process, it has become increasingly evident that the training needs of workers are subject to variation depending on a range of factors. A number of these factors will be discussed throughout this report. The results of the needs assessment bring to light the complexity of the issues pertaining to undertaking sexual health interventions with marginalised young people in Queensland. The range of interpretations of, and/or variations within, the primary topics under investigation – “sexual health interventions” and “marginalised young people” - further compound this complexity. This section explores how these conceptual issues impact on training needs and data interpretation.

4.2.1 Research Categories

In assessing the sexual health training needs of workers in the field, two central foci provide the basis of this needs assessment:

1. Sexual Health
2. Marginalised Young People

These two foci or categories may be seen as prescribed in so far as they define the topic of research. It was necessary to isolate these components in the research design phase in order to sequester the scope and boundaries of the study. They were used to determine the range of issues to be investigated, as well as to identify appropriate participants. Nevertheless, despite the utility of these categories in the research design process, the practical, conceptual and interpretational difficulties that result from their use should not be ignored. The following provides an overview of these categories, drawing attention to their limitations with respect to the current study.

4.2.2 Sexual Health

The World Health Organisation (WHO 2000) defines the concept of sexual health to include three basic elements:

*A capacity to enjoy and guide sexual and reproductive behaviour in accordance with a social and personal ethic.*

*Freedom from fear, shame, guilt, false beliefs and other impairing psychological factors which inhibit sexual response and affect social-sexual relationships.*

*Freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions.*
Queensland Health (1998) further adds:

A holistic approach to young people’s sexual health builds on this definition by considering sexuality within the context of lives and culture. It is difficult to isolate sexual health from other aspects of their lives, but as a minimum, needs to include sexuality and sexual well-being, reproductive health and pregnancy, and the effects of sexual violence. For the purpose of this review, sexual health is also extended to include matters related to blood-borne viruses such as hepatitis C (although sexual transmission is rare) because of the commonality in unsafe behaviours which can lead to infection.

The instruments used in this study were designed to measure aspects of sexual health referred to in the above descriptions. Through situating sexual health in a holistic framework it is possible to conceive of a wide variety of activities, situations and life circumstances that will influence a marginalised young person’s sexual health. Interventions therefore must be flexible and diverse in order to meet the specific needs of the marginalised young person. Some may target obvious sexual health issues such as transmission of STIs, pregnancy, sexual violence, etc. Others may not necessarily target sexual health issues directly, yet have a net result of improving the sexual health of marginalised young people. Examples of these interventions include those targeting injecting drug use practices and facilitating access to housing and employment.

However, while the research incorporates a holistic understanding of sexual health and endeavours to explore sexual health training needs in this framework, it is necessary to recognise the potential influence of “common sense” interpretations of the term. Given that many of the participants in the research do not undertake sexual health interventions as a core activity and/or lack adequate training with respect to sexual health, it is inevitable that many are not well rehearsed in conceptualising sexual health in a holistic fashion.

The tendency for participants to interpret sexual health in terms of a limited number of items relating directly to sexual practices was also noted by the youth workers from Brisbane Youth Service who facilitated the focus groups held in the Southern and Central Health Zones. Subsequent to the first focus group, these youth workers found it necessary to initially explain to the participants the way in which sexual health is understood in broad holistic terms. This was done in order to stimulate discussion regarding the range of issues that relate to sexual health over and above the ‘obvious’.

Similarly, the survey administered included the excerpt from Queensland Health’s Review of Sexual Health and Young People at Risk cited above, that describes a holistic understanding of sexual health. However, despite that some effort has been made to encourage participants in the research to interpret sexual health in a holistic fashion, it should be recognised that this does not preclude “common sense” understandings from prevailing and subsequently influencing the nature of some responses. This issue has been highlighted throughout this report, where relevant.
4.2.3 Marginalised young people

The current research has been conducted with people who undertake service delivery with “marginalised and at risk young people” in Queensland. The category “marginalised young people” therefore operates to identify the research participants as well as to indicate the range of sexual health issues that are relevant to the training needs of the participants. According to Queensland Health (1999: 4):

> Research confirms that there are populations of young people who are at increased risk of poor sexual health because their circumstances, environment and behaviours compound and can lead them to becoming disenfranchised from mainstream support. Marginalisation can lead to risky sexual and injecting practices. Examples include those with emerging homosexual or bisexual identity, those young people who are homeless or at risk of being homeless, those who have or are experiencing violence, abuse, or non-consensual sex, young offenders, and those for whom foster care arrangements are not appropriate.

This description of marginalised young people provided in the survey sets this category up with specific reference to “increased risk of poor sexual health” in the absence of “mainstream support”. For the purpose of this research, this is an adequate point of reference that achieves an appropriate distinction between “marginalised” young people and young people in general with respect to the need for sexual health interventions. Nevertheless, the category of “marginalised young people” may be subject to some internal and geographical variation. Variations internally stem from the fact that there are a wide range of “circumstances, environment and behaviours” that may lead a young person to become ‘marginalised’ from mainstream support. These can include family background, living conditions or circumstances, culture, drug use, general health issues, mental health, life events and limited access to services.

As outlined above, many of these issues compound, however it is reasonable to expect that all may not be relevant to a single young person who may nevertheless be described as “marginalised”. Consequently, the need for sexual health interventions will inevitably differ depending on the factors that contribute to the marginalisation of an individual or clusters of individuals.
SECTION FIVE: DATA ANALYSIS AND FINDINGS

5.1 SEXUAL HEALTH ISSUES OF MARGINALISED YOUNG PEOPLE

The questionnaire asked respondents to rank the categories of marginalised young people with whom they most often worked. The results are outlined in Tables 8 and 9. However, before moving to a discussion of the results, it is important to highlight the way in which many of these categories can overlap. Consequently, the identification of young people according to these factors is reliant on the respondents’ perceptions of either the central source of a young person’s marginalisation or a young person’s main reason for accessing their services.

For example, a young person who is identified as “homeless” may also be indigenous, a survivor of child sexual abuse and/or accessing HIV/STI prevention education. Similarly, a young person accessing drug and alcohol education may simultaneously be an injecting drug user, a young mother/father and/or a sex worker.

The way in which respondents have categorised marginalised young people may be influenced by a number of factors including their experience with marginalised young people, training and occupation, the type of organisation within which the respondent works, their own attitudes and environmental influences. Interpretative variations and the subjective basis by which respondents may have identified characteristics of marginalised young people should be considered when interpreting Table 8.

