

Report on the Youth Health Workforce Service Review

April 2011

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Members of the Review Team

Lead:	
Maria Kekus	Executive Officer SYHPANZ and Clinical Leader Child, Youth and Primary Mental Health, HealthWEST PHO
Gill Alcorn	Nurse Practitioner, Youth Health Vibe Youth Health Service, Hutt Valley DHB
Stephen Bell	CEO and Specialist Youth Worker Youthline
Dr Sue Bagshaw	Specialist in Sexual Health and Youth Health, Christchurch
Dr Hugh Clarkson	Child and Adolescent Psychiatrist Counties Manukau DHB
Dr Terryann Clark (Nga Puhī)	Specialist Youth Health Physician Department of Paediatrics, Child and Youth Health, University of Auckland
Dr Simon Denny	Specialist Paediatrician, Department of Paediatrics, Child and Youth Health, University of Auckland
John Heyes	Principal Mangere College, Mangere College
Dr John Newman Tainui	Specialist Youth Health Physician, HealthWEST PHO and Raukura Houora O Tainui
Dr Tania Pinfold	General Practitioner, specialising in Youth Health Rotovegas Youth Health
Project Manager	Sue Ineson
Senior Policy Analyst, HWNZ	Megan Larken

1. Introduction

The aim of the youth health workforce service review is to develop a vision of quality health services for young people and the workforce needed to deliver those services by 2020. This review was one of several such reviews conducted with the support of Health Workforce New Zealand.

These health services need to be youth-centered, involve young people and wherever possible be delivered in primary care. The services also need to address inequalities and increase access for vulnerable and at risk young people.

New Zealand has a poor youth health record, not only in terms of young people's wellbeing but also in terms of the current health services structure and its ability to meet their needs. In comparison with other OECD countries, New Zealand's young people have among the highest rates of suicide, motor vehicle accidents and STIs. Their health status has made least improvement than any age group over the past 40 years. New Zealand has been slow to address these issues. Historically, response to these issues has been poor, with low rates of training in adolescent medicine among primary care providers, few specialist youth health clinicians nationally and few services available specifically for young people.

To address these concerns and develop ways to improve services for youth, the working group developed their recommendations during two meetings followed by email and phone contact. The group began by discussing several vignettes or scenarios which illustrated typical health issues facing young people (10 - 24 years). The group then developed an "ideal" model of care for each vignette, based on their combined experience and drawing on information from a range of other sources including data from consultation with young people and youth workers in Te Remu Tohu.

The resulting analysis forms the basis for the recommendations outlined in this report. The vignettes /scenarios are detailed in Appendix 1.

2. The vision for effective health services for young people

The vision for 2020 is that:

- Young people have access to quality acceptable healthcare, readily and frequently.

- Major morbidity and mortality for young people arising out of emotions, behaviours, violence and problems of youth development will have decreased.
- Young people lead healthy lives so they can contribute actively to society.

These services will include the following:

- Primary care services which are acceptable to young people – youth friendly services.
- Secondary and tertiary services which are responsive to young people’s health and development.
- Youth specific health care services for young people who are vulnerable or at risk – these are health services which are focused on the major causes of morbidity and mortality and need to include services for rangatahi that reflect their cultural needs.
- Services where young people’s needs are regularly reassessed.
- Services where young people are involved in healthcare as participants as well as consumers.
- Services which are based on new learnings, research and skills are incorporated into services and resources are diverted away from ineffective services.
- Interdisciplinary ways of working with effective contracting

To deliver these services the workforce needs:

- A primary health care workforce that has basic training in youth health
- A secondary and tertiary workforce that is responsive to young people’s health and development.
- Medical and nursing leaders available to research, train, teach and guide service development.
- Career paths and recognition of those wishing to specialise in youth health
- An integrated youth worker in a health role – who can support young people to navigate health services.

To increase the productivity of service provisions by 2020 while delivering enhanced care for young people the following is required:

- Appropriate primary care services (such as school-based clinics and community based health care services) which will encourage young people to access care earlier and thus reduce the delayed treatment which is often more costly and complex.
- Investment in preventative health services for young people to reduce the costs of treating the diseases and ill-health among adults that result from adolescent-onset behaviours.

- Services which are developmentally appropriate for young people, with staff being trained to deliver comprehensive psychosocial assessment tools to identify current and potential health risks early.
- Contracts with providers of services for young people that have interdisciplinary ways of working to reduce transactional and compliance costs.

3. Primary recommendations

Recommendation 1 – *That appropriate and accessible services for young people are developed.*

It is recommended that the NHB require all DHBs to provide supportive interdisciplinary care that is accessible and appropriate to young people who are consumers of that care. Holistic multi-agency care provided across sectors will reduce inefficiencies and provide more cost-effective services.

Recommendation 2 – *That the workforce for young people is trained so it is competent.*

It is recommended

- that HWNZ purchase post graduate clinical training so that there is an increase in the number of well trained health professionals who work with young people.
- that the NHB and DHB use the contracts negotiated with youth health care services to ensure all health professionals who work with young people are trained and have the necessary skills and competencies to interact appropriately and effectively with this age group.

Recommendation 3 – *That future clinical leaders and researchers are developed to support the workforce and inform service development.*

It is recommended that NHB and DHB use the contracts negotiated with youth health care services to ensure clinical leadership is evident and service delivery is based on good research.

4. Secondary recommendations

It is recommended that:

- The following effective models of primary health care services are funded and developed to meet specific communities' needs:
 - School based health services,
 - Enhanced general practice services,
 - Youth health community services.
- Contracts between DHBs and youth service providers require interdisciplinary and coordinated care.

- Contracts between DHBs and reliable and proven youth service providers are for longer terms.
- Health services for young people do not focus on a single issue (that is, not on single issues like reducing violence, crime, alcohol and drugs including tobacco use and risky sexual behaviour) but collaborate with other government departments, NGOs and voluntary services to deliver a holistic service.
- Inter Ministry work is undertaken to define and implement a framework so that all school nurses whether employed by health or education are competent and skilled to deliver safe, quality nursing care.

HWNZ facilitate the implementation of the development of a ten year workforce development plan based on the framework Te Remu Tohu¹.

- Resources are moved from the DHB mental health services into supporting those working with youth in the community which will decrease costs, result in better health outcomes and help break down the primary- secondary service divide.
- Public health nurses (PHN) are employed by primary care and allocated to secondary schools and the associated intermediate and primary schools to deliver school based services and effective health promotion.
- Effective use of social media is explored to promulgate specific, positive public health messages for young people in the context of the audience's wider needs, rather than in a problem-specific way.

5. Recommendations to develop effective services for young people

Recommendation 1 - *That appropriate and accessible services for young people are developed.*

It is recommended that the NHB require all DHBs to provide supportive interdisciplinary care that is accessible and appropriate to young people who are consumers of that care. Multi-agency care provided across sectors will reduce inefficiencies and provide more cost-effective services.

¹ Te Remu Tohu is an overarching framework for youth health workforce development.

Background

Young people need developmentally appropriate health services that are able to engage, identify and treat youth health concerns in primary care settings and secondary and tertiary services. There is good evidence that these services and interventions can improve young people's health and wellbeing.

Unfortunately, most health care providers have little training in adolescent health, feel uncomfortable providing care to adolescents and don't know what to do when faced with an adolescent engaging in risky behaviours. They are, therefore, ineffective in addressing the main health concerns of this population. This has important implications for the future health of our population, as the main determinants of adult health, such as smoking, obesity and lifestyle behaviours have their onset during childhood and adolescence. The costs of treating the resulting diseases and ill-health among adults that result from adolescent-onset behaviours are immense and much higher than investing in preventive health services for young people. Furthermore, the health issues during adolescence impact on young people to engage in education and training and to participate positively in their communities which is vital if New Zealand is to have a functioning workforce and vibrant healthy communities in future years.

Appropriate and accessible services include the following services.

5.1 Primary care services which are acceptable to young people – youth friendly services

In general New Zealand primary care services are not orientated to the needs of young people and this is demonstrated through large numbers of young people reporting unmet healthcare needs and low uptake of primary care services (Ministry of Health, 2002).

Young people identify a number of barriers to accessing health care, distance to travel, cost, inconvenient times, concerns about confidentiality, lack of cultural appropriateness, and not feeling comfortable with the health provider (Buckley et al 2009).

Youth-specific services are designed to overcome these barriers. **Models of care such as school-based health services and community based services such as 'one-stop shops' and enhanced general practice services which are staffed by people who are welcoming are easier for young people to access.** Young people's perceptions of services and willingness to seek care are dependent on the quality of such services and especially whether they are assured of confidentiality and privacy. Appendix 2 indicates the services that can be provided by a school clinic, where most of the health needs of 3750 young people are met within a budget of less than \$400,000 p.a.

5.2 Secondary and tertiary services which are responsive to young people's health and development

Young people with chronic illness are identified as having high needs and are often high frequency consumers of healthcare throughout adolescence. Untrained clinicians complain that young people with chronic illnesses are often non-compliant and frequently do not attend follow-up clinic appointments.

