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A Qualitative Exploration of Community-Based Organization Programs, Resources, and Training to Promote Adolescent Sexual Health

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Abstract

Background—Youth development professionals (YDPs) working at community-based organizations (CBOs) can promote adolescent sexual health through programs. This study explored the programs and resources that youth access at CBOs and training YDPs receive.

Methods—Twenty-one semi-structured interviews were conducted with YDPs. Qualitative content analyses were conducted using NVivo.

Results—Most YDPs ($n = 15$, 71.4%) described sexuality-related programs for youth. Some YDPs provided informal information ($n = 11$, 52.4%) and/or referrals for youth ($n = 6$, 28.6%). Few YDPs ($n = 8$, 38.1%) were trained to address adolescent sexuality, but some ($n = 10$, 47.6%) sought outside resources.

Conclusions—YDPs have a unique opportunity to improve adolescent sexual health and sexuality. Five considerations for organizations that develop programs and training for CBOs are suggested.

Keywords

Community-based organizations; adolescents; youth development professionals; sexually transmitted infections (STI)

Introduction

Sexual health and sexuality remain salient topics in the lives of adolescents in the United States. Though the overall prevalence of many sexually transmitted infections (STIs) and unplanned pregnancies have decreased in recent years, there remains much room for improvement in these health outcomes (CDC, 2014a; CDC, 2014b). According to the National Campaign to Prevent Teen and Unplanned Pregnancy (2012), from 2011–2012 the prevalence of chlamydia decreased 5.6% and 5.1% among 15 to 19 year-old women and men, respectively. Yet, disparities still exist, as 70% of the reported cases occurred in people under the age of 25. Likewise, the prevalence of pregnancy among teenagers has decreased

by 42% in the last 20, but over 305,000 women aged 15 to 19 gave birth in 2012 (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2012; CDC, 2014b).

In addition to STIs and pregnancy, issues related to lesbian, gay, bisexual, transgender, and queer (LGBTQ) identities are increasingly more important to young people. Though there is a growing social support for LGBTQ youth, problems related to bullying and violence contribute to disparities in school-related and social outcomes. Aragon and colleagues (2014) reported that victimization of LGBTQ students contributed to higher truancy, lower grades, greater expectations to drop out of school, and lower expectations to attend college. Other researchers have noted the disruptive role that victimization plays in interfering with family and peer relationships, creating a hostile social environment, and feelings of emotional distress among LGBTQ youth (Kosciw et al., 2012; Mitchell, Ybarra & Korchmaros, 2013; Schneider et al., 2012; Robinson, Espelage, & Rivers, 2013).

The issues related to sexual health and sexuality that adolescents face are often addressed by schools and in families, though many researchers have recommended using the ecological approach, multilevel approach or multi-system perspective to address these issues related to adolescent sexuality (DiClemente et al, 2007; Kirana et al, 2009; Kotchick et al, 2001; Mabray & Labauve, 2002). These approaches suggest that health behaviors, including those related to sexual health and sexuality, are influenced across different levels, including the intrapersonal, interpersonal, institutional, community, and policy levels. Therefore, community-based organizations (CBOs) that address adolescent sexual health and sexuality can positively influence the behavior of the youth they serve (Constantine et al, 2007; Ott et al, 2011; Romeo & Kelley, 2009; Fisher et al., 2010; Fisher et al., 2012).

Youth development professionals (YDPs) from CBOs have been working with young people to address various adolescent issues (Bowie & Bronte-Tinkew, 2006; Border & Perkins, 2006). YDPs directly contribute to the promotion of adolescent sexual health through programs and resources for youth and are well-positioned to help adolescents address issues related to sexual health and sexuality; specifically, YDPs provide young people with a trusted source for information on issues such as relationship and sexual behavior negotiation and sensitive issues often not covered in school such as abortion and sexual and gender identity issues (Fisher et al., 2010; Gupta et al., 2015). Thus, YDPs at CBOs play an important role in promoting youth sexual health, but we have little understanding of the context in which this occurs. While much research exists on evidence-based and evidence-informed programs, little research has explored adolescent sexual health programming and the needed training for implementation from the perspective of YDPs. The purpose of this qualitative study was to explore how the CBOs and YDPs address adolescent sexual health issues by, 1) describing adolescent sexual health programs/interventions (used interchangeably throughout), and resources for adolescents and 2) examining the sexual health and sexuality-related trainings for YDPs.

