THE DISTINCTIVE CONTRIBUTION OF YOUTH AND COMMUNITY WORK TO THE PROMOTION OF YOUNG PEOPLE'S SEXUAL HEALTH:

A case-study

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Introduction

The central government intervention in the 'curriculum' of the youth service via a series of Ministerial Conferences in the late 80s and early 90s was partially predicated on the identification of 'what is it that youth work can uniquely offer?' (National Youth Agency, undated). The Labour minister with responsibility for the Youth Service, Kim Howells, has recently echoed this requirement to demonstrate a distinctive role for youth work as a condition of bringing the service onto a statutory footing (Young People Now, 1998). A vision of what this distinctive role might be is clearly evident in recent policy developments. For example, with employment perceived as the key solution to social exclusion, poverty and crime, a role is suggested for youth services in using their special relationships and skills with disaffected young people, to 'bring them in' to the new (and old) schemes and courses that will be the 'Gateway' to improved employment prospects (Policy Update, 1997). Indeed, even in the secondary school phase, youth services are being increasingly engaged by schools in efforts to raise achievement and break the cycle of low achievement and truancy which are considered significant causes of unemployment in young adults.

As always, identifying the purpose of youth work involves a philosophical struggle for 'Youth and Community workers' in finding a role (and funding) which doesn't conflict with their analysis of the social condition of young people; the perennial dilemma of 'in and against the state'. This is no less so in relation to the contribution of 'Youth and Community workers' to sexual health interventions, which forms the subject of this article.

Sexual health has become a major concern and current 'issue', particularly the sexual health of young people. The cultural ambiguity about what constitutes 'sexual health' for young people means that the topic is usually considered in a negative light, associating it with the absence of sexually transmitted disease (STD) or unplanned teenage pregnancy (Aggleton 1991). Adolescent pregnancy has clearly been seen as a problem in recent years. This is evidenced by the 1992 government statement 'The Health of the Nation' which set a target for a 50% reduction in pregnancies to under 16s by the year 2000. Furthermore, the 1993 Conservative party conference was surrounded by considerable debate about developing policies to discourage young single women from becoming pregnant. The current Labour government has continued the theme with a major emphasis on reducing the dependency of single mothers on welfare benefit. They decided to implement the previous government's

decision to axe Lone Parent Benefit and Labour politicians have continually emphasised 'never married' young mothers as the fastest growing group of single mothers. This is reflected in the 1998 Green Paper on welfare reform which includes a target to reduce teenage pregnancies as part of the strategy to support families and tackle child poverty (Guardian 1998).

Harris (1991) argues that immature motherhood, and sexuality and pregnancy outside of marriage, are seen as a threat to the institution of the family. She suggests that 'The control of women's sexual and reproductive lives is of fundamental importance for the preservation of the modern, nuclear family' (p1). From her perspective, the family is seen as having an essential role in meeting the labour needs of a capitalist society, where *wives* meet the physical, emotional and sexual needs of the *male* workforce and raise the next generation of workers and mothers.The *family* of the 1990s does not fit comfortably with the notion of two married parents with dependent children, supported by an employed father.

However, what is clear from studying the field of teenage pregnancy and childbirth is that this is no new phenomenon in either its reality for young women or its investigation by professional researchers and policy makers. As Bury (1985) says, we know which girls are likely to get pregnant and we know what efforts can be made to reduce unplanned teenage pregnancies. It is easy to find publications from the 60s, 70s and 80s which have explored the antecedents and outcomes of adolescent sexual activity and pregnancy. Indeed, the figures suggest that teenage pregnancy, if anything, is on the decrease (Phoenix 1990) although there has been a significant increase in pregnancies to under 16s with 'between a quarter and a third of girls now claim(ing) to have first had sexual intercourse before the age of 16, compared with 2% in 1964' (Guardian 1993). Nevertheless the majority of teenage mothers are in the over 16 age group (Peckham 1992).

Consequently, the new concern with teenage parenthood is more to do with the social context of that parenthood and the growth of 'single' rather than 'teenage' mothers. According to the Department of Social Security, figures for 1992 show that nearly a million lone parents were claiming income support at a cost of £3.4 billion per year. Of this figure, £145 million a year went to those under 20 (Guardian, 1993). Perhaps policy targets for young people's sexual health are inappropriately located in a *Health* report because they are clearly financial targets associated with *Benefit* policy.

