



Formative evaluation report:

School Based Health Services

February 2022



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Executive summary

Background

School Based Health Services (SBHS) is a nurse-led primary care service available to decile one to five mainstream secondary schools, Kura Kaupapa, Special Character schools, Teen Parent Units (TPUs), and Alternative Education sites (Alt-Eds) nationally.

SBHS currently supports around 300 schools with approximately 98,000 students and 150 clinicians across all District Health Boards (DHBs). It aims to take a holistic approach to supporting rangatahi. The most common issues for which support is provided include, but are not limited to, acute and chronic physical health conditions, mental health and wellbeing, sexual health, alcohol and other drug abuse, school engagement, teenage pregnancy and accident and emergency presentations.

The enhancement and expansion of SBHS was a key initiative of Budget 2019's 'Taking Mental Health Seriously' package of initiatives. The enhancement programme is led by the Ministry of Health (MoH) in partnership with Te Tatau Kitenga, an advisory group representing the youth health and wellbeing sector, the Ministry of Education (MoE), DHBs and most recently the National Youth Committee. Te Tatau Kitenga has developed recommendations for the enhancement programme and Te Ūkaipō, a vision and values framework to guide the delivery of SBHS with the potential to be applied to the broader youth health and wellbeing sector.

The evaluation

The evaluation of SBHS will run from 2020 to 2024. This report summarises the findings of the first year of the evaluation. It aims to provide an overview of the different models used to deliver SBHS around the country. It does not aim to define exactly the prevalence of different approaches and practices but instead to highlight challenges and strengths.

This report draws on information from administrative a stocktake of SBHS completed by the DHBs, interviews with kaimahi¹, providers², DHB informants and school staff across all regions of Aotearoa New Zealand. It also draws on focus groups with rangatahi, though rangatahi data collection was limited by the impact of COVID-19 restrictions.

Findings

Interviews with kaimahi, providers, DHB informants, school staff and rangatahi supported the underlying rationale of SBHS that delivering health care in the school setting improved access to health care for rangatahi. However in most settings the effectiveness of SBHS was enabled by financial contributions of providers and kaimahi who worked more than their allocated hours.

There were differences in the implementation of SBHS between and within regions. The differences were often a response to the needs and context of each community but were also influenced by the constraints of resourcing and rangatahi need. Even areas with overall high socioeconomic status had pockets of whānau with higher need. Rangatahi could make a strong contribution to guiding SBHS delivery, but often were not involved in leadership.

The SBHS workforce was primarily made up of registered nurses. They came to youth health from a range of backgrounds, but providers, nurse educators and DHB informants saw the role as requiring experience and capacity to work independently along with expertise in working with rangatahi. Including other roles in SBHS, for example nurse practitioners, nurse educators, mental health nurses and General Practitioners (GPs), and the nurse prescriber qualification, could increase the scope of practice of nurses delivering SBHS. Taking a multi-disciplinary approach within SBHS and with other professionals working in education and the youth health and wellbeing space was widely supported but required time away from HEEADSSS assessments and other clinical work.

Cultural capability was crucial for engaging rangatahi from all backgrounds. Māori and Pacific clinicians were an important and valuable part of the workforce, but the limited number of staff and limited FTE available for smaller schools highlighted the importance of cultural capability for all staff. Some DHBs provided professional

¹ Defined in this report to include clinicians (including nurses, nurse practitioners, nurse prescribers and GPs) and nurse educators. Providers, DHB informants, MoE stakeholders and rangatahi are referred to separately.

² Includes DHBs, Non-governmental Organisations (NGOs) (including Youth One Stop Shops (YOSSs), Primary Health Organisations (PHOs), schools and primary and community health care services.

development opportunities and paid time in school holidays were excellent times for staff to engage. Making a clear requirement for support to access professional development along with clinical and cultural supervision in SBHS contracts could remove some of the barriers for clinicians.

Making SBHS accessible meant giving rangatahi a way to engage with SBHS that suited their preferences. Services often had multiple modes of access, including different ways to make appointments, informal drop-in appointments or text message contacts. The quality of the spaces allocated within schools varied from the corner of a staff room to wellbeing hubs. The space had a big impact on the experience of care for rangatahi. Supporting privacy in accessing and speaking with clinicians was essential but some SBHS spaces did not do that at all.