Table 8 outlines the most prevalent categories of marginalised young people with whom the survey respondents work by Health Zone. Table 9 outlines the most prevalent categories of marginalised young people with whom the survey respondents work by the organisational priority given to sexual health issues.
Table 8: Five major categories of Marginalised Young People by Health Zone and total sample

<table>
<thead>
<tr>
<th>CENTRAL (n=86)</th>
<th>SOUTH (n=66)</th>
<th>NORTH (n=64)</th>
<th>TOTAL (N=225)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Homeless</td>
<td>• Homeless</td>
<td>• Indigenous</td>
<td>• Homeless</td>
</tr>
<tr>
<td>• In supported housing</td>
<td>• Accessing drug and alcohol education</td>
<td>• Homeless</td>
<td>• Accessing drug and alcohol treatment</td>
</tr>
</tbody>
</table>
| • Survivors of child sexual abuse | • In domestic violence situations  
  • Survivors of child sexual abuse | • Rural/remote | • Survivors of child sexual abuse |
| • Mental illness | • Young mothers | • Young mothers | • Mental illness  
  • Young mothers |
| • In domestic violence situations | • Indigenous | • Accessing HIV/STI prevention education/ support  
  • Accessing clinical services | • In domestic violence situations |

Table 9: Five Major Categories of Marginalised Young People by Priority Organisation

<table>
<thead>
<tr>
<th>High to Moderate Priority Organisations (n=143)</th>
<th>Low to Not A Priority Organisations (n=82)</th>
</tr>
</thead>
</table>
| Homeless  
Accessing drug and alcohol treatment  
Survivors of child sexual abuse  
Mental illness  
Domestic violence | Homeless  
Domestic violence  
Housing  
Young mothers  
Mental illness |
5.1.1 Geographical and Organisational Issues

Table 8 and 9 reveal that there are some geographical and organisational variations in the characteristics of marginalised young people with whom respondents have most frequent contact.

Overall, survey respondents reported that of the marginalised young people they worked with, young people marginalised due to homelessness most frequently accessed their services. In all three regions, homelessness was reported to be a common characteristic of young people with whom the respondents worked, scoring as the ‘most frequent’ group of marginalised young people in the Central and Southern Zones and ‘second most frequent’ group in the Northern Zone. Homeless young people were identified consistently by workers in high to moderate and low to not priority organisations as their ‘most frequent’ contact.

The only differences between the categories of young people frequently accessing organisations was that in the high to moderate organisational grouping, marginalised young people frequently sought support for alcohol and drug treatment and childhood sexual abuse. In the low to not a priority group, workers more frequently provided support to young mothers and marginalised young people with housing needs.

Notably, the workers in the Northern Zone worked ‘most frequently’ with indigenous young people. Given that overall and in the Central Zone, “indigenous” as a category did not score at all in the top five, and in the Southern was listed only ‘fifth most frequent’, this group of marginalised young people appear to be clustered in the Northern Zone.

There is, however, recognition that interpretations can be subjective and based upon geographical, cultural and social influences. Therefore, there is a possibility that the high number of indigenous young people in the Northern Zone may lead respondents to classify a person as “indigenous” before “homeless” or “injecting drug user”, etc. Also specific to the Northern Zone is the common classification of marginalised young people on the basis of “rural/remote”. This highlights the way in which the environment is seen to contribute to marginalisation.

Focus group data collected in Innisfail and Cooktown supports the contention that regional isolation may contribute to the marginalisation of some young people. Further to this, the data highlights the reflexive relationship between marginalisation and sexual health risk behaviours of young people. Several features of rural communities were outlined in response to the question “What are the major issues that impact on the sexual health behaviours of marginalised young people in your region?”

The focus group participants from Innisfail strongly emphasised the dominant role of the community in rural towns in as much that tension exists between the beliefs and values of the hegemonic community and the more marginalised youth culture. Reference was also made to young people feeling “left behind” in Innisfail, which can impact on their self-esteem. In Cooktown the focus group participants highlighted isolation and a lack of community support as impacting upon the sexual health behaviours of marginalised young people. In both of these focus groups further reference was made to the lack of educational and employment opportunities in these areas.
While these comments were produced with respect to the issues that impact upon the sexual health behaviours of marginalised young people, they also implicitly suggest that it is these issues that contribute to marginalisation in the first place. It is therefore necessary to acknowledge that while marginalisation can lead a young person to engage in risky sexual health behaviours, it is also possible that the sexual health behaviours of some young people may contribute to their marginalisation.

**IMPLICATIONS FOR TRAINING**

The primary characteristics of marginalised young people with whom workers have contact should be taken into account when developing training programs. To ensure that sexual health interventions are undertaken in a holistic manner, sexual health workers should be equipped with the knowledge and skills to access additional support that will assist young people to overcome the factors that led to their marginalisation. Alternately, workers who are undertaking interventions, such as housing or mental illness, should be trained to be aware of the sexual health implications of the young persons marginalisation and access appropriate support.

### 5.2 SEXUAL HEALTH AND INJECTING DRUG USE RISK BEHAVIOURS

In order to identify the most prevalent issues for which training is required, an exploration of the range of sexual health issues that are commonly experienced by marginalised young people with whom workers have contact, has been undertaken. In the survey questionnaire, respondents were asked to identify the “five most prevalent ‘risk’ sexual health and injecting drug use (IDU) behaviours [of marginalised young people] in [their] geographical area”. Tables 10 and 11 outline these results.

Table 10: Five most prevalent ‘risk’ sexual health and injecting drug use behaviours by organisational priority

<table>
<thead>
<tr>
<th>TOTAL SAMPLE (N=225)</th>
<th>HIGH/MOD PRIORITY ORGANISATIONS (n = 144)</th>
<th>LOW/NOT PRIORITY ORGANISATIONS (n = 81)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsafe vaginal intercourse (no condom)</td>
<td>Unsafe vaginal intercourse (no condom)</td>
<td>Unsafe vaginal intercourse (no condom)</td>
</tr>
<tr>
<td>Risky forms of contraception</td>
<td>Unsafe vaginal oral sex (no dental dam)</td>
<td>Sexual assault</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>Sexual assault</td>
<td>Risky forms of contraception</td>
</tr>
<tr>
<td>Underage sex</td>
<td>Underage sex</td>
<td>Underage sex</td>
</tr>
<tr>
<td>Sharing syringes Intoxication (drugs and/or alcohol)</td>
<td>Intoxication (drugs and/or alcohol)</td>
<td>Sharing syringes and intoxication (drugs and/or alcohol)</td>
</tr>
</tbody>
</table>

*Multiple responses possible*
Table 11: Five most prevalent ‘risk’ sexual health and injecting drug use behaviours by health zone

<table>
<thead>
<tr>
<th>CENTRAL (n=86)</th>
<th>SOUTHERN (n=66)</th>
<th>NORTHERN (n=64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsafe vaginal intercourse (no condom)</td>
<td>Unsafe vaginal intercourse (no condom)</td>
<td>Unsafe vaginal intercourse (no condom)</td>
</tr>
<tr>
<td>Unsafe vaginal oral sex (no dental dam)</td>
<td>Unsafe vaginal oral sex (no dental dam)</td>
<td>Risky forms of contraception</td>
</tr>
<tr>
<td>Risky forms of contraception</td>
<td>Sexual assault</td>
<td>Sexual assault</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>Underage sex</td>
<td>Underage sex</td>
</tr>
<tr>
<td>Underage sex</td>
<td>Intoxication (drugs and/or alcohol)</td>
<td>Intoxication (drugs and/or alcohol)</td>
</tr>
<tr>
<td>Intoxication (drugs and/or alcohol)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Multiple responses possible

Results from Tables 10 and 11 suggest that the most prevalent sexual risk behaviours are generally consistent across organisations and regions. Interestingly, ‘intoxication (drugs and/or alcohol)’ was noted as a risk sexual health issue across all Health Zones. This was regardless of whether respondents were from high to moderate or low to not priority organisations.