Of course, treating teenage motherhood simply as something that can be manipulated by punitive alterations to the welfare system and local authority housing obligations, is simplistic and reductionist. It presumes a level of control over one's life, a degree of advance planning, and an ability to assert oneself in relationships with men that are highly unlikely amongst this age group, even if they *wished* to avoid pregnancy. And its implications will be to intensify the poverty and disadvantage already linked to young motherhood.

There are clearly identifiable patterns regarding teenage sexual activity. The proportion of young people reporting first sexual intercourse under 16 differs across social classes (Johnson et al 1994) and teenage girls in deprived areas are six times more likely to have unwanted pregnancies than those in affluent areas (Smith 1993). Furthermore young women from affluent areas (Smith) were more likely to have abortions if they became pregnant. However, Phoenix strongly challenges the notion that teenage parenthood *causes* poverty and argues, from her research, that the young women who have children early are the same women who face poverty and hardship whenever they have children. It is their poor educational background and employment prospects that create the poverty, not their motherhood.

This suggests that it is at least an *education* issue in its widest sense (that is: the broad education of young people, not just health or sex education) and it is highly spurious to argue that it is different levels of sex education which are the key factor in young people's understanding of and control over their sexuality. Nevertheless there are key weaknesses at the level of specific sexual health education and services for young people. These include inadequate access to advice, information, and contraceptives, and inadequate or inappropriate sex education (Thomson & Scott 1992).

Of course, enabling young people to avoid unplanned pregnancy (although the most current and contentious area) is only one aspect of adolescent sexual health interventions. However, although the advent of HIV/AIDs brought the issue of sexually transmitted diseases amongst young people into sharp focus, there is considerable evidence that sexual health provision remains largely directed at preventing unwanted pregnancies and providing appropriate contraception (Pitts et al 1996). This is despite the fact that young people are at particularly high risk of contracting STDs (British Co-operative Clinical Group 1997). For example it is reported that 10% of sexually active young women are infected with Chlamydia which can develop into pelvic inflammatory disease with with long term potential for infertility (Brook Advisory Centres, 1997). However, it is easily left undetected because it is often asymptomatic and only 23% of 16-24 year olds have ever heard of it (Brook).

This broader social context for young people's sexual health has the potential to disable 'Youth and Community workers' likely to experience a conflict between supporting young people in their choices and sexual expression whilst acknowledging both the potential for social exclusion and poverty that may accompany young parenthood, and the risk of contracting diseases with long term consequences to their health. What are the 'best interests' of young people in relation to sexual behaviour? In addition, 'Youth and Community workers' have usually focused at the individual and small group level with a concentration on building self-esteem, information and decision-making skills, yet they are clearly tackling an issue which is influenced by a much broader (and uncontrollable) set of factors, not least gender relations. Their dilemma is not helped by the controversies and debates surrounding welfare dependency and the possible role of early, unmarried parenthood in prolonging that dependence.

Despite these uncertainties, there is growing evidence of the importance placed on sex education and sexual health promotion by 'Youth and Community workers' with a range of reports (Burke 1994a, Burke 1994b, Coyle & Loveless 1995, Public Health Resource Centre 1995, Waldock 1991) and relevant resources (Jewitt 1994, Lyford 1991, Youth Clubs 1994), particularly linked to HIV/AIDS. What should the role of 'Youth and Community workers' be in this field of sexual health? How can they operate alongside other health and education agencies who may have very different 'performance indicators' in this field, yet retain their own integrity in what they are doing? What might their distinctive contribution be which enables them to work in young people's interests? This article explores these issues by reporting on a case study in collaborative approaches to sexual health intervention with young people.