HEEADSSS assessment targets put pressure on clinician time but were seen as valuable for whakawhanaungatanga as well as identifying need for rangatahi. Establishing relationships with all rangatahi made it easier for them access support when they needed it. Standing orders, nurse prescriber qualifications and access to GPs and nurse practitioners supported nurses to work to the top of the scope of practice and reduced the need for rangatahi to access primary care outside SBHS. Connections to primary care and other services was important because not all needs could be adequately supported by clinicians or within the school setting. Absence of options in the community could leave clinicians managing rangatahi issues that would be better managed in specialist settings.

Kaimahi and other SBHS stakeholders across the regions described strengths and challenges in the way SBHS was implemented in their regions. Strengths identified in some regions included:

Regional and school models adapted to the needs of their communities, which could be supported by engagement with rangatahi.

Clinicians were experienced and had youth health expertise and experience.

Clinicians were supported by the school.

SBHS was delivered through a wellbeing hub in the school. The hubs provided privacy and a youth-friendly physical space.

Nurses were enabled to work at the top of their scope through standing orders, nurse prescribing abilities or access to a GP or nurse practitioner.

There were good networks with other community services.

Challenges to SBHS included:

Lack of regional integration of SBHS across the key education, health and social service providers.

Workloads and rangatahi need that exceeded funding.

Recruiting clinicians with the right skills and experience and a demographic profile that matched the community in which they were located.

A funding structure that limited FTEs and did not pay clinicians over school holidays.

Lack of supervision and professional development opportunities.

Conclusions

The description of SBHS implementation in different regions provides information to assess the current state against some of the key aspects of the Te Tatau Kitenga recommendations for the enhancement of SBHS. Several areas of the recommendations were highlighted as areas where change will be difficult and/or there is a significant gap between the current state and the recommendations.

Many kaimahi, providers and DHB informants identified the need for additional resourcing to support workforce quality and clinician time availability to complete assessments, clinical work and other SBHS activities. Many improvements require clinician time to implement and many clinicians were already trading off clinical work against non-clinical activities.

1. Background

1.1. School Based Health Services (SBHS)

Delivering services in schools has the potential to reduce barriers and provide rangatahi with health care many would not receive outside of their school setting. Improvements in mental health symptoms³ and receiving preventative care⁴ are described in the literature for similar services. Other outcomes of school-based health services also include improved school engagement and an increase in academic success⁵.

In Aotearoa New Zealand, SBHS is a nurse-led primary care service available to decile one to five mainstream secondary schools, Kura Kaupapa, Special Character schools, Teen Parent Units (TPUs), and Alternative Education sites (Alt-Eds) nationally. Figure 1 shows the location of schools with SBHS to give a sense of its national coverage.

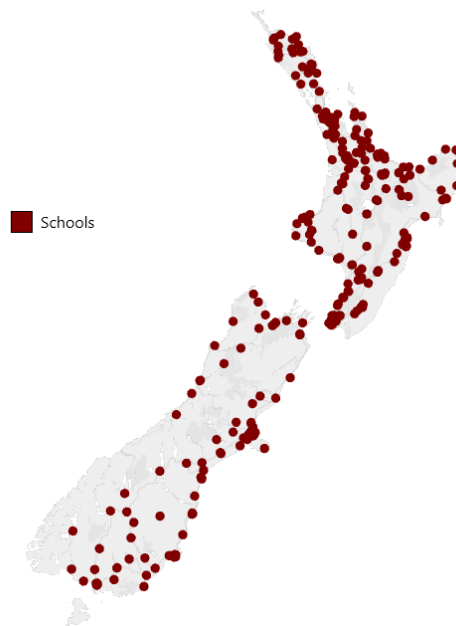


Figure 1. Schools delivering SBHS (Source: DHB SBHS stocktake 2021⁶)

³ Woods, B., & Jose, P. E. (2011). Effectiveness of a School-Based Indicated Early Intervention Program for Māori and Pacific Adolescents. *Journal of Pacific Rim Psychology* vol. 5(1).

⁴ McNall, M., Lichty, L., & Mavis, B. (2010). The Impact of School-Based Health Centers on the Health Outcomes of Middle School and High School Students. *American Journal of Public Health, 100*(9), 1604-1610.

