



THE UNIVERSITY  
OF AUCKLAND

FACULTY OF MEDICAL  
AND HEALTH SCIENCES

# Youth'09: The Health and Wellbeing of Young People in Alternative Education

A report on the needs  
of Alternative Education  
students in Auckland  
and Northland



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The report, tables and further publications by the Adolescent Health Research Group (AHRG) are available at [www.youth.2000.ac.nz](http://www.youth.2000.ac.nz)

*Front cover image: The 'hands' graphic represents the need for coordination and contribution from multiple agencies to improve the health and wellbeing of young people attending Alternative Education.*



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# Executive summary

This report presents findings from a health and wellbeing survey of 335 students attending Alternative Education facilities in the Auckland and Northland regions, carried out during term 4 of 2009. It also presents findings from interviews with key stakeholders that highlight the health, social, and educational needs of young people in Alternative Education.

Most students in Alternative Education viewed themselves as healthy. However, there are some concerning findings which indicate a vulnerable population. Compared to students in mainstream education, young people who attend Alternative Education are significantly more likely to experience high levels of socio-economic deprivation, to be exposed to environments that are harmful, and to engage in risk-taking behaviours. All these factors impact on their health and wellbeing now and in their future.

There have been few changes in the health and wellbeing of young people attending Alternative Education since the previous health and wellbeing survey of 268 students in 2000; in particular young women's health and wellbeing has not improved. The young men in the 2009 survey reported better mental health and higher levels of satisfaction with relationships with friends and family/whānau. However, compared to their mainstream peers, students who attend Alternative Education are significantly more likely to report a whole range of health and social issues of concern.

Alternative Education endeavours to provide a safe and positive environment for those students for whom mainstream education has failed. For many of them, Alternative Education is a venue for social and personal change. Tutors' relationships with students are key to engaging them in education. The majority of the students at Alternative Education facilities report that they feel part of their Alternative Education facility, feel valued, and have more hope for their future since attending Alternative Education.

A long-term approach based on good relationships with young people and their whānau, and involving multiple collaborating agencies is recommended to improve the health and wellbeing of students in Alternative Education. Given the many challenges involved in this sector, and the relative isolation from other services, we cannot expect Alternative Education tutors to change the trajectory of these young people's lives without attention to its resources and workforce capacity.

Health and social services in Alternative Education must be high quality, consistent, confidential, with well-trained youth health staff. We recommend free onsite primary care in the Alternative Education environment provided by health professionals who have good relationships and communication with Alternative Education staff and students. Consistent policies and processes for referral to specialist services, whānau collaboration and clinical supervision are required.

Considerable health, education and social disparities are evident among young people in Alternative Education, demonstrating a broader failure of services to meet the needs of this group. Alternative Education students and their tutors do not have access to the same resources that are available to students and teachers in mainstream schools, and they do not have adequate healthcare or social services. We hope that this report serves to highlight and advocate for young people in Alternative Education, who deserve quality education and health services with improved resources and coordination, to reduce their risks and increase their chances of growing up healthy and successful.

*“Young people have to be given ...  
the courtesy and respect that they actually have a role in life...”  
(Health professional)*

# Introduction

Education is one of the strongest predictors of good health status (1). Young people who succeed at school are more likely to grow up healthy. Conversely, young people who drop out of school prematurely are more likely to engage in risky behaviours and to have negative health and social outcomes (2-8). It is these young people who in New Zealand are assigned to the backstop system of 'Alternative Education'. Although health inequalities for such young people have been reported internationally, New Zealand has limited health service provision, research and policy for these students. Alternative Education facilities provide an educational avenue for them, but there is very little research that identifies the resources and protective assets in their lives that could help these young people remain in education and achieve a healthy and fulfilling life.

This report presents the results of a study which sought to identify the risk and protective factors for young people in Alternative Education, and to identify the health services and interventions required to improve their health, social and educational outcomes. Findings are presented on:

1. The prevalence and range of health risk and protective factors among young people in Alternative Education.
2. Changes in health status of young people in Alternative Education since 2000.
3. Differences in health status between young people in Alternative Education and those in mainstream secondary school education.
4. An overview of existing health service provision in Alternative Education.
5. Barriers and challenges to the provision of health services in the Alternative Education setting.
6. Recommendations for providing coordinated and comprehensive health and social supports to young people in Alternative Education.

## What is Alternative Education?

Alternative Education (AE) is the term used in New Zealand for the system of educational provision established in 2000 for those students aged 13-15 years who have become alienated from the mainstream education system. Under the Education Act (1989) (9) all young people are required to attend a registered school from the age of 6 years to their 16<sup>th</sup> birthday. For those who drop out or are excluded from mainstream schools, Alternative Education is provided to ensure that they can be taught in a safe environment with an appropriate education curriculum.

AE programmes are funded through mainstream schools, which either establish AE facilities themselves or more frequently contract community partners to deliver the education programmes. Students are enrolled and oversight is maintained by the lead school. Community providers meet the needs of students by engaging with them in a 'non-traditional' way - with a focus on attendance, engagement and addressing behavioural issues as a foundation for educational achievement (10).

The criteria for a student to be admitted into Alternative Education are that: the student must have been out of schools for two terms or more, and/or have a history of multiple exclusions, and/or have been absent for at least half of the last 20 weeks for reasons other than illness, and/or have been suspended or excluded and at risk of further suspensions or exclusions (11).

## Why was this study undertaken?

There is increasing evidence that young people who are excluded from mainstream education are vulnerable to a number of negative health and social outcomes. In an attempt to understand and identify the health and social issues for students in Alternative Education in New Zealand, the first health and wellbeing survey of these students was undertaken in 2000 by the Adolescent Health Research Group (AHRG) of the University of Auckland. This information was used to advocate and initiate health and social service delivery to some students in Alternative Education.

In 2008, The Ministry of Health announced new funding through District Health Boards to develop and support existing health services for Alternative Education facilities, Teen Parent Units (TPU) and Decile 1 and then Decile 2 secondary schools in 2009/10. The Government allocated \$17.2 million over a 4 year period (12). District Health Boards (DHBs) are thus responsible for providing some healthcare for AE students.

Up-to-date information about the health and wellbeing of Alternative Education students will assist these agencies to identify and prioritise the types and nature of services required for this population. Therefore, the Adolescent Health Research Group considered that it was timely to conduct another study to:

1. Gather up-to-date information about the health and wellbeing of AE students.
2. Identify changes in the health status of AE students between 2000 and 2009.
3. Identify how health and social services are currently provided for AE students.
4. Develop recommendations for the delivery of health and social services for students attending AE.

## The Adolescent Health Research Group

The Adolescent Health Research Group (AHRG) of The University of Auckland has been actively working since 1997 with the aim of improving the health and wellbeing of New Zealand's young people by providing accurate and timely data to inform decision-making at all levels.

The AHRG has undertaken a series of surveys of the health and wellbeing of young people, including national surveys of secondary school students in 2001 and 2007, surveys of Teen Parenting Units in 2006 and Wharekura in 2007. Alternative Education facilities were first surveyed in 2000 and this report describes a wider study in 2009.

The research team for this Alternative Education study were: Dr Terryann Clark, Jodi Smith, Deborah Raphael, Dr Simon Denny, Terry Fleming, Dr Catherine Jackson, Elizabeth Robinson and Dr Shanthy Ameratunga, with support from the Adolescent Health Research Group. Research assistants who assisted in collecting the data were: Charlotte Lloyd, Murphy Morris, Brigid Ross, Jayraj Unka and Renee Wood.

For further information, publications and reports on all AHRG studies please visit our website: [www.youth2000.ac.nz](http://www.youth2000.ac.nz)

## About the Alternative Education study

We used both qualitative and quantitative approaches to explore health and social issues for young people attending Alternative Education. The qualitative arm of the study consisted of interviews with Alternative Education providers, tutors and allied health professionals. The quantitative arm was an anonymous survey of young people in Alternative Education.

## About the interviews

Interviews were conducted with 11 Alternative Education providers and allied workers. Key informants were identified by a snowball technique identifying various people who worked in the AE setting and who had been involved in health care delivery. We interviewed a diverse range of disciplines (tutors, AE coordinators, youth workers, nurses and doctors), with a range of experiences, and coming from rural and urban settings.

Consent was gained from all participants. Semi-structured interviews were conducted by the Principal Investigator (Dr Terryann Clark) and the Senior Research Assistant (Jodi Smith). Questions related to: existing health service utilization; difficulties accessing health services for students; whether healthcare was perceived as an important component of Alternative Education; current health services accessed by the AE facilities; successful healthcare interaction experiences; perceptions of healthcare needs for students, and thoughts

about who or what might be the appropriate provider/s of health services in Alternative Education environments.

Interviews were recorded and transcribed verbatim. Data were entered into NVivo (version 8), a qualitative analysis software package for coding (data reduction and organisation) and interpretation. A general inductive approach for analysing the qualitative data was used (13), with independent analysis of themes by the two research assistants. This approach involved both research assistants independently reading through the data multiple times to become completely familiar with it, and then collaborating to identify common threads amongst the interviews. These commonalities helped to determine a number of broad themes or categories which were used to further organise and refine the data. The data were then refined further into a smaller number of themes that, alongside direct quotes from the participants, aimed to provide more in-depth examples of what was found in the quantitative data.

For the purposes of this report, the qualitative interview data are used to highlight the main findings and themes. Future publications will feature the in-depth analysis of the qualitative interviews and their themes.



## About the Survey

The survey aimed to provide information that was as representative as possible of young people in Alternative Education. As in our previous survey in 2000, we focussed on Auckland and Northland - which include a mixture of large and small urban and rural Alternative Education facilities. We acknowledge that these may not be fully representative of AE throughout New Zealand and that caution is needed in generalising the results to all students attending Alternative Education in New Zealand.

### Who participated in the survey?

In 2009, there were 50 Alternative Education facilities in Auckland and Northland, of which two were excluded from the study as their students did not fit the Ministry of Education criteria. Of the remaining 48 facilities, all but one agreed to participate in the survey - a school response rate of 98%.

In term 4 of 2009, there were 541 students enrolled in these 47 Alternative Education facilities in Auckland and Northland. All students who were present at each AE facility on the day of the survey were invited to participate. A total of 335 students completed the survey - a student response rate of 62%. The reasons that students did not take part in the survey included: 5 students declined to participate, 187 students were absent from school on that day, and 14 were reported to have 'other reasons' (e.g. attendance at counselling) for not participating.

### What did the survey ask?

The survey was a 345-item, anonymous, self-report questionnaire. A range of questions were asked about demographics, ethnicity, home life, school life, physical and emotional health, food, activities, sexual health, injuries, violence, tobacco, alcohol, drugs, and the student's home neighbourhood. There were questions about risk factors for physical and emotional health, but also questions to identify protective factors for young people. A branched questionnaire design was used, so that participants with no experiences or behaviours in particular areas were not asked all the questions on those subjects.

## How was the survey carried out?

At each Alternative Education site the survey was administered in a classroom. The survey was carried out using internet tablets – essentially hand-held computers. These enabled the questionnaire to be presented in audio-visual form: the survey questions were displayed on the internet tablet's screen and also read out over headphones. No keyboard data entry was required; questions were answered by 'point and click' responses, by touching the screen with a stylus.

Each participating student was given an internet tablet and a random anonymous code number to log in to the survey program on it. Students were able to choose not to answer any question or any section of the survey. Questionnaire responses were automatically transmitted by a Wi-Fi web server to a laptop database. Files were then directly imported into statistical software and collated for analysis.

## What were the ethical procedures for the survey?

Ethical approval for this study was obtained from The University of Auckland Human Subject Ethics Committee (Reference 2009/013). Written consent to conduct the student survey in the AE facilities was obtained from AE coordinators. Information on the survey was sent home to parents of AE students a few weeks before the day of the survey, and a student participant information brochure was given to each AE student a week prior to the survey. Students and their families were able to ask questions about the survey, and understood that their participation was voluntary. They were also assured that all information collected from participating students would remain anonymous and confidential. On the day of the survey, students were able to choose whether to participate in the survey or not. All participating students gave their written consent to be surveyed. They were also reminded that they were able to withdraw from the survey at any time.

At the beginning of sensitive sections of the questionnaire reminders were given that involvement in the survey was voluntary and that answers would remain confidential

and anonymous. For questions thought to be potentially upsetting for students, 'safety messages' were added providing advice and contact details of people to talk to (including the people administering the questionnaire) should the student wish to do so. A protocol for 'incidental findings' was developed in case a student made a personal disclosure to a research assistant. If a student disclosed personal issues regarding safety, the research team involved local services and agencies to get support for the student.

## How are the results reported and analysed?

### Age and gender

Age is reported in two age brackets: 14 years and younger, and 15 years and older. Differences between the two age groups are only reported when they are statistically significant. Similarly, we report on differences between male and female students only when they are statistically significant.

### Socio-economic deprivation

We report socio-economic deprivation based on the socio-economic characteristics of the neighbourhood in which each student lived, as measured by *New Zealand Index of Deprivation 2006* (NZDep2006) scores. NZDep2006 is a measure of socio-economic deprivation calculated from 9 variables (including household income, beneficiary status, home ownership, single parent families, employment, qualifications, home overcrowding, and access to telephone and car) drawn from the 2006 census data for each of the census meshblocks, or neighbourhood areas. NZDep2006 scores are grouped into ten bands or deciles, with decile 1 being the least deprived and decile 10 the most deprived (14). In this report, the NZDep2006 scores for the students' neighbourhoods are grouped further into low deprivation (deciles 1-3), medium deprivation (deciles 4-7) and high deprivation (deciles 8-10).

## Ethnicity

Ethnicity is reported in five main ethnic groups: Māori, NZ European, Pacific, Asian and Other. We have used the NZ census prioritisation method for classification of ethnicity (Statistics New Zealand, 1996). We have not made comparisons between ethnic groups because of the small numbers of some of the groups involved.

## Mental health

We utilised several validated mental health measures:

### WHO 5 Wellbeing Scale

The WHO 5 Wellbeing Scale (15, 16) measures overall wellbeing (feeling cheerful and in good spirits, calm and relaxed, active and vigorous, wake up feeling fresh and rested, my daily life is filled with things that interest me).

### RADS-SF

The RADS-SF (17) is a validated scale that measures the level of an adolescent's depressive symptoms. We report the students who scored above the cut-off score, who may be at risk of a depressive disorder or a related disorder.

## Changes in health and wellbeing between 2000 and 2009

We compared the survey data sets from 2000 and 2009 to determine changes between these time points. These comparisons are limited because some survey questions were changed or added in the second survey. Differences or changes from 2000 to 2009 are reported in the text only when they are statistically significant. It should be noted that these changes are based on only two time points and cannot be interpreted as trends. Please note, even though some percentages may look different between 2000 and 2009, the difference is not statistically significant unless we report it in the text.

## Comparisons between Alternative Education students and mainstream students

We have made some key comparisons between Alternative Education students and mainstream education students based on results from the national youth health survey (Youth'07) conducted in mainstream secondary schools in 2007. Since our sample of Alternative Education students came from Auckland and Northland, we used a subset of Youth'07 results for mainstream students from Auckland and Northland for comparison.

The Youth'07 survey used different sampling and selection strategies than those used for the Alternative Education survey and their results are therefore not directly comparable. In order to make comparisons between the AE and Youth'07 surveys we conducted additional analysis to allow for the effects of differing sample stratification and weighting, and differing levels of clustering of students in large mainstream schools and small AE facilities.

Since AE and mainstream students differ in other ways (AE students include more boys, more aged 14 and 15, more Māori and Pacific, and more from neighbourhoods of high socio-economic deprivation), in our comparisons between Alternative Education and mainstream students we used logistic regression to control for differences in these other factors of gender balance, age, ethnicity and NZDep level.

The resulting adjusted comparisons are reported using odds ratios (OR) which gives the ratio of the odds of the particular condition or behaviour occurring among AE students to the odds of it occurring among mainstream students of the same gender, age, ethnicity and NZDep level. We report on differences between AE students and mainstream students only when they are statistically significant – i.e. when the odds ratio between them is significantly different from 1.

## Interpreting the results and statistics for the report

Results for the prevalences of key factors and statistics for comparisons between AE and mainstream students are given in the results section following. Full tables of results and statistics for this report are posted on our website [www.youth2000.ac.nz](http://www.youth2000.ac.nz).

In the tables we report 'n' which refers to the number of students who answered that particular question.

The percentage (%) refers to the proportion of students who reported a particular behaviour. This can be regarded as an estimate of the true proportion in the population of all Alternative Education students in Auckland and Northland.

The confidence interval (95% CI) indicates the precision of this estimate by providing an interval in which we are relatively sure the true value lies.

All statistically significant differences in this report are reported with a p value (p), which is the probability that the difference could have occurred in the samples we surveyed by chance if there was in fact no difference between the two groups.

The odds ratio (OR) gives a measure of the extent of the difference between the group of interest (in this case students in Alternative Education) and a reference group (in this case students in mainstream education). The odds ratio compares the odds of the particular condition or behaviour occurring in the group of interest (i.e. the chance of it occurring as against the chance of it not occurring) compared with the odds of the same condition or behaviour occurring in the reference group. An odds ratio greater than 1 indicates that the condition or behaviour has higher odds (i.e. is more likely to occur) in the group of interest than in the reference group, while an odds ratio less than 1 indicates that the condition or behaviour has lower odds (i.e. is less likely to occur) in the group of interest than in the reference group.

## Limitations of the study

This survey is the largest health survey of young people attending Alternative Education. It is of considerable importance for communities, schools and policy makers for the purposes of planning and programme development. However, caution needs to be taken when interpreting the results. The results represent the characteristics and behaviours of the students who attend Alternative Education facilities in Auckland and Northland and were present on the day that the survey was undertaken in each facility. These findings from Auckland and Northland may not reflect the entire population of students in Alternative Education in New Zealand. And by leaving out those students who were absent on the day of the survey, the results may overestimate the health and wellbeing of AE students. Students who are absent from education, tend to have greater health, behavioural and social issues (18). It should also be noted that the survey data relates to one specific point in time and cannot be used to determine cause and effect relationships.