These issues are costly and impact negatively on young people's health, and reflect that current services are not meeting the needs of adolescents with chronic illness.

Therefore staff who work with young people in secondary and tertiary services must be able to engage and work effectively with young people with chronic health conditions, and refer on to expert youth health services when necessary.

In turn this will result in cost savings, for example a youth focused diabetes early intervention service delivered by appropriately trained clinicians', costs in the order of \$2000 compared to the cost of treating renal failure later in life which is about \$1 million. This is illustrated in Appendix 3.

Young people are not always appropriate users or attendees of hospital based services. For example young people are high users of emergency services as they are open long hours and are free of charge. Often the young person does not engage with the service until crisis point. This is neither cost-effective nor a good use of resources. Use of emergency services by young people is higher than other age groups as shown by the graph in Appendix 4.

5.3 Youth specific health care services for young people who are vulnerable or at risk. These are health services which are focused on the major causes of morbidity and mortality and need to include services for rangatahi that reflect their cultural needs.

While for the majority of young people, the adolescent years are navigated successfully and without problems, there is a substantial minority for whom the adolescent years herald the onset of mental health concerns, risky behaviours such as substance use and other issues that can impact negatively on their current and future wellbeing.

Various estimates of the numbers of young people experiencing such issues and concerns are between 5 and 10%² of the total youth population. The magnitude of which means that in the future a stepped approach to youth health services is required with primary care and school-based services providing the bulk of care to young people.

In addition, skilled clinicians are required to address the needs of young people with chronic illness and disease (e.g. diabetes, mental health concerns), those who are in care and protection and/or the youth justice system, refugee, migrant and homeless young people, and those with high needs relating to socio-economic factors.

Māori young people have significant health disparities and require specific strategies and a workforce that acknowledges their cultural and developmental needs.

Therefore specialist youth services are required to provide support to primary care providers and further care and intervention as necessary throughout New Zealand. For some marginalised and vulnerable young people, specific youth health services are required in order to be able to provide outreach and other services to this population.

To date service provision has been developed along systems or problem focussed domains for example alcohol and other drugs, mental health, sexual health. Sooner, better, more convenient services would take a holistic approach and be able to work across agencies, deal with co-morbidities and identify health and disability needs earlier and therefore intervene, treat and case manage these young people's complex health and social problems effectively and efficiently.

Therefore health services for young people should not focus on a single issue; they should deliver a holistic service.

5.4 Services where young people's needs are regularly reassessed

Early intervention and anticipatory strategies will reduce the costs and the resources required to deliver effective health services to young people by decreasing the need to refer to, and the use of, expensive secondary and tertiary services.

Use of a comprehensive psychosocial assessment tool (for example HEeADSSs³) will ensure a developmentally appropriate history is taken and appropriate case

² This percentage was assessed by reviewing statistics from the Police, Youth Justice and CYF including numbers of children in need of care and protection, youth offending statistics, youth apprehension rates and court appearances by young people.

³ HEeADSSs is a screening tool that includes interview questions relating to the Home, Education and employment, Exercise and Eating, Activities, Drugs, Sexuality, Suicide and depression and other mental health issues, spirituality including culture, safety and strengths.

management, interdisciplinary care and care plans are developed in consultation with a young person and their whānau/family. This would require adequate training, and resources so any identified concerns could be followed up.

A skilled youth health workforce will ensure early identification of the health needs of specific groups. These include those who may be vulnerable to risky behaviour or poor health. For example, Chlamydia screening and early treatment is far more cost-effective and will reduce morbidity compared to the costs of treating serious short and long-term reproductive health problems and infertility resulting from untreated Chlamydia. (Ward, 2006) (Paavonen, 1997).

School based health care provides an environment where young people can access and receive consistent health care. The Lane (Literacy and Numeracy Empowerment) research project at Linwood College gave Year 9 students a health assessment, offered treatment. This was followed up by comparing the academic results of the treated group with a control group. The results showed that the interventions had a positive impact on student academic performance with the most significant impact being the acquisition of glasses in year 10.

5.5 Young people are involved in healthcare as participants as well as consumers

Youth participation describes young people's active involvement in developing, implementing, reviewing and evaluating services and programmes intended for their benefit. It requires designing formal structures and youth-friendly mechanisms through which young people can express their opinions and exercise decision-making power. Where youth specific community health services are provided it is recommended that youth participation is required as part of the service specifications in funding contracts.

5.6 Services are based on new learnings, research and skills are incorporated into services and resources are diverted away from ineffective service

An evidence-based programme is able to demonstrate that its development has been based on a reliable assessment of need derived from a range of information sources ('evidence'), and also that its strategies were designed according to good practice standards determined by local, national and international guidelines. Adopting an evidence-based approach uses lessons learned from other programmes, thus reduces the risk of 're-inventing the wheel'. Also, an evidence-based approach helps to ensure an efficient use of resources.

For example, evidence for specialist services that are single issue based may not be the solution for good health outcomes for young people who may have multiple needs.

5.7 Interdisciplinary ways of working with effective contracting

As can be seen by the scenarios, a proportion of young people (5-10%) have to deal with many agencies. Many of the health problems young people experience are psychosocial, so holistic, youth-specific primary care with links to other social services, will save downstream costs in the form of a reduced burden on secondary health services, ACC, Child Youth and Family services, police, the justice system, local governments, income support services and housing. **Interdisciplinary and coordinated care will be more effective and less expensive.**

As noted in the vignettes, those delivering services to young people often work with multiple service contracts, for small amounts of money, for short time periods, with multiple reporting requirements.

This method of funding fragments service provision, is inefficient and deters all except the most committed people to engage in service development. **Better, longer contracts would reduce transaction and compliance costs improving efficiency for both funders and providers.**

6. Recommendations to ensure the workforce is competent

Recommendation 2 – *That the workforce for young people is trained so it is competent.*

It is recommended

- that HWNZ purchase post graduate clinical training so that there is an increase in the number of well trained health professionals who work with young people.
- that the NHB and DHB use the contracts negotiated with youth health care services to ensure all health professionals who work with young people are trained and have the necessary skills and competencies to interact appropriately and effectively with this age group.

Recommendation 3 – *That future clinical leaders and researchers are developed to support the workforce and inform service development.*

It is recommended that NHB and DHB use the contracts negotiated with youth health care services to ensure clinical leadership is evident and service delivery is based on good research.

Background

Healthcare providers who have been trained in youth health have unique skills and abilities that make them effective in improving outcomes for young people. They are able to engage and communicate with young people, which is a fundamental attribute required before effective interventions can even be considered. These

providers are trained to work with families because most effective interventions with young people have, as their basis, a family/ whānau approach and orientation. They can also work across the traditional silos of healthcare systems; they can diagnose mental health issues and treat appropriately; they can work with drug and alcohol issues; they can provide as-needed sexual and reproductive health treatment and advice; they can address behavioural issues in the home and school. Lastly, they are able to work across agencies and disciplines, such as school systems, effectively. Research again has demonstrated that these are essential attributes of effective services for young people. No other discipline has this requisite set of skills and knowledge and is able to provide services that are cost-effective and appropriate. To date, New Zealand's approach has been to treat adolescents as either children or adults, or ignore them altogether.

A workforce with these capabilities would result in an improvement in young people's health and wellbeing, reducing the rates of teen pregnancy, road traffic injuries, violence and substance abuse and thereby reducing immediate and future costs to the health system. High quality youth health services delivered in a primary care setting would also be likely to result in fewer youth suicides and less utilisation of hospital services by young people with chronic illnesses. There are also likely to be wider benefits, including better engagement in education and training, more young people prepared and ready for employment opportunities and greater stability and functioning within communities.

To achieve a workforce with these capabilities investment is required both in training in adolescent health and also in the leadership of this workforce.

Appendix 5 sets out a potential framework to support workforce development. A curriculum for qualifications in Youth Health for entry into a vocational scope of practice is in draft.

Strategies to ensure the workforce is competent are as follows.

6.1 A primary health care workforce that has basic training in youth health

Undergraduate training for doctors and nurses

All doctors and nurses should have basic knowledge and skills in engaging and assessing young people learnt via a curriculum that includes youth development issues, physical health issues and talk therapies. Therefore youth health training needs to be embedded in undergraduate training in nursing and medicine

School nurses

School nurses are an important part of the primary health care workforce working with young people.

Currently, school nurses are employed by health or education. There is health funding for school nurses in Decile 1 and 2 schools only. School nurses require diverse skills and knowledge to address the needs of the young people they see. They often practice in isolation to other health professionals. There are many inconsistencies in training and competence between those employed by the Ministry of Education and those working in Health. For example, school nurses employed by the Ministry of Education have little or no access to professional development and it is not known how many have a current practicing certificate under the Health Practitioners Competence Assurance Act 2003. Education does not have guidelines on employing school nurses.

One of HWNZ's criteria for post-entry nursing education funding the requirement that the nurse "be currently employed as a registered nurse by a health service that is funded by the District Health Board or Ministry of Health from Vote Health", this excludes school nurses who are paid by the Ministry of Education.