Methods

Participants

Participants (n=21) were recruited using a purposive sampling, specifically a modified snowball sampling method; saturation theory (e.g., no new information being observed in the data) guided the end of data collection (Bernard & Ryan, 2010). The study's inclusion criteria included being 19 years of age or older, working for pay for one year or more for at least 20 hours per week at a CBO, and having contact (e.g., one-on-one interactions, group facilitation, mentoring) with adolescents, ages 13-21, for at least half of their typical working hours. Organizational affiliations were limited to community-based organizations focused primarily on adolescents. Faith-based organizations such as those that may run community-based after-school and/or weekend programs were included in the definition as the research team theorized youth may experience interactions with YDPs in such settings similar to non-faith-based CBOs.

Recruitment

The initial pool of participants was comprised of the professional contacts of the research team and their community partners. A modified snowball sampling method was used to identify subsequent potential participants, who were then contacted via e-mail with information about the study, including the study eligibility and contact details of the research team if they were interested in participation. To maximize the response rate, the research team sent recruitment messages three times over the course of several weeks.

Of the roughly 200 individuals and organizations in Nebraska and Indiana that received the recruitment emails, 47 individuals responded, and 39 of these met the inclusion criteria. After interviewing 21 participants, the researchers had reached data saturation (Bernard & Ryan, 2010).

Procedures and protocol

The PI and two trained graduate research assistants conducted the interviews. Informed consent procedures were approved by the University of Nebraska Medical Center's Institutional Review Board.

The recorded interviews began with questions which confirmed the participants' eligibility; no participants were turned away during this screening. The incentive for participating in the study was a \$50 Visa gift card. Interviews were professionally transcribed verbatim, and interviewers verified the accuracy of each transcription. Study data were stored on a secure server at the PI's institution.

The semi-structured interviews, for the purposes of this study, focused on programs and resources related to sexual health and sexuality, in which the participants indicated what, if any, sexual health and/or sexuality-related programs or interventions the CBO offered its adolescents, what information sources were available for youth, and what resources and training opportunities were available for the participants. The participant explained their

thoughts about the program's usefulness, importance to their work and for the youth, and identified who decided whether the program or resource was available for staff.

Analysis

We used NVivo 10.0 (QSR, 2013) to manage and code the data, and conducted a deductive content analysis (Bernard & Ryan, 2010) examining the programs, interventions, and resources that were available for youth as well as the programs and resources that were available for the participants. The coding scheme aligned with the interview protocol. The coding team consisted of three trained graduate students. Each interview transcript was coded by 2 members of the coding team. The team analyzed the results, convened a consensus meeting to resolve disagreements between coders. Inter-coder reliability across all coded data ranged from 90-100%.

Results

Participant characteristics

A total of 21 YDPs from diverse organizations participated. On average, the audio-recorded telephone interviews lasted 1 hour and 15 minutes. Participants' ages ranged from 27 to 59 years, with a mean age of 37.6 years. The majority of participants were female (n = 16, 76.2%), African American (n = 10, 47.6%) or White, non-Hispanic (n = 8, 38.1%), had a high degree of educational attainment (college and bachelors; n = 18, 85.7%), and most (n = 13, 61.9%) had 3-5 years' experience working in their field. Table 1 provides demographic information.

Emergent themes

Six codes were generated from the 21 interviews using content analysis. The structured coding scheme and the frequencies of the codes are presented in Table 2 below.

Resources and programs for youth

Participants were asked to describe the programs and resources, if any, offered by their organizations to address sexual health and sexuality issues among adolescents. Three themes were identified: (a) programs for youth, (b) informal information for youth, and (c) referrals for youth. Participant names are pseudonyms given by the research team.

Programs for youth

Sexuality education programs were characterized as providing youth with information inclusive of but not limited to dating, romantic relationships, negotiating sexual activity, STIs, HIV, sexual orientation, gender identity, reproduction, and puberty, and were reported by most of the participants (n=15).

Jacob, a 45 year-old white man who worked for an organization which serves lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth and straight allies, described sex-positive interventions for sexual and gender minority youth. He explained that these programs cover topics such as

...love, dating and relationships where we talk about...the dating scene and starting to date and are you in a safe relationship, are you in a controlled relationship? We also have our safer sex discussions... [and have an outside facilitator] come in once a month to do...HIV/AIDS testing and we also once a quarter [have another facilitator] come[s] in to do STD testing.

