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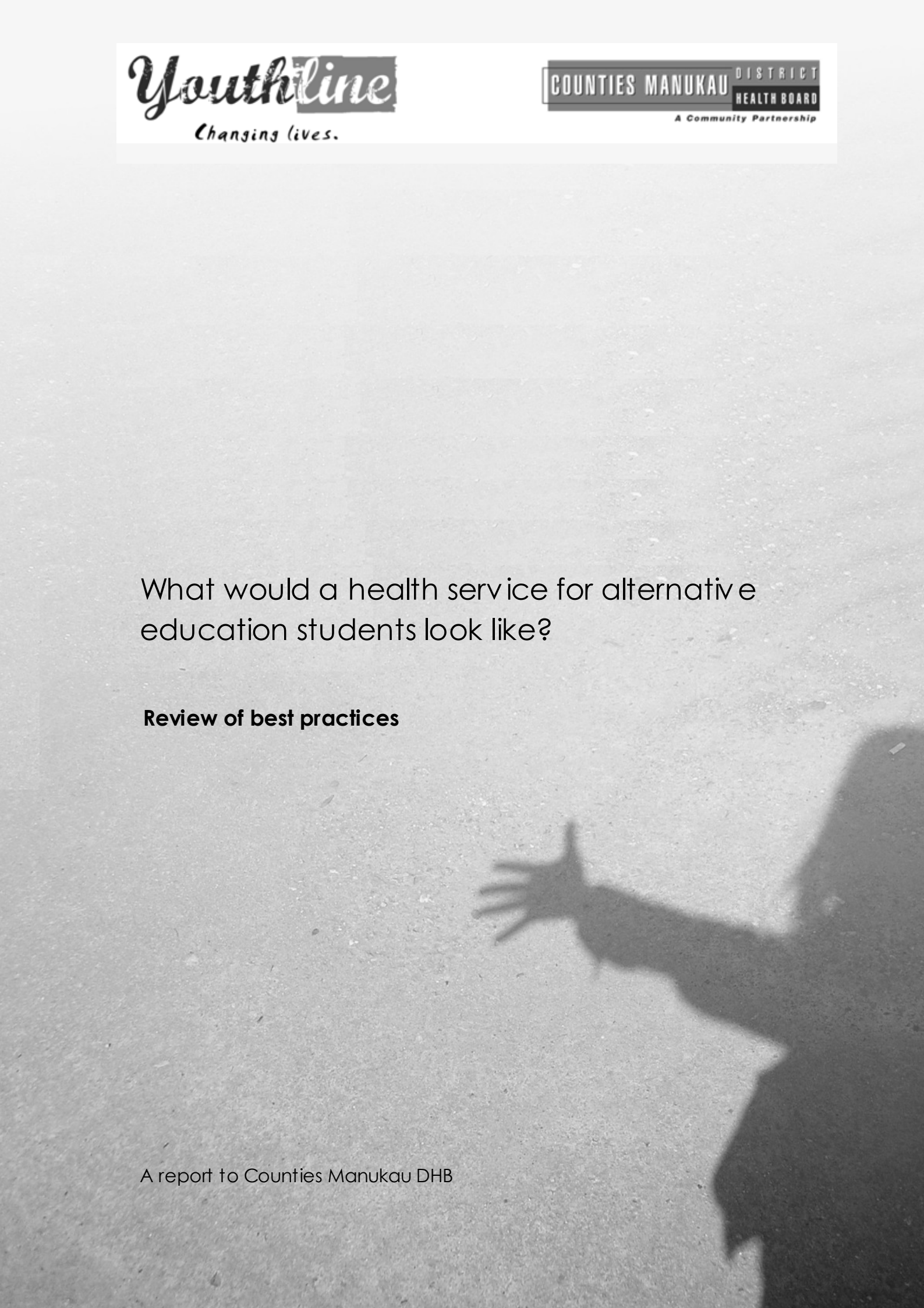
COUNTIES MANUKAU DISTRICT HEALTH BOARD
A Community Partnership

What would a health service for alternative education students look like?

Review of best practices



A report to Counties Manukau DHB

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This report was prepared by Youthline Auckland for Counties Manukau District Health Board.

Youthline is a regionally focused, nationally linked service promoting community-based youth development. Youthline operates from an integrated model of evidence-based practice within a community development, training and youth development, and clinical services framework. Youth development is about being connected, having quality relationships, fostering participation and being able to access good information.

Counties Manukau District Health Board (CMDHB) was established on 1 January 2001 under the provisions of the New Zealand Public Health & Disability Act (2000). CMDHB is responsible for the funding of health and disability services and for the provision of hospital and related services for the people of Counties Manukau (Manukau City, and Franklin and Papakura Districts) as set out in the DHB functions and objectives in the Act. CMDHB's shared vision is to work in partnership with our communities to improve the health status of all, with particular emphasis on Māori and Pacific peoples and other communities with health disparities. Child and Youth health is one of the development areas the CMDHB will be focusing on over the next three years.

Disclaimer

This review was commissioned to inform best practice and guide development of a health framework for alternative education students. The opinions expressed in this document do not necessarily reflect the official views of Counties Manukau District Health Board, nor Youthline.

Acknowledgements

The authors would like to thank the advice and information contributed by Alternative Education students for whom this project was not a priority at this stage in their lives but who willingly participated in the research. To the managers and teachers of Alternative Education who kindly fitted the research into their busy programmes as part of their continuous commitment to the wellbeing of their students. Special thanks also to Ivy Smith as facilitator of the focus groups, for her experience and understanding of the issues experienced by young people in Alternative Education.

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EXECUTIVE SUMMARY

Purpose and methods

The purpose of this project was to establish what might be best practices for a health service suitable for Alternative Education (AE) students and how that service might operate. This was achieved through semi-structured interviews with 17 key informants to identify the theoretical base for the recommended best practices and three focus groups (36 AE students) with young people attending AE services in the Auckland region. A review of both national and international literature of best practices and the current availability of New Zealand youth health services was also completed as part of the project. The Youth Development Strategy Aotearoa (Ministry of Youth Affairs, 2002) was used as a framework for the analysis.

Background

AE providers aim to cater for the needs and rights of students aged 13 to 15 years who have become alienated from 'mainstream' schooling. AE students experience higher levels of socio-economic hardship than their peers, they are more likely to be vulnerable to behaviours that endanger their health, such as drug and alcohol use, risky sexual behaviours and risky motor vehicle use than secondary school students (Denny et al., 2005; Adolescent Health Research Group, 2003; Sinclair, 2007). In terms of negative life experiences, these young people are more likely to have attempted suicide, witnessed violence in their homes and many females have been sexually abused (Sinclair, 2007).

Despite the high level of need for this group of young people, they have been relatively ignored by policy and the underfunded services are reduced to a minimum in spite of a number of studies (e.g. Fleming, 2007; Denny, 2004) pointing out the groups high need characteristics. Research indicates that preventative counselling in primary care settings reduces these health risk behaviours such as teen pregnancy, smoking tobacco and improves use of contraception and yet this is often not provided to young people (Denny et al., 2005.)

Literature review

Research findings indicate that the most promising outcomes for significant long-term gains are from intensive, integrated or 'joined up' services that meet a range of student needs (Fleming et al, 2004). The main barriers to young people's use of services relate to the three 'A's, availability, accessibility, acceptability, with equity of health services also being an important factor (Tylee et al., 2007; World Health Organisation, 2001).

'Turf' issues often caused by an overlap in roles are mentioned in a number of studies (Martinez, 2003; Waxman, 1999). This point emphasises the need for information on what makes multi-disciplinary teams work and what are best practices for inter-agency work in the area of youth health and complex needs.

> "Collaborations between community health providers, specialist youth and mental health services and educators are vital to most effectively utilise available resources and improve health services access" (Denny et al., 2004b, 147).

A meta analysis of best practices for youth-friendly health services (Tylee et al., 2007) included a summary of successful outcomes from evaluations of a number of international youth health services of different types. This summary and Kisker et al (1996) indicated while for some youth health services health awareness can increase, this does not mean health risk behaviours will be reduced. The type of youth health services that address risk most successfully were peer led, youth-friendly and free youth health services. Better practice in health care provision is about delivery that is of high quality and in an acceptable manner to consumers and providers at an affordable cost. Much of the international literature supports a wrap-around model of social and health service delivery for AE students (Furman, 2002). Other studies identified a range of helpful practices including outreach, removing the cost barrier, use of peers, provider training, and the provision of school-based health services (Tylee et al., 2007).

Although the literature suggests that YOSS can result in over-centralisation that restricts accessibility, it also stresses the importance of a comprehensive range of services being provided from one site. It is doubtful that school provision can be comprehensive enough to meet the needs of high-risk young people such as AE students. Currently, there is a lack of evidence showing a reduction in negative behaviours despite an increase in information awareness.

Irregular and unsustainable funding is a feature universally experienced by youth health services (Homans, 2003; Buckelew et al., 2008). While there are increasing numbers of youth services delivering health services to young people, very few have been evaluated in ways that can identify practices that work and outcomes that can be validated. This point illustrates the importance of evaluation frameworks being established alongside the development of a project that not only assess impacts but also build evaluation capacity. The standardisation of data collection methods and analysis is often not accounted for until too late in a project's development.

Research findings indicate that the most promising outcomes for significant long-term gains are from intensive, wrap-around, integrated or 'joined up' services that meet a range of student needs (Fleming et al, 2004). Evidence shows that agencies whose practices work alongside and wrap around the young person and their family have a positive effect on long term outcomes (Fleming, 2007). The literature also indicates that this approach has proven effective with 'difficult to treat' or high-risk youth (Fleming et al.,2004).

Both AE and secondary school students report high levels of support in school environments however, a higher proportion of AE students say their teacher has got to know them well (Denny, 2004b). The relationship between any service and the AE teacher is a critical one and is built on trust. This is the person who would be most appropriate to negotiate health access for students. There is also evidence that AE acts as a holding mechanism providing stability and allowing supportive and comprehensive health and social interventions to be implemented (Fleming, 2007). Continuity of care on exit beyond 16 years remains an important issue.

What young people and key informants thought would work

Young people saw a range of services being necessary, reflecting their complex and varied needs. Feedback from students emphasised the need for health and social services that are affordable, accessible, culturally friendly and which provide early identification of need and effective follow up. Young people need access to a flexible, youth-friendly health service coordinated in a way that ensures they get to know one or preferably two workers well, to provide staffing options and to ensure continuity.

The work is multi-agency, systemic and broad spectrum; it is clear that this needs to be a wrap-around service. When necessary, the professionals can refer on and offer support and advocacy as part of this process. The young person's own GP would be linked to this service with their consent and where the young person is not registered with a PHO they would be encouraged to do so.

The proposal: a community-based AE Youth Wellness Clinic

The structure of the Youth Wellness Clinic

Level 1
The mobile clinic would have:

- Senior Youth Health Nurse (Lead)
- Two Youth Health Development Workers
- Community Social Worker
- Youth Primary Mental Health Worker

Level 2
The clinic would be strongly linked to larger community-based YOSS providers such as the CfYH, Youthline and comprehensive school-based services. The point made again and again by AE young people both in this report and others emphasises the need for a drop-in component as in a comprehensive YOSS, containing a variety of activities both entertainment, health and education both physically and electronically provided making a centre based in a community at a point of maximum accessibility for young people a critical issue.

Level 3
At another level would be the essential auxiliary services provided by a community-based YOSS offering a flexible 24 hour service including, counsellors, a mentoring service, education (youth development, self awareness and a variety of other services.

Services in addition to those already mentioned and as identified by AE students were:

- Mental health provision
- Dentist
- Māori wardens
- Police support – a familiar person young people can trust
- Physiotherapy
- Alternative therapies
- Specialised health services e.g. diabetes, eating disorders
- Training e.g. parenting, self esteem.

This mobile service would be further supported by a range of locally appropriate delivery mechanisms. A flexible internet and telephone-based service has been shown in an Australian context to be most effective at reaching the profile of AE students especially young men making this an essential component of the service.

A ***Youth Wellness Clinic Project Coordinator*** would be necessary to manage, develop and promote the service. This role is shown in the literature and in the attempts by local AE consortiums, to be an effective component that assists the sustainability of such a project and essentially improves access to health services for AE students.

Funding also needs to be sustainable rather than the hand-to-mouth approach taken for many youth services to date. Unsustainable funding results in restricted services to young people and limits their access to health services with negative outcomes on young people's wellbeing, particularly for AE students.