To ensure that all school nurses are competent and skilled to deliver safe, quality nursing care it is essential that inter-Ministry work is undertaken. This would require the Ministry of Health and the Ministry of Education to develop guidelines on employing nurses in educational settings. Requiring contracts that specify a level of youth health training would help to ensure that all school nurses are competent and skilled to deliver safe and effective care to students in school settings.

6.2 A secondary and tertiary workforce that is responsive to young people's health and development

This requires a medical and nursing workforce who can address young people with complex, severe and chronic problems. These highly complex problems require highly trained and skilled staff who work in multi-disciplinary, multi-agency ways.

There are many who work with young people in this workforce. But some work particularly closely within their specialist area, e.g. respiratory medicine, rheumatology, mental health, addiction, oncology, and gastroenterology. This workforce requires knowledge and skills to engage and work effectively with young people. A recent example of a workforce initiative from the Royal College of Australian Physicians is the development of the Adolescent and Young Adult Advanced Training Curriculum (www.racp.edu.au) The aim of this Advanced Training Curriculum is to train specialists who will not only become excellent clinicians but who will also become leaders in the field of adolescent and young adult medicine.

Staff who work with young people in secondary and tertiary services must be able to engage and work effectively with young people with chronic health conditions and refer on to expert youth health clinicians when necessary.

6.3 Medical and nursing leaders are available to research, train, teach and guide service development.

Currently there is a shortage of services that are youth focused and these may not be able to be delivered in some rural and provincial communities. Networks of clinicians' expert in working with young people will be able to support and advise staff in general services in these communities. These networks will support implementation of DHB youth strategies and service delivery and link with HWNZ regional service delivery and training hubs. The networks also have the ability to support and connect primary, secondary and tertiary services that interface with young people.

Therefore there needs to be investment in the development and training of future clinical leaders and researchers able to support workforce and inform service development.

It is recommended that NHB and DHB use the contracts negotiated with youth health care services to ensure clinical leadership is evident and service delivery is based on good research.

6.4 Career paths and recognition exist for those wishing to specialise in youth health

This requires a recognised curriculum, diplomas, Medical and Nursing College recognition, Medical Council recognition (scope of practice).

A specialised youth health workforce is needed across all professional disciplines. Training can be altered in a number of ways but some strategic changes would result in enduring and broader change. Postgraduate training in youth health should be aimed at two groups:

- **Fellowships for clinical leaders. This training should be at post fellowship level lasting around two years and be built around:**
 - Research
 - Clinical skills
 - Clinical leadership

This will require funding for a two year fellowship for clinical leadership in each of the four main academic centres with consideration given to a post in the Hamilton region as well. This training could be overseas in recognised youth training universities but

some could perhaps be done in New Zealand if any training centres meet criteria. The objective would be to train four or five academic and clinical leaders over a ten year period. Some bonding may be required. The academic level is at doctorate standard. Suitable candidates would be physicians, paediatricians, psychiatrists and expert nurses. This links with HWNZ's regional training hubs. In addition, HWNZ could ensure youth specialties are included in its investment plan, voluntary bonding scheme and advanced trainee fellowship scheme.

- **Diplomas for youth health practitioners. This training should be pre-fellowship training at a postgraduate diploma level.**

This would be either full or part time with an opportunity for the majority by distance learning. The target clinicians would be trainees in general practice, paediatrics, psychiatry, nursing and would be at the early training scheme years. Ten to twenty graduates per year would result in 100 to 200 medical and nursing practitioners with good youth skills over a ten year period. A proposed curriculum is in draft and can be accessed from SYHPANZ.

This would result in:

- Improved practice over a large part of New Zealand,
- Recognition of knowledge and skills in youth health
- Establishment of career paths in youth health
- Impact on other medical and nursing practitioners through dissemination of knowledge and skills through teaching and practice.

6.5 An integrated youth worker in health role – to support young people to navigate services

The vignettes described one worker who has the primary relationship with a young person and his family who can assist the young person and their family access the service providers they need. This would be “a **connector person**” or “**health navigator**” to link the young person and their family to other service providers, someone who engages well with the young person and gives the young person a consistent point of contact and a way to access other expertise and services.

7. Workforce Implications

As noted in the recommendations, a well trained workforce is crucial to deliver effective services for young people. Currently this workforce is often not appropriately trained, supported, or rewarded. There are few options for career development, so experienced workers often do not remain in the health workforce.

Many health professionals can have difficulty maintaining general scope of practice when they work predominantly or exclusively in the area of youth health. Additionally there has been little or no investment in workforce development for this sector. Recent philanthropic investment has created the capacity for it to gain traction to date.

A better trained workforce could be achieved by ensuring that there is a recognised, nationally consistent career pathway for all health professionals (doctors, nurses and allied health professionals including youth health workers).

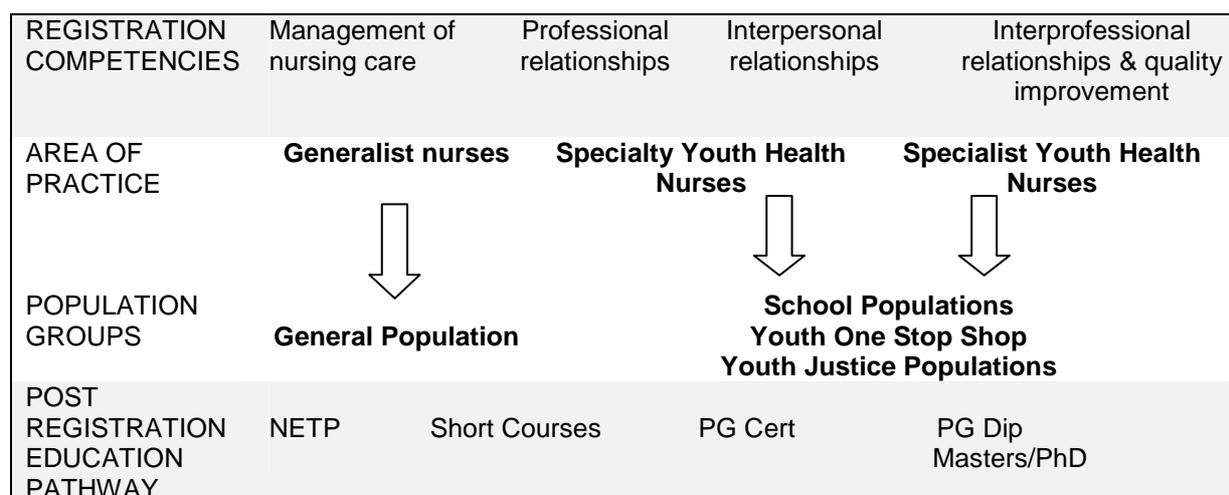
As noted in the recommendations, a framework for those who work with young people should have modules of learning aimed at:

- Giving youth workers in health a recognised qualification on the NZQA framework.
- Giving allied health professionals modules for professional development.
- Giving nurses who work with young people, regardless of their employer, access to postgraduate training.
- Giving doctors a specialist qualification that could lead to a vocational scope of practice recognised by the Medical Council.
- Requiring a specific youth module for GPs training to gain vocational registration.

This modular approach to training focuses on the specific professional's needs and takes into account their former training at all levels and across all those in health working with youth. The result would give more expertise and effective professional development and lead to better services for youth. Evidence shows that this modular multi-disciplinary approach is effective.

Diagram 1 from the Draft National Youth Health Nurses Knowledge and Skills framework demonstrates how these standards can sit alongside the current competencies for the Nursing Council of New Zealand and add value to practice knowledge and skills.

Diagram 1: Youth Health Nursing Career pathway



It is also recommended that HWNZ facilitate the development of a ten year plan based on the framework Te Remu Tohu⁴

Te Remu Tohu is an overarching framework for youth health workforce development. What is unique about this workforce framework is that it was developed by an interdisciplinary group which also included young people and youth workers. Its recommendations also support a commitment to ongoing interdisciplinary work. Further investment is required to develop an action plan for the next ten years. This would then inform workforce planning, ensuring the right workforce is present to meet the needs of young people and their families/whānau in 2020.

8. Links to HWNZ Major Themes

8.1 Move to hub and spoke service configurations/regionalisation of services

There is limited expertise in the delivery of youth health services. The sector would benefit from development of formal regional “centres of excellence” and/or a “hub and spoke service configuration” with networks of clinicians’ expert in working with young people will be able to support and advise staff in general services in these communities.

These networks will support implementation of DHB youth strategies and service delivery and link with HWNZ regional service delivery and training hubs. Therefore there needs to be investment in the development and training of future clinical leaders and researchers able to support workforce and inform service development.

⁴ Te Remu Tohu is an overarching framework for youth health workforce development.

It is recommended that the NHB and DHB use the contracts negotiated with youth health care services to ensure clinical leadership is evident and service delivery is based on good research.

This would be a cost-effective way of organising the services, improving knowledge, and working with young people in primary care and smaller community services. A regional configuration of services would be especially useful in smaller provincial centres which may not be large enough to support youth specific health services.