⁵ Walker, S. C., Kerns, S. E., Lyon, A. R., Bruns, E. J., & Cosgrove, T. (2010). Impact of School-Based Health Center Use on Academic Outcomes. *Journal of Adolescent Health* vol. 46.

⁶ DHB SBHS stocktake. Unpublished – provided by the Ministry of Health

SBHS aims to take a holistic approach to supporting rangatahi. The most common issues for which support is provided include, but are not limited to, acute and chronic physical health conditions, mental health and wellbeing, sexual health, alcohol and other drug abuse, school engagement, teenage pregnancy and accident and emergency presentations. Clinicians provide clinical primary health care (both student-requested and clinician-initiated), referral onto required services and support health promotion campaigns. Year nine students are also expected to receive a health, disability and youth development check (HEEADSSS)⁷.

SBHS has evolved over time. The concept was initiated in 2001 when MoE commenced a pilot programme, the *Healthy Community Schools* (HCS) initiative, which was funded up to 30 June 2007 in nine *Achievements in Multi-Cultural High* (AIMHI) schools.

In 2007 MoH took over SBHS, taking a staged, equity-focussed approach to rollout by beginning with those most in need. They first provided funding for decile one and two schools, and TPUs and Alt-Eds in 2008 followed by decile three in 2015. SBHS in decile four schools began in 2018 and expanded to decile five schools in 2019. SBHS currently support around 300 schools with approximately 98,000 students and 150 clinicians across all DHBs.

The enhancement and expansion of SBHS was a key initiative of Budget 2019's 'Taking Mental Health Seriously' package of initiatives. Opportunities to strengthen SBHS include:

Workforce capacity and competency: No skills and practice framework and variable access to consistent training and professional supervision.

Facilities: Challenges for schools to provide appropriate facilities for SBHS to meet requirements such as privacy and hygiene.

Service specification: The Tier two specification was last reviewed in 2011 and a new Tier three specification has since been developed for SBHS delivered in decile four schools leading to confusion, inconsistent expectations and difficulties in monitoring services.

Funding and contracting: Funding and contracting for SBHS is unnecessarily complex and not aligned to achieving quality or equity with inconsistencies in purchase units, funding amounts and contracts.

Information system: No consistent client information system or data storage which means data are of poor quality and inaccessible for monitoring or research on

⁷ The check gathers information on the most common influences on a young person's life at home, school and other social environments. It is often conducted using the HEEADSSS Tool: **H**ome, **E**ducation/employment, **E**ating, **A**ctivities, **D**rugs, **S**exuality, **S**uicide and **D**epression, and **S**afety from injury and violence.

contribution to rangatahi health outcomes. Having agreed goals and objectives of SBHS and expected outcomes, alongside delivery and quality measures, will define the role and function of the technology systems needed for SBHS.

Evaluation and monitoring: No agreed outcome framework for what SBHS is to achieve or how it contributes to the Child and Youth Wellbeing (CYW) Strategy, inadequate delivery and quality measures to monitor the service and little formal evidence on impact of SBHS on student outcomes.

MoH funds SBHS but its delivery in education settings and focus on rangatahi wellbeing requires strong connections to other government agencies and to the broader youth health and wellbeing sector. MoH recognised the importance of those connections for SBHS by taking a partnership approach to the national leadership of SBHS. The partners are:

Te Tatau Kitenga and Te Rōpū Mātanga o Rangatahi: Representing SBHS kaimahi and the wider youth health and wellbeing sector

National Youth Committee (NYC): Representing rangatahi voice and convened in the last quarter of 2021

MoE: Responsible for schools and the wider education settings

DHB working group: Representing DHBs who are contracted by the MoH to deliver SBHS in their regions

Evaluation: Malatest International, contributing to the evaluation and quality improvement programmes.

MoH, MoE and Te Tatau Kitenga have developed recommendations for the enhancement programme and Te Ūkaipō, a vision and values framework to guide the delivery of SBHS with the potential to be applied to the broader youth health and wellbeing sector.

Programme implementation started around mid-2021 and will continue over the next five years.

1.2. The evaluation

MoH wants to develop a clear accountability framework for SBHS with a better reflection of te Tiriti o Waitangi principles and long-term system outcomes and performance measures for SBHS. This will support quality improvement and outcomes evaluation to build the contribution of SBHS to rangatahi wellbeing.