Objectives for the community-based AE Youth Wellness Clinic

- Improved access of AE young people to health assessment and services given their previously identified high need
- Improved resiliency of young people by supporting current mentoring and resiliency development services.
- Improved health outcomes over years, including -
    - Reduced suicide attempts,
    - Reduced substance abuse,
    - Reduced binge drinking,
    - Improved management of chronic illnesses,
    - Safer sexual health practices,
    - Improved hope and trajectories, and
    - Improved personal safety of each young person.
    - Encourage and support transition to regular primary health care providers (Sinclair, 2007).

As noted above the transitioning of young people post 16 would need special attention.

The culture of the Youth Wellness Clinic would be one of inclusivity and collaboration; drawing together as a team and over riding professional boundaries and concerns. As noted in the research, so called 'turf' tensions do not serve young people well. The service is concerned with building strong, professional connections and having positive impacts in all areas of a young person's life including:

- family and whanau
- schools, training institutions and workplaces
- communities (sports, church, cultural groups)
- Peer groups (Counties Manukau DHB, 2003).

The Youth Wellness Clinic service delivery (replicating components identified by Sinclair (2007) and data developed as part of this research):

a) Service delivery characteristics

- Relationship building and engagement are essential, with each young person having a lead worker. This would ensure a well coordinated and appropriate response that wraps around each young person.
- Effective links to wider community services and networks.
- Young people would be linked to their PHO and other appropriate services.

- Services would be wrap-around and focus on supporting the parents and whanau as a positive parent-young person interaction is critical to health and well-being.
- Culturally competent and appropriate, community-wide planning, development and delivery of services.
- The service is strength-based.
- The service needs to address broader community issues.
- The service is free and voluntary using positive persistent outreach efforts to build family trust.

b) Service delivery protocols

- A comprehensive service delivery focus including home (family) visiting and youth health centre-based strategies.
- All AE young people would be assessed on entry to AE using standardised (i.e. consistent across all people) health assessment tool, specifically developed to be youth-friendly along the lines of the process used by the OYWC and to systematically identify young people and their families who are most in need of the service.
- Have clear programme goals and outcomes that are based on individual needs as well as broader measures.
- Target those in need (AE students) rather than the general youth population.
- The Youth Wellness Clinic would provide regular and frequent visits that are of flexible duration and intensity.
- Offer services intensively - i.e. at least once a week with well-defined criteria for increasing or decreasing the service and over the longer term (3-5 years ideally).
- Include educational components and problem-solving.

c) Staff

- Involve well trained and supervised staff members.
- Team members would have limited case loads and adequate supervision.
- Staff members would be selected because of their personal as well as professional characteristics: their willingness to work in or their experience working with culturally diverse communities and their skills to do the job.

The objective of this new service is to provide for each AE student a holistic, seamless, wrap-around health service. Using information provided in this report and advice received from the youth health team at CfYH, the following process is recommended:

1) Each new young person is assessed by the team using a youth-friendly version of HEADSS[1] and an appropriate lead worker is appointed.
2) Each AE provider is visited by a youth health nurse and a youth worker (including other staff if necessary) at least once a week.
3) Individual cases are reviewed at the weekly meeting where complexities need to be discussed
4) All cases are reviewed once a term during school holidays

[1] See Otago Youth Wellness Centre process and assessment tool.

While it appears that mobile services are viewed somewhat negatively by health professionals (key informant interviews), the flexibility of the proposed service is essential and does not imply any lack of professionalism. Community-based social workers are increasingly going back to a more flexible service that goes to where people are and takes them to where they need to go. Rather than contributing to dependency, outcomes show that the changes made for whanau supported in this way are more profound (Milne and Sanders, 2008; Sanders and Munford, 2001). Being able to deliver a holistic health service where young people live and work and assisting them to get to other services they might need by offering multiple access points, transport and advocacy, especially in an area such as Auckland, will make a difference between these high need young people getting health services or not.

Professional development and training

Professionalisation of the youth health sector for all professionals on the Youth Wellness Clinic team including nurses, community social workers working with young people and youth workers and the associated core competencies[2] in the specialised field of youth health need to be urgently addressed and given appropriate support. All health professionals who work with young people in any capacity, regardless of discipline should master these core competencies including understanding the relationship between youth development and youth health, being able to identify factors that place youth at-risk for poor youth health outcomes and being able to identify factors that are protective and enhance good health outcomes (Centre for Youth Health, 2006). This would ensure that young people receive the best and most appropriate care and that professional career pathways are developed in the area of youth health.

An essential component of any youth-specific service development would be working with GP medical services to educate GPs and nurse practitioners to become youth-friendly providers.

Evaluation and capacity building

- Providers should involve young people in the planning, development and running of programmes.
- All services should contain well-designed planning and reflection processes (based on an action research model) with evaluation capacity building as an objective.
- The service as a whole would benefit from having formative, process and impact evaluations running alongside the service from the start of the project.
- Providers should look for existing programmes that have been well evaluated and have clear planning and implementation procedures.

Conclusion

The development of appropriate new services must be prioritised to counter a feeling of fatigue amongst young people who have been involved in numerous focus groups. New services should clearly reflect the youth development model of service delivery to ensure they don't feel marginalised and ignored. Young people in frequently accessed groups should be informed of developments so that they have a sense of progress.

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[2] The CfYH are currently developing a set of core competencies for their service

The full and active support of DHBs for the proposed Youth Wellness Clinic as a provider of youth health services to AE students provides a model that would work well for all young people as well as other similar groups such as Teenage Pregnancy Units (TPUs), CYF residential units and community-based services such as Bethany in Auckland. While the school-based model may work in smaller localised areas such as Wainuiomata, urban centres such as Manukau, Auckland City and Waitakere need a more flexible response if we are to accept that access to youth-friendly services in these areas is a considerable problem. In this case, the proposed model that identifies a smaller flexible health delivery service that is linked to a larger primary youth health provider such as a community-based youth health provider or YOSS, would be a more appropriate response for this more challenging high need youth population who are predominantly to be found attending AE services.

RECOMMENDATIONS – KEY ISSUES

That the CMDHB endorses the proposed model consisting of a Youth Wellness Clinic for AE students that is strongly connected to a community-based youth primary healthcare centre.

The Youth Wellness clinic needs to:

- Be a wrap-around, highly flexible service delivery rather than one size fits all that delivers to AE providers and their students but also works with young people where they live, work and play.
- Use the Youth Development Strategy Aotearoa (YDSA) as a basis for the development of the clinics.
- Support the principles of the YDSA and encourage creative responses from young people at a community level.
- Provide a 24-hour, multi-access service with innovative access points including the provision of electronic and telephone access.
- Have secure and long term funding that offers the continuity that is essential for these young people and ensures sustainability.
- Young people need regular and consistent feedback on the progress of this development.

Other special issues include:

- The transitioning of young people post-16 out of the service would be a critical issue to address as this is a time when many young people can be lost to services.
- The relationship between any service and the AE teacher is a critical one and is built on trust. The AE teacher is the most appropriate person to negotiate health access for students.
- Young people requested that ordinary people like whanau and other respected adults be part of the service so it reflects familiar faces and positive role models in ways that will resist the development of a medical model both physically and in the service delivery.
- All young people entering the service would have an initial health assessment similar to the OYWC model of development and final form of the HEADSS assessment.
- Youth development training be incorporated into the educational provision and care plans of all AE students to support the growth of personal health awareness.
- The training of the clinic staff in social assessment and advocacy for adolescents of young people is essential.
- Serious consideration needs to be given to the development of the clinic's relationship with a primary youth health service or YOSS that is youth-friendly and provides the entertainment and other services young people consistently request.
- Attention needs to be given to developing an effective interface between professionals and services and researching a model of what makes multi- disciplinary teams work and what are best practices for inter-agency work in the area of youth health and complex needs.
- Planning and evaluation frameworks and capacity building processes need to be established alongside the project.

INTRODUCTION

> "…if children are to survive threats to their wellbeing, they require a complex weave of health resources that is best provided by multiple service providers working in a seamless continuum of care" (Ungar, 2005, 424)

The purpose of this project was to establish what might be best practices for a health service suitable for Alternative Education (AE) students and how that service might operate. This was achieved through semi-structured interviews with key informants to identify the theoretical base for the recommended best practices and focus groups with young people attending AE services in the Auckland region. A review of both national and international literature of best practices and the current availability of New Zealand services was also completed as part of the project. The Youth Development Strategy Aotearoa (Ministry of Youth Affairs, 2002) was used as a framework for the analysis.

There has already been considerable focus on what young people – especially Pacific young people – might like in terms of health and social services. For example, Youthline's 'Youth Engagement Project' (2006) and the 'Pacific One Stop' (2006) reports prepared for Counties Manukau District Heath Board (CMDHB) and others focused specifically on the needs of AE services (Denny et al., 2004a; Sinclair, 2007). The AE health service research used these pieces of research as a basis for analysis while reflecting on responses from AE users and found a considerable degree of resonance between all three pieces of research with perhaps more detail recorded as part of the Youth Engagement Project, reflecting a sample and age range that was potentially more stable and informed.

RESEARCH METHODS

Literature review

The methodology employed for the literature reviews could not be comprehensive since there is a very little evidence-based literature specific to provision of health services for AE students as although services do exist they are often unevaluated or documented. The AE wrap-around research is similar to the One Stop Shop (YOSS) literature review recently completed by Youthline for Counties Manukau DHB, *Pacific Youth One Stop Shop: a review of research, best evidence and youth* opinion *(*Youthline, 2006). This latter report "noted, and this applies equally to literature available on wrap-around health services for AE students, that there are few comprehensive evaluations using proven and robust methods such as randomised controlled trials (RCTs). This is because the services provided by 'one stop shops' are extremely varied and many young people access the services in a 'drop-in' manner. This would present a significant barrier for any randomization. The second limitation noted in this report is that,

> "… most of the research surrounding 'one stop shops' is currently in an exploratory stage. There are no published long-term evaluations of existing 'one stop shops'. Many of the evaluations were retrospective and qualitative or descriptive in design." (Youthline, 2006,18).

The literature also tends to have a bias towards school-based services in an American setting and the true value of community-based youth health services or YOSS is hidden. It is also important to note that the literature mainly focuses on access for all young people and rarely covers the specific needs of at the risk young people, aged 13-15 years in AE services.

However, systematic principles were applied to the literature review with priority given to collating findings from comprehensive and large-scale evaluations where they exist. A search that initially canvassed AE and then focused on supplementary services was employed.
The literature review was sourced from the following databases:

- PSYCHinfo,
- ERIC,
- EMBASE,
- Medline
- CINAHL,
- Australian Education Index
- British Education Index
- Index to New Zealand Periodicals.

In addition, grey material and reference lists from the reviewed literature were also utilised. With a couple of exceptions, literature canvassed, was confined to reviews and evaluations dated from 2000. Google was used as a guide to peer reviewed material or reports from reliable sources that could be replicated as part of University library collections.

Initially a group of keywords was developed using as a base line, those provided in the report mentioned above (Youthline: 2006). Keywords from this source include, "one stop shop", "youth centre/center", "integrated care", and "drop-in centre." The other source was *AE: Literature Review and Report on Key Informants Experiences* (O'Brien, Thesing and Herbert, 2001). Keywords from that source included: "non-traditional education OR special programmes, OR special schools OR dropout programmes OR high school equivalency programmes OR residential schools" and this set was modified using "AND" high-risk students OR dropouts OR truancy OR out of school OR special needs students OR student alienation". Further development of keywords focused on this first level search. One particularly productive and relevant search phrase was "youth-friendly services". Varied understandings of young people's health was evident across the international literature but every effort was made to choose articles that would be relevant to the NZ experience.

Focus Groups

Three focus groups were completed with young people as service users in Waitakere (Waipariera Trust AE Programme - 10 students), Auckland Central (Youthline AE Unit – 12 students) and Pakuranga (ATC Trainme AE Programme – 14 students) – a total of 36 young people. These focus groups were conducted by Ivy Smith, an experienced facilitator contracted by Youthline. The researcher actively engaged students in the process and elicited information in a layered approach that gradually built trust and enriched the information received from the young people. Students worked in groups with each group reaching agreement through consensus, facilitated by the researcher and in some cases an AE employee.

Where young people found it difficult to write or express their opinions, the researcher acted as interpreter and with their agreement wrote down the words. It is important to remember that these students are not necessarily at their most articulate at this stage in their lives and many have critical issues they are currently resolving, including serious concerns such as family breakdown and in some cases suicide. Their particular stage and experiences can form significant barriers to engagement as well as more common issues such as literacy. Their responses sometimes reflected the sorts of disconnection and dissonance that may have led to their disengagement with education in the first place. The comments we received and the obvious difficulty they had in developing their views on the sort of service that would be most helpful to them had to be drawn out in ways that leaned heavily on the skills of the facilitator and interviewer. The research skills of the support people who were identified by the AE provider had at times a necessary but limiting effect on the research process and data. This experience indicated a definite need for intensive youth development training, orientated specifically towards the needs of AE young people. This could have enabled them to more easily express themselves.