While personal contact with young people is ideal, in rural areas the development of confidential services using text and email may be appropriate. These services could gain supervision and advice from others in the region or at the hub.

8.2 Moving from specialist, office based services towards flexibly sited services that relate to the wider community can result in better, sooner more convenient and timely services

Generally the working group was concerned that well funded, office based specialist services such as in mental health are under-delivering compared with holistic youth services that take into account youth development and work intersectorally.

Advice from secondary mental health specialists directly to those working in the community with youth would be a more effective way of delivering these services to young people. **Therefore moving some resources from the DHB mental health services into supporting those working with youth in the community will decrease costs, result in better health outcomes and help break down the primary- secondary service divide.**

Mental health problems for young people are often related to lifestyle and environment and may be very amenable to a developmental approach coupled with good primary mental health services.

Young people and Maori typically do not want to attend an identifiable mental health service; they want a holistic service that meets all their health needs in the community. This reorientation would result in better use of resources, as has been shown by utilisation rates by young people who are Maori in the primary mental health service called Your Choice. This service is built into the existing Waitakere Youth Health Clinic, which is itself a 'hub' allowing seamless youth services to West Auckland youth. Your Choice operates by contracting out community-based psychologists, psychotherapists and counsellors. This innovative approach to mental health service delivery has allowed Your Choice to work alongside existing services (GPs, secondary services and NGOs) to reach vulnerable young people. Evaluations of this service show that 34 percent of the young people who completed a care

package were Maori, and 21 percent were 'hard-to-reach' (quintile 5). (HealthWEST PHO, 2011)

Young people are not always appropriate users or attendees of hospital based services, for example young people are high users of emergency services as they are open long hours and are free. **Often the young person does not engage with the service until crisis point.** This is neither cost effective nor a good use of resources. Use of emergency services by young people is high as shown by the graph in Appendix 4. Appropriate and accessible primary health care services delivered through enhanced general practice teams, school based and community youth health services may reduce this high utilisation.

Services that focus on reducing violence, crime, alcohol and drugs including tobacco use and risky sexual behaviour need to look to functional collaborations with other government departments, NGOs and voluntary services. **While focus on secondary prevention (“fixing up the mess”) is still necessary, interventions that engage young people who present with risky and dangerous behaviours need health sector involvement but not health sector control. This can be provided by health staff working in an intersectoral team.**

8.3 Impact of new technology

Communication technologies such as website, Facebook, and texting have become important and useful ways of reaching young people with information and messages.

Youthline uses telephone and texting for crisis intervention and existing on-line platforms are already being used to allow youth workers to text clients safely. There are cases of suicides being prevented via digital communication. A body of knowledge around online/text is being developed in Youthline.

There could be benefits by an increased use of social media for public health messages. Already young people are using these forms of communication in negatively influenced sites where young people can “talk” about self harm and anorexia, or risky behaviours such as heavy drinking. Alcohol marketers make full use of social media. We need to counter these negative influences.

Social media can be used to promulgate specific, positive public health messages. To ensure that digital tools such as websites and new media are cost-effective, it is important that options are considered in the context of the audience's wider needs, rather than in a problem-specific way.

Another possible use is that in certain situations, “good behaviour” may be incentivised using the value of cell phones, for example, giving phone credits to a young person who achieves improved diabetic control.

Response to new media in the sector has been slow and the concern is that huge resource is needed. That said, the great potential of these advances cannot be ignored.

In terms of usage of services, young people are better users of technology which may lead to better use of technology to maintain self care. SPARX is a computer-based cognitive behaviour therapy programme for young people with mild to moderate depression. The programme is being piloted (University of Auckland) and an evaluation report (to the Ministry of Health) is due shortly.

8.4 Impact of generation “y”

Youth workers in health and peer educators are a potentially important health workforce for this age group. As noted in section 6.5, they need good training and supervision programmes and appropriate recognition of their expertise with improved pay. Currently low rates of pay and lack of career development discourage youth workers from making this work a long term commitment.

Many young people are interested in the work environment as much as professional issues and in order to attract good staff for youth health services, more flexible employment and the ability for staff to incorporate work life balance is needed. Employers need to capitalise on the attributes of generation Y rather than focusing on their differences from older generations with a different attitude to work.

8.5 Improved productivity (to meet increased demand for services in 2020 in a constrained fiscal environment)

More effective youth health services and early intervention would make savings.

To increase the productivity of service provisions by 2020 while delivering enhanced care for young people the following needs to happen:

- Appropriate primary care services (such as school based clinics and community based health care services) will encourage young people to access care earlier and thus reduce costs to the system of delayed treatment, which is often more costly and complex.
- Investing in preventative health services for young people reduces the costs of treating the diseases and ill-health among adults that result from adolescent-onset behaviours.
- Services must be developmentally appropriate for young people, with staff being trained to deliver comprehensive psychosocial assessment tools to identify current and potential health risks early.

- Contracts with providers of services for young people should require interdisciplinary ways of working to reduce transactional and compliance costs.

8.6 Clinical networks

SYHPANZ has already started to develop clinical networks across New Zealand to spread expertise, enable access by smaller services to advice and to increase professional development for a youth focused workforce. **These clinical networks need to be formalised and increased to support clinicians working in isolation.**

9. Sector Activity

9.1 Ministry of Health and intersectoral initiatives

There are a number of intersectoral government initiatives at various stages of development. Inter-sectoral stakeholders include: the Ministries of Education, Youth Development, Social Development, Child Youth and Family, Justice and Police.

Current intersectoral initiatives relevant to youth health are:

- Whānau ora services, which aim to provide integrated services – this is similar to a youth health development approach.
- Trialling New Approaches to Social Sector Change is intended to improve the social sector by focussing responsibility for social outcomes and reorganising funding and decision rights. The Ministry of Social Development (MSD) is leading a multi-agency team which is piloting four pilots, beginning January 2011. These will see diverse contracts being pulled together and managed in a cohesive manner through one point to ensure that the right services are provided to meet outcomes for young people (12-18 years), responsive to local needs.
- Youth Pipeline is work by MSD and the Ministry of Education on services and supports for youth 15-24 to stay in employment, education and training. The report to the SOC meeting proposes a work programme to June 2011. It identifies mental health and AOD as important barriers, which need responses. MSD intends to involve Justice and Health in the next phase.
- The Drivers of Crime work programme, which aims to address crime prevention. The four streams of this programme are focussed on parent education programmes for families with primary school aged children, alcohol policies, and managing offending.
- The Government's response to the Welfare Working Group's recommendations.

The first three of the above initiatives affect youth health services and could potentially improve outcomes. However, there is a risk that resources may be targeted to specialist services such as AOD for youth, or top-heavy pilots or programmes, whereas resources could be better spent on youth health services.

Some primary mental health funding has been used in youth services. The total primary mental health funding is \$23.7 million per year, administered by Ministry of Health contracts with DHBs, which allocate the money to PHOs for primary mental health services, particularly targeting disparities.

Another relevant primary care initiative is the proposals for Integrated Family Health Centres.

9.2 National Health Board

This paper has identified recommendations relevant to the National Health Board's contracting function, and the Health IT Board. There are no recommendations for the Capital Investment Committee.

9.3 Regional Plans

There is potential for a regional approach to identifying the best spread of youth health services.

9.4 DHBs

DHBs are required to produce a 'Youth Health Plan' as part of their accountability package. However, these are not always available on DHB websites, nor is it clear whether they are being implemented.

10. Rationale and evidence for need for and effectiveness of youth health services

10.1 Introduction

Adolescence is a period of significant developmental change spanning physical, biological, social and psychological transitions from childhood to young adulthood. There are well established developmentally based services for age groups like paediatrics for children and in gerontology for the older adult. These developmental approaches acknowledge that specialist knowledge and skills are required to provide appropriate and effective healthcare. Providing effective healthcare for young people will require a similar developmental approach in order to reduce any excess morbidity and mortality.

Health-seeking behaviours established during adolescence can have a significant impact on immediate and long-term health and social outcomes.

10.2 Statistics on young people's health concerns

The main health concerns during adolescence are related to:

- Persisting childhood chronic health conditions and disabilities
- Emerging health issues related to lifestyle and behavioural issues.

Most young people are healthy and have a low incidence of acute illness and chronic conditions; however a disproportionately high number of attendances at emergency departments are for young people with chronic conditions (Smiley, 2010). These are often associated with compliance issues, poor knowledge and risk-taking behaviours. The major causes of morbidity and mortality are associated with risky behaviours that emerge during this developmental period. It is these behaviours, such as binge drinking, drug taking, unprotected sex, violence and dangerous driving that can result in preventable injury, disease and death.

These health concerns result in considerable costs for the health system, the individual, their whānau/family and the wider community.