## Funding for the study

Funding for this research and report came from The University of Auckland, Faculty of Medical and Health Sciences (FMHS) Faculty Research Development Fund (FRDF), with support from the School of Nursing and the Adolescent Health Research Group (AHRG).

### For more information

For more in-depth information on the methodology please contact Dr Terryann Clark or refer to our website [www.youth2000.ac.nz/publications](http://www.youth2000.ac.nz/publications).



# The Alternative Education Student Survey

# Demographics

Of the sample of 335 AE students surveyed, 70% were male, and most were aged 14 (30%) or 15 (50%).

The ethnic groups that the AE students identified themselves with were: NZ European/Pākehā (18%); Māori (50%); Pacific (29%), Asian (1%) and other (2%). These are prioritised ethnic groupings (19) with each student assigned to a single group; 49% of the AE students identified with more than one ethnic group. Most AE students (86%) reported that they were proud to be from their ethnic group and 79% reported that it was important to them to be recognised as being from their ethnic group.

Most AE students (93%) live in urban and town areas (classified by the Statistics New Zealand definition, where populations are greater than 1000) (20).

These demographics (Table 1) reflect what is known about students who are excluded from mainstream education: they are more likely to be male and Māori (21). Their age distribution reflects the criteria for entry into AE.

**Table 1: Demographics of Alternative Education students**

		2009	
		n	%
Gender	Male	232	69.5
	Female	102	30.5
	Total	334	100.0
Age	13 or less	20	6.0
	14	101	30.1
	15	166	49.6
	16 or older	48	14.3
	Total	335	100.0
Ethnicity (prioritised)	NZ European/Pākehā	61	18.4
	Māori	167	50.3
	Pacific	96	28.9
	Asian	2	0.6
	Other	6	1.8
	Total	332	100.0

## Comparisons 2000 to 2009

The proportions of males and females in AE in 2009 were no different from those in 2000. However, the proportions of NZ European/Pākehā students and of Pacific students in AE increased from 2000 to 2009, while the proportion of Māori students in AE decreased.

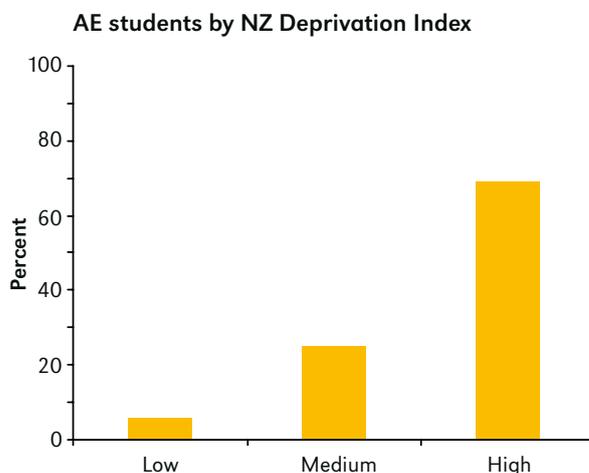
## Socioeconomic environments

*“...that’s where I find where you can see the long term effect of what education has done for families, in that a lot of the families on the real breadline and who have the most issues are those who have had the least amount of education.”*  
(AE tutor)

Poverty and health are strongly related. As family/whānau income drops, child and youth health outcomes worsen (22-24). We know that factors such as poor education, exposure to negative physical environments, stressful life situations, and lack of resources can all contribute to the quality of people’s health and wellbeing.

## NZ Deprivation Index

Most AE students (69%) live in neighbourhoods with high levels of deprivation; only a small proportion (6%) live in neighbourhoods with low levels of deprivation.



## Parental employment status

Two thirds (68%) of AE students reported that their father was working: 51% reported that he was in full-time employment and 17% that he was in part-time employment. 23% reported that their father was unemployed and 9% were unsure about their father's employment status. AE students whose father was not working reported that this was because he was at home looking after family/whānau (reported by 25% of these students), sick (reported by 17%), retired (reported by 16%), looking for work (reported by 13%) or was studying (reported by 2%). 28% of the AE students whose father was not working were not sure why.

Just over half of AE students reported that their mother was working: 38% reported that she was in full-time and 15% that she was in part-time employment. 39% reported that their mother was unemployed and 7% were unsure of their mother's employment status. AE students whose mother was not in paid employment reported that this was because she was looking after family/whānau (reported by 57% of these students), or she was sick (reported by 9%), not working but looking for a job (reported by 9%), retired (reported by 3%) or was studying (reported by 2%). 22% of the AE students whose mother was not working were not sure why.

## Student employment status

Many AE students have part-time work, with this being more common among males than females: 37% of males and 18% of females reported that they had a regular part time job. The most common reason AE students gave for working was to have money of their own to spend on the things they want (reported by 57% of those who had work), while 12% reported that they worked to get money for their families.

## Other socio-economic concerns

42% of AE students reported that their family/whānau sometimes worried about not having enough money for food. Many AE students reported overcrowding in their home: 20% reported more than 2 people per bedroom; 32% reported that their living room was used as a bedroom and 21% that a garage was used as a bedroom. 38% of AE students reported moving home 2 or more times in the previous 12 months. 28% of AE students reported that they did not have a computer or a laptop in their home.

## Comparisons between students in AE and mainstream schools

AE students were significantly more likely than mainstream students to move home two or more times in the previous 12 months (reported by 38% of AE students but only 14% of mainstream students; adjusted OR = 2.9,  $p < 0.0001$ ); more likely to live in an overcrowded household (reported by 20% of AE students but only 7% of mainstream students; adjusted OR = 1.45,  $p < 0.0415$ ). AE students are less likely to report having a computer in their home compared to mainstream students (reported by 72% of AE students and 94% of mainstream students; adjusted OR = 0.4,  $p < 0.001$ ).

### Key findings about socio-economic environments

Alternative Education students are more likely than mainstream students to live under conditions of socio-economic deprivation and stress:

- Half report they have a parent working in full-time employment.
- Many have families that worry about not having enough money to buy food and live in overcrowded homes.

# Home and family/whānau

*“Health is about the wellbeing in all aspects of it. We, Māori Ora conduct on the Whare Tapa Whā, you know if one wall is broken then the other walls will crumble as well along the way. So the hugest impact for AE kids is the whānau wall, their...that structure is crumbling and everything else around them falls apart.” (AE coordinator)*

Supportive, safe and caring home environments are essential for the health and wellbeing of young people (25). They need adults who care about them, support their growth and development, and provide supervision as they grow and learn adult behaviours. Young people need families who have high expectations for their behaviour, provide safety from physical and emotional harm and offer meaningful participation within the family/whānau unit (26, 27).

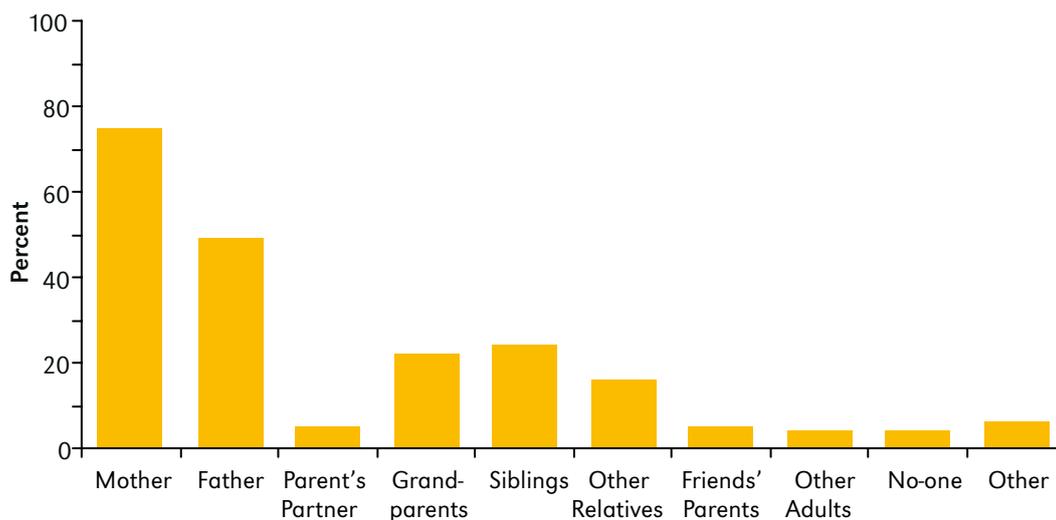
## Family/whānau background and circumstances

Half (50%) of the AE students reported that they lived in one home, 49% that they lived between two homes, and 1% that they did not have a home at the time of the survey.

Just under half (48%) of AE students reported that they live with two parents, and 38% that they live with one parent. 10% reported that they live with family/whānau members other than their parents, and 4% reported that they do not live with anyone from their family/whānau.

AE students indicated various parenting or guardianship arrangements. 75% reported that their mother acted as their parent/guardian and 49% that their father did so. Siblings were reported as guardians by 24% of AE students, grandparents by 22%, other relatives by 16%, parents of friends by 5%, and other adults by 4%. A small number of AE students (4%) reported that no one acted as their parent or guardian.

People who act as parents or guardians for AE students

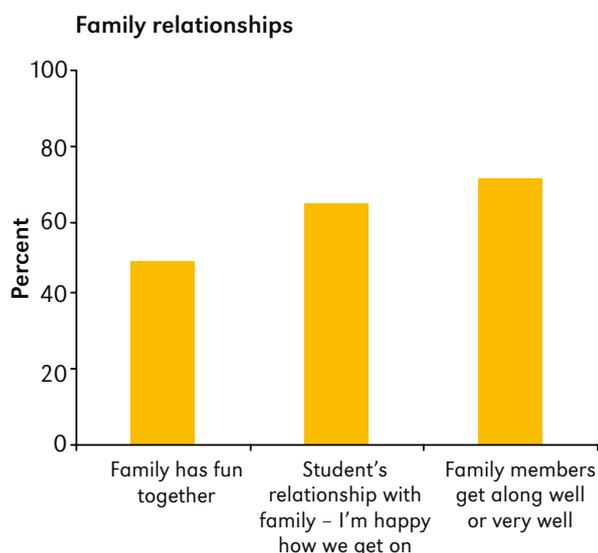


Nearly half (49%) of all AE students had run away at least once in the previous 12 months. Running away was more common among females (60% of whom had run away in the previous 12 months) than males (44%), and more common among AE students 14 years or younger (55%) than those 15 years or older (46%).

## Family/whānau relationships

*“... in my experience I’ve discovered that a lot of the students in Alt Ed come from lower socio-economic backgrounds where parenting skills aren’t quite as advanced as some other students. I think that has a really big factor on their ability to achieve and their ability to recognise consequences and to develop resilience factors ... maybe they come from several generations of ... low education, low paid work, maybe not so much emphasis on education, maybe drug and alcohol issues in the family/whānau or mental health issues in the family/whānau so it sort of becomes a generational factor.” (AE Health professional)*

Many AE students (72%) consider that their family/whānau gets along well or very well. Many AE students (64%) feel close to their mother and/or father most of the time and 72% think that their mother and/or father cares about them a lot. 61% think that their mother and/or father is warm and caring most of the time, 50% report that they have fun with their families, and 62% report being able to talk to their mother or father about their problems some or most of the time.



Only 35% of AE students felt they spent enough time with their mothers most of the time. Of the AE students who felt that they did not get enough time with their mother, the most common reasons they gave was that she was busy with housework, other children or other family/whānau members (reported by 50% of

these AE students), or that she was at work (reported by 42%), or that she did not live with them (reported by 23%). Of the AE students who felt that they did not get enough time with their mother, 11% reported that their mother did not want to spend time with them and 30% reported that they did not want to spend time with their mother.

Only 37% of AE students felt they spent enough time with their father most of the time. Of the AE students who felt that they did not get enough time with their father, the most common reasons they gave was that he was at work (reported by 48% of these AE students) or he did not live with them (reported by 42%). Of the AE students who felt that they did not get enough time with their father, 13% reported that their father did not want to spend time with them, and 25% reported that they did not want to spend time with their father.

Over half (53%) of AE students reported that their siblings care a lot about them and 58% reported that they have other family/whānau members who care a lot about them. 56% can talk to their siblings about problems some or most of the time, and 53% reported that they are able to talk to someone else in their family/whānau about any problems some or most of the time.

Less than half of the AE students thought their parents knew a lot about who their friends were (reported by 41% of AE students), where they went after they had finished their AE course for the day (reported by 46%) or where they went at night (reported by 42%). Less than half of AE students (48%) reported that their family/whānau always wanted to know where they were and who they were with.

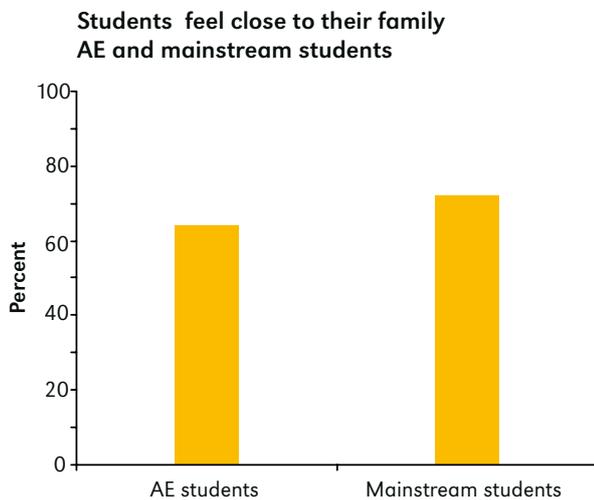
A third of AE students (34%) reported that someone in their family/whānau had been involved with Child, Youth and Family Services (CYFS).

## Comparisons 2000 to 2009

There has been an increase in AE students' perceptions of how well their families get along in 2009 (65%), compared to 2000 (49%).

## Comparisons between students in AE and mainstream schools

AE students are significantly less likely than mainstream students to report feeling close to their parent/s most of the time (reported by 64% of AE students but 72% of mainstream students; adjusted OR = 0.7,  $p < 0.001$ ).



### Key findings about home and family/whānau

Alternative Education students report:

- Their families get along well most of the time.
- They feel close to their parents and feel their parents care about them.
- Most report that they have siblings that care about them.
- Almost half live in two parent homes.
- Half of them live between two homes.
- Half of them have run away from home in the past 12 months.
- A third have someone in their family/whānau who has been involved with CYFS.



# The Alternative Education (AE) setting

*“AE is actually interesting because it questions the mainstream. And that’s why we have problems, because we reflect the failure of the mainstream system. Because we’re picking up the kids and nobody wants to acknowledge their failings.”*  
(AE coordinator)

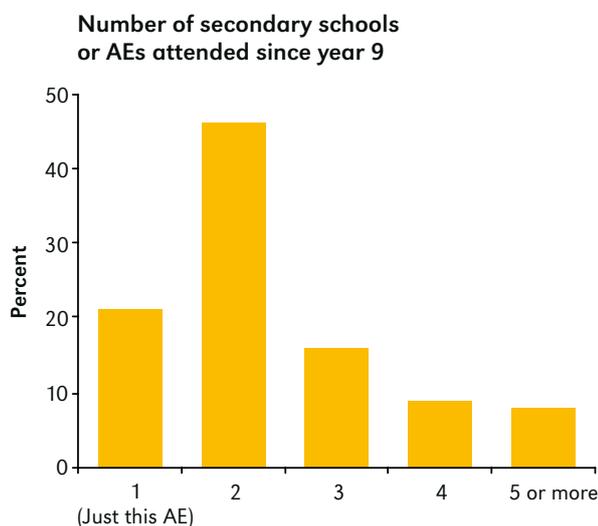
Active engagement in education is associated not only with educational achievement but also with better health and wellbeing outcomes. Alternative Education facilities, like schools, need to provide effective learning environments for their students. Tutors should have high expectations; provide opportunities for meaningful participation and offer caring adult relationships with students (28, 29).

## Students’ experience of AE

44% of the AE students reported that they had been at their AE for 6 months or more. When asked how many secondary schools they had attended (including their current AE) 46% reported that they had been to two; 16% had been to three; 9% had been to four; and 8% had been to 5 or more. 21% of AE students reported that they had attended no other secondary school but AE only.

Most AE students enjoy being at AE: 46% reported that they like AE a lot; 14% like AE a bit; 36% indicated that AE was OK; and only 4% reported that they did not like AE.

Most AE students (92%) felt they were part of their AE. Many (74%) reported that they were more comfortable and happy at AE than they had been at their previous mainstream school; 19% thought there was no difference



between AE and their previous mainstream school, while 9% reported that they had been more comfortable and happy at their previous mainstream school.

## School engagement

When asked what they enjoyed about AE, 79% of AE students said they enjoyed hanging out with friends, 61% enjoyed the sports, 51% enjoyed being away from home, and 41% enjoyed the school work.

A higher proportion of males (69%) than females (43%) gave sport as a reason they enjoyed AE, while a higher proportion of females (64%) than males (45%) said they enjoyed AE because it meant being away from home.

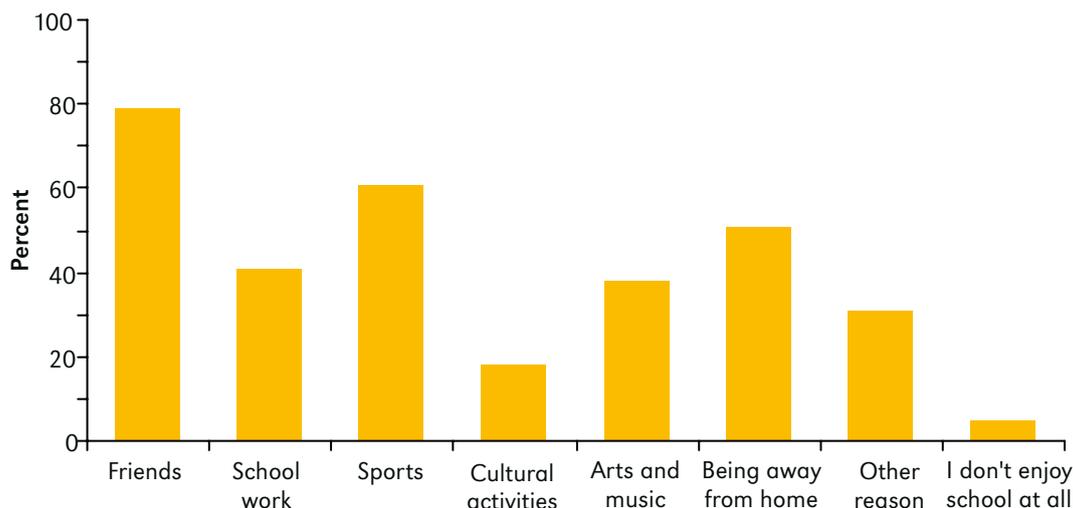
64% of AE students admitted that they had been truant from AE at some time in the previous year.