Sarah, a 27 year-old white female working for a health services and health advocacy organization described a multi-component intervention, consisting of services such as 1) free birth control and STI testing for youth, 2) discussion group meetings for youth to learn and talk about topics including healthy relationships, sexual decision making, refusal skills, and information about birth control and STIs, and 3) a group session for parents to learn about having conversations with their teens about sex, sexual decision making (e.g., abstinence), values and expectations, and how teens can protect themselves if they choose to engage in sexual activity (e.g., condom use).

Even when CBO staff were comfortable addressing sexuality related issues, it seemed that they were not always confident that their colleagues would have the same ability to address sexuality-related issues for youth. As an example, Jennifer a 38 year-old female who worked at a domestic violence and rape crisis shelter and had over 10 years of experience working in the field, had concerns about her colleagues talking with youth. She stated, *“Pretty much, I can’t guarantee that somebody else in my position would be able to talk to a young person about issues of sexuality. I work in a pretty homophobic organization and so it’s hard to discuss issues of sexuality.”*

Only one participant described an abstinence-based or abstinence-plus program that was characterized by stressing the importance of refraining from sexual activities outside of marriage. John, a 41 year-old African American male working as a group program director for the youth group of a fraternal organization discussed the abstinence-based program:

Unwanted or unplanned pregnancies are prevalent in the communities with the young men we work with, so we try to help combat that issue head on. But just make sure young men know their roles in the process and we... focus on the importance of abstinence... if that’s not an option or young men choose not to exercise that right, we want to make sure they are educated in the actions that they do take and understand the consequences.

Though most participants in this study reported offering some kind of program or intervention for youth, five individuals reported an absence of any such resources. Megan, a 27 year-old white female who worked as an outreach specialist for an organization that serves girls, indicated that her organization was not open to including any sexual-health or sexuality-related programs and would be unlikely to do so in the future. Disagreeing with the CBO’s stance, she said she would be open to

Inviting an adolescent gynecologist to our program [and]...giving the opportunity to the girls if they wanted [to talk]... So I try to put girls in situations where they have access to someone that they normally would not have access to and hope, and all I can do is hope, that they take the opportunity. Which is a terrible, terrible way of dealing with it. And I know that. But that’s what I can do.

Others participants who worked at CBOs that did not offer programs, like Megan, indicated they were limited in what they could do because of organizational policies. Other YDPs had not considered providing sexual health services for youth. Taylor was a 31 year-old African American woman and the founder and executive director of a Christian mentoring program that did not actively address adolescent sexual health or sexuality. Taylor explained that the mentoring program did not specifically address sexual health and sexuality because the youth were not asking their mentors about these topics. She said she didn't want to address it because, *"it's just a matter of are they going to be receptive [to talking about sexual health and sexuality]? Is this something that they are dealing with? Is this something that is going to fly over their head because it's just not them."* However, later in the interview, Taylor revealed, *"I don't like to talk about sexuality...I don't feel that is something you need to talk about."*

Informal information for youth

Slightly more than half (n=11) of participants described providing informal information to youth. Informal information took many forms, including pamphlets, brochures, handouts, videos, hotlines, websites, and/or one-on-one counseling. In describing the informal information that Jacob's organization provided for their youth, he stated,

We also have a lot of pamphlets, we have them in the bathroom where people can come in and shut the door and... if they are curious about chlamydia or they are curious about abstinence or they are curious about getting tested for HIV, all those pamphlets are right there for them to look at to take home with them. Then we also have our safer sex things in the bathroom as well. [We have] condoms and lube and non-latex gloves, we've got out there for them to use. We have dental dams on demand, we don't keep them in there but if anyone needs one, we've got them.

Sometimes informal information was disseminated via social media. Jennifer, who does outreach activities in schools in an abstinence-only state explained,

Yeah, we have a 24-hour hotline and we have a Facebook page...Because I can't handle things out of school so it has to be virtual, so we do Twitter and we do Facebook mostly. So that's the only way that I can hand out healthy sexual resources and...sexuality [information] is through the web basically.

