

# Outside the Mainstream: Young People in Alternative Education

## Youth Health and Development for Counties-Manukau

*The 2005 Annual Report by Kidz First Community Health - Centre for Youth Health to Child and Youth Funding of Counties Manukau District Health Board*

by

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### Executive Summary

1. A comprehensive multidisciplinary youth health and development service has been provided for 97 students (82 new) from 4 Alternative Education Schools (AEs).
2. Our approach is effective in identifying health and development needs. Ninety four out of 97 students required health services and/or referrals on to other services.
3. Effective relationships have been established with AEs and other agencies enabling many students to be transitioned effectively to those agencies.
4. Over one-half of the students required referrals to other primary or secondary health services.
5. We have involved students in the development of the service.
6. We have provided proactive and responsive health promotion.
7. There are continuing gaps in core health provision – dental and immunisation services.
8. There are unmet social and family issues which are outside health but impact on health and development.
9. The service provision for 4 AEs currently consumes slightly more resource than funding allows. Roll out to further AEs requires at least an equivalent level of incremental funding.

### Introduction

Young people who are under 16 years of age and outside mainstream educational settings are at increased risk of multiple problems including suicide attempts, early parenthood, substance abuse, problem behaviour and poor educational achievement.

While there is no simple single answer, youth friendly health services with the following features have been proven to make a real difference.

1. easy to access
2. address multiple issues
3. provide continuity of care
4. can be intensive
5. that are linked in with education, other specialist services and families.

This is the second year that Centre for Youth Health has provided a comprehensive health service to 4 AEs in CMDHB (and our second report).

## Who we are

We are a multi-disciplinary youth health team from the Centre for Youth Health, Kidz First. We comprise Social work, Nursing and Doctors who come from various professional health settings which means we have a broad and varied skill base i.e. alcohol and drugs, sexual health, mental health, primary healthcare and care and protection. Given the varied skill sets we have the ability to manage the health and development needs for the majority of the AE students. This team is led by Yvonne Kainuku-Walsh and comprises of Dr John Cosgriff, Analosa Ulugia, Annabel Prescott and currently our Registrar Dr Jamie Speeden.

## Demographics

### Output Statistics

Initial Assessments = 82

Follow-ups (from last year) = 15

### Demographics

Male = 53

Female = 44

### Ethnicity

Maori = 70

Pacific Islands = 22

European = 1

Unknown = 4

## What Have We Done?

### 1. Services provided

We have developed and maintained primary and adolescent specialist clinical services which address the unique needs of young people in AEs who have complex health concerns, chronic illnesses and disabilities. The service provides co-ordinated care that is youth oriented and responsive. It also promotes appropriate utilisation of other primary and secondary care providers.

Over the last 12 months many more needs affecting the young people's health, particularly in complex social and family areas have been identified. The service is evolving further as an authentically youth orientated and responsive model. This model (in a fluid state) is delivering services far beyond the original intention, beyond the bio-medical and into holistic management.

We have managed to participate and engage in some interventions i.e. Family Group Conferences, utilising skills involving behaviour change (which is only more likely to be effective if delivered by someone who has an ongoing relationship with the young person) and engaging parents' involvement in the care plan.

- Initial assessment

We engage students in non-traditional ways i.e. over their lunchtimes, at AE special events, health promotion sessions. During their initial assessments a huge effort is made to ensure students have a positive experience with a health professional, demystifying perceptions and

restoring any previous unpleasant experiences. We perform multidisciplinary physical and psychosocial (ecological, whare tapa wha) assessments.

- Individual interventions

We address all health needs identified during screening, either ourselves or by referring on. In these discussions we often have to utilise skills which support behaviour change models i.e. motivational interviewing and cognitive behavioural therapy approaches. These issues take time and need intensive work with the students to increase their motivation and/or to undertake therapeutic intervention.