- In 2007, the death rate for Maori males was 123.8 per 100,000. The death rate for non-Maori males was 88.9.
- Six out of ten pregnancies among young women under the age of 25 years are reported as being “unwanted”. (Dickson et al, 2002)
- Unprotected sexual intercourse during adolescence is associated with high rates of pregnancy, abortion and sexually transmitted infections. (Ministry of Health 2002b).
- Motor vehicle crashes are the leading cause of death amongst young people in New Zealand and are associated with high rates of morbidity (Ministry of Transport, 2009).
- Young people have a high prevalence of potentially hazardous drinking, with males aged 18-24 having the highest prevalence (one in two) (Ministry of Health, 2008).
- The second leading cause of death amongst young people is suicide. In comparison with other OECD countries, New Zealand has unacceptably high rates of youth suicide (The Social Report, 2010). This is frequently associated with emerging mental health concerns during adolescence, with 37% of young people by the age of 18 years old having a diagnosable psychiatric disorder (Fergusson & Horwood, 2001).

- The Youth 2007 survey of secondary students found that within the previous 12 months:
 - 26.0% of female students and 6.1% of male students had deliberately hurt themselves or done something they knew may have harmed or even killed them.
 - 19.4% of female students and 9.4% of male students had suicidal thoughts.
 - 11.5% of female students and 6.1% of male students made suicide plans.
 - 6.7% of female students and 2.9% of male students had attempted suicide.
 - Of the students who reported a suicide attempt, 21.5% did not report having serious suicidal thoughts.

10.3 Studies on effective interventions

As a developmental stage adolescence is obviously a dangerous time for some. Increased investment in services is required in order to produce better outcomes for young people in New Zealand. A developmental approach to provision of services is much more likely to produce effective results, as is the case in paediatrics and geriatrics. A developmental approach uses a multidisciplinary workforce to redirect risky lifestyle and behavioural choices into areas which have less unhealthy consequences: e.g. sports, adventure therapy, etc.

There are a number of interventions and services that have improved access to healthcare and health outcomes for young people:

- Youth specific primary health services: for example, Youth One Stop Shops (YOSS).
- School-based services.
- Youth work activities: for example, mentoring.

In 2002 the Ministry of Health commissioned a systematic review of New Zealand and international evidence for the effectiveness of youth-specific health (primary care) services in relation to access to health services and health outcomes (Matthias 2002).

The review concluded that youth-specific primary care (e.g. school-based health services, 'one-stop shops') increase access and use of health care significantly for young people. The evidence suggests that young people who particularly benefit from enhanced access are those who are socio-economically less advantaged,

females and high-risk youth. Similarly, a number of studies demonstrated reduced use of emergency departments among youth who have access to youth-specific primary care services. There was some evidence of better health outcomes, but it was difficult to attribute a change to a single intervention.

Many of the effective programmes and interventions include similar components. They build on creating strong adult-youth relationships, recognise and build on the strengths of youth, actively involve youth and give them opportunities to contribute, have a clear youth development philosophy and strategy and build interventions on the theory of youth development based on research. Involving the consumer, young people, at all levels of their health experience is necessary.

Development of effective services for youth is an investment as ***“adolescence is a period when patterns of health promoting or health damaging behaviours are established that will have a substantial influence on health status during adulthood, affecting rates of acute and chronic disease and life expectancy”*** Committee on Adolescent Health Care Services.

10.4 Population forecast

In New Zealand, young people (10-24 years) are 18.3% of the population; and this is estimated to decrease to 16.6% by 2020. By 2026, a cohort bulge means the total youth population will increase again.

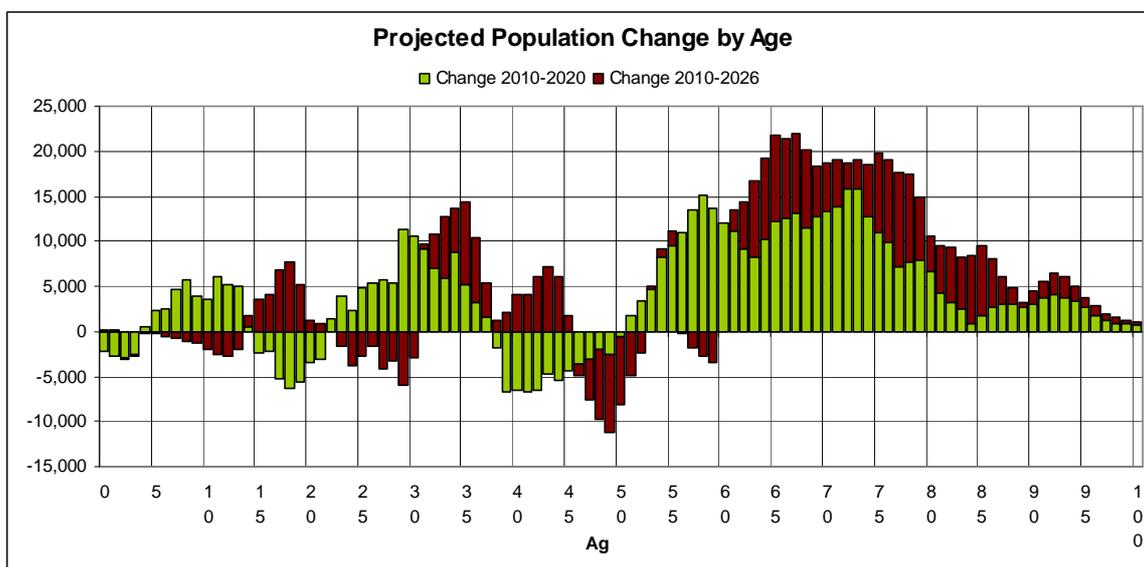


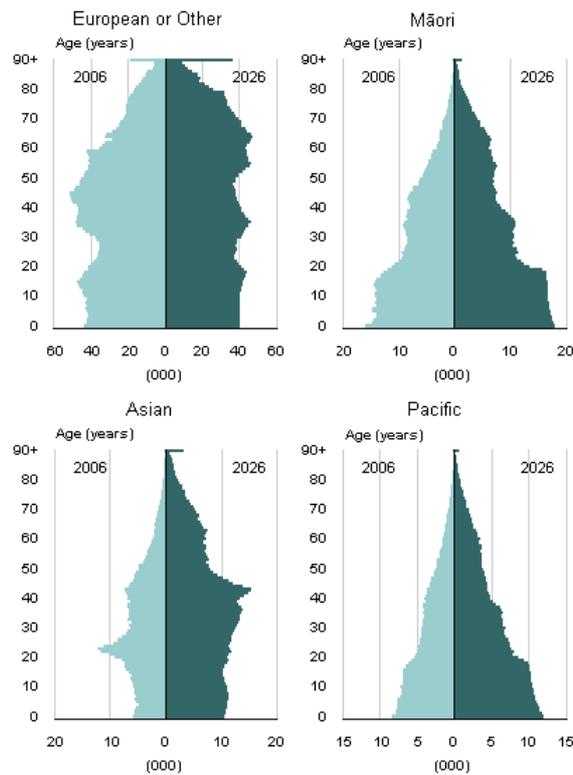
Diagram 2 Showing Projected Population Change showing a dip in youth population to 2020 followed by a bulge.

In three DHB districts (Counties Manukau, Waitemata and Canterbury), the proportion of young people is increasing, (see Chart 3). In addition, numbers of Maori and Pacific Island young people are increasing.

Population age pyramids

By ethnic group

2006 and 2026, series 6



Source: Statistics New Zealand

Diagram 3 : Population age pyramid shows young people comprising a large proportion of the Maori and Pacific populations in 2026.

The increasingly diverse youth population will have high needs. It is important to plan for this increase now and have services in 2020 ready to meet and manage their needs to reduce the impact on all sectors.

Approximately 5% of young people have multiple needs and are poorly cared for by the current health model. Up to 15% have serious health needs. This has serious implications for long term use of health resources once the proportion of young people in the population increases again unless services for young people are improved.

11. Barriers to change

11.1 Complexity of service provision contracting, funding and compliance costs in the sector

The scenarios in Appendix 1 and charts 1 and 2 show the complex inter-linkages between the multiple government departments that work with young people. The scenarios also show the number of agencies that may be required to interact with

one young person, shown diagrammatically in Chart 2. This complexity results in services that are ineffective and inefficient.

A more efficient approach to contracting would reduce transaction and compliance costs, saving money and resources for both the funders and providers. The fragmented contracting is a reflection of a lack of whole-of-government approach to youth services. While there are clear high-level strategic documents championing a whole-of-government approach to youth development and youth-specific services (e.g. MSD's Youth Development Strategy, Ministry of Health's Youth Action Plan), this has not been translated into operational funding policies and practices.

11.2 Health funding models

The ten minute GP consultation is not conducive to dealing with anything but the presenting condition which may not be the underlying issue.

Current funding models do not reflect need, as they are based on figures of youth attendance and did not take into account non-attendance of young people or the reality that many young people attend multiple healthcare services.

Fragmented health funding means that one person with a relatively modest set of problems may have multiple providers with conflicting or overlapping practices (e.g. alcohol use and mental health problems).

Government silos result in a focus on uni-dimensional approaches, separating funding, culture and legislation for education, health and welfare for youth. While great changes are planned at the top, contract management and operational management remain focused on narrow services, narrow approaches and narrow goals.