## Relationships with tutors at AE

*“... we do feedback with the students once a year, and we ask them some serious questions from health and safety to education, to their achievements, to their transition goals ... The best part of the programme is usually...it’s the tutors and the types of comments you’ll get is they’ll put ‘because they listen to me and they take notice of what I’m saying’, ‘I feel like I’m achieving here’. You know those types of good comments.”*  
(AE coordinator)

Almost all AE students (94%) reported that people at their AE care a lot about them; 64% considered that the tutors treat students fairly most of the time; and 78% reported that the tutors go out of their way to help them. 73% of AE students reported that they usually get along with their tutors.

## What students enjoy about AE



## Academic expectations at AE

Almost all AE students (93%) thought it was somewhat important or very important for them to be proud of their school work.

Most AE students (86%) reported that people at AE expected them to do well, while 23% reported that tutors were very strict at AE.

## AE environment compared to mainstream

Compared with their previous mainstream school, many AE students report a more positive experience at AE. Most AE students agreed that the tutors at AE care about them more than teachers at their previous mainstream school (reported by 73% of AE students); that tutors at AE expect them to do better (reported by 64%); that they can contribute more in class discussions (reported by 74%); that AE tutors have more time to help them (reported by 75%); that AE tutors want to help them more (reported by 77%); and that AE tutors listen more than the teachers at their previous mainstream school (reported by 74%).

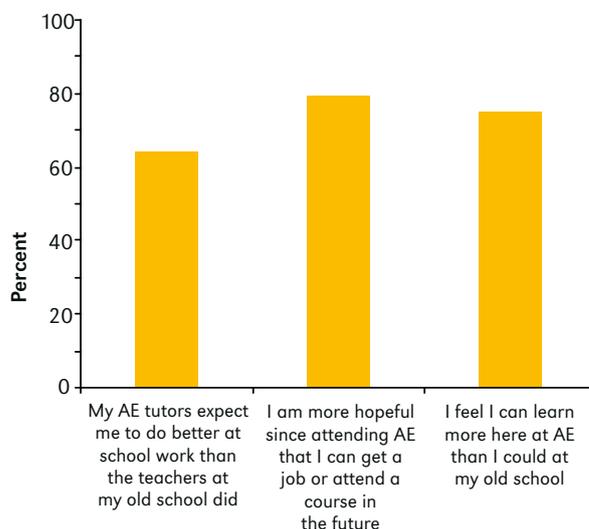
Most AE students consider that they can learn more at AE than at their previous school (reported by 75% of AE students); that the work at AE is easier (reported by 75%); and that students in their AE try to get the best grades they can (reported by 63%).

72% of AE students considered that they were doing better academically at AE than they had done in mainstream education.

56% of AE students felt they have a say in how their AE works; however this was reported by fewer students who were 14 years and younger (45%) than students 15 years or older (63%).

Most AE students (79%) reported feeling more hopeful that they will be able to get a job or attend a course since attending AE.

## AE students' feelings about AE compared to their previous mainstream school



## Family/whānau interaction with AE

*“... I think if you’re really going to make big changes the family/whānau do need to be involved. And sometimes I think that it’s a big struggle getting the family/whānau involved ... that follow through stuff is quite hard with the family/whānau ... Some families are good and want to make changes”. (Health professional)*

Over a third (38%) of AE students reported that someone from their family/whānau had met with an AE tutor in the previous year. This was reported by more male AE students (45%) than female (24%). A third of AE students (35%) reported that family/whānau members had asked them about their homework, and 20% that a family/whānau member had helped them with homework in the previous year. Only 14% reported that a family/whānau member had helped out at their AE in the previous year.

Most AE students (90%) reported that they talked with their family/whānau about how things are going at AE. Nearly all (97%) reported that it was important or very important to their parents (or those acting as parents) that they went to AE every day - only 3% of AE students believe their parents do not think it is important they attend school/AE.

## AE safety and bullying

Most AE students (88%) felt safe at their AE facility. However, 12% of AE students had experienced bullying there in the previous year, with 5% experiencing bullying weekly or more often. 5% of AE students reported that they had been afraid at least three times in the current school year that someone would hurt or bother them at AE.

Of those AE students who had experienced bullying at AE, 32% reported they had not gone to AE one or more times in the previous month because of it, and 28% described the bullying as ‘bad’, ‘pretty bad’ or ‘terrible’.

21% of AE students had experienced bullying at their previous schools, with more females (31%) than males (16%) reporting this.

AE students’ experiences of bullying included having lies or false rumours spread about them

(reported by 56% of all AE students), someone intentionally damaging their property (reported by 45%), someone threatening to hurt them (reported by 47%), having things taken from them (reported by 41%), or someone made sexual jokes, comments or gestures to them (reported by 46% of females compared to 30% of males).

## Student Plans Following School/AE

A third of AE students (33%) planned to go back to secondary school. Of the AE students who planned to return to mainstream education, a higher proportion of those 15 years and older (66%) than those 14 years and younger (29%) indicated that they intended to continue until Year 13 of secondary school.

Of the AE students who did not plan to return to mainstream education, 56% planned to start work or look for a job when they left AE, 31% planned to get more training or education, while 13% either had no plans for what they would do after leaving AE, would do nothing, or intended to start a family.

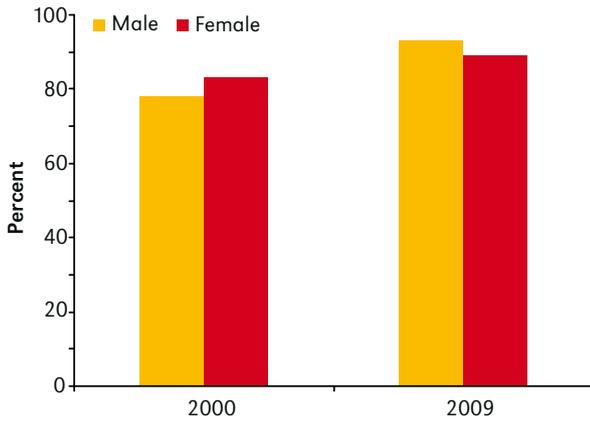
## Comparisons 2000 to 2009

The proportion of AE students who reported that they liked AE a lot, a bit, or thought it was OK increased from 82% in 2000 to 96% in 2009. The proportion who specifically reported they liked AE ‘a lot’ increased from 18% in 2000 to 46% in 2009.

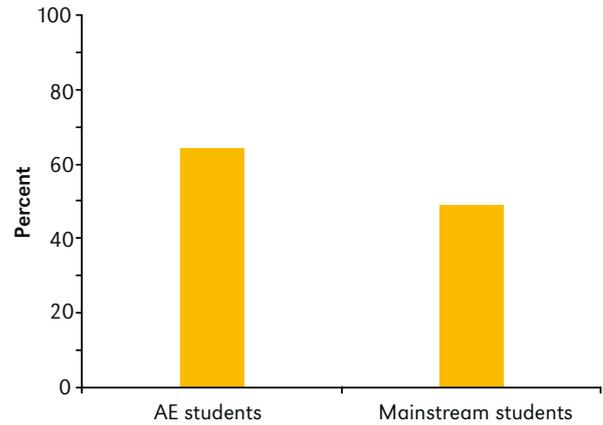
The proportion of AE students who reported that they feel part of their AE increased from 80% in 2000 to 92% in 2009. The change was primarily among the male AE students (an increase from 78% to 93%); among females there was no significant change.

The proportion of AE students who reported that their family/whānau helped them with homework decreased from 36% in 2000 to 20% in 2009.

Proportion of AE students who feel part of their AE 2000 and 2009



Students report that teachers treat them fairly AE and mainstream students



## Comparisons between students in AE and mainstream schools

The proportion of students who felt that their teachers or tutors treated them fairly was significantly higher among AE students (64%) than mainstream students (45%) (adjusted OR = 3.2,  $p < 0.0001$ ).

The proportion of students who were afraid that someone would hurt or bother them at school was lower amongst AE students (5%) compared to mainstream students (9%) (adjusted OR = 0.6,  $p < 0.0075$ ).

### Key findings about the Alternative Education setting

- Alternative Education students generally regard AE more positively than their previous mainstream school, and feel they are making better academic progress there.
- AE students were significantly more likely than mainstream students to feel that their tutors or teachers treated them fairly.



# Health and wellbeing

*"...[health] will impact on the educational aspect because they're tired and restless and if they can't concentrate and if there is so much stuff going in their head, you can't fill a glass that's full, if there is so much going on in there. So you've got to empty that tank somehow for them to engage."*

*(AE coordinator)*

For young people to thrive in an education environment, health is an essential component. Adolescents who experience poor health are less likely to achieve academically, which is likely to affect later occupational attainment and earning capacity (30).

## General health

*"he's got eczema, skin disorder from head to toe, you know, he's just covered and so this has just become the norm for the kids that... the child's sick you get it seen to"*

*(Health professional)*

Most AE students (83%) reported their health as being excellent, very good or good. More females (11%) than males (3%) report their health as being poor. 14% of AE students reported a chronic (long-term) health condition and 6% reported a chronic (long-term) disability.

Of those students with a chronic illness or disability, 34% report they have difficulty or are unable to perform everyday activities that other people their age can usually do.

50% of students reported that there is someone in their home that is sick, disabled or can't do things for themselves. 41% of students who reported this, said they had to do extra things around the home (caring for the person, housework, cooking) to help out someone who is sick or disabled.

## Injuries

More than half (55%) of AE students reported that they had suffered an injury in the previous 12 months that required treatment by a health professional. Their injuries arose from sports (35%), falls (33%) assaults (26%) and road accidents (17%).

## Access to health care

*"... there's no point seeing the doctor getting a script if they haven't got the money to pay for it. And sometimes as tutors we would pay for it... But some days we don't actually have the \$3."* *(AE tutor)*

Most AE students (79%) had accessed some health care in the previous 12 months. Of these students, 81% had been to their family doctor, medical centre or GP; 25% of females but only 5% of males had been to Family Planning or sexual health services; 21% had seen a health professional at their AE facility; 18% had seen an alternative health worker or traditional healer; 18% had been to a hospital Accident and Emergency (A&E) Department; 7% had been to an after-hours A&E clinic; and 3% had been to a youth health centre.

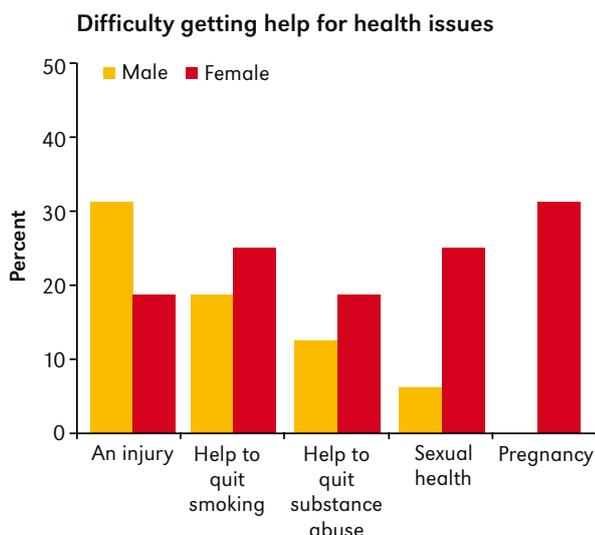
9% of AE students reported that they do not go anywhere for health care.

The usual source of healthcare is a family doctor (75%), alternative health worker/traditional healer (6%) and AE health clinic (4%).

Of those AE students who had accessed health care in the previous 12 months, only 57% had been able to see the doctor or health provider in private (without a parent or other person), and only 69% had been assured by the doctor or health provider that what they talked about would be confidential. More of the female AE students (80%) than the males (63%) had been assured of confidentiality.

Many AE students (58%) reported that they had had difficulty accessing health care. In particular, AE students reported difficulty getting help for health issues such as: an injury or an accident (reported by 26% of AE students), help with stopping smoking (reported by 18%), help with stopping alcohol or drug use (reported by 15%), help for a pregnancy or a pregnancy test (reported by 29% of female AE students),

and help for sexual health and contraceptive needs (reported by 22% of female AE students).



29% of AE students reported that they had not been able to access health care when they needed it in the previous 12 months. The main reasons these AE students gave for not being able to access health care were that they did not know how to make an appointment (33%); they couldn't be bothered (32%); they didn't want to make a fuss (30%); they were too scared (37% of the females but only 8% of the males); or they were worried it would not be kept private (31% of the females, but only 6% of the males).

## Oral health

*"... the boys teeth were bloody horrendous and then she (AE nurse) got them all to have free dental treatment you know and now they've got flashy smiles. A lot better than what they had, even some of them had missing teeth".* (AE tutor)

53% of AE students reported that they had been to the dentist within the past year. 8% reported that they had not been to the dentist within the past five years. 20% reported that they had been unable to access dental care when they needed it. 57% indicated they brushed their teeth twice or more in the day preceding the survey.

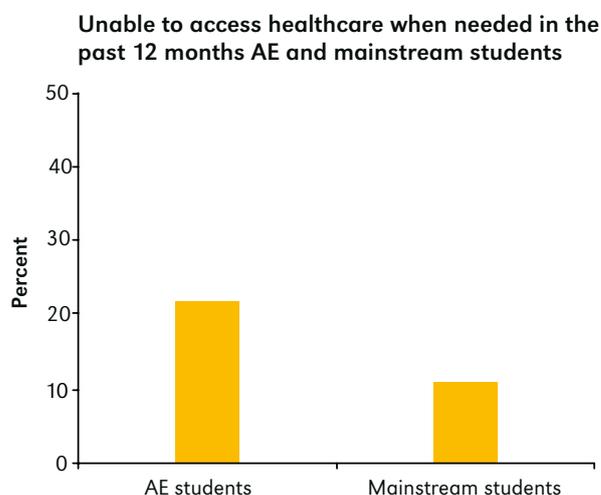
A third (35%) of AE students reported experiencing pain in their teeth or mouth that had kept them awake at night. Over three quarters (78%) reported that they had ever had

a tooth filled and 19% reported that they have had a tooth pulled due to tooth decay or gum infection.

## Comparisons between students in AE and mainstream schools

Among those students who had seen a doctor or other health professional in the past 12 months, a higher proportion of the AE students (57%) than the mainstream students (32%) had been able to talk to them in private (adjusted OR = 2.6,  $p < 0.0001$ ), and a higher proportion of the AE students (69%) than the mainstream students (41%) had been assured by a doctor or other health professional that what they said would be confidential (adjusted OR = 2.7,  $p < 0.0001$ ).

Higher proportions of AE students than mainstream students had been unable to access health care (29% of AE students compared with 17% of mainstream students; adjusted OR = 1.5,  $p < 0.0002$ ) or dental care (22% of AE students compared to 11% of mainstream students; adjusted OR = 1.8,  $p < 0.0001$ ) when they needed to in the previous 12 months.



### Key points about health

AE students:

- Feel their health is good.
- Had accessed some kind of health care in the previous 12 months.
- Had difficulty accessing help for health issues such as injury and quitting substance use.
- Were significantly less able to access health care or dental care when they needed it compared to mainstream students.

# Nutrition, exercise and activities

Ensuring a good diet and adequate physical activity in adolescence helps maintain an appropriate body weight and contributes to good self-image and the prevention of chronic diseases later in life. Good nutrition increases the ability to concentrate and actively participate in education and other activities including sports (30).

## Nutrition

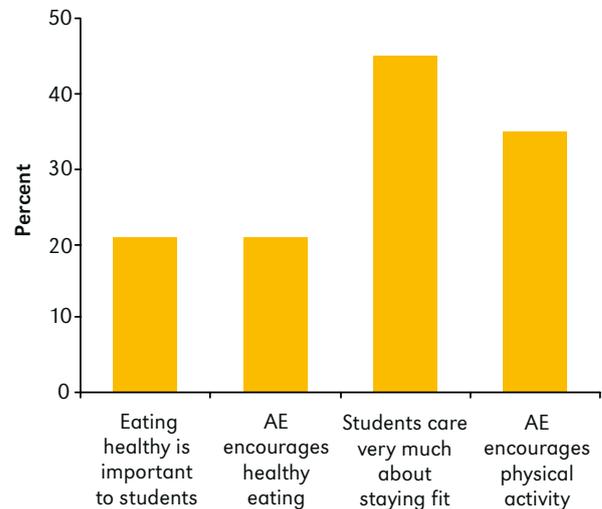
*“... If I could wave my wand and the Ministry of Health could come up with the money it would be the nutrition element I think ... A component of resourcing AE centres could come from the health budget ... if we’re providing the food for the kids, maybe the health sector could have something to do with that...”* (AE coordinator)

Only 28% of AE students reported that they always have breakfast. Significant numbers of AE students ‘hardly ever’ have breakfast: this was reported by 30% of AE students. 75% of students reported getting breakfast at home; 59% get lunch from home; and 95% get dinner at home (of those who eat these meals).

When AE students were asked whether they got meals from shops or takeaways 46% reported that they sometimes get their breakfast, 64% that they sometimes get lunch, and 64% that they sometimes get their dinner there. More females (75%) than males (58%) reported that they sometimes get dinner from shops or takeaways. 24 % of AE students reported that they had eaten fast food or takeaways four or more times in the previous week.