Referrals for youth

About a third (n=6) of participants indicated their CBO provided youth with referrals and services to healthcare providers and other professionals. Jennifer explained, *"we are able to refer our teens, depending upon what additional resources that they need, we serve as a health center and providing as much of the health, direct health services that we can related to sexual health and sexual health issues."* Likewise, Jacob indicated *"the [health center] is another one that we use that does HIV testing and has case management... They are trying to get a clinic started and LGBTQ clinic started here too that we have been trying to assist with."* Other organizations focused on aspects of reproductive health; for instance, one participant partnered with a program which encouraged pregnant women to obtain prenatal care and provided incentives for contraceptive use after delivery.

Resources for YDPs

Participants were asked to describe the training and resources they receive through their organization which helped them address adolescent sexual health and sexuality. Three sub-themes emerged, including (1) training for YDPs, (2) absence of resources for YDPs, and (3) outside resources for YDPs.

Training for YDPs

Almost half of participants reported that they received some kind of formal training from their CBO to help them address adolescent sexual health and sexuality (n=8). Sandra, a 45 year-old African American woman working as a health educator for a large hospital explained her experience related to grand rounds, saying *“they have different positions come in and talk about the latest research ... it is like a roundtable discussion about what is hot right now in sexual health. What is hot right now in terms of childhood development anyway or pediatric development... We have trainings... right now I think it is condom use awareness month so they have a training offered this month and they have different workshops throughout the hospital.”*

Like grand rounds, much of the formal training was sporadic, opt-in, and based on what was available outside of the organization at the time. Beth, a 47 year-old African American woman who worked with foster youth explained that she and her colleagues could opt into training sessions which occurred relatively often and addressed many aspects of positive youth development. She goes on, *“they can pop up at any time. We will have classes in reference to how to better work with youth, how to communicate better with foster parents, how to address certain issues, certain hard issues with youth. It will be an array of different titles or classes but once they get them, once they come and we have to sign up for them.”* Others had some initial training, although it was not ongoing.

Many YDPs sought training outside of their organizations. Sandra, who worked for a hospital, reported that she received some training through her employer, but *“I usually access trainings outside of my organization. Because I mean we are [a large hospital] but we do way more than just sexual health. And because my department or my team is focused primarily on sexual health, at least historically, right now we are branching out, a lot of our trainings come from outside organizations.”*

Absence of training for YDPs

For a variety of reasons, nearly half of the YDPs in this study (n=10) reported that their employer did not provide any training to address adolescent sexual health or sexuality. Some organizations were strategic about not providing training for YDPs to address adolescent sexual health and sexuality. For instance, Taylor, the executive director of a Christian mentoring program who indicated her discomfort with discussing sexuality explained that the role of the mentors in her program was *“to be a guide. So if [the youth]... ask[s]... about STDs... that is an easy question to answer. If you have one and you don't know what to do about it, the mentors are not doctors so that would be a situation where they would need to reach out and find resources...”* She went on to explain that not all adolescents in the

mentoring program would experience an STI, so she thought it most appropriate not to address adolescent sexual health or sexuality. She continued, *“if I bombard [youth] with information that most of them are not going to use that is just going to... wear the mentor out...”*

Other organizations were less strategic in their decision not to provide training for YDPs to address adolescent sexual health and sexuality. Cindy, a 36 year-old Native American woman who works for a faith-based organization, explained that the pastor and other decision-makers view teen pregnancy as a *“top priority”* but explain that their discomfort with the subject makes it difficult to directly address teen pregnancy or other aspects of adolescent sexual health and sexuality. She explained,

there is a disconnect between... the outcome of not dealing with sexual health... They are looking at the symptoms, not the root of the problem.... There is no logic model, [their approach] is not well organized, and there is no real plan. It would be awesome... to have a logic model to have a plan where people could see this is what you do [to address these topics]. I think that is something that they would pay attention to... They are all really well educated... I think the[y would] get it if I presented [the pastor and other church leaders] with [a logic model] they would go, ‘well yeah, well this is one of our main goals maybe we should give it more direct attention’ ... [but they] are more reserved, more conservative, more closed off and uncomfortable. I think that is our main barrier is people are uncomfortable with the topic.

Likewise, Mark, a 59 year-old white male who was the executive director of a youth ministry organization succinctly describes his reason for not providing training opportunities for himself and his colleagues who work with youth. He stated, *“that’s just not who I am... I am personally not oriented to data and resources and that sort of thing. So it just doesn’t cross my mind to make it available. That’s probably the bottom line.”* The decision not to provide training was seen in all religiously affiliated organizations.

