

Outside the Mainstream:

Health Services to young people who are outside of mainstream education settings

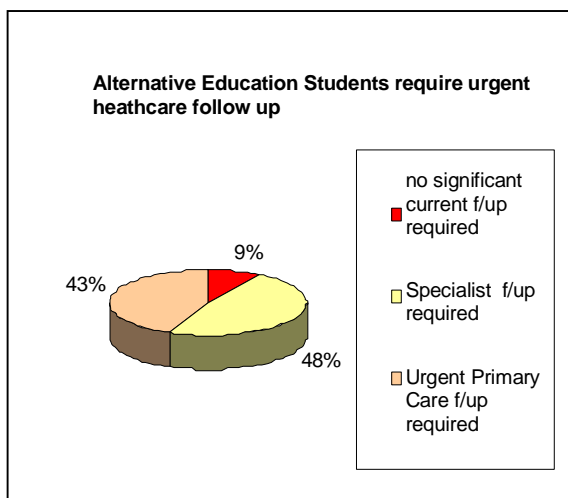
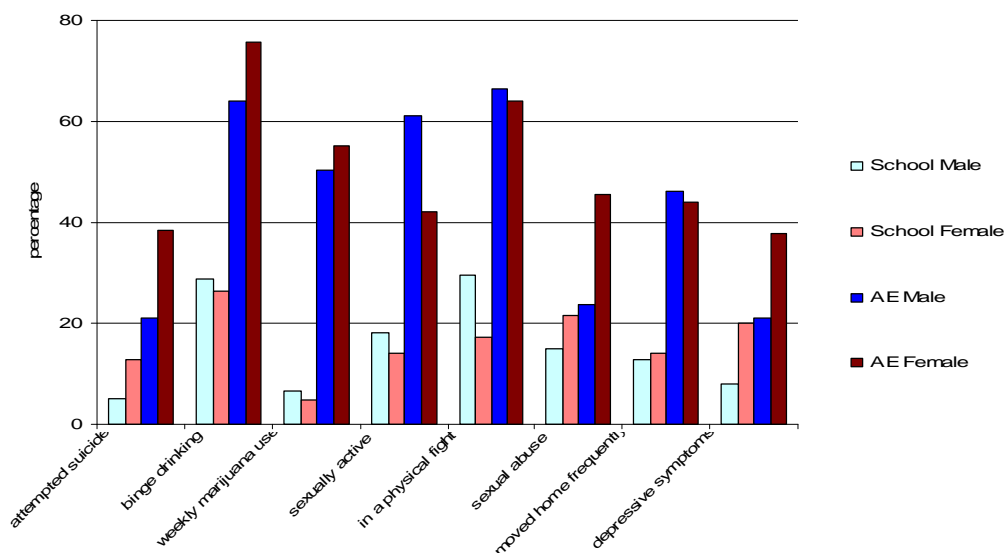
Terry Fleming & Yvonne Kainuku-Walsh, Kidz First Centre for Youth Health, 2004

In the Counties Manukau District Health Board (CMDHB) region under 16 year olds who are outside of mainstream education settings include young people in Alternative Education (AE) settings, Teen Pregnancy Units, residences (CYPS, Justice, community agencies); correspondence school, those who have exemption from school and those who are not enrolled and truant¹. This report is provided to the District Health Board by the Centre for Youth Health (CfYH) to outline health needs and service provision opportunities for young people outside mainstream education in the CMDHB area. There is a particular focus on young people in AE as a group where there are current opportunities to intervene and current health information is available.

Current health needs

Young people outside mainstream education settings typically have higher rates of current and future health issues than young people in school. A range of these needs are significant, restrict life options and involve significant social and economic cost.

Young people in New Zealand AEs have higher rates of risk than mainstream high school students on almost every health behaviour measured.²



In CfYH service delivery to AEs during 2004 over 90% of students required follow-up for significant, current health issues. Several required urgent assessment and treatment of issues including suicide intent; significant substance abuse and chronic illnesses. Many students (approx 80%), do not have a General Practitioner that they regularly use and most have multiple needs across several sectors (e.g. health, education, welfare and justice) and multiple needs within a single sector (e.g. sexual health and mental health needs). Assessment and initial follow up for these students has required significant clinician hours. There is a lack of data regarding young people in other 'non mainstream' educational settings in New

Zealand, however available data does suggest high levels of need, e.g.