The only inconsistencies that arose with respect to prevalent risk behaviours relate to unsafe vaginal oral sex and sharing syringes. Notably, unsafe vaginal oral sex was categorised as the second most prevalent in the high to moderate priority organisations. With respect to injecting drug use risk behaviours, sharing syringes was only reported as the fifth most prevalent risk behaviour in total and by respondents who worked in low to not priority organisations.

The relative lack of reference to injecting drug use behaviours as a prevalent issue for workers in high to moderate priority organisations is potentially a result of workers not conceptualising drug use in the context of sexual health. This is supported by results that show that the workers who were employed in drug and alcohol organisations only ranked “sharing syringes” as the third most prevalent sexual risk behaviour after “unsafe vaginal intercourse” and “sexual assault”.

**IMPLICATIONS FOR TRAINING**

The reported prevalence of particular ‘risk’ sexual behaviours engaged in by marginalised young people (documented in Tables 10 and 11) should provide a guide to the subject matter of training schemes, particularly in their initial stages. To focus on sexual health specific information and skills that are most relevant to the common sexual health behaviours of their client group will provide a sound foundation for further training. However, training packages should not be limited to educating workers on the sexual health ‘risk’ behaviours of marginalised young people.
5.3 BARRIERS FOR YOUNG PEOPLE

There is a range of reasons why marginalised young people may engage in ‘risk’ sexual health behaviours. Recognising the influences that affect sexual health practices among this group is pertinent in the development of training schemes that will facilitate the application of successful interventions by workers in the field.

In the survey, respondents were asked to rank in order of importance, five barriers to resources and five interpersonal barriers that prohibit marginalised young people from engaging in safer sexual health and injecting drug use practices. The results are outlined in Table 12.

Table 12: Interpersonal and Resource Sexual Health Barriers for Marginalised Young People

<table>
<thead>
<tr>
<th>Total sample (N=225)</th>
<th>High to Moderate Priority (n=143)</th>
<th>Low to Not A Priority (n=82)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BARRIERS RESOURCES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack youth friendly services</td>
<td>Lack youth friendly services</td>
<td>Lack youth friendly services</td>
</tr>
<tr>
<td>Lack knowledge</td>
<td>Confidentiality fear</td>
<td>Lack of knowledge</td>
</tr>
<tr>
<td>Confidentiality fears</td>
<td>Lack knowledge</td>
<td>Confidentiality fear</td>
</tr>
<tr>
<td>Expense of contraception</td>
<td>Expense contraception</td>
<td>Low literacy skills</td>
</tr>
<tr>
<td>Access to contraception</td>
<td>Low literacy levels</td>
<td>Transient lifestyle</td>
</tr>
<tr>
<td>Low Literacy skills</td>
<td>Low literacy levels</td>
<td></td>
</tr>
<tr>
<td><strong>BARRIERS to INTERPERSONAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low self worth</td>
<td>Low self worth</td>
<td>Low self worth</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Substance abuse</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Lack of negotiation skills</td>
<td>Lack negotiation skills</td>
<td>Pressure to have sex</td>
</tr>
<tr>
<td>Pressure to have sex</td>
<td>Pressure to have sex</td>
<td>Lack negotiation skills</td>
</tr>
<tr>
<td>Invincibility</td>
<td>Unplanned sex</td>
<td>Invincibility</td>
</tr>
</tbody>
</table>

The survey respondents were generally consistent in their identification of barriers that young people face with respect to resources, service access and information relevant to sexual health matters. Respondents from both high to moderate and low to not priority organisations report that the “lack of ‘youth friendly’ services” is the most important barrier for marginalised young people in this regard.

Notably, neither a “lack of prevention education services” nor a “lack of clinical services” rated in the five most important barriers to resources suggesting that it is the ‘youth friendly’ aspects of some of these organisations that is left wanting. The only significant variation with respect to reported barriers to resources by participants from different level priority organisations is the increased tendency for respondents from high to moderate priority organisations to rate the expense of, and access to contraception as an important barrier. Respondents from low to not priority organisations did not identify any specific sexual health resources as a barrier. This is possibly due to the fact that sexual health specific issues are periphery to the core duties of the latter group.
Types of interpersonal barriers that inhibit young people’s ability to effectively engage in safer sexual health and injecting drug use practices were also identified consistently by respondents from both high to moderate and low to not priority organisations. Interestingly, substance abuse was rated the second most important barrier by the total sample as well as both priority organisation groupings, yet a “lack of access to safe injecting equipment” was not rated at all in the top five barriers to resources.

Given that “intoxication” was seen as a significant sexual health risk behaviour by respondents (outlined in Tables 10 and 11), it is possible that many of them perceive substance abuse to be an important barrier in terms of marginalised young people’s sexual behaviour because of the effect the substance has on decision making rather than the method of administering the substance. While a number of focus group participants do refer to unsafe injecting practices, it is the issue of intoxication that is perceived as more problematic in terms of risky sexual health practices.

The barriers that marginalised young people face are important indicators of the type and nature of sexual health specific and generic interventions that will increase their ability to exercise safer sexual health practices. Clearly, many of the factors that most workers identify as ‘barriers’ to safer sexual health practices are not related to sexual health specific issues. Many of these barriers may affect many aspects of a marginalised young person’s life including, yet not exclusive to, sexual health. This highlights the benefits of conceptualising sexual health in a holistic fashion.

Focus group data provides some perspective of the various influences that impede marginalised young people’s ability to engage in safe sexual health practices. These are summarised in Table 13.