There seemed to be an element of over-consultation of AE young people when they had already advised on similar issues as part of youth consultation for the Youth Engagement Project and Pacific One Stop reports or were already participating in other research projects. Achievement in Multicultural High Schools (AIMHI) Consortium did not participate on this basis as they are currently working on a survey with Centre for Youth Health (CfYH). However, the manager of the consortium was interviewed as a key informant. Many of young people's responses in this study reflected and sometimes duplicated the range of responses found in these studies. While indicating that the research methodology had validity and is easily duplicated, it also emphasises the point that we need to pay special attention to what these young people are saying.

The focus groups were implemented in two stages. The first two groups were done using one question schedule and the last focus group was completed using a second interview schedule that was adapted as a response to the data gathered so far and as a means of further enriching the data.

Twelve key informants from AE services within the Auckland region and nationally were interviewed including the interviewer of the focus groups. While five key informants were proposed in the original research plan, snowballing from those people interviewed was the method utilised to establish appropriate representation and expertise. These interviews were both face-to-face and by telephone depending on the availability of informants. The services consulted were identified by Youthline staff and AE Consortium staff.

Sites visited included Youthline Auckland, AIMHI Manukau, Impact Tauranga, YMCA Education Centre Christchurch, Creative Learning Scheme Auckland, Waitakere Consortium (Group consultation with researcher from WDHB and Community Action on Youth And Drugs (CAYAD) people from Waitakere City Council), Wellington City Mission AE and the National AE Consortium, CfYH. The Ministry of Education Operational Manager was also consulted.

Terms used in this report

Health

Many of the journal articles cited herein discuss health of young people from a medical perspective whereas this report adheres to a notion of health that is holistic. A holistic notion of health is the most appropriate for approach for young people as this approach addresses the young person as a whole, not merely as a set of risk factors, acknowledging that risk and protective factors are interrelated and should be addressed in relation to each other (NSWCAAH, 2006). The model of Te Whare Tapa Wha (Mason Durie) is an accepted indigenous understanding of holistic health; Te Taha Hinengaro (mental health), Te Taha Wairua (spiritual health), Te Taha Tinana (physical health) and Te Taha Whanau (family health)

One Stop Shops

These are youth specific health centres that attempt to provide health, social and others services for young people from one site. This may be an integrated service with one provider or a collaborative service with a range of programmes delivered by a number of providers sited in one location.

Stand down

The formal removal of a child from school for a specified period. The period may not exceed 5 days in any term and 10 days in any year. Following stand down a child automatically returns to school.

Suspension

The formal removal of a child from school by the Principal until the Board of Trustees decides the outcome at a suspension meeting.

Exclusion

The formal removal of a child less than 16 years from school and the recommendation that they enrol elsewhere

Strengths-based practice
Strengths-based practice is performed when focusing on the strengths or positive characteristics of the young person rather than the negatives. It is also based on a respectful relationship with clients and third parties.

Literature outlining the background of students attending AE services
AE is a reasonably new concept in New Zealand. Programmes were established in 2000 as a result of concerns expressed by schools, communities and family members about the numbers of young people who had been excluded from mainstream education and had few other educational options.

AE aims to cater for the needs and rights of students aged 13 to 15 years who have become alienated from 'mainstream' schooling. Students may fall into this category for a number of different reasons. Some students are habitual truants, while others are behaviourally challenging and are consequently excluded from school. The AE policy aims to provide a constructive alternative delivery of education for these students. AE is designed as the last resort in a range of responses to ensure that all students engage with education (Te Kete Ipurangi: the online learning Centre, http://www.tki.org.nz/e/community/alterned/about/index.php). These young people have typically been suspended, expelled or have been out of school for over six months. They may be reluctant to attend regular schools or schools are unwilling to enrol them (Sinclair, 2007).

The conditions on which a young person is accepted into an AE programme include:

- have been out of school for two terms or more
- have a history of multiple exclusions
- were referred to The Correspondence School as a last resort and have dropped out
- have been absent for at least half of the last 20 weeks, for reasons other than illness and the absence has meant that they are unable to maintain a mainstream programme OR
- have been suspended or excluded and at risk of further suspensions / exclusions. (Te Kete Ipurangi: the online learning Centre, http://www.tki.org.nz/e/community/alterned/about/index.php).

In many cases there are a range of issues that need resolving before these educational objectives can be realised.

The AE programmes provide these young people with an opportunity to continue their education as schools are often unwilling to take students back and students frequently have no desire to return. However AE programmes also aim to provide skills that will enable young people to re-enter regular education, enrol in training or tertiary education or enter the work force. The Central Auckland Consortium has employed a person whose role is to transition these young people back into mainstream schooling or further education.

Between 1995 and 2005 the proportion of children leaving school with little or no formal attainment was generally higher in Counties Manukau than other parts of New Zealand (Counties Manukau, 2006). In NZ during 2005, there were 21,862 stand-downs and 5,154 suspensions. Suspension was more likely to happen amongst those aged 13–15 years and male and Māori students (Manukau Counties, 2006, p160). However, numbers of suspensions, exclusions and expulsions declined in 2006, it is suspected

due largely to the Suspension Reduction Initiative (Counties Manukau, 2006, p162). Alongside this reduction, the number of stand downs has increased (Counties Manukau, 2006, p164).

In 2001, one in three Manukau City residents lived in areas designated as decile 1 (the most deprived areas) by the New Zealand Deprivation Index. While the deprivation index indicates that some areas of Manukau City have low levels of socio-economic deprivation, notably in the eastern wards, the western and southern wards of Mangere, Manurewa, Otara and some parts of Papatoetoe have high deprivation scores: 94% of people in Otara and 78% of people in Mangere are living in some of New Zealand's most disadvantaged areas, i.e. decile 1 and decile 2 areas (Auckland Youth Support Network, 2006).

Children and young people make up 40.9% of CMDHB's population and are of greater ethnic diversity than the NZ average. Māori and Pacific make up 23 and 26 % respectively (CMDHB, 2006). Health outcome data show that improvements in health for young people have been less than any other age group and Counties Manukau has a higher youth mortality rate for the 12–24 age group than the national rate (Sinclair, 2007).

In 2002 there were 2756 students in AE schools in New Zealand, 1.6 % of young people aged 13–15 (Denny et al., 2004). Most of the students in AE are males of Māori or Pacific Island ethnicity. In 2004 44% were Māori, 17% Pacific/Māori, 17% Māori/European, 14% European/Other and 8% Pacific (Denny et al., 2004). AE students experience higher levels of socio-economic hardship than their peers in secondary school and are more likely to experience overcrowded housing, higher levels of violence and sexual abuse and high-risk behaviours (Denny et al., 2004). Over 25% of the students in this study had made a serious suicide attempt in the past 12 months (Sinclair, 2007; Adolescent Health Research Group, 2003). The total environment of AE provides an opportunity for these young people to re-engage with learning and education whether they wish to or are obliged to return to school or not.

There are two AE Consortiums in Counties Manukau and 18 providers of AE who have a 'placement' of 227 students at any time or 500 students in any given year (Sinclair, 2007). These Consortiums are AIMHI, with 154 students, and Counties Manukau with 95 students (Fleming, 2007). AE students in Counties Manukau have a high incidence of unmet health needs (Fleming, 2007; Sinclair, 2007) despite CMDHB being particularly supportive of youth health.

Young people in AE services are reported (Fleming, 2007; Denny et al., 2004) as often coming from socio-economically disadvantaged backgrounds. However, while they do report socio-economic difficulty and less parental correction (Denny, 2004b) they do not necessarily perceive themselves as disadvantaged perhaps indicating the normalisation of their experiences. Research shows that the needs of AE students outside mainstream schools are significantly higher than those students within schools (Denny et al., 2004b).

1. A REVIEW OF INTERNATIONAL LITERATURE ON BEST PRACTICE FOR YOUNG PEOPLE'S HEALTH SERVICES

Introduction

As noted in the methods there are very few evaluations conducted on youth one stop shops or comprehensive youth health services. However, there have been evaluations done on school-based services, mainly originating in the United States. While these services are somewhat different to youth one stop shops there are some similarities therefore this literature has also been included. As mentioned above, 'youth-friendly services' was a category that also uncovered a range of useful evidence-based material.

Overseas research also suggests that young people excluded from mainstream education are more likely to have significant health issues compared to students attending mainstream education (Denny et al., 2004). Many young people have unmet health needs especially those with chronic conditions and those who underutilise services (Britto, 2001). Research in developing countries suggests that 70% of young people contact health services on average once a year mostly for respiratory or dermatological reasons. Tylee et al. (2007) notes that in developing countries young people are less likely to attend professional health services for mental health issues and other sensitive matters preferring instead to seek help from family members they can trust.

International studies do reveal that young people in AE are more likely to experience negative problems. Many of these students have high rates of socio-economic disadvantage, negative life experiences and concerning health risk behaviours (Britto, 2001).

Best practice - what works?

The New South Wales Centre for the Advancement of Adolescent Health (NSWCAAH) adheres to a principle of 'better' practice rather than 'best' practice suggesting that this leaves room for continuous improvement.

Structure of youth health services

Internationally, youth-friendly services are provided in a range of settings including purpose built environments or clinics especially for young people and in situations where 'adolescents-only' hours are added to existing facilities, providing emergency hotlines, or offering services in places where young people congregate, such as schools, youth centres, sporting events or work sites (The Safe Project, 2006).

Tylee et al (2007) has identified a number of types of youth health services available internationally:

- A hospital-based centre specialising in adolescent health.
- A stand-alone community-based health facility.
- A school-based or college-based health service in or close to the premises of schools or colleges offering a preventive and curative health service.
- A community-based centre that is not only a health facility, but also provides other services. They often have links with health facilities nearby where young people could be referred.
- Auxiliary services offering information and advice legal, sexual health etc. in the community.

In a meta analysis of best practices for youth-friendly health services, Tylee et al (2007) included a summary of successful outcomes from evaluations of a number of international youth health services of different types. Some examples of successful services relevant to this literature review include:

- (UK) Nurse led general practice wellness visits for 14–15 year olds (Walker et al., 2002). *Outcome*: Exposed teenagers more aware about confidential and reproductive services but minimal reduction in health-risk behaviours,
- (USA) School-based services (Brindis, 2003). *Outcome*: significant enrolment and use reported, wide variety of services provided and able to reach minority students due largely to the locating of these clinics at schools in communities where there are few health resources, however school-based services cover only 2% school population in the US and health insurance is a significant issue. Buckelew, Yu, English and Brindis (2008) note that youth should have multiple entry points to available services.
- (USA) Providing free and affordable services to under 19 year-olds and involving them in setting up clinics (Brindis et al, 2003). *Outcome:* Reported increase in access especially by minority groups and high satisfaction rates.
- (USA) Peer-led sexual health clinic for young men (Raine et al., 2003). *Outcome:* Young male attendees increased greatly and females did not reduce attendance or express dissatisfaction.
- (Bangladesh) Reproductive health intervention to improve access for people aged 13–19 years, including provider training, subsidised services, improved confidentiality (Bhuiya et al., 2004). *Outcome*: Service use doubled in group one and increased ten-fold in group two.
- (USA) Peer-led sexual-health promotion for 15–19 year-olds (Brindis et al., 2005) *Outcome*: Improved likelihood of returning for a yearly visit and reduction in sexual-health risk behaviour.
- (USA) Outreach to HIV-infected 15–54 year-olds to improve access (Martinez et al., 2003) *Outcome:* improved transition to care with reduced barriers.

Other studies identified a range of helpful practices including outreach, removing the cost barrier, use of peers, provider training, and the provision of school-based health services (Tylee et al., 2007).

Delivery of service – best practices

Better practice in the delivery of health care is about delivery that is of high quality and in an acceptable manner to consumers and providers at an affordable cost. A number of authors (Marcel, 2002; Kozhukhovskaya, 2004) note the lower numbers of young males accessing services emphasising the need to adapt policies to encourage young men to use services. However, Marcel does note in this study that although young men used the centre less frequently than females they were nevertheless well satisfied with services indicating the pattern of usage was different.

