Evaluation of
Healthy Community Schools
Initiative in AIMHI Schools

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MINISTRY OF
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MANATŪ HAUORA

Foreword

Students who are healthy and well supported in school and home are more likely to achieve better educational outcomes. Unresolved health and social issues can have a significant impact on a student's ability to learn and participate in the classroom and, if not dealt with promptly, can lead to more serious issues.

School-based health and social support services reduce barriers to learning and improve young people's access to care and support.

There has been an increasing investment in school-based health and social support services by health, education and social service agencies, particularly for students in low decile secondary schools, teen parent units and alternative education centres. However, models of care and support vary widely across the country.

This report, undertaken by PricewaterhouseCoopers on behalf of the Ministry of Health, builds on our understanding of the value and the role of school-based health and social support services in improving young people's access to care and support, and will inform future development.

Our thanks to PricewaterhouseCoopers who undertook this evaluation and all the nurses, social workers, counsellors, students, parents, school principals and staff who contributed to the report.

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Ministry of Health

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Introduction

Healthy Community Schools initiative

In 2001, the Ministry of Education (MoE) commenced a pilot programme, the Healthy Community Schools (HCS) initiative, based upon research into how the achievement of students in nine Decile 1 multi-cultural secondary schools could be enhanced.

These schools, known as the Achievement in Multi-cultural High Schools (AIMHI) schools, had, and still have, high numbers of Māori and/or Pacific students. Eight of the AIMHI schools are located in Auckland and one in Porirua.

The goal of the HCS initiative, also known as AIMHI, was to improve educational outcomes by:

- increasing effective learning time
- reducing barriers to learning
- improving health and social support services with the schools
- gaining greater connectivity and congruency of the school with its community.[1]

Funding was specifically given to the AIMHI schools to support the provision of health and social support services. In 2007 the Ministries of Health and Social Development took over the commitment of funding these services within these schools.

Context

The AIMHI students come from the most deprived areas in New Zealand, where family incomes are low and English may not be a student's first language. These factors alone are active barriers to accessing health services in the community.

Students often come from large families, which are poorly housed (often in overcrowded conditions) and lack disposable income. These factors mean that students are at risk of greater health problems and have less chance of having these health issues addressed. Visits to doctors are often delayed until serious, and prescriptions are not filled.

The health and social issues of students can directly impact on their ability to learn and achieve academically if they are not addressed and managed. In turn, lack of educational achievement limits job opportunities and income, perpetuating poverty and its associated health and social issues.

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1 Hill J, Hawk K. 2001. *Achieving is Cool: What we learned from the AIMHI Project to help schools more effectively meet the needs of their students*. Palmerston North: Massey University.

Auckland Uniservices Ltd. 2004. *Evaluation of the Healthy Community Schools Initiative in the AIMHI Schools: Final Evaluation Report*. Auckland: Auckland Uniservices Ltd.

Evaluation

This report is in response to an evaluation of the HCS that was commissioned by the Ministry of Health in August 2008. The prime objective of the evaluation was to 'inform the development and implementation of school-based health and social support services in the future.'[2] The evaluation gave particular focus to the school nurse component of the HCS initiative, to identify:

- how well the initiative is working in improving student access to health and social services
- whether improved educational outcomes have been achieved through the health and welfare needs of students being addressed
- the types of resources required for the future development of school-based student health services.

Key findings

Breaking the cycle

The HCS initiative in the AIMHI schools breaks the cycle through providing the means for students to access health and social services which would otherwise be difficult, if not impossible, to access.

Changes to the services through the HCS initiative have provided immediate health benefits, as well as opened the pathway for many students to access services in their wider community.

Today's major health issues (for example obesity, diabetes, heart disease and lung cancer) largely originate from the choices people make in their youth. To address these issues effectively through school health support services, at a time before students permanently make adverse lifestyle choices, will decrease the ongoing health costs associated with treatment.

Improved student access to student support services

The evaluation has demonstrated that the provision of a student support service in schools significantly improves student access to health and social services.

Students and staff in the survey expressed increasingly positive views on services and their willingness to use them. A comparison of the perceptions of services across AIMHI evaluation surveys 2003–2008 shows a steady improvement over time.

Students' perceptions

'Someone that understands you, listens to every word and keeps your secrets.'

Students were positive in their feedback about school health services. Students found that school health services provided:

- easy and ready access
- a private and confidential service within the bounds of the facilities

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2 Ministry of Health. Unpublished. Request for Proposal for an Evaluation of the School Nurse Component of the Health Community Schools Initiative in the AIMHI Schools. Wellington: Ministry of Health.

- supportive, professional and non-judgmental staff
- a means to safely and legitimately consult a nurse or doctor without their parents knowing
- a wealth of knowledge they could tap into to learn about their own health and wellbeing
- the opportunity to set different expectations for themselves in terms of the way they were prepared to live
- experience in managing their own health
- confidence to navigate and use other health services in the community[3]
- first-hand observation of career options in the health sector.

Teachers' perceptions

'If the students are healthier, their problems dealt with, and they are safe, they do better. This is not rocket science.'

Teachers viewed student support services as an essential part of the school and believed the school would not be able to function as effectively as it did without the services. Teachers had a high degree of comfort referring students to school-based health services. The teachers found that the presence of the health service in the school:

- enabled students' health issues to be dealt with more effectively, which had a positive impact on learning
- relieved teachers of the stress of having to manage situations concerning student health issues, which they were not well equipped to do
- provided a source of information, advice and resources for teachers in interacting with students with health problems
- along with the presence of other student support services, enabled teachers to focus more on their teaching and students to focus more on their learning
- contributed to reduced truancy and students staying at school longer
- gave greater depth to the school's ability to provide and support the health education syllabus.

Parents' perceptions

'As a parent I think the health service is good. The nurse got hold of me about my daughter and we got her hearing fixed up. The nurse got her seen by the doctor and got it sorted out.'

Only limited feedback was able to be gleaned from parents. Of the parents that did give feedback, 91 percent said that they were particularly pleased that the school had a health service. The parents thought that the student health service:

- was accessible
- was helpful
- had improved the health of their child(ren).

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3 This feedback from the students is supported by the observations of the health providers (Earp et al 2007).

None of the parents surveyed or consulted expressed any negative experiences or concerns about their children using school-based health services.

Improved educational outcomes

The AIMHI initiative takes a multi-faceted approach to the needs of students and teaching staff in Decile 1 schools. Isolating the health service in terms of cause and effect on educational results is difficult. However, research both in New Zealand and internationally consistently indicates that to learn effectively, students need good health.

The educational results of the students in the AIMHI schools reinforce this research. Compared with their peers in other Decile 1 schools:

- academic achievement is higher regarding literacy, numeracy and National Certificate of Educational Achievement (NCEA) qualifications attained

- retention levels are higher

- truancy is lower.

Overall, both Māori and Pacific students in AIMHI schools have tended to perform at higher levels than their peers in other Decile 1 schools. In some cases, performance levels were higher than the national average.

Pacific students have benefited to a greater degree than Māori students, who are a minority group in these schools.

Role for student-based health support services

The AIMHI initiative has shown in New Zealand (and overseas) that student-based health support services play a significant role in the health and welfare of students and have specific advantages over mainstream services outside of the school environment.

In summary, the AIMHI school-based health services:

- provide readily accessible health services for young people

- meet an otherwise largely unmet need in terms of health assessment, early intervention, health education and health promotion

- focus on the early identification of health issues and high-risk behaviours

- address health issues that can have a significant impact on learning, for example hearing, vision and mental health

- contribute to young people making better health choices that can have a life-long impact, for example diet, smoking and safe sex

- follow up with students to ensure any health issues are resolved or are being appropriately managed

- provide, with counselling and social work services, a safe environment for disclosure of family violence and sexual abuse

- impact positively on students' health status and educational achievement.

While school-based health services would provide these benefits to any student, regardless of school decile, the roll-out of similar services in schools needs to be directed at those in most need first.

Resources and facilities

The level of student health and social support resources and facilities in AIMHI schools differed (at times markedly) from school to school. Resources ranged from no purpose-built facility and less than a day of health professional availability (nurse, general practitioner (GP)) per week to a fully resourced purpose-built centre with reception staff and a range of full and part-time staff available.

Funding and employment

Some of the schools augmented the funding they received from their respective district health boards (DHBs) to employ nurses so they could have a greater ratio of nurses to students.

The social workers were all fully funded by the Ministry of Social Development (MSD) and were all employed full time. The social workers were employed by non-government organisations (NGOs) who had a contractual agreement with the school to provide services.

Employment of nurses, by contrast, varied. Nurses in eight of the nine AIMHI schools were employed by the school (the ninth by a primary health organisation (PHO)). The principals of the schools tended to employ nurses for school hours only as this enabled them to have more nurses available when students were present at the school for the funding they received and in effect also increased the ratio of nurses to students.

Integration of services with the school

The integration of student support services also varied from school to school. Where there was a common locality for student support services (for example a health centre) and an identified person within the school responsible for student support services, there was greater integration between support service providers as well as greater connectivity with deans, teachers and other school staff. The orientation of the principal towards the service played a key role in the degree of integration of the service and how the services were viewed by teachers and other school staff.

Service providers were also able to influence the degree of integration with the school through their own proactive efforts to promote their service.

Generally, there was a positive perception of the health service amongst staff and teachers at the schools.

Co-ordination and co-operation among health and social service providers

In most schools, the different health and social service providers engage in joint planning and regular meetings. This was found to greatly assist the provision of a timely and comprehensive service to students through referrals and collaboration.

Student experience and perceptions of the service

The student survey results clearly show that students who have already had experience of the service have a better understanding of it and are more likely to use it again. Perceptions, particularly of the health service, were positive. A key influencer for the use of the service by students was the level of confidence and trust in the service providers, particularly regarding privacy and confidentiality.

The health assessment provided an opportunity for promoting the service to students. Students who have had a health assessment are almost twice as likely to use a school-based health service in the future. In turn, students who use school-based health services are more likely to access community-based health and support services.

Students are far more likely to use the services of the school social worker and counsellor if they have already had experience of the school nurse. The school nurse has a key role to play in the integration of school support services.

Requirements for an effective school-based health service

Key factors in the effectiveness of school-based health services include:

- support from the school principal, board of trustees and school staff

- a youth-friendly, confidential and private service that the students can trust

- student input in the provision of health services and initiatives

- a committed partnership between health and education to ensure the appropriate resources and support

- experienced and mature practitioners who are qualified and confident in their role with youth and within the education setting

- a ratio of nurses to students that adequately addresses students' need

- practitioners who embrace opportunities to actively promote and support the health of young people, as opposed to taking a passive 'band-aid' approach

- ready access, preferably on site, to a medical practitioner at least once per week

- a purpose-built and designed facility that ensures the privacy and safety of students and staff

- a supportive infrastructure both within the school and externally, from the provision of a receptionist and governing body to professional development and collegial support.

Introduction

Context

Background

The HCS initiative was implemented by the Ministry of Education (MoE) in 2001, originally as a pilot, in recognition that students with health and social issues faced barriers to achieving positive educational outcomes. The pilot was known as AIMHI, representing the mission of the initiative to facilitate 'Achievement in Multi-cultural High Schools'. The MoE initially provided funding to nine Decile 1 schools ('AIMHI schools') with high numbers of Māori (20 percent) and Pacific students (72 percent) to assist the schools to better meet the health and welfare needs of their students.

The schools used this funding, augmented by funds from their operational budgets, to employ social workers, community liaison officers (CLOs) and school nurses.

The nine AIMHI Schools are:

- De La Salle College
- Sir Edmund Hillary Collegiate
- McAuley High School
- Mangere College
- Otahuhu College
- Porirua College
- Southern Cross Campus
- Tamaki College
- Tangaroa College

Programme evaluation

The AIMHI pilot had a three-phase evaluation process, with reports completed in 2002, 2003 and 2004.[4] The evaluation tracked the development of the initiative, with the final report documenting the progress of the schools. The evaluation showed that the AIMHI schools made significant gains over a number of areas when compared with other low-decile schools between 2002 and 2004. The AIMHI students expressed greater satisfaction with the school and felt they had greater support with their achievement. The AIMHI students also felt that there was support for ethnic diversity within their school, unlike their peers in other low-decile schools. In terms of educational outcomes, the AIMHI students significantly increased their educational achievement levels, which were comparable to national results for the respective ethnic groups drawn from all decile schools.

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4   Auckland Uniservices Ltd. 2004. *Evaluation of the Healthy Community Schools Initiative in the AIMHI Schools: Final evaluation report.* Auckland: Auckland Uniservices Ltd.

Scope of AIMHI

It should be noted that the initiatives that have been put in place by the AIMHI schools are achieving more than just meeting the health and welfare needs of students. The AIMHI programme takes a multi-faceted and holistic approach to facilitate students' educational achievement based upon formative research and feedback from students[5]. This has included, but is by no means limited to:

- different organisational structures and support systems for students, for example horizontal form groups and whānau groups
- skill development programmes for students
- tutor periods with smaller teacher-to-student ratios
- additional professional development and coaching for teachers
- more effective tracking of students' attendance
- more effective strategies for dealing with student behaviour issues.

New Zealand health issues

Compared with other Organisation for Economic Co-operation and Development (OECD) countries, New Zealand's youth have considerable health issues, including comparatively high rates of suicide, unintended pregnancies, abortions and sexually transmitted infections.[6] In addition, compared with other age groups, young people have higher injury rates (intentional and unintentional) and higher rates of mental illness and alcohol and other drug use and abuse.[7]

Health inequalities between ethnic groups also exist. Māori have poorer health outcomes when compared with their non-Māori peers. The mortality rates for Māori youth are almost twice that for non-Māori youth.[8]

Service funding

In the beginning of July 2007, the funding of school nurses and social workers was taken over by the Ministry of Health and the MSD. In the past, schools have been funded directly by DHBs. From July 2008 the MSD has contracted with various NGOs to provide social work services for schools.

Scope of the evaluation

Evaluation

The evaluation was commissioned by the Ministry of Health with the purpose of informing the future development of school-based health and social support services in Decile 1–3 secondary schools throughout New Zealand. The Ministry wished to harness the knowledge, experiences and outcomes of those involved with the HCS Initiative and the original nine AIMHI schools

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5   Hill J, Hawk K. 2001. *Achieving is Cool: What we learned from the AIMHI Project to help schools more effectively meet the needs of their students*. Palmerston North: Massey University.

6   Ministry of Health. 2003. *Sexual and Reproductive Health: A resource book for New Zealand health care organisations*. Wellington: Ministry of Health.

7   Ministry of Health. 2002. *New Zealand Youth Health Status Report*. Wellington: Ministry of Health.

8   Ministry of Health. 2006. *Whakatātaka Tuarua: Māori Health Action Plan 2006–2011*: Wellington: Ministry of Health.

Objectives

To evaluate whether the AIMHI initiative is improving:

- access to health and social services for students
- educational outcomes through meeting students' health and social needs.

The evaluation principally involved meetings with representatives from the individual schools (principals, teaching staff and student support service providers), the MSD and the three DHBs,[9] AIMHI staff and the Auckland School Nurses Group. The scope is represented in Figure 1.

Figure 1: AIMHI school, nursing and social services

Wider education sector

AIMHI
school
services

1.
Collaboration
teamwork

4.
Collaboration
teamwork

3.
Improved
educational
outcomes

AIMHI
nursing
services

AIMHI
social
services

2.
Collaboration
teamwork

Wider
health sector

Wider
social sector
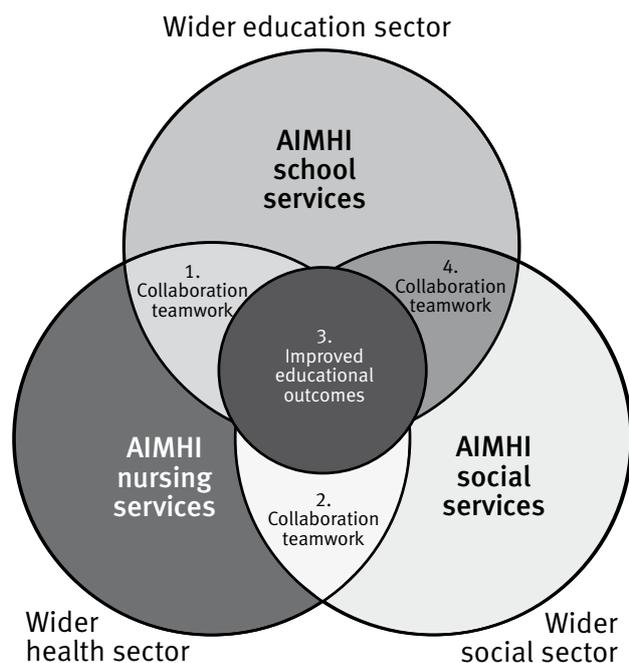
In particular the initiative set out to:

- evaluate the collaboration amongst student support service providers with the school and wider community
- evaluate the integration of student support services within schools
- assess the impact of student support services and intermediate outcomes, specifically retention rates of students at school and educational outcomes
- provide a resource toolkit for future development and implementation.

Resources for future development and implementation

The evaluation was also to include recommendations for the types of resources (such as a toolkit or guidelines) that will be necessary for the future development and implementation of school-based health and social services.

Accordingly, the analysis provides the basis for two main outputs: the current Evaluation Report and a separate Resource Statement/Guidelines for the future development and implementation of school-based health and social services.

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9   Auckland, Capital and Coast and Counties Manukau

Report structure

Beyond this introduction, the report outlines the methodology employed for school visits and survey analysis in Section 3. Key findings and conclusions are presented in Section 4. Profiles of AIMHI schools are set out in Section 5. Findings from school visits and interviews, including school service data, are discussed in Section 6. Section 7 provides an analysis of results of the surveys of students, staff and parents, including a comparison of 2008 results with the 2003, 2004 surveys of the HCS initiative. A comparative analysis of trends in educational performance for AIMHI and Decile 1 schools is provided in Section 8. This complements findings from the primary research of the current evaluation. Finally, Section 9 outlines key considerations for the implementation of a school-based health service. These considerations are explored in more detail in Appendix A: 'Health Service Implementation Considerations'.

Methodology

Introduction

Balanced framework for analysis

The methodological framework for the review comprised four parts:

- desktop research on the HCS initiative

- visits to schools for observation, data collection and interviews with health providers, staff and students

- a structured survey of the perceptions and experiences of students, staff and parents

- an analysis of education and health performance trends for AIMHI schools, Decile 1 schools and nationally.

This provided a balanced mix of primary and secondary research data, and qualitative and quantitative results.

Impact on students

A key part of the evaluation was to assess the impact of student support services on students. In 2004, a final evaluation of the HCS Initiative was completed by Thomas et al of Auckland Uniservices Ltd.[10] Through the evaluation process, the researchers had designed climate surveys for students and staff which they could compare on a year-to-year basis. The paper also cited a number of factors as indicators of student engagement, meeting students' health needs, school climate and student achievement.

Where possible, this evaluation used tools that could be compared with the work that previous evaluators had done in order to look at the continued impact of student support services since the 2004 evaluation.

Approach

Prior to commencing any active field work, PricewaterhouseCoopers reviewed the literature pertaining to the HSC, youth health and social and educational outcomes. The Ministry sent a letter to AIMHI school principals and relevant DHBs and provided PriceWaterhouseCoopers with a list of AIMHI school principals.

PricewaterhouseCoopers followed up the Ministry's letter with an email introducing themselves, outlining the involvement of the school that they would be seeking and attaching an initial information sheet for the school and information sheets for teachers and students (Appendix I).

The email was followed up either by telephone or email, depending on the response of the schools. Once the schools were engaged, PricewaterhouseCoopers were able to begin collecting their primary sources of information, which included:

- interviews with the school principal, support service providers and senior teaching staff

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10 Auckland Uniservices Ltd. 2004. *Evaluation of the Healthy Community Schools Initiative in the AIMHI Schools: Final Evaluation Report.* Auckland: Auckland Uniservices Ltd.

- surveys of school students, staff and parents

- separate meetings with school students and school staff

- interviews with the portfolio managers for nurses in schools from the relevant DHBs (Auckland DHB (ADHB), Counties Manukau DHB (CMDHB) and Capital and Coast DHB (CCDHB))

- interviews with MDS portfolio managers for social workers in schools

- meetings with the extended group of AIMHI principals, the MoE representative, AIMHI Centre staff, the original school nurses group and the current AIMHI nursing team

- a workshop with the Auckland School Nurses Group

- data from the AIMHI schools, complemented by data from the MoE, the MSD, the DHBs and the AIMHI Centre

- information from others who had a direct involvement in the initiative and the associated formative evaluations, or an interest in youth services in schools.

Research

The desktop research focused primarily, though not exclusively, on New Zealand sources. The initial research informed PricewaterhouseCoopers' understanding of the HSC itself, as well as the issues it was put in place to address (Appendix A). The literature also enabled them to establish similar tools to use in gathering data so that their findings could be reviewed in the context of the comprehensive and formative research that had been previously undertaken on the HSC.

Throughout the evaluation process, they continued researching for information the service providers and schools were not able to readily supply.

Some information was in the public domain, but a considerable amount of information was made available to them by the AIMHI Centre, the Auckland School Nurses Group and the MoE and MSD.

School visits

The team initially visited the principal of one of the nine AIMHI schools to provide an outline of the project and discuss proposed methodology and the data requirements of schools. This visit provided a preliminary insight into the needs of schools in relation to the undertaking of the evaluation.

The health providers in this first school suggested PricewaterhouseCoopers visited a neighbouring Decile 2 school with a different configuration than its own that might also inform their interview questions and evaluation.

These two visits enabled them to refine their approach to the remaining schools. These schools were also encouraged to provide feedback on PricewaterhouseCoopers' proposed approach so they could ensure it would suit the needs of their particular school environments.

This process included meeting with groups of student representatives from the schools.

The focus of these meetings was threefold:

- to gain feedback on the content of the student surveys and the logistics of their administration

- to gain feedback about how best to involve students' parents/caregivers

- to give students an opportunity to tell us directly about how they felt about student support services and their impact.

When required, PricewaterhouseCoopers also augmented their approach in order to meet schools' specific needs. For example, a number of the schools wanted PricewaterhouseCoopers to get input from a larger number of teaching staff than had been originally planned.

In all, the AIMHI schools were visited between two and five times in the information-gathering phase. The number of times depended on the availability and work commitments of the staff and students.

PricewaterhouseCoopers gathered both quantitative and qualitative data from these visits. Some schools provided PricewaterhouseCoopers with additional information, for example, school strategic plans, reports to boards of trustees and other internal documents.

The greatest difficulty was getting the quantitative data from some of the schools, because providing it was time consuming for them at a busy time of the school year.

Of PricewaterhouseCoopers' proposed approaches one was abandoned from the outset. They intended making a wiki site available for the students in which they could contribute interactive free-form comments regarding student support services. However, after discussions with both the students and teachers, this option was not considered practicable. To gain open feedback:

- a free-form comments section was included in the student survey
- focus group meetings were held with a representative group of students.

At all the schools, PricewaterhouseCoopers were able to view the facilities of the student support services.

Interviews

An interview timetable was compiled during and after the initial school visits. The evaluation team requested to meet with groups of students and with counsellors, youth workers, social workers, nurses and teachers, including deans and other pastoral staff. PricewaterhouseCoopers were also able to interview two GPs who worked on-site in schools and meet the governance group of one school's student support services.

The interviews took place on site, at the school, in various private locations. Interviews with school staff and student service providers were scheduled to take place over 1–1.5 hours. Generally, the staff interviews kept to this schedule. With some of the student service providers, more time was needed. This was accommodated on the scheduled day, if possible; otherwise a subsequent time was arranged. Generally 2–2.5 hours needed to be set aside for this purpose.

The interviews were semi-structured, with a set of specific questions relating to demographic data about the staff and service and more open questions exploring:

- use of the services by students
- integration with the other support services in the school
- integration with the school and teaching staff
- links with the wider community
- perceptions of strengths and weaknesses of the support services and facilities at the school

Semi-structured interviews were also held with the respective DHB portfolio managers, the MSD portfolio manager, the AIMHI Principals Group, the chief executive officer of South Seas PHO,

members of the CMDHB school health team and a University of Auckland doctor, lecturer and lead researcher in youth health who has an active involvement with the HCS and the research and publication of 'Youth 2007'.

The latter interviews provided opportunities for gathering information as well as opportunities for discussion and debate about our observations, organisational aspects of the service and critical success factors.

Focus groups and workshops

The group meetings varied in duration from 0.5 to 4 hours, depending on the purpose and nature of the group, which included:

- teachers
- students
- the original AIMHI nurses
- the Auckland School Nurses Group.

Focus groups with teachers were small, with no more than seven teachers at any one time. Some schools instead scheduled individual teacher meetings. The teachers involved included the school deans, deputy principals and heads of technology.

Other teachers included at some schools were those that were involved in health education, heads of English as a Second Language (ESOL), the senior management team and any other teachers who were prepared to give us their time to participate.

The focus group with students took place at school: four over lunch time and five during school time. These group meetings took between 30 and 60 minutes and were valuable in providing direct student feedback and an appreciation of the students' world and lived experiences, particularly in relation to student support services. Student groups across the schools brought up consistent issues and messages.

Likewise, the meeting with the original AIMHI nurses provided insights into the historical journey they had taken. It was possible to explore the nature of the particular challenges they had faced and still face.

The Auckland School Nurses Group agreed to meet PricewaterhouseCoopers for a workshop to provide them with insights of nursing services in other schools outside of AIMHI. These schools included Deciles 1 though to 10, and public as well as private schools. This meeting was invaluable in terms of hearing first-hand about the realities of establishing a professional health service in schools.

It was hoped to have a focus group at each school for parents, and while some of the schools considered ways of arranging this no focus groups eventuated. To include parents' perspectives of the student support services provided by the schools, a five-point Likert scaled one-page survey was provided to the schools for distribution to parents.

Surveys

Surveys were designed in line with those that had been used in previous evaluations of the HCS and provided as a web-based or paper-based option.

The surveys collected some base demographic data (for example, school, ethnic group, gender) and asked questions using a five-point Likert scale with the format strongly disagree, disagree, not sure, agree or strongly agree.

For the school staff, there was also provision for 'cannot answer' at the request of some schools. When the 'cannot answer' was ticked, these responses were omitted from the count of the responses to the question. This was done so that comparisons could still be made with the climate surveys of the previous evaluations. The most 'cannot answer' responses to any one question was 17 (6.6 percent). The questions that had the higher proportions of 'cannot answer' referred to whether the respondent related improved behaviour and attitude to the student support services.

Questionnaires used a mix of positive and negative statements to manage acquiescence bias (respondent agreement with statements presented). The category 'not sure' was used instead of 'neither agree nor disagree' to assist with managing central tendency bias (avoidance of extreme categories by respondents).

The survey also provided an opportunity for respondents to provide any further comments regarding the support services.

The target for staff was 20 percent but this was greatly exceeded, with 258 staff returning completed questionnaires either online (54 percent) or in hard copy (46 percent). In all, 38 percent of teachers participated in the survey.

For students, the target was to least 10 percent. This was achieved, with 800 students completing the survey out of a possible 7016 (11 percent). Of these, 30 percent completed the survey online, while the remainder completed paper-based surveys, which were manually entered into the database.

Parent surveys were provided to the schools in Tongan, Samoan, Māori and English. Four of the nine AIMHI schools returned completed parent surveys: 66 percent in English, 22 percent in Samoan and 12 percent in Tongan. Of 68 surveys in all, 6 percent identified as European, 22 percent Māori, 74 percent Pacific Islander and the remainder 'other'.

Ministry of Education data

Where the schools had not been able to provide a complete data set we sourced the school information from the MoE. The MoE also provided data for all schools and for all Decile 1 schools for comparative purposes. The data included:

• number of students by gender and ethnicity

• literacy and numeracy rates

• stand-downs, suspensions, exclusions and expulsions

• under 16-year-old exemptions from school

• level of school leaver qualifications

• retention rates

• teacher turnover.

PricewaterhouseCoopers also requested information that was not readily available:

- transience rates (percentage of students who were only at school for part of the year exclusive of those leaving school permanently)
- number of students enrolled during the school year (as opposed to the beginning of the school year).

The AIMHI schools make up 63 percent of the Decile 1 Year 9–13 (Y9–13) population in New Zealand. Differences between the AIMHI schools and all Decile 1 schools have been moderated by the greater influence of the AIMHI schools. This gave conservative comparisons for the impact of the AIMHI schools. The data that PricewaterhouseCoopers could not get either from the schools themselves or from the MoE would have enabled a more detailed context analysis of school outcomes. For example, if the AIMHI schools have a higher transience rate than other schools this may be contributing to variance in the educational outcomes of students.

Student support services data

PricewaterhouseCoopers prepared templates to be completed by student support staff that gave PricewaterhouseCoopers both qualitative and quantitative data, including:

- professional qualifications
- employment details
- experience
- ethnicity
- consultation patterns 2004–2007
- committee attendance.

This data complemented the interview, which covered in more descriptive detail how the service worked, governance, policies, procedures, the facility and the strengths, barriers and issues of the service.

The actual data in regard to consultations that the service providers themselves did was the most difficult to obtain. Previous to 2007 the AIMHI Centre collected the information across the schools for social work and health services. Some schools were better than others at providing the information and composite data had to be used, for example, across different time frames from the respective schools.

From the CMDHB, PricewaterhouseCoopers were able to get aggregated data across all the schools that use their nursing services. Some of the individual schools also provided reports from their pupil database, which were useful.

The social work data was accessed through MSD, but again this was inconsistent across schools and included schools outside of the AIMHI network. This has limited the comparative observations able to be made and highlighted the need for robust and consistent data collection across schools.

Conclusions and Key Findings

Conclusions

Improved student access to student support services

The evaluation has demonstrated that the provision of a student support service in schools significantly improves student access to health and social services.

Students and staff surveyed expressed very positive views on the service, and their willingness to use it. A comparison of the perceptions of the service across AIMHI evaluation surveys 2003–2008 shows a steady improvement over time.

Improved educational outcomes

The AIMHI initiative is made up of a multi-faceted approach to the needs of the students and teaching staff in Decile 1 schools. Isolating the health service in terms of cause and effect on educational results is difficult. However, research both in New Zealand and internationally consistently indicates that to learn effectively students need good health.

The educational results of the students in the AIMHI schools reinforce this research. Among AIMHI students, when compared with their peers in other Decile 1 schools:

- academic achievement is higher in terms of literacy, numeracy and NCEA qualifications attained

- retention levels are higher

- truancy is lower.

Role for student-based health support services

The AIMHI initiative has shown in New Zealand (and overseas) that student-based health support services play a significant role in the health and welfare of students and have specific advantages over mainstream services outside of the school environment.

Breaking the cycle

The HCS initiative in AIMHI schools breaks the cycle through providing students with health and social services which would otherwise have been difficult or impossible to access.

Availability of the services at school has provided immediate health benefits, as well as opened the pathway for many students to access services in their wider community.

The major health issues that we are dealing with today (for example obesity, diabetes, heart disease and lung cancer) largely originate from the choices people make in their youth. Addressing these issues effectively through school health support services, before students permanently make adverse lifestyle choices, will decrease the ongoing health costs associated with treatment.

Key findings

Requirements for an effective school-based health service

Key factors that influence the effectiveness of school-based health services include:

- support from the school principal, board of trustees and school staff
- youth-friendly, confidential and private service that students can trust
- student input in the provision of health services and initiatives
- a committed partnership between health and education to ensure the appropriate resources and support
- experienced and mature practitioners who are qualified and confident in their role with youth and within the education setting
- a ratio of nurses to students that adequately addresses student need
- practitioners who embrace opportunities to actively promote and support the health of young people, as opposed to taking a passive 'band-aid' approach
- ready access, preferably on-site, to a medical practitioner at least once per week
- a purpose-built and designed facility that ensures the privacy and safety of students and staff
- a supportive infrastructure both within the school and externally, from the provision of a receptionist and governing body to professional development and collegial support.

Resources and facilities

Student health and social support resources and facilities within schools in the AIMHI programme differed (at times markedly). The lowest level of resource we observed comprised:

- no purpose-built facility
- seven hours of a nurse per school week
- three hours of a doctor per school week
- a community liaison officer for school hours
- a full-time, but not fully qualified, social worker
- a full-time school counsellor.

By contrast other schools had in place:

- purpose-built facilities with a reception area and receptionist who could triage students
- a mixture of full and part-time nurses
- a full-time social worker and guidance counsellor
- a community liaison worker
- cops in schools
- youth workers.

Integration

The integration of student support services also varied from school to school. Where there was a common locality for student support services and an identified person within the school responsible for them, there was greater integration between support service providers as well as greater connectivity with deans, teachers and other school staff.

Where the principal had a high degree of interest in and respect for the services provided by the nurses and social workers:

- the services were more closely integrated with the school
- the student support staff were more likely to be included in wider school activities such as daily staff briefings, general staff meetings, parent evenings and so forth.

The principal in this way also influenced how the student support services were viewed by teachers and other school staff.