Table 13: Specific and General Influences on the Sexual Health Practices of Marginalised Young People

<table>
<thead>
<tr>
<th>Specific Influences</th>
<th>General Influences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of access to resources, particularly contraception, including condoms</td>
<td>Belief systems</td>
</tr>
<tr>
<td>Lack of Sexual Health Knowledge</td>
<td>Lack of future life goals</td>
</tr>
<tr>
<td>Sexual Health Myths e.g incorrect sexual health information perpetuated by peers, parents and the community</td>
<td>Low self-esteem, lack of assertiveness and low level negotiation skills</td>
</tr>
<tr>
<td>Relationships – prioritise relationship over safe sex and safe injecting practices</td>
<td>Parental and community attitudes and inadequate support</td>
</tr>
<tr>
<td>Effects of drugs and alcohol on decision making processes</td>
<td>Organisational discrimination, particularly related to a fear of disclosure in Schools</td>
</tr>
<tr>
<td>Media and popular portrayals of ‘normal’ sexual behaviour that conflicts with the safe sex message</td>
<td>Cultural</td>
</tr>
<tr>
<td>Lack of visible and tangible evidence of the effects of unsafe sexual health practices</td>
<td></td>
</tr>
</tbody>
</table>
The influences outlined in the above table present evidence of complexity of issues confronting marginalised young people that inevitably impact on their sexual health practices. These issues highlight the necessity to compliment sexual health training packages with broader campaigns that target and stimulate change at a number of levels.

### IMPLICATIONS FOR TRAINING

<table>
<thead>
<tr>
<th>Sexual health training should incorporate the provision of both sexual health specific and general information to workers in the field:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Sexual health specific training issues are addressed in more detail below.</td>
</tr>
<tr>
<td>- General training refers to equipping workers in the field with the appropriate knowledge and skills to address the more generic influences that affect marginalised young people’s ability to engage in safer sexual health practices. Focus group participants mentioned a range of general training needs that will enhance their ability to work with marginalised young people and consequently, to undertake sexual health interventions with this group:</td>
</tr>
<tr>
<td>- communicating with young people</td>
</tr>
<tr>
<td>- challenging attitudes of young people</td>
</tr>
<tr>
<td>- relationship building with young people</td>
</tr>
<tr>
<td>- culture (youth and ethnic)</td>
</tr>
<tr>
<td>- counselling and therapy skills, motivational interviewing</td>
</tr>
<tr>
<td>- conflict resolution and dealing with aggressive behaviours</td>
</tr>
<tr>
<td>- accessing resources such as housing and employment</td>
</tr>
<tr>
<td>- policy guidelines that address confidentiality and conduct issues when working with minors</td>
</tr>
<tr>
<td>- working with the community</td>
</tr>
</tbody>
</table>

It is important to note that some workers may have had some difficulty articulating their training needs in this respect. These issues highlight the importance of trainer flexibility and therefore applying the principles of Action Research to the conceptualisation of a training model would be of benefit in this regard.

### 5.4 CURRENT SEXUAL HEALTH (SPECIFIC) KNOWLEDGE OF WORKERS

In the development of future sexual health training schemes, it is important to take into account the current skills and knowledge of workers in the field. Survey respondents were asked to rate their level of knowledge and skills with respect to sexual health in general as well as Hepatitis C and HIV/AIDS. Of the total sample:

- The majority felt they had extensive knowledge of sexual health (43%). Just over a quarter were neutral (28%) and less than a third (29%) did not feel they had extensive knowledge of sexual health issues of marginalised young people.
- Approximately half of the sample (49%) felt that they had an extensive knowledge of the Hepatitis C needs of marginalised young people.
• There was a mixed reaction to knowledge of HIV/AIDS. The majority (39%) did not feel that they had an extensive knowledge of HIV/AIDS. Of the remainder, 29% were neutral and 32% felt they did have extensive knowledge of HIV/AIDS.
• Approximately half of respondents felt confident in carrying out sexual health (57%), Hepatitis C (50%), HIV/AIDS (47%) interventions.
• Whilst the majority of the respondents perceived they had adequate skills, just over a third of the sample believed they did not have adequate skills to carry out Hepatitis C and HIV/AIDS interventions.
• Regional comparisons show that there are no statistically significant differences between the levels of knowledge, skills and confidence of workers across regions.
• Workers from high to moderate priority organisations recorded higher degrees of sexual health knowledge and skills than those from low to not priority organisations.

It is interesting to note that whilst only 32% of respondents felt they had extensive knowledge of HIV/AIDS needs of marginalised young people, 47% of respondents claimed to feel confident when undertaking HIV/AIDS interventions. This discrepancy could suggest that the knowledge deficit exists with particular respect to the needs of marginalised young people rather than general knowledge regarding HIV/AIDS in particular.

### IMPLICATIONS FOR TRAINING

| Training programs that target various levels of sexual health expertise are required in order to cater for the varying needs of workers who undertake sexual health interventions with marginalised young people. The direction and content of training packages should take into account whether sexual health is a core or marginal aspect of the workers' service provision. Training packages should be graded by criteria that include skills and knowledge of sexual health and IDU and the priority of sexual health and IDU in service provision. Given that the priority attributed to sexual health by organisations is an indicator of the proportion of sexual health specific knowledge of workers this could be used to identify different ‘target groups’ for training. Other possibilities include targeting different ‘levels’ of training at workers based on their expertise or allowing workers to select the ‘level’ of training they feel is appropriate for them. |

### 5.5 INTERVENTIONS CURRENTLY EMPLOYED BY WORKERS

Survey respondents were asked to identify the types of sexual health information they had supplied on both a formal and informal basis to marginalised young people in the course of their service delivery.
Table 14: Top 5 Formal and Informal Sexual Health Interventions Nominated Across the Entire Sample

<table>
<thead>
<tr>
<th>Formal Sexual Health Interventions – top 5</th>
<th>Informal Sexual Health Interventions - top 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>referral 55%</td>
<td>safer sex 98%</td>
</tr>
<tr>
<td>self esteem 52%</td>
<td>assertiveness 61%</td>
</tr>
<tr>
<td>relationships 50%</td>
<td>sexual practices / relationships 60%</td>
</tr>
<tr>
<td>physical sexual development 49%</td>
<td>condoms 59%</td>
</tr>
<tr>
<td>gender issues/assertiveness 43%</td>
<td>public health, health promotion and</td>
</tr>
<tr>
<td></td>
<td>education 56%</td>
</tr>
<tr>
<td></td>
<td>self-esteem 53%</td>
</tr>
</tbody>
</table>

*Multiple responses possible

Respondents were asked to identify the types of formal and informal interventions that they had undertaken. Most notably, safer sex interventions were undertaken on an informal basis by 98% of the sample. Of those surveyed the most frequently identified formal sexual health interventions was referrals (55%). Self-esteem interventions were carried out on both a formal and informal basis by over 50% of the sample, and interventions regarding assertiveness skills by 43% and 61% respectively.

Whilst there is a range of interpretative limitations with respect to this data, it does provide an indicator of the approach taken by many workers in the field to the provision of particular interventions. Therefore, the development of a training package should consider a range of strategies that compliment the range of informal, and presumably opportunistic, interventions that are currently being carried out.