The Government's priority of achieving equity means the programme has a focus on populations currently under-served by the system – rangatahi Māori, Pacific young people, rainbow rangatahi, rangatahi in care and rangatahi with disability.

The objectives of the evaluation are to provide information to:

Ensure that SBHS contributes to improving rangatahi outcomes and achieving equity
Set the standard for equitable, effective and efficient SBHS, including options for proportional delivery of service related to need

Drive quality improvement

Further build the evidence base for investment in and implementation of SBHS

Inform any expansion of SBHS.

The evaluation is guided by the Te Rapunga model (outlined in full in Appendix 1), a logic model for the SBHS evaluation (Appendix 2) and a framework that describes the vision of the enhancement programme for SBHS, the change that is expected over time and the intended outcomes (Appendix 3).

1.2.1. Ethics

We submitted an application and received approval from the New Zealand Ethics Committee⁸ and adhere to the ANZEA best practices in evaluation and to Māori and Pacific research guidelines. All data collected were stored in a de-identified form. Reporting protects participant confidentiality and privacy by anonymising information reported.

1.2.2. Data collection

We built a basis for our understanding of SBHS through a synthesis of the literature and meetings with SBHS stakeholders across government.

The synthesis summarised national and international evidence SBHS and similar initiatives for adolescents. It is a working document for Malatest to use as an overview of the evidence base and is not intended as a standalone, comprehensive review of all SBHS literature. The synthesis will be updated over the course of the evaluation as new information is accessed.

The focus of data collection for this phase of the evaluation was interviews with stakeholders across all regions of Aotearoa New Zealand (Table 1). We completed interviews in person during site visits or by videoconference where we were not able to attend in person.

We planned ten site visits, but the impact of COVID-19 meant we were only able to travel to two. Additional site visits will be completed in later phases of the evaluation.

⁸ <https://www.nzethics.com/>

Table 1. Number of stakeholders interviewed (count of individuals – many interviews were in a group setting)

Role	Number interviewed
Rangatahi (six focus groups)	45
Clinician (registered nurses, public health nurses, nurse prescribers, nurse practitioners and GPs)	43
Provider (individuals in management positions within the provider)	28
Nurse Educator	2
DHB Informant	25
MoE regional staff	12
School staff	21

Results of the 2021 DHB SBHS stocktake are also presented throughout the report. It is important to note these results present a wider picture of SBHS than just strictly MoH funded SBHS. The stocktake included SBHS where schools, DHBs and other organisations provided additional funding alongside the core MoH funding.

1.3. Purpose of this report

This report presents the findings from the first year of the SBHS evaluation which has focussed on these stages of the evaluation model – see Appendix 1: Te Rapunga (planning and preparation), Te Kitenga (collecting data) and Te Whāinga (connecting with stakeholders and assessing progress so far).

It describes the variation in approaches to implementing SBHS. In doing so it highlights strengths and challenges in the delivery of SBHS. This report does not focus on rangatahi outcomes. The SBHS enhancement programme aims to create significant change for the approach taken to delivering SBHS alongside the expansion of the service. Outcomes will therefore be a greater focus in later stages of the evaluation.

1.4. Strengths and limitations

The evaluation was strengthened by:

Inclusion of perspectives of SBHS kaimahi, providers and other stakeholders in all regions of Aotearoa New Zealand.

The number of different perspectives enabled a depth of understanding of SBHS implementation and delivery in different settings.

The evaluation was limited by:

COVID-19 lockdowns which hindered face-to-face engagement. We understand the importance of whakawhanaungatanga and capturing participant voice in-person. However, lockdowns and safety of all participants and evaluators meant videoconference and phone calls were the main ways of including different perspectives.

These circumstances limited our ability to hear from rangatahi who we intended to involve in face-to-face focus groups during site visits to focus on Te Ūkaipō. Hence information on rangatahi experiences and the framework is limited.

2. Overview of SBHS models and context

2.1. Overview of model

Figure 2 provides an overview of the most common SBHS model and some of the variation SBHS stakeholders described in interviews.

