Appendix 7: Expansion of School-Based Health Services

Description of the initiative and problem definition	
What is this initiative seeking funding for?	This initiative will expand School-Based Health Services (SBHS) [redacted (f)(iv)] Delivery will be based on a ratio of 1 nurse FTE to every 700 students, equivalent to the 240 nurse hours per every 100 students a year stated in the Labour Party 2017 election manifesto. It will also improve ratios at decile 1-4 schools. Larger schools will have one or more FTE nurses, while smaller schools will have a part-time nurse, who may work in more than one school. [redacted] SBHS will include health promotion, sexual health services, and a universal health, disability and development check in Year 9 including an electronic HEEADSSS[2] assessment. It will also provide referrals to other services, and assistance with PHO enrolment of students and their families if required. An electronic database will be established to record SBHS activities, outputs and outcomes. The database will be managed by the Ministry of Health, with annual reporting on the performance of SBHS. The Speech from the Throne made reference to putting more nurses in schools in order to help young people access health care. This initiative also relates to the Confidence and Supply Agreement commitment to ensure that everyone has access to timely and high quality mental health services, including free counselling for those under 25 years. SBHS is a means for delivering the Coalition Agreement commitment to provide Teen Health Checks for all Year 9 students. This initiative relates to two of the Budget 2019 priorities, namely: • Supporting mental wellbeing for all New Zealanders, with a special focus on under 24s • Reducing child poverty and improving child wellbeing, including addressing family violence
Why is it required?	**A significant number of young people are unable to access primary care** The Youth 2012 survey found that 18.6% of secondary students were unable to access health care when they needed it. Even amongst students from low deprivation areas, 15.5% were unable to access care.[3] Inaccessibility increases the chances of young people waiting until a crisis point before they seek treatment, resulting in greater negative health and social outcomes, and higher treatment costs.

[1] Salary figures are averages – actual salaries will vary according to experience and qualifications, as per MECA.

[2] A psychosocial assessment covering **H**ome, **E**ducation/employment, **E**ating, **A**ctivities, **D**rugs (including alcohol and medicines), **S**exuality, **S**uicide and depression, **S**afety from violence and risky behaviour.

[3] Adolescent Health Research Group. 2013, page 85

Young people, Māori, Pacific peoples, disabled people, and those on low incomes are particularly vulnerable to cost barriers.[4] Other barriers to primary care access include not knowing how to access health care, privacy concerns, and lack of transport.[5] SBHS will help overcome those barriers by providing a confidential youth-focused service in an easily accessible location.

New Zealand has high rates of youth mental health issues

Young New Zealanders have high rates of mental health issues and the highest youth suicide rate in the OECD. Of the young people surveyed in 2012, 12.8% had experienced significant depressive symptoms in the previous 12 months, 24.0% had deliberately self-harmed, and 15.7% had had serious thoughts of suicide. There was little variation by deprivation level. Only 18.4% of young people had seen a health professional for emotional worries, with students from low deprivation areas being least likely to have done so, despite similar rates of depression.[6]

Mental health issues are associated with risky behaviours, and decreased participation and achievement at school. This can flow through to lower rates of workforce participation in later life. Recurrence of depression between ages 16-21 leads to worse mental health outcomes, and is correlated with increased welfare dependence and unemployment in early adulthood.[7]

Easily accessible care at an early stage can make a big difference

Easily accessible health care increases the chances that problems will be addressed early. Early intervention can prevent the development of more serious mental and physical health conditions and their associated costs.

Many mental health conditions have their origins in early life, with symptoms often beginning in adolescence[8]. Half of all mental health conditions begin by age 14.[9] By providing students with accessible and age-appropriate care at this crucial point in life, we can help mitigate the effects of mental health problems. This will reduce the future number of people on benefits, in prison, and/or needing intensive mental health support.

This initiative will complement other components of the mental health package by providing early intervention mental health care to young people, reducing the likelihood that they will require more

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[4] Although Māori, Pacific, and low income students are more likely to attend low decile schools, a significant proportion of each group attends decile 5-10 schools.

[5] Adolescent Health Research Group. 2013, pages 86-87

[6] Adolescent Health Research Group. 2013, pages 97-98. Of young people from least deprived areas, 30.0% had been depressed for at least two weeks in a row, but only 15.4% had seen a health professional for emotional worries. For young people from the most deprived areas, the figures were 32.6% and 22.2%, indicating that the treatment gap is wider for more advantaged students. This may reflect the accessibility of SBHS in low decile schools.