Similarly, the service providers themselves influenced the degree of integration of their respective services within the school. Some providers had a greater appreciation than others of the need to promote their services and themselves as a key part of the professional school staff. Some service providers contributed to wider school activities, for example coaching sports teams, training waka ama teams and taking kapa haka groups. This enhanced their profile within the school with both teachers and students.

Generally teachers understood the role of the counsellor and saw them in more of a collegial manner than nurses and social workers. This was primarily because the counsellors came from teaching backgrounds and were perceived to understand the student issues teachers had to deal with.

Teachers also perceived that they understood the role of the school nurse and were confident in referring students to the service, with 87 percent of teachers having done so. The nurse's role was seen as a separate service offered to students and quite distinct from that of the social worker and counsellor. The nurse was valued as a member of the school staff, but seen more as a part of the supportive infrastructure for teachers rather than as a professional colleague. This is reinforced by the fact that nurses are usually employed as part of the school support staff, rather than in a separate professional grouping like the teachers.

The social worker role was the least understood by teachers, despite 65 percent of teachers that responded to the survey having made referrals to them. The teachers were not as clear about how the role of the social worker complemented that of the school counsellor as they were of the role of the nurse.

Funding and employment

Some of the schools augmented the funding they received from their respective DHBs to employ nurses so they could have a greater ratio of nurses to students.

The social workers were all fully funded by the MSD and were all employed full-time. The social workers were employed by NGOs who had a contractual agreement with the school for the services they provided.

The employment of nurses, by contrast, varied. The nurses in eight of the nine AIMHI schools were employed by the school (the ninth by a PHO). The principals of the schools tended to employ nurses for school hours only, as this enabled them to have more nurses available when students were present at the school for the funding they received and in effect also increased the ratio of nurses to students.

As a result, nurses had to spend their own time outside of school hours doing reports, preparing for health promotion activities and other health projects, attending school nurse meetings and undertaking their own professional development and education.

Nurses' earnings from their school employment, primarily because of their 'part-time for term time only' status, were less than those of the social worker, which in turn was less than those of the school guidance counsellor. The school counsellors, like the social workers, were all employed on a 52-week basis, whether part or full-time.

As a result, some nurses needed to augment their earnings by working on a casual basis during the school holidays. Working school hours only, however, did suit some of the nurses and was a factor in applying for the position.

Meetings for school nurses held within school hours were not popular with principals, as schools were effectively left without a health service for the duration the nurse was away. A number of the principals stated that alternative nurse coverage should be provided when the nurse was obliged to attend such meetings.

Co-ordination and co-operation amongst health and social service providers

In most schools, the different health and social service providers engaged in joint planning and regular meetings. This was found to greatly assist the provision of a timely and comprehensive service to students through referrals and collaboration.

Student experience and perceptions of the service

The student survey results clearly show that, where students had prior experience of the service, they understood it better and were more likely to return. Perceptions, particularly of the health service, were positive. A key influencer for the use of the service by students was the level of confidence and trust they had in the service providers, particularly regarding privacy and confidentiality.

The health assessment provided an opportunity for promoting the service to students. Students who have had a health assessment are almost twice as likely to use a school-based health service in the future. In turn, students who use school-based health services are more likely to access community-based health and support services.

Students are far more likely to use the services of the school social worker and counsellor if they have already had experience of the school nurse. The school nurse has a key role to play in the integration of the school support service.

Health services

Health services across the schools varied from being a five-day per week, purpose-built, accredited and comprehensive service, with formal governance, to a service limited to two mornings per school week, with a one-person sick bay and a single room that acted as office and consulting room for two practitioners simultaneously.

Health assessments

All but one of the schools provided Y9 health assessments (HEADSS assessments). These were introduced with the establishment of the school-based nurses. They are considered invaluable by health practitioners, other student support providers and the school alike. Issues arising from these assessments need to be addressed for students to be able to engage effectively in learning.

HEADSS assessments from three of the AIMHI schools showed:

- between 5 and 25 percent of students were obese
- 6 percent of students had elevated blood pressure (greater than 130/90)
- 10 percent had impaired hearing
- 8 percent had impaired vision
- between 6 and 23 percent had low levels of resilience.

The assessments take one to two hours per student, with up to five hours' follow-up required. The assessment work takes the nurse anywhere from half to all the school year to complete, depending on the number and complexity of the students' needs.

Compared with students who have not had a Y9 health assessment, students that have are:

- more than twice as likely to use the health service again
- more likely to access mainstream primary and secondary health and support services.

Use of services

Data collected from six of the AIMHI schools over a four-year period showed:

- over 500 referrals are made each year to other services such as counselling, social support and primary and secondary health services
- 10 percent of students failed tests for vision
- 24 percent of students failed tests for hearing
- the average body mass index (BMI) of the students had reduced by 1.1 over the period.

All secondary school students from Y9 to Y13 in the survey had access to nurses and, where provided, on-site doctor's clinics and physiotherapists. On average between 30 and 50 students were seen on any one day in the eight AIMHI schools that had a full school-based health service operating. This was consistent with other secondary schools in the Auckland region, where over 900 students are seen each day in Decile 1–10 secondary schools with school-based health services.

Data on consultations, collected as part of this evaluation from five of the AIMHI schools, showed on average that:

- 9 percent were for sexual health
- 16 percent were for accidents and injury
- 1–2 percent were for mental health issues
- 14 percent were for dermatology
- 10 percent were for neurology
- 10 percent were for gastroenterology.

Students who accessed the health service were:

- more than six times as likely to use the services of the social worker
- more than three times as likely to use the counsellor
- more likely to perceive that the school listened to their problems.

Stakeholder perspectives

The main stakeholders for school health support services are students, teachers, parents and practitioners themselves. The following summarises their perceptions of the service.

Students' perspectives

'Someone that understands you, listens to every word and keeps your secrets.'

Students were positive in their feedback about school health services. Students found that school health services provided:

- easy and ready access
- a private and confidential service within the bounds of the facilities
- supportive, professional and non-judgemental staff
- a means to safely and legitimately consult a nurse or doctor without their parents knowing
- a wealth of knowledge they could tap into to learn about their own health and wellbeing
- the opportunity to set different expectations for themselves in terms of the way they were prepared to live
- experience in managing their own health
- confidence to access other health services in the community[11]
- first-hand observation of career options in the health sector.

Where a school had doctors' clinics as well, or had an arrangement with a GP close by the school, students saw these as a key part of the service. Students did not find it easy to access medical services outside of those linked with the school. Reasons for this included:

- unwillingness to go to the doctor independently of their parents
- reluctance on their parents' part to go to the doctor

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11 This feedback from the students is supported by the observations of the health providers (Earp, Dawson and Davison 2007).

- the costs involved in accessing a doctor and/or the potential costs of the treatment

- not knowing the doctor enough to be comfortable to confide in him or her

- fear of being seen by relatives attending the same health centre.

The Pacific students stated that they preferred health practitioners, (both nurses and doctors) who were not of their own culture. This gave them assurance that their consultation would remain confidential, as the health practitioner would not know any of their relatives or be part of their family's wider networks, precluding their parents and other close relatives from being able to 'quiz' the health practitioner and press them for information.

Students spoke about the nurse's ability to access specialist services on their behalf and to have their health issues properly attended to, for example:

- hearing deficits

- impaired vision

- poorly controlled asthma

- poorly controlled diabetes.

Students with chronic conditions said that the school health service had enabled them to:

- gain a better understanding of their condition

- manage their condition in a way that allowed them to maximise their participation in other school activities

- spend less time not well and off school

- reduce their admissions to hospital.

These students appreciated the follow-up that the health service provided in ensuring they managed their condition effectively, as well as the positive manner in which they were treated if they had not been acting responsibly with their condition.

Teachers' perspectives

'If the students are healthier, their problems dealt with, and they are safe, they do better. This is not rocket science.'

Teachers viewed the student support services as an essential part of the school and believed the school would not be able to function as effectively as it did without the services. Teachers had a high degree of comfort referring students to the school-based health services. They said that the presence of the health service in the school:

- enabled students' health issues to be dealt with more effectively, which had a positive impact on learning

- relieved teachers of the stress of having to manage situations concerning student health issues, which they were not well equipped to do

- provided a source of information, advice and resources for teachers in interacting with students with health problems

- along with the presence of the other student support services, enabled teachers to focus more on their teaching and students to focus more to their learning

- contributed to reduced truancy and students staying at school longer
- gave greater depth to the school's ability to provide and support the health education syllabus.

Teachers noted that:
- the resourcing of health services has not kept pace with the increasing complexity of problems and issues that students now present with
- coverage of the school-based health service needs to be extended beyond school hours so students can be seen outside of classroom hours
- there needed to be greater collaboration and feedback between teachers and health providers.

There were three teachers of those surveyed (1.1 percent) who said that they did not see the necessity for school-based health services.

Parents' perspectives

'As a parent I think the health service is good. The nurse got hold of me about my daughter and we got her hearing fixed up. The nurse got her seen by the doctor and got it sorted out.'

Only limited feedback was able to be gleaned from parents. Of the parents that did give feedback, 91 percent said that they were particularly pleased that the school had a health service for their children. The parents thought that the student health service was:
- accessible
- helpful
- had improved the health of their child(ren).

No parents expressed any negative experiences or concerns about their children using the school-based health services.

Practitioners' perspectives

Nurses

The nurses all acknowledged that the health needs of students were largely unmet without a school-based health clinic. This included health issues the students and their parents were aware of, as well as a significant number of health issues students and their parents were not aware of, for example hearing and vision deficits.

The nurses also saw their role as one of providing early intervention health services to students and managing normal teenage risk-taking behaviour to prevent it escalating and having a significant impact on their health and wellbeing and future lives.

Having two nurses available when health assessments are being undertaken ensures the assessments are completed without interruption by other students with an urgent need to see a nurse. Having uninterrupted time with a student is seen as important, particularly when the visit is a student's first.

Where schools have invested further operational funds into nursing services, the nurses have been able to work more proactively in the areas of health promotion and health education, including participating in the school's education curriculum.

Nurses also need to be able to reliably refer students to a GP.

Ideally, nurses see that the health service should be provided from purpose-built or modified facilities. This ensures that students get the privacy they require and the nurses can provide a safe and quality service. It also enables the health service to adequately accommodate visiting practitioners, such as GPs, physiotherapists and nurse educators. Having close proximity to the other student support practitioners, such as the school counsellor and social worker, is seen as advantageous, as is distance from other school areas where teacher and student traffic is commonplace.

In terms of employment and funding it is important to nurses that they are professionally accountable to a body that understands the profession, their scope of practice and the resources they need.

Social worker

The social workers, similar to the nurses, have had to actively establish their role within the school environment. They have found being employed by an organisation outside of the school to be advantageous in this regard. Having an employer outside of the school has enabled them to:

- maintain their autonomy and effective advocacy role for students and their families
- work within their professional codes without being compromised by conflicting school protocols and processes
- be recognised as a professional in their own right
- be protected from having to perform non-social work functions, such as hand-delivering notices to parents.

Such issues are typically discussed by the school and the social worker's employing body at the time the service to be provided is negotiated.

The most common issue for social workers was the clear delineation of their role in relation to that of the school counsellor. In most of the schools this was successfully resolved. Where there were ongoing issues, it was usually because the social worker believed the school counsellor was doing work that they should be doing or vice versa.

The social workers saw their relationship with the nurse as effective, with both understanding each other's roles and providing complementary and collaborative services as appropriate to meet the needs of the students.

The social workers felt they could provide nurses with links to community resources to support students as well as explain cultural and family values that might be impacting on a particular student in terms of their health and wellbeing.

Similarly, the nurses could provide the social workers, as appropriate and with consent, with information from the Y9 health assessments that may impact on the social worker's management of the student's issues.

Social workers saw advantages in having student support services co-located, as this enabled:

- ease of mutually referring students to other student support service providers
- timely exchange of information outside of set meeting times
- ease of meeting to discuss students with complex needs
- a greater sense of involvement and reduced sense of isolation within the school environment.

Counsellor

School counsellors are a well-established part of the school environment and generally have a teaching background. The expansion of student support services has influenced their role within the school. Most have found this a positive development and feel that the social worker and nurses are better placed to deal with some of the issues they previously picked up by default.

Like the social workers, the counsellors saw the benefits of being co-located. The location of all the student support services together lent itself to the provision of appropriate reception and scheduling services for students. It also meant that meetings could be held in common spaces, and there were safe places in which to let students regain their composure.

The counsellors generally understood the role of the nurse and liaised well with the nurse. Like the social workers, the counsellors acknowledged that their respective roles needed to be clearly understood to ensure there was no duplication of effort or confusion for students or staff.

Counsellors and social workers expressed a great deal of satisfaction with the student support services team's ability to work together to provide wrap-around services for students

Issues

Support for the school

To establish school-based health services requires schools, and particularly principals, to understand the associated philosophies, goals and objectives and to feel empowered and well-supported with the process. If a principal is expected to employ the nurse, for example, he or she will need hands-on help, having an education-based rather than a health-based scope of expertise.

Having a group of principals that can support each other while going through the process fosters camaraderie, information sharing and shared problem solving.

One school in the current study had not established a full nurse-led school-based health clinic. This school was isolated geographically from the other schools, which were all located in South Auckland. The principals in South Auckland have always been able to meet regularly and give each other support with this process. Likewise, originally one DHB was involved in supporting the establishment of the service at the eight Auckland schools.

Both the CMDHB and the ADHB have established comprehensive processes to support schools in establishing school-based health clinics and helping nurses to establish and develop their roles within the schools.

Support in schools

If principals are well supported, they in turn are able to ensure support is present within the school for the school-based health service and the changes that may be required in the school to accommodate it, along with any changes in roles, processes and infrastructure. Ensuring key staff (for example, the school counsellor and other staff involved with pastoral care) are involved from the start facilitates a smooth introduction of the service and demystifies this service for staff and students.

Where the lead nurse has been with the service since its inception, services tend to flourish and develop to a greater extent than those that have had a turnover of nurses.

Where there has been a higher turnover of staff, the development of services tends to slow, and the focus to remain primarily with completing Y9 health assessments and meeting a demand-driven service, for example students' first aid needs.

Where schools had also invested operational funding to augment the nurse-to-student ratio, this had strengthened the services provided to support students and enabled the school-based health service to become more actively involved in:

- health promotion initiatives

- health education

- sourcing additional health services for students within the school (for example GPs and physiotherapists)

- sourcing additional funds for student health initiatives and to meet individual student health needs.

These activities had lifted the visibility of the health service in the school and promoted its integration and support. One school's health service had gained external standing by being accredited by Quality Health New Zealand.

Facilities for the schools

Some of the schools did not have adequate facilities to provide a confidential service to students. Available capital funding had not always been used on the health service. For example, one school used their funding (with other monies) to ensure their classrooms were acoustically sound so the students could effectively hear their teachers, as this was seen as a more pressing priority.

At one school, where there were new school buildings being commissioned, the health service and student support services had not been factored into the build, though their facilities were inadequate at the time.

A number of the schools had modified buildings which were not sound-proof and did not afford the students privacy when waiting to be seen: students had to sit or stand in hallways and corridors.

Consulting areas that are too small to accommodate any support person the student might want with them – particularly for students for whom English is their second language – are not student-friendly either.

One facility had two practitioners working from one room simultaneously. The staff that used the facilities had not had input into their design.

The best arrangement of facilities a purpose-built area where student support services are co-located, are serviced by a receptionist and have a common waiting area.

Infrastructure for nurses

Nurses need support both external to the school and within the school to function in a safe and optimal way.

The ADHB and the CMDHB have established formal processes to ensure their school nurses are supported through a process of peer support and external supervision.

Auckland school-based nurses have established the Auckland School Nurses Group, a professional body affiliated with the College of Nurses Aotearoa (NZ) Inc. In Wellington there is also a school nurses group that meets on a regular basis.

Within the AIMHI schools, multi-disciplinary meetings of student support and pastoral care teaching staff were generally well established and occurred in a structured way.

Processes by which nurses worked, however, in some schools limited the nurse's autonomy to practice. For example, in one school, before the nurse could refer the student to an outside agency, approval had to be sought from the person in charge of pastoral care. Nurses were in some cases answerable to someone who did not give them latitude to practise autonomously, or to someone who had minimal understanding of health and was controlling and restrictive. Nurses need an infrastructure that facilitates their work and the effectiveness of the services the provide.

Turnover of nurses

The turnover of school nurses in the AIMHI schools has been high (40 percent), with some schools having had more than three different nurses leading their health service in the past five years. Four of the nurses in the nine AIMHI schools were new to the position in 2008.

Such turnover slows the development of the service and its integration within the school and wider school community. While staff turnover is inevitable, and to some extent desirable, it is important that the role and employment conditions provide an attractive and satisfying career choice for nurses with the level of skills, knowledge and attributes required to fulfil and develop the role effectively.

Data collection

School-based health clinics are potentially a rich source of information about the health needs of young people. At present there are a variety of databases used to collect information which do not have standardised, defined categories. To make useful observations and meaningful comparisons, a standardised data dictionary is required.

Added to this, nurses should feel confident and be proficient in using the database and extracting information relevant to their school and service.

Ratio of nurses to students

The ratio of registered nurses to students within the AIMHI schools varies considerably. Six of the schools had ratios better than the 1:750 which is funded by the Ministry of Health through DHBs. The remaining three schools had ratios that were 20 percent higher than that funded by the Ministry. Some schools also had enrolled nurses.

Many students in these schools have high and complex needs. Ideally resourcing ratios should take account of the level of these needs in each school.

Profile of the AIMHI Schools

Introduction

Understanding the profile of the AIMHI schools is important to put the findings of the current evaluation in context. All but one of the AIMHI schools are located in South Auckland. The remaining school is in Cannons Creek, Porirua. Seven of the schools are co-educational; McAuley High School (McAuley) is an all-girls school and De La Salle College (De La Salle) is an all-boys school (Table 1).

Composition and comparison with 2004

McAuley and De La Salle are the only integrated schools (both have the special character of being Catholic schools), with the remainder being state schools. Three schools also had pupils from Y1 to Y8. Southern Cross Campus (Southern Cross) and Sir Edmund Hillary Collegiate (Sir Edmund Hillary), for example, have pupils from Y1 to Y13, and De La Salle has pupils from Y7 to Y13. For the purposes of this evaluation we only considered the Y9–Y13 students of these schools.

Student numbers

Overall, the numbers of students within the AIMHI schools have increased by 5 percent since 2004.[12] While Mangere College's (Mangere) roll has fallen by 8.7 percent, all the other schools have increased their rolls. Porirua College (Porirua) has experienced the greatest growth of the AIMHI schools, at 22.4 percent (Table 2). The two full Y1–Y13 schools, Southern Cross and Sir Edmund Hillary, have also had significant growth of 7.6 percent and 9.8 percent respectively.

The growth in the AIMHI schools has been three times greater than that in other Decile 1 schools, which have had 1.47 percent growth in numbers over the same time period.

Table 1: Gender mix of AIMHI schools, 2008

School	Male	Female
De La Salle College	100%	0%
Mangere College	48%	52%
McAuley High School	0%	100%
Otahuhu College	49%	51%
Porirua College	49%	51%
Sir Edmund Hillary Collegiate	47%	53%
Southern Cross Campus	44%	56%
Tamaki College	54%	46%
Tangaroa College	48%	52%
Total	**49%**	**51%**

Sourced from Ministry of Education Data Management Unit

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12 Ministry of Education data, 2008

Table 2: AIMHI school rolls – 2004 compared with 2008

School	2004	2008	Growth
De La Salle College	690	733	6.2%
Mangere College	724	661	-8.7%
McAuley High School	624	636	1.9%
Otahuhu College	1341	1387	3.4%
Porirua College	478	585	22.4%
Sir Edmund Hillary Collegiate	499	548	9.8%
Southern Cross Campus	751	808	7.6%
Tamaki College	610	682	11.8%
Tangaroa College	1028	1046	1.8%
Total	**6745**	**7084**	**5%**

Sourced from Ministry of Education Data Management Unit

In terms of year groups, the AIMHI schools have their greatest number of their students in Y10. This was the case in 2004 and 2008 (Figure 2). More students, however, are remaining at school into the senior years. This year, the AIMHI schools have had a total of 1427 Y9 students. These Y9 numbers are a principal driver of the school nurse's work. Since 2004, there has been a 2 percent decline in Y9 students but a 5 percent increase in students overall. This is a reflection of increased retention of senior students in the AIMHI schools. Since 2004, there has been a 29 percent increase in Y13 students and a 9 percent increase in Y12 students. This compares to 9 percent and 6 percent increases across all schools (Figure 3).

Ethnicity

The ethnic profile of the schools collectively is predominantly made up of Pacific (78 percent) and Māori (16 percent) students (Table 3). The proportion of Pacific students has increased since 2004 by 3 percent, while the proportion of Māori students has dropped by 3 percent over the same time.

Only two of the schools, Mangere and Sir Edmund Hillary, did not follow this trend. In both these schools the Māori roll increased, and the Pacific roll decreased and stayed constant respectively. Only Porirua reduced its percentage of both Pacific and Māori students.

Nearly a quarter of all Pacific students in New Zealand attend one of the AIMHI schools (23 percent). Only 2 percent of all Māori students in New Zealand attend one of the AIMHI schools. This compares with less than 1 percent of Pacific students attending other Decile 1 schools in New Zealand and 6.9 percent of Māori (Table 4).

The AIMHI schools make up 61 percent of the population of all Decile 1 schools in New Zealand. Between the AIMHI and other Decile 1 schools Māori and Pacific students predominate.

Figure 2: Comparison of student numbers by year group, 2004 and 2008
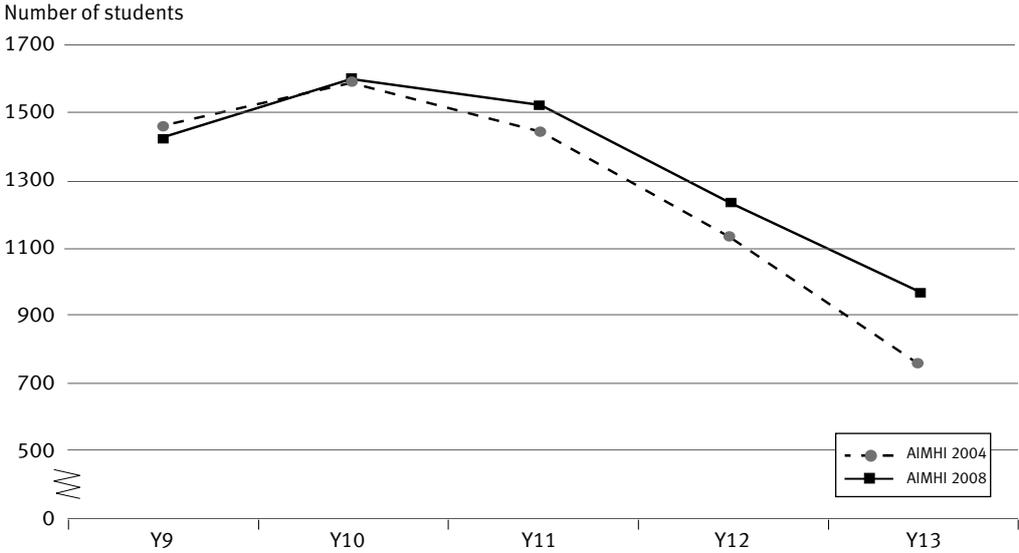
Number of students

Figure 3: Comparison of percentage change between 2004 and 2008 in numbers of students in each year group
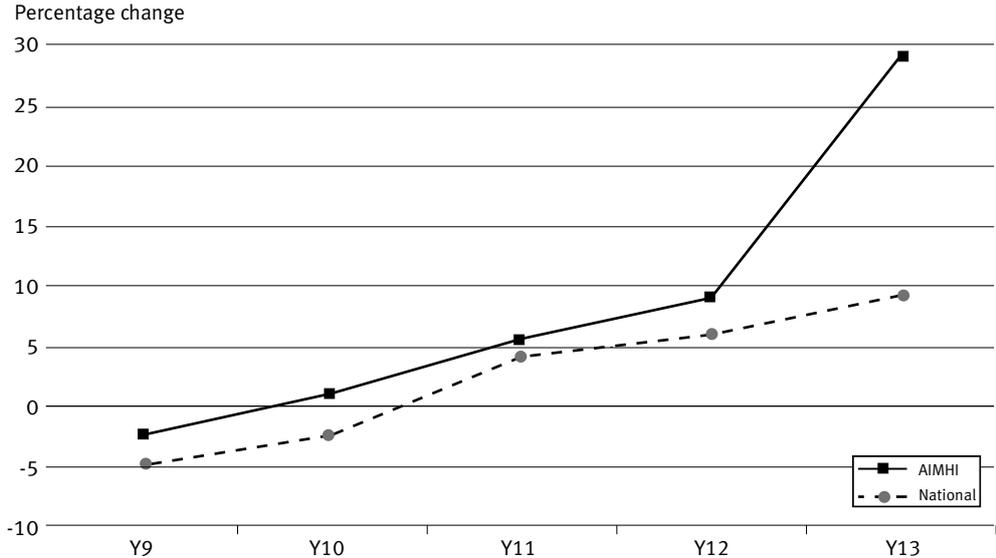
Percentage change

Table 3: Percentage of Māori and Pacific ethnicities in the AIMHI schools, 2004 and 2008

School	% Māori		% Pacific	
	2004	2008	2004	2008
De La Salle College	6	4	83	89
Mangere College	18	22	77	74
McAuley High School	6	5	86	88
Otahuhu College	17	15	72	77
Porirua College	23	20	71	70
Sir Edmund Hillary Collegiate	13	15	85	85
Southern Cross Campus	33	25	64	72
Tamaki College	30	26	64	70
Tangaroa College	21	15	75	80
Total	**19**	**16**	**75**	**78**

Sourced from Ministry of Education Data Management Unit

Table 4: Ethnicity of AIMHI school students, 2008

Ethnicity	AIMHI	Decile 1*	National
% Māori	16.0	79.8	19.0
% Pacific	78.0	4.1	8.5
% European	1.3	15.1	58.6
% Asian	3.7	0.7	9.1
% Other	1.0	0.3	4.8

*Decile 1 exclusive of the AIMHI schools

Sourced from Ministry of Education Data Management Unit

Service profile of AIMHI schools

Initially the schools had used their operational budget for education, with special grants to meet the costs of providing health and social worker support services for their students. It was recognised that a minimum level of funding needed to be provided, with additional money for those schools who had larger rolls.

This model of funding was not sustainable in the longer term, and the responsibility for the services was transferred to the Ministry of Health and MSD respectively. Funding for nurses was allocated on a 'per student' ratio of 1:750, based on an estimate of hours required. Funding for social workers was originally based on a 1:500 ratio. This is no longer evident, with fully funded ratios for social workers varying from 1:350 to 1:1100, reflecting funding allocations for social workers done more on a school–case-by-school-case basis than by a fixed ratio.

Figure 4: Typical numbers of students to support providers
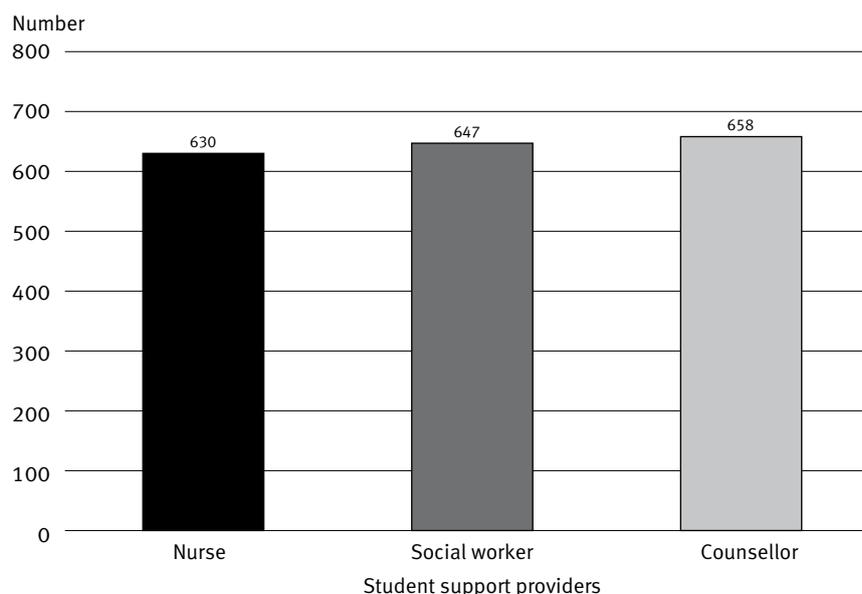
Source: PricewaterhouseCoopers using data provided by the AIMHI schools, 2008

The AIMHI schools have used whatever means they can to maximise their professional student support coverage. In some instances, schools have continued to provide additional funding from operational funds and/or have employed part-time nurses for formal student contact hours only. As a consequence, the ratio of nurses to students can be greater than that funded by the DHB and varies more widely than that of social workers (which is 1:333–1:3716). Figure 4 shows the more typical pattern of the schools, with outliers removed (‹1:400, ›1:1000). One school had not been able to effectively access the funding to establish a school nurse position within the school. At this school there was already an agreement in place with the DHB for the PHO to provide limited cover for a nurse (seven hours per week) and GP (three hours per week). This situation has since been addressed, and the school has been able to employ a nurse from February 2009.

The make-up of student support services differs within each school (Tables 5 and 6: RN refers to 'registered nurse' and EN to 'enrolled nurse').

Table 5: Support services in AIMHI schools

School	Number of nurses	Full time equivalent (FTE)			
		RNs	RNs and ENs	Social workers	Counsellors
De La Salle College*	1	0.75	1.38	2.0	0.6
Mangere College	2	1.17	1.17	1.0	1.0
McAuley High School	2	1.28	1.28	1.0	1.0
Otahuhu College	3	2.00	2.00	2.0	2.0
Porirua College	1	0.15	0.15	1.0	1.0
Sir Edmund Hillary Collegiate	3	1.30	1.30	1.0	1.2
Southern Cross Campus*	3	1.18	1.82	1.0	1.0
Tamaki College*	2	1.00	2.00	1.0	0.8
Tangaroa College	2	1.06	1.06	1.0	1.0

* Has a combination of registered and enrolled nurses
** Full-time equivalent based on 2080 hours per annum

Source: PricewaterhouseCoopers using data provided by the AIMHI schools, 2008

Table 6: Other support staff in AIMHI schools

School	Other support personnel available to students
De La Salle College	Youth worker, resource teacher: learning and behaviour (RTLB)
Mangere College	RTLB, youth worker, community liaison officer
McAuley High School	Community liaison officers, careers counsellor
Otahuhu College	GP, community liaison officers, cops in schools
Porirua College	GP, community liaison officers, RTLB
Sir Edmund Hillary Collegiate	Cops in schools, youth workers
Southern Cross Campus	RTLB, cops in schools
Tamaki College	RTLB, GP (limited to one hour per week), teacher aides
Tangaroa College	Cops in schools, youth workers

Source: PricewaterhouseCoopers using data provided by the AIMHI schools, 2008

Findings: School Visits

Introduction

The AIMHI school visits provided an opportunity to observe the facilities and operation of school student support services and to meet with service professionals, school management and staff and students. The visits also enabled the evaluation team to communicate the objectives of the evaluation exercise and provide information about the staff, student and parent surveys.

The approach was structured around gaining an understanding of each individual school student support service – the type and quality of the facilities; the service's interface with the school, the service's configuration and integration, and the experience and attitudes of student support service staff and teachers. The visits also explored the use made of Y9 health assessments and how student support services facilitated better outcomes for students.

This section of the report summarises observations and findings from the school visits. The results of the surveys of students, staff and parents are presented in Section 6. A quantitative analysis of the outputs associated with student support services is discussed in Section 7, along with the overall student outcomes associated with education.

Type and quality of student support service facilities

Size and set-up

The size and set-up of facilities for student support services varied from school to school (Figure 5). Some schools had purpose-built facilities that incorporated health, counselling and social work services. Other schools had student support services in the same vicinity, but they did not share a common reception area. There were also schools that had two services close by and a third service some distance away. One school had all three services separated.

Figure 5: Comparison of waiting areas in AIMHI schools

(a) Specifically designed reception area and support service facilities

(b) No reception area and use of small rooms designed for other purposes

Facilities

The standard of the facilities varied markedly from being less than adequate to being well designed and purpose-built.

Adequacy of facilities

The least adequate situation was that in which no physical purpose-built modifications had taken place for support services. For example, at one school student support staff were housed in three small separate spaces, some distance apart, which opened directly to a main thoroughfare for both staff and students (Figure 5 (b) shows one of the two main corridors involved).

The facilities at this school (School A) are briefly described below.

- The health facility was no more than a 'first aid' room that included a toilet accessed from this room only and a sick bay (Figure 6 (a)). The room, named the 'sick room', had a plinth, desk, which was incorporated with a cupboard, and a sink. The toilet off the room did not have its own sink. Sitting at the desk obstructs the doorway. This room was used simultaneously once a week by the visiting doctor and the nurse. The sick bay was a single room.