Definitions of sexual health

A positive definition of sexual health adopted by Orton (1994) encompasses 'informed individual self-direction and mutually protective collaboration between individuals', and Goldsmith (1992) includes 'sexual expression and enjoyment without exploitation, oppression or abuse'. Brooks-Gunn & Paikoff (1993) have developed a similar definition of adolescent sexual well-being. It would be hard to quibble with these statements but the translation of these broader definitions into appropriate objectives for practical interventions is loaded with controversy particularly when considering target outcomes. Indeed, it seems far more reasonable to identify underlying skills and self-attitudes, and access to appropriate information, counselling and clinical services, than to specify what particular outcomes should emerge from that provision, because the latter should be in the control of the young people, themselves. Consequently, in identifying the interpretation of sexual health for young people, the research team drew on a range of sources (Ingham 1993, Doppenberg 1993 & Jewitt 1994) in order to specify what elements should be provided. These are:

- *Development of high self-esteem, self assertion, and decision-making especially in the area of relationships and sex*
- *Development of 'interactional competencies'- skills to handle sexual relationships*
- *An opportunity to discuss their developing sexuality openly with adults and peers*
- *An opportunity to discuss sexual behaviour and contraception*
- *Easy access to information, advice, and contraception*
- *Easy access to information, advice about and treatment of, sexually transmitted infection*

This list strongly suggests that providing for the sexual health needs of young people demands a range of different professional interventions. Some of the elements are so clearly educational services whilst others are clinical, and yet others feature

the skills of individual support and counselling. Consequently, not only is there a recognition of the need for services specially targetted at young people (Allen 1991, Pitts et al 1996), there is a strong argument for planned multi-service provision in the field of adolescent sexual health.

Interagency collaboration

In the wider field of health and welfare, there has been an increasing belief in the benefits of collaboration between different professional groups (Rawson 1994, Casto 1994, Delaney 1994 and Mackay et al 1995), particularly in relation to health care and health promotion (Butterfoss et al, 1993). In this regard, Leathard (1994) identifies over 50 terms to describe the idea of people from different professional groups working together, and for the purposes of this paper I shall use the term 'interagency collaboration', defined as shared planning and/or delivery of work across different organisations, involving different professional traditions and skills.

The benefits of collaboration are considered to be numerous and include rationalisation of resources, a reduction in duplication of effort and the provision of 'a more effective, integrated and supportive service for both users and professionals' (Leathard, 1994 p7). It is also seen as a response to the increasing complexity of society (Casto 1994), where focussing on the behaviour of individuals without attention to other factors in their environment is likely to have less impact (Butterfoss et al). Interprofessional collaboration may also contribute to improved communication between professionals working with the same clients (Mackay et al, 1994) and Nezlek and Galano (1993) point to the increased potential of 'coalitions' to influence policy making in a positive way. Youth and community agencies, with considerable experience of working alongside other agencies such as schools, have also been part of this movement towards interagency collaboration (Jobstown Youth Action Project 1990, Waldock 1991, Allen 1991, Public Health Resource Centre 1995).

Yet interagency work is not without problems (Mackay et al 1995) and as Dryfoos points out 'Collaborative plans are difficult to achieve because of the differing characteristics of the agencies involved' (1994, p145). The research points to a range of factors which appear to enhance or constrain collaboration. These include the extent of shared aims and values, good interpersonal relationships including understanding and mutual respect between the professional groups, the existence of shared and relevant training, the inclusion of both grassroots' commitment and formalised co-ordinating strategies, and the role of organisational power (Bloxham 1996). It could be anticipated that the controversial field of sexual health would place additional pressures on collaborative ventures with greater need for shared values and mutual respect.

The case-study

The research team identified an initiative in a district in the North of England which comprises a medium sized town (pop.40,000) plus surrounding villages. The research focused on this particular initiative because it involved shared planning

and delivery of sexual health activity involving four different professional fields: 'Youth and Community workers', secondary school teachers, health promotion officers and staff working in community health services. However, it was not a centrally planned initiative.

The aim of the research study was to examine interagency collaboration in the field of young people's sexual health. This paper forms part of the results of this study and concentrates on the perceived contribution of 'Youth and Community workers' within the overall experience of interagency collaboration. Limitations on space prohibit more extensive reporting of the research findings but they are published elsewhere (Bloxham 1996 and Bloxham, 1997).

A small group of staff from the different organisations involved participated with the research team in designing a research strategy. A qualitative, interview-based method, was selected as most likely to allow for the collection of material both because some of it, such as the personal relationships involved, may be sensitive, but also because of the narrative nature of respondents answers about the development of the collaboration.