Ø	Sexual health:	Assessment for risks of STI PCR testing for Chlamydia Treatment Sexual abuse support and referral
Ø	Reproductive health:	Contraceptive choices and options Commencing contraception Pill teach Condom teach/demonstrations Pregnancy testing Supporting pregnancy options ECP
Ø	Mental health:	Assessment and treatment
Ø	A & D:	Screening Therapy – one on one or small groups
Ø	Vision and hearing:	Screening
Ø	Other:	Skin Chronic illness management
Ø	Social health:	Follow up with social service agencies i.e. welfare and justice sector
Ø	Education:	Fortnightly case reviews with the AE providers Supporting transition plans.

## 2. Referrals

Of the total 97 students, only 3 have not required current follow up for health issues. A total of 53% of students required specialist referrals, which were of an urgent or high priority nature and included;

- Child and Adolescent Mental Health;
- Residential Alcohol and Drugs Services;
- Sexual and Reproductive Health;
- Dermatology;
- Audiology;
- Dentistry;
- Optometry;
- Radiology;
- Cardiology;
- Neurology;
- Diabetes clinic;
- Child Youth and Family Service;
- NZ Housing.

Other types of follow up care have been managed by our team with skills in primary health care, sexual health, A & D, mental health and social work.

### 3. Transitions

A priority is given to ensure effective transitioning of students to other agencies/services. Many of the students referred on don't have the confidence or ability to get to services. We advocate for them to get extra support for this and offer a lot of direct support. Most of the referrals wouldn't have got to their appointments without our direct involvement in appointment keeping and transport.

### 4. Health Promotion

As referred to in our last report, we aim to support and participate in the delivery of health promotion, therefore, increasing access to health provision. Our goals are to;

- engage students
- increase their knowledge of particular health issues and resources available to them
- partner opportunities to support mutual capacity building for ourselves and the AE tutors i.e. sharing skills, resources and knowledge in the delivery and content of specific health topics.

In response to not only the providers but also the students, we have undertaken sessions this year in each of the 4 AEs by addressing topics in -

- Accessing health services: "who we are and what we do"
- Nutrition: "My Goodies"
- Alcohol & Drugs: "wasted time"
- Sexual & reproductive health; "tap, gap & mac'n it"
- Communication and relationships
- Skills in decision making

Other topics commonly identify and requested are smoking cessation and anger management.

Opportunities to share information and to discuss decision making and behaviour change are always taken by our team not only in group teaching sessions but also during our 'one-on-one' korero with each student.

### 5. Health promoting Schools

This is new this year. "Health Promoting schools approaches" support principles that promote a holistic understanding of health as total wellbeing/hauora. More recently we have actively been supporting the AEs to provide a programme which addresses issues around obesity. Supporting and introducing ideas to increase activity, supporting healthy eating (cooking classes) and considering options offered in their vending machines. We also have proceeded with a 'step' competition, whereby we have provided pedometers to each student and staff member to clock up mileage with incentives for those who have scored the most steps during one week. Comprehensive and mentored cooking classes have also been introduced in some of the AEs.

### 6. Inter-agency Co-operation

Several students identified that they had been through Youth Justice and/or had a history/current involvement with Care and Protection. Often plans for follow up or action had been arranged, yet they were not sure about current progress or action on these. We have undertaken to ensure that these plans are progressing - this has consumed a significant amount of our time.

A total of 31 students have had a history of social services involvement i.e. CYF (care and protection and/or youth justice). We have needed to link with their case managers to gather an insight into the plan they have set for these students. This continues to be a time consuming challenge. Social issues are not 'core business' of any one agency except where the problems are severe.

## 7. Youth Participation

Most of the students have an interest in their futures and all of these students stated they wanted 'a better life' and didn't want to 'be a bum' yet most were unsure of how they may achieve/progress a plan towards their goals. One way that has been found to be successful in gaining the necessary life skills to create change for themselves and to successfully move to a better trajectory is youth participation in planning and programme delivery.