- The social worker's room has two small windows approximately five metres above the floor level, just below the ceiling of an ex-store room (Figure 6 (b)). The room is shared with the community liaison officer, and appeared to be less than three metres square. It was furnished with two very small desks and small chairs.

Figure 6: Student support facilities

(a) Health facilities at school A

Consulting room ('sick room')   Sick bay

- The counsellor's area at this school is only marginally better (Figure 6 (c)). The counsellor does not have to share the office, which does have a proper external window and can accommodate two chairs for people to sit on, albeit within touching distance of the door. However, it is not a room that is conducive to taking the heat out of situations, dealing with behavioural issues or meeting more than a single person. Like both the social worker's and nurse's areas it is not sound-proof or conducive to privacy, and does not have a discrete access.

Providers commented on the need for adequate space to enable families to meet in the room, particularly in the case of the social worker. Some facilities had a meeting room available for family and group meetings.

Most facilities had a separate sick bay for students. In some cases there were two beds in one room. This was cited by students as less than ideal, since it provided limited privacy and meant both genders had to share a room (in co-educational schools). The nurse's room doubled as a sick bay in two schools, which limited the ability of the nurse to work effectively.

Privacy

Privacy and confidentiality were considered by providers, staff and students to be an important aspect of the service. Students felt more comfortable when it was not obvious in the waiting area which service they were about to use. This was a challenge to achieve in some facilities, where the professionals' doors opened into the waiting area, or the group meeting room was in view of the waiting room. Students commented that they did not like sitting in an open waiting area.

Figure 6 (continued)

(b) Social worker's room at school A

Picture taken with flash   Only source of natural light

(c) Counsellor's area at school A

Left: Entrance to
L-shaped room

Right: Desk taken
from window

In some schools, there were interconnecting doors between professionals, and it was therefore not obvious who was being visited.

Some of the consultation rooms were adjacent to one another, and an issue of overhearing voices was raised several times. One way of overcoming this was to have a radio on in one room, which seemed to 'drown out' the voices.

In addition to trying to manage the space to ensure confidentiality, schools have a confidentiality policy in place, aligned with the legislation, which guarantee that a student's issues are not divulged to other providers except in the event of the student being at risk of harm from someone, at risk of harming themselves or at risk of harming someone else.

Equipment

Most nurse rooms had equipment that enabled basic emergency care to be provided, as well as necessary dressings and so on for wound care and a refrigerator for drugs and vaccines. One nurse commented that it was like 'running a ward and an Emergency Department at the same time'. Equipment was generally considered adequate for nursing requirements.

School information systems

Information systems played an important role in the schools. Schools used various administration systems which could provide real time reporting for such things as administration, attendance, pastoral care and statistics. KAMAR is a student management system (SMS) that has been designed for New Zealand schools to assist teachers and administrative staff in the day-to-day recording and reporting of students during their time at school. This system enables the school to know where any particular student is, and to collect information on students.

This information system is also used by the student support service for managing students and tracking common information.

Support service information systems

School-based health providers currently use a variety of information technology (IT) systems to collect data and record information from consultations. Some of the IT systems currently used can only be accessed by the particular professional who enters the information. This is seen to serve as a barrier that prevents the sharing of information between providers working with students. Some of the student support professionals commented on the need for confidentiality of some information, and that information systems need to be able to cater for this.

School nurses across the country use at least six different information management systems. Amongst the AIMHI schools nurses used either Medtech32 or the specifically designed PUPIL database. Social workers have their own system, while counsellors often use paper-based notes or enter generic details into the school pastoral care system, KAMAR.

Service availability

Service providers were generally available to students and staff during school hours, typically 8.30 am to 3.00 pm. In some schools, nurses, social workers and counsellors needed to work after these hours in order to meet student demand, or to see parents and/or caregivers as a part of resolving the student's health or wellbeing issues.

Comment was made by teachers that the whole student support service needed to be available at the margins before and after school (at least 8.00 am–4.00 pm) to enable greater access for students.

Attendance of service providers at school assemblies and meetings is sometimes affected due to appointments with students, and they are often busy at the start of school and during breaks as well.

Several of the nurses indicated it is really difficult to get other nurses to cover for them during holidays or sickness. Unlike counsellors and social workers, many school nurses are employed only for school hours during school term time only, making their position part-time. This may be a contributing factor to the difficulties in attracting appropriate nurses to this role.

Service interface with the school

Meeting and briefing attendance

School student support services generally seemed well integrated into the mainstream activities of the school. Nurses, social workers and counsellors, where their workload permitted, attended school assemblies, as well as daily/weekly staff briefings. Service providers generally have regular weekly, monthly or quarterly meetings with senior teachers and deans. Several comments were made that health staff need to attend assemblies and other school activities, in order to build rapport and trust with the students. In one case the social worker had also taken on the role of the manager of the school rugby team.

Teachers and service providers generally felt that the service was integrated with the school.

Class contribution

At some schools nurses provide in-class education sessions on topics such as healthy eating. It was noted by some nurses, however, that pressure on time and resources (for example, one nurse undertaking HEADSS assessments and one nurse providing walk-in consultations full-time) makes the provision of such sessions a challenge. As one nurse stated, many nurses would welcome the opportunity 'to get into the classroom if we were adequately staffed to do so' to provide health education and health promoting sessions for students. The nurses did note, however, that they were not at the school to take the place of teachers and their role in delivering the formal health curriculum.

School strategy or charter

Often the student support service was integrated into the school strategy and/or charter. This achieved alignment for the school, and also enabled service staff to feel that they were not doing things that were inconsistent with the school philosophy.

For example, one school included the health service in its school strategy, supporting a vision for a 'wrap-around service' that is 'interdisciplinary, integrated and holistic'.

At another school, a student support service provider has involvement on the school's policy committee, enabling consistent policy development and implementation within both the support service and pastoral care service.

Key relationships

Nurses, social workers and counsellors meet regularly with school senior management (heads of departments, deans, principals) and the school pastoral care team (where this is in place).

The dean in some schools is the point of referral to other student support services and therefore can build a key relationship with support staff.

The location of the school dean near to the health service was considered a benefit in one school – others felt it was disadvantageous for students.

One issue is that deans provide both pastoral care and discipline, therefore close location with the support service can have a negative effect.

Staff use of services

Staff generally felt able to and did use the services of the health service, particularly the nurse. The counsellor was used, but less often. This use was seen by the staff to have the beneficial effect of supporting them in their teaching. Service providers seemed happy to provide services to staff, but some did comment that this was more appropriate for emergency situations.

Schools affiliated with a religious denomination

Provision of health services in a religious school poses a challenge where the values of the school are potentially different from those of a secular service (for example medical and counselling advice on sex education, abortion and so on). Currently this is overcome through having some staff in the service from the same religious background as that of the school.

Service configuration and integration

Support service providers

The configuration of nurses, counsellors and social workers differed from school to school (see Section 3 above). The most common configuration of providers for the student support service comprised two nurses, a counsellor and a social worker. In some schools a youth worker worked alongside the social worker.

Service administration

A number of schools had staff dedicated to 'receptionist' duties within the service centre. In these centres the administrative staff contributed to the efficiency of the service through assessing the veracity of students' needs for the support service (for example, filtering the 'waggers'), ensuring that students with genuine needs were not waiting unnoticed, maintaining safety in the waiting area and ensuring that immediate service was provided to students in acute need of attention. In other schools the professional staff took turns to check the waiting area.

Schools also used paper-based booking systems (booking slips) and collection boxes for self-referral and booking of appointments with service providers. Boxes were examined for slips several times a day.

Access to GPs

GPs were used for those matters beyond the scope of the nurse. Practice regarding GPs differed in schools. One school arranged access for students to a nearby local GP, who was willing to take students at no cost for consultation. This access to the GP was seen to be a real strength of the service by staff. In contrast, another school relied on students seeing their family GP for more complicated matters. Students found this to be less than satisfactory, as they would have liked to see a GP not connected with their family. In other schools, nurses took the students to the local GP practice, waited until the consultation was completed and then took them back to school.

External networks

Service providers valued the opportunity to establish and be part of the community network of other health and social service providers. This was particularly the case for social workers.

At least one school worked with a local health provider and included them in their service steering group – this meant education opportunities could be tapped into by the health service staff as well as assistance with issues such as sterilisation of equipment/general infection control.

Co-ordination and integration

In most schools the different service providers engaged in joint planning and regular meetings. Service providers also met informally during the working day. This was seen to help facilitate integration between multi-disciplinary providers.

People commented that they often provided support and counselling to each other in the face of the stresses that were part of their job.

Comment was also made that a youth worker was needed to help with following up truants, as it was very time-consuming. Similar opportunities exist for collaboration in situations in which students tell one service provider of an issue that needs another to resolve.

Service provider ratios

Schools are funded on the basis of one fte nurse to every 750 students. However, some schools have lowered this ratio by using operational school funds to provide the level of service they believe the school needs. In schools visited there did not seem to be one ideal nurse to student ratio – this is very much dependant on the needs of the young people, and should ideally take into account the characteristics of the school student population, for example, numbers of students who have special health needs or who speak English as second language. Such a system has been introduced in Vermont in the United States[13].

Many of the nurses working in student support service centres commented that they do not get any breaks during the day and frequently go into the school during school holidays (for which they are not paid) to complete reporting requirements. This would indicate that there is some pressure on nursing resources in schools.

The nurse in one school noted that the more nurse time they have, the busier the health clinic becomes. One nurse commented 'in this school there is limitless scope to make a difference – the more resources we get, the better we can be'.

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13   Vermont State School Nurses Association Inc. 1999. *School Quality Standards*.

Experience and attitudes of student support service staff

Qualifications and experience

The experience, professional qualifications and attitudes of student support service staff were considered very important. Teachers commented that they want to focus on educational outcomes for students, and rely on the professional expertise of student support providers to deal with social and health issues.

Generally service providers (nurses, counsellors and social workers) in the AIMHI schools had professional or tertiary qualifications for their respective professional service. Some social workers and counsellors were currently studying towards their professional qualifications.

Teachers commented that they had confidence and trust in the nurses, counsellors and social workers, and this allowed them to get on with their own teaching jobs.

Professional development

Ongoing professional development opportunities were considered important for service staff. Service providers across all disciplines felt that it was important to maintain currency in their respective disciplines. They commented, however, that it is difficult to find time to attend professional development training that is run during the day. They also commented that some of the professional development training that is available is not really geared to the issues they deal with – those of Decile 1 students, few of whom are European or come from other than low socio-economic backgrounds.

Training in dealing with abuse disclosure and recognising abuse, drug and alcohol issues, mental health issues and other psychosocial issues is considered very applicable. Training in counselling for nurses is also considered important. Nurses, along with the counsellor and social workers, are told things that teachers do not get to hear. One nurse stated that students tell her it's easier to explain to teachers that they have a 'sore tummy' than revealing that their home situation is upsetting them or making them angry and disruptive. Information regarding current youth health issues, the latest party drugs and side effects and so forth are more useful than information applicable to more generic populations.

As school nursing is a developing specialty, it is good for nurses to have the opportunity to share their experiences and acquired knowledge with their peers from other schools. This enables a collective body of knowledge to built up and become available – an invaluable resource.

Impact of Y9 health assessments

Y9 health assessments place a high workload on the nursing service in the schools. However, it is considered to be worth the effort, as the assessments can make a significant difference to the students, their health, their wellbeing and/or their ability to learn. The assessments pick up hearing and sight issues, hypertension, obesity, lack of health knowledge about managing chronic conditions and issues that have not been revealed for fear of adverse consequences. This can include medical issues, sexual abuse and dysfunctional family environments.

Students' experiences

Students in group interviews generally expressed positive reactions to the service. Students stated that the services are easily accessed and have personnel readily available most of the time. Where the school only had limited coverage of student support staff this was raised as an issue. Some students said that they would like a choice of gender when it came to health services providers, as it can be embarrassing discussing some issues with someone of the opposite sex.

Confidentiality was considered to be important and respected by the service providers, particularly the nurses. The physical facilities, however, did not lend themselves to confidentiality, as rooms were not always sound-proof or out of earshot of waiting areas. There was concern expressed that teachers did not respect confidentiality and would discuss things that had been told in confidence with 'people they shouldn't'.

The students stated that using school-based health services had given them confidence to use other services within their communities, including local medical centres. Attributes of the school-based health service that were important to students included:

- the opportunity to talk about things that they couldn't talk about with their parents
- the opportunity to express themselves more freely about health issues because the practitioners were outside their own culture and did not know their family networks
- sufficient time set aside with the service provider (20 minutes at least), so that they did not feel rushed
- a GP who practiced at the school, because there was a chance of seeing relatives while waiting to see a local GP
- an area free from school deans, senior management and teaching staff 'as they want to know why you are there and ask you questions.'

What makes a great nurse, social worker or counsellor?

Students had definite views on what they valued in the service providers. They said:

- 'we tell them about our problems and they keep it to themselves'
- 'someone that understands you and listens to every word, and keeps your secrets'
- 'someone with a wide range of knowledge about different things to do with health'
- 'they do more than what we ask – they know when we are down or sad'
- 'staff need to be open minded and approachable'
- 'they need lots of resources and access to medicine for us'
- 'they need to be good listeners, give good advice and to know when you are uncomfortable with what is happening'
- 'they stick by you, no matter what, you can trust them'
- 'someone who is considerate of religion and asks questions to check it out with you'.

Student perceptions are more fully explored in the next section, which analyses the results of the surveys.

Intermediate outcomes

It is difficult to assess the direct impact of the student support service on educational outcomes. Teachers and support service staff, however, did express the opinions that there were positive impacts.[14]

- One teacher told the review team that 'we are a no excuses school – we tell the students that if they need help with anything they have options – tell us or tell the health centre staff – one of us will help you'.

- The ability to resolve social and physical or emotional issues as they arise has been highlighted as a key benefit for schools with an on-site health service. The students were seen to focus better in lessons: 'they are not sleepy', 'we can see the difference'.

- Resolution of physical difficulties such as hearing and eyesight were seen to have a positive impact on learning.

- Staff commented that the students feel happy that someone is caring for them, and this has a positive effect for education.

- Teachers expressed the view that 'the Health Centre keeps them at school longer' and that the work of the centre contributed to lower truancy.

In the words of one teacher: 'You need to know the whole package of what is going on for the young person – health underpins educational achievement'.

Conclusions from school visits

From visits to schools and interviews with management and teachers, students and student support service staff, a number of conclusions can be drawn regarding the aspects of the service that are making a positive impact or going well, and the key issues and challenges for the service.

The opinion of the students in regard to ethnicity of the practitioners was consistent across all the schools.

Students preferred that health practitioners were not Pacific Islanders, as this increased their confidence in getting good information and non-judgemental support that would remain private to them.

On the other hand, the students saw it as important that the social worker or counsellor, if they were likely to communicate with their family on sensitive issues, was of their culture. This gave the student confidence that as the practitioner could relate to their family at home, in terms of language and cultural understandings, they would not experience adverse consequences from the interaction. That is, the practitioners that were of their culture could navigate situations safely, because 'they know what the rules are.' In one school, students stated that they would not go and see the counsellors if the issue they wanted to discuss might lead back to their home because, while the counsellors were 'well meaning', they were known to 'cause more grief than they had already.'

Similarly, students openly commented about nurses of Pacific Island culture being a barrier to accessing the school-based health service. Sometimes it was a matter of values, other times about being of a different Pacific Island background, causing tension.

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14 The survey analysis in Section 7 below provides a detailed assessment of the perceptions of staff and students.

Positive impacts of the services

All parties (teachers, support service providers and students) mentioned positive impacts from school-based student support services, including:

- the services' contribution to the school's vision to provide a 'wrap-around service' to students. This was summed up by one teacher in the following words: 'staff could not do without it, it is an integral part of the school, caring for the whole student'

- the ready and timely provision of health information for both students and staff

- the services' effect on teachers' ability to teach, as students were less disruptive when their health needs were met

- students being more focussed in class and able to concentrate better

- teachers being able to be 'more than just a teacher', which is seen to be key to working in a Decile 1 school

- support for special needs students who are mainstreamed, giving the teaching staff more confidence in being able to manage the student and meet the student's health and safety needs

- the success of the Y9 HEADSS assessments in identifying health issues that acted as barriers to learning (for example hearing and eyesight issues)

- the effect on the confidence of students who had used the health service, in terms of navigating other health and support services in the community;

- the effect on the self-confidence of students who used the service, and on their resourcefulness in participating in community and school-based activities, as well as applying for positions, scholarships and so on

- less truancy and greater length of stay at the school. One teacher said 'the health centre keeps them at school longer'

- the availability of the service for emergency use by teachers, which was seen to support their teaching efforts and time in the classroom, as they did not have to take time away from school to see a doctor

- the services' strong contribution to the health curriculum in the school.

Key elements for a successful service

The school visits indicated the following as important for a successful programme:

- effective communication amongst the service professional staff, and co-ordination of effort

- effective integration with the school, with regular communication between service providers and school management and teachers

- effective information systems for tracking students, sharing key information (with appropriate privacy protocols) and ensuring information security and back-up;

- maintenance of privacy and confidentiality, including agreements to this effect with students

- facilities that are well resourced with medical equipment for attending to a range of regular and emergency situations

- facilities with consultation rooms that are large enough for small groups to meet in them (especially for the social worker)

- meeting and waiting rooms that provide privacy for students and families

- administration staff such as a receptionist for efficient management of bookings and student screening for the service

- the availability of the service beyond the normal school hours, according to need

- professionally qualified service providers, who have the opportunity for ongoing professional development to keep their knowledge and skills current.

Key issues and challenges for service delivery

Issues and challenges for school student support services that emerge from the findings from the school visits include the following.

General

- The high turnover of nurses (40 percent) is difficult for both students and staff. There is a steep learning curve for new staff and a lot of time and work required to develop relationships within both the school and the community and establish the health practice.

- It takes time to build trust, which is an important factor in encouraging students to use the service. Retention of quality and trusted service providers is key to the success of the service.

- Where nurses or social workers are transporting students to appointments outside of the school, risk needs to be managed (for example, parents' consent to their children being transported during school time needs to be obtained). Time and flexibility is required to be able to provide this service, as there are only limited resources in terms of cover for the nurse, particularly, and school transport is often a priority elsewhere, if it is a school resource at all. Currently both nurses and social workers often resort to using their own vehicles, which can be at their own expense.

- There may be a gap in some schools between the behaviours exhibited by support service providers and teachers. For example, students report different attitudes to confidentiality between teachers and service providers. Teachers may also 'interrogate' the student, to the extent that students see teachers as a potential barrier to accessing the support they need. Some teachers have confidence that student support practitioners will tell them what they need to know, but others feel that they have been, and continue to be, inadequately informed to manage a student appropriately.

- Achieving alignment between the interests and values of religious schools and secular school-based health clinics and an understood and agreed modus operandi can be a challenge. This is more of an issue where the nurse is employed by the school and professional codes of ethics conflict with school protocol and values. Social workers, being employed by an outside agency, have greater autonomy and are less likely to be challenged by the school.

- Funding of incidentals for students across all the student support staff can be problematic, with some staff just paying out of their own pocket or chasing trust funds to meet student need. Incidental expenses can be as small as providing breakfast, or as substantial as the cost of prescription lenses.

Facilities

- Buildings and facilities, even when new or renovated, do not always adequately ensure privacy of meetings, confidentiality of entry and exit for students, or enough space for meeting families and students. Nurses have often not been consulted in the planning of a building or renovation of an area for the health service, with the result that they do not meet the standards required to ensure safe and efficient practice.

- Brand new health service facilities are often quite make-shift. The challenge is in ensuring that temporary arrangements are not extended beyond a reasonable period of time.

- Sick bays within health centres need to be able to accommodate at least two students of differing genders. Students surveyed reported that they didn't like others to see them unwell, nor did they like to share a sick bay with a member of the opposite sex.

Nurses

Recruitment and retention

- There is still a stigma on the role of the school nurse, in that it is seen as being nothing more than 'plaster, panadol and poor pay'.

- There is an issue in regard to remuneration and employment status. Nurses are generally paid for 40 weeks of the school year, not 52 weeks on salary. While schools may be funded to employ a full-time nurse, they sometimes elect to employ two nurses for school contact hours only, on a school support staff agreement. This leaves school holidays as unpaid leave over and above the four-week entitlement.

Workload

- If nurses are employed for the school term only they have little, if any, non-contact time to plan, prepare health promotion initiatives, analyse attendance data, write reports and attend supervision and ongoing professional development.

- The workload involved in Y9 health assessments is a challenge, because there is always other reactive work to be done at the same time. This situation disrupts the Y9 assessments at an individual level, compromising the building of trust, and at a collective level, in that time pressures have an effect on the quality of the information that can be gleaned.

- In order to provide the Y9 health assessments to all students, there needs to be two nurses working concurrently – one to do the assessments and another to undertake general consultations.

- The nurse-to-student ratio in the past has been based on a full-time position, the nurse giving approximately half of his or her time to health assessments and half to other activities. In practice, the school hours available to see students on a demand or arranged basis are limited to less than 1200 per annum or 1.5 hours per student per annum, inclusive of Y9 health assessments.

- Schools ideally need a funding system that recognises the extent of the complex issues and health and welfare risks that their population of students has.

Experience

- The scope of practice of a school nurse is very wide. It ranges from acute physical care and emergencies to complex psychosocial issues.

- It is unlikely that an appointee will have all the experience required. They will need to feel supported while gaining experience in the role.

- Maintaining a current knowledge of best practice/evidence-based care is also difficult in a non-health environment as an autonomous practitioner. Hours need to be allocated to ensure the nurse is able to access appropriate professional support and ongoing development.

Integration

- Nurses are generally well respected within the school environment, though not necessarily seen as having the same professional status as a teacher. Nurses still suffer from educational staff seeing health as primarily physical, and involving mainly emergency care and first aid. Nurses need to be able to demonstrate, to the school management and teaching staff, their wider value to students and the school.

Social workers

- The biggest challenge for social workers is establishing their role in the school and points of difference from school counsellors and teachers. It is sometimes a challenge for social workers, as for nurses, to be recognised as a professional in the school environment.

- Brokering an agreement between the NGO employing the social worker and the school can be a challenge, as the school management does not feel in control of the person working with 'their' students. This is reflected in comments from teachers such as 'they should be at the school from 9 til 5 so I know where they are and what they are doing'.

- Teachers can be unsure who they should refer a student to in terms of student support staff or pastoral care staff such as deans. Some schools have protocols that dictate the flow of referral from teachers that are not always advantageous to the student.

- Teachers may also 'interrogate' the student, to the extent that students see teachers as a potential barrier to accessing support.

- The social worker also faces the challenge of engaging with parents. Schools generally find this a challenge, and social workers in particular can spend many hours tracking parents down in order to provide support that will in turn support the student. This contact time can often be outside normal working hours and raise personal security issues for the social worker.

Counsellors

- Counsellors in the past have often been the single student support person in schools besides teachers. Having other support professionals within the school has altered what they do and how they do it. Some counsellors have welcomed the change, but others have not. All expressed a keenness to have been involved earlier in the process of the implementation of support services in schools. This would have helped them gain clarity about support roles, particularly that of the social worker, and the impact it would have on their own role.

- Like other practitioners, counsellors can feel professionally isolated and have a sense that there is no one else that can do their job if they are absent.

- Similarly, the professional development they need is not satisfied by the generic professional development offered in schools, as it does not develop their knowledge and skills in dealing with the specific needs of students in Decile 1 schools.

Information technology

- There are a number of different software information management programmes and databases in operation across the AIMHI schools. This leads to different data being collected, different classifications and definitions being used and a lack of interconnectivity with school databases, as well as between professional groups. These differences preclude robust collective data from being analysed. A data dictionary and the standardisation of information systems would enable better monitoring of outcomes and impact on students, both in the short and longer term.

- Information systems also present a challenge to effectively managing the confidentiality of information and the need for sharing data amongst professionals working with the same students.

- Teachers may also 'interrogate' the student, to the extent that students see teachers as a potential barrier to accessing support.

- The social worker also faces the challenge of engaging with parents. Schools generally find this a challenge, and social workers in particular can spend many hours tracking parents down in order to provide support that will in turn support the student. This contact time can often be outside normal working hours and raise personal security issues for the social worker.

Findings: Evaluation Survey

Introduction

The evaluation of school student support services in the AIMHI schools included surveys of school students, staff and parents. Surveys provided data on the perceived effectiveness of the service, areas where things were working well and areas where there was room for improvement.

Results are discussed here according to responses from the different respondent groups (students, staff and parents).

Survey design

Format

The surveys collected demographic data (for example, school, ethnic group and gender) and explored questions using a five-point Likert scale with the format strongly disagree, disagree, not sure, agree and strongly agree. There was also provision for a 'cannot answer' response.

Questionnaires used a mix of positive and negative statements to manage acquiescence bias (respondent agreement with statements presented), and the category 'not sure' (instead of 'neither agree nor disagree') to assist with managing central tendency bias (respondents' avoidance of extreme categories).

In the analysis, the response categories 'agree' and 'strongly agree' have been treated as a positive response to the question.

The survey also provided the opportunity for respondents to provide comments on the school, or to answer the survey questions in their own words. These provided a useful commentary to complement the survey analysis.

Historical comparisons

The survey design took into account those areas of the services that were assessed in the formative evaluations of the HCS initiative in AIMHI schools in 2003 and 2004.[15]

This allowed the evaluation to compare progress on these dimensions across 2003, 2004 and 2008.

Student surveys

Introduction

Students from all nine AIMHI schools responded to the surveys: a total of 784 respondents. There was a fairly even spread of students across the years, and slightly more female respondents (57.1 percent) than male (42.9 percent). The predominant ethnicity was Pacific Islander (83.4 percent). New Zealand Māori made up 12.7 percent of respondents.

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15   Auckland Uniservices Ltd. 2004. *Evaluation of the Healthy Community Schools Initiative in the AIMHI Schools: Final evaluation report*. Auckland: Auckland Uniservices Ltd.

Use of services

General trends

Three quarters of the students had used the services of the school nurse or GP (75 percent). Fewer had used counsellors (38.5 percent) and fewer still social workers (26.2 percent). These lower numbers, however, are still significant for the services involved.

Table 7: Student usage of support professionals

	Used nurse	Used social worker	Used counsellor	Total respondents
All respondents	75.0%	26.2%	38.5%	100%
Female	58.3%	52.9%	63.5%	56.5%
Male	41.7%	47.1%	36.5%	43.5%
New Zealand Māori	13.5%	10.01%	12.8%	12.5%
Pacific Islander	84.0%	87.4%	81.7%	83.6%

Source: PricewaterhouseCoopers Survey, 2008

The percentages in Table 7 indicate that female students tended to use the services of the nurse and social worker a little more than male students, and that females used the service of the counsellor much more than male students.

They also indicate that use by ethnic group is roughly the same as the representation in the total sample population. A slightly greater percentage of Māori use the nursing service (13.5 percent) than their representation in the total population of respondents (12.5 percent). Similarly, a slightly greater percentage of Pacific Island students used the services of the social worker (87.4 percent) than their representation in the total population of respondents (83.6 percent).

Perception of service providers (nurse, social worker and counsellor)

Perceptions of the service

Students were surveyed as to their perceptions of the service in terms of how helpful it was, how easy they found it to talk with providers, its privacy and their satisfaction with the service. In general, students expressed positive perceptions of the school nurse/GP service (in excess of 70 percent) and somewhat lower perceptions of counsellors and social workers, in that order.

In this regard, it is important to note that often students did not register negative perceptions, but rather were 'not sure'. We note that, for all of the questions regarding perceptions of the service, there were low numbers of responses for 'disagree/strongly disagree' (under 8 percent combined). The 'not sure' responses are recorded in Table 8 below.

Table 8 also presents a comparison of responses for the total population of respondents, and for those students who had used the services of the nurse, social worker or counsellor.

Table 8: Comparison of student users and total responses

Question	Total respondents		Service users
	% Not sure	% Agree/ Strongly agree	% Agree/ Strongly agree
School nurse/GP is very helpful to students	13.5	81.1	85.9
Social worker/youth worker is very helpful to students	39.3	55.2	74.0
School counsellors are very helpful to students	30.6	62.8	76.7
It is easy talking to the school nurse/GP	22.6	71.3	76.8
It is easy talking to the social worker/youth worker	41.3	50.7	65.3
It is easy talking to the school counsellor	35.6	57.5	70.1
Students' privacy is respected by the school nurse/GP	23.3	70.2	74.1
Students' privacy is respected by the social worker/youth worker	34.1	59.4	68.2
Students' privacy is respected by the school counsellor	30.6	62.4	72.2
I am satisfied with the services of the school nurse/GP	21.4	71.9	76.8
I am satisfied with the services of the social worker/youth worker	35.2	58.4	71.4
I am satisfied with the services of the school counsellor	31.9	61.3	73.1

Source: PricewaterhouseCoopers Survey, 2008

These results indicate the following.

- On all parameters, the school nurse service is perceived more positively than those of the social worker and school counsellor amongst the total population of respondents.

- A sizeable number of respondents answered 'not sure' regarding perceptions of the school counsellor and social worker (and in particular, the social worker), possibly because they have not used these services.

- Several students made comments such as the following: 'the reason why I'm not sure about the social worker and counsellor […] is because I haven't been to them before'.

- Amongst those students who had used the service, there were positive perceptions across all services,[16] for example:

  - helpfulness (nurse – 85.9 percent, social worker – 74.0 percent, counsellor – 76.7 percent)

  - ease of talking to (nurse – 76.8 percent, social worker – 65.3 percent, counsellor – 70.1 percent)

  - privacy (nurse – 74.1 percent, social worker – 68.2 percent, counsellor – 72.2 percent)

  - satisfaction (nurse – 76.8 percent, social worker – 71.4 percent, counsellor – 73.1 percent).

- Students' perceptions are more positive in descending order for the nurse, then counsellor, then social worker – reflecting perhaps the nature of the issues that are discussed with each of these.

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16 A positive response is the combined percentages for the response categories 'agree' and 'strongly agree'.

- Once students know more, particularly about the social worker and counsellor services, through experience, they have a more positive perception of it – there is on average a 13 percent increase in positive perception of these services by users.

Perceptions of health services

During the course of this review, visits to schools indicated some issues with achieving privacy and confidentiality in the health facility, in the waiting rooms and even in some consulting rooms (see previous section). As Table 9 shows, only 53.6 percent of students are likely to 'agree' or 'strongly agree' that the school health service is private.

Table 9: Student perceptions of the health service

Question	% Not sure	% Agree/ Strongly agree
The school health service is private	36.6	53.6
It is easy to get an appointment with the school health service	31.5	58.6
The school health service has a nice environment	22.1	68.4

Source: PricewaterhouseCoopers Survey, 2008

Only 68.4 percent of students are likely to rate the school health service as having a nice environment. On examination, this result tended to correlate with our impressions of the standard and the placement of the facilities. Where schools had a purpose-built facility with waiting and reception areas away from other school services, the students rated the facility as more private than those that had facilities off main school corridors. Similarly, backing up the comments students made when interviewed, students rated those facilities where sound-proofing was an issue as less private than where sound-proofing was not issue. The students distinguished between the practitioners respecting their privacy and the facility.

The school that had the least developed student support service as an entity, when compared with the other schools, had the lowest levels in students' perceptions of:

- privacy ratings for each of the practitioners (counsellor, nurse and social worker)
- ease of access to all practitioners
- the practitioners being easy to talk to
- feeling OK about seeing the practitioners
- satisfaction.

Interestingly, the students in the AIMHI schools rated their social workers and counsellors as being just as helpful as the students in other schools. The nurse who, in this school, was only available for two mornings per week (as opposed to a full school week service in the other schools) had the lowest ranking. This was primarily because far more students said they were unsure, as they had not used the service.

Attitudes towards the service

A number of questions surveyed the attitudes of students towards the service. This included having no problem seeing the provider, feeling OK about it and feeling disposed to use the service if needed. The results are presented in Table 10.

Table 10: Student perceptions of support services

	Total respondents		Service users
Question	**% Not sure**	**% Agree/ Strongly agree**	**% Agree/ Strongly agree**
I have **no problem** seeing the school nurse/GP	14.1	79.9	81.9
I have **no problem** seeing the social worker/ youth worker	28.1	61.4	70.8
I have **no problem** seeing the school counsellor	23.7	66.8	75.7
I **feel OK** about going to the school nurse/GP	18.7	74.9	79.0
I **feel OK** about going to the social worker/ youth worker	32.3	58.6	69.8
I **feel OK** about going to the school counsellor	26.7	64.3	74.3
If needed I **would use** the services of the school nurse/ GP	19.9	74.5	78.1
If needed I **would use** the services of the social worker/youth worker	32.4	59.6	68.4
If needed I **would use** the services of the school counsellor	28.1	64.3	74.0

Source: PricewaterhouseCoopers Survey, 2008

These results indicate the following:

• As with perceptions of the service, there were overall positive attitudes towards all the services, with the school nurse viewed most positively.