Wrap-around services

Much of the international literature supports a wrap-around model of social and health service delivery for AE students (Furman, 2002). The wrap-around model of service delivery is a philosophy of care, a process, a modality and an intervention that utilises a planning process involving the young person and their family resulting in an individualised set of services that supports the young person and their family to improve their situation, address problem behaviours and reduce risk. The plan of care is always developed jointly between the young person and important individuals within their world (Paccione-Dyszewski, 2002). Parent-family connectedness and school connectedness are protective factors for emotional health, violence, and substance use (Bernat & Resnick, 2006). Furman et al. (2002) suggests that well implemented services for young people can be an antidote to the fragmentation of services and

costs that contribute to treatment failure for young people and families with multiple problems. Effective services such as these can also build social capital. Services such as counselling, doctor check-ups, sexual health information would all be beneficial.
As far as integrated[3] service provision is concerned, as opposed to collaborative provision, the literature provides no agreement about what is meant by having integrated services, about which services should be integrated, or where integration should happen and there is a lack of evidence that this option is more cost effective than collaborative integration of services (French et al, 2006). However, this lack of evidence should not detract from the potential effectiveness of integrated services merely because currently there is no evidence to be found. The literature does suggest that YOSS can result in over-centralisation that restricts accessibility, it also stresses the importance of a comprehensive range of services being provided from one site. This is especially notable in sites such as Auckland.

According to Miller (1999) effective therapeutic services are built on four common ingredients regardless of dosage, discipline or approach:

- External factors including a person's strengths and resources, existing social support network, and the occurrence of any change producing events in the person's life (40%).
- The relationship between the person and a helping professional, in particular, the person experiencing the worker as warm and empathetic as well as collaborative in terms of the goals, method and pace of the help [30%]. Personal experience of staff is a critical element of best practice (Toomet, Part & Haldre, 2004) with tolerance and non-judgmental attitudes being paramount as well as the ability to listen well and explain clearly.
- Hope and expectancy, including the helpers ability to inspire self-confidence and belief in the possibility of change [15%].
- Structure of the help including the accessibility and acceptability of the services to the person.

The international literature would generally affirm these principles as baseline criteria for youth health services. Centrally located youth services obviously meet the needs of larger numbers of young people in the city centre but rural locations and the young people for whom access is an issue would make outreach services a necessity (Homans, 2003).

Accessible school-based services can increase use and knowledge of health services(NSWCAAH) but Kisker et al. (1996) notes that there is little evidence that school-based services have any direct effect on high-risk behaviours reinforcing the findings of Tylee (2007) as above. However, this writer goes on to say that the nature and intensity of service delivery may be a key factor in effectiveness and recommends exploring issues such as early intervention, intensity of treatments, consistency of service delivery, skill building and the provision of a wide range of services. This point emphasises the difficulty of school provision being comprehensive enough to meet the needs of high-risk young people such as AE students and the lack of evidence showing a reduction in negative behaviours despite an increase in information awareness.

[3] Integrated services are where services are provided as part of one service and collaborative provision is where the services located in the same place but operate separately.

Furman (2002) warns that this sort of service needs to be highly flexible rather than one size fits all and advises providers to set up a programme that supports and actually encourages creative responses at a community level. It also needs to be free. Staff that are well trained in delivery of services to adolescents is essential to service development and this is noted by both The SAFE Project (2003) and Stiffman et al. (2006).

Service exemplars

The NSWCAAH reviewed six youth health services:

- The Youth Health Service - similar to a Youth One Stop Shop – this service had limited evaluation.
- The Area- based Youth Health Coordinator Model: a coordinator who facilitates and supports activities and projects as part of the strategic development of youth health services in a particular area – not yet evaluated.
- The GPs in schools model – primarily to encourage young people to use GPs by educating them and overcoming any barriers to accessing services with no demonstrated effectiveness for young people but there was an improvement in GPs understanding of young people's needs.
- GP-run outreach clinics – the idea here was to build trust so the young person would eventually use the GP. Some programmes demonstrated increased utilisation of GP service and there was an increase in GPs understanding of youth issues for all clinics.
- School-based clinic[4] - provision of clinic or health services and information at school. Impacts include increased health service use by students but needs excellent collaborative relationships with other services.
- Innovative access points – methods rather than models including arts, music, Internet and telephone (such as Youthline's counselling services) showed high level of awareness among young people and high level of satisfaction with the service. A health promotion site was found to have high levels of accessibility and acceptability , increased help seeking and coping skills among young people including valuable opportunities to participate (Inspire Foundation,2001 http://www.inspire.org.au/). Most importantly, these Internet-based services offer confidentiality an extremely important concern of young people and particularly popular with young men. Art and music were very effective with hard to reach populations (NSWCAAH, 2006).

An international study exploring best practice for youth-friendly services of nine European countries (The Safe Project, 2006) affirmed optimum youth-friendly services for sexual health services as an

[4] See also the Health Hut established by Chris Stein at Stoke Newington School supported by the Learning Exchange , Hackney, London UK as an example of this service http://www.sns.hackney.sch.uk/healthhut/index.htm Personal anecdotal evidence from this project highlights some of the problems of operating within an environment that does not necessarily understand the health and social needs of at risk young people and the level of staff education and training required to get schools up to speed that siphons off valuable energy required for the young service users. It also emphasises a youth development framework as an essential starting point for this and any other sort of service.

integrated range of different services, or a good referral system to high-quality specialist services concluding that this sort of service should include:

- sexuality information,
- counselling,
- family planning,
- pregnancy testing,
- safe abortion,
- testing and treatment for sexually transmitted infections (STIs) and HIV,
- services for those who experience emotional or physical, and
- (domestic) violence, rape, gender-based violence or trafficking.

The WHO framework for development of youth-friendly health services (Tylee et al., 2007) covers all the important features identified in other literature (The SAFE Project, 2006; Martinez et al., 2003; Brindis et al., 2003; Britto et al., 2001; Mmari, 2003).

The WHO framework is based on five basic principles:

- Adolescents lack knowledge about what services are available and how to access them.
- There may be legal restrictions on the use of services or cultural reasons why young people do not wish to be seen there.
- Adolescents give high priority to confidentiality. This may be more important than seeking treatment.
- They are put off if the services are a long distance away or are expensive.
- They will not use unfriendly services or those with poorly trained staff (McIntyre, 2002).

A further expansion of these key principles of best practice for youth health provision is as follows (Tylee et al., 2007; NSWCAAH, 2006):

An equitable point of delivery is one in which:

- Policies and procedures are in place that do not restrict the provision of health services on any terms and that address issues that might hinder the equitable provision and experience of care.
- Health-care providers and support staff treat all their patients with equal care and respect, regardless of status.

An accessible point of delivery is one in which:

- Policies and procedures ensure health services are either free or affordable to all young people.
- Point of delivery has convenient working hours and convenient location. Young people are well informed about the range of health services available and how to obtain them.
- Community members understand the benefits that young people will gain by obtaining health services, and support their provision.
- Outreach workers, selected community members and young people themselves are involved in reaching out with health services to young people in the community (Tylee et al., 2007).
- Flexible service provision, such as allowing for drop-in visits, after school and weekend visiting hours (NSWCAAH, 2006).

An acceptable point of delivery is one in which:

- Policies and procedures are in place that guarantee client confidentiality.
- Adequate information and support are provided to enable each young person to make free and informed choices that are relevant to his or her individual needs.
- Employees are motivated to work with young people.
- Employees are non-judgmental, considerate, and relate well to young people.
- Employees are able to devote adequate time to their patients.
- Employees act in the best interests of their patients.
- Support staff are motivated to work with young people and are non-judgmental, considerate, and relate well to young people.

The point of delivery:

- Ensures privacy (including discrete entrance).
- Ensures consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral.
- Lacks stigma.
- Has an appealing and clean environment.
- Has an environment that ensures physical safety.
- Provides information with a variety of methods.
- Ensures that young people are actively involved in the assessment and provision of health services (Tylee et al., 2007).

Other research indicates important factors as:

- Being in settings where young people themselves felt most comfortable – an important point in relation to this particular youth population. The physical surroundings in this study were less important than the atmosphere which needed to be friendly and informal.
- Being able to use a pseudonym.
- Being able to choose the gender of provider and someone who they could trust and who was tolerant.
- Alternative means of contact including telephone, websites and video (NSWCAAH, 2006).

The appropriateness of health services for young people is best achieved when:

- The health services needed to fulfil the needs of all young people are provided either at the point of delivery or through referral linkages.
- Health-care providers deal adequately with the presenting issue yet strive to go beyond it, to address other issues that affect health and development of adolescent patients (Tylee et al., 2007).

The effectiveness of health services for young people is best achieved if:

- Health-care providers have required competencies.
- Health-service provision is guided by technically sound protocols and guidelines.
- Points of service delivery have necessary equipment, supplies, and basic services to deliver health services (Tylee et al., 2007).

The main barriers to young people's use of services relate to the three 'A's, availability, accessibility, acceptability, with equity of health services also being an important factor (Tylee et al., 2007; World Health Organisation, 2001).

"Turf" issues often caused by an overlap in roles are mentioned in a number of studies (Martinez, 2003; Waxman, 1999) recommending that this issues can be resolved by developing an effective interface between professionals and services. There is a strong thread of evidence that points to the problematic nature of inter-professional collaboration (Easen, 2000). A programme called 'Connexions' was initiated in the UK to address this issue with the appointment of personal advisors to support 'joined up' interagency responses to the needs of students identified by schools at risk of exclusion (Webb and Vulliamy, 2001). Relationship-building and partnership both within the service and between the health service and other agencies was supported by this research. However, strategies to enhance collaboration are rarely identified by services and it is acknowledged that the establishment of collaborations is regarded as a time consuming task that often never eventuates. This point emphasises the need for information on what makes multi-disciplinary teams work and what are best practices for inter-agency work in the area of youth health and complex needs.

Success in establishing and maintaining contacts with some groups of 'at-risk' young people can depend on service staff seeking to build trusting relationships through outreach work (Martinez, 2003) emphasising the importance of a flexible service delivery that works with young people where they live, work and play. Programmes should:

- Be informed by pertinent theories and incorporate validated strategies and/or best practices.
- Promote protective factors and reduce risk factors.
- Accept multiple behaviours and multiple systems focus.
- Focus on prevention and health promotion.
- Be of an appropriate duration and intensity.
- Undergo rigorous evaluation.

Capacity building for assessment and evaluation

Irregular and unsustainable funding is a feature universally experienced youth health services (Homans, 2003; Buckelew et al., 2008). While there are increasing numbers of youth services delivering health services to young people, very few have been evaluated in ways that can identify practices that work and outcomes that can be validated. This point illustrates the importance of evaluation frameworks being established alongside the development of a project that not only assesses impacts but also builds evaluation capacity. The standardisation of data collection methods and analysis is often not accounted for until too late in a project's development. A useful site concerning health delivery to young people is the New South Wales Centre for the Advancement of Adolescent Health http://www.caah.chw.edu.au/resources/ which includes a GP resource kit and best practice guides. Evaluation is also linked to sustainability and funding.

> "I think for us, sustainability is more around things like relationships and getting better at writing up what we do …because at the end of the day the only thing that does become evidence-based is what people write up." (NSWCAAH, 2006, 49).

2. A REVIEW OF NEW ZEALAND BEST PRACTICE

Introduction: Why AE students need access to a Youth Health Service

AE students experience higher levels of socio-economic hardship than their peers, they are more likely to be vulnerable to behaviours that endanger their health, such as drug and alcohol use, risky sexual behaviours and risky motor vehicle use than secondary school students (Denny et al., 2005; Adolescent Health Research Group, 2003; Sinclair, 2007). In terms of negative life experiences these young people have often attempted suicide, witnessed violence in their homes and many females have been sexually abused (Sinclair, 2007). Fleming et al. (2004) note that AE students are mainly Māori and Pacific youth and the majority have:

> "…no regular primary health care provider and have rates of depressive symptoms; suicidality; sexually transmitted infections; early unplanned pregnancies; substance abuse; exposure to violence and physical ill health several times higher than mainstream secondary students of the same age." (Fleming, 2004,1).

These young people are also more likely to suffer from high levels of depressive symptoms indicative of significant psychopathology. Many of these students have been or are currently clients of multiple agencies such as Child Youth and Family Service (CYFS) without much effect (Fleming et al., 2004).

Despite the high level of need for this group of young people, they have been relatively ignored by policy and the underfunded services are reduced to a minimum in spite of a number of studies (Fleming, 2007; Denny et al, 2004) pointing out the groups high need characteristics. Research indicates that preventative counselling in primary care settings reduces these health risk behaviours such as teen pregnancy, smoking tobacco and improves use of contraception and yet this is often not provided to young people (Denny et al., 2005).