There are two specific events that were highlights for the year in terms of youth participation:

- At the end of last year we had a focus group of two young people from each AE who volunteered to help shape our service. They gave us some excellent ideas which have indeed helped to re-shape the service. These were - firstly to develop and present a couple of talks to the young people about what our health team could do for them and secondly they affirmed that they valued seeing the health team on their own and that they would only like their parents to be involved at their request. Another focus group has been planned for November '05.
- Every school term the AIMHI AE Consortium have an activity day, where one group takes responsibility to arrange a day of learning/activity for the 13 AE's in the consortium. Our youth health team with the support of Manukau Youth Centre AE staff and students and CMDHB Pacific Unit supported a Youth Health Promotions day. It was decided (under consultation from the students we would run interactive workshops discussing the topics of; Nutrition, Alcohol & Drugs, Sexual Health and Body Odessey in the morning and then with the support of local hip-hop artists and inspirational speakers we ran an afternoon concert where the students were entertained but also had opportunities to "free style" their talents with incentives. The young people were involved in the planning, implementation and leadership of this whole day event. They also led the manuhiri and tangata whenua parties at the powhiri.

## 8. Collaboration with AE providers -

We have developed our service in partnership with the AIMHI AE providers and AE students from 4 AE services residing in the CMDHB area.

We review each case with the AE providers. The AE provider knows each of their students well and has valuable insight and knowledge of them and their family/communities.

We continue to meet on a regular basis with the head tutor if not with the whole AE team. This process allows an opportunity for health, education, social and pastoral care to be discussed and share information on each individual student (health will only offer information at these meetings to which students have consented). This continues to allow each of our teams (CfYH/AEs) to form a clearer picture of the students' needs and come up with a comprehensive plan for action.

We meet regularly for 1 - 1.5 hours a fortnight with each AE. This time is spent also discussing how we may best work more effectively with young people i.e. youth development. Also issues arise regarding the challenges and resolutions we have in navigating systems i.e. social/welfare services, health and education.

- Individual plan is negotiated and agreed with by the student
- a further review of the assessment and plan is done with the AE tutors (information shared by us is only shared with the explicit permission of each student)
- follow up.

## 9. Quality Framework (case review)

- All initial assessments reviewed in multidisciplinary team the following week
- Weekly review meeting to discuss issues arising from follow-ups

- Weekly review of investigations and results.

## Future Opportunities to Address Unmet Needs

### 1. Clinical

There have been difficulties getting access for these young people to routine core health services. Examples that have arisen this year are meningococcal vaccination and dental care.

### 2. Engagement with families/whanau

The family is critical in a young person's healthy development. However, by the nature of our service, with the initial assessment being undertaken at the education provider site, there is a lack of involvement with families. We often identify significant family issues but we have been limited in our ability to engage and fully involve parents/families and struggle to address these adequately. Often the issues are complex, for example, parental substance abuse, ongoing criminal activity, or family violence. To work more effectively with these young people it is vital to have resources to engage and work intensively with some families.

We want to work with families intensively and over a long period of time because this is known to be effective. The issues include problematic family relationships, parental substance use, ongoing criminal activity, fighting and anger issues. We fully appreciate and value the connections the AE providers have with parents and whanau, yet, to ensure we are able to work more effectively to support youth healthcare it is vital to have the resources to directly engage families. More social work/family work provision would strengthen connections and resiliencies for families and their young people.

### 3. Advocacy for young people within the system.

A number of young people have had current or past involvement with Justice, Child Youth and Family or social agencies e.g. Waipareira Trust. Often plans for ongoing action had been made but the young person was unaware of their current position. We often spent considerable time engaging with these agencies about their plans for the young person. There is a need to develop better working relationships with these agencies.

### 4. Mentorship

Many of the young people attending AEs would blossom with mentoring. We know that mentoring needs to be intensive and sustained over at least a year to make a real difference in outcomes. We struggle to find agencies within the South Auckland community that can provide intensive or long term mentoring.