• A sizeable percentage of the total population of respondents were 'not sure' of their attitudes, particularly towards the social worker and counsellor – this tallies with the lower use of these services by students (see Table 10).

• There is a sizeable increase in positive ratings for those who have used the service, particularly that of the social worker and counsellor, with, on average, a 10 percent increase.

Comparative usage of services

It is useful to compare the patterns of usage of services to gain insights for improved communication, service synergies and ways to encourage greater awareness and use of services by those students with a need.

Table 11: Student usage of multiple service provider

	Used social worker	Used counsellor
Used nurse	33.2%	46.9%
Not used nurse	**4.8%**	**13.9%**

	Used nurse	Used counsellor
Used social worker	95.4%	81.3%

	Used nurse	Used social worker
Used counsellor	90.8%	56.1%

Source: PricewaterhouseCoopers Survey, 2008

These results indicate that students are far more likely to use the services of the social worker and counsellor if they have seen the nurse (for example, through Y9 HEADSS assessments) than if they have not. They also are likely to have used the counsellor if they use the services of the social worker. This reinforces the pattern observed above of the flow from nurse to counsellor to social worker (Table 11).

This has implications for the role of the nurse in promoting access to the other services and referrals, and highlights the importance of integrating services to ensure that students access the social worker and counsellor where this is needed.

Ethnic diversity

The responses from students to questions pertaining to ethnic diversity indicate that there is room for improvement in this area. On average, 10 percent of student respondents had negative perceptions of the schools' orientation to ethnic diversity[17], and around a quarter did not commit to an opinion. It is to be remembered that all the AIMHI schools have a high level of ethnic diversity. We note that staff indicated there was room for improvement in this area as well (see Table 20). These questions rated amongst the lowest, along with questions on feeling safe and secure, bullying and the school setting good standards of student behaviour (Tables 13 and 14).

Table 12: Student perceptions of support for ethnic diversity

Question	% Disagree/ Strongly disagree	% Not sure	% Agree/ Strongly agree
ESOL students get enough help	10.1	26.3	63.7
Teachers have good understanding of working with different ethnic groups	9.1	24.9	65.9
The school encourages students to get along with students from different ethnic groups	10.9	22.1	67.1
Teachers have good skills for working with students from different ethnic groups	11.1	22.1	66.7

Source: PricewaterhouseCoopers Survey, 2008

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17   A negative response is the combined percentages for the response categories 'disagree' or 'strongly disagree'.

Māori students

Of those students who chose 'strongly disagree' or 'disagree' that teachers have a good understanding of working with different ethnic groups, 17.4 percent were Māori. Given that only 12.5 percent of the total survey sample is Māori, this number indicates that there is room for improvement in the way that Māori needs are met in these schools. This is consistent with the comparative educational indicators for Māori students (Section 8) as well as the staff survey results, which also indicate potential room for improvement in addressing the needs of Māori (see Table 20).

School environment

A number of survey questions assessed the general school environment to provide contextual information for the survey, as well as the opportunity of assessing the impacts of the school student support service on broader outcomes within the school (Table 13).

Table 13: Student perceptions of the school environment

Question	Total respondents % Agree/Strongly agree	Service users % Agree/Strongly agree
The school wants students to get good marks	84.5	N/A
The school listens to any problems I have	45.1	N: 45.9 SW: 53.1 C: 48.5
The school sets good standards of student behaviour	56.9	N: 57.2 SW: 59.3 C: 52.4
The school deals effectively with bullying	54.2	N: 54.2 SW: 59.8 C: 54.0
Needs of students are important to teachers at this school	62.1	N: 72.6 SW: 61.0 C: 61.2
The school makes an effort to encourage my parents to be involved	59.4	N: 60.4 SW: 65.3 C: 61.4
My parents have become more interested in my learning since I started at this school	62.8	N: 63.5 SW: 64.1 C: 63.0

Source: PricewaterhouseCoopers Survey, 2008

These results indicate the following.

- The schools have impressed on the students the importance of educational achievement (84.5 percent).

- Where students have used the social worker, there is a slightly more positive agreement with most of the statements about the school – reflecting perhaps some effect from the work of the social worker on student perceptions of the school.

- One exception to this is amongst those students who have used the health service, where the students were more likely to agree with the statement that 'the needs of students are important to teachers at this school' (72.6 percent). Two factors that may be influencing this result are:

  - the greatest volume of referrals by teachers are to the nurse (see Table 18)

  - students that use counselling and social work services are more likely to have more complex needs than those who use the health service only. These issues are often exhibited by disruptive behaviour in the classroom, which in the first instance may be dealt with through punitive means.

Student happiness and motivation

For questions exploring student happiness and motivation, there was little difference between the responses from the whole respondent population and those who had used school support services. Overall, students have reasonably positive attitudes towards the school.

The one area where students were less likely to be positive was regarding feeling 'safe and secure' at school. Only 62.3 percent of students responded positively that they felt safe and secure at the school, and 14.2 percent of the respondent population indicated that they did not feel safe at school. Note that only 54.2 percent of students responded positively to the question whether 'schools deal effectively with bullying' (Table 13).

Table 14: Student satisfaction with the school

Question	Total respondents % Agree/Strongly agree
I feel satisfied with my education at the school	70.1
Life at the school has got better compared with when I first started	65.5
I feel safe and secure at this school	62.3
It is easy to make friends at this school	76.5
School reports give enough information about my achievements	75.3
School reports describe all of my achievements	70.2

Source: PricewaterhouseCoopers Survey, 2008

Comparisons with previous AIMHI surveys

Comparisons with the two previous formative surveys of 2003 and 2004 (Table 15) show that the positive perceptions of students have been more than maintained over all the dimensions measured, namely:

- service – effective student support services in the school

- satisfaction – satisfaction with the school overall

- achievement – support for achievement

- ethnic – school support for ethnic diversity.

Table 15: Student mean scores for perceptions on key dimensions

	Effective support service	Satisfaction	Support for achievement	Support for ethnic diversity
AIMHI 2003 (n=590)	18.82	44.90	18.04	25.85
AIMHI 2004 (n=603)	18.82	44.58	17.93	25.99
AIMHI 2008 (n=784)	19.17	48.59	18.53	26.08

Source: PricewaterhouseCoopers Survey, 2008. Thomas, D. et al (2004).

Conclusions for student survey

In comparison with previous AIMHI surveys, the 2008 survey indicates that there has been an improvement in student perceptions of school support services since their establishment in the AIMHI schools in 2003. In particular, there has been an improvement in perceptions of the effectiveness of the service and satisfaction with the schools between 2004 and 2008.

Overall students' perceptions of school health and social services are very positive for 'helpfulness', 'ease of talking to', 'privacy' and 'satisfaction'. This was particularly the case amongst those students who had used the service.

By contrast, there was less agreement that the school health service facilities were private. These results confirm observations from school visits that there are some issues with achieving confidentiality and privacy in health facilities, in waiting rooms and even in some consulting rooms.

The school nurse service is perceived more positively than that of the social worker or counsellor, and is the most commonly used student support service.

Similarly, student attitudes towards their comfort with using or potentially using the service are more positive for the school nurse than for the social worker or counsellor.

Students are far more likely to use the services of the social worker and counsellor if they have already had experience of the school nurse. This suggests that the school nurse has a key role to play in the integration of the school support service.

Staff surveys

Introduction

Staff from all nine AIMHI schools responded to the surveys – a total of 245 respondents. Staff respondents were predominantly teachers at the schools (81 percent). The current evaluation study separated the three components of the service (nurse, social worker and counsellor) for questions, and explored the degree that services were referred by staff and the degree to which the services were used by staff.

Perception of service providers (nurse, social worker and counsellor)

Staff generally felt that service providers were available to help students as required. The school nurse was seen as the most available (93.8 percent choosing 'agree' or 'strongly agree'). We note that for the other providers, staff were 'not sure' of the availability of social workers (13.5 percent) and counsellors (10.2 percent) – indicating that their levels of awareness of the health service are higher than for those of the social worker or counsellor.

There was strong agreement that the presence of support service providers makes the staff's work less stressful. Again the school nurse rated slightly higher (77.8 percent) than the others (both at 72 percent). This is summarised in Table 16.

Table 16: Staff perceptions of student support services

Question	% Agree/ Strongly agree
Service provider is available	88.6
Service provider provides effective assistance	81.1
Service availability makes staff work less stressful	74.0

Source: PricewaterhouseCoopers Survey, 2008

Staff referral to the service

Staff were asked two types of question about referrals. First, they were asked to rate their levels of comfort with referring students, and second, they were asked to indicate whether they had actually referred students. Staff were also asked if they had used the support service.

Comfort with referrals

There was a high level of staff comfort in referring students to all providers of support services, and responses tended to be more 'strongly agree' than 'agree' (Table 17).

Table 17: Staff's comfort in referring students to support services

Question	% Agree	% Strongly agree	Total A/SA
Comfortable to refer to nurse	37.0	56.4	93.4%
Comfortable to refer to social worker	40.2	44.3	84.5%
Comfortable to refer to counsellor	39.0	46.3	85.3%

Source: PricewaterhouseCoopers Survey, 2008

Actual referrals and personal use of the service

There were high levels of referrals from staff across all services. The school nurse, however, rated considerably higher in terms of both personal use and referral, followed by the counsellor and then the social worker (Table 18).

Table 18: Percentage of staff who had referred students and/or personally used support services

Question	Referred	Personally used
School nurse	86.8%	57.8%
Social worker	65.3%	10.2%
Counsellor	74.6%	19.8%

Source: PricewaterhouseCoopers Survey, 2008

These results suggest a possible relationship between staff referrals and their own use of the service (perhaps because of increased awareness through use). This tallies with the previous observation that perceptions on availability and comfort are more positive for nurses than for social workers or counsellors.

Relationship between staff perceptions and referral rates

Referral rates for all service providers appear to be related to staff's positive perceptions as to the availability of service providers to students. This is shown in Figure 7.

Figure 7: Comparative positive staff perceptions of service availability for students of referrers and non-referrers
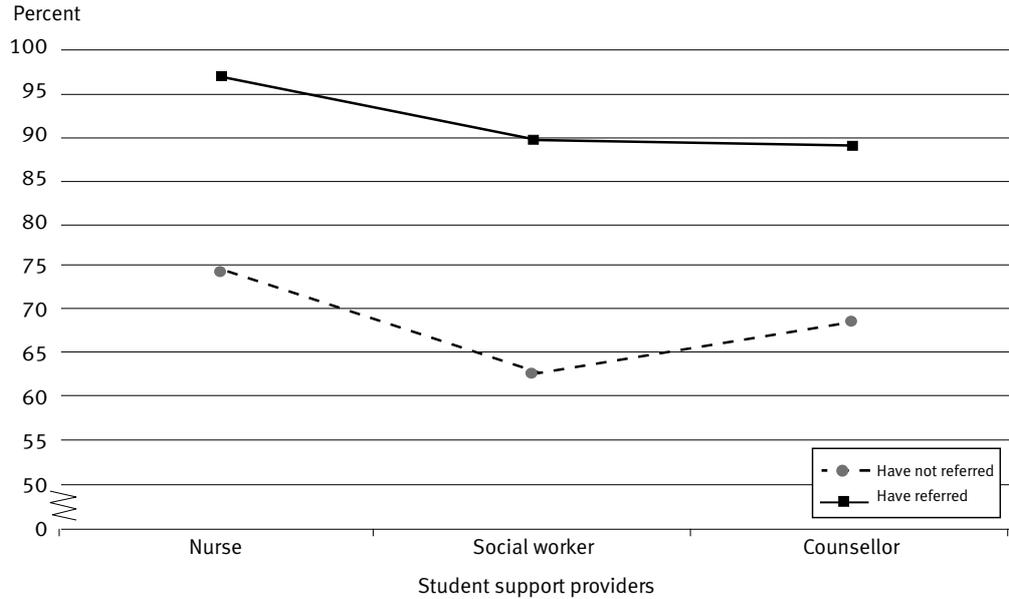
Source: PricewaterhouseCoopers Survey, 2008

These results would indicate that where staff have positive perceptions of the service they are more likely to refer students.

Referral rates for all service providers also seem to be related to staff's positive perceptions of comfort with referring services to students. This is shown in Figure 8.

Figure 8: Staff with a positive perception of comfort with referring students
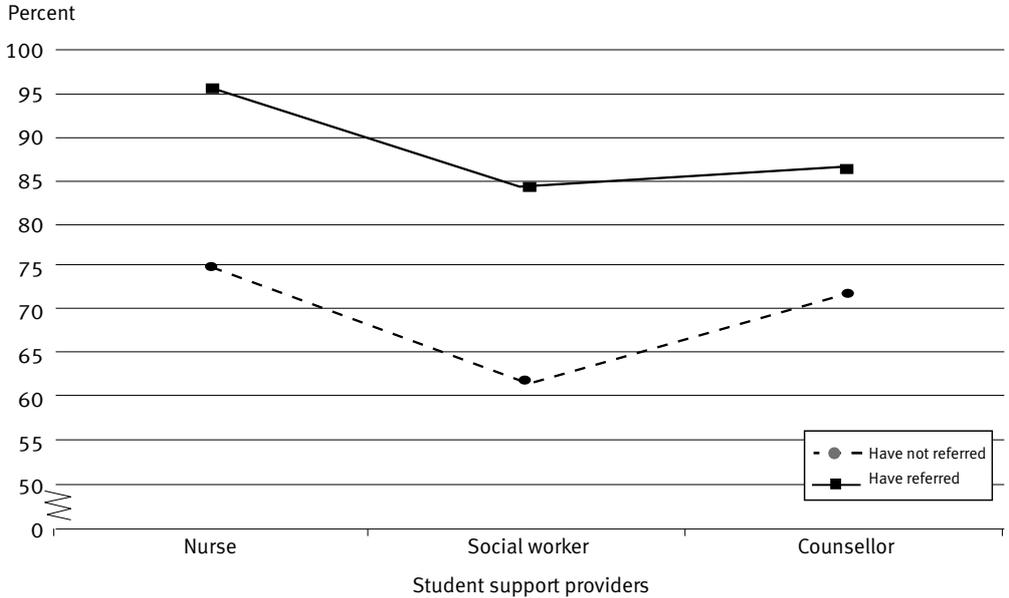
Source: PricewaterhouseCoopers Survey, 2008

The size of the gap between referring and not referring for the two aspects of availability and referral comfort, as illustrated, is worth noting. The results indicate that staff appear happier to refer students to a service they know and understand, and one which has delivered a positive result in their personal experience.

Ethnic diversity

Staff perceptions as to the way that the schools are able meet the needs of an ethnically diverse student population were generally positive (Table 19). This was an area where, after positive responses, there were more 'not sure' responses recorded than negative comments.

Table 19: Staff perceptions of support for ethnic diversity

Question	% Agree/ Strongly agree
The school is able to meet needs of ESOL families	71.6
The presence of several ethnic groups at school creates problems	37.1
Staff have good understanding of working with different ethnic groups	79.6
Staff are encouraged to learn effective skills for working with different ethnic groups	79.6
Staff have skills to address needs of ethnic diversity	**63.1**
Staff lack the skills needed to work with ethnic diversity	**53.7**

Source: PricewaterhouseCoopers Survey, 2008

The responses suggest, however, that despite generally positive comments, staff perceive that school staff could have more skills to address the needs of, and work with, diverse ethnic groups.

There were some perceived differences in regards to meeting the needs of Māori and Pacific students. While many staff were not sure of a response to questions comparing the effect of the nurse and the social worker on the needs of Māori and Pacific students, of those who did, results indicate that in this respect social workers and nurses are viewed in a similar way.

The significant difference is that the needs of Māori students are perceived as being less well addressed than those of Pacific students. It should be noted that Pacific ethnic groups predominate in the AIMH schools. A recognition that Māori, as a minority, do not receive as much focus as Pacific students may explain this perception (Table 20).

Table 20: Comparative perceptions of staff of support of Māori and Pacific students

Question	% Not Sure	% Agree/ Strongly agree
Needs of **Māori** students are addressed more effectively since the introduction of the **school nurse/GP**	53.0	28.6
Needs of **Māori** students are addressed more effectively since the introduction of the **social worker**	51.2	29.2
Needs of **Pacific Island** students are addressed more effectively since the introduction of the **school nurse/GP**	44.6	39.9
Needs of **Pacific Island** students are addressed more effectively since the introduction of the **social worker**	42.5	41.9

Source: PricewaterhouseCoopers Survey, 2008

School environment

Staff generally perceive that there is opportunity for change and innovation in the schools, and that schools have indeed changed over the past three years.

They also perceive to a large extent that the school addresses student needs. Staff perceptions were somewhat less positive than those of parents for this same question, but not inconsistent with the staff tendency to be unsure when responding to questions on outcomes (Table 21).

Table 21: Staff perceptions of the school's ability to meet student needs and be innovative

Question	% Agree/ Strongly agree
The school effectively addresses students' needs	67.6
It is difficult to change anything in the school	27.5
New and different ideas are being tried in this school	79.5
The school has not changed the way it operates over the last few years	16.0

Source: PricewaterhouseCoopers Survey, 2008

Student happiness and motivation

Staff, generally, have very positive views on the attitudes and deportment of students in their schools (Table 22).

Table 22: Staff perceptions of students' attitudes

Question	% Disagree/ Strongly disagree	% Agree/ Strongly agree
Most students are well mannered and respectful of staff	9.5	83.9
Most students are friendly to staff	7.0	91.3
There are many disruptive, difficult students in this school	49.2	44.6
There are fewer disruptive students in the school compared to a year ago	34.9	22.4

Source: PricewaterhouseCoopers Survey, 2008

Responses indicate that there are still 'many disruptive, difficult students' in the school, despite the AIMHI initiative. Staff also perceive that the numbers of disruptive students have not reduced compared with a year ago – although 36.6 percent of staff were unsure on this question.

Outcomes

Staff perceptions of the impacts and outcomes of school student support services were not as certain as their responses to other questions. There were higher percentages of 'not sure' responses for outcomes pertaining to behaviour, attendance, class attention, learning outcomes and truancy.

Despite this, more than half of staff respondents felt that the student support services brought positive changes in student behaviour and attendance in class. Just under half felt that there had been positive changes in student attention in class and in their learning outcomes.

These results tally with a comparative analysis of the 2003, 2004 and 2008 survey results (Table 23). In general the perception is that there have been gradual improvements to the school and students over these years.

Table 23: Staff perceptions of students' behaviour

Question	% Not sure	% Agree/ Strongly agree
Positive changes in the behaviour of students	33.5	54.6
Positive changes in the attendance of students	36.7	50.2
Positive changes in the attention in class of students	40.4	46.1
Positive changes in the learning outcomes of students	39.6	47.4
Parents show more interest in children's learning	56.5	14.3
Student behaviour is better since nurse/GP introduced	39.5	37.1
Student behaviour is better since social workers introduced	43.5	32.3
Lower rates of truancy than a year ago	48.3	23.1

Source: PricewaterhouseCoopers Survey, 2008

Effectiveness of health and social support services

Staff were more positive in their comments relating to the specific student support services provided than in expressing their perceptions of what might be the broader effects and outcomes of the services. This was demonstrated by staff perceptions of the school's effectiveness in meeting student health and social support needs.

Table 24: Staff perceptions of the school's effectiveness in meeting students health and welfare needs

Question	% Not sure	% Agree/ Strongly agree
The school is more effective in meeting student health needs	26.9	66.5
The school is more effective in meeting student social support needs	28.4	64.2

Source: PricewaterhouseCoopers Survey, 2008

Comparisons with previous AIMHI surveys

Comparisons with the two previous formative surveys of 2003 and 2004 indicate progress on a number of key dimensions for the student support service. While the progress is not in the nature of a marked improvement, the schools have seen positive progress in the perceptions of staff for key dimensions of:

• *service* – effective student support services in the school

• *improvements* – improvements to the school and students

- *friendliness* – helpfulness and friendliness of students

- *ethnic diversity* – school support for ethnic diversity

- *innovation* – a culture of innovation in the school.

A comparison of the mean scores for staff perceptions shows a small increase in positive perceptions across all of these dimensions, with the exception of innovation. The comparison indicates that there were lower perceptions of innovation in AIMHI schools in 2008 than previously. This may be because earlier surveys reflected the newness of AIMHI student support services in schools, and that in 2008 the service had become more mainstream. The results are shown in Table 25 below.

Table 25: Staff mean scores for perceptions on five key dimensions of school climate

	Effective support service	Improvements to school and students	Friendliness of students	Support for ethnic diversity	Innovation culture
AIMHI 2003 (n=227)	23.73	16.16	17.18	22.70	38.48
AIMHI 2004 (n=257)	24.05	16.90	17.84	24.33	40.14
AIMHI 2008 (n=245)	24.92	17.13	17.63	24.25	36.77

Source: PricewaterhouseCoopers Survey, 2008. Thomas, D. et al (2004).

Conclusions

In comparison with previous AIMHI surveys, the 2008 survey indicates that staff perceptions of the effectiveness of the student support service have improved over the period since 2003, as have their perception of improvements to the school and to students. Staff perceive that, since the introduction of the service, the school is more effective in meeting student health and social support needs.

There is a high level of comfort amongst staff in referring students to all of the providers of the service, and in particular the school nurse.

More than half of staff respondents felt that the school health service resulted in positive changes in student behaviour and attendance in class. Just under half felt that there had been positive changes in student attention in class and in their learning outcomes.

Parent surveys

Introduction

Parents from four of the nine schools responded to the survey.[18] While the numbers of respondents (68) are not numerous enough for the drawing of strong conclusions, there are consistent themes that emerge. Of parent respondents, 22.1 percent identified as New Zealand Māori and 73.5 percent as Pacific Islander.

Levels of awareness of the components of the school support service were reasonable, and were highest for the school nurse (and visiting doctor), at 85.1 percent, with the counsellor at 76.6 percent and social worker at 72.7 percent.

Survey results

Overall the responses to all questions were positive, with the majority of parents agreeing or strongly agreeing with a positive response.

Parents demonstrated relatively positive views of the nurse, social worker and counsellor in the four schools concerned. They were also positive about the school's ability to care for their students and enhance student happiness and motivation.

Perception of service providers (nurse, social worker and counsellor)

Parents felt that the service providers were accessible and helpful, and they were particularly pleased that the schools had this service in place. There was very little variation between perceptions of accessibility and helpfulness for the individual types of providers.

Table 26: Parent perceptions of service providers

Question	% Agree/ Strongly agree
Service providers are accessible	76.2
Service providers are helpful to students	74.7
Parents are pleased that the service is in place	90.9
School nurse has helped student towards better health	74.7

Source: PricewaterhouseCoopers Survey, 2008

School environment

The views of parents were generally positive and supportive of their school in terms of the attention the school gave to their children and its ability to address student needs and safety. There was a strongly positive view of teachers' responsiveness to students.

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18 School visits indicated that parents are the most difficult group to engage with, reflected in the response rates for the current survey.

Table 27: Parent perceptions of the school

Question	% Agree/Strongly agree
The school listens to students' problems	75
The school effectively addresses students' needs	78.8
Teachers see students' needs as important	86.6
Students feel safe and secure	81.8
The school deals effectively with bullying	73.5

Source: PricewaterhouseCoopers Survey, 2008

Student happiness and motivation

Parents were very positive about the contribution of the school to student happiness and motivation, and to involving them as parents.

Table 28: Parent perceptions of their child(ren) at school

Question	% Agree/Strongly agree
The student is happy at the school	90.87
The student is motivated to learn	86.4
The school encourages parents to be involved	89.5

Source: PricewaterhouseCoopers Survey, 2008

Ethnic diversity

Parents saw schools as generally supporting ethnic diversity. The comments regarding the proportion of teachers with a good understanding of working with different groups were a little less positive than those in other areas.

Table 29: Parent perceptions of the school's support of ethnic diversity

Question	% Agree/ Strongly agree
The school encourages students to get along with other ethnic groups	77.3
The school helps those with English as a second language	75.4
Most teachers have a good understanding of working with different ethnic groups	70.8

Source: PricewaterhouseCoopers Survey, 2008

Conclusions

Overall, parents who responded were positive in their perceptions of school health services.

They perceived service providers as helpful and accessible, and 91 percent were very pleased that the service was in place.

There was strong agreement that the school nurse had helped students towards better health.

Parents were very positive about the contribution of the school to student happiness and motivation, safety and security, and to involving them as parents.

Findings: The AIMHI Schools and Educational Performance

Introduction

The current evaluation has involved gathering information from AIMHI school visits and a survey of students, staff and parents. Perceptions and anecdotal evidence provided through this research indicate that the AIMHI schools have benefited positively from the HCS initiative (see discussion in Sections 5 and 6 above). A review of data trends for educational performance over the period of the HCS initiative (2004–2008) provides quantitative evidence to support the conclusions from the evaluation.

Three results areas were assessed for trends:

- the AIMHI schools[19]
- other Decile 1 schools[20]
- all schools nationally.

Data trends – Conclusions

Trends were assessed across two main areas: educational achievement and educational behaviours. Overall, the results demonstrate that educational achievement rates for the AIMHI schools are higher than for other Decile 1 schools regarding literacy, numeracy and NCEA qualifications attained.

The results are similar for educational behaviours. The AIMHI schools performed better than other Decile 1 schools on parameters of truancy, stand-downs, suspensions and expulsions.

Overall, both Māori and Pacific students in the AIMHI schools have tended to perform at a higher level than at other Decile 1 schools. In some cases, Māori and Pacific students in the AIMHI schools have performed higher than the national average (across all schools).

The results do show, however, that while comparisons may be positive with other Decile 1 schools, the performance of the AIMHI schools is still generally below the national average.

Educational achievement

Literacy

Data were obtained for the rates of literacy achieved in the AIMHI schools, Decile 1 schools and nationally. In comparison with the national data (see Figure 9), the AIMHI schools have a much lower literacy rate. However, the AIMHI schools are generally achieving at a higher rate than other Decile 1 schools. AIMHI schools have shown a 16.9 percent improvement in the proportion of their students achieving literacy credits between 2004 and 2007, compared to a 14.9 percent improvement in Decile 1 schools and a 9 percent improvement nationally.

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19   AIMHI schools make up 63 percent of the Decile 1, Y9–13 population.

20   Other Decile 1 schools account for 37 percent of the Decile 1, Y9–13 population.

Figure 9: Literacy rates
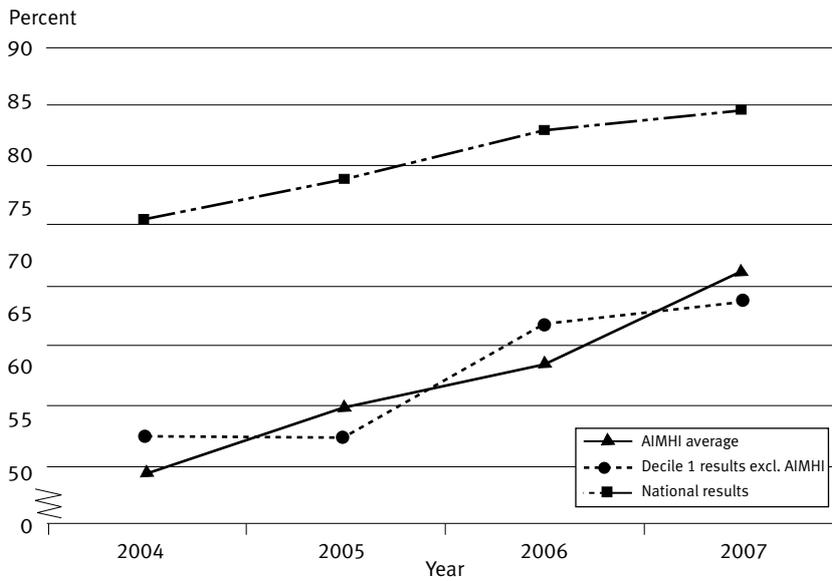
Sourced from Ministry of Education Data, 2008

Numeracy

Similarly, the rates of numeracy are much lower in the AIMHI and Decile 1 schools than the national rates. Again the AIMHI schools are generally achieving at a higher rate than the Decile 1 schools. The AIMHI schools have only shown an 8.2 percent improvement in the proportion of their students achieving numeracy credits, compared with a 9.8 percent improvement in Decile 1 schools and a 9 percent improvement nationally.

Figure 10: Numeracy rates – National, decile 1 and AIMHI
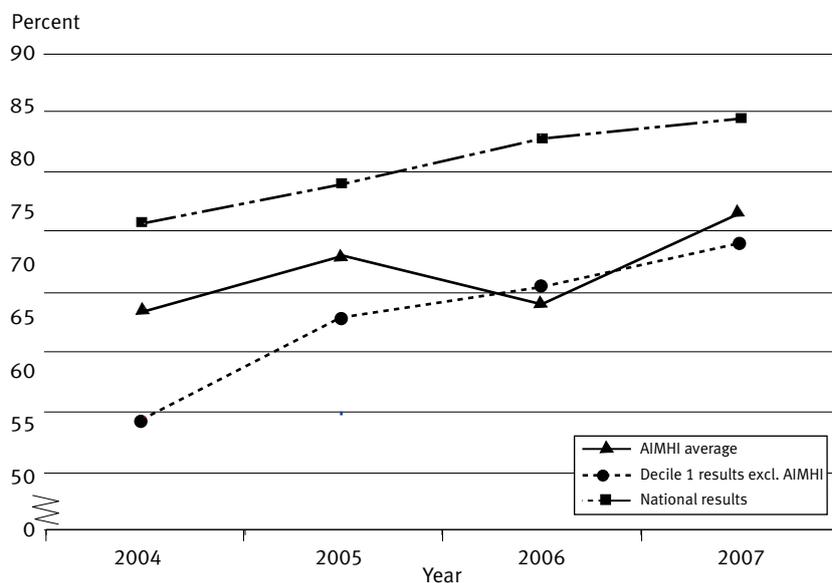
Sourced from Ministry of Education Data, 2008

NCEA level 3+ attainment

Across the board, there has been an overall increase in the proportion of students leaving with NCEA Level 3 or higher. The AIMHI schools have made the largest gains, improving by 9.5 percent between 2004 and 2007. While they have had a consistently higher rate of achievement than other Decile 1 schools, their rate of achievement is still much lower in comparison with the national data.

Figure 11: Total population NCEA level 3+
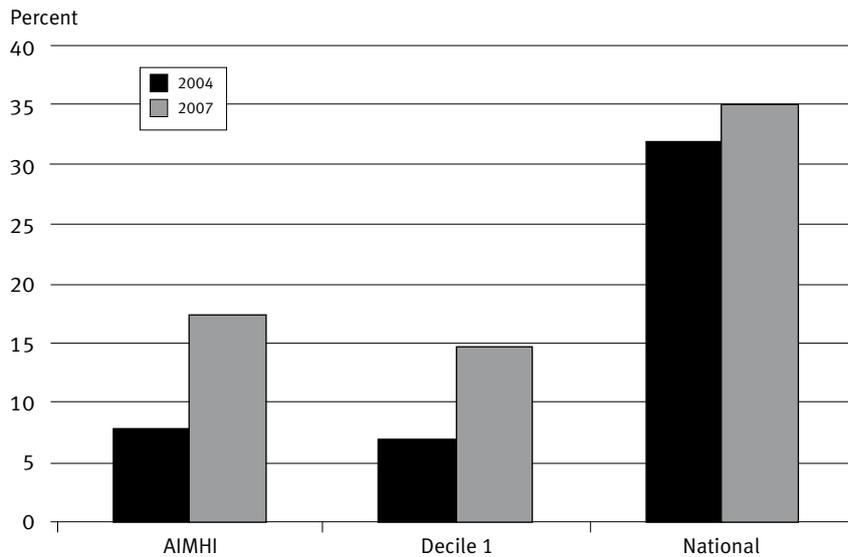
Sourced from Ministry of Education Data, 2008

NCEA level 2 attainment

In 2007, 36.8 percent of AIMHI students left school with NCEA Level 2 as their highest qualification.

This means that in 2007, in total, 54.3 percent of AIMHI students left school with NCEA Level 2 or above. This is an improvement of 31.8 percent from 2004, when only 22.5 percent of AIMHI students left school with NCEA Level 2 or above.

This significant improvement is also reflected in the other Decile 1 schools, but not to the same degree.

