Outside the Mainstream:

Health services to young people who are outside mainstream education settings

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*Teenagers who are under 16 years old and are outside mainstream educational settings are at increased risk of multiple problems including suicide attempts; early parenthood, substance abuse, problem behaviour and poor educational achievement. Yet, these young people typically have **less** access to health services than teens at school.*

While there is no single, simple answer, youth friendly health services that are: easy to access; address multiple issues; provide continuity of care; can be intensive and that are linked in with Education; other specialist services and families have been proven to make a real difference.

Health, education and other sectors currently have opportunities to work with young people to reduce offending, early parenthood, early school leaving and chronic health problems.

This report outlines current issues, evidence and ways forward for providing effective health services for young people outside mainstream educational settings.

Background

In New Zealand young people are required to be enrolled in school from their 6th until their 16th birthday.

Young people aged less than 16 years who are outside mainstream education settings include young people in Alternative Education (AE) settings, Teen Pregnancy Units, Residences (CYFS, Justice, community agencies); correspondence school, those who have exemption from school and those who are not enrolled and truant.

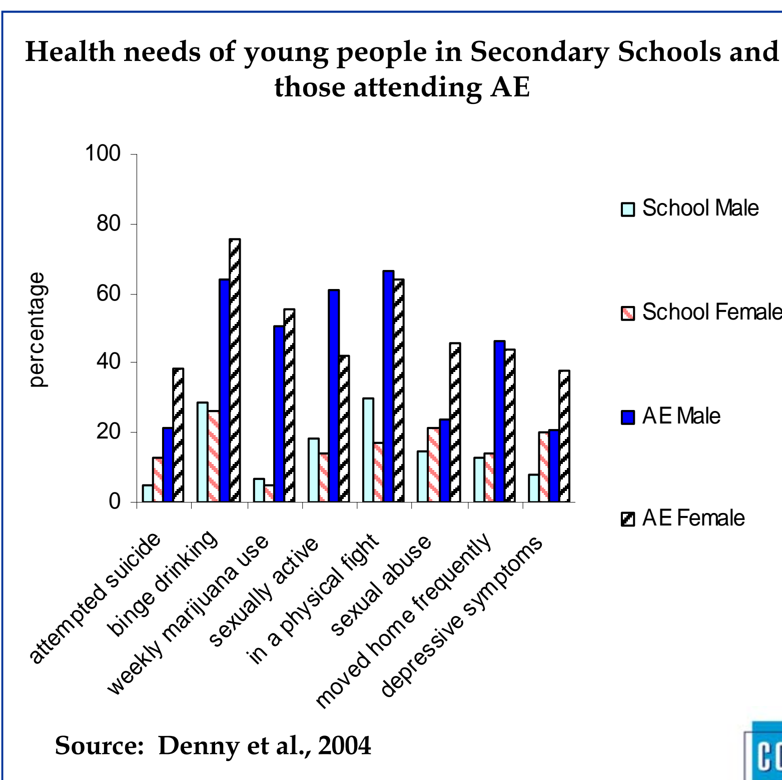
It is known that students who do not complete secondary school are more likely to be unemployed, receive welfare benefits, be convicted of criminal offences and have poorer health outcomes.

This report outlines the health needs and service provision opportunities for young people outside mainstream education in New Zealand. There is a particular focus on young people in AE settings as contemporary comprehensive health information is available for this group and there are current opportunities to intervene.

AE programmes often perceived as a last chance many students have to succeed in education, they also provide important opportunities for health promotion and positive youth development. The challenge is how services respond to this need.

Health issues and needs

Recent research indicates that young people attending New Zealand AEs have significantly higher rates of socio-economic disadvantage, negative life experiences and concerning health risk behaviours than mainstream secondary school students (Denny et al., 2004).