35% of AE students reported that their family/whānau had eaten meals together seven or more times in the previous week. 34% of male AE students but only 14% of females reported that they eat the recommended 2+ fruit and 3+ vegetables a day. 28% of students report that they cared very much about eating healthy food, and only 21% say that their AE encourages them to eat healthily.

Nutrition and physical activity



## Exercise

*“... another person I’d love to have on board is a health and physical activity kind of coordinator that could pretty much oversee the health side ... I mean we’ve got diabetes, we’ve got obesity, alcohol and drug users. They can’t access school sports teams. Everyone says you need to be involved in a sports team and there isn’t one and they’re not going to go into their local community and join up, they’re just not sporty kids so we need to bring it in-house again and although physical activity is compulsory, it depends on the tutor and the tutor’s time and their interest.”* (AE coordinator)

More male AE students (52%) than females (32%) indicated that they cared very much about staying fit and keeping physically active. Similarly, more males (31%) than females (14%) considered that they had done enough physical activity in the previous seven days to be healthy.

Male AE students were: more likely than females to see physical activity, sports or exercise as definitely an important part of their life (reported by 57% of males and 17% of females); more likely to participate in team sports

(reported by 59% of males and 24% of females); more likely to have been very physically active over the previous weekend/after school (reported by 77% of males and 50% of females); and more likely to have been very physically active at least once after school in the previous week (reported by 86% of males and 68% of females).

47% of AE students reported that they participated in a sports team or club outside AE. The AE students who did not participate in such sports indicated various reasons why they did not do so including 'I'm not interested' (reported by 28% of these AE students); 'it takes up too much time' (reported by 20%); 'I have other responsibilities' (reported by 19%); 'I feel too shy, nervous or embarrassed to belong to a sports team' (reported by 17% of females but only 4% of males). More AE students 15 years or older (25%) than those 14 years and younger (10%) said that belonging to a sports team or club 'takes up too much time'.

## Body Size

Most AE students (89%) were very happy, happy or okay with their weight. More males (40%) than females (23%) reported feeling very happy about their weight.

Most AE students (60%) consider that they are about the right weight; 26% consider that they are underweight; and 13% consider that they are overweight.

Females were more likely than males to be worried about putting on weight (reported by 60% of females and 33% of males), more likely to try to lose weight (reported by 52% of females and 27% of males); and more likely to be teased by family/whānau members because of their weight (reported by 36% of females and 16% of males).



## Activities

AE students engage in many activities. Those occupying more than three hours every day included: hanging out with friends (reported by 65% of AE students), watching TV (reported by 50%), texting cell phone messages (reported by 57% of females and 33% of males) or playing computer games (reported by 37%).

Other activities that AE students engaged in for one hour or more a day included: doing chores to help their families (reported by 55% of AE students), doing arts or music (reported by 47%), looking after younger family/whānau members (reported by 24%), or doing homework (reported by 16%). More AE students 15 years or older (31%) than those 14 years or younger (10%) reported that they look after younger family/whānau members for more than an hour a day.

74% of AE students reported that they used the internet to chat or talk. Of these, more females (92%) than males (67%) used it to chat or talk to others, while more males (38%) than females (19%) used it to play games with others, and more males (22%) than females (3%) used it to look at porn or sex sites. 49% of the AE students who spent time on the internet used it to find out about music, sport or other interests; 25% used it to look at things to buy or sell; and 30% did their own website or blog.

80% of AE students reported that they used a cell phone. The proportion was higher among females (90%) than males (75%), and females were also more likely to report that their cell phone was 'very important' for keeping in touch (reported by 73% of females and 55% of males).

## Comparisons 2000 to 2009

The proportion of female AE students who considered themselves overweight decreased from 36% in 2000 to 17% in 2009, but the proportion of males who considered themselves overweight did not change.

## Comparisons between students in AE and mainstream schools

AE students were significantly less likely than mainstream students to be worried about their weight (reported by 42% of AE students compared with 54% of mainstream students; adjusted OR = 0.6,  $p < 0.0001$ ).

AE students were significantly more likely than mainstream students to report they had eaten takeaways four or more times during the previous week (reported by 24% of AE students compared with 7% of mainstream students; adjusted OR = 2.1,  $p < 0.0001$ ). AE students were significantly less likely than mainstream students to report that their family/whānau had eaten meals together five times or more times in the previous week (reported by 43% of AE students compared with 59% of mainstream students; adjusted OR = 0.67,  $p < 0.0003$ ).

### Key points for nutrition, exercise and activities

- AE students rarely eat breakfast on a regular basis.
- Nearly two thirds of AE students buy lunch from a shop or takeaways.
- AE students report eating takeaways more often than mainstream students.
- Many AE students are happy with their weight and less likely to worry about their weight than mainstream students.
- More AE students consider themselves underweight than overweight.

# Emotional health

*“... but some of the stories that these young fullas come out with, cause I thought I had seen it all through my life, everything that I’d been through...and some of the stories with those students come out, I thought oh Jesus. I don’t wish it on anyone... to have to go through that.”* (AE tutor)

Most AE students (90%) reported feeling ok or very happy/satisfied with their life. However, males were more likely than females to report feeling ok/very happy/satisfied with their life (reported by 94% of males compared to 80% of females); more likely to report generally being in a good mood (reported by 66% of males compared to 33% of females).

Most AE students (78%) scored good, very good or excellent on the WHO 5 Wellbeing Scale.

13% of students report that they have definite or severe difficulties with emotions, concentration, behaviour and getting along with others. Many (44%) of those who report difficulty say that these difficulties have been happening for longer than a year.

## Depressive symptoms

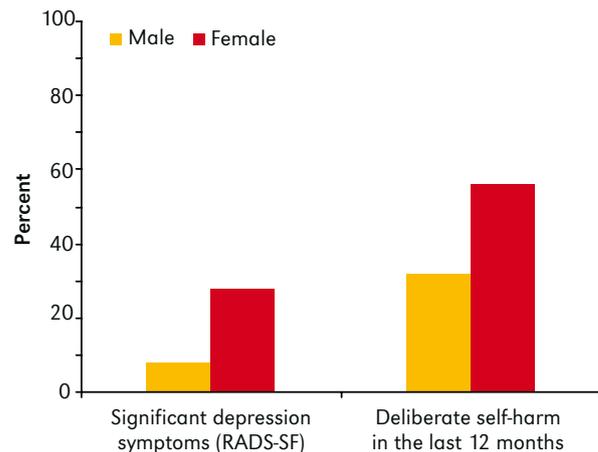
25% of male AE students and 53% of females reported that they had felt sad, blue or depressed for two weeks or more in the previous year.

Scores on the Reynolds Adolescent Depression Scale-SF indicated that 8% of male AE students and 32% of females had significant depressive symptoms.

## Self-harm

56% of female AE students and 28% of males report deliberate self-harm in the previous 12 months; of those who had self-harmed, 9% reported that they had required medical attention as a result.

Depressive symptoms and self harm



## Suicidality

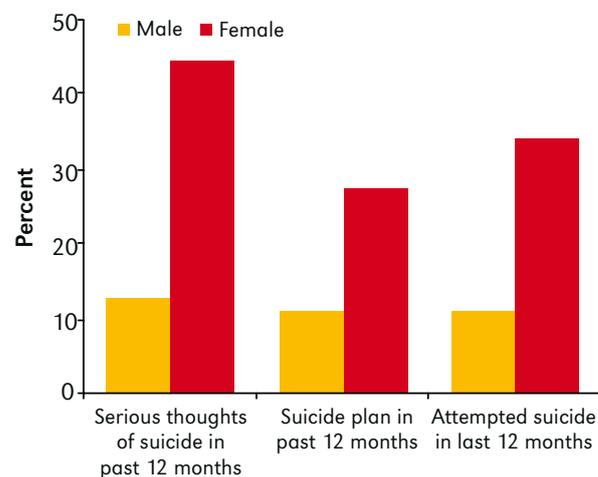
*“So you know, [nurse] comes up against students that have attempted suicide and 3 of their family/whānau members have been successful about it.”*

*(Health professional)*

Nearly one quarter (23%) of AE students reported that they had seriously thought about suicide in the previous 12 months. Much higher proportions of female AE students than males had in the previous 12 months: seriously thought about suicide (reported by 44% of females compared to 13% of males); had made a suicide plan (reported by 27% of females compared to 11% of males); and had attempted suicide (reported by 34% of female students compared to 11% of males).

Of those AE students who had attempted suicide, 8% reported that they had required medical treatment as a result.

Suicidal thoughts and attempts



## Access to emotional help services and support

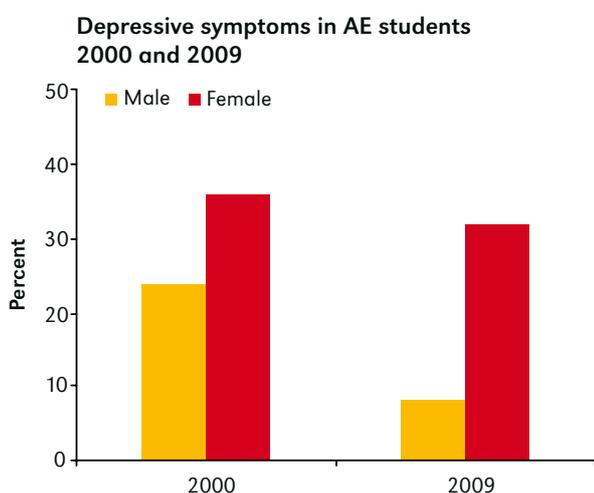
“... I think really what’s missing is a stronger link with the mental health services really. I think that is a big gap.” (AE coordinator)

43% of female AE students and 27% of males reported that they had seen a doctor, nurse, school guidance counsellor or other health professional for emotional problems in the previous 12 months.

## Comparisons 2000 to 2009

The proportion of male AE students who reported that they feel very happy or satisfied with life increased from 27% in 2000 to 48% in 2009, but there was no significant change among females.

Similarly, the proportion of male AE students indicating significant depressive symptoms reduced from 24% in 2000 to 8% in 2009, while there was no significant change among females - the proportion with significant depressive symptoms remained high at 36% in 2000 and 32% in 2009.



## Comparisons between students in AE and Mainstream Schools

More AE students (17%) than mainstream students (11%) had RADS scores indicating significant depressive symptoms (adjusted OR = 1.9,  $p < 0.0001$ ). More AE students (37%) than mainstream students (19%) reported self-harm in the previous 12 months (adjusted OR = 2.1,  $p < 0.0001$ ).

More AE students than mainstream students who had self-harmed sought treatment for their injuries (reported by 9% of AE students who had self-harmed, compared to 3% of mainstream students who had self-harmed; adjusted OR = 2.9,  $p < 0.0001$ ), which suggests that AE students were more likely to attempt serious self-harm. AE students are more likely to attempt suicide than mainstream (reported by 18% of AE students compared with 5% of mainstream students; adjusted OR = 3.4,  $p < 0.0001$ ).

### Key points for mental health

- AE students are mostly satisfied with their life.
- They have high rates of significant depressive symptoms, self-harm and suicide attempts - significantly higher than among mainstream students.



# Sexual health

*“We’ve probably at this stage got the most girls that we’ve had in quite a while, maybe in a couple of years. Predominantly it’s been boys but at the moment we’ve got some girls who...the sexuality stuff is quite huge for us at the moment.”*

*(AE coordinator)*

The development of sexual attractions and behaviours in adolescence is a normal and healthy part of growing up. However, unsafe sexual behaviours place young people at risk of negative health outcomes such as sexually transmitted infections and unintended pregnancy (31).

## Sexual activity

Most AE students (89%) reported that they had had sex, and 75% reported that they were currently sexually active (i.e. had sex within the past 3 months).

Of those AE students who had ever had sex, 19% reported that they had had four or more sexual partners in the past three months.

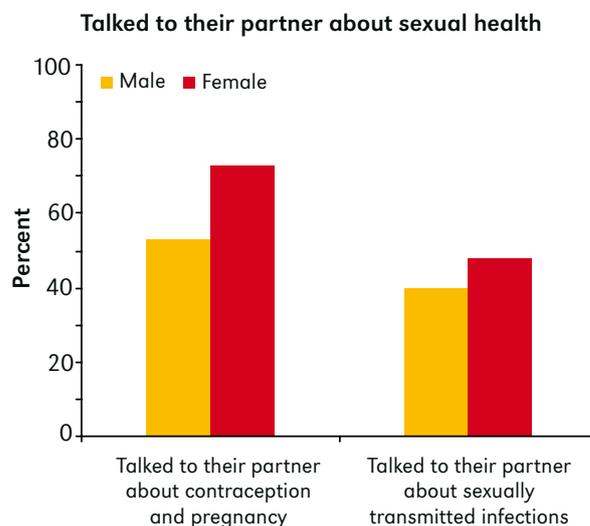
## Contraception

Of those AE students who had ever had sex, 73% of the females but only 53% of the males reported that they had talked with their partner about preventing pregnancy. 57% reported that they or their partner used contraception most or all of the time to prevent pregnancy. 56% reported that they or their partner used contraception the last time they had sex.

Of those AE students who did use contraception, 60% reported that they or their partner used condoms, 30% that they used the oral contraceptive pill, and 9% that they used the Depo Provera injection.

Of those AE students who had ever had sex, 43% reported that they had talked to their partners about preventing sexually transmitted infections and HIV. 51% reported that they used a condom most or all of the time to protect against sexually transmitted infections. A few AE students (7%) report having had a sexually transmitted disease (although this is likely to

significantly underestimate sexually transmitted infections since many infections do not have symptoms, and students may not have been tested).



## Pregnancy

*“... and then those really sort of at risk behaviours, the unprotected intercourse, the pregnancies, driving, you know drinking driving...normal at risk behaviours for normal adolescents but at a higher level.”*

*(Health professional)*

Of those AE students who had ever had sex, 34% of the females reported that they had ever been pregnant, and 21% of the males reported that they had ever got someone pregnant. 12% were unsure whether they had been pregnant or got someone pregnant.

Of those who had been pregnant or got someone pregnant, 12% reported that the pregnancy was still continuing; 35% reported that the outcome had been a miscarriage; 30% reported a termination of pregnancy/abortion; 7% reported a birth, and 16% were unsure of the outcome.

## Sexual/Gender identity

Most AE students (86%) indicated that they were sexually attracted to the opposite sex; 3% to the same sex; 3% to both males and females; 3% were not attracted to either sex; and 5% were unsure who they were attracted to. A small number of AE students (N=4, i.e. 2%) indicated their gender identity as transgender. All of these students were aged 15 or older.

## Comparisons 2000 to 2009

There were no significant differences in sexual behaviour between 2000 and 2009.

## Comparisons between students in AE and mainstream schools

AE students were more likely than mainstream students to use contraception inconsistently (reported by 33% of AE students compared with 16% of mainstream students; adjusted OR = 2.1,  $p < 0.0001$ ).

### Key points for sexual health

- Many AE students report that they are sexually active.
- They also report that they do not consistently use contraception or condoms.
- Pregnancy is common.
- AE students are more likely than mainstream students to be inconsistent in their use of contraception.

## Substance use and gambling

*"...the health issues for kids in AE are drug and alcohol. Are definitely the top of the list. But I understand though that underneath those major headings are actually deeper issues to do with mental health and self-esteem, that sort of stuff ... so sometimes when I think when we just deal with the alcohol and drug issues is really just like we are continually putting plasters over the surface."*  
(AE coordinator)

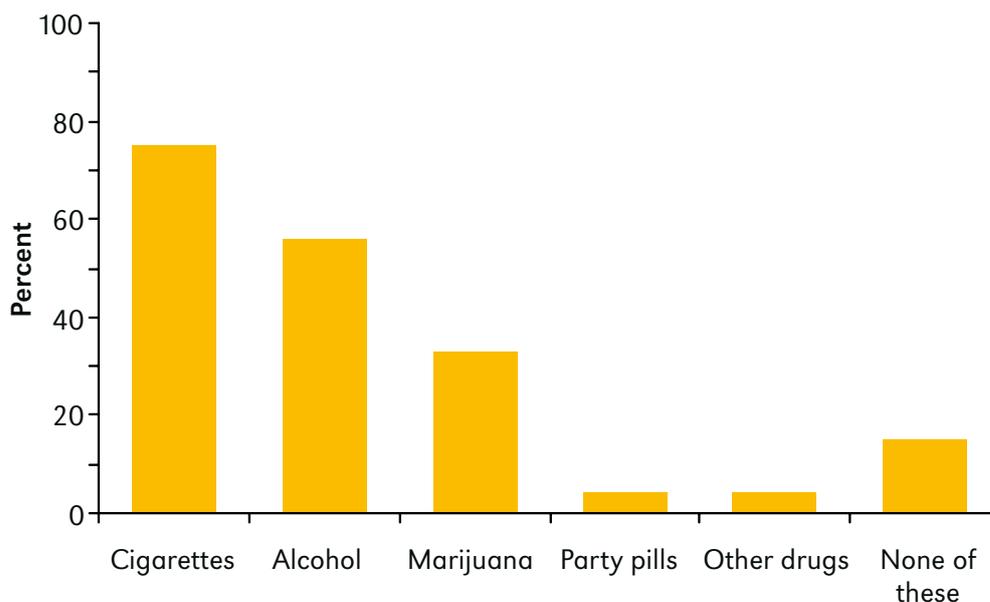
### Friends and family/whānau use of substances

*"I see from the kids' point of view. They do what's accepted ... which is why we were saying it's hard to battle drugs and alcohol, because it's accepted so lightly in their own homes."*  
(AE tutor)

When AE students were asked about the substances used by their parent or parents, 75% reported that they smoked cigarettes, 56% that they drank alcohol, 33% that they used marijuana, 4% that they used party pills, and 4% that they used other drugs. Only 15% of AE students reported that their parent or parents used none of these substances.

When AE students were asked about the substances used by their friends, 92% reported that their friends smoked cigarettes, 86% that they drank alcohol, 86% that they used marijuana, 39% that they used party pills, and 31% that they used other drugs. Only 3% of AE students reported that their friends used none of these substances.