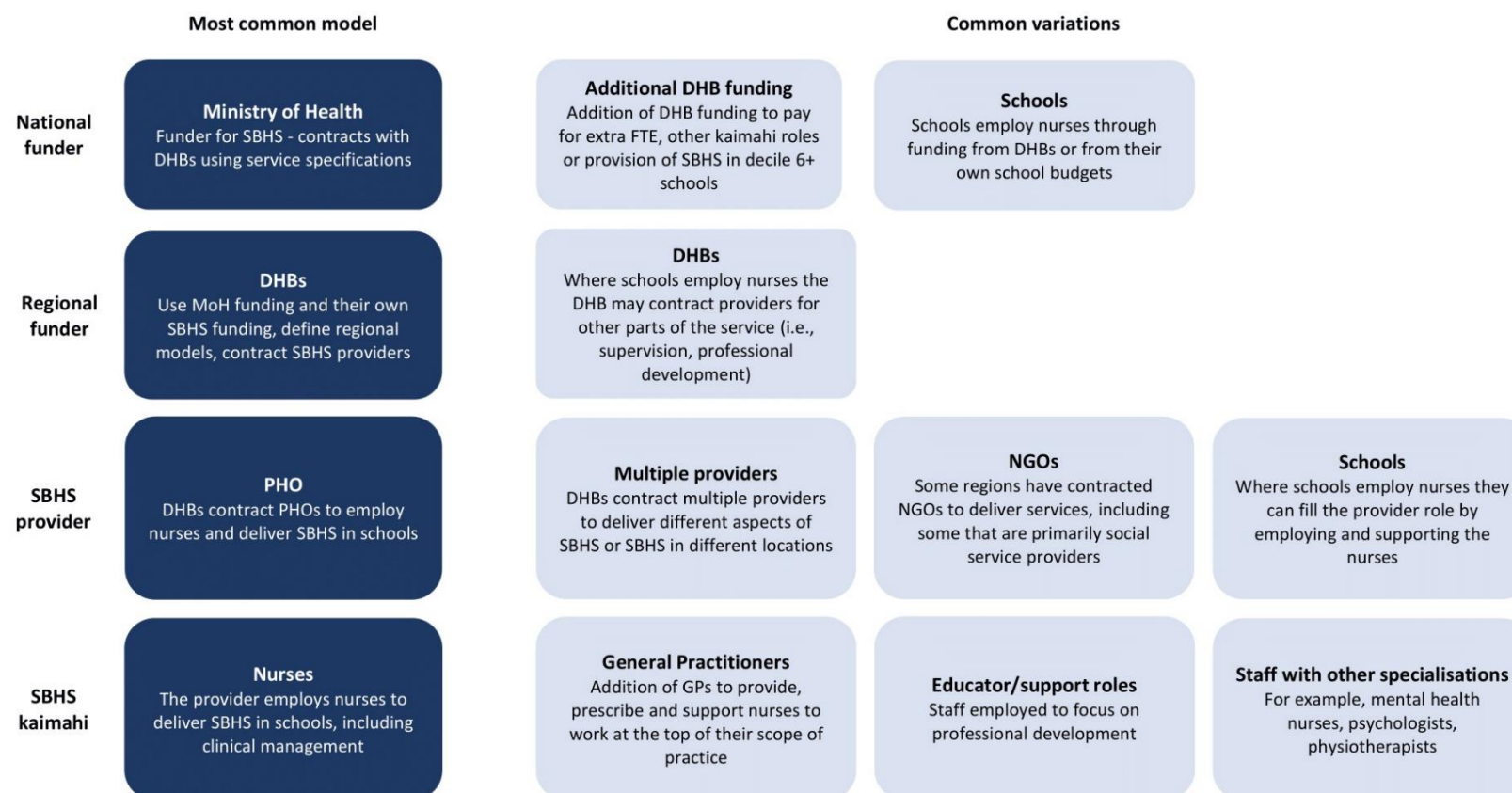


Figure 2. The most common model for SBHS and variations seen at different levels of the model

2.2. The context for SBHS

Interviewed stakeholders described SBHS as a main source of primary health care for rangatahi.

*If they weren't seeing their school doctor, they wouldn't be seeing anybody.
(Provider)*

Occasionally, young people accessed other health and social services such as YOSSs and other programmes funded or supported by government, local councils, marae or churches.

Ensuring equitable and accessible health care for all is a SBHS priority for MoH. To achieve this MoH has identified five priority groups: rangatahi Māori, Pacific young people, rainbow rangatahi, rangatahi in care and rangatahi with disability.