Outside resources for YDPs

Almost half of participants (n=10) indicated that they sought out resources which they located themselves to help them address adolescent sexual health and sexuality. For instance, Jessica reported that she used a telephone resource organized by another CBO. She said, *“you can just call them and say ‘hey I need a referral for this’ or ‘I need information on this’ and [they] just look it up for you based on your zip code and give it to you. That’s one thing here I really like. And then I can [contact a health center and] our community centers. If we had anything... we needed assistance with I could probably ask them [if] they had some training or whatever.”* Brook, a program coordinator for an organization that serves 7th and 8th grade girls explained that not only did her organization provide direct training, she could also rely on the expertise of her network, which was very supportive of its members.

Many other YDPs indicated their willingness to obtain relevant resources online. Some YDPs incorporated the youth into the search for relevant resources. As an example, Brook, a 53 year-old African American woman working as a program coordinator for an organization for girls, indicated that

if [there] was a question I just didn't really know [the answer to]... I will tell them 'I don't know but I can help' and 'let's do the research together'... We might go in and sit down together [at the computer and] they become my teacher... they get a big kick out of that. And I say, 'now how do I do this and where do I? What do you do with stuff here? I know how to do it on my computer a little bit but how do you guys Google stuff here at this? Is there a Google search or whatever?' They are like, 'no, no we will show you. We will do it like this.' And then we start delving into it and seeing what [information is available].

Most YDPs who sought outside resources were similarly comfortable with reaching out to others in their network when they needed help or found resources online as issues needed to be addressed.

Discussion

This qualitative study sought to investigate the programs, interventions, and resources that CBOs offer youth and to examine what resources and training opportunities YDPs receive that helped them address adolescent sexual health and sexuality. No other known studies have examined programs, interventions, and resources and the related training for YDPs making the findings unique to the literature. Interviews with 21 YDPs revealed much diversity in terms of the content of the programs, interventions, and resources that CBOs offered to youth; similarly, the training and resources that were available for YDPs to use to help them address adolescent sexual health and sexuality, varied considerably.

The themes that emerged regarding resources included programs for youth, informal information for youth, and referrals for youth. A majority of participants indicated their CBO provided some type of programming for the youth they served. The research team believes the high number to be an inflated representation of the broader YDP community. At the same time, there is strong support for YDPs and CBOs being capable of providing sexual health and sexuality information to adolescents.

The types of sexual health programs implemented by the CBOs in this study were often related to the mission of the organization. Individuals from faith-based organizations stressed the importance of sexual abstinence before marriage and of following other religious teachings related to sexual behavior; likewise, organizations which provided direct sexual health services to youth (or partnered with another organization which would do so) seemed to gravitate towards an approach to adolescent sexual health and sexuality education that focused on providing medically accurate information which would enable youth to make the best decisions for themselves. Developing programs (and resources) for implementation by YDPs likely needs to have a modular approach (e.g., pick and choose modules) with each module covering different content (e.g., STIs, sexual behavior negotiation) with a baseline of accurate information that could be layered upon with more detail and/or different value considerations. In this way, CBOs can align a program with their mission and values (e.g., faith-based missions) and the needs of the youth attending their programs.

Just over half of YDPs also provided some form of informal information to the youth they served. Providing pamphlets, brochures, palm cards, videos and other similar forms of information may be somewhat less than expected given how many provided programming. New and innovative forms of informal information for distribution to youth, perhaps using technology such as social media (Bull, Levine, Black, Schmiede, & Santelli, 2012), should be further explored as a possible avenue for improving supports for YDPs.

Only about a third of YDPs indicated their CBO provided sexual health-related referrals to youth. Those who did were able to develop partnerships with other organizations and develop a referral network of their own. Organizations that did not provide referrals may not have had the connections to develop a referral network. Future efforts to support YDP efforts in addressing sexual health and sexuality issues might consider providing a guide on how to develop local referral networks to address adolescent sexual health issues as well as provide a ready-made national list of referral organizations.

The second research topic we sought to address was the training and resources that were available to YDPs to help them better address adolescent sexual health and sexuality. We found that both the amount of training and the types of training and other resources available to YDPs varied considerably between participants. Training was some times encouraged by the organization and, at other times, sought out by individual YDPs. Others received no training nor sought out learning opportunities, particularly those from religiously affiliated organizations. YDPs who did receive training of some type typically indicated it was opt-in, informal, and generally not extensive enough. There was a clear consensus from participants that more training was desired.