- Young women aged 13-16 in contact with Child Youth and Family have **23x the suicide rate** of their same age peers³
- Young offenders aged 10-20 years in a large Australian cohort had **mortality rates 9 – 40 times greater than that of same aged non-offending peers (SMR of 9.4 males and 41.3 for females)**⁴. The 2003 NSW health survey reported that of young people in juvenile justice residences 66% reported abuse or neglect as child; IQ av 82 = low average (75% below 100); >80% had clinical psychiatric disorder; >50% had conduct disorder or substance use and 7% males and 11% females had attempted suicide in the last 12 months.

Evidence and options for providing health care to young people outside of mainstream education settings

Summary

- There is no single demonstrated best model to provide healthcare to young people who are outside mainstream school settings.
- Such evidence that is available points towards promising outcomes of long-term, intensive and integrated or 'joined up' services that meet a range of student needs. **Interventions that rely on short term, information only or assessment and referral only, strategies have not usually been able to demonstrate significant sustained health gains.**
- These findings are consistent with evidence from other areas of youth health, which identify that most programmes which reduce youth health problems (such as early unplanned parenthood; violence; substance abuse or suicide risk) are **most successful when they are:**
 - **intensive, continuous and have staff that are available over time (i.e. the intensiveness of the programme matches the intensiveness of the problems)**
 - **are about developing youth skills/resources as much as reducing a given problem**
 - **have staff that are available, youth friendly, culturally sensitive and 'willing to do what it takes', i.e. identify and address multiple issues and systems**^{5,6}.

Effective service delivery to students outside mainstream education settings in the present day in CMDHB needs to be guided by best principles and current needs rather than necessarily following a specific delivery model.

Background

Most evidence regarding effective healthcare models for young people comes from overseas and is not focused on Māori or Pacific communities. Further there is currently a lack of rigorous systematic reviews of school based healthcare services (for both mainstream and non-mainstream settings) and a lack of large scale, controlled trials or long term outcome based studies. However a number of models have been developed and evaluated in some way as follows:

Option	Description	Evidence
Wrap around services	Intensive multidisciplinary teams which service all client needs on an intensive basis, usually co-ordinated by a case worker. (e.g. services available 24 hours a day by clinical staff member with a small caseload such as 12 clients per year)	Long term positive outcomes demonstrated with intensive, multi-intervention models. Has been used with most 'difficult to treat' or high risk youth and in mental health settings

Comprehensive healthy school environment or co-ordinated school health programmes	Multiple components: Health services Counselling and social services Health education Health promotion for staff Healthy school environment Nutrition services Physical education Family/community involvement Some include youth development programmes	'Promising evidence', for mainstream students where programmes have been comprehensive and longer term reported outcomes include; -increased access to medical care; -increased academic performance ⁷ , -decreased emergency room usage ⁸ -increased contraceptive use for pregnant/parenting teens ⁹
Comprehensive school based clinics	Clinic at the school typically including medical, mental health and nursing services, usually provided free for all students with high priority on enhancing access to healthcare. Often include some involvement in health education at the school	Lack of systematic reviews however reported findings include: -Increased access to health care ¹⁰ , including increased use of other health services ¹¹ ; at least for some students, -decreased emergency room usage ¹² -some but not all studies find changes in health status e.g. suicide ideation, physical health status
Community based school linked youth health services e.g. Youth health centres/ one stop shops	Off school site, multiple function youth focused team, often with outreach clinics to communities of young people. Typically have an emphasis on enhancing access for young people with poor access to health	Current best practice for young people with multiple health risk behaviours and poor access to other healthcare systems.
Primary Health Care	Off school site but may have formal school links or provide school outreach clinic	Improved health outcomes for students who access the service. Less evidence for 'high risk' communities of youth.
School nurse only	Part-time or full-time nurse position within the school	Lack of systematic evidence of impact on students health
Suitcase/mobile clinics	Mobile clinic/van, typically provided from youth health centre or similar	Usually evaluated as part of a service – lack of evaluation data available for outreach only
Family-school-community collaborative model	A social work lead multi-system assessment and intervention for AE students (required approx 50 hours of casework per student)	Lack of systematic evidence of impact on students health ¹³

Local Realities

Many of the students in non-mainstream settings are Māori or Pacific Island

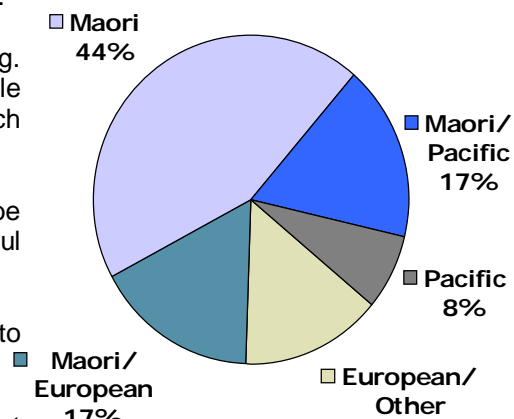
AEs have often operated on limited resources, without qualified teachers, without GSE, Special Education support or health support.