In areas with high Māori and/or Pacific populations, schools, DHBs and MoE regional staff were aware of the profile of their communities. They often acknowledged that little progress had been made towards national, equitable and accessible health care for the other priority groups. Kaimahi and providers supported the equity and showed an awareness of rangatahi missing out.

What we're finding is that our heavy focus on equity, while it is the right thing to do, there is still a sect of our community that is missing out. So the working class poor, for instance, the disabled sect and potentially the rainbow community as well. So it's something we've identified as a DHB that we need to try and come up with a solution for. (DHB informant)

Interviewed stakeholders identified other population groups as having health needs that were difficult to meet:

Rural communities

I would like to see the model change and include area schools that are really rural and remote and might have a high decile but we have got, what we call 'white flight', which is those that can afford to go to boarding school do. Then there's the ones that are left where there's really high need ... (Provider)

Immigrant and refugee communities

We have also got a migrant workforce down here ... their young people are going to be attending schools if they bring families with them; some of them do. (Provider)

Rangatahi in Alt-Eds with very high health and social needs that are not supported by the SBHS model

The issues that they have in the Alt-Eds usually come with a lot of other issues. You might go there expecting that there has been an injury but they have had a fight in

the weekend and there's ... tools, live weapons involved, gangs. It always explodes into something a lot bigger. (Kaimahi)

2.3. Barriers for rangatahi accessing health care

Interviewed stakeholders noted multiple barriers to accessing health care for rangatahi and their whānau (Table 2).

I speak as a parent and as a teacher, what are the barriers to accessing health needs? Somebody just getting that appointment, scheduling the time? It could be resources: people don't have transport, funds, some of the physical things. (School staff)

Table 2. Common rangatahi needs and issues identified in school (Source: all interview participants)

Barriers to accessing health care for rangatahi	Quotes from interviewed stakeholders
Availability of other services: Long waitlists to access mental health and GP services.	<i>Mental health is becoming bigger and bigger. What's the capabilities outside schools to provide that support? Really, really, really limited. We have a community organisation that is amazing. They started with a no waitlist policy and they have a six-week waitlist now and that's just because of need. (MoE regional staff)</i>
The cost of accessing services: Some services in the community had costs which was an issue for some rangatahi.	<i>The local GPs are pretty good but they are overrun and ... they're not a free service so they're not as accessed by young people. (Kaimahi)</i>
Economic status: Rangatahi Māori, in particular, continue to face significant disparities in socioeconomic status and access to resources and health care.	<i>So the decile rating in our area is decile one to three so very low socioeconomic rural Māori. Only 20% of our community have access to the internet or Chromebook devices because of our isolated communities. Barriers with health access due to inequalities of being to afford or get to health services ... (Provider)</i>
Lack of choice for service providers, particularly in rural settings: The realities of rural health care mean there can be challenges involving privacy and confidentiality due to overlapping relationships and familiarity with rangatahi and communities.	<i>So you might have known them since they were born and then suddenly they are an adolescent who you saw when they were naked on the scales. So that transition from a person that knows you from zero to 14 I think can be difficult for some young people. (Kaimahi)</i> <i>That is an issue [when the nurse is their] mum's friend or dad's friend and ... [they] need to have somebody who's theirs. (School staff)</i>

These are consistent with barriers observed in the literature, although rangatahi also noted that unfamiliarity with clinicians at GPs can lead to feeling uncomfortable seeking help⁹.

⁹ Ministry of Health. (2009). *Evaluation of Health Community Schools Initiative in AIMHI Schools*. <https://www.health.govt.nz/system/files/documents/publications/aimhi-08-10-09.pdf>

2.4. Monitoring and reporting

MoH service specifications include a requirement for DHBs to report back to MoH. In areas where DHBs contract other organisations to provide SBHS they have to receive and process data and/or reports from other sources.

... every six months we do a report to the Ministry of Health. They have quite an extensive report so we moved from monthly to six monthly ... it's very intensive reporting. How many kids we saw, how many were eligible, how many consented, where the referrals went, a breakdown of ethnicities, how many of them arrived obese ... It's a dreadful time. (DHB informant)

Kaimahi and providers were unsure why some components of the reporting were included and felt others were not meaningful in demonstrating the quality of the support they provided for rangatahi.

DHB informants and providers differed in their views of the time it took to complete the reports. Some were able to generate the information directly from their patient management systems. Others found it a much more onerous process, particularly where they were reporting back on multiple providers or schools. Lack of feedback about the reporting content was a disincentive to provide potentially useful detail.