20% of young people leave school with no formal qualifications (Ministry of Health, 2002) and approximately 10 to 15% of 15–19 year olds in NZ are not participating in regular work, education or training which is high by international standards. Those students identified as having the highest unmet needs often only attend AE for a short time or are frequently absent. In addition, these students also often have fluctuating needs so that although referred to health services in crisis the problems often abate by the time the student's appointment is due so that the appointment is cancelled and treatment discontinued (Fleming et al., 2007). This lack of continuity in treatment results in negative outcomes for many of these students emphasising the point that the social contexts of these young people play a large part in their access to health services. AE students often fall just below the CYFS funded category of high and complex needs even though most have a history of abuse and neglect and their needs have been poorly met (Fleming et al., 2007).

What works: New Zealand Best Practices Literature

> "The strength based model is more likely to achieve success than a deficit-based model that focuses on what is going wrong." (Yuschik, 2004, 6).

As noted previously, there are few evaluations of wrap-around health services for young people. This should not imply that there are few effective services as there are a range of effectively delivered wrap-

around youth social services, however these services are rarely evaluated and go largely unrecorded in the literature. There are even fewer evaluations of practice.

Denny et al. (2004a) concluded that there is a need for specific policies and programmes for AE students to address urgent and serious threats to their health and well being. Utilisation of existing services has been found to be poor with students often not referred due to a lack of information concerning available services, diffidence as to the level of need of particular students, pointing to lack of expertise. Services were not trusted or the student and/or their family refused to use the service and services did not seem to be skilled at engaging with these particular students (Fleming, 2007).

> "Collaborations between community health providers, specialist youth and mental health services and educators are vital to most effectively utilise available resources and improve health services access." (Denny et al., 2004b,147).

The New South Wales Centre for the Advancement of Adolescent Health (NSWCAAH, 2006) affirms these comments stating in a recent study of youth health services that there is inconsistent communication and knowledge sharing between health-related services especially those working with young people's health and wellbeing. Anecdotal evidence suggests that this is often the case where schools are involved despite the best efforts of community-based providers. There is also little research that establishes whether online websites and databases make any difference. Models of collaboration do not feature often in the literature. Anecdotal evidence suggests community development methods can be useful in this work. These comments also reinforce the importance of liaising with schools and other youth organisations.

Evidence for wrap-around models of service delivery

> "…it is increasingly recognised that positive and holistic approaches to youth health are more effective than negative-based strategies such as reprimanding young people about their behaviour." (Denny, 2004,6).

Research findings indicate that the most promising outcomes for significant long-term gains are from intensive, integrated or 'joined up' services that meet a range of student needs (Fleming et al, 2004). Evidence shows that agencies whose practices work alongside and wrap around the young person and their family have a positive effect on long term outcomes (Fleming, 2007). Evidence also indicates that this approach has proven effective with "difficult to treat" or high-risk youth(Fleming et al, ,2004). A wrap-around service often includes the following components:

- A comprehensive service delivery focus including home (family) visiting and centre-based strategies.
- Culturally competent and effective links to wider community services and networks.
- Is strengths-based.
- Services consist of regular and frequent visits that are of flexible duration and intensity.
- Offers services intensively – i.e. at least once a week with well-defined criteria for increasing or decreasing the service and working over the longer term (3-5 years ideally).

- Offers services voluntarily and using positive persistent outreach efforts to build family trust (Sinclair, 2007).

These features are further reinforced by the Youth Engagement Project model of service delivery (Youthline, 2006) which includes:

- Youth participation in the design of services for young people is the key to success.
- Transport to be provided for young people to increase their access to services.
- Services must actively engage with the community and young people in their own environment.
- Services need to link together to meet the needs of young people and their families in their community.
- Integrating services with a place to hang out or with recreational, social, musical and cultural activities will improve utilisation of services.
- Services need to create environments which reflect youth culture and the local community.
- Staff don't need to all be young people but there is a strong preference for young people to be the first point of contact. Adults involved need to dress casually in a way that is natural and relaxed.
- Young people want to access people who have themselves experienced the issues they are helping with.
- Young people want services to address issues such as boredom, provide activities and events and safe places for people to gather.

What works for AE young people?

- Young people need support and opportunities.
- Young people need opportunities to contribute and participate.
- Interventions need to be intensive and sustained.
- Successful programmes are often multi-component, provide long-term interventions and involve a range of community agencies.
- Forming alliances and partnerships with other agencies.
- Building evaluation into programmes (Denny, 2004a).

In addition, young people mentioned:

- Being able to establish rapport quickly and pick up where they left off as well as maintaining the relationship.
- Sense of humour.
- Realistic expectations.
- Passion.

Some names suggested for a Counties Manukau youth health service in previous Youthline consultations included, 'Kick Back Shack', 'Pacific Vibe', 'Southern Vibe', 'Dial Up', 'Clendon Youth Centre' and 'One Stop Youth Shop'. These more youth-friendly names for the service could enhance its attractiveness to young people.

When considering how young people would hear about the service these young people said that it would be by word of mouth spread by youth who had experienced the service first hand. Many of these points were affirmed by key informants in this project..

The Pacific Youth One Stop Shop consultations (2006) indicated that while a youth health service needed to be attractive to mainstream or young people of other ethnicities, a Māori and Pacific focus would best suit Counties Manukau. These consultations also noted strong connections to family, emphasising the need to have families involved without compromising confidentiality.

Practices identified as strengthening include:

- Strengths-based perspective.
- Combination of education and social work in one setting is effective.
- Traditional approaches do not always work (Sanders and Munford, 2001)

AE practices that are health enhancing

Both AE and secondary school students report high levels of support in school environments however, a higher proportion of AE students say their teacher has got to know them well (Denny, 2004b). The relationship between any service and the AE teacher is a critical one and is built on trust. This is the person who would be most appropriate to negotiate health access for students. Research suggests that the most effective response for these young people is the provision of intensive, joined up or integrated services that meet a range of student needs (Fleming et al.,2004; Denny & Watson, 2004).

There is also evidence that AE acts as a holding mechanism providing stability and allowing supportive and comprehensive health and social interventions to be implemented (Fleming, 2007). Tutors report that this support, frequently also given voluntarily and outside school hours, can provide a turning point for many students offering a 'second chance' and enabling them to make significant changes in their life (Fleming, 2007). However, the window of opportunity is small stressing the importance of professionals, trained in social assessment and advocacy for adolescents and being able to support the young person at this critical time is essential, rather than the responsibility resting with AE staff. When AE providers are able to link with social support services that can work alongside a young person and their family through ups and downs and for a minimum of a year there are long-term positive impacts (Fleming, 2007).

Health services that are appropriately set up, accessible and, as in some cases, attached to an AE service have a positive impact on students' access to healthcare (Fleming, 2007). However, where this is not the case and students are not linked to health and social services, health access is poor. Continuity of care on exit beyond 16 years remains an important issue.

What AE young people and key informants thought would work

Young people consulted in this research identified issues that most affected them and were perceived as most valuable and relevant in their community. Examples given included: gangs, violence, drugs, boredom, youth offending, alcohol, teen pregnancy, lack of family time, lack of community pride and belonging, suicide, problems with police, racism and bullying.

The students saw a range of services being necessary reflecting the complexity and varied nature of their needs. Their suggestions fell into a number of broad categories including; an awareness of physical, mental and emotional health, need for social services, service delivery mechanisms and physical environment and relationship building.

> "We need this service for flu shot, if you are sick, you got HIV, if a family has no dosh, scared to go to your family doctor, if you are pregnant, to check it out and not go with family, (maybe being able to check the service out before you use it?) Free to save money".

Access

Lack of transport and money make health services inaccessible to young people. This situation can be compounded when young people are concerned about confidentiality and do not trust the healthcare provider. A service that provides 24 hour care was consistently mentioned as a high priority for these young people. This could be provided in a variety of ways emphasising flexibility of service delivery as a critical factor.

Service delivery

Confidentiality was referred to both indirectly and directly.

> "Not too close to area where we live because parents might catch you and ask too many questions".
> "Support person needs to be, confident, confidential, be full on, be humble".
> "Confidentiality is important to the service because people overdose and can't talk with families".

Creative ways of approaching a youth health service were a critical consideration. One young person suggested writing down what his visit to a health service was about; perhaps selecting issues from a box of cards and passing them to a health professional rather than talking.

Once again multiple service access points would support this concern especially if electronic and telephone access to health services was provided. Only 36% of young people in one survey had spoken to the nurse or doctor in private or had confidentially explained to them and about the same number were not asked about issues such as drinking and driving, healthy eating, condom use, sexually transmitted infections or birth control, emotional health and relationship issues (Denny et al., 2005). It is relevant to note that early onset psychiatric disorders were diagnosed for 20% of young people in the Denny et al survey who had not completed high school. The mental health needs of AE young people needs a special response that is as important as the quality of service delivery.

> "Services that helped me talk to someone, that counselled me – but it's not good if [they] could not relate to young people and just wanted to put me on drugs".

AE students who experience high levels of stress and anger problems tend to have shorter attention spans. The consistent mention of entertainment be that pool tables, electronic games, controlled tagging opportunities and spaces for hanging out and cooling down to "take their minds off things", had a high frequency making this an important consideration for young people although often regarded as superficial by adults.

> "Arcade games because it will take people's mind off what they're angry for, so it keeps them busy until someone talks or helps them in the waiting time. If nothing is there, people will go away".

Best practices for service delivery

Blum (1998) found that youth-orientated clinics screened for more health risk behaviours than general clinics and that this was due not to the setting as much as the provider characteristics such as variations in training, prior experience and attitudes to young people. It was clear in this study that many mainstream providers felt uncomfortable talking to young people and believed they were inadequately trained in adolescent health (Denny et al., 2005). The AE students emphasised the importance of relationship building and the way health professionals behave and look. They identified the best health professionals as those who had a similar background to them and dressed in ways they recognised.

AE students made the following comments concerning provider characteristics:

Experienced workers who are youth-friendly, young and care. *"Someone who's been through the same as us"*.
"Helpful and respectful staff"
*"*Not judgmental
Staff – dressed in black
Under cover security/Bouncers – dressed in green or undercover and *"keep the hood good"*
Card number system (for help services) so that people don't have their names called out for privacy.

Free or by donation "as most people can't afford much and won't be able to pay" or "so we can use it"..
"Some staff white and some brown and mixed cultures".
Working with families.
Walking distance to AE service or free bus service.
Visiting services.
"Useful services – otherwise we would be unhealthy. To help huge people with diabetes".
"Write instead of talking"
24 hour service or after hours service" because that's when a lot of stuff goes wrong and we have no where sometimes to go".

Young people mentioned role models as an important component of any service and contrary to expectations that young people would be the focus they indicated that normality was an important factor and positive roles, no matter what age, are valued,

> "Have some normal whanau people to make us comfortable like cool Mums and Dads".

Some aspects of the physical shape of service were also described by AE students as part of focus groups – one group also emphasised that, *"if this could happen…some of us young ones [could] help put it together".*

Located in South and East Auckland
Counselling rooms
Welcoming, comfortable and friendly
Entertainment room with computers, tables, couches, a TV and Playstation 3.
Youth services (including D&A) *outside* hours
Arcade game room (pinball, car racing games, shooting games). *Note: 'a place to chillout if*

A safe place
Office – "with young people as helpers and a separate waiting room".
Pool table. Note: 'to take your mind off things'
Graffiti wall. Note: 'to take your mind off stuff while tagging'
Back wall bombings
Heater
Reception area

you're angry.'
CounterStrike
Internet available
Movie room with seats arranged like a cinema and a projector. Large projector screen.
TV Room: With (blue) couches and a table and TV. "Comfortable furniture but not flash ones that look good but you don't want to sit in it".
Food bank room with separate door to enter.
Projector
Free headphones
Art "Eazy-E and Tupac"
Jars of lollies
A big wall or paper to bomb on
Vending machine
"Outside kick back spot'
Boys and girls toilets
Smoking room with a fan to suck air out
Kitchen to cook food
Table
Gym with boxing and kickboxing
Couches with flat screen TV and DVD, Playstation
[Boxing] Ring
Flowers
Separate rooms: because some people don't like heaps of noise if they're stressed out but some might want loud music that helps them.
A "kick back" room with nice couches, a pool table and a stereo system
Back door entrance
Quiet timeout room
Mean sounds
Bean bags

Young people consistently stressed the need for 24 hour services. While a service could be supplemented by telephone and internet access to assist with this request, any delivery of services should be as flexible as possible and not just 9 to 5pm but also evenings and weekends as is offered by YOSS in some areas of NZ.