[7] Gibb SJ, Fergusson DM, Horwood LJ. 2010. Burden of psychiatric disorder in young adulthood and life outcomes at age 30. *British Journal of Psychiatry*. 197: 122-127, doi: 10.1192/bjp.bp.109.076570

[8] Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R. 2003. Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. *Arch Gen Psychiatry* 2003; 60(7): 709-17; Copeland WE, Shanahan L, Costello EJ, Angold A. 2009. Childhood and adolescent psychiatric disorders as predictors of young adult disorders. *Arch Gen Psychiatry*. 66(7): 764-72; Copeland WE, Adair CE, Smetanin P, et al. 2013. Diagnostic transitions from childhood to adolescence to early adulthood. *J Child Psychol Psychiatry*. 54(7): 791-9.

[9] World Health Organisation. Adolescents and Mental Health. *Available at*: http://www.who.int/maternal_child_adolescent/topics/adolescence/mental_health/en/

	intensive intervention later in life. It will also help identify young people who do require more intensive mental health support, and refer them to appropriate services. SBHS will also help improve other health and socio-economic outcomes. For example, there is a strong association between teenage pregnancy and inability to access healthcare.[10] Improving youth access to primary care will help reduce teenage pregnancy rates and prevent the poor outcomes associated with teenage parenthood. It is likely that improved access to primary healthcare, particularly the universal health check, will increase the number of young people referred to specialist services. However this increased demand should be balanced by decreased demand for intensive services, as problems are addressed before they reach a crisis point.
Implementation, Monitoring and Evaluation	
How will the initiative be delivered?	The Ministry of Health will fund the required nurse FTEs to implement SBHS. As is currently the case, the FTEs will be delivered in a range of ways including via PHOs, public health nurses, Youth One Stop Shops (YOSS), and direct employment by the school or DHB. **Risks:** The Ministry of Health has identified three key risks to this initiative: workforce capacity; lack of infrastructure and/or non-teaching spaces suitable for healthcare provision; and the need to balance delivery of universal health checks with other priorities. **Workforce capacity** The main risk to this initiative is inadequate workforce capacity. s 9(2)(f)(iv) [redacted] Workforce capacity issues will be addressed in the following ways: • s 9(2)(f)(iv) [redacted] • The Ministry will work with the Ministry of Education to identify health services already provided in schools that can be leveraged as providers of SBHS. • An electronic HEEADSSS assessment will be introduced. This should reduce the time required with individual students at each appointment, allowing SBHS nurses to focus on young people who need the most help. **Infrastructure / non-teaching spaces** An unknown number of schools lack the infrastructure and/or suitable non-teaching spaces needed to deliver SBHS. The results from the Ministry of Health stocktake of SBHS, due in January 2019, will examine the extent of this issue, s 9(2)(f)(iv) [redacted]. In the interim, roll out will be based on the availability of facilities for the delivery of SBHS.

[10] Copland R, Denny S, Robinson M, et al. 2011. Self-reported pregnancy and access to primary care among sexually experienced New Zealand high school students. *Journal of Adolescent Health*. 49(5): 518-524. https://doi.org/10.1016/j.jadohealth.2011.04.002

	s 9(2)(f)(iv) [redacted] **Balancing universal health checks with other priorities** SBHS is a means to deliver the coalition agreement commitment to a universal health check [redacted] s. 9(2)(f)(iv) [redacted]. There is a risk that the check, which would normally take about 45 minutes per student, will dominate nurse time. This would prevent students from accessing SBHS for individual health issues. In order to mitigate this risk, the Ministry is introducing an electronic HEADSSS assessment, which would reduce time spent on Year 9 health checks.
How will the implementation of the initiative be monitored?	s 9(2)(f)(iv) [redacted]
Describe how the initiative will be evaluated	Funding for an evaluation of SBHS is included in the initiative. The evaluation plan will be established in Year 1. [redacted] The evaluation will provide data on the mental and physical health of young people in relation to the availability and use of SBHS. [redacted]
Detailed funding breakdown	
Please provide a breakdown of the costs of this initiative	[redacted]

[redacted]

The majority of the funding is directly for increased service provision, including improving nurse/student ratios and nurse salaries at decile 1-4 schools. The rest will be spent on workforce development, programme support, and evaluation, [redacted]

[redacted]

No capital funding is sought for this initiative.

[redacted]

Options for scaling and phasing

Scaling, phasing or deferring - including 75% and 50% scenarios

Deferring

Deferring this initiative will delay the benefits. It is not anticipated that it would cause any other changes.

Phasing

s 9(2)(f)(iv) [redacted]

[redacted]

Scaling

s 9(2)(f)(iv) [redacted]

[11] For comparison, expanding to decile 3 (an additional 20,000 students) took two years.

[12] The Ministry of Education funds all aspects of state-integrated school operations, except some property expenses, on the same basis as state schools.

	s 9(2)(f)(iv) [redacted]

	s 9(2)(f)(iv) [redacted]

[13] No figures are available on the level of unmet need by school type.