Figure 12: Total population NCEA Level 2 +
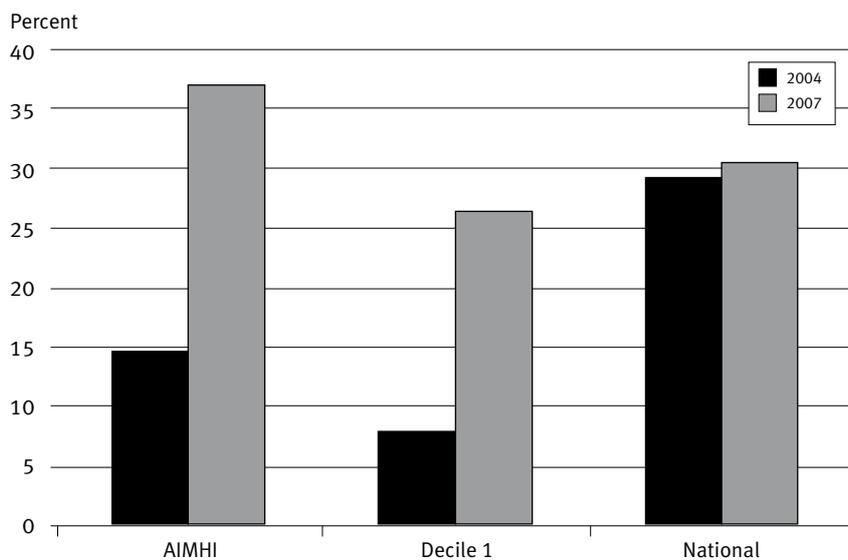
Sourced from Ministry of Education Data, 2008

Little or no NCEA qualifications

In both AIMHI and other Decile 1 schools, there has been a drop in the proportion of students leaving school with little or no attainment, although not as large as the drop nationally (3.4 percent and 3.2 percent respectively, compared with 7.9 percent). These drops have been offset by large increases in the rates of achievement at NCEA Levels 2 and 3 at these schools.

Figure 13: Total population – little or no attainment
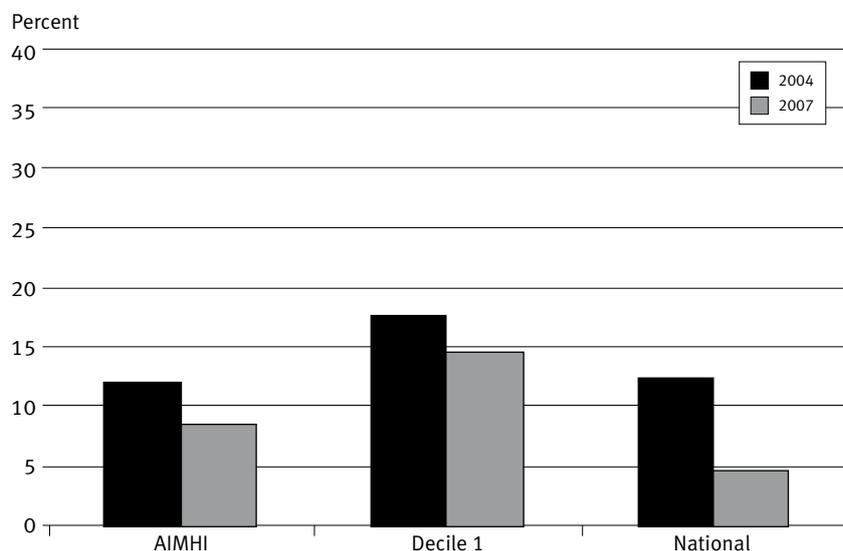
Sourced from Ministry of Education Data, 2008

Māori achievement

There have been large gains in the AIMHI schools in the proportion of Māori students achieving NCEA Level 2, with an improvement of 15.5 percent between 2004 and 2007. However, the gains in Level 3 are considerably less dramatic, with an improvement of only 2.3 percent over the same time period. In 2007, NCEA Level 2 achievement by Māori students in AIMHI and Decile 1 schools compared well with national Māori achievement. However, at NCEA Level 3 this was not replicated, with only 8.8 percent of Māori in the AIMHI schools achieving NCEA Level 3 or higher, compared with 17.1 percent of Māori nationally. It is observed that although the proportion of Māori students in the AIMHI schools leaving school with little or no attainment decreased by 3.7 percent between 2004 and 2007, nationally there was a 15.3 percent decrease over the same time period. In 2007, the proportion of Māori students in AIMHI schools leaving with NCEA Level 2 or higher was 36.4 percent, compared with 43.9 percent nationally.

Table 30: Māori student achievement

Māori	AIMHI (%)		Decile 1 (%)		National (%)	
	2004	2007	2004	2007	2004	2007
Level 3 +	6.5	8.8	5.6	14.9	11.7	17.1
Level 2	12.1	27.6	8.0	26.3	25.8	26.8
Level 1	28.6	21.5	40.5	20.4	21.4	23.8
Limited attainment	33.7	26.8	27.8	24.1	13.4	24.6
Little or no attainment	19.1	15.4	18.1	14.3	25.4	10.1

Source: Ministry of Education, 2008

Pacific student achievement

There has been a dramatic increase in the proportion of Pacific students in the AIMHI schools achieving NCEA Level 2. Overall, there was an improvement of 25.5 percent between 2004 and 2007. Level 3 achievement similarly improved, with a 10.6 percent increase in the proportion of Pacific students achieving at Level 3: markedly better than Māori improvement. Achievement of NCEA Levels 2 and 3 by Pacific students in AIMHI and Decile 1 schools compare well with national rates of achievement.

It is interesting to note that more Pacific students at the AIMHI schools left school with NCEA Level 2 or higher than Pacific students nationally (57.6 percent compared with 55.9 percent in 2007). Pacific students in other Decile 1 schools, however, fell behind, with only 38.1 percent of students leaving school with NCEA Level 2 or higher in 2007. These figures show that, comparatively, Pacific students in AIMHI schools are not only achieving at a higher level than Māori but are also making greater improvements in their level of achievement.

Table 31: Pacific student achievement

Pacific	AIMHI (%)		Decile 1 (%)		National (%)	
	2004	2007	2004	2007	2004	2007
Level 3 +	7.1	17.7	12.5	2.4	14.0	18.5
Level 2	14.4	39.9	4.2	35.7	37.9	37.4
Level 1	46.2	15.5	37.5	23.8	20.4	18.0
Limited attainment	21.5	19.6	20.8	23.8	11.7	19.7
Little or no attainment	10.8	7.3	25.0	14.3	15.9	6.3

Source: Ministry of Education, 2008

Educational behaviours

Truancy

Data collected, as shown in Figure 14, demonstrates that the rates of truancy for both Māori and Pacific students were substantially lower in the AIMHI schools than in other Decile 1 schools. Although AIMHI Pacific students had a lower truancy rate than AIMHI Māori (7.5 percent compared with 9.6 percent), Decile 1 Pacific students had a higher truancy rate than Decile 1 Māori students (19.2 percent compared with 14 percent).

Figure 14: Percentage of truancy by ethnicity, 2006

Percent

- Frequent truancy
- Unjustified absences

AIMHI Māori   AIMHI Pasifika   Decile 1 Māori   Decile 1 Pasifika
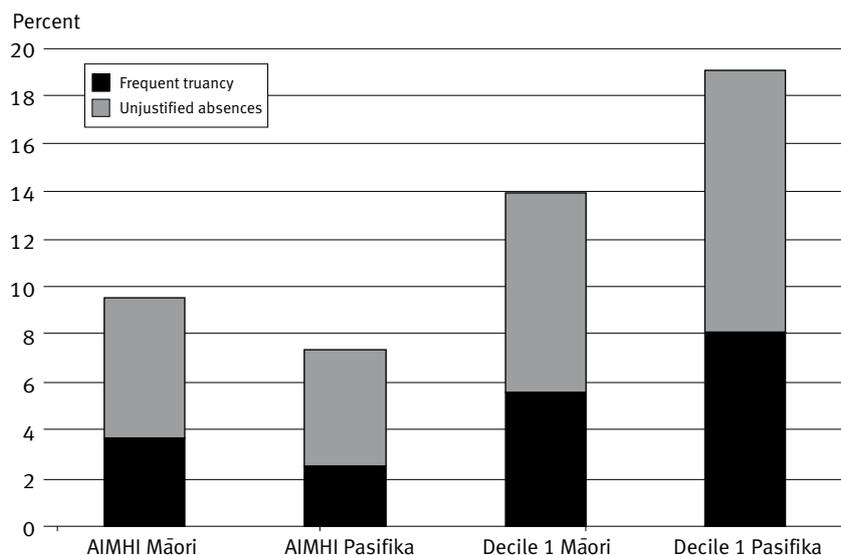
Sourced from Ministry of Education Data, 2008

Nationally, as in the AIMHI schools, Māori had a higher rate of truancy than Pacific students, and both Māori and Pacific students had a substantially higher truancy rate than the total national rate (7.7 percent and 6.2 percent compared with 3.4 percent respectively: see Figure 15).

Figure 15: National truancy data by ethnicity, 2006

Percent

- 2004
- 2007

National Māori   National Pasifika   National total
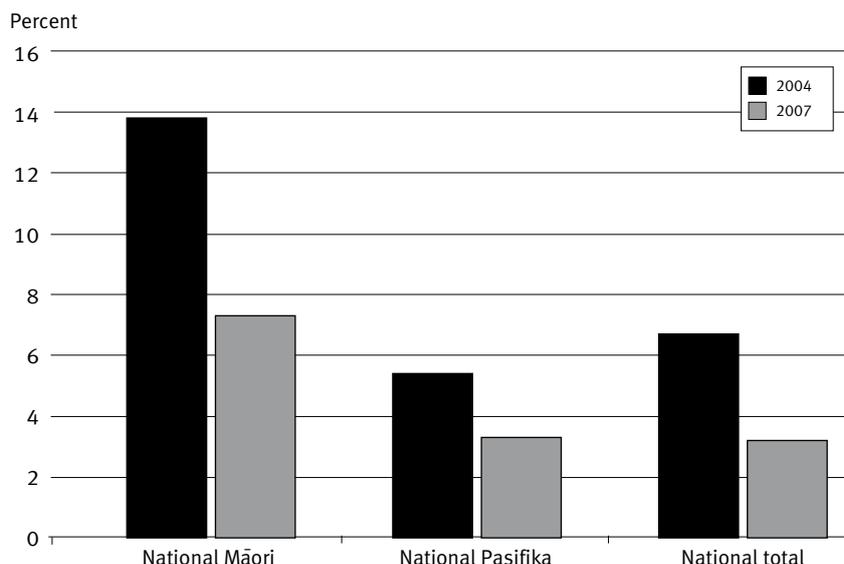
Sourced from Ministry of Education Data, 2008

Early leaving exemptions (ELE)

In 2007, 10.3 percent of Māori students in the AIMHI schools received ELEs. Although this reflected a 3.7 percent decrease since 2004, it is a rate 7 percent higher than that of Pacific students receiving early leaving exemptions in 2007 (3.3 percent). A similar trend is seen between Māori and Pacific students in other Decile 1 schools. In 2007, 7.9 percent of Māori students received an early leaving exemption, compared with only 3.4 percent of Pacific students. It is interesting to note that Māori and Pacific students in the AIMHI schools received a higher proportion of ELEs than those in other Decile 1 schools.

Figure 16:   AIMHI Māori and Pacific ELEs, 2004 and 2007
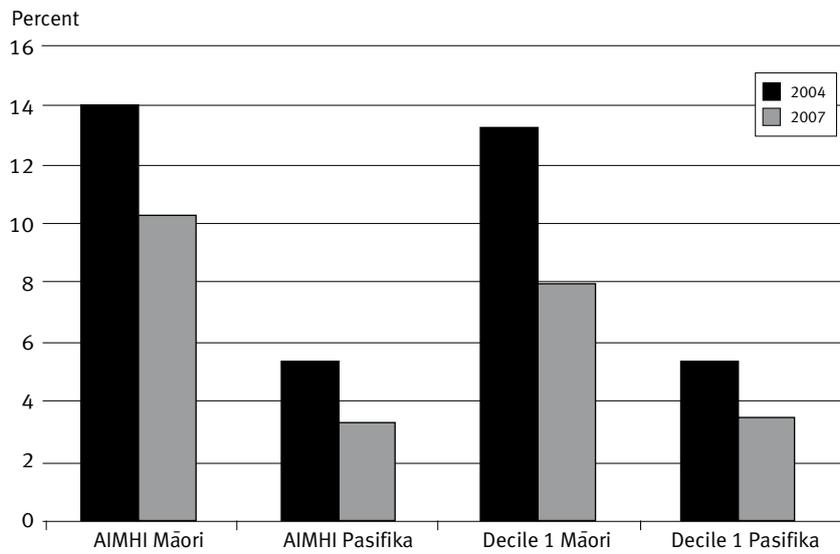
Percent

Sourced from Ministry of Education Data, 2008

Nationally, there has been a large drop in both Māori and Pacific students receiving ELEs. Despite this, in 2007, Māori students still had a much higher rate (7.3 percent) than their Pacific classmates (3.3 percent), whose rates were much closer to the national average, 3.2 percent.

Figure 17:   National Māori and Pacific ELEs, 2004 and 2007
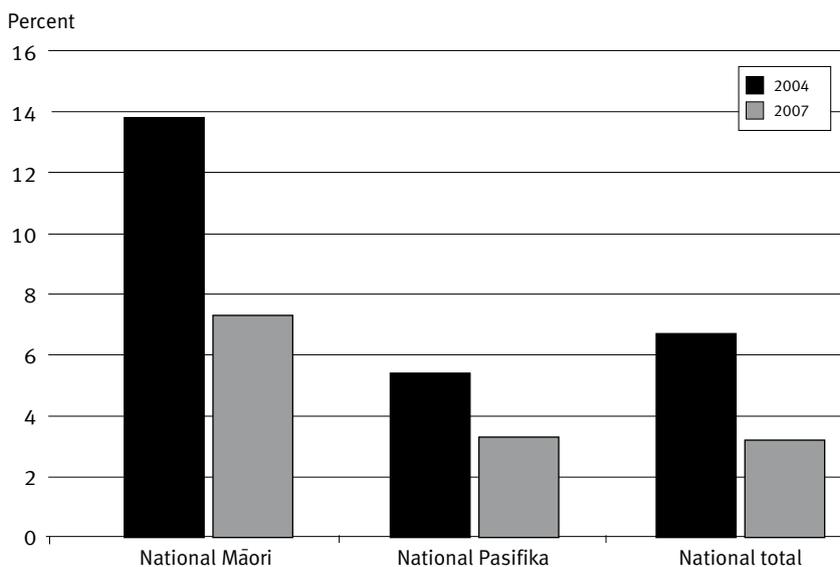
Percent

Sourced from Ministry of Education Data, 2008

Stand-downs

In 2007 3.3 percent of Māori students in the AIMHI schools were stood down, compared with 2.3 percent of Pacific students. In other Decile 1 schools there was a slightly higher proportion of students stood down: 4.5 percent of Māori students, and 2.7 percent of Pacific students.

Figure 18: AIMHI and decile 1 stand-downs by ethnicity, 2004 and 2007
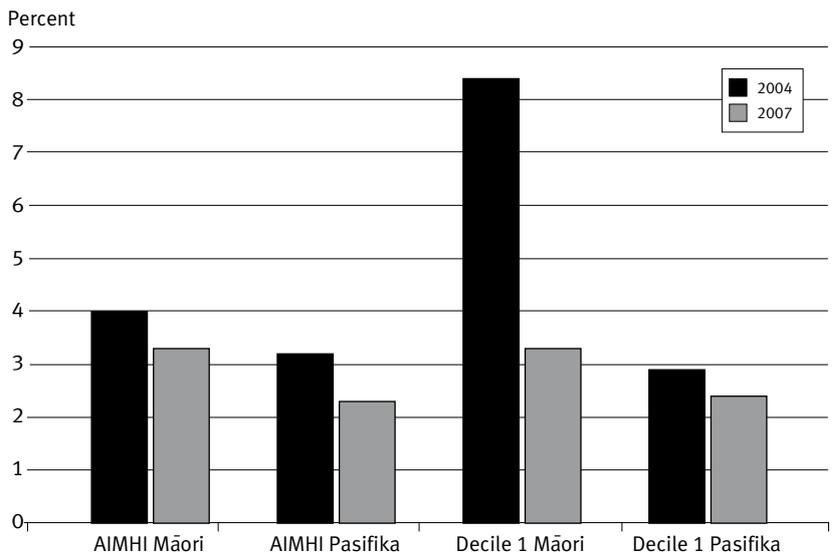
Sourced from Ministry of Education Data, 2008

Nationally there was little change between 2004 and 2007 in the rates of Māori and Pacific students being stood down. In 2007, there was a lower proportion of Māori and Pacific students being stood down in AIMHI and Decile 1 schools than there was nationally. In both 2004 and 2007, however, the national rates of Māori and Pacific students being stood down exceeded the total national average.

Figure 19: National stand-downs by ethnicity, 2004 and 2007
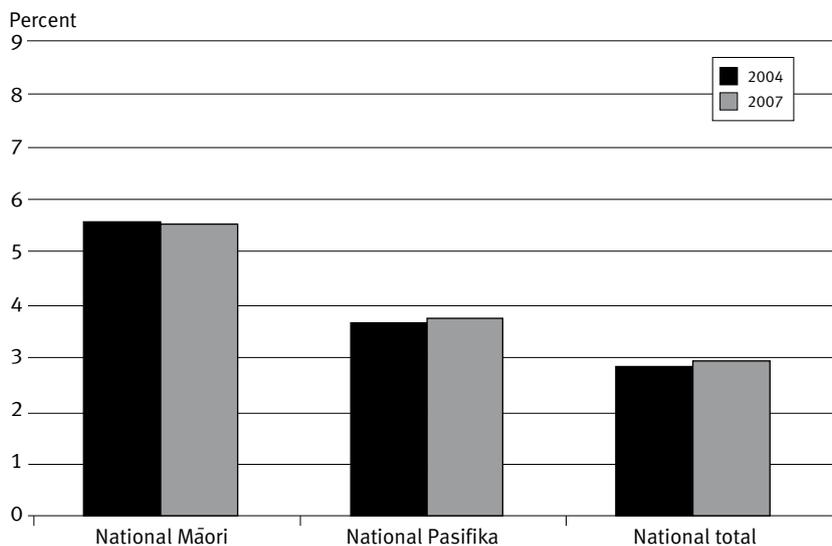
Sourced from Ministry of Education Data, 2008

Suspensions

Māori and Pacific suspensions: AIMHI and decile 1 schools

Data obtained for the number of Māori and Pacific suspensions in 2004 and 2007 show that Māori students in Decile 1 schools had by far the highest rate of suspensions in both years (1.6 percent and 1.5 percent). In 2007, Pacific AIMHI students had the lowest rate of students suspended (0.4 percent). Between 2004 and 2007 there was a decrease in suspension rate in both AIMHI and Decile 1 schools for Māori and Pacific students.

Figure 20: AIMHI and decile 1 suspensions by ethnicity, 2004 and 2007
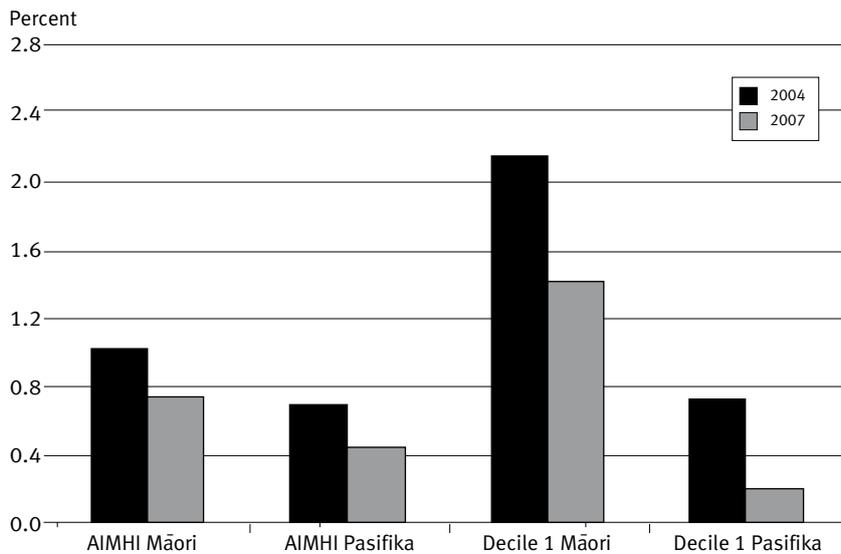
Sourced from Ministry of Education Data, 2008

In both 2004 and 2007 the national Māori rate of suspension was higher than the national Pacific rate and the total national rate (1.4 percent, compared with 0.9 percent and 0.7 percent respectively.) There was a slight decrease of 0.1 percent between 2004 and 2007 for both national Māori and Pacific rates, while the national total has remained unchanged.

Figure 21: National suspensions by ethnicity, 2004 and 2007
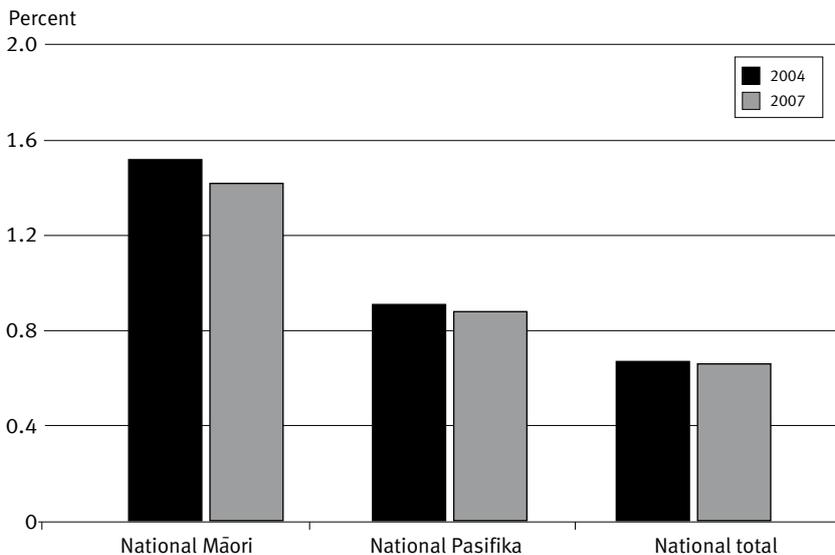
Sourced from Ministry of Education Data, 2008

Expulsions

In 2007, AIMHI schools had the highest rate of total expulsions (0.4 percent, compared with 0.2 percent nationally). We were unable to get the exact figures for other Decile 1 schools, as they were so low. Between 2004 and 2007, the rate of expulsions decreased by 0.1 percent in AIMHI schools and 0.2 percent in other Decile 1 schools. The national rate has remained unchanged.

Figure 22: Total expulsions, 2004 and 2007

Percent

Legend:
- Frequent truancy
- Unjustified absences

X-axis: AIMHI, Decile 1, National
Y-axis: 0.0, 0.1, 0.2, 0.3, 0.4, 0.5, 0.6
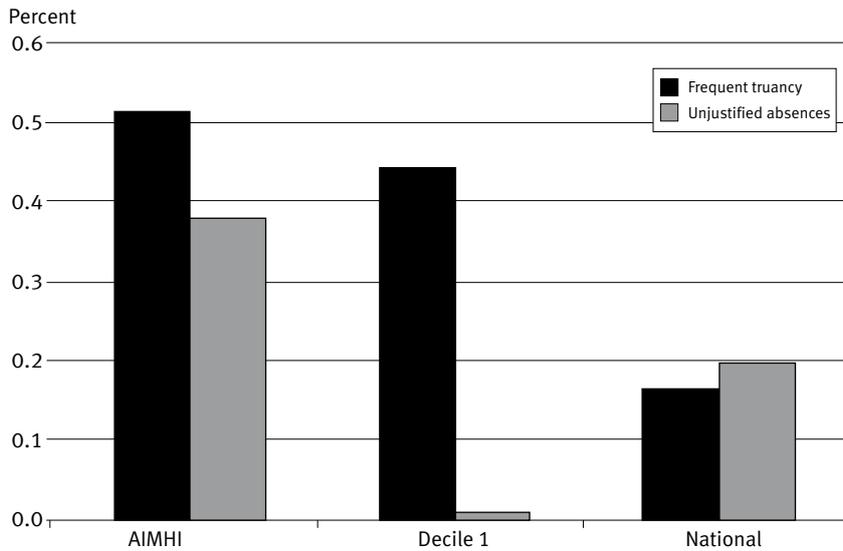
Sourced from Ministry of Education Data, 2008

Retention rates

Between 2004 and 2007, Pacific students had higher rates of retention than Māori students every year. Between 2004 and 2007, the proportion of both Māori and Pacific students still enrolled at school at age 16.5 years of age slightly decreased in the AIMHI schools from 49.6 percent to 48.3 percent and 82.1 percent to 80.6 percent respectively. In Decile 1 schools the retention rates of Māori students slightly increased, from 59.4 percent to 62.5 percent between 2004 and 2007, and they also increased for Pacific students from 41.4 percent to 64.1 percent. In 2007, Māori students in Decile 1 schools had a higher rate of retention than those in AIMHI schools (62.5 percent, compared with 48.3 percent). Pacific students, however, had higher rates of retention in the AIMHI schools than in Decile 1 schools (80.6 percent, compared with 64.1 percent).

Figure 23: AIMHI and decile 1 retention rates at 16.5 years by ethnicity

Percent

Legend:
- 2004
- 2005
- 2006
- 2007

X-axis: AIMHI Māori, AIMHI Pasifika, Decile 1 Māori, Decile 1 Pasifika
Y-axis: 0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100
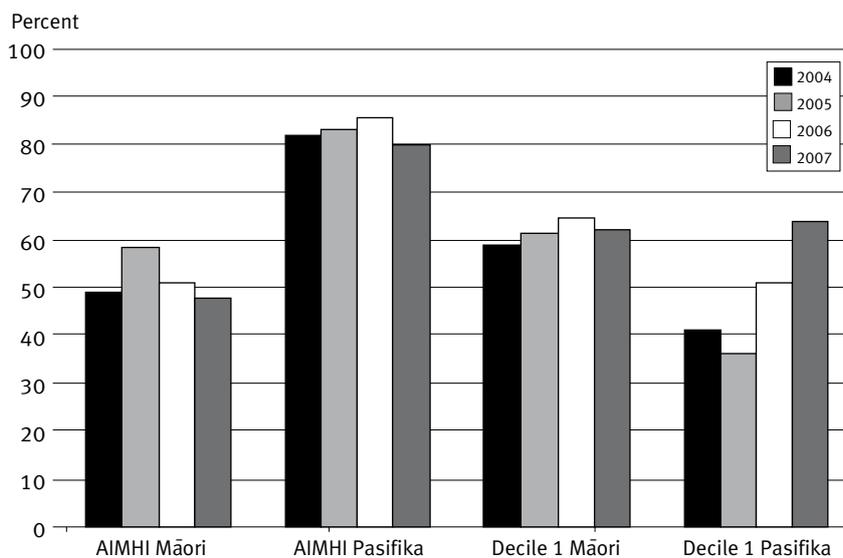
Sourced from Ministry of Education Data, 2008

As was to be expected, both Māori and Pacific students in the AIMHI schools had a lower rate of retention at 17.5 years of age than at 16.5 years of age. In 2007, 26.5 percent of Māori students in the AIMHI schools were still enrolled at 17.5 years of age, as opposed to 48.3 percent at 16.5 years of age. Likewise, in 2007, 67.6 percent of Pacific students were still enrolled at 17.5 years of age, compared with 80.6 percent at 16.5 years of age. Again, Pacific students had a higher retention rate at both ages than Māori students.

Figure 24:   Comparison of retention at 16.5 and 17.5 years by ethnicity for AIHMI and decile 1
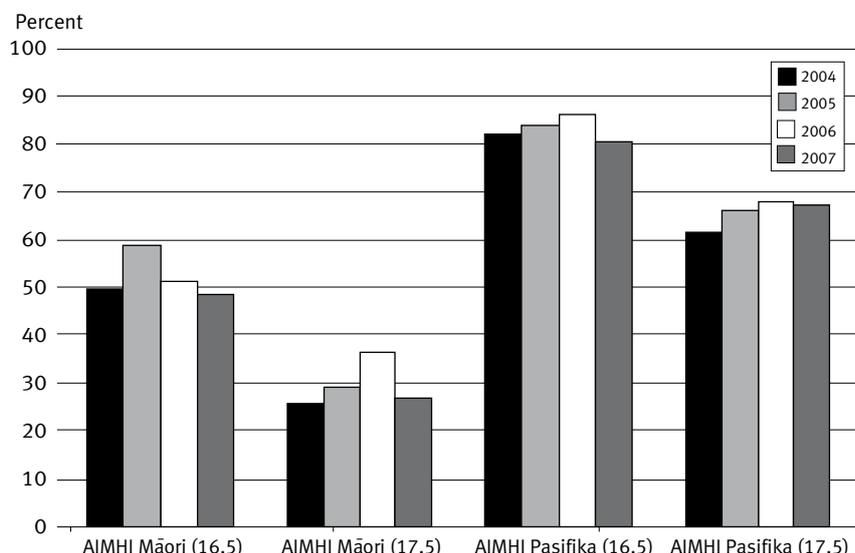
Sourced from Ministry of Education Data, 2008

Figure 25:   National retention rates at 16.5 and 17.5 years by ethnicity, 2004 and 2007
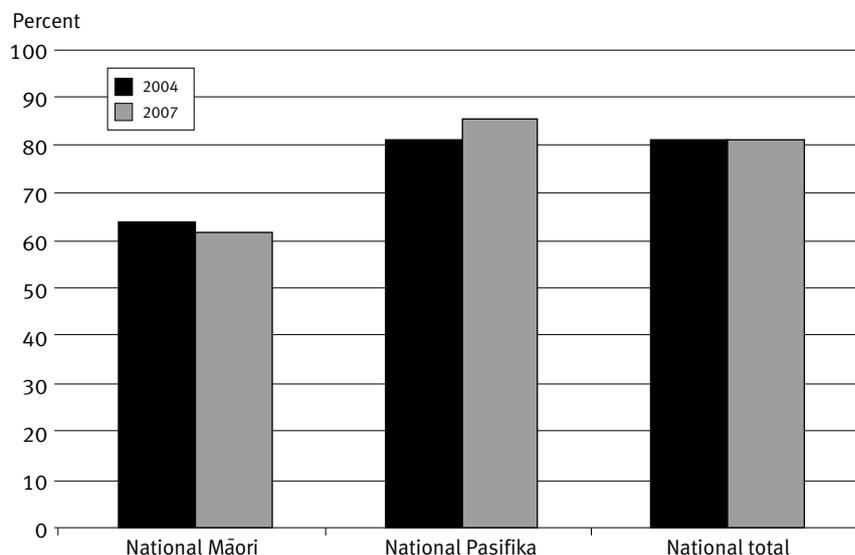
Sourced from Ministry of Education Data, 2008

In 2007, data shows that at age 16.5 years nationally, Pacific students had the highest proportion of students still in school (85.7 percent, compared with 62.6 percent of Māori students and 81.4 percent of all students). It is interesting to note that between 2004 and 2007, the national Māori and total national retention rate slightly decreased (by 1.8 percent and 0.6 percent respectively), while the national Pacific rate increased by 3.4 percent.

Similarly, in 2007 Pacific students, nationally, had the highest number of students still enrolled in school at age 17.5 (68.3 percent, compared with 39.5 percent of Māori students and 61.4 percent of the national total). Pacific retention rates between 2004 and 2007 also had the largest increase (2.3 percent, compared with only a 0.8 percent increase in Māori students and no increase in the national total).

Figure 26:   National retention rates at 17.5 years by ethnicity, 2004 and 2007
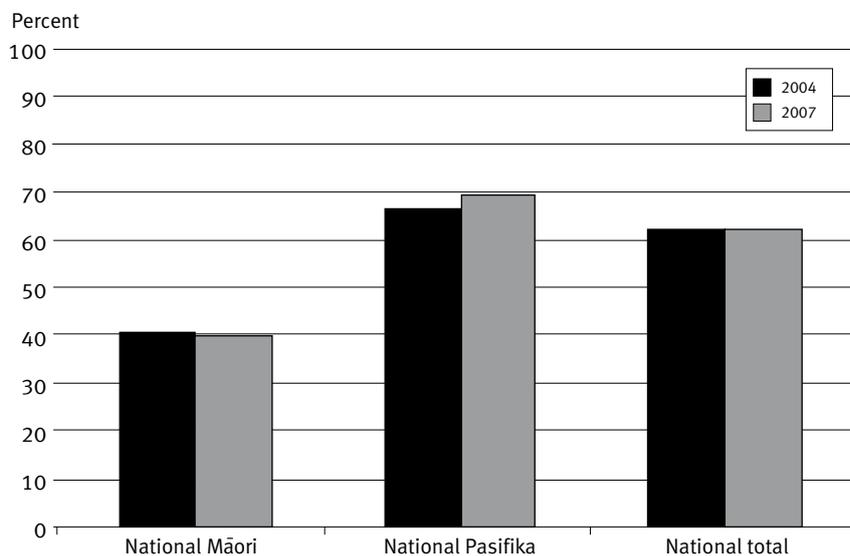
Sourced from Ministry of Education Data, 2008

Summary and Implementation Considerations

Introduction

The current evaluation has drawn conclusions for the implementation of school-based health services from three main activities:

- a review of the literature and previous evaluations of school-based health services
- visits to schools for observation, data collection and interviews with health providers, staff and students
- a structured survey of the perceptions and experiences of students, staff and parents.