Health assessments

Health assessments for AE young people are rare as AE teachers have little time to implement them. Teachers/tutors report that over time they gain a good idea of the problems and needs of students. An initial health assessment would be completed when a young person begins at the AE service. The Otago Youth Wellness Centre (OYWC) has reviewed the commonly used HEADSS Assessment Tool in a process that asked staff to question the youth friendliness of the tool. As a result they have developed a new version of the tool that more appropriately matches the needs of the young people who use the OYWC.

All AE providers interviewed involved young people's families to varying degrees and in some cases referred them to counselling or other services. In the example of one consortium, young people 15 years and over are supported by a specially trained transition worker who does a care plan for each student and advocates on their behalf to facilitate their re-entry into school or entry to either further education or work.

Access to mental health and drug and alcohol services was identified as a serious gap for Manukau. Feedback from students emphasised the need for health and social services that are affordable, accessible, culturally friendly, provide early identification of need and effective follow up.

3. BEST PRACTICE PRINCIPLES FOR AN AE HEALTH SERVICE BASED ON THE YOUTH DEVELOPMENT FRAMEWORK

> "Multilevel interventions have amply demonstrated that reducing risk factors and promoting protective factors in ways that both enhance youth competence and transform their social environments result in multiple, positive long-term outcomes for young people." (Bernat & Resnick, 2006).

This is the essence of a youth rights-based or youth development approach. In 2002, after extensive discussions with young people, youth practitioners and academics with an overseas peer review process, government introduced the Youth Development Strategy Aotearoa (YDSA). This had been motivated by a need to develop a common framework that would guide policy development. The youth transition policy for young people 15–19 years not in education, training or employment was strongly influenced by the strategy and its evidence base (Bagshaw, 2005). As with all important documents such as these, their uptake and frequent use is important in embedding the ideas in the consciousness of the wider community.

This national framework provides an integrated set of principles that provide a basis for the following discussion. The Manukau Youth Development Framework was developed from the YDSA and includes six key principles:

- Youth development is shaped by the 'big picture'.
- Youth development is about young people being connected.
- Youth development is based on a consistent strengths based approach.
- Youth development happens through quality relationships.
- Youth development is triggered when young people fully participate.
- Youth development needs good information.

The Ministry of Youth Development promotes a youth development philosophy with a focus on keeping students well and building on their strengths. Youth health services provide an excellent opportunity to put youth development principles into practice. They note that a youth development approach can be applied in many ways:

- Involve young people as partners.
- Provide opportunities for learning and mastering new skills.
- Ask young people for their help and advice to make the new health service work effectively.
- Support young people and listen carefully to their concerns.
- Work to each young person's strengths and talents to help them develop their own solutions to their health concerns.
- Give as much attention to keeping young people well as to treating their ill health.
- Actively involving students in all aspects of the service, its design, governance and service delivery.

Students can be involved in a variety of ways in health centres, as the experience in existing school-based services overseas shows for example:

- as peer support workers,
- on the management committee,
- on the board, or
- as graphic designers and artists (Ministry of Youth Affairs, 2005).

Research notes a range of issues that are important for the delivery of youth health services, including:

- Close and caring relationships between parents/families and youth should be promoted and strengthened.
- Continuity of service – "in for the long haul" after they have finished with AE.
- Sustained attention recognising that health and wellbeing crises will ebb and flow.
- Offering things the young people and their families actually want.
- Offering things that will make a difference in the long term.
- Being accessible.
- Being able to address a range of issues with a minimum of referral.
- Being skilled at working with young people who have been abused or have anger issues.
- Families need to be involved (Youth 2000, 2003).

As noted above, a number of key informants mentioned the difficulty of accessing services for young people who fall below the Child Youth and Family Service (CYFS) and Child and Adolescent Mental Health Services (CAMHS - community-based mental health services) funding cutoff but were still at-risk young people. Another provider identified the need for 24/7 support for some high-risk young people.

Models

The literature has identified a number of models of delivery that attempt to have youth-friendly practices. However, it is clear that no one service is the same emphasising the high degree of flexibility required. Analysis of both the literature and research data suggests four predominant models exist in New Zealand.

Four models of delivery:

- Stand alone provision of a nurse set up by AIMHI Consortium
- Community-based AE linked youth health services
- Community-based youth health service or YOSS
- Comprehensive school-based clinics

Model A. Stand alone provision of a Youth Health Nurse set up by AIMHI Consortium

This service is one set up by an AE consortium to meet the urgent need for healthcare by AE students. The AIMHI consortium has set up a room which provides a skeleton health service linking to CfYH. This minimal service provides a nurse who sees students on a regular basis and can treat minor ailments referring other issues to CfYH or other more specialised services. There is limited evidence as to the effectiveness of this response (Fleming et al, 2004, Tylee et al, 2007). The Consortium manager fully acknowledges the limitations of this service but feels this is the only response possible under current funding restrictions.

Model B. Community-based AE linked youth health services

This model shows some promising outcomes for young people with multiple health risk behaviours and poor access to other healthcare systems (Fleming et al., 2004). It is a model that is similar to the model being proposed and is currently being developed by CfYH in Manukau. Their outreach service consists of a social worker and youth health nurses who offer special youth clinics and a mobile service for 4 AE providers. CfYH are currently considering employing a youth worker.

This sort of service could potentially be complemented by other mediums such as internet and telephone services as identified by NSWCAAH (2006)as innovative access points. The service proposed in this report would be shared among a number of providers of AE services giving a more comprehensive service than is possible for CfYH or any other community-based YOSS can offer to deliver alone. It is also well matched to the infrastructural complexities of the Auckland region and reflects the model proposed by Counties Manukau DHB (Sinclair, 2007). However it would need to be physically based with and supported by a more comprehensive, community-based, primary health, youth service.

Model C. Youth health centre (One Stop Shop) or community-based youth health service
Young people have specific needs that are not well met by general medical services. The term 'One Stop Shop' is in some ways inaccurate as none of these types of services provides everything a young person may require. There are approximately 14 of these services in New Zealand (Bagshaw, 2006). These types of YOSS offer different combinations of services such as that provided by 198 Youth Health in Christchurch, OYWC in Dunedin, YOSS in Palmerston North, Evolve, Vibe and Kapiti Youth Service in the Welington region and the youth health service in Whanganui. There are others. Some provide a comprehensive health services for young people including leisure activities and education opportunities with direct delivery of some services and outreach for other services with a referral an option when required. The YOSS model of delivery, is still developing as the concept becomes more accepted, albeit slowly, as a number have existed for many years.

Using CfYH as an example (Fleming, 2004)[5] the Centre provides the following services:

- Sexual health
- Reproductive health
- Mental health: assessment and treatment
- Alcohol and drugs: screening and therapy – one on one or small groups
- Vision and hearing: screening
- Skin and chronic illness management
- Social health: follow up with social service agencies i.e. welfare and justice sector
- Education: fortnightly case reviews with the AE providers supporting transition plans. This includes continuous communications with the head tutor in the school if not with the whole AE team and regular meetings once a fortnight for 1–1.5 hours

However, CfYH is not a drop-in facility, hence the development of their outreach service.

[5] In the proposed model, each community based youth health service would deliver different combinations of services in different ways and based on local needs.

One of the key issues for young people in the Auckland regional cities is access. If it were economically possible to deliver this service to all AE providers in Auckland, this model of service would, with some adaptations, meet many of the service requirements outlined in this report. Auckland's physical layout does not ensure youth health access for all AE providers and their students, hence the need for a connecting mobile service in this particular region.

Model D. Comprehensive school-based clinics
This option is not ideal for AE students who may have left schools in negative circumstances and in this context, locating a youth health service in schools may be a barrier to access for these students. It is interesting to note that in the school plus policy announced recently there was no mention of Alternative Education services in the document except indirectly in a paragraph referring to young people whose needs are not being met at school or who have disengaged and left school with low or no qualifications. School-based health services vary considerably in quality. It was beyond the scope of this research to study available services in detail but they range from the extensive to the rudimentary and can include, medical, mental health and nursing services. The service is free for all students and has a high priority on enhancing young people's access to healthcare.

Research suggests *that* school-based health services that usually address the needs of all students may increase access to healthcare, positively affect the health status of some students and decrease emergency room usage for some other students. Denny et al. (2005) also noted that young people who used school-based health services were more likely to receive private and confidential care than students who went to private medical practices for care. The percentage of young people with whom other issues such as contraception, sexual health and sexually transmitted infections were discussed by health professionals etc. rose to 50% for those using school-based services although young people's ratings of the care they received from different delivery sites was no different. 79% of the students in this survey had seen their family doctor in the last 12 months indicating that alternative healthcare does not displace traditional providers. Young people receiving healthcare from school-based services found it helpful (Denny et al., 2005).

It is important to note that most of this evidence would be comparing services offered in schools with those offered by private medical practices. The results should be taken in context and do not necessarily imply that this service provision is necessarily better than that provided by community-based youth health services. The lack of published evidence from youth health services does not allow a robust comparison to be made. It is also a mainstream service and may not be capable of attracting the students most at risk and unlikely to meet the needs of AE students. CfYH reports that 41% of their clients had no contact with health services in the last six months prior to their health visit (CfYH, 2007). This may indicate that community-based youth health services such as CfYH are more likely to reach young people with higher needs.

The Wainuiomata and Te Rangitahi AE Unit is however, successfully accessing school-based services through their consortium. Anecdotal evidence suggests that where these services are comprehensive and youth-friendly and the relationship between the school and provider is strong this can be a successful partnership. This unit has access to all Wainuiomata High School services including a GP, health nurse and counselling. They can also refer to Kokare Marae and link with the J Team youth development service. It is important to note that Vibe, the YOSS in Lower Hutt is an integral part of

provision for students. The Unit also participates in Strengthening Families monthly meetings. The coordinator of the AE unit noted that the coordination of agencies for each young person is essential in making sure the individual care plan is implemented. It is also essential to emphasise that this is a small, very localised area and the model would not work so readily in the complex environment of Auckland with it's and distances from services and lack of cheap, easily accessible transport.

An Australian evaluation of this sort of service found that although the service was well utilised the quality and effectiveness of the service depended on excellent collaboration between the service, the school and other community agencies (NSWCAAH, 2006). Legally, schools in NZ are only required to employ a first aider to deal with incidents and injury (Ministry of Health, 2004). The Ministry notes that the provision of a higher quality adolescent health service depends on the individual school and trustees, the funding available and the District Health Board under which the school is based. Every school is obliged to provide a "safe physical and emotional environment" for their students and some schools are beginning to take a "whole of school" approach to student wellbeing and linking good health to learning. In fact, most school-based services have an external provider with very few having dedicated health professionals (Bagshaw, 2006).

Overall, evidence suggests that while school-based provision can work well, this success can be based on locational strengths and is highly influenced by the management model of the school. School-based service provision is also more likely to meet the needs of the general youth population rather than youth at risk and AE students mostly represent extremely complex cases. Schools are often not experienced in health and social matters and what these young people might need and services tend to be diverted away from high need young people to other young people who while requiring services are not as urgently in need of health care. Accessibility, due to the size, structure and availability of transport in all areas of Auckland, and confidentiality were the most important issues identified by AE students.

4. A PROPOSED BEST PRACTICE MODEL FOR A HEALTH AND SOCIAL SERVICE FOR AE STUDENTS

Introduction

Young people need access to a flexible, youth-friendly health service coordinated in a way that ensures they get to know one or preferably two workers well, to provide staffing options and to ensure continuity. The work is multi-agency, systemic and broad spectrum and significantly needs to be a wrap-around service. When necessary, the professional can refer on and offer support and advocacy as part of this process. The young person's own GP would be linked to this service with their consent and where the young person is not registered with a PHO they would be encouraged to do so.

Transitioning young people post-16 out of the service would be a critical issue to address as this is a time when many young people can be lost to services. The relationship building implicit in the following recommended model would increase the chances of young people remaining engaged. While there is a need for any model to be universally applicable this is not in the best interests of particular locations so the proposed model is flexible. One barrier identified in this research is the boundaries of the DHBs which do not seem to match the natural city boundaries of Auckland leading to situations where services are required to relate to services in other areas of Auckland that they do not naturally fit with. Auckland does present a special case where successful arrangements in smaller localised sites would not be appropriate.

Te Whare Tapa Wha (Durie, 1994 *in* Weld and Greening, 2004) is a framework drawn from a Māori model of health, based on concepts of resilience theory, solution-focused theory and strengths-based practice including the "signs of safety framework". The Māori philosophy of health is based on a wellness or holistic health model. Māori see health as a four-sided concept representing four basic beliefs of life: Te Taha Hinengaro (psychological health), Te Taha Wairua (spiritual health), Te Taha Tinana (physical health) and Te Taha Whanau (family health). The proposed model of youth health delivery draws on this model as well as the Youth Development Strategy Aotearoa. With some adaptation regarding a link to a comprehensive community-based youth health service where none exists, such as in central Auckland, it is a model that would be of interest to other areas of Auckland not only Counties Manukau.