The interviews were designed to elicit information and views regarding the nature and funding of any inter-agency collaboration in the field of young people's sexual health, the aims of the work, training available, how the collaboration was established and developed, constraints on the work, perceived difficulties in collaborating, contributing factors to effective collaboration, and future plans. The interviews took place during March to June 1995. Minor amendments to the question schedule were included after the first six interviews to improve the clarity and relevance of the questions. The interviews were carried out with 25 staff from the community health service (8), health promotion (3+1 joint appointment), the youth and community service (7+1 joint appointment) and four secondary schools (6), who were identified by senior staff in each organisation. The interviewees included a combination of managers with some policy making authority (for example: heads of school departments, the clinical services manager for the health authority, the HIV prevention co-ordinator) and those delivering the services (for example: classroom teachers, the doctor and family planning nurses at the young person's clinic, school nurses, health visitors, and health promotion officers.) In the case of 'Youth and Community workers', those interviewed were generally staff who both worked with young people themselves, and managed the work of part-time staff.

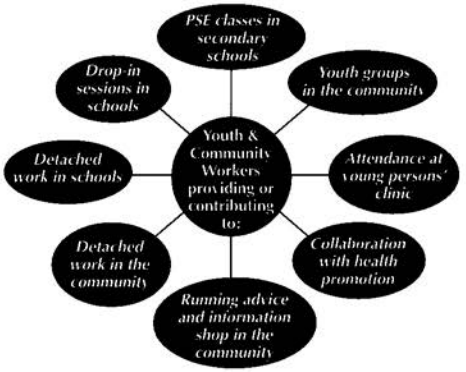
The interview material was analysed, firstly, by categorising the different practical elements of the provision and identifying the respondents' views about the specific contribution of interagency working to that service. Secondly, the analysis focused on the perceived effectiveness of, and constraints on the provision. The data reported here pertains particularly to the specific contribution of the youth and community work to the collaboration.

The findings

This interagency collaboration, discussed below, had been established slowly over a number of years and it had built up largely on the basis of networks of contacts between interested individuals. For example, 'Youth and Community workers' had developed links with secondary schools and gradually gained a key role in delivering elements of personal and social education. Teachers had asked their school nurse to participate in sex education lessons in order to provide more current and specialist information. An information shop had obtained the services of a health visitor to provide regular advice sessions and emergency pregnancy tests.

Informal, early arrangements had gradually become more formalised. For example, a joint appointment was created between the Health Promotion Unit and the youth and community Service to specialise in sexual health work with young people and a youth worker was appointed to work at a young people's clinic. At the point when the research took place, the specific elements of the collaborative provision were: personal and social education (PSE) and 'drop-in ' facilities in school, advice and information facilities in the community, detached youth and community work, clinical provision, youth groups and support and training from a health promotion unit. The diagram (fig. 1) attempts to illustrate the different roles that 'Youth and Community workers' played in the initiative, and the following text explores the nature of their contribution to each element of provision.

Fig 1: **The role of Youth & Community Workers in the different elements of provision**



Personal and Social Education in Schools

Sexual health education was offered in school as part of a broad curriculum of PSE including essential elements of building self esteem and confidence, personal relationships, decision-making, and taking risks. This, largely group-based work was mostly delivered by school staff, but 'Youth and Community workers' frequently went into schools to contribute to the curriculum. Other key professionals in the collaboration such as the school nurse, and health promotion personnel also contributed to PSE.

These external staff were felt by teachers to bring a specific range of knowledge and skills which can enhance the teaching in the sensitive area of sexual health. The PSE teachers interviewed generally agreed that such people can bring in up-to-date information. The reported benefits of the youth and community contribution were that pupils were more likely to open up to strangers, they worked in an informal way in class creating a better atmosphere for discussion, the absence of authority, and the fact that youth work staff were more comfortable working in a field which was difficult or embarrassing for some teachers. 'Youth and Community workers' also considered that their particular approach enabled them to establish different kinds of relationships with pupils compared with teachers and they felt able to involve young people with all levels of ability.

Language and communication appear to be at the heart of this ability of 'Youth and Community workers' to create an appropriately informal atmosphere. Whilst other professional groups such as teachers may feel heavily constrained in their use of language, or uncomfortable hearing adolescents' use of bad language (PHRC, 1995), 'Youth and Community workers'' understanding and familiarity with young people's expressions can prove important in developing non-authoritarian and trusting relationships. As trusting in the confidentiality of staff is considered vital by young people in this area (Allen 1991, PHRC 1995, Pitts et al 1996, Health Education Authority 1996, Jackson & Plant 1996), such relationships would seem an important first step to increasing their participation and openness.