11.3 Services that do not meet youth needs

Young people assess the barriers to accessing services as:

- Doesn't fit for them
- No money
- No time
- No transport
- Unfriendly / inflexible
- Perceived as un-confidential.

Many young people, especially those who feel "disenfranchised", do not go to Integrated Family Health Centres or attend a GP practice, so they do not seek help until a crisis occurs. Health literacy is poor among population groups and this includes young people, for example many young people do not realise that GPs deal with mental health issues, so do not go for that reason.

11.4 Poor knowledge about youth development

Adolescence is a period of significant and dramatic change spanning physical, biological, social and psychological transition from childhood to young adulthood. Taking risks is integral to a young person's development but it can have negative outcomes.

When time and energy has been invested in teaching youth development for instance with the Youth Court Judges, it has resulted in a greater use of youth health services.

Many new youth services have been introduced without adequate local evaluations or accompanying research. This has resulted in a culture of anecdote and personal opinion which is not persuasive to healthcare practitioners or planners. Evaluation research needs to be paid for as an inherent part of every contract so that evidence can be gathered to be able to base services on models that produce cost-effective results.

11.5 Lack of a national framework that supports advanced nursing practice within school and community settings.

Nurse led services can be effective for young people. School nursing is an example of this and has developed without any framework/model to define it. The service is inconsistent and there is a large variation in this workforce across the regions/schools. If school nurses don't have access to a GP then the young person often has no access to timely treatment through standing orders, for example, or to referral onto other services. Currently doctors remain the gateway to more health/social care in terms of certificates and referral letters.

Nurse practitioners are well trained to undertake these autonomous roles in schools and community settings but there is no planned approach and no money or GMS that follows the patient when they are seen by a nurse. Nurses and GPs working as part of a team will always provide the most comprehensive care. But nurse practitioners and other skilled nurses can provide high quality care and services to vulnerable young people and communities.

12. Influencing Models of Care and workforce innovation

Nationally and internationally there are already examples of effective models of care that improve access to quality primary health care services for young people and their family/whānau.

12.1 AIMHI schools (Achievement in Multicultural High Schools)

This model includes a nurse and a social/community worker employed at each school and focused on early identification and intervention.

An evaluation of the AIMHI pilot project concluded that not only had it significantly improved access and outcomes for young people in all areas of health care, it also demonstrated an improvement for some students in educational achievement by increased levels of attainment in NCEA qualifications. (Sinclair 2006).

12.2 Health Services in Secondary Schools

Other models of health care in schools have developed in response to the needs of young people and their whānau/family. Schools are an obvious and appropriate place for service delivery but currently service delivery varies enormously across New Zealand secondary schools. Provision of services range from a parent who is called the school nurse through to a coordinated team which include the assistant principal, school guidance counsellor, family planning nurse, school nurse, public health nurse, general practitioner, social worker, and Maori and Pacific community/youth health worker.

Other initiatives to support this service delivery model include:

- Best practice guidelines for school based services developed with the support of CMDHB.
- Ministry of Health school nursing service for Decile 1 secondary schools, teen parent units and other alternative education units.

Whilst some of these examples are innovative, often they rely on individual relationships between health and education. School based health services need to be regulated and available equitably across New Zealand.

A study in 2009 (Buckley et al, 2009) found that:

- Only 75% of schools have some level of nursing available. The amount of this service, the qualification levels of the nurses, the funding sources and the services they provide vary considerably.
- About half of all nurses employed in schools are directly employed by schools. Almost all others are employed by district health boards, about half of these through public health units.
- Nurses provide a range of services including personal health, referrals to other providers, first aid, health assessments, health education and health promotion.
- There is no direct relationship between the deprivation rating of the school and the services provided.

- There is no direct relation between the numbers of students employed and the numbers of nurses. For example one nurse for 2500 students.
- There is great variation across the country. Most schools have no specific funding for nursing services and there is no clear policy direction. Individual school nurses are employed by either the school, the regional public health service, a DHB, PHO or a youth health centre.
- The Ministry of Education does not support school nursing. A few schools have services provided by outside providers such as GPs, psychologists and physiotherapists.

12.3 Youth health one stop shop services

The evaluation of one stop shops in 2009 by Communio for the Ministry of Health found that the fourteen services provide a range of accessible, youth-friendly health and social services at little or no cost to young people. The report noted that the services provided 137,000 occasions of service in 2008.

Most services were able to transition young people to mainstream services well, e.g. to a GP service by age 25 years. The majority of clients were aged between 15 and 24 years and the services were used more by females and Māori.

The evaluation identified a number of gaps and overlaps in service provision. While these centres do not provide any services that are not available elsewhere, the integrated and free youth-specific model of care attracts youth, particularly for those who have higher need.

12.4 Interdisciplinary and inter-agency services

The Centre for Youth Health (CMDHB) and the Waitakere Youth Health Clinic (WDHB and HealthWEST PHO) are examples of different service models/initiatives where agencies are working together. This interdisciplinary and inter-agency way of working provides access at one point for young people and their whānau/family to specialist youth health services. Both models have developed to meet the needs of the community.

13. Potential for Demonstration Sites

13.1 Collaboration between secondary school nurses and primary health care

SYHPANZ submitted an innovation proposal to HWNZ in 2010 for collaboration between secondary school nurses and primary health care. (It was unsuccessful in gaining funding at that time).

This links school nurse supervision/peer review with a GP practice team for rural schools and some urban areas.

Currently school based clinics are shown to be effective. In smaller areas where the workforce is limited a possible pilot would build on current school service experience and explore and evaluate a sustainable model for nursing in schools that is linked and supported by existing primary health care networks.

The goal is to link the isolated school nurse into a collaborative practice model. This will then facilitate clinical supervision, case review, provision of standing orders, referral pathways to primary care and specialist services for young people and access to professional development/training through CME/CNE.

13.2 Public health nursing

A pilot to look at redeploying public health nurses (PHN). For example in Christchurch the PHNs are employed by the DHB out of the secondary care system. They work across schools providing some vision and hearing testing and basic health advice in primary schools, and they visit secondary schools about once a week more or less. The pilot would examine:

- the practical logistics
- the cost-effectiveness and
- the satisfaction level of both school students and nurses.

Nurses would be employed by primary care, and they would be allocated one secondary school each and its associated intermediate and primary schools.

They would be trained to deliver primary health care services, health promotion and to prescribe where appropriate under standing orders. It may be beneficial where possible to allocate two nurses to one school “cluster” - one who “specialises” more in children’s issues and one for adolescents. If the school nurses who are already employed in some of the schools were also utilised in this overall team approach it could mean that no new staff need to be employed, but that all could be provided

with improved support from the primary care budget holder, with supervision and authority for standing orders where appropriate. If the budget holder was an organisation already experienced in delivering youth health services, it would be even more cost-effective – utilising the hub and spoke model of spreading expertise most effectively.

13.3 Using community youth health services as a hub and spoke model

The youth health workforce faces challenges within most areas due to limited workforce numbers but significantly more issues are raised for rural and isolated communities. **A hub and spoke model has the capacity to utilise limited numbers of specialists to support larger numbers of generalists**, in the following ways:

- provide clinical leadership and governance
- provide access to best practice and policy
- support clinical practice
- provide training and supervision
- and outreach to schools, general practices, child youth and family, youth justice teams, youth transition services (WINZ) for example.

13.4 Right Services at the Right Time.

The pilot would explore the way in which agencies such as CYF, youth community social service providers, youth health providers, youth AOD and secondary care mental health providers, education providers (especially alternative education) and youth employment and housing providers might work together to help solve some of the issues for a young person with high and complex needs.

Any agency who was in contact with such a young person could (with the young person's permission) present their needs to a panel formed from the pilot agencies, who would then decide the most appropriate care pathway and facilitate it to happen.

This could perhaps be an avenue the new CYF HEAP or Gateway assessments could use to facilitate care.

Funding would be needed to facilitate care but it could be money that already exists in the pilot agencies. Because care would be focused it would reduce waste and duplication and therefore would save funding to put back into the scheme, after the initial investment.

13.5 Nurse practitioner development within the youth health scope of practice

Consideration needs to be given to nurse managed health centres. Nurse-managed health centres based in vulnerable communities in the United States are an example of service delivery where between three and ten NPs work in partnership with

registered nurses, psychologists, mental health workers, physiotherapists, dentists and consulting doctors. This model of primary health care delivery is congruent with whanāu-based services and integrated service models and provides comprehensive health care to vulnerable populations. Within this model of care NPs play a significant role in primary health care and improving access to health care in underserved communities (American College of Physicians, 2009).

Currently there are examples of innovative practice by nurse practitioners working within community-based services such as EVOLVE (Wellington), VIBE (Hutt Valley) and WAVES (New Plymouth). They provide clinical nursing and nursing leadership, and are involved in regional and national youth health policy and practice development (Alcorn, G. & Zonneveld, R, 2010).