**IMPLICATIONS FOR TRAINING**

Training programs should be developed with reference to the types and styles of formal or informal interventions commonly undertaken by workers in the field. The interventions listed in Table 14 should guide the subject-matter of training programs. The research suggests that safer sex interventions, for example, are carried out by 98 per cent of the entire survey sample on an informal basis. Therefore, training that will enhance the capability of workers to undertake sexual health interventions opportunistically, situationally and informally is a way of increasing the number of successful interventions that are carried out in the field.

### 5.5.1 Interventions successful and unsuccessful

In the development and delivery of training programs it is important to consider the types of interventions that are already utilised by workers in the field. Taking note of workers opinions regarding the advantages and disadvantages of particular types of interventions is essential in order to establish ‘best-practice’ interventions. In other words, the provision of training with respect to interventions that are not deemed by workers to be useful or successful will potentially decrease their enthusiasm and willingness to participate. It is essential to recognise that while some workers in the field lack adequate sexual health training, their hands-on experience allows them to acquire a working knowledge of their target group and consequently, the types of sexual health interventions that are most useful.
Information pertaining to the level of success and innovation of sexual health interventions was collected in the questionnaire and focus groups. Survey respondents listed a range of intervention methods that they felt were either successful or unsuccessful in targeting young peoples sexual health needs. The more frequent responses have been categorised in Table 15.

Table 15: Successful and Unsuccessful Sexual Health Interventions

<table>
<thead>
<tr>
<th>Successful Interventions</th>
<th>Unsuccessful Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Informal education or interventions</td>
<td>• Overly formal education or interventions</td>
</tr>
<tr>
<td>• One-on-one education, interventions and referrals</td>
<td>• Mass interventions (large groups)</td>
</tr>
<tr>
<td>• Personal Counselling</td>
<td>• Information overloading</td>
</tr>
<tr>
<td>• Applied/interactive workshops</td>
<td>• Long education or intervention sessions</td>
</tr>
<tr>
<td>• Provision of sexual health specific resources (Including condoms and pregnancy tests)</td>
<td>• Culturally inappropriate interventions</td>
</tr>
<tr>
<td>• Use of printed resources that are ‘young people friendly’ – stickers, posters, KISS booklet</td>
<td>• Printed resources that are not ‘young people friendly’ – internet, pamphlets, brochures too wordy</td>
</tr>
</tbody>
</table>

The reasons given by respondents for the relative success / lack of success of the intervention methods described above were generally complementary. Factors absent from the unsuccessful interventions were those factors that were attributed to successful interventions and vice versa. Respondents regularly cited the ‘atmosphere’ that was created during interventions as contributing to their relative success or failure. Casual, non-threatening atmospheres for interventions were held in high regard. Overly formal atmospheres were noted to discourage disclosure on the part of young people.

Linked to ‘atmosphere’ is a range of responses that highlight the importance of building positive and trusting relationships with young people. Respondents placed particular emphasis on showing respect to marginalised young people, being non-judgmental, respecting confidentiality and listening to clients, as contributing positively to the success of an intervention. An informal setting inevitably facilitates the relationship-building process. Other comments from respondents centre around the issue of being ‘youth friendly’. Successful interventions were noted to be fun, lively, visual and invoke language that is youth focused and simple. Conversely, unsuccessful interventions were criticised for being insensitive to the capabilities of the client group invoking difficult language and attempting to provide too much information at once.
Focus group data supports the comments of survey respondents, particularly with respect to the need for a ‘young people friendly’ approach to service delivery and corresponding resources. Focus group participants referred regularly to factors such as the use of resources that are visually interesting and sensitive to the low level literacy skills of many marginalised young people. Further to this, peer education was singled out by focus group participants as an important ‘youth friendly’ approach to sexual health education amongst this target group.

### IMPLICATIONS FOR TRAINING

| Participants in the survey and focus groups were quite specific about the strategies that lead to the ‘success’ of sexual health interventions with marginalised young people. Enhancing workers ability to utilise these strategies, for example facilitating interactive workshops, should be a key goal of training programs. The availability of resources that complement these strategies will enhance the capacity of the workers to undertake successful interventions. |

#### 5.6 BARRIERS TO WORKERS’ ACCESS TO TRAINING AND SEXUAL HEALTH INTERVENTIONS

The ability of workers in the field to provide appropriate and successful sexual health interventions to marginalised young people is impeded by a variety of barriers that are linked, yet not exclusive to, appropriate training. This section includes a discussion of a range of issues that have been identified by participants in the research as barriers to their ability to provide adequate service delivery with respect to sexual health.

##### 5.6.1 Environmental and Geographical Issues

There are many environmental factors that influence workers’ abilities to undertake sexual health interventions with marginalised young people. Here, “environmental barriers” imply any circumstances or conditions surrounding a worker that may not be directly related to sexual health, yet nevertheless influence the degree to which sexual health interventions are carried out and the quality of such interventions. The following outlines the way in which geographical, organisational and attitudinal environments are reported by respondents to affect their ability to access appropriate training and to carry out sexual health interventions with marginalised young people.

According to the survey data, over a third of the sample (37%) reported that they felt too geographically isolated to access appropriate sexual health training and support. This highlights a significant barrier to the ability of many workers in the field to maintain their sexual health knowledge base and up-to-date training that is not necessarily linked to a lack of available training per se. Notably, while workers in the Northern Health Zone reported that geographical isolation did inhibit their access to sexual health training and support more than workers in the Southern Zone, there was no significant difference between the Northern and Central Zones with respect to this issue.
This indicates that the problem of geographical isolation is not a characteristic of particular Health Zones but rather is experienced by workers in distinct locations within the Health Zones. In this regard, it is important to note that although fewer workers from the Southern Zone reported that geographical isolation was a barrier to accessing sexual health training, this may be a result of response rates from particular locations, rather than a reflection of true circumstance for many workers.

Focus group data provides some more insight into the frustration of workers who evidently feel geographically isolated with respect to sexual health training and support. During focus group sessions, participants were asked to identify their training needs with respect to sexual health. In response to this, workers who attended sessions in Gympie, Emerald, Rockhampton, Tablelands, Innisfail and the Gold Coast referred to the need/desire for “local” training. Given common-sense understandings of ‘geographical isolation’ there appears to be a wide distribution of degrees of ‘isolation’ relative to these areas.

The Gold Coast, in particular, is not commonly described or understood as ‘geographically isolated’. However, given that sexual health training needs set the context for discussion in the focus groups, this raises the possibility that although the workers may not be considered ‘isolated’ by way of general geographic location, they are nevertheless, isolated in terms of local access to training. Workers in some districts perceived that limited accessibility to training programs in other districts contributed to their perception of being isolated from training. A focus group participant in the Tablelands group who described the Tablelands as “Remote yet not remote” succinctly highlighted this dilemma.