Source: Denny et al., 2004

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There remains a lack of data regarding young people in other 'non-mainstream' educational settings in New Zealand; however available data from New Zealand and Australia suggests high levels of health needs. Examples include:

- Young women aged 13-16 years in contact with the Department of Child, Youth and Family have 23 times the suicide rate of their same age peers (Beautrais et al., 2001).
- Young offenders aged 10-20 years have death rates 9-40 times great than that of samed age non-offending peers (SMR of 9.4 males and 41.3 for females) (Coffey et al., 2003).
- Of the young people in juvenile justice residences in California 66% reported abuse or neglect as a child and 80% had clinical psychiatric disorders, with over 59% having a conduct or substance abuse disorder (California Department of Education, 1999).

Evidence and options for providing health care

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 shown in Table 1 (Overleaf).

Summary of Evidence

1. There is no single demonstrated best model to provide healthcare to young people who are outside mainstream school settings.
2. Research findings identify the most promising outcomes for significant, long-term health gains are from intensive, integrated or "joined up" services that meet a range of student needs.
3. These are services that are:
   - intensive, continuous and have skilled staff that are available over a long period of time
   - 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 (Pruett et al., 2000; Dryfoos, 1998)

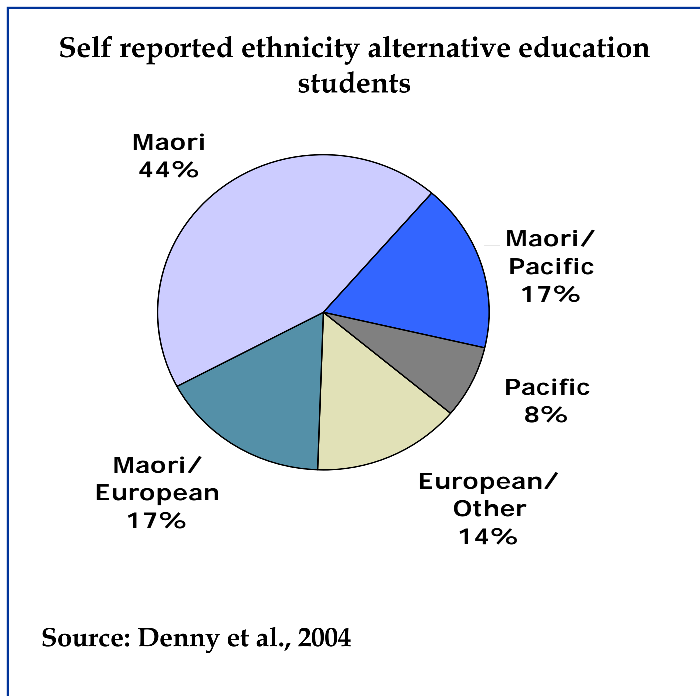
Table 1. Youth Health Services: Options and Evidence

Options	Description	Evidence
Intensive and comprehensive or Wrap-around Services	Intensive multidisciplinary teams which service all client needs on an intensive basis, usually in the context of the client's family and co-ordinated by a case worker (such as 12 clients per year).	Long term positive outcomes have been demonstrated with intensive, multi-level intervention models. Has been used with most 'difficult to treat' or high risk youth and in mental health settings (Woolston, 1998).
Comprehensive healthy school environment or co-ordinated school health programmes	Consisting of multiple components including: ➤ 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, the re-ported outcomes include: ➤ increased access to medical care ➤ increased academic performance (California Department of Education, 1999) ➤ decreased emergency room usage (Britto et al., 2001) ➤ increased contraceptive use for pregnant/parenting teens (Amin & Sato 2004).
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 health-care. Often include some involvement in health education at the school.	Lack of systematic reviews however reported findings include: ➤ Increased access to health care (Hacker et al., 1997), including increased use of other health services (Kaplan et al., 1998; Kisker & Brown, 1996) ➤ at least for some students, decreased emergency room usage (Adams & Johnson, 2000) ➤ 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 healthcare.	Promising outcomes 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 (approx 50 hours of casework per student).	Lack of systematic evidence of impact on students health (deemed insufficient hours per student to be effective) (Carpenter-Aeby et al., 2001).