What AE young people need: a model of health service delivery

A comprehensive youth health service is proposed, composed of community-based, AE-linked health and social delivery units attached to a YOSS. The CfYH is currently developing a model of health service delivery to Alternative Education students that is similar to what is being proposed. The proposed Youth Wellness Clinic would consist of five staff, led by a senior youth health nurse practitioner working with two youth health development workers, a youth primary mental health worker and a community social worker. The social worker would work closely with the youth workers and take a role of case coordination ensuring a wrap-around service is in place for each young person. Ideally the lead would be an appropriately trained youth worker, however until the professional development and recognition required exists in this specialised area the best lead would be the senior youth health nurse specialised in adolescent health delivery. A physician specialising in adolescent health would support the clinic but as required with most needs being met by the team. One essential component of the service is the development of a strong link between the service and the AE teacher as this is often the most trusted person for the young person.

The team would be specialised in delivering services to youth and of mixed gender and ethnicity but acknowledging that a Māori and Pacific focus would be the most appropriate in Counties Manukau area especially considering these are the predominant ethnicities of AE students. Each clinic would be delivered from multiple access points (with some fixed sites that could be used itinerantly), highly flexible and closely linked to community-based AE school services. Where young people needed to be referred, the staff would facilitate the process and support the young person through this process. The Youth Wellness Clinic would be structured on a model of youth health promotion, fully aware of the Youth Development Strategy Aotearoa and include the active involvement of young people at all levels of the planning and implementation of services.

The Youth Wellness Clinic would be linked to a comprehensive community-based youth health service or some other youth-specific health service like the Centre for Youth Health that would provide upper level primary health care.

Objectives for the community-based AE Youth Wellness Clinic

- Improved access of AE young people to health assessment and services given their previously identified high need.
- Improved resiliency of young people by supporting current mentoring and resiliency development services.
- Improved health outcomes over years, including -
- Reduced suicide attempts,
- Reduced substance abuse,
- Reduced binge drinking,
- Improved management of chronic illnesses,
- Safer sexual health practices,
- Improved hope and trajectories, and
- Improved personal safety of each young person.
- Encourage and support transition to regular primary health care providers (Sinclair, 2007).

As noted above the transitioning of young people post 16 would need special attention.

The structure of the Youth Wellness Clinic

Level 1
The mobile clinic would have:

- Senior Youth Health Nurse (Lead)
- Two Youth Health Development Workers
- Community Social Worker
- Youth Primary Mental Health Worker

Level 2
The Youth Wellness Clinic would be strongly linked to larger community-based YOSS providers such as the CfYH, Youthline and school-based services. The point made again and again by AE young people both in this report and others emphasises the need for a drop-in component as in a comprehensive

YOSS, containing a variety of activities both entertainment, health and education both physically and electronically provided making a centre based in a community at a point of maximum accessibility for young people a critical issue.

Level 3
At another level would be the essential auxiliary services provided by a community-based YOSS offering a flexible 24 hour service including, counsellors, a mentoring service, education (youth development, self awareness and a variety of other services.

Services in addition to those already mentioned and as identified by AE students were:

- Mental health provision
- Dentist
- Māori wardens
- Police support – a familiar person young people can trust
- Physiotherapy
- Alternative therapies
- Specialised health services e.g. diabetes, eating disorders
- Training e.g. parenting, self esteem.

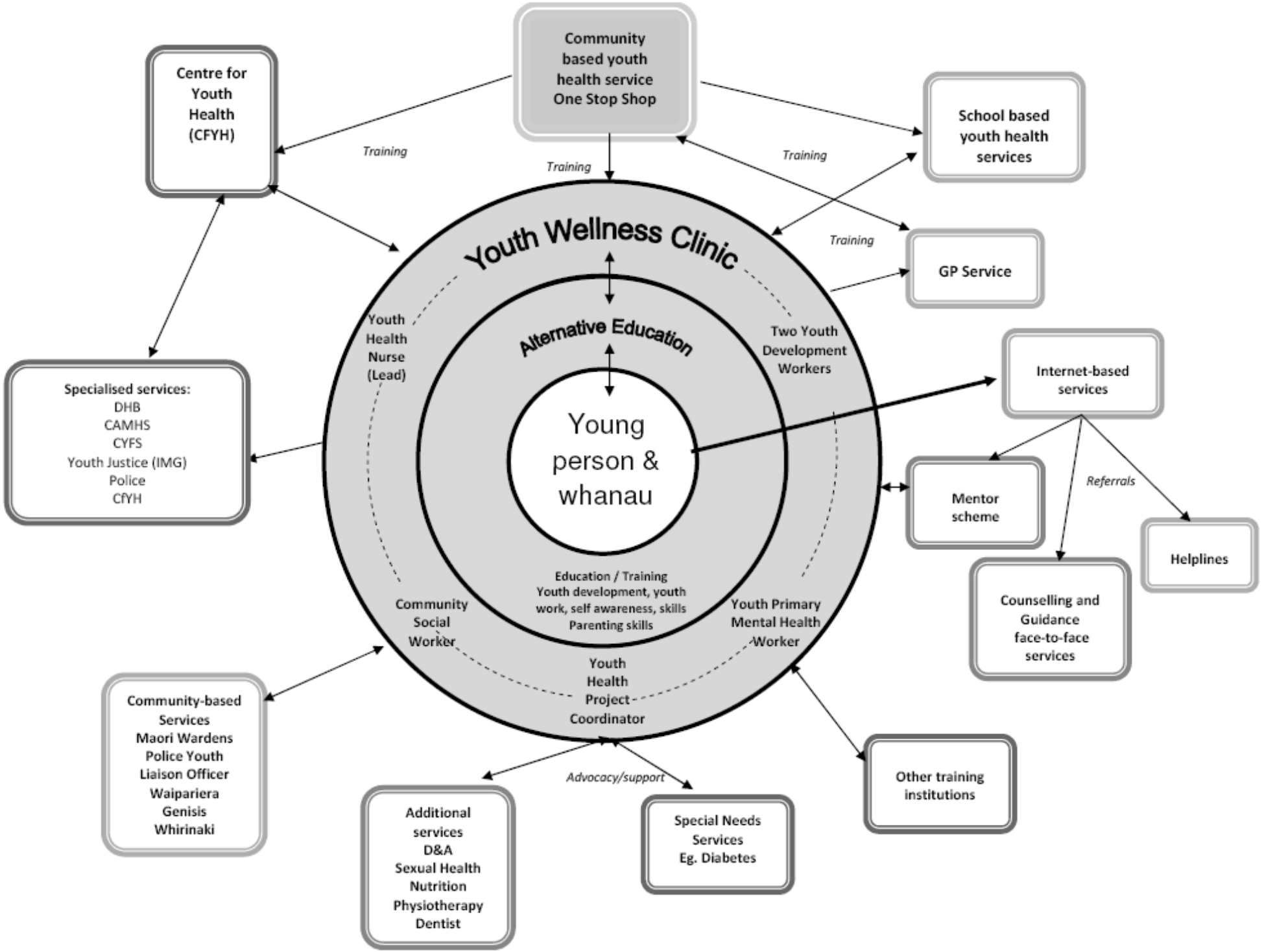
This mobile service would be further supported by a range of locally appropriate delivery mechanisms. A flexible internet and telephone-based service has been shown in an Australian context to be most effective at reaching the profile of AE students especially young men making this an essential component of the service.

A ***Youth Wellness Clinic Project Coordinator*** would be necessary to manage, develop and promote the service. This role is shown in the literature and in the attempts by local AE consortiums, to be an effective component that assists the sustainability of such a project and essentially improves access to health services for AE students.

Funding also needs to be sustainable rather than the hand-to-mouth approach taken for many youth services to date, that results in restricted services to young people and limits their access to health services with negative outcomes on young people's wellbeing particularly for AE students.

The following diagram illustrates the structure of the proposed Youth Wellness Clinic:.

YOUTH WELLNESS CLINIC (*Multiple access points)*



The culture of the Youth Wellness Clinic would be one of inclusivity and collaboration; drawing together as a team and over riding professional boundaries and concerns. As noted in the research, so called 'turf' tensions do not serve young people well. The service is concerned with building strong, professional connections and having positive impacts in all areas of a young person's life including:

- family and whanau
- schools, training institutions and workplaces
- communities (sports, church, cultural groups)
- Peer groups (Counties Manukau DHB, 2003).

The Youth Wellness Clinic service delivery (replicating components identified by Sinclair (2007) and data developed as part of this research):

Service delivery characteristics

- Relationship building and engagement are essential, with each young person having a lead worker. This would ensure a well coordinated and appropriate response that wraps around each young person.
- Effective links to wider community services and networks.
- Young people would be linked to their PHO and other appropriate services.
- Services would be wrap-around and focus on supporting the parents and whanau as a positive parent-young person interaction is critical to health and well-being.
- Culturally competent and appropriate, community-wide planning, development and delivery of services.
- The service is strength-based.
- The service needs to address broader community issues.
- The service is free and voluntary using positive persistent outreach efforts to build family trust.

Service delivery

- A comprehensive service delivery focus including home (family) visiting and youth health centre-based strategies.
- All AE young people would be assessed on entry to AE using standardised (i.e. consistent across all people) health assessment tool, specifically developed to be youth-friendly along the lines of the process used by the OYWC and to systematically identify young people and their families who are most in need of the service.
- Have clear programme goals and outcomes that are based on individual needs as well as broader measures.
- Target those in need (AE students) rather than the general youth population.
- The Youth Wellness Clinic would provide regular and frequent visits that are of flexible duration and intensity.
- Offer services intensively - i.e. at least once a week with well-defined criteria for increasing or decreasing the service and over the longer term (3-5 years ideally).
- Include educational components and problem-solving.

Staff

- Involve well trained and supervised staff members.
- Team members would have limited case loads and adequate supervision.

- Staff members would be selected because of their personal as well as professional characteristics: their willingness to work in or their experience working with culturally diverse communities and their skills to do the job.

Specific services requested by AE students

Some of these services would be more appropriately delivered by a YOSS or a similar service already in existence in the wider community emphasising the importance of strong links to other services.

Physical health
Pregnancy support
Gym
Food available
Health checkups
Medication
Operations
X-rays,
Drug and alcohol counselling
First aid supplies such as plasters

Social services
Library
A youth food bank
Emergency housing support for youth

Courses
Leadership courses
Anger courses
Unit standards accreditation

Other services
Safe, after-hours meeting place
Youth-friendly banks

Sexual health
Family planning (free products)
Sexual health information and counselling

Mental health services
CADS
Counselling (Youthline, Whirinaki)
0800WASSUP
Smoking and other addictions
Gambling
Violence
Sexual abuse

Relationship counselling covering the following issues:
family stress and problems
personal stress,
self esteem skill building
friend problems
girl problems
Grief counselling- "help with big problems like someone has passed away"
Relationships (with family and/or the adult)

The objective of this new service is to provide for each AE student a holistic, seamless, wrap-around health service. Using information provided in this report and advice received from the youth health team at CfYH, the following process is recommended:

1. Each new young person is assessed by the team using a youth-friendly version of HEADSS[6] and an appropriate lead worker is appointed.
2. Each AE provider is visited by a youth health nurse and a youth worker (including other staff if necessary) at least once a week.
3. Individual cases are reviewed at the weekly meeting where complexities need to be discussed

[6] See Otago Youth Wellness Centre process and assessment tool.

4. All cases are reviewed once a term during school holidays

While it appears that mobile services are viewed somewhat negatively by health professionals (key informant interviews), the flexibility of the proposed service is essential and does not imply any lack of professionalism. Community-based social workers are increasingly going back to a more flexible service that goes to where people are and takes them to where they need to go. Rather than contributing to dependency, outcomes show that the changes made for whanau supported in this way are more profound (Milne and Sanders, 2008; Sanders and Munford, 2001). Being able to deliver a holistic health service where young people live and work and assisting them to get to other services they might need by offering multiple access points, transport and advocacy, especially in an area such as Auckland, will make a difference between these high need young people getting health services or not.

Professional development and training

Professionalisation of the youth health sector for all professionals on the Youth Wellness Clinic team including nurses, community social workers working with young people and youth workers and the associated core competencies[7] in the specialised field of youth health need to be urgently addressed and given appropriate support. All health professionals who work with young people in any capacity, regardless of discipline should master these core competencies including understanding the relationship between youth development and youth health, being able to identify factors that place youth at risk for poor youth health outcomes and being able to identify factors that are protective and enhance good health outcomes (Centre for Youth Health, 2006). This would ensure that young people receive the best and most appropriate care and that professional career pathways are developed in the area of youth health.