### 5. Access to sport, recreation activities and holiday programmes.

Many of the young people have displayed talents in a variety of activities prior to attending AE. However now that they are outside mainstream their continued access to sports teams and other activities is extremely limited. Given what we know about the value of feeling connected to prosocial peers and developing competency that is provided by these activities, we feel this is a significant gap. We recognise that the solution to this will involve building on and establishing relationships with other groups within our community.

### 6. Extension of Quality Framework

We will be instituting a manual routine bring-up system in the coming year. We will monitor the following quality indicators:

- a. Consent obtained and recorded
- b. BMI recorded
- c. Vision screening performed
- d. Sexual activity recorded
- e. STI screening for all sexually active students



## CASE STUDY ONE

F is a 14 year old Pacific Island young man who has been attending an Alternative Education provider since February 2005. He was seen by the Youth Health team as concern was raised regarding his chaotic thoughts and state of dishevelment.

F has lived in South Auckland most of his life. His parents are separated and he is the 3<sup>rd</sup> child of 4 from this relationship. He describes his relationship with his family as close and caring. F has roles within the family such as preparation of family meals. F was moved last year to family overseas due to his behaviour and drug use. He stayed there for a year until he exhausted family supports through his continued and escalating drug use.

F has been removed from mainstream schooling due to fighting and drug use for the past three years hence his enrolment in AE. F wishes to either join the army or become a rapper.

F reports stealing goods and property since aged 11. He has been involved in numerous fights and gangs. There are also a number of social service agencies involved with his care and family.

In relation to his drug use, F has been sniffing glue, paint and diesel from age 11. He has now given up sniffing due to family pressure and personal choice. He developed hallucinations while sniffing - "racing cars and talking cats". These stopped once solvent abuse ceased. There are no other signs or symptoms of psychosis currently. F binge drinks at weekends until he is comatose usually with his brothers and friends. He continues to smoke up to a packet of cigarettes per day at weekends. He accepts this is unhealthy but sees it as part of kicking back with the boys and relaxing.

F is not in a current relationship. During the interview F expressed discomfort on screening for sexual abuse. It became apparent that he most probably has been abused in the past.

F described feeling 'angry' most of the time except when smoking or drinking with his mates. F denied any suicidal thoughts or attempts.

Currently F has been linked to an established army recruitment programme. He continues to have interagency involvement (Waipareira Trust/Child Youth and Family Services). We will be continuing to engage with him allowing the opportunity to work with his ambivalence regarding his drug and alcohol use. It is hoped with a trusting relationship F will be able to disclose any past abuse.

## CASE STUDY TWO

AR is a fifteen year old Maori young woman who is currently attending an AE in South Auckland, she has been there for three months. Initially AR was concerned whether or not she was pregnant as she does not use contraception.

Home - AR comes from a family of five siblings with her stepfather being the father of the two youngest children. AR has been physically abused by her biological father resulting in Child Youth and Family Services being involved. She is currently living with her sixteen year old boyfriend (M) and he is living next door to AR's biological father. M is currently involved in the youth justice system with impending court trial.

Education - AR has been going to the AE for three months; prior to this she went to Onehunga High School for two days and then was truant. Prior to attending Onehunga AR was enrolled in a school in Northland while living with CYFS appointed foster parents.

Activities - AR has nil involvement with prosocial activities and her socialising is mainly around substance use at parties. She has no long term career plans or goals.

Drugs and Alcohol - AR comes from a family where substances, particularly alcohol, cannabis and tobacco, are frequently used. AR smokes daily and has a risky binge drinking behaviour. However has limited insight to the risk associated with her drinking.

Sexuality - AR is sexually active and has been in her current relationship for approximately two years but uses no form of contraception. Her last STI screen was two years ago and she has no symptoms. She disclosed historical sexual abuse from multiple family members and then went on to describe symptoms consistent with Post Traumatic Stress Disorder (PTSD).