Outside the Mainstream

Alternative Education Realities

Many of the students in alternative education programmes are male and of Māori or Pacific Island ethnicity.

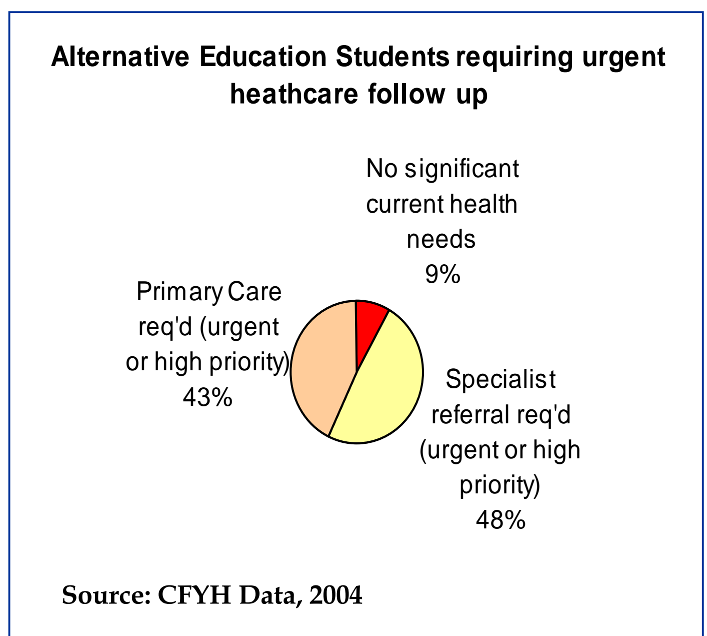


AE providers often demonstrate very high levels of commitment to their students. Students are often very positive about the AEs, in the NZ Adolescent Health Survey 90% of AE students said that adults at their school care about them a lot (Denny et al., 2004). Further the students often present as eager for opportunities to 'turn their lives around' or 'not make the mistakes' they have seen others make. Many students report that they see the AE as 'giving them a new chance' and say they would like help to address issues.

AEs have often operated on limited resources, often without qualified teachers, and with limited health sector support. Transition out of AE (to school, course or work) is proving to be challenging (as often students experience a lack of meaningful options to go on to).

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

The Centre for Youth Health (CfYH) has provided clinical youth health service delivery to AEs in Counties-Manukau for several years. In the first six months of 2004, more than 90% of students following their initial health assessment required follow-up for significant, current health issues. Several young people required particularly urgent assessment and treatment of current safety issues including suicide intent, significant substance abuse and serious chronic illnesses. Many students (approximately 80%), had multiple health needs (e.g. sexual health and mental health needs), did not have a General Practitioner that they regularly used and had needs across several sectors (e.g. health, education, welfare and justice). These young people have required significant levels of clinician input (10 or more clinician hours per month for 4 or more months).



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RECOMMENDATIONS

Health services to young people outside mainstream settings 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.
2. Use of a comprehensive AE or school based clinic.
3. Use of comprehensive, community based, educational linked services.

Whichever models are used, to maximise chances of efficacy, health services need to:

- Be skilled at working with Māori and Pacific young people and their families
- Be highly approachable, accessible and engaging of young people
- Provide continuity of service and especially continuity of clinical staff members
- 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
- Provide proactive comprehensive health screening
- Have knowledgeable and experienced staff who can deal with multiple health issues including screening and immediate safety management and ongoing health care
- Be able to provide or ensure intensive proactive follow up
- Consider students needs once they leave their current educational setting.

One-off health education sessions; assessments without proactive follow-up or occasional health interventions on an as required basis only; are unlikely to improve student health outcomes and hence are **not recommended**.

Outside the Mainstream

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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 an 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.