All Clinic staff would be trained in the delivery of health and social services to youth. A mental health component to the training would be essential. Youth mental health remains a neglected and undeveloped area (Taylor, 1988) stressing the necessity of a special focus on primary mental health delivery for youth with a position that delivers to and promotes youth mental health concerns. This point needs to be emphasised as while the experienced health professionals required for this service would undoubtedly have some training in mental health, given the high incidence of mental health issues in this particular population of young people, designating a specific role of a mental health worker would signal a focus on this area of health to promote and develop a youth specialism not just treat the problem.

In summary, the Youth Wellness Clinic would require the following professional development components:

- Comprehensive specialisation with competencies carefully defined using the YDSA and with young people as advisors.
- A professional career path identified for youth health professionals in recognition that it is an area of specialisation that receives scant attention in the training of most health professionals.
- Staff members would receive training in service delivery as well as clinical skills, youth worker standards and other specialised training for adolescent service delivery as a priority.

[7] The CfYH are currently developing a set of core competencies for their service

- A supervisory framework for handling the variety of experiences staff may encounter when working with at-risk young people needs to be developed. On-going supervision should be available to all workers acknowledging the complexity and challenging nature of the work.
- All staff members should receive basic training in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drugs and availability of services in their communities.
- Tertiary training students should be encouraged to work alongside the service with appropriate guidance and supervision.

An essential component of any youth-specific service development would be working with GP medical practices to educate GPs and nurse practitioners, in the delivery of adolescent health services and becoming youth-friendly providers.

Evaluation and capacity building

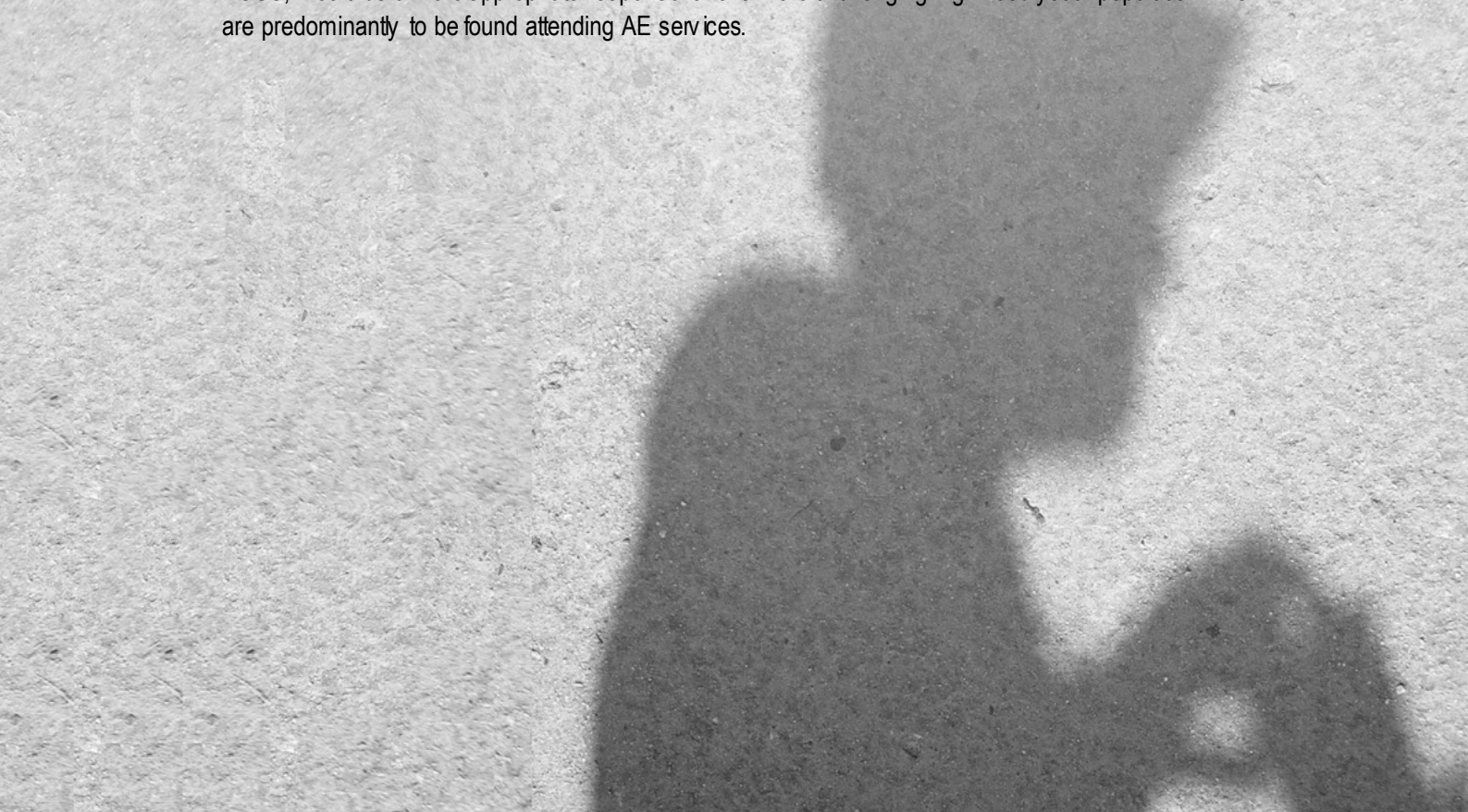
Providers should involve young people in the planning, development and running of programmes.
All services should contain well-designed planning and reflection processes (based on an action research model) with evaluation capacity building as an objective.
The service as a whole would benefit from having formative, process and impact evaluations running alongside the service from the start of the project.
Providers should look for existing programmes that have been well evaluated and have clear planning and implementation procedures.

CONCLUSION

The need for and provision of holistic services, accessible and adequately supported, for all young people while officially acknowledged as part of the Youth Health Action Plan (Ministry of Health, 2002) is "patchy at best and often non-existent" (Bagshaw, 2006). In *Youth health: A guide to action* (2002) the Ministry of Health promised "the provision of high quality, youth-friendly, accessible health services" for youth. A further barrier to these objectives is that the way services are used by young people does not match PHO's funding framework (Bagshaw, 2006a). As a result, the full funding of new services and maintenance of current services has yet to be achieved (Pinfold,2006).

The development of appropriate new health services must be prioritised to counter a feeling of fatigue amongst young people who have been involved in numerous focus groups on this topic. New services should clearly reflect the youth development model of service delivery to ensure they don't feel marginalised and ignored. Young people in frequently accessed groups should be informed of developments so that they have a sense of progress.

The full and active support of DHBs for the proposed Youth Wellness Clinic as a provider of youth health services to AE students provides a model that would work well for all young people as well as other similar groups such as Teenage Pregnancy Units (TPUs), CYF residential units and community-based services such as Bethany in Auckland. Anecdotally, it is acknowledged that schools do not see health as their core business and yet this is the direction they are being coaxed towards over the years. Despite the best efforts of a few, an effective response across the educational spectrum, to the health needs of AE students who represent the most high need section of the youth population, is in many cases overdue. While the school-based model may work in smaller localised areas such as Wainuiomata, urban centres such as Manukau, Auckland City and Waitakere need a more flexible response if we are to accept that access to youth-friendly services in these areas is a considerable problem. In this case, the proposed model that identifies a smaller flexible health delivery service that is linked to a larger primary youth health provider such as a community-based youth health provider or YOSS, would be a more appropriate response for this more challenging high need youth population who are predominantly to be found attending AE services.



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APPENDICES

Appendix 1 Focus Groups AE

Research Questions - AE Focus groups

To be used in the way that best suits each focus group.

A. Round 1 focus groups (3)

Discuss what health services are currently provided, how they are accessed and do they meet the need?

Design What types of services would be useful for young people who attend AE? What might be an ideal health and social service for AE users. What would this service….

look like – draw, map, describe - off site, mobile, on site or a mix, one link person?

How would the service ***work***?

- Where would these services be located?
- Drop-in, appointments – how would this happen?
- Linked to mainstream school health and social services?
- Who should the service be accountable to and how?
- How should young people be involved in the management and governance of this service?

What would the service ***feel*** like – what's important?

- What sorts of people would deliver these services?
- Who else should be involved?
- Who would use these services?
- What would make you want to use these services?
- Safety - how would you ensure confidentiality?

Other questions

Please discuss how important do you think it is for AE students…

To have health and social services

For the services to be easy to get to

For the services to be cheap or free

For the services to be confidential and people don't know you are using them

For services to be delivered away from the AE site

For services to be delivered to you at the AE site

For young people to be involved in developing the services

For the services to have young staff

For young people to say how the services should work

ii) Are there any other issues concerning access to services that you think are important for young people?

iii) What other advice would you give about providing health and social services for AE students?

B. Some questions for the interviewer

1. What are the issues for these young people in

a) participating in focus groups?

b) articulating their health or other needs?

2. What are the health and social needs for these young people as you have heard in the focus groups?

3. What are the barriers for AE students in accessing health and social services?

4. What might be the best form of health and social delivery for AE students?

Using the youth engagement research framework we re-worked the questions to get a more detailed response and used these for 2 more interviews.

1. Brainstorm around the six areas of wellbeing

Body/Tinana; Family/Whanau; Spirit/Wairua; Mind/Hinengaro; Community/Whanaunaatanga and School/ Employment

For each area describe:

1. What they needed to be well and happy and how others could help that happen?
2. What sorts of health and social problems do young people need help with?
3. Where do they go when they have health and social problems?
4. What would stop them using health and social services that are available?
5. Create a health and social service that would be well used by young people in AE.
   a) What would the service look like? What would be important?
   b) What would the people who worked there look like? What service would each of those people offer to young people?

Appendix 2: Key Informants AE

Interview

Best Practice in health and social services for AE young people using a Youth Development Model and in conjunction with Centre for Youth Health.

The purpose of this research is to collect a range of information that will establish what type of holistic or educational, social and health environment might best suit young people who are users of AE. The research will explore what services are currently available and what an ideal service might look like - what are the theoretical bases and best practices of these types of services for young people.

Research Questions

- What are your thoughts on the particular health and social needs of AE students ?
- How does your service meet these needs?
- What health and social services are provided for your students alongside AE?
- Who are the providers, what are their roles and relationship with your service?
- How well is this working and what are the gaps?
- What might an ideal health and social service for AE look like?
- What services would be provided and how,
- Where – on-site or off-site,
- Care pathways and referrals

Appendix 3: Information sheet

Youthline Research Projects for Counties Manukau DHB
This research includes the scoping of a health and social services for AE service users and the development of an evaluation tool for a One Stop Shop health and social service for young people. Results from this research will support Counties Manukau DHB infrastructure developments aimed at improving the health status of young people by reducing risk taking behaviours - one of the greatest causes of youth mortality. The One Stop Shop service will be for all youth health providers, young people to self refer, all interested child and adult services working with young people and youth workers and services that employ youth workers. The service for AE will be for users of that service and may overlap with the One Stop Shop services.

Research Project 1: Best Practice in health and social services for AE young people using a Youth Development Model in conjunction with Centre for Youth Health.
The purpose of this research is to scope what data would need to be collected to demonstrate the effectiveness of One Stop Shops or youth health services. This will be achieved through a national and international literature search of effective self-evaluation practices and a scoping of what evaluative material is currently collected, and with what processes, by youth health services in New Zealand to demonstrate good outcomes for New Zealand adolescents using these services.
The information will be used to develop an effective (easy to collect) self-evaluation tool that fits best practice and youth development. This tool will then be tested using a representative cross section of these informants.

Invitation and Consent
As a young person who might use these types of services or as someone who works with young people you are invited to participate in this research. If you agree, you will be interviewed either face to face or by telephone or as part of a focus group. The interview will take approximately 1 hour and the focus group around 2 hours. All interviews will be recorded either manually or on audio tape.

The interviews will be summarised then analysed, coded and themed and a report prepared for Counties Manukau DHB. With the permission of each participant all data will be kept in secure files for a maximum time of one year after which time it will be shredded or if electronic data, deleted. The information you give will be confidential and used to develop effective and appropriate services for young people.

You are under no obligation to accept this invitation. If you refuse to participate, this will not in any way compromise any services you may receive from Youthline or Counties Manukau DHB. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time before March 2008
- ask any questions about the research at any time during participation;
- ask for the audio/video tape to be turned off at any time during the interview.
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the research findings when the project is concluded.
- If you require any further information please contact,

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