### IMPLICATIONS FOR TRAINING

| In order to overcome geographical barriers that inhibit some workers ability to access sexual health training, a range of mechanisms can be used. The provision of training at a local level is preferred. Additionally, resources such as video conferencing and the internet were suggested as flexible and useful tools to be utilised in conjunction with direct facilitated training courses. These resources are particularly relevant to ensure that workers are kept up to date with epidemiological and behavioural trends. The internet component could potentially be expanded to include ‘virtual’ training with a resource down-load capacity. |

#### 5.6.2 Organisational Issues

Organisational structures, budgetary constraints, environments and workers’ positions and duties within their organisations may act as hindrances to workers’ abilities to provide sexual health interventions to marginalised young people.

There were no differences across the region in terms of workers’ perceptions of organizational support received. The extent to which they felt there were a range of structures in place within their organisation, the availability of resources to carry out their sexual health interventions or the level of access to other agency networks in their region.
The most obvious barrier to some workers’ abilities to provide of sexual health interventions is working in an organisation that does not prioritise sexual health issues. The survey results indicated that the workers ability to undertake sexual health interventions is related to the priority given to sexual health by their organisation. Table 16 presents the percentage of respondents who believed they receive adequate organisational support with respect to sexual health interventions and training.

Table 16: Organisational Support by Priority Organisation

<table>
<thead>
<tr>
<th>Organisational Support</th>
<th>High to Moderate Priority Organisations</th>
<th>Low to Not A Priority Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate level of organisational support to undertake sexual health interventions</td>
<td>47%</td>
<td>21%</td>
</tr>
<tr>
<td>Adequate structures within organisation for sexual health training</td>
<td>44%</td>
<td>22%</td>
</tr>
<tr>
<td>Adequate resources within organisation for formal sexual health interventions</td>
<td>32%</td>
<td>15%</td>
</tr>
</tbody>
</table>

The above results are reflective of the positive correlation between the level of organisational support for workers to carry out sexual health interventions and training and the priority the organisation attributes to the sexual health needs of marginalised young people. Notably, however the majority of workers in high to moderate priority organisations are either neutral or believe that their organisation does not provide adequate organisational, training or resource support. This finding attests to the possibility that some workers are unsatisfied with the level of organisational support and/or the resources available within their organisation to effectively undertake sexual health interventions with marginalised young people.

Whilst it is impossible to determine from the survey data the specific issues that contribute to workers perceptions of the relative support offered by their organisation, focus group data suggests that the attitudes and knowledge base of other workers within an organisation can influence this perception. In the focus groups participants were asked “What issues affect whether you as a service provider can undertake sexual health interventions?”

The following examples represent the range of responses received in relation to organisational issues:

- Other workers’ lack of confidence in delivering sexual health interventions
- Workers’ perceptions of needs versus clients perception of needs
- Agency not sensitive to the sexual health needs of marginalised young people
- Limitations related to staff numbers
- Lack of staff training
- Bureaucracy
- Training the ‘Bosses’
IMPLICATIONS FOR TRAINING

To resolve organisational issues that pertain to a lack of internal support for workers to undertake effective sexual health interventions with marginalised young people, training should be expanded to include other key workers. Without appropriate training regarding the importance of providing sexual health interventions to marginalised young people, workers such as managers can indirectly impede the potential of their workers to undertake such interventions. Training at this level should aim to provide an overview of the issues rather than targeting direct service delivery. Training of this type will potentially position the sexual health needs of marginalised young people on the agenda of a wider range of organisations.

5.6.3 Impact of Organisational Type

It is inevitable that the specific type of organisation will influence the capacity of workers to provide sexual health interventions, particularly certain ‘sensitive’ aspects of sexual health education. The focus group data reveals that workers in organisations such as schools and hospitals most often encounter this problem. With respect to schools there was some frustration expressed regarding the fact that the subject matter covered in sexual health education programs is often restricted to basic and superficial issues. These restrictions reportedly impede the workers’ abilities to provide information that may contribute to the prevention of unsafe sexual health practices.

Enhancing these workers’ capacity to undertake early prevention/interventions is crucial to adopting an effective broad based sexual health worker network for marginalised young people in Queensland. Particularly, as has been reported earlier, misinformation and myths proliferated through peer networks can act as a barrier to safe sexual health practices.

In addition to limitations placed on workers who are responsible for providing sexual health education in schools, are restrictions to the types of resources they can use and distribute. The example of being unable to “give out condoms” because of organisational policy and attitudinal barriers was regularly mentioned by focus group participants. Similarly, hospital staff are limited by the types of literature they can display. For example, posters promoting safe sex and drug use are often prohibited by hospital management. This may compound the problem of staff attitudes towards undertaking sexual health interventions and seeking training in this regard. This appears to be particularly problematic in rural and regional areas where hospitals, in some instances, serve as the only needle exchange site in the area.

IMPLICATIONS FOR TRAINING

In order to enhance the benefits of sexual health training for some workers, lobbying should be undertaken at a governmental and/or management level in order to challenge conservative cultures and attitudes that exist within some organisations such as schools and hospitals. The restrictive policies about the sexual health of young people that exists in a number of these organisations limits the capability of the workers to undertake effective sexual health interventions with marginalised young people.
5.6.4 Time Available to Workers

Approximately half of those surveyed (48%) felt they did not have enough time to devote to undertaking sexual health interventions with marginalised young people. As with the case of organisational support, the level of time workers can devote to undertaking formal sexual health interventions with marginalised young people correlates positively with the level of priority the organisation grants to sexual health issues. In other words, the higher the level of priority given to sexual health issues by their organisation, the more time the worker reports having available for undertaking sexual health interventions. In addition to this focus group data indicates that time constraints impact on the workers’ abilities to attend sexual health training workshops. “Travel time” was particularly emphasised by workers from regional and rural centres.

5.6.5 Impact of Community Attitudes

Survey respondents and focus group participants highlighted the impact of community attitudes on their ability to undertake sexual health interventions with marginalised young people. Conservative community attitudes towards marginalised young people and their behaviours are reported to inhibit the types of interventions that many workers in the field are able to provide. Some participants commented that conservative community attitudes tend to coincide with geographical isolation.

Focus group data supports this claim to the extent that participants attending sessions in regional and rural areas were more likely to discuss community attitudes than those in urban areas. However, the possibility that there is no profound difference between community attitudes in isolated and less isolated areas should not be overlooked. That is, it is conceivable that the sexual health interventions undertaken by people who work with marginalised young people are more ‘visible’ to the general public in smaller communities and hence, are subject to more public scrutiny.

The influence of community and parental attitudes on workers’ abilities to undertake successful sexual health interventions with marginalised young people was further emphasised by some survey respondents. These respondents highlighted the need to have parents and the community ‘on side’ in order to increase the success of sexual health education and interventions. Some focus group respondents also recognised the way in which parents play a role in perpetuating sexual health myths and encouraging (whether intentionally or not) unsafe sexual health practices. In this regard, the provision of sexual health education for parents and the general community may enhance the success of interventions with marginalised young people.