Conclusions for implementation

An effective school-based health service

Based on this evaluation, key attributes of successful school-based health services include:

- support from the school principal, board of trustees and staff
- a youth-friendly, confidential and private service that the students can trust
- student input in the provision of health services and initiatives
- a committed partnership between health and education to ensure appropriate resources and support
- experienced and mature practitioners who are qualified and confident in their role with youth and within the education setting
- a ratio of nurses to students that accommodates need
- practitioners who embrace opportunities to actively promote and support the health of young people as opposed to taking a passive 'band-aid' approach
- ready access, preferably on-site, to a medical practitioner at least once per week
- a purpose-built and designed facility that ensures the privacy and safety of students and staff
- a supportive infrastructure both within the school and externally, from the provision of receptionists and governing bodies to professional development and collegial support.

Nine success factors

These considerations can be summarised as nine success factors to consider when developing and implementing a school-based health service in a low-decile school (9Cs). The factors are inter-related and have implications for the orientation and commitment of government agencies (the Ministries of Education, Health and Social Development) and school stakeholders, as well as for the functional design of a school-based health service (processes, resources, systems and practices). The diagram below summarises the factors and their inter-relationships (Figure 27).

Figure 27: Success factors and inter-relationships
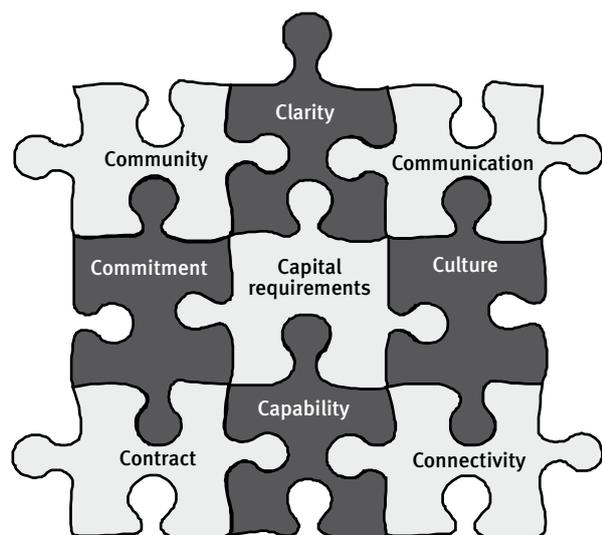
The setting up of a school-based health service is an iterative process. It builds upon the knowledge of the community and the health needs of students to inform the appointment of an appropriate nurse and provision a supportive infrastructure and evaluative framework within which the nurse can work.

The 9Cs are designed as an easy way to remember and reflect upon the fundamental considerations for delivering a school-based health service.

Each school will exist in a unique community with specific issues and characteristics. In addition, schools will have an individual culture and interact with their wider community in different ways.

There is likely to be a variation in the capability of the wider community to provide resources, as well as variation in levels of service provision that can support or augment the work of a school-based health service.

Successful service design and implementation will need to recognise and respond to the uniqueness of each individual school.

This is not to say that there are not common principles and approaches that will apply across all schools, which, when aligned with the unique requirements of individual schools, will deliver a robust solution.

'Appendix A: Health Service Implementation Considerations' provides more detail on each of the 9C success factors, which are summarised below.

Community

It is important to research and understand the community in which the school is located. Demographics and characteristics of the community, present services and community resources, and the present school environment all need to be addressed.

Clarity

There needs to be a clear and shared understanding of the purpose for establishing a school-based health service in the school, and of the possibilities and benefits such a service could provide. In addition, the roles of health professionals associated with the service and the policies and processes needed for an effective service need to be clearly defined.

Communication

Effective communication with schools, staff, students and health professionals is vital for a successful service. The voices of students need to be heard to ensure a youth-led and relevant service.

Commitment

The commitment of all key stakeholders to the implementation of the school-based health service is essential for its success. There needs to be commitment to the service roll-out at a number of levels: government, schools, DHBs, other agencies and students.

Capital requirements

There are a number of specific capital requirements for a well-functioning school-based health service. These include:

• the physical facilities of the service

• the equipment and resources required by each of the health service providers

• the information systems and technology necessary to support the service (including its reporting requirements).

The configuration of capital items is also an important part of the design of facilities for each school. As discussed above, some requirements will be dictated by the specific nature of the school and its student community, and others will be applicable to all schools, as they reflect fundamental best practices for health service provision.

Culture

The importance and role of culture in health and wellbeing is recognised as fundamental to the effective provision of primary health care[21]. Culture includes not only ethnicity, but also the student's specific generation and school environment. There are other influences that may affect the uptake and effectiveness of health services: for example, religion and gender. The extent of the influence of these factors may vary for any one student.

Contract

The notion of contract is applicable to three main areas: service and funding provision, nurses and students.

For each service or funding provision arrangement, there should be an appropriate contract (or memorandum of understanding) in place which documents the agreed objectives to be achieved, the expectations of parties involved, agreed roles and responsibilities of parties, and required standards of performance.

To encourage student engagement with the service some key rights and protocols might be codified into a formal statement for communication to students. For example, a youth-friendly version of a code of rights could be presented to students.

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21 Kidz First Community Health – Centre for Youth Health. 2005. *Successful School Health Services for Adolescents: Best practice review*. Manukau: Centre for Youth Health.

Capability

Provision of quality school-based health services requires sufficient staffing by health professionals who are adequately trained and possess the required knowledge, skills and attributes to deliver specific health services appropriate for the individual school. Capability covers both the ability and the capacity to fulfil a role and provide a service. It also involves the dimensions of acquisition, retention and development of skills.

Connectivity

Connectivity is about ensuring there are linkages between the school-based health service and the students, the rest of the school, the community and other student support service providers. It also means that the school-based health clinic and what its services are visible to the school and wider community, and vice versa.

Connectivity is facilitated through structures and processes for governance and management.[22]

Dimensions for implementation

The dimensions for establishing (or enhancing) school-based health services comprise the factors for success (9Cs), specific design of the services, the needs and contributions of stakeholders and a pathway for implementation. This is illustrated in the diagram below (Figure 28).

Figure 28: Requirements for establishing school-based health services
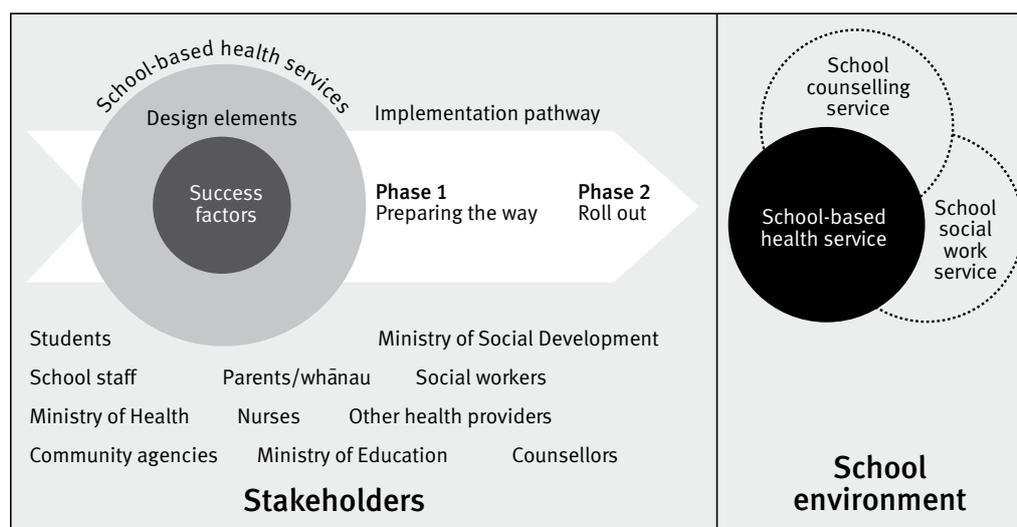
Details of these dimensions are outlined more fully in 'Appendix A: Health Service Implementation Considerations'. They are provided as a guideline only. Specifics for any school will be influenced by the particular context and the levels of funding available.

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22 Kidz First Community Health – Centre for Youth Health. 2005. *Successful School Health Services for Adolescents: Best practice review.* Manukau: Centre for Youth Health.

Glossary

Term	Definition
ADHB	Auckland District Health Board
AIMHI	Achievement in Multi-cultural High Schools
BMI	Body mass index
CCDHB	Capital and Coast District Health Board
CMDHB	Counties Manukau District Health Board
CYF	Child Youth and Family – the part of the Ministry of Social Development that is involved in the Healthy Community Schools project
Decile	A rating allocated to schools for funding purposes, based on a range of socio-economic factors, Decile 1 being the lowest socio-economic grouping and Decile 10 the highest
Deprivation	The scale of deprivation ranges from 1 to 10, where 1 represents the least deprived areas and 10 the most deprived areas
DHB	District Health Board
EN	Enrolled nurse
GP	General practitioner
HEADSS Assessment	Psychosocial screening tool for young people assessing various domains such as home, education, activities, drugs and alcohol, suicide risk and sexuality
HCS	Healthy Community Schools Initiative (also known as AIMHI)
HealthLink Messaging System	A secure system that provides real time and store-and-forward electronic data interchange (EDI) in a context specifically tailored to the requirements of health providers
MECCA	Multi-employer collective contract agreement
Medtech-32	Patient management system used by primary care providers in New Zealand, especially in the general practice environment
MoE	Ministry of Education
the Ministry	Ministry of Health
MSD	Ministry of Social Development
NGO	Non-government organisation
PDRP	Professional Development Recognition Programme –provides the opportunity for registered nurses to obtain professional recognition of their practice through the assessment of supportive evidence
Performance Monitoring Reports	Reports provided to HealthPAC/the Ministry of Health detailing progress against budget, programme and specifications
PHO	Primary health organisation

Term	Definition
Professional development	Ongoing education requirements for health professionals under the Health Practitioners Competency Assurance Act 2003
Query Builder	A reporting tool used to interrogate and retrieve data that has been entered into the system, used for reporting and measurement of activities
RN	Registered nurse
Service providers	Providers working within school-based services as part of a multi-disciplinary team, for example social worker, counsellor, nurse, doctor, youth worker
Standards New Zealand	New Zealand-based organisation responsible for the development of standards and standards-based solutions. Standards New Zealand is the operating arm of the Standards Council, an autonomous Crown entity operating under the Standards Act 1988
Standing Order	A written instruction issued by a medical practitioner or dentist, authorising the school nurse to supply and administer specified medicines and controlled drugs to students according to specified circumstances, without a prescription
SWiS	Social Workers in Schools programme

Appendix 1:
Health Service Implementation Considerations

Dimensions of school-based health services

Introduction

Previous research has identified some specific important considerations for implementing effective school-based health services in New Zealand.[23]

- wide engagement with school and community

- youth focus and participation

- delivery of high-quality comprehensive care

- effective administrative/clinical systems and governance to support service delivery.

This PricewaterhouseCoopers evaluation of the HCS initiative in the AIMHI schools confirms these considerations. It concludes that key factors that influence the effectiveness of school-based health services include:

- support from the school principal, board of trustees and staff

- a youth-friendly, confidential and private service that the students can trust

- student input in the provision of health services and initiatives

- a committed partnership between health and education to ensure appropriate resources and support

- experienced and mature practitioners who are qualified and confident in their role with youth and within the education setting

- a ratio of nurses to students that adequately addresses student need

- practitioners who embrace opportunities to actively promote and support the health of young people, as opposed to taking a passive 'band-aid' approach

- ready access, preferably on-site, to a medical practitioner at least once per week

- a purpose-built and designed facility that ensures the privacy and safety of students and staff

- a supportive infrastructure both within the school and externally, from the provision of receptionists and governing bodies to professional development and collegial support.

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23 Kidz First Community Health – Centre for Youth Health. 2005. *Successful School Health Services for Adolescents: Best practice review*. Manukau: Centre for Youth Health.

Overview

In order to establish school-based health services in schools beyond those in the AIMHI initiative, the following need to be addressed:

- defining the dimensions of school-based health services (comprising key factors for success and the specific design elements that need to be in place for effective operation of the service)
- securing the required commitment and contribution from key stakeholders to inform the proposed design and implementation pathway
- developing the implementation pathway for the roll-out of the school-based health services' design to designated schools.

The broad context for establishing (or enhancing) school-based health services is illustrated in the diagram below (Figure 1.1). This document outlines specific details to assist with design of health services and their implementation.

These details are provided as guidelines only. The specifics for any school will be influenced by the particular context and the levels of funding available.

Figure 1.1: Requirements for establishing school-based health services
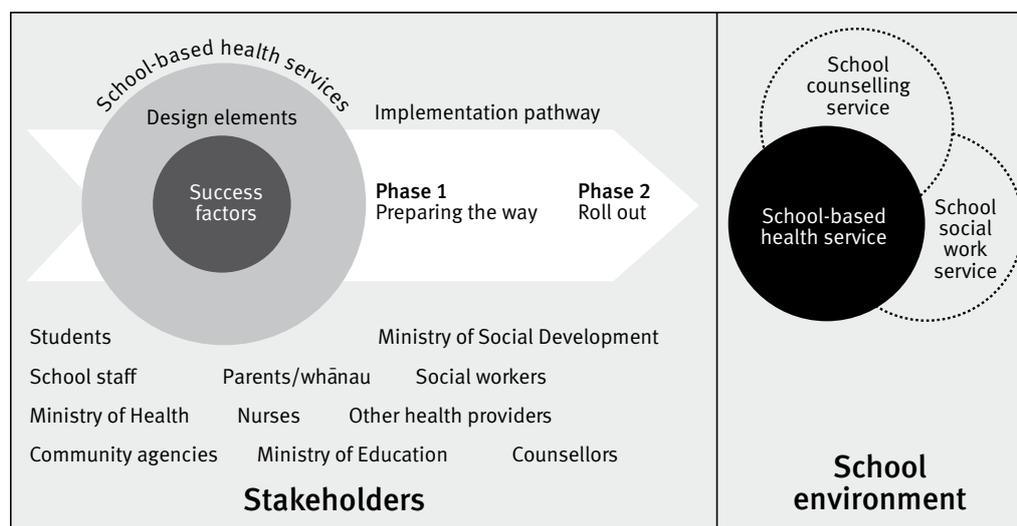
Success factors

Previous research and the results of the PricewaterhouseCoopers evaluation of the HCS initiative in AIMHI schools indicate that there are nine success factors (the 9Cs) to consider when developing and implementing a school-based health service in a low-decile school. These are inter-related and have implications for the orientation and commitment of government agencies (the Ministries of Education, Health and Social Development) as well as for the functional design of a school-based health service (processes, resources, systems and practices). The diagram below summarises the factors and their inter-relationships (Figure 1.2).
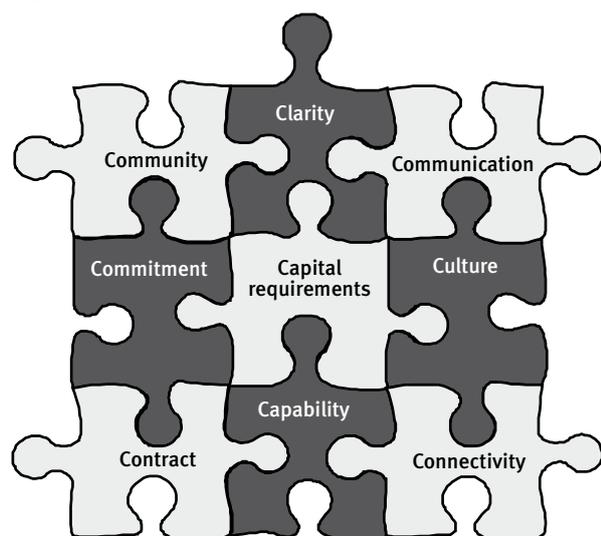
The 9Cs

The setting up of a school-based health clinic is an iterative process. It builds upon the knowledge of the community and the health needs of students in the appointment of an appropriate nurse and the provision of a supportive infrastructure and evaluative framework within which the nurse can work.

The 9Cs have been designed as an easy way to remember and reflect upon the fundamental considerations in delivering a school-based health service.

Each school will exist in a unique community with specific issues and characteristics. In addition, schools will have an individual culture and interact with their wider community in different ways.

There is likely to be variation in the capability of the wider community to provide resources, as well as variation in levels of service provision that can support and augment the work of a school-based health service.

Successful service design and implementation will need to recognise and respond to the uniqueness of each individual school.

This is not to say that there are not common principles and approaches that will apply across all schools, which, when aligned with the unique requirements of individual schools will deliver a robust solution.

Community

It is important to research and understand the community where the target school is located. This will enable planning on three fronts.

- Establishing the demographics and characteristics of the community will:
  - highlight the issues and constraints that the school-based health service may have to manage
  - clarify the level and nature of resourcing that may be required.

- Knowing the present services and community resources will:
  - ensure key community stakeholders can be involved in the introduction of the school-based health service
  - highlight the potential options in terms of the best model to use to provide the service
  - identify the health professional networks operating in the wider community and the support or professional development they might offer the service
  - establish the options in linking the school-based health service with a GP
  - ensure that the services at the school can be designed in a way that makes best use of community resources and minimises duplication.
- Understanding the present school environment will:
  - allow the concerns of the school to be addressed in an appropriate manner
  - ensure that timing of the introduction of a school-based health service will be appropriate
  - facilitate 'buy-in' and support for the service and more effective planning by the school
  - provide information about the physical resources available within the school to establish the health service
  - establish what health services are currently provided in the school, how these are organised and by whom.

Information gleaned from the community should include:

- a population profile and growth rate
- the socioeconomic status of the area
- the social issues prevalent in the community that may impact directly or indirectly on the provision of health services for youth, for example:
  - availability of public transport
  - unemployment levels
  - housing resources
  - availability of utilities such as power, water and sewage
  - prevalence of drug and alcohol issues
  - prevalence of gangs.
- present levels of access to health and social services and uptake of these services
- health and social service providers and funders present in the community, including local iwi
- the pressing concerns of the principal and staff at the school and how these may relate to the provision of school-based health services
- the receptiveness of the school's culture
- an ethnic and cultural profile of the students
- the level of resources likely to be required, including ratio of registered nurse to students.

Clarity

Purpose

The purpose of establishing a school-based health service is to improve:

- access to health and social services for students

- student achievement and educational outcomes through meeting students' health and social needs.

There needs to be clear and shared understanding of this purpose amongst all key stakeholders (government agencies, school personnel, health professionals and students). Full appreciation of this purpose will contribute to levels of support for the service. School personnel are more likely to appreciate the value of the service if they understand how they themselves will benefit, both individually and collectively.

School-specific understandings

Consistent with the overall purpose, there needs to be a clear vision and shared understanding (in agencies and schools) of the possibilities for a school-based health service in each school, and of the specific benefits, in terms of contribution to student health and educational outcomes, that the service will bring to the school.

Each school-based student support service needs to have a clear objective. The school and the DHB acting on behalf of the Ministry of Health should have common goals, which need to be agreed and documented.

Similarly, the Ministry of Health and the DHB need to have a clear understanding of the school's educational and other priorities, and understand the particular pressures and issues at individual schools.

Roles of health professionals

There should be clarity of understanding of the roles of respective health professionals in the school-based health service. At the earliest opportunity in the planning phase, the schools should have an understanding and acceptance of:

- the scopes of practice of school nurses and GPs, where applicable

- how the different services provided within the health service will fit together

- how the health services will fit with other student support services already provided or planned.

Comprehensive understanding will facilitate the implementation of the school-based health service and its effective ongoing operation. For example, schools should clearly understand what a registered nurse can do, what other health professionals and resources the nurse can access on behalf of the students and the services the nurse will provide to benefit the students.

All school-based health services need to be delivered to agreed standards. This means that the school nurse must have sufficient time not only to directly provide the service but also, as a recognised part of the role, for:

- collaboration with colleagues

- follow-up with students and parents/whānau

- follow-up of student referrals with community-based agencies and other health and support services

- regularly informing students, staff and parents of:
  - the health services provided
  - how students can access these services
  - how these services can benefit the students in terms of their health and wellbeing, as well as their education
- data collection, research and report writing
- supervision of any second-level nurses working in the service
- supervision and education of student nurses
- their own supervision and professional development.

These roles should be included in the job descriptions of the health practitioners.

It is crucial for all student support professionals to understand each other's roles and scope of practice.

Policies and processes

Schools may well have health policies and processes in place that cater for their present circumstances and set-up. As part of preparing the way, these policies and processes will need to be revisited and modified to facilitate the effective operation of the school-based health service.

Some changes may need to be negotiated, as the school and board of trustees become familiar with the scope of services the health service will provide and the respect required for the professional ethics of the health providers.

Likewise, the school may have general school policies and processes that can be accommodated by the health service without any detrimental effect on service provision.

Transparent and agreed policies and processes within the school, inclusive of those related to the health service, will help facilitate the integration of the service within the school and avoid any misunderstandings.

Teachers should know, for example, when they should refer a student to the health service, and to whom. The necessity to leave class early or arrive late as a result of using the service should be able to be accommodated by all parties. Parents should be aware of the policies around students' consent, and students should be aware of the service's policy on and commitment to confidentiality.

Communication

A major factor for achieving clarity of understanding and commitment from stakeholders to a school-based health service is effective communication.

Schools

Communication with schools should be interactive and involve:

- meeting with the school principal and those that have responsibility for pastoral care, including deans and counsellors, to gain an appreciation of the specific needs of the school
- developing an understanding of the profile of the students at the school (through the school as well as through studies such as 'Youth 2007')
- exploring with the school what its student health needs are

- listening to the school's views on its unique characteristics, issues and culture

- suggesting, in the light of school-specific characteristics, the possibilities for a school support service to improve health and educational outcomes

- asking the school for its view on how this might fit in with its priorities and longer term interests

- ensuring that the concept of a school-based health service is explained and communicated in the context of the school's specific needs

- discussing what the school might need to do to realise the concept.

School staff

Once the decision has been made to implement a school-based health service within the school, there should be presentations to staff explaining the purpose and scope of the proposed service. This should also include communication of how the service will fit with the rest of the school.

An orientation programme for staff would ensure that staff understood:

- the role of the health professionals and their scope of practice

- how the health professionals can facilitate the work of other staff

- their role in interacting with health service practitioners

- how to refer students

- any changes in school policy, protocols and processes resulting from the implementation of the school-based health service

- privacy and confidentiality considerations.

An orientation programme could also provide the opportunity for staff to raise concerns and possible resolutions.

Establishing an ongoing communication infrastructure for school staff and the health providers that keeps both staff and health providers informed is important. This will help ensure staff:

- maintain a current understanding of the school-based health service

- can interact and discuss the services that are seen to be required from their experiences with students

- can discuss health concerns they might have for a student

- can collaborate, where appropriate, in providing effective wrap-around services for students with complex needs.

School nurse

An orientation programme (or induction) to the proposed service, the school itself and the wider community should also be available to the school nurse. The extent of this would depend on their role, professional experience and background, as well as their knowledge of the school and community.

An orientation programme for the school nurse would be designed to ensure the nurse was familiar with:

- the philosophy and background of school-based health clinics

- the specific characteristics and needs of the students

- the physical layout of the clinic and its resources

- the relevant school policies and procedures

- the other pastoral care services and staff within the school

- the governance structure and personnel within the health clinic

- the representative student groups within the school: for example, the student council, the health council, class representatives and prefects

- the general workings of the school, including school meetings and extra-curricular activities, and a list of 'who's who' within the school and connected with the school

- service providers, funders and other agencies and resources in the community: for example, local iwi

- the school health curriculum

- the HEADSS assessment process

- key areas of service provision: for example, family planning and sexuality, abuse, emergency care, drugs and alcohol, obesity and health promotion

- any other school-based health clinics and school health professionals in the region.

The school nurse needs to spend time to become familiar with the school's systems, people and environment, as well as local support networks, prior to making the health service available to students. This includes time to establish relationships with local iwi, parent groups, churches and other community groups who either impact on local youth or influence their attitudes and behaviours in regard to their health and wellbeing.

This will ensure the nurse is well prepared to provide services and resources to students. Such an orientation will minimise the need to interrupt the flow of work with students, which affords little time for such activity.

To facilitate the health service and nurses being well integrated within the school, school nurses need to be included within the existing staff communication infrastructure of the school: for example, school staff briefing meetings (before and after school), assemblies, school planning days and parent/teacher evenings.

As importantly, being part of this infrastructure will ensure that the school nurses are:

- kept abreast with current events within the school

- visible and available to staff and parents

- able to tailor their services to maximise uptake by students and effectiveness

- able to provide feedback about the service on a regular basis.

The relationship between the health service and the school can be further enhanced through the school nurse:

- attending regular meetings with pastoral care staff, deans and principals

- attending school management team meetings, board of trustee and staff meetings

- making presentations to staff on demographics, health trends and health-related issues

- participating in extra-curricular school activities (for example, coaching)

- contributing to health programmes to support school objectives and reporting on the success of initiatives

- contributing to the school health curriculum.

The school nurse is often the only member of their profession in their workplace. Maintaining links with their professional group external to the school and maintaining effective communication networks with their peers in other schools will provide professional support, sharing of knowledge and ideas.

Students

The school-based health service should be youth-led and meet the range of health needs of the students. To facilitate understanding, it would be useful to have a youth advisory group that represents the students in each school. Such a group would be able to communicate the needs of students to the school-based health service and provide regular feedback from students.

Ministry of Education

A school needs to communicate to the Ministry of Education:

- the positive impacts of the school-based health service on student achievement and educational outcomes
- what, exactly, facilities need in order to provide a successful service: for example, to ensure privacy, enable effective meetings, facilitate student and ambulance access and provide quality health and social service delivery
- the nature of the investment school health services are required to make, above and beyond the provision of a 'first aid' service to students
- the role the Ministry can play in ensuring that funding provided to schools for health service facilities is spent on these facilities as intended.

Other student support and pastoral care providers

The school-based health service is part of a wider student support service.

Students with complex needs may require a wrap-around and multi-disciplinary approach. This requires ongoing communication between those that can contribute to collaboratively supporting the student, for example through regular case management meetings.

Commitment

The commitment of all key stakeholders to the implementation of the school-based health service is essential for its success. There needs to be commitment to the service roll-out at a number of levels: government, schools, DHBs, other agencies and students.

Government

For the services to be sustainable they need ongoing funding. This includes funding for capital requirements (buildings, fit-outs), staffing (appropriate ratios of nurses to students) and resources (equipment).

The MoE has responsibility for ensuring that school facilities meet students' requirements. The MoE recognises that the students' health and wellbeing impacts on their ability to learn and their educational outcomes. The health service needs to be located in a suitable facility that enables health providers to effectively meet needs of the students. This may require additional capital investment.

Similarly, the school-based health service relies on the commitment of the Ministry of Health, through DHBs, for the funding of adequate resources. This includes adequate nurse-to-student ratios and funding for professional development of the school-based health service providers at a level that also accounts for at-risk and special needs students. Staff need to be supported by an adequate professional infrastructure.

DHBs and other agencies

DHBs will need to invest the requisite time to ensure the schools are engaged with, and committed to, the roll-out of school-based health services.

The commitment of DHBs will also need to extend to ensuring that:

- those employing school nurses are familiar with this role and its associated responsibilities, or have the support to do it
- school-based health services are adequately equipped
- professional support for school nurses is available
- there is ongoing monitoring of the progress of health services and nurses within schools.

Other agencies that might be involved may include PHOs, local general practitioners, iwi and other community-based groups. These agencies may provide resources and support in varying degrees, depending on the characteristics of the individual school community. It is important that commitments to provide resources and support are well planned, so that any change can be managed without negatively impacting on students and the health service.

Schools

For maximum impact, schools need to be committed to the service: for example, by:

- ensuring any capital grant given towards health facilities is fully used for the health service
- the principal, or senior management representative, committing the time required to engage with the DHB or service provider (NGO/PHO) to set up the service
- the principal fully ensuring the board of trustees and school staff are well informed in regard to:
  - the benefits the health service will bring for students
  - what needs to be done to accommodate the health service
  - how the health service fits within the school's strategy and will help it become a health-promoting school.
- having a formal orientation programme for new school nurses
- enabling the school nurse to make presentations to staff, students and parents with regard to the health service
- ensuring the school nurse has access to ongoing professional development
- enabling students to be involved in the establishment and ongoing direction of the health service within their school.

To encourage ongoing commitment from the school to provide facilities and services to the required quality standards, consideration should be given to formal recognition of the school's achievement and innovation in service provision. Possibilities include the introduction of a 'School Health Service Award' scheme, and quality accreditation.

Health professionals

Any professional working as part of the health service needs to be committed to providing a quality, youth-friendly, culturally appropriate service for students. The school nurse needs to be committed to the philosophy of the service being youth-led and having a strength-based health-promoting approach.

As this is a developing specialty of work for nurses, it is important that school nurses are committed to their ongoing education and professional development in the field of youth health. This may involve personal time as well as paid work time.

Students

Students can provide valuable insights into aspects of the potential health service that. Students who have the opportunity to be involved with the inception of the health service and its ongoing direction need to be committed to representing their colleagues as effectively as they can.

Students also need to make a commitment to using the health service appropriately. Abuse of the service (for example, as an escape from a class) will render the service less effective to their fellow students.

Capital requirements

A well-functioning school-based health service entails a number of specific capital requirements. These include:

- the physical facilities of the service

- the equipment and resources required by each of the health service providers

- the information systems and technology to support the service (including its reporting requirements).

The configuration of capital items is also an important part of the design of facilities for each school. As discussed above, some requirements will be dictated by the specific nature of the school and its student community, and others will be applicable to all schools, if they are based on fundamental best practices for health service provision.

Capital requirements should be developed through a process of discussion amongst the key stakeholders of agencies, schools and health professionals. It is important to develop the specific requirements and identify the specified funding for these in the schools themselves. This will ensure that funds provided for health service facilities survive the many competing priorities for use of funds in schools.

If the communication has been managed as suggested above, and all parties in the school are committed to the service and its agreed design, there will be fewer issues with the application of funds to the required capital items.

A proposed list of capital requirements and resources (including information systems) is presented below in the discussion on design elements for school-based health services.

Culture

The role of culture in health and wellbeing is recognised as fundamental to the effective provision of primary health care.[24] Culture includes not only ethnicity, but also a student's specific generation and school environment. Other influences may affect the uptake and effectiveness of health services: for example, religion and gender. These factors can have varying influence.

The cultural needs of the students need to be considered in:

• the design of the health service

• the general and clinical operation of the service

• the competencies and orientation of health service staff.

Nurses, like counsellors, social workers and other support staff, will need to have a good understanding of different cultural influences that might impact upon students. The nurse will need to be adept at being able to engage a wide diversity of students and have the knowledge to respond appropriately to keep students safe.

Ethnic needs

Ethnicity can have an impact on how or whether the student accesses school-based health services. For example, in some cultures, notably Pacific, there is an ethos of 'what happens at home, stays at home'. This can present students with a dilemma. They know that they need support and help, but fear involving others will have adverse repercussions that might outweigh the benefits of seeking help.

Being familiar with, and using, holistic and ethnically appropriate models of care may reduce psychosocial barriers to access.[25] Similarly, in some communities there will need to be recognition of the cultural needs of students who are migrants or refugees from non-Pacific countries.

Youth culture

The wider context of New Zealand youth culture and the influence of their peers may have a strong influence on students in accessing health services. It is important to engage students in having an active role in the governance and management of the health service, beginning with its development.

School culture

The school culture will have an impact on how quickly and effectively the health service will be seen be seen as an integral part of the school.

For a health service to be sustainable and effective, the culture of the school needs to be open to new initiatives and change. The school needs to see its role as a school that promotes health and wellbeing as part and parcel of an effective learning environment.

This can be realised from the earliest communications with staff and health professionals, and the inclusion of the school-based health service as an element in the strategy of the school.

Changes may be needed to the way school staff work and the roles and functions people perform, to achieve this assimilation of the service into the school. There may need to be some re-alignment of school protocols and policies within the school to accommodate the practice and professional autonomy of the school nurse. Likewise some standard school-based health service protocols and policies may need to be re-aligned to fit within the school environment.

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24 Kidz First Community Health – Centre for Youth Health. 2005. *Successful School Health Services for Adolescents: Best practice review*. Manukau: Centre for Youth Health.

25 The Māori 'Te Whare Tapa Wha' model is part of the foundation of the health and physical education curriculum used in schools, with similar concepts underpinning the Pacific model for holistic approaches to health and wellness.

There may also need to be adjustments of the school culture and processes to accommodate student access to the service. For example, the health service may need operating hours available to students outside of class time, which could have an impact on policy and operations to do with school security.

The recommendations above for communication and commitment from schools and health professionals will assist in developing an inclusive culture within the school to the extent that the school-based health service is seen as a natural part of 'the way we do things around here'.

Principals will need to recognise that in some schools this may require a conscious approach to managing change, so that the health service fits in readily with the school.

Contract

Funding and service provision

For any configuration of the school-based health service there will be a range of stakeholders contributing to funding for the provision of services. This includes government ministries, DHBs, PHOs, local service providers, GPs, NGOs, the schools and others.