There was general agreement amongst all parties about the complementary nature of their different roles in the delivery of the sexual health curriculum with benefit to both pupils and professionals.

Drop in facilities in schools

A more recent development designed to contribute to the provision of sexual health services for young people has been the establishment of drop-in facilities for young people in their secondary schools. All four of the schools involved in the research provided a drop-in advice and information facility for pupils. This was a general facility and not specifically focussed on sexual health. The sessions were usually provided by school nurses but two schools provided a weekly lunchtime drop-in staffed by 'Youth and Community workers', to which access was limited to older pupils in one of the schools. Drop-ins also provide a referral point for teaching staff when pupils bring up questions or problems that are beyond their expertise or outside their area of responsibility. The broad remit of drop-in facilities acts to protect young people's confidentiality as they are not specifically linked to sexual health.

Interviewees identified this provision as an important addition to the educational programme as it allows young people to gain one-to-one information and advice; it reflects the fact that the development of young people's sexuality and sexual activity takes place at different rates and therefore it is impossible to neatly match all pupils individual needs with the age-related school curriculum; it provides the

confidentiality required by young people and it enables staff to suggest specific clinical and advice facilities outside school.

Detached/outreach work in schools

One youth and community worker indicated she was trying to establish an extension of their school-based drop-in facility to include mixing with young people in school recreation areas during their break times in order to help them become aware of what services are available both in and out of school. A further advantage of this informal 'detached' work is seen to be the opportunity it gives pupils to develop a vocabulary regarding sexual health issues that will assist them in discussions with health professionals and others.

Kirby et al (1994) stressed the importance of follow-up and outreach activities by health personnel in schools, and the targeting of sexually active students, although recent UK work suggests that young people prefer facilities away from school (Jackson & Plant 1996).

Advice and information Services in the Community

Outside school, the youth and community service operated a range of advice and information projects for young people which are seen to play an important role in the overall access to sexual health services by young people. One organisation that featured in our research data offered both general drop-in sessions and specific advice sessions on subjects such as health, contraception and parentcraft. Staff from Community Health Services and Health Promotion work alongside 'Youth and Community workers' in this facility, and where appropriate, young people are referred to other services.

An 'information shop' such as this project can offer an approachable, central, access point for young people, unsure of what specific service they need. Staff can provide first-line information and advice, using appropriate personnel (for example health visitors) where necessary to carry out services such as pregnancy tests. However, the strongest feature is the link they offer to other agencies. In the case of sexual health, this may be referring users to a Young Persons Clinic, a Family planning Clinic or a GUM Clinic. This link may involve taking a young person to the appropriate service in order to provide support and advocacy. The research indicated that other services, considered this 'link' function to be very important in helping users access their facilities.

However, the youth and community worker managing the shop was the only interviewee to question whether such interagency work might compromise young people's confidentiality. He felt that health and social services' staff considered that discussion of cases between professionals was acceptable whereas he believes that staff should strive to preserve client confidentiality at all times. In general, interviewees argued that the range of provision acted to protect confidentiality for young people. For example, teachers were able to refer pupils to other professionals who would not be under the same duty to disclose information regarding underage sexual

activity. Clearly, discussion of confidentiality policy and practice is essential to effective working relationships in this area of provision.

Detached youth work in the community

Detached youth and community work has a long history of provision designed to make contact with and offer support and services to young people on the street and in other places where they gather. A strong feature of the local Youth and Community Service strategy emerging from this research, is the emphasis on using detached work. Respondents felt that detached workers can gradually gain the confidence of young people and encourage them to discuss issues such as sexual health. They have also provided young people with condoms and helped them to access other relevant provision such as Family Planning and GUM Clinics, an information/advice shop, the Young Persons Clinic, and various specialist youth groups. The research suggests that the existence of detached 'Youth and Community workers' is considered very important by health professionals in helping young people to become aware of, and access, clinical and other services related to sexual health. It was also seen as important for young people's confidence in using services that they can meet the same faces in school, on the street, in the Information /advice shop and at the Young Persons' Clinics.