In addition to attitudes of the general community influencing workers’ abilities to undertake sexual health interventions with marginalised young people are the attitudes of some key community service workers. Some focus group participants emphasised the attitudes and lack of knowledge on the part of police and medical professionals as a barrier to the success of sexual health interventions. It was noted by one focus group participant that the negative attitude of some nursing staff to substance abuse, discourages young people from accessing sexual health and IDU services. In this sense, sexual health interventions that aim to encourage marginalised young people to utilise medical services may be counteracted by young people’s experience when they act on this advice.
IMPLICATIONS FOR TRAINING

To address the impact of community attitudes on the capacity of workers to carry out effective service delivery in relation to sexual health, community and parental education programs should be developed. Targeting sexual health within a broader framework may have a productive outcome for the workers’ potential to effect change for the sexual health of marginalised young people.
SECTION SIX: A TRAINING MODEL

Diagram 1: Sexual Health Training Model

Access
Network and
Referral
Support

Interpersonal and
Communication
Skills

Common Sexual
Health Risk
Behaviours

Types and Styles of
Interventions (formal
and informal)

Lobbying
and
Advocacy

Community
and Parental
Education

Stream 1 Training
Awareness Training
Target: Management
and Co-Workers

Stream 2 Training
Basic Sexual Health
Information, Interpersonal and
Informal Sexual Health Interventions
and Resources
Target: Non-Specific
Sexual Health Workers

Stream 3 Training
Advanced Sexual Health Information,
Interpersonal and Counselling Skills,
Formal and Informal
Sexual Health Intervention Skills
Target: Core Sexual
Health Workers

TRAINING

Delivering
TRAINING

Formal
Training at a
Local Level

Flexible
Delivery and
Electronic
Training
Capabilities

Regular
Sexual Health
Information
Updates and
Resources
A comprehensive Sexual Health Training Model is required in order to address the range of training needs identified by participants in this needs assessment. The implications for training that have been outlined throughout this report inform the training model outlined above. The above Figure incorporates five central elements that contribute to the development of a useful and comprehensive training scheme oriented to workers who undertake sexual health interventions with marginalised young people. Each of these five elements is explored in more detail below.

6.1 GENERAL TRAINING NEEDS

Access Network and Referral Support:
- Create awareness amongst non-sexual health workers who work with marginalised young people regarding the importance of linking their clients into appropriate sexual health services.
- Create awareness amongst sexual health workers regarding the importance of linking their clients into appropriate services that can assist young people with issues that contribute to their marginalisation.
- Create awareness of existing databases and resources that can assist workers in this regard.

Interpersonal and Communication Skills:
- Communicating with young people
- Challenging the attitudes of young people
- Relationship building with young people
- Understanding cultural issues (including youth culture and ethnicity)
- Counselling and therapy skills, motivational interviewing
- Conflict resolution and dealing with aggressive behaviours
- Interactive workshop skills

6.2 SEXUAL HEALTH SPECIFIC TRAINING NEEDS

The specific information required from respondents and focus groups include:

Common sexual health risk behaviours:
- Definition of ‘Sexual Health’
- Prevention
- Intervention
- Support

Types and Styles of Interventions:
- Formal and Informal
  - Education
  - Information dissemination
  - Resource distribution (including condoms)
  - Referrals
6.3 THREE STREAMS OF TRAINING

Criteria should be developed that enables individual workers to select the Stream of training appropriate to their needs. However based on the research data, each stream below includes a suggested definition of the target workers to be trained in each stream.

**Stream 1 – Creating a supportive organisational environment**

**Target:** Management and workers within organisations who may not be responsible for direct service delivery.

- Definition of ‘Sexual Health’
- Enhance the priority given to sexual health in a range of services that have contact with marginalised young people
- Create awareness of sexual health issues confronted by marginalised young people
- General education on sexual health and marginalised young people aimed at creating an organisational environment conducive to enhancing the ability of key workers to undertake interventions, at least at an informal level

**Stream 2 – Maximising the capacity of non-core sexual health workers**

**Target:** People who work with marginalised young people and undertake sexual health interventions as periphery to their core duties.

- Definition of ‘Sexual Health’
- Basic Sexual Health Information
  - Risk behaviours
  - Formalising referral network links
  - Resource access
- Enhance workers’ capabilities to undertake opportunistic informal sexual health interventions
- Education regarding successful sexual health intervention styles
- Enhance workers’ capabilities to communicate effectively with marginalised young people about sexual health
- Ethical and policy guidelines pertaining to working with minors, underage sex and information and resource dissemination
Stream 3 – *Maximising the capacity of core sexual health workers*

**Target:** People who work with marginalised young people and undertake sexual health interventions as a core duty.

- Advance training in sexual health and associated issues
  - Risk behaviour trends
  - Epidemiological trends
  - Treatment updates
- Formalise referral and network links with other workers who have contact with marginalised young people
- Enhance interpersonal and basic counselling skills
- Education regarding ‘successful’ formal and informal sexual health intervention styles
- Provide workers with the means to effectively exchange sexual health information and support to other non-core sexual health workers in the field

### 6.4 TRAINING DELIVERY METHODS

**Formal Training at a Local Level:**
- Brisbane Youth Service and Youth Link to facilitate bi-annual sexual health training forums for key sexual health workers throughout Queensland
- Train the Trainer - enhance the abilities of key sexual health workers to facilitate ongoing training within particular districts
- Incorporate action research principles into formal sexual health workshop training as a means of targeting knowledge deficits

**Flexible Delivery**
- Self administered training packages
- Electronic access to training packages
- Electronic links with sexual health trainers, including video conferencing

**Regular Sexual Health Information Updates and Resources**
- Availability of electronic sexual health information, including useful internet sites
- Resource updates and resource ordering capacities
- Formal sexual health e-mail discussion groups
6.5 ACTIVITIES COMPLIMENTARY TO TRAINING

Lobbying and Advocacy – Breaking down organisational barriers

- Challenging restrictive organisational sexual health cultures and policies
  - Harm Reduction education

Community and Parental Education – Breaking down community barriers

- Overcoming sexual health myths
- Challenging attitudes towards young people in general and marginalised young people in particular
- Community education campaigns
- Encourage parents to access sexual health information and link into appropriate sexual and community health services
SECTION SEVEN: INFORMATION AND RESOURCES

In addition to identifying the training needs of sexual health workers, another aim of this project is to list existing information resources on young people’s sexual health, and consult workers across the state on information resource needs. Prior to the change in focus of the HIV Project, BYS and YouthLink produced information resources for their clients. In the implementation phase of this project, BYS and Youth Link will produce information resources on sexual health for marginalised young people to be distributed across Queensland. The SNAP provides an opportunity to consult with these workers (at the same time as identifying their training needs) to identify the types of resources on sexual health they would find useful when working with young people.