For each service or funding provision arrangement, there should be an appropriate contract (or memorandum of understanding) in place which documents the agreed objectives, the expectations of parties involved, agreed roles and responsibilities of parties, and standards of performance required. Contracts should also provide for a process of monitoring and evaluation of performance against documented objectives and expectations.

Nurses

There are three main employment options for nurses: they can be employed by the school, a PHO or NGO, or the DHB.

The principal consideration, in terms of who employs the nurse, has to be which arrangement will best facilitate the nurse working effectively with students. Ultimately the effectiveness of the configuration of employment will rest with both the employer and the employee, and the arrangements and trust between them. Some potential advantages and disadvantages are outlined in Table 1.1 below.

All these factors can be managed and are not listed to favour or preclude any one arrangement, but rather to highlight potential issues that may need to be addressed. For example, if the school is the employer, they may have more control over the services offered and limit services they perceive could have a negative impact on their school image, such as contraception and sexual health services.

Table 1.1: Potential advantages and disadvantages of different employment arrangements of the school nurse

	School	PHO/NGO	DHB
Potential advantages	Increased sense of ownership by school Ease of access to staff resources Inclusion in staff meetings and school activities Involvement in school planning Direct general management of nurse eg, pay, leave School knows availability of nurse and health service	Independent of board of trustees and school Autonomy of health service Recognition as a professional Avoids conflict of interest with school policies Access to professional support and development Has safe out-of-hours location eg, in school holidays Networks with community agencies Familiar with DHB data requirements	Independent of board of trustees and school Autonomy of health service Recognition as a professional Avoids conflict of interest with school policies Access to professional support and development Ready network to specialist support and advice Direct feedback on issues and service Access to DHB infrastructure Strong nursing focus and links with peers
Potential disadvantages	Nurse could be directed to work outside their role Nurse's autonomy to practice could be curbed Limited ability to appraise and monitor performance Perceived as 'non-professional' staff Isolation from peers and support Subject to influence of changing principals and board of trustees Unfamiliarity with nursing competencies May choose to have school hour coverage only Ministry of Health/DHB has limited influence over principal to ensure compliance with agreement eg, provision of data, support of professional development and full set of services eg, sexual health	Less ownership and engagement by school Less integration with school Health service seen as an 'add-on' to the school Professional development may be generic/PHO focus Uncertainty of nurse's availability May limit referrals to primary health providers outside of PHO Partnering agreement can be difficult to negotiate with school	Nurse could be directed to work outside their role Less ownership and engagement by school Less integration with school Uncertainty of nurse's availability Partnering agreement can be difficult to negotiate with school Remote day-to-day management of nurse

Source: PricewaterhouseCoopers, 2008

Student expectations

To encourage student engagement with the service, consideration could be given to codifying key rights and protocols into a formal statement for communication to students. For example, a youth-friendly code of rights could be presented to students.

Similarly, students should understand the way the health service operates and their consent should be compulsory for protocols that have a personal impact on them: for example, the sharing of confidential information between the wider student support team.

This approach provides transparency for the student as well as clarity for the provider.

Capability

Provision of quality school-based health services requires sufficient staffing by health professionals who are adequately trained and possess the required knowledge, skills and attributes. Capability covers both the ability and the capacity to fulfil a role or provide a service. It also involves acquisition, retention and development of skills.

Qualifications and experience

Minimum competency specifications for school nurses need to be developed, which include clinical competence, cultural competence and competence in working with youth. The scope of a nurse's work is wide. It ranges from provision of emergency, clinical, sexual and mental health services to Y9 HEADSS assessments, health promotion initiatives, data collection, research and report writing.

The school-based health clinic requires the depth of knowledge and experience of a registered nurse who has relevant clinical experience and undertaken post-graduate study in one or more of primary, public or youth health areas. In addition, a nurse should have experience in working with youth.

The cultural competence of staff should be considered, and developed, if necessary, in accordance with the needs of the community.

The recruitment process for school nurses should ensure that applicants' attitudes, knowledge and skills are thoroughly assessed, along with their ability to establish a health service and work autonomously in an otherwise 'non-health' environment.

Where the most suitable applicant does not have all the desired attributes, their commitment to develop these as a condition of their employment should be assessed.

Capability acquisition

The Ministry of Health may need to develop specific approaches to the acquisition and recruitment of suitably qualified school nurses in a job market in which positions in youth health are difficult to fill. This will include appropriate pay and conditions for full-time and part-time staff. It may require specific recruitment campaigns promoting the benefits of working in a school-based health service. It would also be useful if working as a school nurse could be seen as a career pathway for nurses, either within the school nursing service or within the wider health-provider environment.

Capability retention

Many factors can influence whether a person stays in their role. The main reasons include:

- feeling valued
- personal satisfaction
- opportunities for professional growth and development
- terms and conditions that suit a person's personal needs.

An employer understanding the specific needs, motivations and expectations of an applicant will increase the chance that the appointment is successful and sustained over time. Expectations might include paid professional registration, indemnity and study or conference leave. Motivation may be related as much to the possibility of working school hours as it is to working with youth.

Needs, on the other hand, may cover things like the ability to control, organise and direct one's own work, or to obtain direct feedback from students.

Ensuring a rewarding work environment and a positive relationship within the school and the community will enhance the success of the appointment.

Capability development

School health professionals should receive initial training on the specifics of the job before going into schools to deliver service. This might include the likes of family planning training in sexual health, training in handling abuse disclosure, maintaining current CPR skills, and training on the HEADSS framework, database and report writing skills and so forth.

Training in screening and preventative care approaches will enable the service to be proactive and eliminate potential blockages to student learning early on.

Relevant and effective professional development, along with regular professional supervision, should be conducted to maintain and build upon the capability of the school nurse.

School nurses should have appropriate training in youth health and be supported to work towards a post-graduate qualification in youth health.

To ensure ongoing high-quality service provision, it is important to have in place systems for appraising the performance of the school nurse and monitoring and evaluating service provision. This is discussed in more detail in the section on service design elements.

Connectivity

Connectivity is about ensuring linkages between school-based health services and students, the rest of the school, the community and other student support service providers. Connectivity means that the school-based health clinic and what it offers is visible to the school and wider community, and vice versa.

Connectivity is facilitated through structures and processes for governance and management.[26]

Governance

There are a number of levels of governance that can apply within a school-based health service. Working effectively, governance systems can have a significant impact on the health service, for example in the following ways.

- A student health council could be established. This would enable the service to be youth-led and connected with issues that concern students.

- A student support governance body such as a school health and welfare committee could be established. The composition of the committee might include representatives from:
    - the school (for example, the principal or head of pastoral care)
    - the community (for example, PHO youth health representatives, Child, Youth and Family representatives, youth health experts, cluster school nurse practitioners, special educational services representatives, parent representatives or iwi representatives)
    - the student support service (for example, the principal nurse, social worker and counsellor)

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26   Kidz First Community Health – Centre for Youth Health. 2005. *Successful School Health Services for Adolescents: Best practice review*. Manukau: Centre for Youth Health.

Such a committee has the potential to provide sound strategic oversight and substantial governance advice in the wider context of the community and its resources. It would have the potential to ensure that the school had in place suitable policies and programmes that link and align with community initiatives and that can be enhanced by community support.

- The governance structure of the employer of the nurse, be it the board of trustees of the school, the DHB senior management team dealing with school-based health services or the board of the PHO/NGO, could play a part. If the student health council and the school's health and welfare committee (or equivalent) is working effectively it is likely that there will be minimal oversight required from the governing board of the nurse's employer beyond ensuring that the direction of the school-based health clinic is aligned with the goals and objectives of the school.

School

The school-based health service needs to be integrated with the management and operational processes of the school. It also needs to be linked with school information systems.

Nurses need to be active in maintaining consultation with the school, including the principal, staff, school pastoral team, board of trustees, students and parents. In this regard, the establishment of a role that manages student support services as a whole to act as connection point for the service may assist.

To foster connectivity, a nurse has to gain an appreciation of the school culture and work within it while not compromising professional values such as confidentiality.

Being a welcome part of the school's formal infrastructure will also help. However, this may require some modification by the school, as often formal meetings can take place at times students wish to access the clinic, and certainly at times when teachers want students to access the clinic: before and after school, and in morning tea, afternoon tea and lunch breaks.

Community

Connectivity should extend beyond the school and include local iwi, relevant community groups and parents. Being part of community networks and knowing what is going on in the community as well as what is available in terms of resources for the students will facilitate the nurse's role on two fronts:

- by offering a service that is appropriate and relevant in the context of the students' wider environment
- by strengthening the service offered with the help of community resources and contacts.

Interaction with the community may be as simple as subscribing to local body newsletters, making contact with key local community groups and managers of community facilities and knowing about trust funds that are available for youth or health initiatives. For example, negotiation with a local body may be possible to arrange free student access before school to a local swimming pool, or an application could be made to a special trust fund for prescription glasses.

Health and social support providers

A school-based health clinic is likely to be presented with a broad range of youth health issues, including mental health, sexual health, obesity, drug and alcohol use, family violence and abuse, cultural issues and other personal issues.

Connectivity with primary and secondary providers that supports school-based health services and individual students will enhance the effectiveness of the service.

Knowing about and being part of DHB/PHO health initiatives relevant to young people could provide resources to enhance the work of the school-based health clinic.

Summary

Consideration given to each of the elements of the 9C model when planning a school-based health service will give a strong foundation to its successful design and implementation.

Service design elements

Introduction

In addition to the success factors outlined above, a number of specific elements will ensure an effective school-based health service.

The following pages provide more specific details on the 'nuts and bolts' of school-based health services. These cover facilities, equipment, people, policies, processes and systems (see Figure 2.1). These details are provided as a guideline only. Specifics for any school will be influenced by the particular context and the levels of funding available.

Figure 2.1: Service design elements
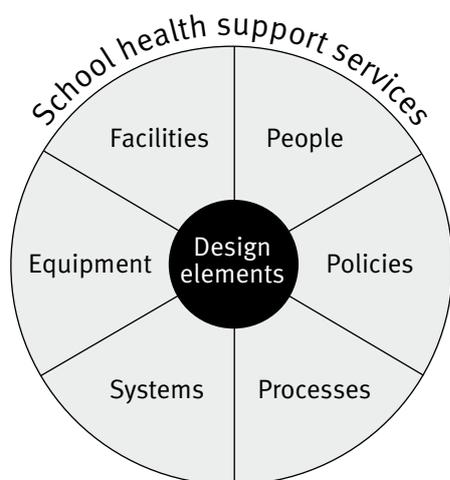
It is important to note that, while there will be many design elements common to all school-based health services, the final configuration will be specific to each school, reflecting the needs of the students, the nature of the community, the availability of local health services already in the community and so on (see discussion on success factors above).

The levels of funding available will also influence the design of the school-based health service, as well as approaches to its implementation (a phased approach may be necessary in some cases).

In 2005/2006 a group of health professionals from within the AIMHI schools produced a *School-Based Health Service Compendium*. This document contains useful detailed information (including job descriptions, clinical guidelines for service delivery, codes of practice and checklists) that may be useful as a starting point in conjunction with the current findings.

Specific design elements

Facilities

Based on the AIMHI experience, the ideal physical facilities for a school-based health service, run in conjunction with a student support service, are outlined below.

The requirements outlined describe a fully functioning health service able to accommodate visiting health practitioners such as a GP, physiotherapist or specialist nurse educators.

It is acknowledged that initially such a facility will not necessarily be available. However, it is desirable in order for the service to comprehensively meet students' needs and provide the required degree of privacy and confidentiality.

Student support facility

The student support facility should include the following:

- a reception facility:
  - reception/waiting area
  - receptionist/administrator (ideally who has first-aid and triage skills)
  - notice-board/pin-board for information sharing with students
- a separate sound-proof room for each service provider, with lockable doors
- a separate room for visiting practitioners/specialists (to provide privacy and confidentiality): for example, GPs, physiotherapists, nurse educators and educational psychologists
- a meeting room for families or student groups such as the health council
- amenities:
  - shower
  - toilets
  - basins
  - kitchen
  - area for waste disposal
- ease of access options:
  - an entrance readily accessible by an ambulance
  - wheelchair access
  - wide doorways and corridors for access
- efficient room design:
  - effective lighting
  - sound-proofing between rooms and waiting/reception areas for privacy and confidentiality
  - specific design features to meet the resource and equipment needs of each service provider (see below)
- a means of transporting students to external appointments
- equipment for acute emergency care
- a security system to ensure the safety of students and staff

Health facility

There should be separate clinical rooms for each practitioner working concurrently, which should be sound-proof and large enough to accommodate the following:

- a basin for hand washing
- a plinth or bed
- two or three chairs for student users and their support

- a desk and chair

- a secure filing area

- medication/equipment storage facilities that are secure and lockable, and include a refrigerator for medicines.

Equipment

The equipment listed below is suggested as the basic tools a nurse will need to run a health clinic.

- Medical:
  - scales
  - height measurement facility
  - sphygmomanometer (blood pressure)
  - stethoscope
  - ophthalmoscope
  - eye-testing board
  - otoscope
  - thermometer
  - medical disposables (and related equipment)
  - medical supplies (for example, bandages, dressing sets, slings, condoms, betadine and sterile water)
  - medications (for example, paracetamol, insulin, adrenalin and emergency contraceptive pills).

- Office equipment:
  - a filing facility
  - office supplies (including health promotion materials)
  - computer hardware and software (including a link to the school database and intranet, a health management system, word processing program, database and presentation software and email).

- Communications equipment (for example, telephone, cell phone, and emergency button or intercom facility).

A fuller list of equipment is compiled in the appendix to the *School-Based Health Service Compendium* ('Environmental Requirements for School-Based Health Centre').

Staffing

Nurses

A school setting often requires complex nursing judgements. It is therefore recommended that all nurses working independently in school-based health clinic are registered nurses.

- Qualifications:
  - registration
  - achievement of post-graduate papers in one or more of primary health, public health or youth health.
- Experience:
  - with youth (for example, other youth health experience, own children or community youth groups)
  - clinical (for example, in primary health, public health, accident and emergency, paediatrics, St John, family planning, health promotion or health teaching.)
- Numbers:
  - A registered nurse-to-pupil ratio that supports the school's capacity to adequately cater for students, including those with special needs.

In addition the following attributes are desirable:

- experience and knowledge of best-practice principles for emergency care, including CPR and first-aid certification
- experience or knowledge of best-practice principles within youth health
- experience or training in conflict resolution, behavioural interviewing and counselling
- ability to recognise physical and sexual abuse, and experience with other mental health issues, such as suicide and depression
- training in the HEADSS assessment framework, and in resilience and strength-based approaches in dealing with young people
- an awareness and understanding of different cultures
- support from colleagues and peers
- access to supervision and debriefing sessions.

Policies, processes and systems

Good policies, processes and systems are needed to ensure that the school-based health service operates effectively and is sustainable.

A regularly updated protocol and procedures manual that collates all this information in one place would be a useful guide for both permanent and visiting professionals.

Policies

The health service should have appropriate written policies on consent, confidentiality, collection and use of health information and protection of records. These policies need to comply with the relevant legislation: for example, the New Zealand Public Health and Disabilities Act 2000 and the Health Information Privacy Code 1994.

The health service's policies on information sharing, consent and confidentiality need to be understood by students, the school, parents and the service's health professionals.

Consent

Young people's and their families' rights, and health professionals' obligations, are covered in legislation and codes of practice.

A useful resource is the Ministry of Health publication, *Consent in Child and Youth Health*, 1998,[27] which addresses some grey areas around the issue of consent and young people. Some key points regarding consent worth noting are as follows.

- Students over the age of 16 may independently consent to health care procedures, though the nurse may overturn this right if they consider the person is not competent to give their informed consent (Guardianship Act 1968).

- Students under 16 may consent to:
  - abortion without parental consent
  - contraceptive advice and treatment.

- For young people under the age of 16, the nurse needs to be assured that the young person is mature enough to make a fully informed and considered decision about the treatment/service in question. If there is any doubt, parental consent needs to be sought.

- Where possible and appropriate, the nurse should encourage the student to involve his or her parents. This avails the student of parental support, as well as respects parents' expectations to be involved in decisions affecting their children.

Privacy and confidentiality

Privacy and confidentiality are important to students seeking health care. A lack of trust in a service's confidentiality can be a barrier to access for students. Thus, nurses need to be sensitive to students' confidentiality concerns.

Students should be fully informed of the health service's policy on confidentiality and information sharing with the wider support services team.

Students need to know what circumstances would lead to the nurse divulging information to others, and who these people would be. Where possible, a student's right to confidentiality should be respected.

In terms of privacy, students have a right to expect that information held about them is secure and confidential, and the right to access it. Parents of students under 16 years, as their representative, also have a right to access information about their children. However, this applies only if the student agrees and access to the information would not compromise the student's interests.

The only situation where information may be disclosed without a student's agreement is 'to prevent or lessen a serious threat to the health or life of an individual'.[28]

Sexual and reproductive health care issues

In some communities, there may be concerns about school support services providing contraceptives, particularly to students under the age of 16. There is no legal barrier to students of any age having access to contraceptive advice or to contraceptives. This can be a controversial

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27 See pp 11–23. An electronic version of the publication can be accessed on the Ministry's website: http://www.moh.govt.nz

28 Ministry of Health. 1998. *Consent in Child and Youth Health*. Wellington: Ministry of Health (p 18).

issue for parents and the school, and may require open and informed discussion. This can be more of an issue with integrated schools whose special character is religious affiliation.

Protecting Records

The Health Information Privacy Code 1994 requires health information held by a health agency to be protected from loss, unauthorised access and misuse.

A school support service should therefore have measures in place to protect the confidentiality of health records, and to ensure that only those directly involved in the treatment and care of a particular young person have access to their case notes.

The Code provides a range of suggestions for ensuring the security of records, whether they are paper-based or electronic. These are comprehensive and practical and are worth referring to.

Further reading on privacy and confidentiality is available from the Office of the Privacy Commissioner. At the time of writing, a revised 2008 edition of the Health Information Privacy Code was due for release. The Code, and a practical guide to health information privacy, *On the Record* (1999) is available from the Privacy Commissioner's website: http://www.privacy.org.nz

Processes

Well-considered processes will ensure that services are effective and safe.

Governance and Management

- Processes should be put in place ensuring effective governance and management, which involve participation of key community and school stakeholders (including students), establishment of an effective oversight committee and the application of sound business principles.
- A staff member should be designated as service co-ordinator, with the purpose of overseeing the linking of the health service with other student support services and with the management structure of the school.

Clinical

- Provision and dispensing of medicines for common medical problems should preferably be on site, and medications securely stored. Alternatively, school support services should arrange for medications to be available free or at a subsidised rate from a nearby pharmacy.
- The service should consider the use of standing orders where a doctor is not on site, or only on site infrequently. These could be arranged with local primary medical care providers to allow dispensing of some medication by appropriately trained nursing staff.
- There should be mechanisms and processes in place for the exchange of medical information (with a student's permission) between providers and other services, such as the school pastoral team, the student's family doctor or nurse and referral agencies.
- An emergency plan should be in place and appropriate easily accessible equipment and drugs for emergencies (for example, adrenaline) should be available and regularly checked for expiry.
- School staff should be trained in general first-aid, including regular CPR updates.
- Opportunistic screening should be undertaken for common adolescent health problems when students receive care, as part of a preventative (or early diagnosis) approach to health care.

Referral

- There should be clear procedures in place for staff and health professionals to follow for referring students to services. The roles of the various parties in the referral process (teacher, dean, counsellor, nurse, social worker) should be clearly defined.

- There should be procedures in place to facilitate student self-referral and the monitoring of this (for example, a self-referral box or website that is regularly monitored).

Appointments

- There should be processes in place to enable the efficient booking of appointments with health service professionals. Systems could be paper-based (booking slips) or electronic.

- Processes should be in place to support the availability of the service beyond normal school hours, according to need.

- There should be processes for :
  - assessing the veracity of students' need for support services (for example, filtering the 'waggers')
  - ensuring that students with genuine needs are not waiting unnoticed
  - ensuring safety in the waiting area
  - ensuring that immediate service is provided to students who are in acute need of attention.

Either administrative staff (for example, a health centre receptionist) or the health professionals themselves could be responsible for overseeing these processes.

Co-ordination of the Student Support Service Professionals

- Opportunities and processes for joint planning and regular meetings of nurses, social workers and counsellors are important.

- Information sharing (within the boundaries of confidentiality – see policies above) amongst professionals is also important.

Systems

Information management

Information management and associated systems are critical for effective service delivery. The school-based health service needs to have:

- information systems to support service administration and delivery that integrate with the student management systems of the school. Systems should allow sharing of information between health service providers

- consistent standards and categories for information collection and analysis across all school-based health support services. A standard data dictionary should be used by all those practising within school-based clinics

- effective information systems for tracking students and sharing key information (within appropriate privacy protocols)

- systems and methods of data transfer which adhere to legislation such as the Health Information Privacy Code 1994 and the Privacy Act 1993

- adequate systems for back-up and security of data, so that all reasonable measures are taken to prevent data loss or corruption

- systems to prompt screening (for example, using attendance trends) and appropriate documentation of care. These systems should track missed and follow-up appointments, and laboratory and referral reports

- a system to gather data on key indicators of quality in youth health services.

Professional development and support

A professional development strategy and programme for the nurse should be in place. This should recognise the importance of quality primary health care, as well as the unique needs of a low-decile school, and the communities the providers are practising in.

In general, the feedback we received indicated that the broad topics that would be most helpful to all professional groups would include:

- orientation to the relevant legislation, such as the Health Information Privacy Code, the Consent, Sterilisation, and Abortion Act 1977, the Code of Health and Disability Services and the Code of Health and Disability Services Consumer Rights Regulations 1996

- orientation to the local community, including its demographics and the services and providers working within it, as well as to areas where young people congregate and engage in at-risk behaviours (information often provided by youth workers)

- orientation to school policies on relevant issues such as security, abuse, accidents, assaults and general discipline, and information on the teaching staff's responsibilities

- orientation to school resources and support services

- clear identification of referral pathways

- identification of local general practices and accident and medical/after-hours clinics (on-site introductions where possible)

- understanding of referral pathways for crisis intervention for acute mental health issues

- basic training in the principles of behavioural interviewing, to assist with initial assessment of students engaging in risky behaviours (for example, alcohol, drugs, tobacco or unsafe sexual practices).

Implementing the school-based health service

Introduction

School-based health services are planned to be implemented progressively, commencing with Decile 1 schools, teen parent units and alternative education facilities from the 2008/2009 year.

Implementation phases

The implementation will require two phases:

- a first phase of 'preparing the way' involving contributions from a range of stakeholders, but principally government agencies (the Ministries of Health, Education and Social Development)

- a second phase rolling out the design and associated infrastructure and context for the service into designated schools.

Figure 3.1: Phased implementation

Implementation pathway

Phase 1
Preparing the way
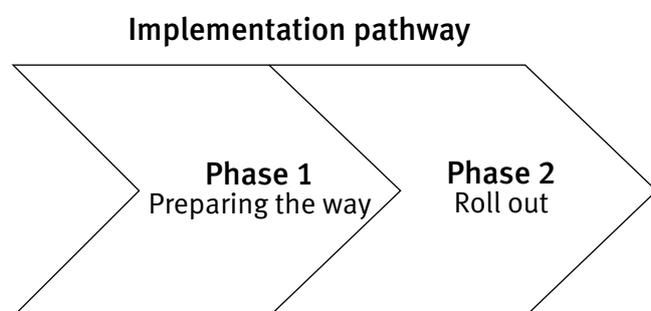
Phase 2
Roll out

Phase 1 – Preparing the way

There are some steps that will need to be taken at a government agency level to ensure that schools will be able to set up effective school-based health services.

Funding

Funding arrangements need to be established to ensure that both capital and operational requirements for setting up services are met, including:

- *Capital expenditure* – buildings and equipment purchases (including IT systems and requirements)

- *Operating expenditure* – marketing internally and externally, recruitment costs, salaries, training and professional development, performance/contract reporting and management (including continuous quality improvement processes), clinical supervision and equipment maintenance.

Communications

A communications strategy to publicise the programme and encourage schools to opt in to the roll-out needs to be developed and implemented. This will require consultation with key stakeholders.

Consultation

Once the broad design elements and funding are in place there needs to be a wide consultation process with relevant groups. These might include:

- school boards of trustees
- school principals, deans, heads of department and teaching staff
- students
- DHB planning and funding/primary care managers
- PHOs
- the MSD
- NGOs
- nurses
- counsellors
- social workers
- youth workers.

Consideration should be given to meetings between professionals and managers from schools that have school-based health services, and those that do not.

School support

Schools would benefit from support to ensure the school staff and wider school community are well informed and can actively support the initiative. Staff or stakeholders in the wider community may provide support by:

- visiting each school to clarify and promote the roles of the professionals who will work within the school support service. This promotion should be targeted at the board of trustees, parents and caregivers, deans, heads of department, teaching staff and students
- establishing support networks for schools setting up a school support service that connect them with schools that already have an on-site service
- establishing building and equipment requirements
- assisting with staff recruitment
- supporting principals to engage the rest of the school staff with the proposed school-based health service and tell them how they can be involved
- encouraging the board of trustees and principal to engage with parents regarding the proposed school-based health service and how they can be involved.

Phase 2 – Rolling out a school-based health service

There are some key steps that will need to be taken at a DHB and school level in rolling out school-based health services.

The schools will need to prepare for implementing a school-based health service within their school. This preparation may include:

- articulating and/or revising a draft of their school charter to incorporate a health philosophy, goals and objectives

- establishing a local governance/steering committee

- preparing physical facilities for the school-based health centre

- preparing key staff (for example, counsellors and deans) for any potential changes to their roles as a result of the school-based health service

- providing ongoing education for staff and students about the service and how it will operate

- giving consideration to integrated school information systems and networks (for example, databases, systems and meetings).

Appendix 2:
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Appendix 3: Survey Data

AIMHI student survey	Used nurse		Used social worker		Used counsellor	
	Yes	No	Yes	No	Yes	No
De La Salle College	11.2%	3.1%	25.1%	3.6%	17.9%	4.0%
Mangere College	7.1%	8.3%	7.5%	7.7%	5.7%	8.7%
McAuley High School	11.9%	9.9%	15.6%	10.3%	11.8%	11.5%
Otahuhu College	29.6%	32.3%	16.6%	34.7%	19.6%	36.1%
Porirua College	0.3%	6.8%	1.0%	2.3%	1.4%	2.3%
Tamaki College	8.0%	6.3%	11.6%	5.6%	9.1%	6.4%
Tangaroa College	16.1%	16.7%	9.0%	18.3%	20.3%	13.8%
Sir Edmund Hillary Collegiate	7.4%	12.0%	3.5%	10.8%	8.4%	8.9%
Southern Cross Campus	8.3%	4.7%	10.1%	6.7%	5.7%	8.3%
Year						
Year 9	23.4%	30.4%	32.8%	22.7%	27.7%	24.4%
Year 10	12.4%	20.6%	8.1%	16.4%	10.5%	16.6%
Year 11	17.2%	17.5%	18.7%	16.4%	19.3%	15.8%
Year 12	17.6%	12.9%	10.1%	18.9%	16.6%	16.4%
Year 13	29.3%	18.6%	30.3%	12.5%	26.0%	26.7%
Gender and Ethnicity						
Female	58.3%	53.2%	52.9%	57.8%	63.5%	52.9%
Male	41.7%	46.8%	47.1%	42.2%	36.5%	47.1%
NZ European/Pākehā	3.6%	3.1%	3.0%	3.6%	4.1%	3.2%
NZ Māori	13.5%	9.8%	10.1%	13.3%	12.8%	11.9%
Pacific Islander	84.0%	82.0%	87.4%	82.2%	86.1%	81.7%
Asian	4.7%	5.2%	5.5%	4.3%	4.4%	4.9%
Other	6.8%	8.8%	5.5%	7.7%	6.8%	7.6%
Service User Profile						
Have you ever used the services of the school school nurse of GP?						
Yes	100.0%	0.0%	95.4%	67.6%	90.8%	64.5%
No	0.0%	100.0%	4.6%	32.4%	9.2%	35.5%
Have you ever used the services of the school social worker/youth worker?						
Yes	33.2%	4.8%	100.0%	0.0%	56.1%	7.9%
No	66.8%	95.2%	0.0%	100.0%	43.9%	92.1%
Have you ever used the services of the school counsellor?						
Yes	46.9%	13.9%	81.3	22.5%	100%	0.0%
No	53.1%	86.1%	18.7%	77.5%	0	100.0%

Rating Average	Used nurse		Used social worker		Used counsellor	
	Yes	No	Yes	No	Yes	No
My school reports give enough information about my achievements	3.95	3.81	3.89	3.89	3.84	3.93
The school nurse/GP are very helpful to students	4.26	3.78	4.17	4.13	4.18	4.11
The school social worker/youth worker are very helpful to students	3.72	3.65	3.96	3.6	3.79	3.64
The school counsellors are very helpful to students	3.82	3.79	3.96	3.74	4.03	3.68
The school listens to any problems I have	3.3	3.2	3.45	3.22	3.26	3.29
This school sets good standards of student behaviour	3.51	3.48	3.54	3.48	3.4	3.57
It is easy to make friends at this school	4.07	3.85	3.99	4.02	3.94	4.07
I have no problem seeing the school nurse/GP if I need to	4.18	3.96	4.1	4.15	4.13	4.13
I have no problem seeing the school social worker/ youth worker if I need to	3.77	3.67	3.92	3.68	3.83	3.69
I have no problem seeing the school counsellors if I need to	3.87	3.72	3.94	3.78	4.04	3.7
I feel safe and secure at this school	3.68	3.72	3.6	3.72	3.53	3.79
The school health service is private	3.72	3.37	3.77	3.59	3.69	3.61
It is easy to get an appointment with the school health service	3.76	3.45	3.7	3.68	3.73	3.66
The school health service has a nice environment	3.88	3.67	3.76	3.86	3.76	3.87
It is easy to talk to the school nurse/GP at this school	4.02	3.67	3.95	3.93	3.96	3.92
It is easy to talk to the school social worker/youth worker at this school	3.61	3.46	3.82	3.49	3.68	3.51
It is easy to talk to the school counsellors at this school	3.77	3.54	3.91	3.64	3.93	3.58
Students who speak English as a second language get enough help at this school	3.74	3.73	3.72	3.74	3.68	3.76
The school wants students to get good marks	4.34	4.21	4.19	4.35	4.21	4.37
My teachers show enjoyment in their teaching	3.68	3.64	3.71	3.64	3.59	3.71
My school reports describe all of my achievements	3.82	3.8	3.76	3.84	3.7	3.89
This school deals effectively with bullying	3.5	3.44	3.54	3.45	3.45	3.5
The needs of students are important to teachers at this school	3.69	3.63	3.62	3.68	3.59	3.72
Most teachers have good understanding of working with students from different ethnic groups	3.8	3.7	3.75	3.77	3.71	3.8
This school makes an effort to encourage my parents to be involved	3.65	3.57	3.64	3.62	3.61	3.64
This school encourages students to get along with students who are from different ethnic groups	3.81	3.77	3.76	3.81	3.69	3.86

Rating average	Used nurse		Used social worker		Used counsellor	
	Yes	No	Yes	No	Yes	No
My parents have become more interested in my learning since I started at this school	3.73	3.65	3.66	3.72	3.67	3.72
The teachers at this school have good skills for working with students from lots of ethnic groups	3.82	3.64	3.76	3.76	3.78	3.75
I feel OK about going to see the school nurse of GP	4.1	3.74	4.02	4.01	4.02	4.01
I feel OK about going to see the school youth worker/ social worker	3.71	3.63	3.8	3.65	3.67	3.71
I feel OK about going to see the school counsellor/ guidance counsellor	3.84	3.67	3.91	3.75	3.96	3.7
Students' privacy is respected by the school nurse/GP	4.03	3.64	3.96	3.94	4.01	3.9
Students' privacy is respected by the school social worker/youth worker	3.81	3.58	3.86	3.72	3.86	3.69
Students' privacy is respected by the school counsellor/guidance counsellor	3.88	3.6	3.94	3.77	3.97	3.71
In general, I feel satisfied with my education at this school	3.84	3.74	3.85	3.79	3.79	3.83
Life at this school has got better compared to when I first started at the school	3.82	3.68	3.84	3.76	3.75	3.81
I am satisfied with the services of the school nurse?/ GP	4.01	3.66	3.96	3.92	4.01	3.87
I am satisfied with the services of the school social worker/youth worker	3.75	3.65	3.91	3.66	3.84	3.65
I am satisfied with the services of the school counsellor/guidance counsellor	3.82	3.63	3.96	3.72	3.98	3.65
If I needed help for a health problem I would use the service of the school nurse/GP	4.08	3.74	4.02	4	4.04	3.98
If I needed help from a social worker I would use the service of the school social worker/youth worker	3.74	3.61	3.84	3.67	3.78	3.67
If I needed counselling I could use the service of the school counsellor/guidance counsellor	3.85	3.64	3.94	3.75	3.96	3.7

Appendix 4:
Student Feedback from Interviews and Focus Groups

The following are direct quotes from the students themselves.