Personnel across all the other professions were very clear that 'Youth and Community workers' provided a vital link in enhancing the work of other agencies in the difficult area of sexual health. Their specific role in meeting young people 'where they are', through detached work, provided access to those young people most likely to have missed schooling and least likely to feel confident accessing formal services such as clinics.

A number of recent reports have similarly identified this link role for 'Youth and Community workers'. A Public Health Resource Centre (PHRC) report on a young people's health clinic and peer education project mentions that 'Youth and Community staff' 'brought a so much better understanding of young people and how to reach them' and particularly emphasises their strength in *accessing* young people and their ability to relate to them. Pre-existing informal education and contacts with young people by 'Youth and Community staff' facilitated unexpectedly high attendance at the clinic by young people. Lynch (1995), in a study of the sexual health needs of young people in the Southampton area, also mentions the particular ability of youth service staff to reach young people in a variety of settings, including outreach work.

This link function appears to be facilitated by 'Youth and Community workers'' ability and experience in functioning across a wide range of professional roles. For example, workers appeared to be successfully managing the varying demands made on them from such widely differing contexts as teaching formal classes in school, being approachable to dissaffected young people on the street, negotiating with health service managers, acting as a receptionist in a young persons' clinic and working one-to-one with young people in drop-in facilities. The different skills and impression management involved in negotiating such a range of roles is significant.

Part of this impression management related to inclusive use of language with young people. The freedom 'Youth and Community workers' enjoy to use young people's colloquial expressions and explicit language in discussion of sex was mentioned as a key feature in helping young people bridge the gap between their existing knowledge and the formal language they are likely to meet in sex education and health settings.

Young Persons' Clinic

As mentioned above, a young person's clinic has been established one afternoon a week after school. The clinic provides a one-stop facility for contraception, diagnosis and treatment of sexually transmitted diseases and advice on sexual health. It is the fairly unique combination of GUM and Family planning Services which has been particularly successful with an unexpected emphasis on STD diagnosis and treatment amongst those attending.

The clinic operates a no-appointment system and attempts a strongly 'non-judgemental' approach in order to encourage young people's use. Although predominantly clinical staff, the team includes a male youth worker. This interagency element is seen as vitally important by the clinic staff interviewed because the youth worker can encourage young people he meets in his other work in schools, on the streets and in an information/advice shop, to make use of the clinic knowing that there will be a familiar face there. This also applies to some of the clinical staff who can refer young people to the clinic from their work in school drop-in sessions. Furthermore, the youth worker is valued for the 'non-medical' dimension that he brings to the clinic; for example stage-managing the reception space with pop videos, drinks and leaflets to create a young people-friendly atmosphere. Clinical staff admitted that these 'user-friendly' ideas would just not have occurred to them. Use of the clinic was steadily increasing at the time of the study and a high proportion of the users are male.

Furthermore, not only did 'Youth and Community staff' appear to encourage young people to make use of other services but they also added to the user-friendly image of various provisions. For example, the research indicated that including a youth and community worker in the staff of a Young Persons Clinic was seen as significant in improving the young people's perception and use of the service.

Other reports (Pitts et al 1996, Allen 1991) point to the importance for young people of meeting a familiar face and knowing who they are going to see when they attend for advice, information and health care. Collaborative work as discovered in this case study appears to provide 'continuity of care' when sexual health services and education are provided across different organisations. The fact that 'Youth and Community workers' can refer young people to other agencies, such as a clinic, where the young person knows they will meet the same familiar youth and community worker seems to be an important asset of collaborative work illustrated by this case study.

Allen, (1991) in an evaluation of three family planning and pregnancy counselling services for young people, suggests that youth services, amongst others, should be involved in an advisory capacity concerned to develop thinking about the best means of offering services for young people. Collaboration and liaison is seen as important in tapping the 'expertise and resources of all possible sources' (p311). She stresses the importance of outreach work with other organisations because 'It must be recognised that professionals and other agencies are usually the "gate keepers" controlling access to groups of young people, and that outreach work can usually only be developed through these gatekeepers' (p294). One type of outreach work is making contact with young people who are not already known by other agencies, but she also emphasises that such work should be done by the same staff involved in providing the direct service. This viewpoint supports the notion of 'Youth and Community staff', with their specific outreach skills, also being an important part of clinical sexual health provision for young people.