## Substance use by parents and guardians of AE students



### Cigarettes

The majority of adult smokers started smoking cigarettes and became addicted as an adolescent. Smoking has multiple health hazards that are avoidable if adolescents can be prevented from starting (32).

Cigarette smoking is common amongst AE students. 89% reported that they had ever smoked a cigarette. Of those who had, 32% reported that they had first smoked a whole cigarette when they were 9 years or younger. Of those AE students who had ever smoked, 79% reported that they currently smoke cigarettes (i.e. at least once a month) and 69% reported that they smoke weekly or more often. Of the current smokers 33% reported that they smoke 6–10 cigarettes a day and 32% that they smoke more than 10 a day.

Of the AE students who were current smokers, 72% reported that they have tried to cut down or quit.

Most AE students (86%) indicated that their AE discourages them from smoking cigarettes; however 45% of those who were current smokers reported that they were smoking more since attending AE.

AE students who were current smokers reported that they obtain cigarettes from many sources: they buy them themselves (reported by 59%);

they get them from friends (reported by 56%); they get them from brothers or sisters (reported by 43%); they get them from their parents (reported by 73% of females and 42% of males); they get them from other adults (reported by 33%); they get someone to buy cigarettes for them (reported by 35%); or they stole them (reported by 19%). Of those AE students who bought cigarettes themselves, 80% bought them from a dairy.

### Alcohol

*“... in the daytime hours when they are with us, they’re easily monitored and they listen ... and they show bright eyes and cheery spirits when they’re in front of you. But as soon as they get home they are surrounded by their mates and aunties and uncles and everyone else is doing nothing but drinking all day and stuck at home and not really doing much. It puts them back into that lifestyle”*  
(AE tutor)

Alcohol use is associated with a range of negative health outcomes, particularly when combined with risky behaviours whilst drinking (33).

Most AE students (93%) reported that they had tried drinking alcohol and of these, 83% reported that they currently drink alcohol, and 59% reported that they drink weekly or more often. When they do drink, most AE students

drink heavily: 90% of those who were current drinkers had engaged in binge drinking (5 or more drinks within 4 hours) in the previous 4 weeks.

The usual alcoholic drinks for AE students were Ready-To-Drink (RTDs) (reported as their usual drink by 31% of male current drinkers compared with 51% of females), beer (reported as their usual drink by 29% of males compared with 10% of females), or spirits (reported as their usual drink by 24% of current drinkers).

AE students usually drink with their friends (reported by 94% of current drinkers); with their family/whānau (reported by 82% of female current drinkers compared to 56% of males); with people other than their friends or family/whānau (reported by 50% of current drinkers); or on their own (reported by 16% of current drinkers).

AE students who currently drink reported that they get their alcohol from many sources: their friends give it to them (reported by 56%); they get someone else to buy it for them (reported by 51%); they get it from brothers or sisters (reported by 47%); they get it from their parents (reported by 57% of females compared with 31% of males); they get it from other adults (reported by 36%); they buy it themselves (reported by 33%); or they steal it (reported by 16%).

For those who buy their alcohol, by far the commonest type of outlet they go to was a bottle or liquor store (reported by 81% of AE students who bought their own alcohol). Of all the AE students who buy alcohol 52% reported that they were hardly ever asked for ID. Even among those aged 14 or under, 47% reported that they were hardly ever asked for ID.

Of those AE students who currently drink alcohol, 17% reported that they were worried about how much they drink, and 24% reported that they had tried to cut down or give up drinking alcohol. AE students who currently drink reported significant problems associated with alcohol including: engaging in unsafe sex (without a condom) (reported by 81% of current drinkers); having unwanted sex (reported by 37%); doing things that could have got them into serious trouble (reported by 74%); or having their performance at AE affected because of alcohol (reported by 80%).

Half (50%) of the AE students who currently drink reported that they had needed medical treatment from a doctor or a nurse for an injury that occurred while they were drinking, and 79% reported that they had injured someone else while they were drinking.

Over half (56%) of the AE students who currently drink reported that they had been involved in a car crash while they had been drinking.

## Marijuana

Early onset marijuana use can considerably impact on a student's academic performance and is associated with negative mental and physical health outcomes (34).

Marijuana use was high amongst AE students, with 86% reporting that they had tried marijuana and 70% that they currently used marijuana (i.e. within the previous four weeks). Just over half of current users (55%) reported that they used marijuana weekly or more often. Almost half (48%) of the current users reported that they used marijuana before or during AE school time.

AE students use marijuana with their friends (reported by 95% of the users), with family/whānau (reported by 56%), with other people (reported by 57%), or they use marijuana alone (reported by 57% of the users).

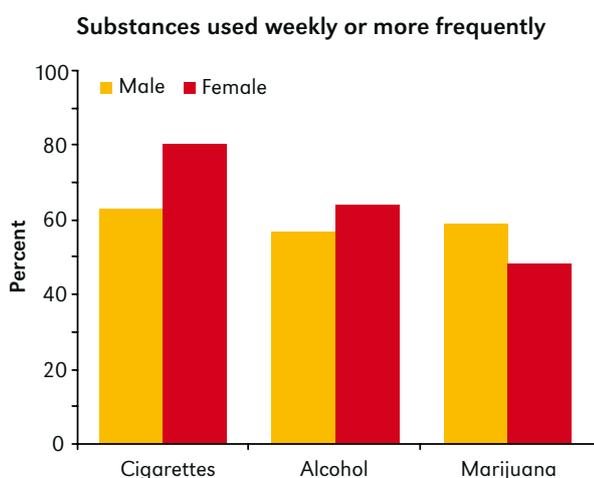
Over a quarter (28%) of AE students who use marijuana reported that they had attempted to cut down or stop using it, and 16% reported being worried about how much marijuana they use.

A third (31%) of the AE students who use marijuana reported that their marijuana use had affected their performance at AE or at work, and 42% reported that they had done things that could have got them into serious trouble.

Of those AE students who use marijuana, 46% reported that someone in their family/whānau had told them to cut down or quit using it. Just over a third (37%) report having unprotected sex after using marijuana and 8% report unwanted sex after using marijuana.

## Other drugs

37% of AE students reported some other drug use, i.e. one or more from the list: 'inhaled glue or gas to get high, inhaled nitrous gas or laughing gas, party pills or herbal highs, acid, LSD, or mushrooms, morphine, heroin or smack, 'P' or pure methamphetamine, speed, dexedrine, whizz, go fast or uppers, ecstasy or 'E', cocaine, including powder, crack or freebase, steroid pills or shots, or used an needle to inject illegal drugs into your body'. Of these AE students who used some other drug, 35% reported being worried about their drug use.



## Concurrent drug use

Concurrent use of several drugs was reported by 61% of AE students: 48% reported combining cigarettes, alcohol and marijuana, and 16% reported combining cigarettes, alcohol, marijuana and party pills.

## Help-seeking behaviour for substance use

AE students reported that if they had any problems over alcohol or drug use the people they would go to for help would be their friends (reported by 81% of AE students); or a drug and alcohol counsellor (reported by 79%), a parent (reported by 74%), a school guidance counsellor (reported by 54%), a doctor (reported by 50%), their AE tutor (reported by 37%), or a school nurse (reported by 32%).

## Gambling

Gambling is less common among AE students: 21% reported that they had gambled in the previous year, and 9% that they had gambled in the previous 4 weeks. Among those AE students who gambled, 51% reported that they bet with friends; 38% that they bet on cards or coins, 21% on instant kiwi ('scratchies'), and 19% on lotto.



## Comparisons 2000 to 2009

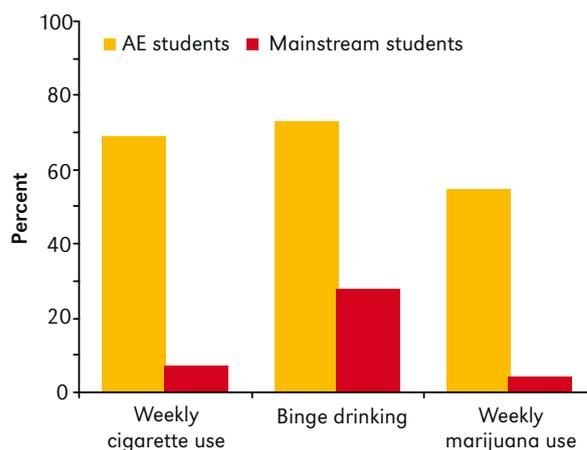
There were no significant changes in weekly cigarette use, weekly alcohol use, binge drinking, or marijuana use among AE students between 2000 and 2009.

## Comparisons between students in AE and mainstream schools

A much higher proportion of AE students (69%) than mainstream students (7%) reported weekly cigarette use (adjusted OR = 19.1,  $p < 0.0001$ ). Similarly, a much higher proportion of AE students (55%) than mainstream students (4%) reported weekly marijuana use (adjusted OR = 12.8,  $p < 0.0001$ ).

A higher proportion of AE students (73%) than mainstream students (28%) reported binge drinking of alcohol (adjusted OR = 5.0,  $p < 0.0001$ ). AE students were also significantly more likely than mainstream students to report problems associated with drinking ( $p < 0.0001$ ).

Substance use AE and mainstream students



### Key points for substance use

AE students report that:

- Many smoke cigarettes regularly.
- Their parents smoke cigarettes, drink alcohol and use marijuana.
- Most have engaged in binge drinking over the previous four weeks.
- Most who drink alcohol report significant problems associated with its use.
- Over half had been in a car crash while they had been drinking.
- They often purchased alcohol themselves.
- Two thirds are regular users of marijuana.

AE students report much higher rates of cigarette smoking, marijuana use, and binge drinking of alcohol than mainstream students, and higher rates of problems associated with drinking.

# Injuries, violence and risk taking behaviours

*“The kids in AE are in risk because they conduct themselves in such a more riskier behaviour than the mainstream ... young people in Alt Ed are disengaged from everything, they are the most in risk young people that we have in New Zealand.”*  
(AE coordinator)

## Motor vehicle risk behaviours

Motor vehicle accidents are among the leading causes of death among young people in New Zealand (35).

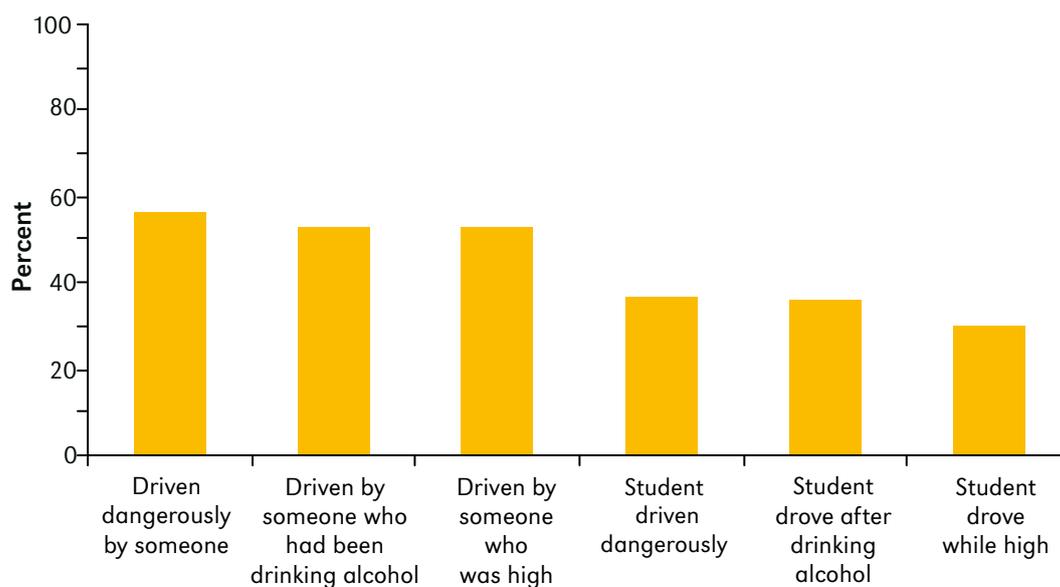
AE students report high levels of risk behaviours on the roads. 70% reported that they only sometimes or never wore a seat belt when they were in a car, and 91% reported that they only sometimes or never wore a helmet when riding a bike.

Most AE students do not have a driver’s licence: only 16% reported that they had either learner’s, restricted or full licence, but 76% reported that they had driven a vehicle on a public road, with just as many of those aged 14 years or under (77%) reporting this as those 15 years and over (76%).

Just over half (56%) of AE students reported that in the previous month they had been in a car with someone who was driving dangerously (i.e., speeding, car chases, burnouts); 54% that they had been driven by someone who had been drinking alcohol; and 54% that they had been driven by someone who had been taking drugs. More females (69%) than males (47%) reported that they had been driven by someone who had been drinking.

Of those AE students who themselves drove (with or without a licence), 30% reported that within the previous four weeks they had driven after drinking two or more glasses of alcohol in the two hours before driving; 36% had driven after using drugs, and 37% had driven dangerously (i.e., speeding, burnouts, or car chases).

Dangerous driving behaviours in the past months



## Witnessing violence

*"... I think there are issues at home. ...it's a compounding thing. I'd say their home lives generally are difficult because ... it's usually drugs, alcohol, domestic violence ... So I guess for a lot of them, their health is impacted on by their home life." (AE tutor)*

The experience of violence either as a victim, a witness or a perpetrator is a threat to a young person's health and wellbeing, and is associated with a range of poor health, social and educational outcomes (36).

Most AE students (89%) reported that they feel safe at home all or most of the time.

However, 29% of AE students reported that they had witnessed an adult hitting or physically hurting a child, and 30% reported that they had witnessed an adult hitting or physically hurting another adult in their home within the previous 12 months.

When asked how bad it was when they witnessed an adult hitting or harming a child in their home, 31% of the AE students described it as pretty bad, really bad or terrible, and when asked how bad it was when they witnessed an adult hitting or harming another adult in their home, 33% of the AE students described it as pretty bad, really bad or terrible

## Experiencing violence

Nearly half (49%) of AE students reported that they had been hit or physically harmed in the previous 12 months, and of these 30% described the violence as pretty bad, bad or terrible.

More female AE students (40%) than males (11%) reported that they had been hit or harmed by their boyfriend or girlfriend. More male AE students (46%) than females (23%) reported that they had been hit or harmed by a stranger.

## Sexual abuse

A fifth (20%) of AE students reported that they had at some time experienced unwanted sexual behaviour from another person. More females (41%) than males (11%) reported experiencing such sexual abuse. Only 59% of the AE students who had been sexually abused had told someone about it. 7% of AE students had experienced sexual abuse in the previous 12 months, and of these 44% reported that the sexual abuse was 'pretty bad', 'really bad' or 'terrible'

## Violence directed towards others

Many AE students reported that within the previous 12 months they had physically hurt or hit another person (reported by 63% of AE students); had been involved in a serious fight (reported by 69%); had carried a weapon (reported by 35%); or had attacked someone using a weapon (reported by 22%).

A small number of AE students disclosed that they had forced someone else to do something sexual that they did not want to do (reported by 6 AE students, i.e. 2%).

## Risk-taking and anti-social behaviours

*"... my major concern is the social, and social ranges from dislocated from the community, from the families, the attachment to risky, high risk behaviours and crime, and the fun of charging around in cars and racing against police and that type of thing through to drug and alcohol, especially alcohol." (AE coordinator)*

Many AE students reported that within the previous year they had been involved in risk-taking or anti-social behaviours, including lying to parents about where they have been and who they have been with (reported by 66% of AE students); painting graffiti or tagging someone else's property (reported by 58%); deliberately damaging property that did not belong to them

(reported by 55%); stealing something worth over fifty dollars (reported by 54%); breaking into someone else's place to steal something (reported by 46%); setting fire to someone else's property (reported by 20%); or deliberately hurting an animal (reported by 13%).

70% of AE students reported that they had been in trouble with the police in the previous year; 49% had been in trouble two or more times. More AE students 14 years or younger (64%) than those 15 years and older (41%) had been in trouble with the police in the previous year.

Among those AE students who had been in trouble with the police, the most common reasons for being in trouble were stealing (reported by 68%), fighting (reported by 62%), graffiti (reported by 49%), taking a car (reported by 39%), something to do with drugs (reported by 36%), damaging property (reported by 36%), being in a gang (reported by 35%), driving offenses (reported by 29%), or running away from home (reported by 21%).

Of those AE students who had been in trouble with the police, 51% considered that they had been treated badly by the police and 23% considered that they had been treated well by the police. A quarter (25%) of all AE students considered that in the previous 12 months they had been treated unfairly (hassled or picked on etc.) by the police because of their ethnicity.

Most AE students (81%) reported that they had friends or family/whānau who were involved in a gang and 40% reported that they belonged to a gang. There was no significant difference between males and females, or between age groups with regards to gang involvement.

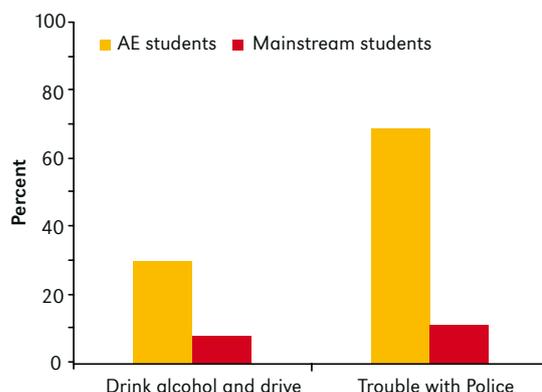
## Comparisons 2000 to 2009

The proportion of AE students who always wear a seatbelt decreased from 44% in 2000 to 30% in 2009. The proportion of AE students who reported that they had been sexually abused decreased among males (from 24% in 2000 to 11% in 2009), but did not change significantly among females.