Safety/Mood - Denies any current suicidal ideation however reports thoughts of self-harm the previous year due to stressful environment. She currently reports a good relationship with K with whom she lives and this is someone that she identifies she is able to talk to.

Medical - There was a history of a 'hole in the heart' and on examination a cardiac murmur was confirmed.

Plan and ongoing management:

1. Pregnancy test - negative.
2. STI screen - positive. AR and M treated.
3. Contraception advice and Depo Provera given.
4. Heart murmur - referred for echocardiogram and cardiac follow-up.
5. Safety concerns - active liaison with CYFS social worker.
6. Mental Health - Follow up with Campbell Lodge with transfer of care to CfYH due to disengagement from CL service.
7. Actively engage with AR and see on regular basis with future plan to address PTSD, A&D and safety issues.

### CASE STUDY THREE

T was 14 years when we first met him for an initial assessment. He is a Maori young man who had recently (2 weeks) started at AE. Presenting with a chronic shoulder pain.

He gave a history of recently (7 months) having moved to Auckland from Tokoroa where he had been raised by his nan (biological grandmother). Due to her having "unexpectedly" passing away, T was now living with his biological mum, dad and an older brother (aged 20) and his sister (18 years) and her 2 year old son. He stated living with his family was OK but he didn't know them well.

In the last 2 weeks T had been excluded from a local high school for truancy and fighting with other students. The last incident involved throwing a chair at a teacher. T's comments on this new school environment was "it's OK, the tutors are funny".

His interests are in playing rugby league yet he was not currently involved in any organised sport.

He was using marijuana on a daily basis.  
Binge drinking every weekend from Friday night to Sunday morning  
Smoked cigarettes (1 packet per week)

Had a regular girlfriend (16 years old) who had a TOP 2 months ago.  
Unprotected sex.  
Nil history disclosed of sexual abuse.

T came across as a very angry and initially difficult to engage young man. He disclosed that since nan died he hadn't had anyone with whom to discuss how he was feeling. He also told us that during her tangi he had attempted to kill himself by hanging, however the branch that he'd tied one end of the rope to snapped and he fell to the ground with his shoulder taking the full force of his fall.

Risk:

- School failure
- violence
- no goals/expectations: "little hope for the future"
- significant substance use
- unsafe sex
- Unresolved grief
- Suicide attempt

Resiliencies:

- Was loved by nan
- Good relationship with mum and dad
- Interested in sports
- New positive school environment
- The potential to develop a relationship with a male youth worker

Plan:

- Continue to engage
- Link with youth worker to mentor
- Encourage and support participation in organised sport
- Information on safe sex
- Access for him and partner to contraception
- Consultation regarding mental health i.e. suicide

Outcome: (1 year on)

- Experiencing success in sports team and whanau involvement
- Built trusting relationship with AE staff
- Regular attendance at AE
- Long term goal: "wants to be a builder"
- Significant reduction in substance use
- Increased responsibility in sexual health behaviour
- Hope for the future.....T said to me.... "Miss, I'm glad I didn't die"

## Acknowledgements

Firstly to Gilli Sinclair, funder, CMDHB. Gilli's vision allowed this programme to start and her enthusiasm keeps the funds flowing. We sincerely appreciate your understanding for our concerns (when taking on this contract) regarding not wanting to dilute our provision, therefore, ensuring we do what we need to do for each young person and do it well!!

To the young people who are in AEs who have allowed us to journey with them for they have contributed to our service.

To the AE providers, who have welcomed our partnership by supporting us to be part of their make-up, which have broken down many barriers to their students accessing our services.

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To Sharon Eketone and the Team at Manukau Youth Centre - for always welcoming us into their whare and supporting our needs.

Lesley Whitehead  
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30<sup>th</sup> September 2005