[The reporting] is a spreadsheet that they supply. I'm going to be really honest with you, over the years I used to put quite a bit of narrative into it and then you get next to no feedback back. So I just keep it really simple. (Provider)

DHB informants, providers and kaimahi also talked about reporting back to schools to keep them informed about rangatahi needs.

We don't actually send anything back to the schools. And so when we get our full years' worth of data, what I usually do is a bit of a summary to each school about this is the amount of students that we engaged with at your school per year, this is the ethnic breakdown. And then just an invitation for them to contact us with any feedback about the service and whether they want to have a chat about that. Usually that feedback comes in in quite an ad hoc way just because I've really good relationships with the school principals and so does our nurse coordinator ... And so we just do it is a matter of relationship building not as a mandated requirement. (DHB informant)

When I do my report to the school at the end of the year ... I can tell the school, yes out of the 100+ Year 10s I've seen this year, this amount are consuming alcohol on a regular basis, this amount are sexually active and are using this type of contraception, this group are using these kind of drugs and this many vaping ... And they get a little bit of information that they actually quite like, like what the popular subjects are. (Kaimahi)

Summary of findings

Stakeholders at all levels wanted to move towards more meaningful, outcome-based reporting. Sharing useful reporting with schools has the potential to help schools promote rangatahi wellbeing.

3. Rangatahi voice

A strong rangatahi voice, influential at all levels, is one of the focus areas of the Youth Action Plan¹⁰. SBHS has the potential to be led by the youth voice in:

National leadership

Regional leadership

Individual school leadership

Feedback from rangatahi as SBHS users.

3.1. Rangatahi voice in national and regional leadership

Te Tatau Kitenga and MoH agreed on the importance of including rangatahi voice in national SBHS leadership. Te Tatau Kitenga drew on its members' connections to consult 112 rangatahi through focus groups from January to May 2021. This consultation informed the development of Te Ūkaipō and the *Discussion Document for Enhancement of SBHS*.

Later in 2021, MoH provided funding for Te Tatau Kitenga to convene and support the NYC. NYC will have an ongoing role in providing a strong rangatahi voice to the other SBHS partners. At the end of 2021 the group had already produced a discussion document with recommendations for SBHS and feedback to a national hui of SBHS partners.

Few DHB informants said rangatahi systematically contributed to the design of SBHS in their regions. Many of the DHB informants were not in their current roles at the time SBHS was first implemented in their regions and may not have been aware of any work done to include a rangatahi perspective in the design of their models.

... the model that we use was driven by our community ... there was a survey done of young people and parents and teaching staff to see what sort of model they would like in those schools. And the community kind of overwhelmingly wanted the nurse to be part of the school community. (DHB informant)

3.2. Individual school leadership

Many schools had student wellbeing groups that could provide a rangatahi perspective on the services delivered under SBHS.

¹⁰ Ministry of Youth Development. (July 2020). *Youth Action Plan 2020-2022*. <https://www.myd.govt.nz/documents/young-people/youth-plan/youth-plan-2020-2022-turning-voice-into-action-rebuilding-and-recovering.pdf>

We had a wee committee of students we organised [to discuss health services at school] ... we wanted to meet with the students, find out what were some of their needs, what were some of the things that was missing and how would we make the space more youth-friendly. (Kaimahi)

A small number of clinicians reported regularly meeting with community-based youth services or a group of rangatahi for feedback and guidance.

We engage really well with all the other services out there trying to find out feedback from youth so we've got a youth collective group that we meet monthly and then we try and meet with selections of students throughout schools and find out what's on top for them. (Kaimahi)

The impact of feedback collected at schools depended on the clinician being able to connect with the school and/or the rangatahi groups. Those who had been able to connect with the school and/or rangatahi groups found the input valuable in guiding their implementation but also emphasised the time required to build working relationships with rangatahi to generate useful input.

It was good to be able to start getting to know the students and their thoughts about how the clinic should look and how it should be accessible. There are still a few barriers around that but I guess it's really for us just to get in and working on those because relationships take a bit of time to develop, they are not going to happen overnight. (Kaimahi)

3.3. Feedback from rangatahi as SBHS users

The MoH SBHS service specifications require all DHBs to complete a rangatahi feedback survey each year. There was variation in how the DHBs approached collecting feedback:

Selection of students: Approaches included a randomly selected sample of students or distribution to all students.