Youth groups

Our research identified a number of different youth groups in the locality for which all or part of their brief was related to young people's sexual health in the broadest sense. These included young women's groups, young men's groups, young (and very young) mothers' groups, youth clubs/groups based on housing estates, junior youth clubs, and drama/arts-based groups. These groups are largely run by 'Youth and Community workers' but in a number of instances, they are jointly run with staff from health promotion or Community Health Services such as a parentcraft sister.

Such groups were seen to provide a unique opportunity to offer young people informal education, away from the constraints of the school curriculum, and centred on the young people's specific needs and experiences. 'Youth and Community staff' felt that activities, discussion topics and explicit language may be used in such groups which may not be tolerated in the school setting and the voluntary nature of attendance by young people is likely to enhance their interest in and commitment to the group, particularly for those young people who have a generally disaffected experience of school. However, staff expressed concern that the voluntary nature of such projects (and the limited resourcing of youth and community work) means that this work reaches a very small proportion of the age range and therefore it can only be seen as an important complementary programme to the general provision offered in school. There is a continuing dilemma for 'Youth and Community staff' in reconciling the competition between high quality work with small numbers of young people and the alternative of a much more superficial approach spread across larger numbers.

Health Promotion Unit

Whilst generally focusing on the role of 'Youth and Community workers' in this initiative, it is important to note the supportive work of the local health promotion unit.

In co-operation with schools, 'Youth and Community workers', and Community Health Services, the unit appears to have had an important impact in encouraging the overall programme of work, particularly a number of innovative initiatives such as the appointment of a Young People's Health Information Worker in conjunction with the Youth and Community Service. Health Promotion specialists see themselves as operating at the level of policy and strategy development, researching needs assessment, and purchasing appropriate services. Rather than face-to-face work with groups, such as young people, they see their role increasingly as one of the training and development of professionals in order that they can have an effective health dimension to their work (in whatever field). They also provide resources for health promotion.

What are the gains for youth and community agencies?

The PHRC report (1995) identifies how an alliance with other agencies enabled other professions to recognise and value 'Youth and Community workers' 'core skills and approaches to the work' and this finding is supported by our case study in that the more contact other professional groups had with 'Youth and Community workers', the greater the understanding and respect for their varied, but distinctive role.

The PHRC report also stated that it provided an 'area of growth and development at a time of repeated budget cuts' for the local Youth and Community Service. The financial benefits are also identified by Burke (1994a) who argues that 'with money too tight to mention in many youth services, collaborating with relatively cash-rich health promotion teams is appealing'.

In this case study, 'Youth and Community workers' considered that their input into the school curriculum was important for other areas of their work because the pupils would become familiar with them, it gave them an opportunity for structured group work that young people would be less likely to tolerate in community settings and it enabled them to inform pupils about other services available to them outside school.

The perceived effectiveness of the provision

The research at this stage was largely concerned with the nature of the project and the processes of collaboration. However, we did ask the respondents how they perceived the effectiveness of the work described above. The data suggests limited agreement over effectiveness. Whereas all staff interviewed demonstrated a commitment and belief in the work, health service staff were more confident about effectiveness, based on the numbers of young people using facilities such as the Young Persons' Clinic and returning for follow up visits. Respondents considered that contraceptive and family planning services had become more accessible to young people than in the past. 'Youth and Community staff' and teachers were more circumspect, indicating that young people's behaviour was difficult to change and the results of the work hard to measure. They were more likely to

'hope' that they were being effective. However, a number of teachers felt that young people were becoming less self conscious, more confident and asking questions that suggested 'something is happening'. 'Youth and Community staff' were pleased with the increased use of services and their information giving function, but less confident that young people were putting their knowledge and assertiveness into practice at the crucial moments during their personal relationships.

This uncertainty regarding outcomes is echoed elsewhere, particularly in relation to 'measurable' outcomes such as increased use of contraceptives and lower rates of pregnancy. Oakley et al (1995) reported on the paucity of evaluation studies which demonstrate a positive impact for sex education projects. It is an extremely difficult area of work to measure effectively and there has been a noticeable lack of evaluative research on which to base future sexual health strategies (Peckham 1992). However, there is some evidence that countries with greater access for young people to sex education and birth control also enjoy the lowest rates of teenage pregnancy, birth and abortion (Ray 1994). Furthermore, research suggests that sex education may lead to a delay in the onset of sexual activity (Baldo et al, 1993).