'Tell us about the student support service.'

- It's a good service it lets us kick back.

- Teachers sometimes ask me why I want to go to the service they think we might be wagging – this puts us off asking to see the health people.

- Teachers need to mind their own business.

- I think the service is confidential.

- Teachers shouldn't ask us why we want to access it – its confidential.

- We need a GP – it doesn't matter what sex they are but it would be better if we had some options.

- It has built up my confidence to see other health people as a result.

- I can talk to some of the teachers about other stuff that bothers me.

- I don't generally talk to my parents about why I come here.

- Sometimes the doors get left open in the health rooms – it means others can hear what we say – that's scary.

- Access is great – we just go over there anytime and know we can talk to the staff.

- It's a Pacific Island culture that 'what goes on at home, stays at home'. It's difficult for us to tell people what happens to us when we go home – a Pacific Island social worker helps because they know what the rules are.

- The service helps us to know its ok to access local medical centres.

- Some would prefer to have a receptionist (I want to see the nurse not the receptionist).

- We don't see the new nurse – we just wait until the old one is here.

- Sometimes the clinic is closed – we need more nurses and a bigger room.

'What makes a great nurse/social worker/counsellor?'

- We tell them about our problems and they keep it to themselves (or within the team).

- Someone that understands you and listens to every word, and keeps your secrets.

- A wide range of knowledge about different things to do with health.

- They do more than what we ask – they know when we are down or sad.

- Staff need to open-minded and approachable.

- They need lots of resources and access to medicine for us.

- They need to be good listeners, give good advice and to know when you are uncomfortable with what is happening.

- Considerate of religion and ask questions to check it out with you.

- The room needs to be private, so no one can hear what you tell them.

'What type of health person would you not see?'

- One that kicks me out when I need to see them.

- One that doesn't care and just wants to get you out of their room.

- If they don't listen to me.

- I wouldn't go to one of those professional places – they only see us there if they get big bucks and then they don't let us talk about stuff.

'What makes a good environment?'

- Sometimes it smells in here.

- Sometimes it gets too hot and too crowded.

- We need cool art work on the walls and cool pamphlets to read.

General

- Sometimes the teachers say 'I don't get paid enough to …'

- Sometimes I don't think the teachers care.

- The school cares about me but sometimes certain teachers don't seem to.

- Some of [the] teachers don't understand about confidentiality and tell people what they shouldn't.

- If we didn't have access to this service we would try to take care of it ourselves – we wouldn't go to the doctors outside of school.

- I don't want my parents to know about my stuff.

- We need air conditioning.

- It's a good place to come to.

- We shouldn't have the deans in here.

- We aren't involved in the interviews when they take on new staff but that would be great if we were.

- The staff are friendly and take me to the doctors or the dentist when I need it.

- They deliver me home after they take me to the other health services.

- We need more room in [the] sick bay – and a boys' and girls' separate areas.

- I go in sad and come out happy.

- The buddy system we have here works well – we look after each other.

- If someone was sick or sad and was too scared to see the nurse or counsellor we would take them to the person and stay with them.

Safety

- Some teachers are uptight.

- There [are] bullying and fights at school – sometimes the bullies get revenge when we tell the teachers and that just makes it worse.

- Some of the senior leaders don't do what they are supposed to do to stop it – their appointments are based on popularity not on their ability.

- We need more productive leaders to stop the bullying.

- We need more penalties for bullying – they should be expelled not just stood down for a while. Youth workers have past experience in gangs so we listen to them.

Appendix 5:
Narrative from Counsellors, Nurses and Social Workers

A boy came into the school counsellor's room with a suitcase in hand – he had been thrown out of home and had nowhere else to go. The counsellor spent the morning seeking accommodation for him. The student had left school two years earlier but the counsellor was the first person he thought of to help him.

Several boys asked for a cappuccino when visiting the counsellor – until that time she only had coffee and milo. The counsellor went out and purchased their preferred beverage. The boys commented she was the first person that had ever done such a thing for them. The counsellor makes the student's milo but her rule is that she does the dishes – 'they just sit with me and talk'.

'Love them, do right by them and leave it there, that's all you can do.'

A social worker encouraged a student to remain at school. The student had very difficult home life. He was the only one in his family who remained at school beyond the age of 15. The social worker saw the student years later and the student reminded her of what she had done for him – 'I am a manager now thanks to your kindness and encouragement'.

Students often come here and say 'can I just smell your room?' – it feels safe to them and reminds them that someone cares about them.

A student whose parents lived in Kaitaia was involved in a custody battle, and this was affecting the student. The social worker arranged for the entire family to meet at the school after hours (7pm in the evening) and facilitated a custody arrangement that provided the best result for the student. The social worker commented that she had to do this – who else would have taken the time to do this outside working hours?

There was a student had who had attended three non-AIMHI schools within three months then started at the AIMHI school just three months ago. She now attends school classes regularly and feels that this is the first school that understands her and makes her feel safe attending. The social worker has done a huge amount of liaison with teachers to ensure support in the classroom. The social worker uses a strength-based approach with the student and sees the student on a regular basis to support her in coping with situations where she feels stressed.

A student had a rotten tooth. The dentist had been sending notes home to the parents for three years to no avail. The student was seen in the health centre, referred to local dentist and taken there by the nurse to have the tooth removed.

A student with boils had not been taken to the GP by their parents. The student saw the nurse and needed admission to hospital. The student was given follow-up education in regards to ongoing hygiene. The nurse also arranged follow-up with a local GP and took the student to the health centre.

A student with a sore thumb phoned their parents to tell them. The parents said they were 'too tired' to take the student to the GP. Two days later, the student had still not seen a GP, so the school nurse took them. The student needed an x-ray and required treatment. Often students won't tell their parents because they know it isn't worth the effort. Students often ask staff 'What happens if they won't take me to the doctor?'

A student had told a teacher she needed to see the counsellor. The counsellor asked if she was trying to get out of class. She said she was, but then later changed her story and said she had been sexually abused at home. There is a need to ensure young people are not prevented in any way from accessing services. Abuse of the service is easily identified, and usually only happens once!

Often students are identified as having 'behavioural problems' and are excluded from school. At this school the multi-disciplinary team works to identify why. For example, a student with psychosis was identified. A psychiatrist commented that in any other school, the student would have been excluded, whereas here it was recognised that they just needed medication and follow-up.

A student was not attending school because he was being bullied on his way home. He came to the health centre with a bruise on his forehead. The teacher assumed he had been bullied. The student didn't deny being bullied but told the counsellor that his father had assaulted him. The student was referred to the social worker. A family meeting was held and the father is now in counselling for family violence. The student is much better and now attends class.

One school social worker keeps track of regular attendees and tracks the time of day they arrive to class. If there is a pattern of the student not attending regularly, they are followed up. The social worker finds this is an excellent way of filtering the students and identifying and addressing issues the students might be having, be it at home or at school.

Appendix 6:
Copies of Surveys and Interview Questions

Interview guide for nurses

Base information

1.   Gender: M/F

2.   Ethnicity:

3.   Live within the community of the school: Yes/No   Important?

4.   How many hours do you work for the school: Part-time _____ hours; Full-time ____ weeks/year.

5.   If part-time, what days do you work?

6.   How were these days decided?

7.   Is there a doctor involved as part of the service?   Hours per week:

Weeks per year

8.   How long have you worked in this position at this school?

9.   What was your experience prior to coming to this position?

  –   how many years as a health professional?

  –   how many years working with youth?

10. What qualifications did you have to take on this position?

11. What qualifications do you have now?

12. Are you doing any studies at present?

Qualifications

13. If you were appointing someone to your job, what qualifications and experience would you expect them to have?

14. What sort of training would prepare someone for this job? (for example, interviewing, psychosocial screening, sexual health/abuse training, cultural training)/What has made you able to do this job?

15. What opportunities do you have for ongoing professional development?

16. Are you supported to do this (for example, paid leave, expenses?)

Employment

17. How are you employed to do the work for the school?

18. Are there any limitations arising from your employment?

19. What are the issues you have/see that need to be resolved?

20. Are there any barriers arising from the way you are employed to you working as effectively as you might?

Service design

21. What are you employed to do / what does your job entail/what services do you offer?

22. How is what you offer and how you do it governed? (for example, is there student involvement? Are there school policies you have to adhere to? Who are you accountable to for your practice?) Is this effective? Could it be made more so?

23. Do you have policies and procedures? How are these formulated and updated?

24. What are your facilities like?

25. Are the facilities conducive to maintaining student privacy?

26. What do your facilities lack?

27. How is your service integrated within the school?

28. What proportion of your time is spent in:

    – direct consultation time with students

    – screening programmes of students

    – dealing with referrals on behalf of the students (for example, to GPs, specialists, other services)

    – liaising/meeting with families

    – involvement in cross-disciplinary meetings/discussions within school (for example, teachers, counsellors, social workers/youth workers/community liaison officers)

    – involvement in cross-disciplinary meetings/discussions beyond school staff (for example Child, Youth and Family, police)

    – participating in delivering the school curriculum (for example, health and physical education, biology/general science, social studies)

    – other administration (for example, record-keeping, statistics, reports)

    – other consultations (for example, for school staff)?

29. Is this balance right?

30. Do you have sufficient resources to meet the needs of the students?

31. Do you need to do things for work in your own time? If so, to what extent and what sort of things, and how could this be curbed?

32. What happens if you are sick or have to take leave?

33. What support/mentoring/supervision is available for you? Is this sufficient?

34. What information do you keep on:

    – demand for your services?

    – consultation types? (suicidality, pregnancy, substance abuse, child/sexual abuse, obesity, chronic conditions)

    – attendance – ethnicity, gender, age/year

    – referrals?

Service delivery/engagement

35. How do you involve families with the services you provide?

36. How do the services you provide link with services in the community?

37. How (and how well) are your services co-ordinated and integrated with that of the:

    – community liaison officer/youth/social worker

    – school doctor

    – school councillor

    – students' families

    – students' GPs

    – year dean?

38. How do you meet/manage the various cultural needs and differences within the school?

39. What are the barriers to access that prevent students from using your services?

40. How has what you do/your practice changed over the past five years?

41. How do you see what you do/your practice changing in the future?

42. Do you carry out Year 9 health assessments? If not, who does, and do they give this information to you?

43. To what extent do Year 9 health assessments help to identify and manage health and welfare issues?

44. How is this information shared with the wider health and wellness team? (for example, social/youth workers, community liaison officers, counsellors, resource teachers: learning and behaviour).

45. How do you track referrals to other health and wellness providers (both within the school and in the wider community)?

46. What happens to students that are under your services that leave school?

47. Do students abuse the service? If so, how, and what are the best ways of minimising this?

48. Do others abuse the service (for example, parents, school staff)? If so, how and what are the best ways of minimising this?

49. What are the worst and best aspects of the work you do?

50. How does your role add value to the students' school experience and learning?

51. How does the school counselling service impact on your practice? Does it enhance it? Does it undermine it?

52. How do the services of the social/youth worker impact on your practice? Do they enhance it? Do they undermine it?

53. If you were designing this service from scratch, what would you do differently/what would you keep / what would you discard / what would you add?

School environment

54. Do you feel the school staff appreciate and respect the value your role adds to the students and school?

55. How have the school and students changed in the time you have been here?

56. Do you feel comfortable discussing issues with teachers?

57. Do you feel comfortable discussing issues with other school-based student support staff:

    – counsellor

    – social/youth worker/community liaison officer

    – resource teacher: learning and behaviour

    – school doctor

    – public health nurse?

58. Do you have regular meetings with other health and wellness practitioners, and/or ad-hoc meetings?

59. Would you like to see your relationship with other health and welfare practitioners strengthened further? If so, how?

60. Would you like to see your relationship with the teaching staff strengthened? If so, how?

61. What other services does the school provide for students?

62. Is it difficult to change things at the school?

63. Does the school support innovation?

64. Does the school support free and frank discussion about issues and their resolution?

65. To what extent do you feel an integral part of the school team? (for example, are you a part of the regular school meetings?) Is this important?

66. To what extent are you involved in planning at the school and involved in the school curriculum and its delivery?

67. Do you believe the organisation of the school reflects its goals?

68. Is there a high degree of consensus within the staff with regard to what the school is trying to achieve?

69. Do you believe:

   – There is good rapport between teachers and students?

   – Students behave in a responsible, self-disciplined manner?

   – Teachers can obtain assurance, advice and encouragement from within the school when dealing with students and their issues?

   – Teachers value the health and support services offered to the students?

Engagement with the community

70. How are you able to keep abreast of the local community and its needs?

71. To what extent do you refer and interface with other primary and specialist services, including relevant social services?

72. How do you maintain relationships with community-based health and welfare providers?

73. How do you ensure the local community and families know about the services you provide at the school for the students?

74. Do you believe the students' families value the services you provide at the school? What makes you believe this?

75. Do you believe community-based health and welfare providers value the services you provide at the school? What makes you believe this?

Results

76. How do your services help:

   – achieve better educational outcomes?

   – achieve better health outcomes?

   – achieve better social outcomes?

   – achieve greater resilience and social cohesion?

   – benefit the school environment?

   – increase effective learning time for students?

77. How do you know your service is achieving these outcomes? (for example, surveys, less absenteeism)

78. What further services would strengthen/improve the service, to enable students to achieve greater:

   – health outcomes?

   – social outcomes?

   – educational outcomes?

79. What are the strengths of the Health Community Schools initiative?

80. Are there barriers or unrealised opportunities for service enhancement?

Healthy community schools parent's survey in English

Dear Parents

We are evaluating the health and support services provided at your son's/daughter's school for the Ministry of Health. The information of this survey will be used to help other schools set up their health and support services.

Confidentiality

You do not need to put your name on this form. No one will be able to identify your responses. All your answers will remain confidential to our research team only.

Support

If you have any questions about this survey, you can contact:

• Sarah Bate from PricewaterhouseCoopers on (09) 355 8512

Email: sarah.s.bate@nz.pwc.com

Background information

Please indicate your responses by ticking the box that applies.

Example :
Do you have a child at _____ College/High School?   ☐ **Yes** / ☐ **No**

Do you have a son/sons at the school?   ☐ Yes / ☐ No

Do you have a daughter/daughters at the school?   ☐ Yes / ☐ No

Which ethnic group(s) do you belong to?

☐ NZ European/Pākehā   ☐ NZ Māori   ☐ Other
☐ Pacific Islander   ☐ Asian

Do you know that the school has:

a) A school nurse and visiting doctor?   ☐ Yes / ☐ No

b) School social worker?   ☐ Yes / ☐ No

c) A school counsellor?   ☐ Yes / ☐ No

Questions about the school and the health and support services

Please read the following statements about your son/daughter's school and indicate the extent to which you agree or disagree with each of the statements by ticking the bubble that applies.

		Strongly disagree 1	Disagree 2	Not sure 3	Agree 4	Strongly agree 5
	Indicate for each statement if you strongly agree, agree, not sure, disagree or strongly disagree by ticking one bubble					
	Example Only: I am pleased my son/daughter attends this school.	O	O	O	O	O
1.	The school listens to any problems my son/daughter has.	O	O	O	O	O
2.	a) The school nurse and doctor are very helpful to students.	O	O	O	O	O
	b) The school social worker is very helpful to students.	O	O	O	O	O
	c) The school counsellor is very helpful to students.	O	O	O	O	O
3.	a) My son/daughter has no problem seeing the school nurse/doctor if they need to.	O	O	O	O	O
	b) My son/daughter has no problem seeing the school social worker if they need to.	O	O	O	O	O
	c) My son/daughter has no problem seeing the school counsellor if they need to.	O	O	O	O	O
4.	a) I am pleased the school has a school nurse/GP for the students.	O	O	O	O	O
	b) I am pleased the school has a social worker for the students.	O	O	O	O	O
	c) I am pleased the school has a counsellor for the students.	O	O	O	O	O
5.	My son/daughter feels safe and secure at this school.	O	O	O	O	O
6.	Students who speak English as a second language get enough help at this school.	O	O	O	O	O
7.	This school deals effectively with bullying.	O	O	O	O	O
8.	The needs of students are important to teachers at this school.	O	O	O	O	O
9.	Most teachers have good understanding of working with students from different ethnic groups.	O	O	O	O	O
10.	This school makes an effort to encourage me, as a parent, to be involved.	O	O	O	O	O
11.	This school encourages students to get along with students who are from different ethnic groups.	O	O	O	O	O
12.	The needs of my son/daughter are addressed effectively at this school.	O	O	O	O	O
13.	The school nurse has helped ensure my son/daughter has better health.	O	O	O	O	O
14.	My son/daughter is happy at school.	O	O	O	O	O
15.	My son/daughter is motivated to learn at school.	O	O	O	O	O

Healthy community schools parents' survey in Samoan

Mo matua

Ua matou fa'amaumauina ma sailiili ile soifua maloloina o lou atali'i/afafine i totonu o aoga mai ile matagaluega ole Soifua Maloloina. O mataupu uma mai nei fa'amaumauga ole a fesoasoani tele lea mo nisi o Kolisi ma aoga ina ia fa'aleleia ai le tautua male lagolagoina o a'oa'oga tau ile soifua maloloina.

O le a le fa'ailoaina

E le mana'omiaina le tusia o lou igoa i nei fa'amaumauga. O le a le mafai fo'i ona fa'ailoaina i se tasi nei tusitusiga. O tali uma e tu'uina mai, ole a malu puipuia e le nei ofisa.

Mo lau lagolago

Mo se fesili i nei fa'amaumauga, fa'afeso'otai Sarah Bate mai ile PricewaterhouseCoopers numera (09) 355 8512.

Imeli: sarah.s.bate@nz.pwc.com

Fa'amatalaga auiliili

Fa'amolemole, fa'ailoa lou ioeina ole tali mautinoa ile makaina ole pusa o lo o i lalo.

Fa'ata'itaiga : E ia i sou alo ile kolisi o?   ☐ **Loe** / ☐ **Leai**

E iai sou atali'i/ni ou atali'i i lenei aoga?   ☐ Loe / ☐ Leai

E iai sou afafine/ni ou alo tama'ita'i i lenei aoga?   ☐ Loe / ☐ Leai

O fea o atunuu nei e aafia ai oe?

☐ Niu Sila Europa/Palagi   ☐ Niu Sila Maoli   ☐ Ma isi
☐ Pasefika   ☐ Asia

O e iloaina ole aoga e iai:

a) Le aoga tausima'i ma foma'i asiasi?   ☐ Loe / ☐ Leai

b) Aoga mo e o lo o fesoasoani malosi ile ile fanau pe a mo'omia?   ☐ Loe / ☐ Leai

c) Aoga mo e fa'atalatalanoaina le foi'a o fa'afitauli?   ☐ Loe / ☐ Leai

Fesili fa'atatau i le Aoga ma le auaunaga ale soifua maloloina

Fa'amolemole, faitau manino fa'amaumauga e fa'atatau i le aoga a lou atali'i/afafine, ma fa'ailoa mai pe ete ioeina pe leai nei fa'amaumauga ile makaina ole li'o o lo o i autafa.

Fa'ailoa mai pe ete matua ioeina, ioeina, le mautinoa, pe le ioeina fo'i	Matua lagolagoina malosi 1	Ioeina 2	Le mautinoa 3	Le lagolagoia 4	Matua le lagolagoina 5
Fa'ataitaiga: Ua o'u fiafia lava ina ua auai lo'u atali'i/afafine ile aoga lenei.	0	0	0	0	0
1. E fa'aogaina ele aoga ni fa'afitauli o lo'u atali'i/afafine.	0	0	0	0	0
2. d) E fesoasoani tele le aoga tausima'i ma foma'i ile fanau aoga.	0	0	0	0	0
e) Mo e o ofoina le fesoasoani i auaunaga ole soifua lelei o tamaiti ua matua mo'omia tele.	0	0	0	0	0
f) Mo e fa'atalatalanoaina fa'afitauli ua matua fesoasoani tele mole fanau aoga.	0	0	0	0	0
3. d) O le a le avea ma fa'afitauli le vaaia e fanau o tausima'i ma foma'i pe a mo'omia.	0	0	0	0	0
e) O le a le avea ma fa'afitauli, le mana'omia o fesoasoani lautele ele fanau i taimi e m'omia ai.	0	0	0	0	0
f) Mo e fa'atalanoaina le foi'a o fa'afitauli, o le a faigofie se feso'otaiga male fanau i taimi uma.	0	0	0	0	0
4. g) Ua matua fa'afetaia le iai ose aoga tausima'i ma foma'i mole fanau.	0	0	0	0	0
h) Ua matua fa'afetaia le auaunaga a'i latou o lo fesoasoani malosi ile soifua maloloina ole fanau.	0	0	0	0	0
i) Mo e o fa'atalanoaina auala e foi'a ai fa'afitauli ua matua ua matua fa'afetaia le latou tautua.	0	0	0	0	0
5. O lo o lagonaina fo'i ele fanau lo latou malupupuia i totonu o aoga.	0	0	0	0	0
6. O i latou ua avea le gagana fa'aperetania ma gagana lona lua, ua tele so latou fesoasoani mai ile aoga.	0	0	0	0	0
7. Ole fa'ailoga lanu ma nisi fa'afitauli, ua tele ina foi'a.	0	0	0	0	0
8. O manaoga ole fanau ua matua taua tele i faiaoga.	0	0	0	0	0
9. O nisi o faiaoga ua tele so latou malamalamaaga i fanau mai isi atunu'u o latou galulue fa'atasi.	0	0	0	0	0
10. Ua fai ma fa'amalosi a'u ia te a'u ose matua ina ia auai i so'o se pokalame fai a le aoga.	0	0	0	0	0
11. This school encourages students to get along with students who are from different ethnic groups.	0	0	0	0	0
O se auala lelei lea e mafuta fa'atasi ai fanau mai atunu'u eseese.	0	0	0	0	0
12. O le manaoga o lou atali'i/afafine e amanaia tele ma fa'atauaina ele aoga.	0	0	0	0	0
13. O le a le fa'aatamala tausima'i ile vaaia lelei o fanau, po o sologa lelei lo latou soifua maloloina.	0	0	0	0	0
14. Ua fiafia tele lo'u atali'i/afafine ile auai atu ile aoga.	0	0	0	0	0
15. Ua avea lea ma ala ua naunau ai le fanau, e su'esu'e ma sailiili.	0	0	0	0	0

Healthy community schools parents' survey in Māori

Ki ngā matua, tēnā koutou

Kei te arotake tatou i ngā ratonga hauora ki te kura o to tamaiti mo te Manatū Hauora. Ka awhinatia o koutou whakautu ki ngā atu kura hei whakaturia to rātou ratonga hauora.

Muna

Kaore mātou e pirangi to ingoa i runga i tenei rarangi patai. No reira, e kore mātou e whakaingoa i a koe. He matatapu o whakautu ki a mātou anake.

Tautoko

Mena kei a koe etahi patai e pa ana ki tenei rarangi patai, korerotia kia:

• Sarah Bate nō PricewaterhouseCoopers ki (09) 355 8512

Imera: sarah.s.bate@nz.pwc.com

Ngā patai e pa ana ki a koe

Waitohungia ēnei patati ki roto i ngā pouaka.

Tauira: Kei a koe he tamaiti ki te kura tuarua o Porirua?   ☐ o Ae / ☐ o Kaore

Kei a koe he/ngā tama ki te kura?   ☐ o Ae / ☐ o Kaore

Kei a koe he/ngā tamahine ki te kura?   ☐ o Ae / ☐ o Kaore

No tehea rōpū matawaka koe?

| ☐ Pākehā | ☐ Māori | ☐ Atu |
| ☐ Pacific Islander | ☐ Hainamana | |

Ka mohio kei te kura:

a) He nehi me he takuta pekaina hoki?   ☐ o Ae / ☐ o Kaore

b) He kaimahi papori?   ☐ o Ae / ☐ o Kaore

c) He tumu korero?   ☐ o Ae / ☐ o Kaore

Ngā patai e pa ana ki te kura me ngā ratonga hauora

Panuitia enei tauaki e pa ana ki te kura o to tamaiti/o tamariki, me waitohungia te kaha o o whakaro ki enei kaupapa.

Waitohungia mo ia tauaki o whakaro tika	Tino tautoko 1	Tautoko 2	Kaore e mohio 3	Whakahe 4	Tino whakahe 5
Example Only: He harikoa ahau kei te haere toku tamaiti ki tenei kura.	0	0	0	0	0
1. Ka whakarongo te kura ki nga take raruraru o toku tamaiti.	0	0	0	0	0
2. g) He tino whaihua te nehi me te takuta ki nga rangatahi.	0	0	0	0	0
h) He tino whaihua te kaimahi papori ki nga rangatahi.	0	0	0	0	0
i) He tino whaihua te tumu korero ki nga rangatahi.	0	0	0	0	0
3. j) Kia hiahia ana toku tamaiti ki te toro i te nehi/takuta e kore ona raruraru.	0	0	0	0	0
k) Kia hiahia ana toku tamaiti ki te toro i te kaimahi papori e kore ona raruraru.	0	0	0	0	0
l) Kia hiahia ana toku tamaiti ki te toro i te tumu korero e kore ona raruraru.	0	0	0	0	0
4. d) He harikoa ahau kei te kura he nehi/takuta mo nga rangatahi.	0	0	0	0	0
e) He harikoa ahau kei te kura he kaimahi papori mo nga rangatahi.	0	0	0	0	0
f) He harikoa ahau kei te kura he tumu korero mo nga rangatahi.	0	0	0	0	0
5. He rangimarie toku tamaiti ki tenei kura.	0	0	0	0	0
6. Kei te rawaka te tautoko mo nga rangatahi hei korero Pākehā mo to ratou reo tuarua.	0	0	0	0	0
7. Ka totika te mahi o te kura ki nga kaiwhakaweti.	0	0	0	0	0
8. He whakahirahira nga take o nga tauira ki nga kaiako ki tenei kura.	0	0	0	0	0
9. He pai te ngakau mohio o te nuinga o nga kaiako mo te mahi tutahi ki nga tauira mai i nga ropu matawaka rereke.	0	0	0	0	0
10. Ka whakakaha tenei kura ki te whakahauhau i au, he matua, hei whakauru.	0	0	0	0	0
11. Ka whakahauhau tenei kura i nga tauira ki te whakahoatia i nga tauira mai i etehi atu ropu matawaka.	0	0	0	0	0
12. Ka totika te titirohia ki nga hiahia o toku tamaiti ki tenei kura.	0	0	0	0	0
13. Kua awhinatia te nehi i hua ai i te hauora o toku tamaiti.	0	0	0	0	0
14. He harikoa toku tamaiti ki te kura.	0	0	0	0	0
15. He whakahauhau toku tamiti ki te kimi te matauranga i te kura.	0	0	0	0	0

Kia ora koe mo to awhina. Koa tēnei pānui me whakahoki ki te tari o te kura.

Healthy community schools parents' survey in Tongan

Ki he mātu'a Tauhi fānau

'Oku mau fakamahu'inga'i mo poupou'i 'a e ngaahi ngāue 'oku fai 'e he Potu Ngāue Mo'ui ma'a ho foha/'ofefine 'i he ngaahi 'apiako. Ko e ngaahi fakamatala 'o e savea ni 'e tokoni ia ki he ngaahi ngaue tatau 'e fokotu'u ki he ngaahi 'apiako kehe'.

Tapuhā

'Oku 'ikai fiema'u ke fakahā ho hingoa 'i he foomu ni. 'E 'ikai ke toe 'ilo 'e ha taha ki ho'o ngaahi tali fehu'i ni. Ko ho'o ngaahi tali fehu'i 'e tapuhā ke faka'atā ki tu'a.

Poupou

Kapau 'oku 'iai ha'o fehu'i fekau'aki o e savea ni pea ke fetu'utaki kia:

• Sarah Bate mei he PricewaterhouseCoopers 'i he (09) 355 8512

Email: sarah.s.bate@nz.pwc.com

Puipuitu'a 'o e fakamatala

Kataki tali 'a e ngaahi fehu'i ni 'o tiki'i 'a e puha 'oku ke pehē 'oku tonu.

Example :
Fakatātā: 'Oku 'iai ha'o ki'i tamasi'i 'i he?   ☐ 'Io / ☐ 'Ikai

'Oku 'iai ha'o fanau tangata 'i he apiako?   ☐ 'Io / ☐ 'Ikai

'Oku 'iai ha'o fanau fefine 'i he 'apako?   ☐ 'Io / ☐ 'Ikai

'Oku ke kau ki he matakali fē?

☐ NZ European/Pākehā   ☐ NZ Māori   ☐ Other
☐ Pacific Islander   ☐ Asian

Oku ke 'ilo 'oku 'iai 'a e:

a) Neesi mo e Toketā 'a'ahi 'a e 'apiako?   ☐ 'Io / ☐ 'Ikai

b) Tokotaha ngā ue fakasosiale 'a e 'apiako?   ☐ 'Io / ☐ 'Ikai

c) Toktaha fale; i 'a e 'apako?   ☐ 'Io / ☐ 'Ikai

Ko e ngaahi fehu'i ki he 'apiako, mo'ui mo e ngaahi tokoni kotoa pē

Kataki 'o lau 'a e ngaahi fakamatala ni fekau'aki mo ho foha / 'ofefine 'i he 'apiako. Pea ke tali tiki'i 'ia 'i he ki'i puha 'oku tonu ki ho'o fakakaukau.

Indicate for each statement if you strongly agree, agree, not sure, disagree or strongly disagree by ticking one bubble	Loto 'aupito kiai 1	Loto kiai 2	Ikai mahino 3	Ikai loto kiai 4	'Ikai 'aupito loto kiai 5
1. **Fakatātā: 'Oku tokanga 'a e 'apiako ki he palopalema 'a hoku foha/'ofefine.**	0	0	0	0	0
2. m) 'Oku fu'u 'aonga 'aupito 'a e neesi mo e toketā ki he fānauako.	0	0	0	0	0
n) 'Oku fu'u 'aonga 'aupito 'a e tokotaha ngāue fakasosiale ki he fānauako.	0	0	0	0	0
o) 'Oku fu'u 'aonga 'aupito ' a e tokotaha fale'i ki he fānauako.	0	0	0	0	0
3. a) 'Oku 'ikai ha palopalema 'a hoku foha/'ofefine ke sio ki he neesi pe toketā 'i he taimi te ne fiema'u tokoni ai.	0	0	0	0	0
b) 'Oku 'ikai ha palopalema 'a hoku foha/'ofefine ke sio ki he tokotaha ngāue fakasosiale 'i he taimi te ne fiema'u tokoni ai.	0	0	0	0	0
c) 'Oku 'ikai ha palopalema hoku foha/'ofefine ke sio ki he tokotaha fale'i he taimi te ne fiema'u ai.	0	0	0	0	0
4. a) 'Oku ou fiefia he ma'u 'e he 'apiako ha neesi/GP ma'a e fānauako.	0	0	0	0	0
b) 'Oku ou fiefia he ma'u 'e he 'apiako ha tokotaha ngāue fakasosiale ma'a e fānauako.	0	0	0	0	0
c) 'Oku ou fiefia he ma'u 'e he 'apaiako ha tokotaha fale'i ma'a e fānauako.	0	0	0	0	0
5. 'Oku ongo'i malu mo hao hoku foha/'ofefine 'i he 'apiako ni.	0	0	0	0	0
6. Ko e fānauako 'oku lea faka-Pālangi ko 'enau lea ua ia 'oku tokoni'i 'e he 'apiako.	0	0	0	0	0
7. 'Oku mātu'aki tokoni 'aupito 'a e 'apiako ki ha me'a 'oku matavaivai.	0	0	0	0	0
8. Ko e ngaahi fiema'u 'a e fānau ako 'oku mahu'inga 'aupito ia ki he kau faiako.	0	0	0	0	0
9. Ko e tokolahi 'o e kau faiako 'oku nau taukei ke ngāue fakataha mo e fānauako mei he ngaahi matakali kehekehe.	0	0	0	0	0
10. 'Oku tokoni'i au 'e he 'apiako ni ko e mātu'a tauhi fānau ke mau ngāue fakataha.	0	0	0	0	0
11. 'Oku tokoni'i 'e he 'apiako ni 'a e fānauako ke nau ngāue fakataha mo e fānauako mei he matakali kehe.	0	0	0	0	0
12. Ko e ngaahi fiema'u hoku foha/'ofefine 'oku fu'u toakaekina 'e he 'apiako ni.	0	0	0	0	0
13. Ko e ngāue 'a e neesi 'o e 'apiako 'oku ne fakapapau'i ke mo'ui lelei ange hoku foha/'ofefine.	0	0	0	0	0
14. Ko hoku foha/'ofefine 'oku ne fiefia 'i he 'apiako.	0	0	0	0	0
15. Ko hoku foha/'ofefine 'oku fai poupoua 'ene ako 'i he 'apiako.	0	0	0	0	0