## Comparisons between students in AE and Mainstream Schools

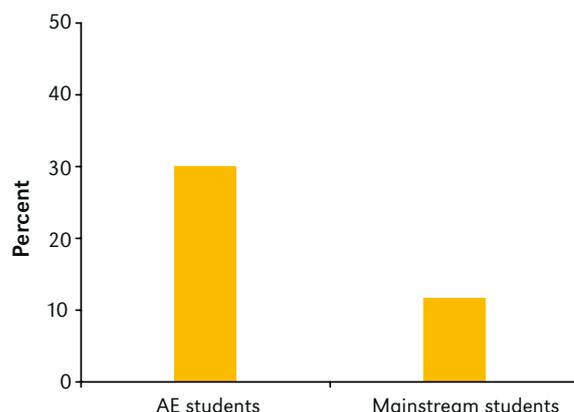
AE students are more likely than mainstream students to engage in risky or antisocial behaviours: they did not always wear a seatbelt when in a car (reported by 47% of AE students compared to 8% of mainstream students; adjusted OR = 5.0,  $p < 0.0001$ ); were more likely to drink and drive (reported by 31% of AE students compared with 8% of mainstream students; adjusted OR = 4.4,  $p < 0.0001$ ); and more likely to have been in trouble with the police in the previous 12 months (reported by 70% of AE students compared with 11% of mainstream students; adjusted OR = 12.0,  $p < 0.0001$ ).

Drinking and driving/Been in trouble with the Police  
AE and mainstream students



AE students were more likely than mainstream students to have experienced sexual abuse and coercion (reported by 20% of AE students compared with 12% of mainstream students; adjusted OR = 1.4,  $p < 0.03$ ).

Witnessed adults hitting or physically hurting each other at home - AE and mainstream students



AE students are more likely than mainstream students to suffer injury or experience violence: they were more likely to have suffered a workplace injury in the previous 12 months (reported by 22% of AE students compared with 11% of mainstream students; adjusted OR = 1.8,  $p < 0.004$ ) and more likely to witness adults hitting or physically hurting other adults in their homes (reported by 30% of AE students compared with 12% of mainstream students; adjusted OR = 2.0,  $p < 0.0001$ ).

### Key points for injuries and violence

AE students report that:

- They are less likely to wear seatbelts than mainstream students.
- The majority do not wear a helmet when riding a bike.
- Many have been driven in a car by someone who had been drinking alcohol or taking drugs.
- Most have driven a car on a public road even though most do not have a licence.
- Many have driven a car after drinking alcohol or taking drugs.
- They are more likely than mainstream students to witness violence in their home.
- They are more likely than mainstream students to report sexually coercive and abusive situations.
- Nearly half have been hit or physically harmed in the previous 12 months.
- Over a third of females who had been hit or harmed named the perpetrator as their boyfriend.
- Over two thirds report being in a serious fight in the previous 12 months.
- Many had been in trouble with the police.
- Nearly half are involved with a gang.

## Community

*As soon as you say AE a lot of people just back away but at the end of the day this child is a member of the community, they have rights as well, and they're not what people perceive them to be. A child might come in with a huge record ... from, you know, misdemeanours in the community but once you get one to one with that child ... they're not nasty and they're really approachable. Breaking down that stigma as well.*  
(Health professional)

### Friends and peers

Friendships in adolescence provide a sense of belonging and support for young people and are important in adolescent development.

Friends are important for AE students: most have a group of friends they can hang out with (reported by 95% of AE students); have friends they have fun with (reported by 94%); have friends who look out for them (reported by 92%); have a friend they are close to (reported by 87%); have a friend they can talk to about anything (reported by 87%); have friends who care a lot about them (reported by only 49% of males compared to 72% of females); and feel that their friends are a good influence on them (reported by 72% of AE students). 63% of AE students said that they were very good at making and keeping friends.

## Participation in the community

*“... I think in terms of the social issues for the kids in AE, the biggest issue they have is that they lose out in their community. Their school is their main community, especially for adolescents who are peer orientated. They get moved from, or stop going to mainstream and lose out on that, so they come into AE and they rebuild communities but the problem can be that they are around less positive kids or kids who have other issues, so you’re putting issues with issues and although we get a good success it’s still not giving the child the best that they could get in a mainstream...so that’s an area that might need some more looking at in the future.”* (AE coordinator)

Engagement and participation in community activities that are meaningful for young people contribute to their healthy development (37).

More male AE students (35%) than females (7%) reported that they belonged to a sports team in their community. 21% of AE students reported that they belong to a church. A third (33%) of AE students reported that they had helped others in their community in the previous 12 months, and 7% that they belonged to a volunteer group in their community.

Most AE students (79%) reported that they feel safe in their community all or most of the time, and 82% that they feel they really belong in their neighbourhood. Three quarters (75%) believed that they can trust people in their neighbourhood and 71% felt that people in their neighbourhood help each other out.

Most (83%) AE students reported that most of the time they liked their neighbourhood, and 79% reported that they liked the people there. Nearly two thirds (59%) reported that they had an adult outside of their family/whānau who they would feel ok talking to.

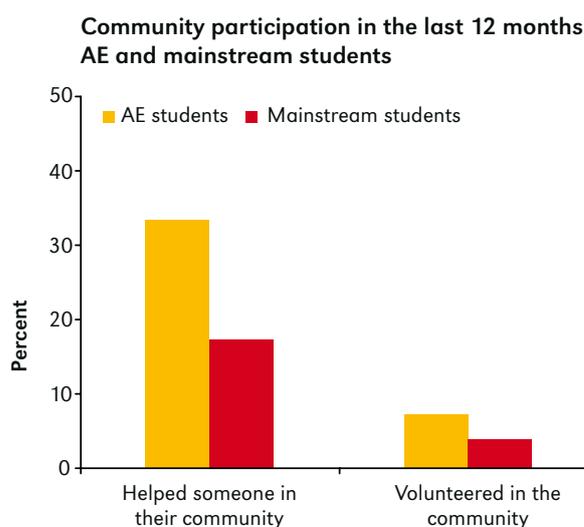
## Spiritual beliefs

A third (33%) of AE students reported that spiritual beliefs were very important to them, and 25% reported that they regularly attend a place of worship.

## Comparisons 2000 to 2009

The proportion of AE students who reported that they were very good at making and keeping friends increased among males (from 46% in 2000 to 65% in 2009), but there was no significant change among females (62% in 2000 and 59% in 2009).

The proportion of AE students who reported that spiritual beliefs were very important to them decreased from 52% in 2000 to 33% in 2009.



## Comparisons between students in AE and mainstream schools

AE students were much more likely than mainstream students to have helped out someone in their community in the past 12 months (reported by 33% of AE students compared with 17% of mainstream students; adjusted OR = 3.1,  $p < 0.0001$ ). AE students were also more likely than mainstream students to belong to a volunteer group in their community in the past 12 months (reported by 7% of AE students compared with 4% of mainstream students; adjusted OR = 1.7,  $p < 0.0164$ ).

### Key points for community

AE students:

- Are more likely than mainstream students to help someone in their community or be involved in a volunteer group.
- Most feel safe in their community and feel they belong there.



## **Interviews with Alternative Education providers and allied health workers**

This section will explore the responses from the eleven semi-structured interviews with Alternative Education providers and allied health workers. The aims of the interviews were to:

1. Identify perceptions of health and social issues for students in AE.
2. Explore the impact (if any) that health and social issues have on the wellbeing of AE students.
3. Identify barriers to providing quality health and social services in the AE setting.
4. Explore the range of health and social services currently available at AE facilities for students.
5. Identify successful models of health service delivery for AE facilities and students.

Key themes were identified using a general inductive approach (13). The data were then refined into themes alongside direct quotes from participants that provided more in-depth understanding of Alternative Education providers' and allied health workers' experiences.

For the purposes of this report, the themes that were identified and categorised under each of the five objectives stated above are used to highlight the health and social issues of students attending Alternative Education. Further in-depth analysis and descriptions of the qualitative interviews and themes will be published elsewhere.

## Perceptions of health and social issues for students in Alternative Education

Alternative Education providers and allied workers described multiple health and social issues affecting their students: tobacco, alcohol and drug use, mental health, sexual and reproductive health and physical health issues.

### Tobacco, alcohol and drug issues

*"...the health issues for kids in AE are drug and alcohol. Are definitely the top of the list. But I understand though that underneath those major headings are actually deeper issues to do with mental health and self-esteem, that sort of stuff."* (AE tutor)

*"Because I see from the kids point of view. They do what's accepted and which is why we were saying, it's hard to battle drugs and alcohol because it's accepted so lightly in their own homes ... I feel if I could change their minds into thinking, taking it from, 'oh it's okay' to 'it's just straight bad'...because at the moment they think it's 'sweet as', cause mum and dad said it's alright and my brother says it's alright, my aunty says it's alright."* (AE tutor)

### Mental health issues

*"...there's depression, emotional trauma and just really low self-confidence ..."* (Health professional)

*"The next priority I guess I would find is mental health issues. A lot of them have got you know varying from ADHD, ADD to learning difficulties, dyslexia..."* (Health professional)

*"...it has been a horrible couple of years experiencing, not directly, indirectly suicide - the impacts it has on the kids and a possible contagion site that had me thinking of pulling AE right out of there, because of what thoughts and behaviours of the kids, you know, come with the suicide."* (AE coordinator)

*"... but some of the stories that these young fullas come out with, cause I thought I had seen it all through my life, everything that I'd been through...and some of the stories those students come out with, I thought oh Jesus. I don't wish it on anyone to have to go through that."* (AE tutor)

## Sexual and reproductive health issues

*"I think lots of the issues have been sexual health, they need contraception and check-ups and STI check-ups."* (Health professional)

*"At present I've got one of my girls which has come back to me, she's bloody pregnant, and she's pretty shattered about it cause the other guy's gone and never coming back again. As much as we try and enforce the importance of contraception and the way things are, as soon as they leave here they get home and back to their same home lifestyle and things that they're surrounded by, they just don't care anymore."* (AE tutor)

*"...mostly the teen pregnancy, and like last year was a real wave of men, boys who became fathers"* (Health professional)

*"one of the things I think we need to be really conscious of is the numbers of young babies that are being born to dysfunctional and highly irregular relationships and you know, I recall last year sitting here...the boy and the girl were kissing out the back there and they were cuddling and they were only 14. So we talked about it and we said you know, hey you keep doing those things, eventually you are going to take the next step... what do they do? Sure enough, you know there's a baby, now he's just turning 16, she just turned 16. But I wonder how...what is the body of care for that little child? Who actually takes responsibility for it?"* (AE tutor)

## Physical health issues

*"the first thing is to clear up ... if there's any learning needs as a result of health issues, so things like hearing, eyesight that kind of thing, if we can identify if there's any brain injury previously"* (AE tutor)

*"Poor diet, lack of exercise, lack of social associations that are positive and there's a lot of negativity. Not with all kids, but generally I would say 40-50% of the kids. You know if you don't eat well, if you don't sleep well, if you don't play sport, if you don't exercise - all those things impact on your ability to get through the day."* (AE tutor)

*"he's got eczema, skin disorder from head to toe, you know, he's just covered and so this has just become the norm for the kids that...the child's sick you get it seen to, and all the rest of it"* (Health professional)

# Impact of health and social issues on the wellbeing of AE students

## Limiting students' ability to succeed in the future

Health and social issues were identified by all participants as having a significant impact on AE students' ability to succeed. In particular, they discussed the failure of mainstream education to identify these health issues earlier so that they did not impact on the educational outcomes of students.

Participants also expressed their frustration at learning and behaviourally challenged students being taught by tutors who have few resources, and less access to Special Education support.

*"so they're the kids with the highest educational needs, highest health needs, social needs going into a course where their education is being taught by not trained teachers, so...I guess that's gonna limit their ability to succeed."* (AE coordinator)

## Family/whānau issues may hinder education and emotional wellbeing

All participants described family/whānau problems as a barrier to accessing good education, health and social services.

*"...their home lives generally are difficult because their home... it's usually drugs, alcohol, domestic violence...yeah. So I guess for a lot of them, their health is impacted on by their home life. That's why a lot of them choose not to be at home, and not to live with their parents."* (AE tutor)

## Family/whānau and student suspicion of agencies affects their wellbeing

Several participants commented that suspicion and mistrust of government agencies affects families' and students' ability to engage with health and social services.

*"I know of one example there was a young man who disclosed physical violence in the family/whānau and so for us they disclose, if there's current physical violence or sexual violence, we have to refer to CYFS and so that ended up being referred to CYFS and the parents were all upset because you know that shouldn't have happened and all that stuff. So that was a huge issue for the nurse to work through that, getting an angry parent. Why did you do that, you know etc..."* (Health professional)

## Generations of exclusion and poverty affects young people's wellbeing

Participants reported that most of their students came from families who have experienced generations of exclusion from the mainstream and the corresponding opportunities to succeed and gain sufficient resources. These stressors affect a family/whānau's ability to support their children's education and health.

*"...they maybe come from several generations of maybe low education, low paid work, maybe not so much emphasis on education, maybe drug and alcohol issues in the family/whānau or mental health issues in the family/whānau so it sort of becomes generational...factor. So therefore they haven't been given the skills that other students have been given to develop resiliency factors, and to identify how to achieve I suppose or how to minimise risk."* (Health professional)

*“... I mean our kids are all here for a reason and most of them if you look at their history and their pathway it’s through neglect or adult deficit, that’s what we call it. And they’re not abused or anything, but they’re just brought up by their cousins or by their own age group. So some of them, a lot of them come through trauma as well, trauma or neglect, and we know that that affects development, so we need to be able to actually draw on specialists.”* (AE coordinator)

In addition, families feel unable to advocate for their children at school and access the services they require.

*“no blame can be laid on the families, cause we’ve got families out there who don’t value education, don’t value health, don’t value...and it’s not in their culture to value, or their awareness to understand what’s the purpose behind it all ...”* (AE coordinator)

*“...the families don’t know how to access the supports for them to do well at school, like you know I was talking to another parent you know and this young person definitely had learning difficulties and none of that was picked up, at intermediate, never went to intermediate, and a few months maybe in the 2 years of college, and then came to Alt Ed. And it was only when we came to Alt Ed did we realise that he might have some learning problems and you know but none of that was picked up.”* (Health professional)



# Barriers to providing quality health and social services in the AE setting

## Stigma associated with being at AE

Several tutors talked about the stigma associated with AE. Many felt that services backed away from providing care to AE students because they are too complex.

*“As soon as you say AE, a lot of people just back away but at the end of the day this child is a member of the community, they have rights as well, and they’re not what people perceive them to be. A child might come in with a huge record you know from you know misdemeanours in the community but once you get one to one with that child. And they’re not nasty and they’re really approachable. Breaking down that stigma as well...”*  
(AE coordinator)

Tutors expressed a passion for working with AE students despite the stigma and lack of resources for these students.

*“I have a lot of trouble with people who say ‘how can you work with those kids?’ – How can you not work with those kids? But once you say to someone, look here’s a little brief on this child and their upbringing and once they’ve realised the whole picture, the behaviours are really understandable. But then the counter action with that is you’ve got to say to the young person, you’ve got to take responsibility cause you’re now at that age where you’re making choices just for yourself and you can’t just get away with it just because you’re a young person. So I think it’s a good balance saying yes you came through shit growing up and that wasn’t your fault, but what are you going to do with that?”*  
(AE coordinator)

## AE students do not have access to the same services as mainstream students

Tutors consistently voiced their concern at a lack of resources to teach and manage learning and behaviourally challenged students. However, they did not want disproportionate resources: they just requested the same resources that mainstream schools are entitled to.

*“...and they lose, by losing the mainstream school they are losing counsellors, RTLB’s, Deans, numerous teachers who the child can usually bond with one teacher. They’re losing that, and they go to all day every day with the same tutor, the same maybe 2 or 3 adults around them, so they actually lose adult role models as well.”*  
(AE coordinator)

*“They can’t access school sports teams. Everyone says you need to be involved in a sports team and there isn’t one and they’re not going to go into their local community and join up, they’re just not sporty kids so we need to bring it in house again and although physical activity is compulsory, depends on the tutor and the tutor’s time and their interest.”*  
(AE coordinator)

## Frequently AE facilities often do not understand the role of health services

Some AE facilities were unsure of the role of health and social services. They were unsure how to utilise the skills of nurses, and what they could do to assist their students.

*“The other huge aspect ... that everyone needs to understand is that the role, what the team does, what the nurses do is more than just you know being the health professional and you know ‘okay let’s go and talk about sexual health’, yeah. The mentoring that comes out of it, the advocacy for the young person’s rights, the fact that they are actually being heard, which I would say doesn’t happen a lot for them.”*  
(AE coordinator)

*“to be honest, I didn’t have any insight into health. I just assumed that their whānau were taking care of them...it wasn’t evident to me that kids weren’t getting their simple injection stuff going on – didn’t think of it at all”*  
(AE coordinator)

Some health providers felt that tutors did not facilitate access to healthcare, or even blocked service entry because they were unclear about the role of these services.

*“it is new, and sometimes they find that when they go to the AE and the AE people are not very forthcoming, they don’t really...like ‘why are you here?’ or ‘we’ve got nothing for you today’. So they’re finding the AE staff are not very welcoming I guess towards them, or...they don’t see what the need is, or ...they don’t know what the nurse is there to do. They don’t know what we can provide I guess.”*  
(Health professional)

## Insufficient policy support and resources

All participants voiced frustration at the lack of resources and political support for AE students to be seen as a group worthy of good quality education, health and social services. They felt that they were invisible and no one cared about their students.

*“I think that government-wise we ought to be disgusted with how...we treat a population like the kids that are attending there. And I just think we all, you know, are given the role to actually put in health services or education or whatever, and I just think because it gets too hard we walk away.”*  
(Health professional)

*“...or they just don’t get picked up properly you know, or you know other agencies maybe don’t follow up the way that maybe they could or should be. So for me it’s actually as a society we’ve actually dropped the ball a little bit.”*  
(AE coordinator)

*“... I know that that’s what they would be keen to see as a social worker in there. But I’ve got grave concerns that what our expectations are of our tutors, and I think this is why you know the government needs to take stock of what they’re doing. It’s all very well for them to say we don’t agree with them [AE students], they shouldn’t be in Alt Ed, but they’re there and we need to... provide for the kids”*  
(Health professional)

## ‘Education failure’ is a symptom of much larger issues in the lives of students

All participants described attendance at AE as a symptom of much larger issues going on for their students.