The results of existing studies give strongest support to comprehensive approaches as in this case study, particularly those linking health care with schools. Studies of young people's clinics in US schools suggest that the greater their emphasis on pregnancy and AIDS prevention, sexual health education and on-site distribution of contraceptives, the more likely they are to improve young people's use of contraceptives (Brookes-Gunn & Paikoff 1993, Dryfoos 1994, Kirby et al 1994).

Certainly this case study suggests that the factors linked with these 'conventional' notions of success in adolescent sexual health are assisted by an interagency approach involving 'Youth and Community workers', where a youth worker methodology enhances access to both education and services. The case study suggests that 'Youth and Community workers'' distinctive skills and unique roles in this process can be summarised as linking young people to services, inclusive use of language, informal style and relationships, working successfully in a range of contexts and increasing the attractiveness of essential services.

However, as discussed earlier, 'conventional' measures of success in sexual health services for the young are highly controversial and would not sit happily within the philosophy of many 'Youth and Community workers' who may be more concerned to support young people in their choices and sexual expression rather than work towards targets for less sexual activity, increased use of contraception, fewer unintended pregnancies and reduced incidence of STD. Nevertheless, I would argue that the distinctive role identified above can be seen as essentially inclusive. 'Youth and Community workers' at their best are providing opportunities for young people to get access to information and public services, in this case health and education related, that many of us take for granted. One could argue that whilst it

may, implicitly, involve working towards government targets, it is also part of ensuring that young people obtain their rights to social citizenship: 'the right to the prevailing living standard in society' (Jones & Wallace, 1992, p 19) which comes from education, health care, welfare provision and housing.

Interestingly, the research evidence did not indicate major differences between the different agencies in their aims for the work. However, this consistency may have been an outcome of the collaborative process. The interview material suggests that those joining the collaboration did not necessarily begin with shared aims, except broadly inasmuch as they wanted to improve education and services to young people in the general area of sexual health. However, it appears that informal training may have been inherent in this collaboration which acted to develop increasingly mutual values and approaches to working. Thus, 'Youth and Community workers' were able to gradually promote a non-judgemental attitude to young people as well as an informal approach which acted to increase access, trust and participation. In other words, youth service involvement may encourage other agencies working with young people to adopt a more empowering and inclusive approach.

Problems and constraints

The growth of mutual values between the staff in the different agencies may also have been a feature of the informal way the collaboration was established with interested staff choosing to become involved. Indeed, an important contribution to the success of interagency collaboration in this project was the unhurried, informal and incremental way that the provision had developed (Bloxham 1996). However consistency and breadth of services has not been assured by such an informal approach to co-ordination. The interview data indicates that provision has grown up gradually and has depended heavily on the initiative of individuals who have made efforts to establish relationships or bring in workers from other agencies.

The research indicated that the health promotion unit and the Youth and Community Service were most active in attempting to co-ordinate provision, particularly through the maintenance of a district wide young people's sexual health group. However, meetings were poorly attended by representatives of other organisations and thus policy making and development of services was extremely limited. These two organisations, as a result of their limited size and influence, had least power to negotiate demands and struggled to involve other organisations in a framework for co-ordination. There was concern that this would have consequences both in terms of resources and in terms of the potential marginalisation of the youth and community service.

Undoubtedly intervention in young people's sexual health will continue to be an area of controversy, not least because of the conflict between the influence of the moral dimension in current debate about sex education (Meredith 1989, Health Education Authority 1994, Lees 1994), alongside the recognition that open acknowledgement of teenage sexuality offers the best promise for reducing the onset of sexual activity and unintended pregnancies.

The challenge for 'Youth and Community workers' is to find an approach which works with the acknowledgement of teenage sexuality, whilst avoiding being forced into putting government targets before the genuine interests of young people. The dilemma, of course, is to identify the genuine interests of young people in this complex area! However, this case-study has reinforced ideas about the distinctive contribution of 'Youth and Community workers' in, at least, ensuring that young people have the opportunity to achieve a number of the key elements of sexual health identified above. Perhaps the most important task still awaiting many local authority youth services is in convincing schools, health services and other agencies to recognise that contribution and build it into their planning.

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