7.1 METHODOLOGY

As with the training needs analysis, information on resources was gathered through both a questionnaire and focus groups. The questionnaire on information resources was developed in consultation with the steering committee and distributed to the same 800 service providers on the database who received the training needs questionnaire. The questionnaire included questions around the following areas:

- List the resources that their organisation produced and the distribution;
- List the resources they currently used in their practice;
- Describe which resources they found useful and least useful in their work, including why they found these resources useful; and
- Describe what they perceived to be young people’s response to these resources.

The 18 semi-structured focus groups held to discuss training needs also included questions and discussion of information resources around the four points listed above.

Unfortunately the response rate to the information resource questionnaire was much lower than the training needs analysis, at only 5% or 40 completed surveys returned from 800 distributed. Given such a low response rate, the information received from the returned surveys cannot be reliably generalised to the entire sexual health workforce. While the reason for such a low response rate is not clear, it is believed the following factors resulted in the low return. The resource questionnaire was distributed separately to the training needs survey and about one month later. Additionally, the first question on the resource questionnaire asked the service provider if they produced any information or education resources on sexual health for young people. It may be that service providers believed this was the focus of the questionnaire, and so if their service did not produce resources they did not complete or return the survey.

While the information collected from the questionnaire cannot be generalised across the sexual health workforce, it does provide some useful data on what workers require from information resources. Additionally, the survey data was confirmed during focus group discussions. As a result, it was decided to report on the results in this document, with a strong qualification that further research is required in this area.
7.2 FINDINGS AND ANALYSIS

The resource questionnaire was distributed throughout Queensland to workers (N=804) in contact with at risk target groups. The response was quite low (n=52) with only forty (n=40) of the questionnaire being fully completed. It appears from the low response rate and notations cited on a number of the questionnaires that the resource questionnaire was not applicable. The survey was formatted on a two-sided form. The first page asked the agency to list resources that they produced. The following side asked the agency to list other sexual health resources they used, and describe why they found these resources useful and if they perceived young people would find these resources useful.

7.2.1 Most Useful Resources

As a result the data reported here is drawn from the 40 completed questionnaires returned. Table 1 is a summary of these responses.

Table 1: Most Recommended Resources for Workers and Clients

<table>
<thead>
<tr>
<th>resources</th>
<th>Kiss Ancard</th>
<th>Contraception Kit FPQ</th>
<th>Various Qld Health</th>
<th>Sex safely FPQ</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>For workers</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>For clients</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

The above mentioned resources represent some of the most widely distributed resources in sexual health promotion in Queensland. Seven respondents also indicated that the ‘Queensland Health brochures’ were the least useful resources. No trend is apparent regarding effective and useful resources for clients, as perceived by workers.

Despite the limited number of responses, there were trends apparent in terms of the specific criteria workers identified with ‘useful’ resources. Table 2 sets out the most common criteria and the frequency with which these criteria appeared.

Table 2: Criteria recommendations relating to design

<table>
<thead>
<tr>
<th>Most Recommended Related comments</th>
<th>Easy to Understand (n=3)</th>
<th>Clear (n=3)</th>
<th>Simple (n=3)</th>
<th>Visual (n=2)</th>
<th>Colourful (n=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related comments</td>
<td>Low literacy Easy to read Brief to read</td>
<td>User friendly Catchy phrases Hands on learning</td>
<td>Not too clinical Simple language Brief Quick Basic info 1or 2 messages</td>
<td>Pictures With diagrams Can visualise contraception</td>
<td>Visuals better Than reading*</td>
</tr>
</tbody>
</table>
Workers identified age appropriate education, which takes into consideration literacy levels and learning styles. These requirements include the need to present information in clear, simple and easy to read ways. Creative formatting which is colourful, catchy and visual can make sophisticated concepts more accessible. Creative formats can include radio, games and even drama. Young people will engage in learning when it is perceived as culturally relevant. The inclusion of young people's statements and "youth friendly" features often assists. Twelve comments in the general comments section of the survey related to ensuring resource design was reflective of youth culture, rather than the more sparse, clinical style of some medical brochures.

Focus group discussions also reinforced the importance of presenting information in formats that young people found attractive and could relate to identify with. One worker explained that some of her young clients would refuse to take home resources that had words like “AIDS” or “Gonnorhea” emblazoned across the front. Sensitivity to these issues has an impact on young people’s uptake of a resource.

7.2.2 Information requirements
Only 10 of the 52 respondents believed they had sufficient information resources, but 29 respondents identified a number of unmet resource needs. Workers indicated that resources became dated, both culturally and educationally, and stated they would appreciate resources being updated centrally and re-distributed. Thirteen respondents stressed the need for the updating of resources. Workers stressed the importance of disseminating reliable and up-to-date resources particularly on health issues (e.g Hepatitis C).

7.2.3 Resource distribution
In focus group discussions workers stated that many of the resources designed for young people, they actually find useful for themselves. Workers identified that time constraints in their work prevented them from an interactive process of resource distribution (reading the resource through with clients, an opportunity to express their feelings and thoughts, games and discussion). Despite these constraints, workers identified that some information and/or training on how best to use a particular resource should be available on distribution. Additionally, ensuring all resources are dated and include contact names for more up-to-date information.
SECTION EIGHT: RECOMMENDATIONS

A generic training model be adopted that has the capacity to be applied in a range of contexts that is flexible enough to account for the wide and varying training needs of people in different regions and organisations.

That training programs emphasise practical skills such as how to communicate with marginalised young people as well as basic sexual health training.

That training programs take into account the pre-existing skills and knowledge of different groups of workers. This requires developing different training schemes to suit the needs of workers based on the extent to which sexual health is primary to their daily core duties.

Action research principles applied to training model that leaves room for trainers to adapt strategies to the particular needs and expertise of workers attending.

Queensland Health policy on the legal and ethical responsibility of workers undertaking sexual health interventions be widely available and incorporated into training packages.

That the training package be sent out to key organisations and focus tested with workers for their input and feedback.

Appoint centralised sexual health trainers that are responsible for the coordination of training in different areas with specific reference to the districts and regions.

That different types of resources be available so that organisations can access literature appropriate to the organisational environment. For example, some organisations may require quite formal material while others require literature that is more explicit.

Community education campaigns be developed that aim to break down the cultural barriers between young people and adults. As these barriers appear to be an impediment to marginalised young peoples’ ability to access effective sexual health education in some districts.

That training and resource partnerships and networks be established by Brisbane Youth Service and Youth Link, in order to develop comprehensive, broad-based and cost effective sexual health training capacities throughout Queensland.

That further research is required on the sexual health information resource needs of young people and those working with them.
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