Nurse practitioners and specialist youth health nurses with postgraduate qualifications in youth health/ primary health care are also able to support geographical groupings of school nurses to deliver quality primary health care to the youth population. It is important that school-based services and community-based youth health initiatives are underpinned by a national youth health knowledge and skills framework, which advances youth development practice, strength-based interventions, and collaborative multidisciplinary practice.

Appendix 1 Scenarios

Scenarios

The most important variables are age, developmental stage and complexity of need. The following cases illustrate a typical path for high-risk youth:

Presenting symptoms change and worsen as time goes on; the most frequent presenting issues are behaviour/family issues, truancy, alcohol and drugs, unwanted pregnancy, depression, offending.

Example One: An 11 year-old boy from an immigrant family who is misbehaving at school. The parents are having difficulties: the mother just “yells at him” and he ignores her, so he is developing insensitivity to authority. The father disengages from these situations. The boy presents with potential to self harm.

This family needs a family therapist to work with the mother possibly instead of the child. There is difficult accessing this in the system and the boy is dropping out of school.

There is no connected and subsidised service. Private family therapists are available for about \$120 per hour and they are overloaded. The term “mental health” can be a barrier. Typically there is a lack of coordination between school and health services. As the young person is at intermediate school there are limited school services.

Ideal scenario

The family has one worker who has the primary relationship with the young person and his family who can assist the family access the service providers they need and to assist the boy reintegrate into school –“a **connector person**” to link the family to other service providers. Someone who engages well with young person “holds them” and continues to have intermittent contact until they are no longer needed as the young person matures. However this model still presupposes that there are services the “connector” can connect the young person to. The connector will soon stop working if gaps in service provision are not addressed.

Example Two: A 16 year old who is dropping out of school because of bullying, has anxiety, doesn't want to leave the house, is overweight, has headaches, possibly suicidal, still in school but hardly attending (because of bullying). The usual GP consultation is too short to assess real needs. Often GPs find dealing with youth difficult.

Ideal scenario:

The parent goes to the GP about the headaches and truancy. The GP has to assess parent's anxiety and young person's anxiety. Possibly do a HEeADSSs assessment as this would assist the GP to pick up all the salient issues as well as the presenting the issues of headaches. Then the GP can arrange other services or refer the young person to a good school service.

This may involved a psychological assessment while the family stays engaged with the GP. A recreational assessment is also needed to deal with issues of weight and lack of exercise. A counsellor or youth worker is needed to see the youth at the GP's practice or at the youth's home (he finds it

difficult to leave home).

In summary, there needs to be good points of entry (GP, school) plus community-based youth health centres with outreach.

Or alternative ideal scenario

The young person had presented at an effective school health service and the nurse could have identified the issues earlier, for example via the bullying concerns and then could have facilitated a multidisciplinary group with the school to address the bullying.

Example three: A 14 year-old Maori female in a secure unit in a Youth Justice residence, presents to the nurse because she thinks she is pregnant. Other issues include STI, AOD, mental health issues (cutting).

Typically she may have answered an AOD/Kessler questionnaire several times and refuses to do another.

She needs to see a midwife but may not be seen until she's out of the residence.

She could be seen by half a dozen health professionals with little cross service coordination.

Ideal scenario

She needs specialist youth health key worker (connector) to coordinate the care needed. This person needs to understand the developmental needs and know the agencies involved to be able to effectively co-ordinate care

Example four: A 22 year old man has opiate dependencies – he uses nicotine, alcohol, cannabis and more recently morphine. He has three children in care from three different women. Chronic bronchitis and eczema. He is unemployable and likely to be sent to jail due to thefts to support his drug habits. He was abused as a child by his drug abusing father.

His contact points are Justice, Work and Income and the late night doctor.

Ideal scenario

He needs assistance to tackle drug issues, which entails communication between justice and health. The GP he sees for eczema, if well trained in youth issues and has time could engage further and assess his needs to ensure appropriate services are accessed.

Or

his late night doctor could connect him to a youth health service which would be able to do a comprehensive psychosocial assessment as they have more time, would provide alcohol and other drug counselling, assist him in addressing the past abuse, liaise with Justice and treat his chronic health issues

All this could happen as the service employs appropriately trained counsellors, and social workers in addition to doctors and nurses. In time, linking him to his children so that he can become a better father would help to prevent a repeat of the cycle he is experiencing.

Appendix 2 Costing of a sample school based student service (based on a service in Counties Manukau)

Personnel	Funding Stream	Annual Cost
1.5 nurses	MOH via Evergreen Contract	71,500
1 Social Worker	MSD via STRIVE formerly Tamaki ki Raro Trust	55,000
1 Guidance Counsellor	MOE	78,000
1 Community Liaison Worker	MOE	30,000
1 Receptionist	MOE	26,000
	Sub-total	260,500
Estimates for other useful services		
Physiotherapist – 1 clinic a week	ACC	5200
GP – 2 mornings a week	CMDHB - PHO	100 000
Full Dental Service 1 week per term	CMDHB	15 000

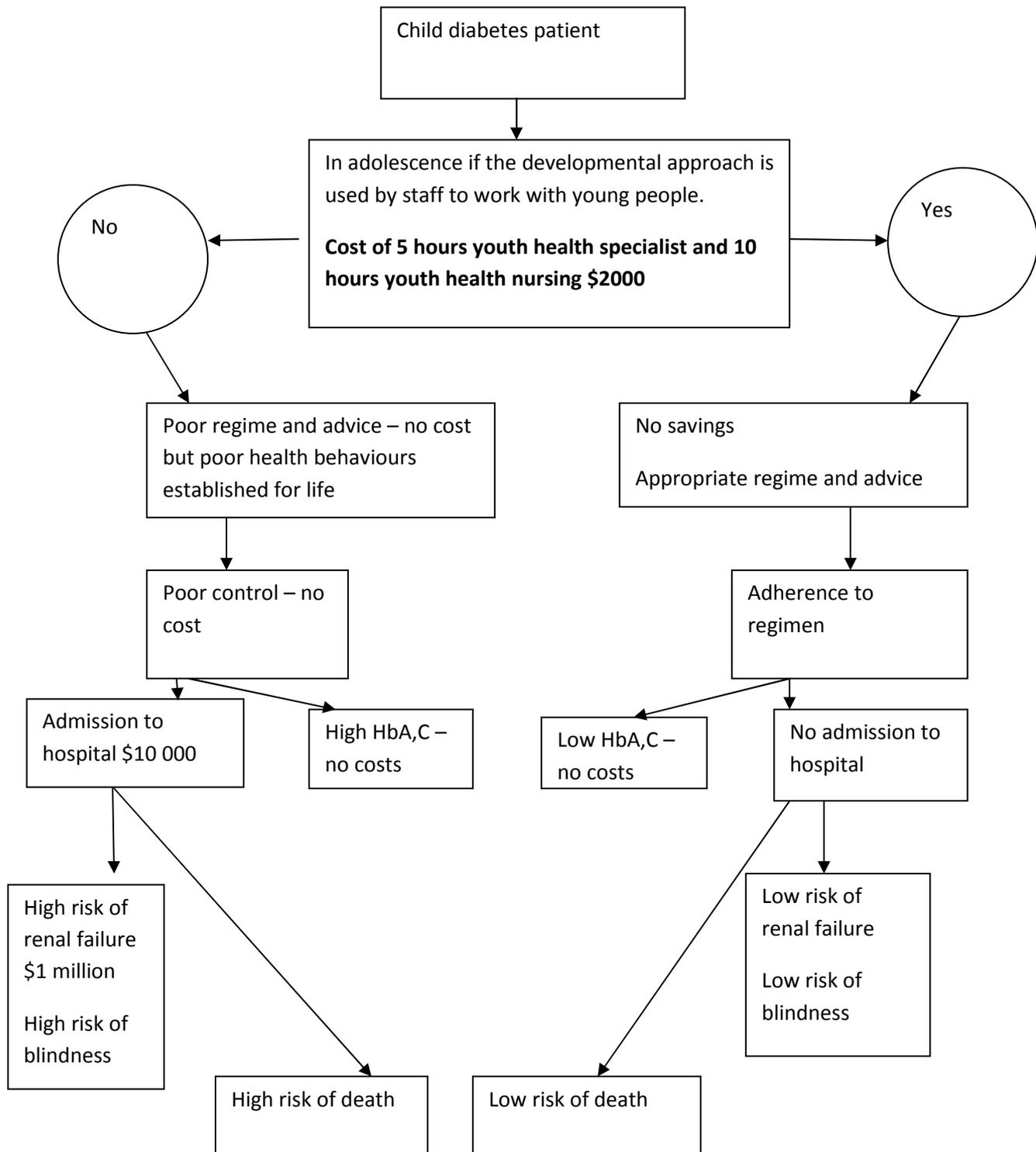
School Clinic Utilisation

In Counties Manukau secondary school based services, every week:

- 3750 students attend
- 830 are seen for accident or musculoskeletal concerns
- 475 students require dressings or have skin related concerns
- 200 young people have questions or concerns relating to sexual health
- 98 students are referred through to another primary healthcare provider
- 95 students present with mental health concerns
- 75 Year 9 Assessments are completed
- 20 students are seen in relation to drug and alcohol concerns
- 17 visits relate to care and protection concerns
- year 9 students fail a vision assessment
- year 9 students fail a hearing assessment