*“you know sometimes they often forget the AE kid is just the index, the person to identify the family/whānau which needs some work. And particularly if there are younger kids in the family/whānau... often they’re going down the same path of disconnecting from the traditional structures like schools, and if you can do some work around that, then it would be valuable.”*  
(Health professional)

Several participants talked about the snowball effect of missing school, family/whānau problems and learning issues all contributing to students being excluded from mainstream education and placed in AE.

*“for whatever reason there’s a huge amount of absenteeism from school right from whenever, you know social or health issues are started for students, therefore they miss a lot of the education so they get further and further and further behind so... the health... is just intertwined... it’s just survival.”*  
(Health professional)

# The range of health and social services currently available in AE settings

In 2008, the Ministry of Health announced funding through District Health Boards (DHBs) for school-based health services for high school students in AE facilities, lower-decile secondary schools, and Teen Parent Units. AE were expected to be among the first educational facilities to receive this funding (12). But although health services have been provided for some AE facilities, there are still some that are yet to receive this kind of service for their students.

AE staff and allied health workers interviewed in term four of 2009 reported a range of health and social services available to their students. Several reported that their AE facility had no health or social service provision. Others reported that they relied on their personal relationships with various community and primary care services and would take students to access healthcare when necessary.

*"no, they don't have anybody on board. So what we do [if our] AE centre has a local doctor or practice or whatever that there's sort of a relationship with, they know that there's the AE provider and they send their kids sometimes. So I think there's some sort of informal networks that are built up between, how shall I say, between sympathetic providers."* (AE coordinator)

*"So when they come in and say we're sick, we take them to the doctor, or we take them home, or we allow them to lie here and just see how things progress during the day. And if it gets bad, we ask the family/whānau to come and pick them up and take them to the doctor. We have Dr [name] which is one of our trustees of something else that we have set up and if it gets to the point that perhaps we've done it only once, we should do it more often. That we felt that the child was being sick, the other children were being sick, it's not anything more than where they lived, cause the house was too damp, it was too crowded, so with Dr [name] we were able to get them a better house. But it would be great if we could do that more for families. But we can't, we just don't have...we do have access to Dr [name] because she's one of our trustees."* (AE tutor)

Some facilities have Public Health Nurses come into the AE environment and others have youth health nurses and doctors attend their facilities on a regular basis either through a Primary Healthcare Organisation (PHO) or District Health Board (DHB).

*"...they needed a coordinated wrap-around consistent service. So what I did at that stage was [I] went and spoke to [the AE coordinator] and all the tutors and many times I said tell me what it is you need for Alt Ed kids. And it was, they wanted assessments... they wanted them to access the doctor, they wanted a nurse to provide consistency...and so we then put that proposal to the other doctor which looked at putting [nurse] in a full time position... But so it made sense that we'd put someone in there that was...the kids then grew to know. That she knew when she was going to be going there and they knew that they could get a hold of her, so what she's done is she works specifically on special days, so each Alt Ed knows when she is coming. But she responds to acute stuff..."* (AE coordinator)



# Successful models of health and social service delivery for AE students

## Health professionals need to be part of the AE, and provide services within the AE environment

Health professionals had to work hard to engage the tutors and students to become part of the AE team, otherwise the service was not as well utilised or trusted.

*"...we refer our kids out so often and we're like, 'well you've got a problem, so off you go and see someone else who you've got no relationship with and they will fix you..."* (AE coordinator)

*"being involved in the life of the AE and not just there to do clinic but to do a bit of health promotion, answer questions, be interested in the young people and to seem to really connect with them, because the tutors look at that and they're much more interested in that, that you connect, rather than whether you know the latest contraceptive. They are much more at that level."* (Health professional)

*"sometimes the health workers come and do their thing on the kids and leave, there's no discussion, not necessarily about what it was – but you know it's a little bit isolated, you know, we'll just come and do our thing and then leave..."* (AE tutor)

*"If you are wanting to provide a service to vulnerable young people, you need to take it to them, they won't come to you. For a variety of those reasons, you know, it might be transport, money; invariably it's about their priorities actually."* (Health professional)

## Health professionals need to be consistent and build relationships and good communication with AE students and tutors

Most participants reported that health professionals could not go into an AE environment without developing trusting relationships with tutors and students. Relationships are essential to the success of a health and education interaction.

*"Health issues – there are none. Because [name of nurse] has that, she has that bond with the students, they're happy to tell her anything. To the point of even some things they'll tell her without even telling me. But they'll come and say to me 'oh [name of AE tutor] I'd rather talk to [nurse] about it, if that's okay?' I'm like yeah, by all means. As long as you're dealing with it, don't hold it in, don't bottle it up. Get it dealt with. And come and see me if you need anything else."* (AE tutor)

*"To provide some sort of referral, to do just the assessments or whatever, and in consultation with the tutors and to make some referrals to other services just for that kid. But also maybe the health nurse along with the tutor visit family/whānau to see if there's...you know if there are ways that the centre can work with the families also in terms of their health. You know. Through diet or mental health or whatever it is."* (AE tutor)

## Specialist services must be youth oriented and culturally appropriate

Participants described the desired characteristics of health professionals they felt would work most effectively with their students. In particular, youth-focused and culturally appropriate services were desired.

*“you have to have staff that are youth oriented or focused”* (Health professional)

*“Most of our kids are Māori and Pasifika, it would be good if there were Māori or Pacific staff available, health professionals to work with our youth.”* (Health professional)

*“so that you know that you’re being culturally appropriate too I suppose, and you know because we have a huge Māori population in Alt Ed. We really do... those Māori role models, we need some role models.”* (Health professional)

*“we don’t have any male counsellors, Pacific Island counsellors, Māori or Pacific nurses. So I think a lot of energy needs to go into that area.”* (AE tutor)

## Health professionals in AE facilities must be multi-skilled and multi-disciplinary

Most participants acknowledged their students were complex, and needed a range of services and skills to improve their wellbeing. Nurses were identified as the first line of service provision.

*“you’d have your health nurses as the first port of call I think, then you’d have your more specialised people...mental health team of some kind...social workers as well, that would be out with the kids on a fairly regular basis so that if a child is going through a crisis there is someone they can relate to straight away and can move that child into a specialist team. But its people they already know.”* (AE coordinator)

Nurses needed to be supported by multi-disciplinary teams, who could provide prescriptions (doctor and nurse practitioners) and specialist supports where needed.

*“so as well as primary care and some sort of specialist stuff, they need to have a whole set of skills around engaging young people and their families and multiple other services...have good links with the community and actually get on with the tutors.”* (Health professional)

*“well, a nurse practitioner attached to every AE who has got prescribing rights, who ... same time every week is always there and who has time put aside whether the students utilise or not...a rounded service, you know sexual health, mental health, alcohol, drug ... health promotion, nutrition...”* (Health professional)

## Connecting with families/whānau is necessary to improve outcomes for AE students

Participants acknowledged the fundamental role that families play in supporting the wellbeing of AE students. Many felt that any interventions and strategies must include the family/whānau to be effective.

*“I suspect they [health services] have traditionally focussed on the young person, but increasingly see as all of us do, that a lot of issues sit inside the family/whānau. They need a broader approach.”* (Health professional)

## Multiple agencies and services should be coordinated and wrapped around AE students and their families

AE students and their families are frequently engaged with multiple agencies. A coordinated approach is required to improve young people's healthy development within the context of their family/whānau.

*"...because they all come with similar issues of housing, health, justice... employment issues. So AE is like a gateway into a whole lot of issues for the whole family/whānau, because if you go, you see one kid, but then you go and visit the house and there are 3 others that are not going to school or, you know there are all these other issues that are there." (AE tutor)*

*"they've got a much more coordinated approach, Child, Youth and Family, the police and all that around the family/whānau, wrapped around some programme and got the child sorted." (AE tutor)*

*"So I think yeah, it's a matter of phoning around and saying what can you do, cause everyone is working in their own little silo, and we're working with the same kids and everyone's focussed and there's no resources and no time, so it's a matter of just bumping into people and networking and saying, we need to support each other and these kids. So most of the stuff we've got this year has come from [nurse] being so proactive." (AE coordinator)*

## Tutors and AE providers require education, support and professional supervision

Several participants felt that tutors were required to take on significant pastoral roles for the health and wellbeing of their students without any support or professional training.

*"I think our tutor carries many hats...I've got grave concerns [about] what our expectations are of our tutors" (Health professional)*

*"And so over the period of time there becomes a greater disclosure, like the students disclose more about what's happening. So there are issues of abuse and things like this that happen at home ... or other criminal stuff, so it's important for us also to have supervision given to our staff because of that, because of the things that are presented to them." (AE tutor)*

*"what I've been trying to do is really push too for child protection, you know, recognising it, and what can tutors ... do with students who they suspect of being sexually or physically abused ... and it's educating our tutors too, I just see that as a real need for us as nurses to educate the tutors as to what to look out for, because if anybody ... that is trusted by the students, it's the tutors." (Health professional)*

Participants felt that training and supervision is required for tutors to maintain their own and their students' safety.

*"..but more of them [AE students] are coming with far more complex [issues] and what we do lack within us, is a lack of in-depth knowledge of handling certain behaviours and adapting them..." (AE tutor)*

*"...and then some training for staff to spot things, you know for the AE staff. Some basic sort of pointers and things, for example ... suicide or other mental health issues." (AE tutor)*

*"...some of the tutors went to the suicide assist programme, that was really beneficial because actually it was implemented the following day. So that was a successful health intervention into the centre - could've saved a life." (AE tutor)*

*"and I think because it should be mandatory that the tutors are having clinical supervision..." (Health professional)*



## **Synthesis of the findings from the survey and interviews**

## Synthesis of findings

This section brings together the findings of the Alternative Education student survey and the interviews with Alternative Education providers and allied health workers. Both the survey and the interviews highlight significant and complex health and social issues for the young people attending Alternative Education. These issues are influenced by the students' peers, wider family/whānau and community environments.

There is increasing evidence internationally that the strongest influences on health and wellbeing are what are known as the 'social determinants' – the economic and social "conditions in which people are born, grow, live, work and age" (24). The World Health Organisation's Commission on Social Determinants of Health report (38) provides three overarching recommendations for achieving health equity:

- (a) Improving the conditions of daily life.
- (b) Tackling the inequitable distribution of power, money and resources.
- (c) Measuring and understanding the problem and assessing the impact of any actions.

A long-term, intensive and systems-based approach is worth the investment for this vulnerable group who have significant health disparities compared to their peers. Failing to address the social determinants of health will almost certainly fail to improve health, social and educational outcomes for students in Alternative Education.

There is a real opportunity to address the fundamental roots of education failure, health and social disparities for young people in Alternative Education by addressing these broader determinants of wellbeing. Therefore, we will use the social determinants principles as a framework to synthesise the findings of this report.

## Improving the conditions of daily life

Young people who feel connected, have good quality relationships, are actively engaged and have opportunities to participate are less likely to engage in risky behaviours – such young people are more likely to enjoy good health and to make positive and valuable contributions to society (28).

### Improving education conditions

#### Access to high quality education

Evidence suggests that access to high quality education, particularly in early childhood, is associated with improved health, social and economic outcomes (39, 40). Students who attend Alternative Education have frequently missed those essential early childhood experiences and educational opportunities. AE staff and others interviewed in this study clearly articulated the view that mainstream education had failed the students who came to AE. In the survey of AE students, they were more positive about AE than about their previous mainstream schools, and considered that they were achieving more academically. However, it should be noted that a review of AE by the Ministry of Education concluded that educational outcomes for students in AE were still generally poor (10).

Improving the conditions of daily living for AE students will require more equitable access to the educational resources and opportunities that students in mainstream education enjoy, while maintaining the positive and supportive learning environments and relationships that AE facilities have established.

#### Caring relationships with tutors/teachers

In order for students to learn effectively in AE, they must have caring and trusting relationships with their teachers/tutors (10). The results of both the student survey and the interviews with AE staff indicate that AE provides students with pro-social adult mentors and relationships that had often been lacking from their previous mainstream school experiences.

These strong relationships lead to a good learning environment for students (41-43). Most students at AE reported that adults at AE cared about them more than teachers at their previous mainstream school. AE students felt tutors had more time to help them and listened more often. Many students felt more hopeful about being able to get a job or attend further education after attending AE compared to mainstream.

AE tutors were hopeful too, and took pride in being able to provide something for students the mainstream system had not been able to help:

*“...but our success is awesome when you consider where the kids have been and what they’re doing. Our attendance is really good, our occupancy is really good. We get kids who come back 5 years down the track, and they were a ‘little thug’ when they were here, but they’ve got a job and maybe they are a parent now, they’ll pop in and see the tutors.”*  
(AE coordinator)

### **Training and supervision for tutors**

Students need access to well-trained teachers and tutors to help them not only to improve their educational outcomes, but also to deal with all the other issues that impact on their health and wellbeing. Tutors must have Special Education support and training programmes that enable them to address these issues.

Many tutors in AE report that the pastoral role in working with AE students can be overwhelming, and they need health and social services to take on more of these responsibilities so that they can concentrate on teaching and learning outcomes

## **Improving home conditions**

### **Improve family/whānau relationships with students**

Supportive family/whānau environments are important to improve educational and health outcomes (44-46). Most students report that their parents think that attending AE is important, and most report talking to their parents or caregivers about how things are going at AE. However, tutors and health professionals report that families can act as barriers to engaging students in health, education and social services.

*“it’s to the point where they [students] are far too distracted by things that are happening at home- instead of focusing on what we’re actually trying to teach them here in class.”*  
(AE tutor)

### **Good interaction between home and education environments**

AE tutors spend a significant amount of their time trying to engage with the parents of their students. Tutors realise that families are intimidated by school systems and need encouragement to become involved in their child’s education (34). Similarly, health professionals reported that families were reluctant to engage with health and social services. Developing positive relationships between students, their families, AE tutors and health professionals may improve education and health outcomes for students. Tutors require assistance from health and social services to facilitate these relationships.

## Improving conditions for health

### Universal access to healthcare for AE students

The conditions for meeting the health needs of young people attending AE vary significantly between AE providers. Some AE centres provide a regular health service while others have none at all. The survey of AE students indicated that many are unable to access the healthcare they need.

In those AE facilities that do not have health services attached to them, the tutors sometimes pay for their students to access a doctor and pay for their medications out of their own pockets.

### Consistency and quality of healthcare between all AE facilities

Young people need access to health care that is coordinated, consistent and collaborative with AE facilities. Young people in AE are complex and require access to specialist youth health services to meet their social, behavioural, mental and physical needs. The areas of need include general physical health, sexual health, mental health, dental care, optometry, audiology, physiotherapy, drug and alcohol services, violence prevention, social services, care and protection and counselling services.

# Tackling the inequitable distribution of power and resources

Health, social and education disparities are shaped by the social structures, policies and practices that tolerate and promote the unfair distribution of power (24). The findings from this report give us insights into the structures and processes that disadvantage the health, social and educational situations of students attending AE compared to students attending mainstream education.

## Inequality of access to quality education

### Access to quality education as a basic right

Education is a basic right in New Zealand, but for students in AE, their access to a quality education that will assist them to reach their fullest potential is limited in its current form (39).

### Māori and Pacific students are disproportionately disadvantaged

Māori and Pacific students are disproportionately excluded from mainstream education and placed in Alternative Education (21). This can be seen from the proportions of Māori (50%), Pacific (30%) and Pākehā / NZ European (18%) students in AE compared to the proportions in the wider mainstream school population (19% Māori, 10% Pacific, 53% Pākehā / NZ European). Ministry of Education data for exclusions (i.e. expulsions from secondary schools of students under 16) show that in 2009 the rate of exclusion among Māori students (3.4 per 1,000 students for females and 7.2 for males) was nearly 4 times higher than the rate among Pākehā / NZ European students (0.6 for females and 2.1 for males). The rate of exclusion among Pacific students (1.4 for females and 5.1 for males) was over 2 times higher than among Pākehā / NZ European students (47). Mainstream education still fails to provide for the unique needs of Māori in particular.

## AE Tutors have unequal access to training and resources

AE tutors with the ability to connect with and educate 'hard to reach' students, do not have access to professional development and wages consistent with that enjoyed by teachers in mainstream education, yet their students are often more complex and challenging. There must be financial incentives to assist and maintain tutors/educators in the AE setting to improve educational outcomes. The Minister of Education has just announced moves in this direction, with new funding to provide for a qualified teacher to be employed by each AE facility, and improved training opportunities for tutors (48).

## AE facilities have a lack of resources to educate their students effectively

AE facilities lack access to basic resources that mainstream schools receive. Exclusion from mainstream education disadvantages students with regard to quality education, teaching resources, special education support, artistic and sporting opportunities. Young people in AE should not be disadvantaged because they are no longer attending mainstream schools.

*"We have kids with huge... health and educational needs with no support, no one, no one, they just have a tutor with a room ... the tutor picks them up. This is no offence to any of the tutors at all, because they are wonderful people with big hearts, they do it because they love the kids but you know, there's no trained teachers... so how can you look after these complex kids with no skills?"*  
(Health professional)

## Inequality of access to healthcare and social services

### Inequality of access to healthcare within the AE environment

Most mainstream schools have access to basic health services (school nurses, Public Health Nurses), yet the interviews with AE staff indicated that many AE facilities do not have similar access. The funding through District Health Boards intended for provision of health services to AE students, which was announced in 2008, clearly has not yet reached all AE facilities or all AE students. District Health Boards must fulfil their obligations to provide appropriate healthcare for AE facilities.

### Socio-economic deprivation affects health

Overall, this report highlights young people in AE as a vulnerable group with lack of power, money and resources. As the survey of AE indicates, most of the young people in AE do not have access to the resources which are a given for the majority of students in New Zealand. There are very high levels of socio-economic deprivation among AE students. Many AE facilities attempt to reduce the effects that poverty has on their students' ability to concentrate during the day, by providing food and basic hygiene resources.