Many AE students have had referrals to multiple agencies (e.g. CYFS, education, health) and are often current clients of multiple agencies but frequently engagement and intervention from each agency has not resulted in significant alterations of identified issues.

Transition out of AE (to school, course or work) is proving to be problematic (as often students experience a lack of meaningful options to go on to).

AE providers often demonstrate very high levels of commitment to their students.

Students are often very positive about the AEs, in the NZ Adolescent Health Survey 90% of AE students said that adults at their school care about them a lot.¹⁴ Further the students often present as eager for opportunities to 'turn their lives around' or 'not make the mistakes they have seen others make. Many report that they see the AE as 'giving them a new chance' and say that they would like help to address issues.



Self reported ethnicity, alternative education students, Northern Region, 2000, 68% were male

Recommendations

Based on local needs, available evidence and current resources, our recommendations for health services to young people outside mainstream settings are that the services need to be intensive and work closely with others. Preferred models (in order of strength of evidence) are;

- 1) Use of a wraparound or comprehensive, co-ordinated healthy school model where available.
- 2) Use of a comprehensive school based clinic where available.
- 3) Use of comprehensive, community based, school linked services.

Whichever models are used, to maximise chances of long-term positive outcomes, health services will need to:

- Be skilled at working with Māori and Pacific young people and their families
- Encourage the development and use of a 'medical home'
- Be a **part** of a comprehensive programme including education, disability services, welfare and justice services, health education and promotion and healthy school environments
- Have good networks, interagency liaison and encourage interagency co-operation
- Be highly approachable, accessible and engaging of young people
- Provide proactive comprehensive health screening

- Have staff who can deal with multiple health issues including screening and immediate safety management and who are knowledgeable about effective practice with young people
- Be able to provide or ensure intensive proactive follow up
- Provide continuity of service, including continuity of staff members and provide a service that students can access over long term
- Consider students needs once they leave their current setting

Explanation of Terms, References and Resources

Explanation of terms

Alternative Education (AE). AE Providers were established in the mid 1990s to provide educational opportunities for young people aged 13.5-15 years who had been excluded from 2 or more mainstream schools, typically because of disruption or behaviour issues. AEs usually provide a mixture of the NZ curriculum (with and emphasis on literacy and numeracy) and life skills. AEs are usually staffed by tutors and are typically off site but under the umbrella of a high school.

Teen Parent Units. There are currently two teen parent units in development in the CMDHB area, these are designed as special programmes by high schools for young woman who are pregnant or have young children.

Residences. In the CMDHB area residences for young people include the CYFS Northern Residential Centre and 'YJ North' (the youth detention facility), Youth Horizons Trust houses; disability supported accommodation, hospital, Dingwall and other special trusts.

Non-enrolled truants. There are an unidentified number of young people under 16 years who are not enrolled in a school or alternative environment, some of these young people have no fixed abode or are living on the streets.

References

- ² Denny, Clark and Watson (2004) the Health of Alternative Education Students compared to Students attending secondary Schools from New Zealand (in press)
- ³ Beautrais, Ellis and Smith 2001
- ⁴ Coffey et al
- ⁵ Pruett M, Davidson L, McMaho T, Ward N and Griffith E. (2000) 'Comprehensive Services for At-Risk Urban Youth: Applying Lessons from the Community Mental Health Movement' *Children's Services: Social Policy, Research and Practice*, 3 (2), 63-83
- ⁶ Dryfoos
- ⁷ California Department of Education 1999
- ⁸ Britto, Klostermann et al (2001) Impact of a School-Based Intervention on Access to Healthcare for Underserved Youth' *Journal of Adolescent Health* 29 116-124
- ⁹ Amin and Sato(2004) 'Impact of a School-Based Comprehensive Program for Pregnant Teens' *Journal of Community Health Nursing* 21 (1) 39-47
- ¹⁰ Hacker, Weintraub et al 1997
- ¹¹ Kaplan, Calonge et al 1998, Kisker, Brown 1996;
- ¹² Adams and Johnson 2000
- ¹³ Carpenter-Aeby, Salloum et al 2001
- ¹⁴ Denny, Clark and Watson (2004) the Health of Alternative Education Students compared to Students attending secondary Schools from New Zealand (in press)