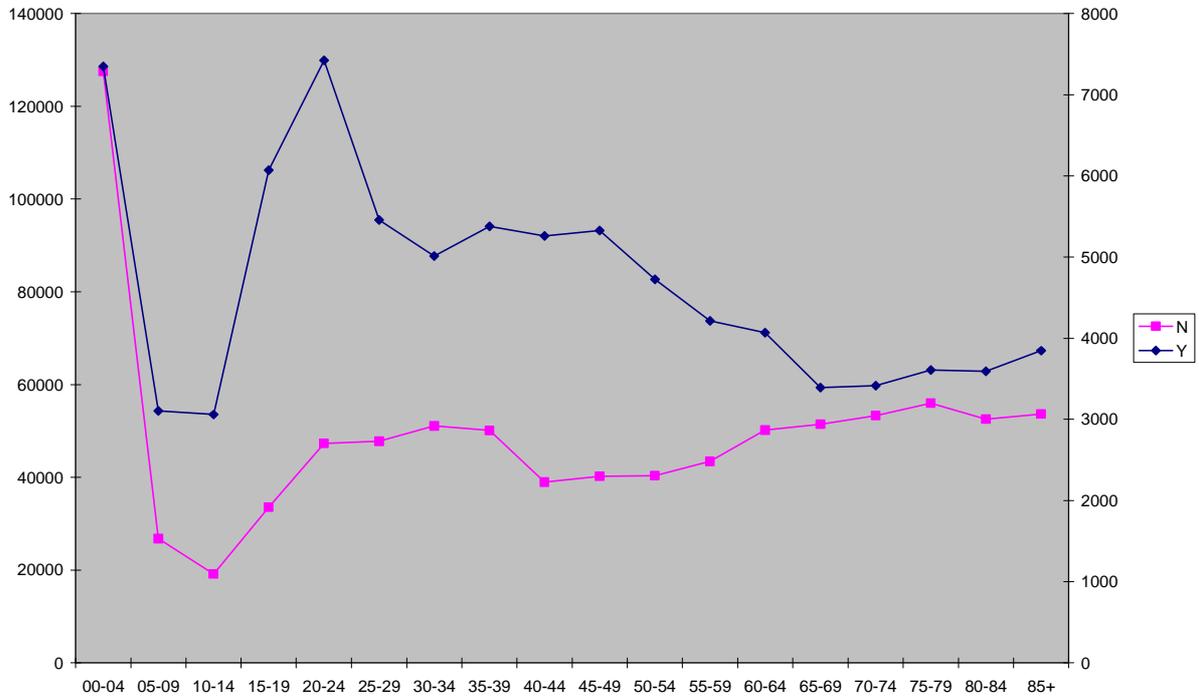
Ref School-based health services in Counties Manukau Oct 2009- Sept 2010. Estimated data, based on actual data from 14 decile 1-4 Secondary Schools.

Appendix 3 Comparison of costs of treatment of type one diabetes



Appendix 4 Admission of young people to Emergency Departments

N = hospital admissions, Y = ED admissions. Shows young people's high level of ED use



Appendix 5 A potential framework to support the workforce development

Stage	Developments required	Outcome required
Novice	<p>Short Courses</p> <p>Undergraduate training</p> <p>Curriculum changes and short courses to include:</p> <ul style="list-style-type: none"> • Engagement • Positive youth development • Interdisciplinary and interagency ways of working 	<p>Courses available and accessible nationally</p>
Competent	<p>Funding for postgraduate training</p>	<p>Sufficient funding and access to places on youth specific PG papers. (Currently limited access to papers.)</p>
Expert	<p>Scholarships</p> <p>Grants</p> <p>Creation of a vocational scope of practice for doctors with ongoing professional development programme</p>	<p>Currently the following can be obtained within NZ and overseas:</p> <ul style="list-style-type: none"> • Leadership-NZ • Training-overseas • Clinical experts-overseas • Researchers -NZ
New workforce	<p>Development of a community youth worker in health role.</p>	<p>Need to work across youth work, public health and other workforce agencies to develop this role. Enhances the health clinician's role by either undertaking youth development activities or connecting young people to these services and activities.</p>

Youth Health - Curriculum development for qualification in Youth Health for entry into a vocational scope of practice- draft

SYHPANZ has started to develop a curriculum that might be suitable for doctors and a knowledge and skills framework for nurses specialising in adolescent/youth health, and to meet the criteria of HWNZ for multidisciplinary training. The main purpose of the qualification is to provide for vocational registration with the Medical Council for doctors working in youth

health. It may also be suitable for Nursing Council regulations but that will be checked out later by a specially convened group of nurses. Some doctors who are already working entirely in youth health and in no other area of medicine may qualify to be grandparented into the qualification. This will be decided at a later date.

It was decided that this is a postgraduate qualification. This training is an additional training to assist doctors and nurses to develop an area of vocational registration if they are predominantly, if not exclusively, dealing with young people between 10 and 25. Doctors who wish to develop a career in youth health will need to approach this training through an already developed pathway such as paediatrics, general practice, sexual and reproductive health, or psychiatry. This curriculum of training can be undertaken simultaneously with another. How this works in practice will need to be developed in consultation with other Colleges.

SYHPANZ and the RACP, RCNZGPs and the College of Nurses colleges are developing memoranda of understandings. Work to date includes:

- SYHPANZ representation on the Royal College of Australasian Physicians and the recent development of the Adolescent and Young Adult Advanced Training Curriculum.
- Collaboration with the College of Nurses for the endorsement and approval of the National Youth Health Nurses Knowledge and Skills Framework.

Alongside the medical and nursing workforce development, the National Youth Workers Collective, Youthline and others have been working on the development of youth worker competencies.

Further collaborative work is planned to progress the recognition and development of this workforce.

Charts and graphs

Chart 1 Government agencies that may fund agencies that work with young people

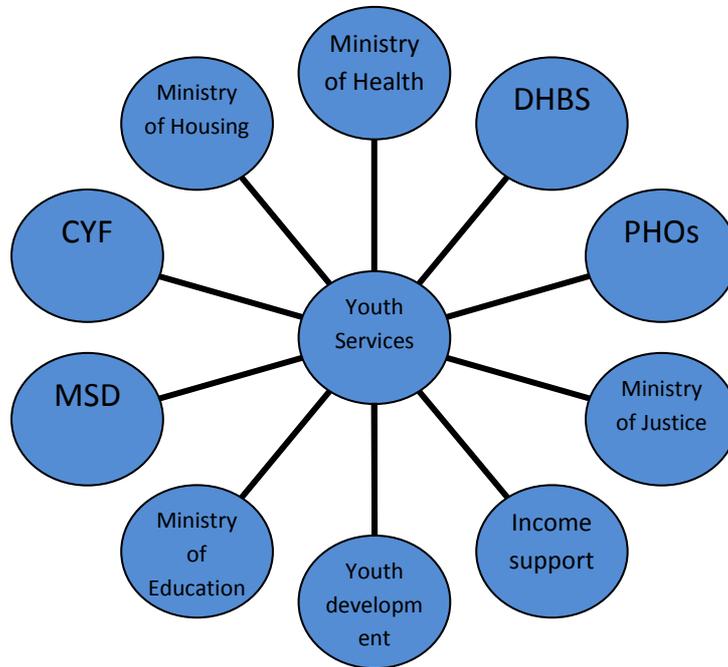


Chart 2 Services that a young person and their family may have to work with



Chart 3 Change in youth population per DHB

District Health Board	Aged 12-24 as % of total pop 2010	% Change in total population 2010-2020	% Change in Aged 12-24, 2010-2020	Aged 12-24 as % of total pop 2020
Auckland	18.8	13.7	-2.3	16.2%
Bay of Plenty	16.6	11.4	-0.9	14.8%
Canterbury	18.1	9.0	4.3	17.4%
Capital and Coast	19.4	9.3	-3.5	17.1%
Counties Manukau	20.4	18.5	10.4	19.0%
Hawkes Bay	18.0	2.8	-8.2	16.1%
Hutt	18.4	2.0	-6.7	16.8%
Lakes	18.0	2.0	-9.0	16.1%
Midcentral	20.0	4.8	-5.8	18.0%
Nelson Marlborough	15.5	6.3	-6.2	13.7%
Northland	16.9	6.1	-10.6	14.2%
Otago	21.1	2.9	-7.7	18.9%
South Canterbury	15.7	1.2	-15.6	13.1%
Southland	16.3	1.9	-11.3	14.2%
Tairāwhiti	18.8	0.7	-13.2	16.2%
Taranaki	16.3	0.4	-15.6	13.7%
Waikato	19.1	7.5	-2.2	17.4%
Wairarapa	15.6	0.7	-17.1	12.9%
Waitemata	18.4	15.3	8.1	17.3%
West Coast	15.8	-0.4	-19.8	12.7%
Whanganui	18.1	-2.9	-20.4	14.9%

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