### Health and social systems disproportionately disadvantage Māori students and their whānau

Māori youth as tangata whenua, have the right to have their health needs met in a manner which is appropriate and accessible. Institutional racism and generations of differential access have resulted in a mistrust of health and social services.

*"there are several layers to it and it might depend on ethnicity too, because I think Māori students may have a perception of particularly a mainstream DHB (District Health Board)... you know that institutional racism. I think that that there is just a huge barrier, their grandmother wasn't treated well by... Dr so and so, whatever, and right there, particularly with Māori I think there is a perception like that, is as an institution we treat them differently and I think in some cases that does happen."*  
(Health professional)

# Measuring and understanding the problem and assessing the impact of any actions

Monitoring the wellbeing of a vulnerable population is essential to ensure that there is evidence-based decision-making and policy development. This is the second survey of the health and wellbeing of youth in Alternative Education. By bringing these issues to the forefront, health, education and social services can be better informed.

The results of the survey in 2009 suggest that there have been some improvements since the previous survey in 2000, with male AE students reporting they are generally happier and healthier, although there has been little change among female AE students. Compared to mainstream students, AE students are significantly more likely to report a range of health risk behaviours and problems. Sexual health, drug and alcohol use, and exposure to violence are particular problems that require urgent attention. Also of concern is the decrease from 2000 to 2009 in AE students wearing seatbelts. Motor vehicle crashes are a major cause of injury and death for young people in New Zealand and a major public health problem. We suggest that in all these areas of concern this survey can be used as a monitoring tool to track health trends in this population.

Many health care providers and AE facilities recognise the need for coordinated health and social services for students attending AE, but require evidence to prioritise resources and services for this population. The first survey of AE health and wellbeing in 2000 (2) assisted in advocating for the development of health care services to a few AE facilities. The funding for school-based health services for students in Alternative Education, low-decile secondary schools and Teen Parent Units which was announced in 2008 (12) was a positive move, but its benefits have not yet reached all AE facilities.

This report contributes to the growing body of evidence of the health needs of young people in Alternative Education in New Zealand. They are vulnerable; they have been excluded from mainstream education for a variety of social, behavioural, health and educational issues. We hope that this report will serve to highlight and advocate for young people in Alternative Education, who deserve quality education and health services with improved resources and coordination, to reduce their risks and increase their chances of growing up healthy and successful.



# Recommendations

# Recommendations for providing coordinated and comprehensive health and social supports for students in Alternative Education

Students attending Alternative Education face complex and problematic health, educational and social issues. There are no quick fix solutions; the issues are interconnected, longstanding and share similar foundations(1). However, there are strategies that are effective at improving the health and wellbeing of vulnerable youth.

Programmes that reinforce pro-social adult relationships, involve multiple social domains (e.g. home, family/whānau, school and community), are longer in duration (longer than two years), are broad in their scope (do not just focus on one issue), involve collaboration between multiple agencies, have a Healthy Youth Development focus and encourage youth participation are more likely to be effective (27, 49, 50). Based on the evidence from this report and the literature pertaining to effective programmes, we make the following recommendations:

## Recommendation 1:

### **Develop caring and supportive relationships with students to engage them in education, health and social services**

This study found that AE tutors were effective at reinforcing pro-social adult relationships, but they often felt overwhelmed and under-resourced with the magnitude of social and health issues affecting their students. The orientation of Alternative Education to ‘focus on attendance, engagement and addressing behavioural issues as a foundation for educational achievement’ has been fundamental to its success in engaging students for whom mainstream education has failed (51).

Although the educational outcomes for AE students are still reported to be poor (10), the pro-social adult relationships and non-traditional learning environments in AE do provide a safer and more productive social environment and a venue for social change for these young people.

## Recommendation 2:

### **Improve interaction and communication between family/whānau, AE providers, health and social services.**

AE students reported that their families were important to them and that their parents want them to attend school, yet interviews with AE providers and allied health workers indicated that they often had difficulty engaging with families of the AE students. Families are fundamental in engaging young people in education and healthy lifestyles – strategies that engage families in a meaningful way are more likely to be effective.

There was also an obvious lack of collaboration between families, health and social services, and Alternative Education staff in many facilities. We recommend a ‘healthy whānau development’ approach that actively fosters positive development and supports young people and their family/whānau to achieve their goals and priorities. This is a long-term approach based on good relationships with young people and their whānau, and involves multiple collaborating agencies. This is consistent with proposed Whānau Ora approaches being developed at present.

### **Recommendation 3:**

#### **Provide free, consistent, high quality, youth appropriate, onsite primary health care for all Alternative Education students**

There was great diversity in the types of services available to Alternative Education students, with some facilities providing fairly comprehensive health and social services while others provided none at all. There was a lack of consistency, quality and provision of health and social services to support students and staff. We recommend that free comprehensive screening and primary care be provided in the AE environment (onsite) by health professionals who have good relationships and communication with AE staff and students.

These services must be high quality, confidential, with well-trained youth health staff, and must work in collaboration with AE and other services. A private and appropriate clinic room should be available for such consultations. Processes for referral to specialist services, whānau collaboration and clinical supervision are required.

Health literacy and transition of students from AE to the community must be addressed. They should know how to access the services they require and be linked to local primary care services for their ongoing health and wellbeing once they leave AE.

### **Recommendation 4:**

#### **Alternative Education facilities require collaborative models of health and social service delivery**

AE tutors and coordinators voiced their frustration at not being able to access the health and social services that they needed for their students. There are some AE facilities that have developed effective and collaborative models of care. They realise that one service cannot provide all the supports needed for their students to succeed.

We recommend well trained social workers/ youth workers and health professionals be placed in the AE environment to provide support for students, staff and to facilitate collaborative care and coordination. Linking multiple agencies and developing trusting and genuine relationships between the various agencies like primary care, mental health, sexual health, Child, Youth and Family (CFYS), ACC, Housing, Police and Justice requires significant negotiation. Alternative Education providers need assistance to develop and coordinate these networks and relationships.

### **Recommendation 5:**

#### **Comprehensive and consistent health promotion policies and procedures are required in Alternative Education**

AE tutors reported inconsistent policies, knowledge and support around health issues like smoking, bullying and suicide. Policies that promote good health and safe environments are necessary for all AE facilities. We recommend that evidence-based policies be shared and implemented in all AE facilities. Tutors must be supported with training and education to implement them.

Health promotion activities were highly dependent on the tutors' knowledge and interest. Given the significant health and social issues amongst this population a comprehensive health and physical education curriculum should be delivered to all AE students in an appropriate manner. Health and social services should be supporting these actions with their expertise and knowledge.

## Recommendation 6:

### Provide more training and workforce development for AE staff

AE students require high quality, well trained tutors, health professionals and social service providers. Most interviewed participants described a need for further training and education, and acknowledged that there was a lack of training to take on these roles.

Working with vulnerable youth requires a specific skill set. There must be training, ongoing education and development strategies to ensure that students are receiving optimal care and services. The youth health workforce development strategy Te Remu Tohu (52) should be used as a framework to develop highly skilled health professionals across the sector, alongside youth work and education workforce development strategies.

## Recommendation 7:

### Address the social determinants of health and educational disparities

Considerable health, education and social disparities are evident among young people in Alternative Education, demonstrating a broader failure of services to meet the needs of this group. AE students and their tutors do not have access to the same resources that are available to students and teachers in mainstream schools, and they do not have adequate healthcare or social services.

Such a vulnerable group should have increased access to resources, skilled teachers, and health and social services to address these disparities. Policies that address and prioritise education failure and truancy, and seek to provide quality education in the Alternative Education setting are urgently needed. The recent decision to provide trained teachers in AE is a welcome move in this direction. In addition, health and social services should work to break down the structural barriers to accessing the care which could help all students to reach their fullest potential.



# References

1. Freudenberg N, Ruglis J. Reframing school dropout as a public health issue. *Preventing Chronic Disease*. 2007;4(4):A107-A.
2. Adolescent Health Research Group. *Alternative education students health: from Northland and Auckland regions*. Auckland: University of Auckland; 2002.
3. Denny SJ, Clark TC, Watson PD. Comparison of health-risk behaviours among students in alternative high schools from New Zealand and the USA. *Journal of Paediatric and Child Health*. 2003;39:33-9.
4. Denny S, Clark TC, Fleming T, Wall M. Emotional resilience: risk and protective factors for depression among alternative education students in New Zealand. *American Journal of Orthopsychiatry*. 2004;74(2):137-49.
5. Fleming T, Kainuku-Walsh Y. *Outside the Mainstream: Health Service to young people who are outside of mainstream education settings*. Auckland: Counties Manukau District Health Board; 2007.
6. Grunbaum JA, Lowry R, Kann L. Prevalence of health-related behaviors among alternative high school students as compared with students attending regular high schools. *Journal of Adolescent Health*. 2001;29(5):337-43.
7. Clark T, Robinson E, Crengle S, Watson P. Contraceptive use by Māori youth in New Zealand: associated risk and protective factors. *The New Zealand Medical Journal*. 2006;119(1228):U1816-U.
8. Clark TC. *Young Māori attending alternative education: A profile of sexual health behaviours and associated protective factors*. Unpublished Masters Thesis. Auckland: University of Auckland; 2002.
9. Ministry of Education. *Education Act 1989 No 80 (as at 20 May 2010)*. [cited 2010 21 September]; Available from: <http://www.legislation.govt.nz/act/public/1989/0080/latest/DLM175959.html>.
10. Ministry of Education. *Findings of review of Alternative Education and future directions*; 2009 [updated 2009; cited 2010]; Available from: <http://www.minedu.govt.nz/NZEducation/EducationPolicies/Schools/PolicyAndStrategy/SchoolingInNewZealand/AlternativeEducation.aspx>.
11. Te Kete Ipurangi. *About Alternative Education*. 2008, July [updated 2008, July; cited 2009 March 19]; Available from: <http://www.tki.org.nz/e/community/alterned/>.
12. Chadwick S. *40,000 to receive school-based health services*. 2008 [updated 2008; cited 2010]; Available from: <http://www.beehive.govt.nz/release/40000+receive+school-based+health+services>.
13. Thomas DR. A general inductive approach for analyzing qualitative evaluation data *American Journal of Evaluation*. 2006;27(2):237-46.
14. Salmond C, Crampton P, Atkinson J. *NZDep2006 index of deprivation user's manual*. Wellington: Wellington School of Medicine and Health Sciences; 2007.
15. Bech P, Gudex C, Johansen KS. The WHO (Ten) Well-Being Index: validation in diabetes. *Psychotherapy And Psychosomatics*. 1996;65(4):183-90.
16. Bech P, Olsen LR, Kjoller M, Rasmussen NK. Measuring well-being rather than the absence of distress symptoms: a comparison of the SF-36 Mental Health subscale and the WHO-Five Well-Being Scale. *International Journal of Methods in Psychiatric Research*. 2003;12(2):85.

17. Reynolds WM. The Reynolds Adolescent Depression Scale- Second Edition (RADS-2). In: Hilsenroth MJ, Segal DL, editors. *Comprehensive Handbook of Psychological Assessment, Volume 2, Personality Assessment*. Hoboken, NJ: John Wiley & Sons Inc; 2004. p. 224-36.
18. Guttmacher S, Weitzman BC, Kapadia F, Weinberg SL. Classroom-based surveys of adolescent risk-taking behaviors: reducing the bias of absenteeism. *American Journal of Public Health*. 2002;92(2):235-7.
19. Statistics New Zealand. Statistical Standard for Ethnicity. *Journal [serial on the Internet]*. 2009 Date: Available from: <http://www2.stats.govt.nz/domino/external/web/carsweb.nsf/55d63ae38ba3a25e4c2567e6007f6686/35d9b7e17a1d6151cc25701100031353?OpenDocument>.
20. Statistics New Zealand. *Defining Urban and Rural New Zealand*. [cited 2010 21 September]; Available from: [http://www.stats.govt.nz/browse\\_for\\_stats/people\\_and\\_communities/geographic\\_regions/urban-rural-profile/defining-urban-rural-nz.aspx](http://www.stats.govt.nz/browse_for_stats/people_and_communities/geographic_regions/urban-rural-profile/defining-urban-rural-nz.aspx).
21. Ministry of Education. *A report on New Zealand student engagement*. Wellington: Ministry of Education; 2005.
22. Ross D. *Insight: rethinking child poverty*. Perception, 22: 1. Ottawa, ON: Canadian Council on Social Development; 1998.
23. Korenman S, Miller JE, Sjaastad JE. Long-term poverty and child development in the United States: Results from the NLSY. *Children and Youth Services Review*. 1995;17(1-2):127-55.
24. Blau DM. The effect of income on child development. *Review of Economics and Statistics*. 1999;81(2):261-76.
25. Wise S. *Family/whānau structure, child outcomes and environmental mediators: an overview of the Development in Diverse Families study*. Research Paper No. 30. Melbourne: Australian Institute of Family/whānau Studies.; 2003.
26. Ministry of Youth Affairs. *Youth Development Strategy Aotearoa*. Wellington: Ministry of Youth Affairs; 2002.
27. Kearney CA. School absenteeism and school refusal behavior in youth: A contemporary review. *Clinical Psychology Review*. 2008;28(3):451-71.
28. Bond L, Butler H, Thomas L, Carlin J, Glover S, Bowes G, et al. Social and school connectedness in early secondary school as predictors of late teenage substance use, mental health, and academic outcomes. *Journal of Adolescent Health*. 2007;40(4):357.e9-18.
29. Haas SA, Edward Fosse N. Health and the educational attainment of adolescents: evidence from the NLSY97. *Journal of Health & Social Behavior*. 2008;49(2):178-92.
30. Kubik MY, Lytle L., & Fulkerson, J. A. Fruits, vegetables, and football: Findings from focus groups with alternative high school students regarding eating and physical activity. *Journal of Adolescent Health*. 2005;36:494-500.
31. Koyama A, Corliss HL, Santelli JS. Global lessons on healthy adolescent sexual development. *Current Opinion in Pediatrics*. 2009;21(4):444-9.
32. CDC. *Preventing tobacco use among young people: a report of the Surgeon General*. 1994 [updated 1994; cited 2010 20 September]; Available from: [http://profiles.nlm.nih.gov/NN/B/C/L/Q/\\_/nnbclq.pdf](http://profiles.nlm.nih.gov/NN/B/C/L/Q/_/nnbclq.pdf).

33. Hingson RW, Edwards EM, Heeren T, Rosenbloom D. Age of drinking onset and injuries, motor vehicle crashes, and physical fights after drinking and when not drinking. *Alcoholism: Clinical & Experimental Research*. 2009;33(5):783-90.
34. Brook JS, Stimmel MA, Zhang C, Brook DW. The association between earlier marijuana use and subsequent academic achievement and health problems: a longitudinal study. *American Journal on Addictions*. 2008;17(2):155-60.
35. Patton GC, Coffey C, Sawyer SM, Viner RM, Haller DM, Bose K, et al. Global patterns of mortality in young people: a systematic analysis of population health data. *Lancet*. 2009;374(9693):881-92.
36. Holt S, Buckley H, Whelan S. The impact of exposure to domestic violence on children and young people: a review of the literature. *Child Abuse & Neglect*. 2008;32(8):797-810.
37. Busseri MA, Rose-Krasnor L, Willoughby T, Chalmers H. A longitudinal examination of breadth and intensity of youth activity involvement and successful development. *Developmental Psychology*. 2006;42(6):1313-26.
38. Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008.
39. Fiscella K, Kitzman H. Disparities in academic achievement and health: the intersection of child education and health policy. *Pediatrics*. 2009;123(3):1073-80.
40. Mitchell L, Wylie C, Carr M. Outcomes of early childhood education: Literature review. Report to the Ministry of Education. Wellington NZCER; 2008.
41. Voisin DR, Salazar LF, Crosby R, Diclemente RJ, Yarber WL, Staples-Horne M. Teacher connectedness and health-related outcomes among detained adolescents. *Journal of Adolescent Health*. 2005;37(4):337.e17-23.
42. Benard B. Fostering resiliency in urban schools. In: Williams B, editor. Closing the achievement gap. Alexandria, VA: Association for Supervision and Curriculum Development; 1996. p. 65-80.
43. Scott KS. Reduce your dropouts: it's not as hard as you think. *Principal Leadership: High School Edition*. 2005;6(3):38-42.
44. Catsambis S. Expanding knowledge of parental involvement in secondary education: effects on high school academic success. Baltimore, MD: Center for Research on the Education of Students Placed at Risk, Johns Hopkins University; 1998.
45. Jeynes WH. Parental involvement and student achievement: a meta-analysis. *Parental Involvement and Student Achievement: A Meta-analysis*. Cambridge, MA: Harvard Family/whānau Research Project; 2005.
46. Henderson AT, Mapp KL. A new wave of evidence: The impact of school, family/whānau and community connections on student achievement Austin, TX: National Center for Family/whānau and Community Connections with Schools; 2002.
47. Ministry of Education. Exclusions from school. 2009 [updated 2009; cited 2010 21 September]; Available from: [http://www.educationcounts.govt.nz/statistics/data\\_cubes/student\\_participation/schooling/80379](http://www.educationcounts.govt.nz/statistics/data_cubes/student_participation/schooling/80379).

48. Tolley A, Sharples P. Brighter future for Alternative Education students. 2010 [updated 2010; cited 2010 20 September]; Available from: <http://www.beehive.govt.nz/release/brighter+future+alternative+education+students>.
49. Brooking K, Gardiner B, Calvert S. Background of students in Alternative Education: Interviews with a selected 2008 cohort. Report prepared for Ministry of Education. Wellington: Ministry of Education; 2009.
50. Youngblade LM, Theokas C, Schulenberg J, Curry L, Huang IC, Novak M. Risk and promotive factors in families, schools, and communities: a contextual model of positive youth development in adolescence. *Pediatrics*. 2007;119:S47-S53.
51. Ministry of Education. Education report: alternative education report back. Wellington: Ministry of Education; 2009.
52. Kekus M, Proud P, Bell S, Clark TC, Newman J, Taylor A, et al. Te Remu Tohu -a framework for youth health workforce development. Auckland: Youth Health Workforce Alliance; 2009.









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