

**Youth in Alternative Education**

**Youth Health and Development for Counties-Manukau**

*Jan – June 2006 Report by Kidz First Community Health –  
Centre for Youth Health  
to Child and Youth Funding,  
Counties Manukau District Health Board*

### **Executive Summary**

1. A comprehensive multidisciplinary youth health and development service has been provided for students from 4 Alternative Education Schools (AEs) in CMDHB
2. Our Service is effective in identifying previously unmet health and development needs. Over one-half of the students required referrals to other primary or secondary health services
3. Often significant social and family issues are identified which have a negative impact on the young person's health and development
4. There are continuing gaps in core health provision – e.g.: immunisation services, linkages with family
5. We have involved students in the ongoing development of the service.
6. Effective relationships have been established with AEs and other agencies
7. Ongoing staff development is a priority
8. We have recently started developing quality indicators which reflect the work being done with the AE's.

## **Introduction**

This report describes the comprehensive multidisciplinary youth health service provision to young people who are outside mainstream educational settings and attending 4 AE in CMDHB.

This is the third year that the Centre for Youth Health has provided a service to these young people. This report covers the final 6 months of the 2005/2006 year to 30 June 2006.

## **Demographics**

### Output Statistics

Initial Assessments = 47  
Follow-ups = 289

### Demographics

Male = 34  
Female = 29

### Ethnicity

Maori = 28  
Pacific Islands = 29  
    Tongan 5  
    Cook Island 16  
    Samoan 4  
    Nuiean 7  
European = 4  
Unknown =

## **What do we do?**

We offer all young people in the AE a biopsychosocial assessment. This includes but is not limited to:

- 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 teaching  
Condom teach/demonstrations  
Pregnancy testing  
Supporting pregnancy options  
ECP
- Ø Mental health: Assessment and treatment
- 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.

## **1. Clinical Services**

We have developed a primary and adolescent specialist clinical service model which looks to 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.

We have participated 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.

We continue to prioritise the engagement process of students in diverse ways, i.e. over their lunchtimes and during their curriculum, becoming part of the make up of the place to support access, in particular male students who are not high users of health care services.

- Initial interviews:  
Initial interviews develop rapport, identify unmet physical health and psycho-social needs. When issues are identified we will proceed with a more thorough assessment. Our team has skills in primary, sexual, reproductive and mental health.
- Individual interventions:  
As previously reported we address all health needs identified during the initial assessment, either ourselves or by referring on. In these discussions we often have to utilise skills, within the team, which support behaviour change models i.e. motivational interviewing. Some issues are time consuming and involve work to increase motivation and treatment. Co-ordination of care is also crucial and remains a large part of our role.
- Referrals:  
Of the total (61) students, all but (8) required current follow up for health issues. A total of (47.5) % of students required specialist referrals, which were of an urgent or high priority nature and included:
  - Child and Adolescent Mental Health
  - Sexual and Reproductive Health
  - Audiology
  - Dentistry
  - Radiology
  - Diabetes clinic
  - Child Youth and Family Service
  - NZ Housing
  - Family Start
  - GP

- District Nursing
  - Youth Line
  - Optometrist
- Transition:
 

The priority of ensuring effective transitioning of students to other agencies/services continues.

This is achieved by several methods:

    - 1) Working with the AE who transition the young person to employment related training.
    - 2) Ensuring that health related issues are addressed prior to the transition or refer them to other Centre for Youth Health clinics
    - 3) Introducing the young person to local GP and Health Services such as Specialist referrals.
  - Health Promotion:
 

We have developed resources on topics such as access to services, relationship building, decision making, Sexual and reproductive health, and supporting a program which aims to intervene Alcohol and Drug use.

We have delivered 4 of these Health Promotion opportunities.
  - Health promoting Schools:
 

We continue to support “Health Promoting schools approaches”. We have done this by:

    - Linking AE to obesity programme – this has been driven by the fact that some of the students were heading towards a diagnosis of diabetes. The program encompassed:
      - Supporting increased activity in AE i.e. supporting gym memberships
      - Healthy eating – lunches – encouraged cooking classes.

As a consequence of this awareness, one AE employed a person to support the development of skill building for the young people.

Vending machine – the AE increased the options available to the young people which encouraged healthy choices.

## **2. Inter-agency Co-operation**

### Relevant Parties:

A number of students have past or current involvement with The Department of Justice or Child Youth and Family Services. Often plans for follow up or action had been arranged, yet agencies were not sure about current progress or action. We ensure that their plans are progressing and the agreed actions are being implemented as part of the coordination of care. We recognise the need to increase networking with other community agencies to ensure effective outcomes for the young people and their families.

### Alternative Education Providers:

We continue to meet with the teaching team from each AE on a fortnightly basis to support the development of our service.

We have a quarterly meeting with the AIMHI consortium.

### **3. Consumer focus**

Youth participation:

Youth participation is recommended best practise in Youth Health. We maintain this best practice by engaging with the young people and have developed a focus group to gain some feedback on the service to date

Families and 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. For us to work more effectively with these young people we would need resources to engage and work intensively with some families.

Evidence supports that some of the families need intensive interventions, support and resources over a period of time. Some of the issues that have been identified through assessment are grief and loss, trauma in relation to family dynamics and violence Roles that young people take on in the family, such as parenting which they are not ready for.

We value the connections the AE providers have with parents and whanau, yet, to implement the evidenced based model of practice and support improved health outcomes for young people, an increase in resource to directly engage with family members would be required. Social work/family work provision would strengthen connections and resiliencies for families and their young people.

### **4. Advocacy and 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. However this has been a possibility over the last 6 months from forming relationships with community and church providers who have been able to link our students with youth events and youth leaders within these settings i.e. Equippers, CLCA, 274 Crew and Youthline "Voice" mentoring.

### **5. Professional Development and Best Practice**

There is a weekly multidisciplinary team review which involves an external reviewer who is a Senior Doctor. This meeting reviews all initial assessments and any concerns arising during follow up appointments with the young person.

This gives opportunity to support and up skill the health team in this work with some of the most complex circumstances these young people find themselves. It has become clear that the health team should consist of some people with life experience and highly skilled.

Weekly in-service training reflects the issues presented to the staff at the AE.