The desire for more training is supported elsewhere in the literature. The field of youth development is calling for greater organizational investment in training staff that work directly with youth (Huebner, 2003). As an example, Borden and colleagues (2002) stated “we can no longer afford to have youth development professionals who are forced to use only their best instincts and guesswork at what makes a difference in the lives of young people” (p. 7, quoted in Huebner et al., 2003). Other researchers have noted the importance of staff training and effective service to youth and in perceiving a higher degree of credibility in their professionalism (Center for School and Community Services, 2002; Fisher et al., 2010; Gupta et al., 2015). Grossman (2002) found that the staff members who led activities with youth were center to high quality interventions. Given the importance of staff training on their effectiveness, Huebner and colleagues (2003) suggested a framework for training youth development staff which relies on “a model of shared learning with trainer as facilitator (not expert) and youth workers as experienced practitioners. The goal was a co-created, mutually respectful model that blended research and theory with critical reflections on practice in the real world.” (p. 214)

Many YDP also sought resources to address sexual health issues for the youth they served. Often, this involved reaching out to other organizations or, innovatively involving youth in seeking out the resources and answers to their own questions. As with training, this study highlighted that youth-serving CBOs must work together, effectively when educating and helping youth with sexual health and sexuality issues. Helping YDP and CBOs to address

sexual health topics with adolescents will require a collaborative approach that facilitates connections and networks, not only for training and resources, but also for support and sharing best practices.

There were several limitations to the present study. As with the vast majority of qualitative research, conclusions are not generalizable to the larger population of YDPs and the CBOs in which they work. However, the geographic and organizational diversity and saturation of data provide a solid foundation for future research that could be more generalizable. The study explicitly identified sexual health as the topic of interest in recruitment messages. It is possible there was a lack of interest in participation from YDPs who were personally uncomfortable with the topic or worked in organizations that did not do sexual health work, resulting in a self-selection bias. Details regarding the CBO mission statements, general policies around the issues of interest, funding sources, and professional development and training requirements were not collected which would have added an additional layer of nuance to the data.

Future research could build on this study by examining the same issues from the perspective of youth engaged in the CBO programs. Layering on details regarding the CBOs (e.g., funding sources, policies and training requirements) would provide additional context to developing a more nuanced approach to the issue. Research more readily generalizable to a larger set of YDPs is also warranted to confirm the findings presented in this study.

Conclusions

An ecological or multi-level approach to sexual health education requires professionals in the field to look beyond parents and schools to include community-level interventions such as those found in CBOs to address the persistent disparities in sexual health outcomes among adolescents in the United States. Given that many YDPs are highly influential in the lives of young people who access CBOs, they are uniquely situated to assist in the efforts to improve the sexual health of adolescents, a notion bolstered by this research. To support YDPs and CBOs in efforts to provide youth with accurate, non-judgmental information on sexual health and sexuality, companies and organizations developing programs, interventions and trainings for CBOs should 1) consider a modular approach to content education that allows the mission and values of the organization to be reflected in implementation, 2) utilize technological innovations to share resources with youth, 3) develop “how-to” modules on developing networks of local sexual health professionals and other YDPs, 4) innovative training materials that are easily accessible by YDPs either through their CBO or on an individual basis (e.g., internet based), and 5) develop a network for sharing of sexual health and sexuality connections, resources and best practices.

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Table 1

Participant Characteristics (N=21)

Demographic Variables	Number	Mean/Percent
Age	21	37.6
Gender		
Female	16	76.2
Male	5	23.8
Ethnicity		
Caucasian/White	8	38.1
African American/Black	10	47.6
American Indian/Alaska Native	1	4.8
Other	2	9.5
Hispanic		
No	19	90.5
Yes	2	9.5
Education		
High School	1	4.8
Some college	2	9.5
College	8	38.1
Graduate	10	47.6
Years in the field		
1–2	3	14.3
3–5	13	61.9
6–10	3	14.3
Over 10	2	9.5

Table 2

Structured Coding Scheme

Code	Count
Resources and programs for youth	
Programs for youth	21
Informal information for youth	11
Referrals for youth	6
Resources for YDP	
Training for YDP	8
Absence of training for YDP	10
Outside resources for YDP	10