Survey level: Some DHBs ran a single survey across multiple schools, while others asked clinicians in each school to run separate surveys of their students.

Survey medium and distribution: DHBs provided examples of email distribution, paper copies and completion on iPads. One Alt-Ed provider shared they run open dialogue sessions to receive feedback.

Survey content: One DHB included students in the development of their survey questionnaire. Question content varied across DHBs but they were generally short (fit on one page) and asked about satisfaction, usefulness/helpfulness and aspects of accessibility (e.g., privacy, comfort) using likert scales with qualitative follow up questions.

In responding to a request from the Ministry, some DHBs provided examples of dashboard reports they shared with schools.

Summary of findings

A strong rangatahi voice, influential at all levels, is one of the focus areas of the Youth Action Plan and the recommendations of Te Tatau Kitenga. Rangatahi voices may be most meaningfully included at school level where rangatahi know the school context and can be empowered to have a voice. However it will be important to ensure representatives from all rangatahi groups are included.

Good data on rangatahi experience and rangatahi outcomes is needed to inform practice and service improvements. A robust and consistent approach to collecting the data is needed, especially in the absence of a single joined-up SBHS IT system.

4. Leadership

4.1. National SBHS leadership

MoH funds SBHS but its delivery in education settings and focus on rangatahi wellbeing requires strong connections to other government agencies and to the broader youth health and wellbeing sector. MoH recognised the importance of those connections for SBHS by taking a partnership approach to the national leadership of SBHS, as described in the background section.

All stakeholders had the opportunity to contribute to the MoH enhancement of the SBHS programme through regular consultation, partner hui and requests for feedback on the enhancement programme workplan. However some SBHS providers wanted communication from a national perspective to have a better understanding of what MoH wanted them to do.

4.2. Regional leadership

At a regional level there was generally not a strong connection between MoE and MoH staff. MoE staff in most regions did not have a role in leading SBHS and many did not understand how it was funded or delivered in their region.

In terms of MoH funding I wouldn't even have a clue what they provide, if they provide, who they're providing it to ... there is some regional involvement around the counsellors and schools and visibility around who is engaged there. But in terms of health services in schools ... zero visibility, zero conversations with the DHB or MoH. (MoE regional staff)

Instead providers and kaimahi formed regional networks to communicate with each other. From the MoE perspective, involvement with SBHS was seen as the responsibility of school principals. When MoE staff did work with SBHS it was mostly focussed on individual cases.

Summary of findings

Supporting regional leadership could strengthen connections between kaimahi and other services, facilitating multi-disciplinary approaches to rangatahi wellbeing.

4.3. Service specifications

The service specifications are the mechanism for translating MoH's SBHS policy and intent into implementation. They provide a set of requirements to ensure each DHB and provider implements SBHS consistently with the national model while still allowing flexibility to respond to regional and local need. The service specifications are divided into three tiers:¹¹

Tier one - services for children and young people: High-level principles, objectives and requirements for all MoH funded services for children and young people.

Tier two – school and pre-school health services: Overarching objectives for MoH funded services delivered for tamariki and rangatahi, focussing on identifying need, improving access, providing youth-friendly services and working with staff in the education setting.

Tier three – additional specifications for SBHS defining the core components of the service: Universal health, disability and youth development checks (HEEADSSS), registered nursing services for all service users and referrals with follow-up to other services.

The recommendations from Te Tatau Kitenga state that the service specifications should be a baseline for services to work from which can then be adjusted regionally and locally. To achieve that aim they need to provide enough guidance that the essential parts of SBHS are present across all regions while leaving room for regions to adapt the service to their communities.

Providers were generally not positive about the current service specifications. Some staff new to their roles described reading the service specifications to attempt to understand what they should be delivering.

Well apart from getting a bit of funding there doesn't seem to be anything else that comes with it so that in itself is a risk. It's not like we get a list of standards of care, a list of what we can and can't do, a list of here's phone numbers if you would like to ask about something that's happening nationally, any of those things. So it doesn't seem to be particularly well supported. (Provider)

Some also criticised the guidance in their contract about the health care that should be provided.

¹¹ Service specifications available at: <https://nsfl.health.govt.nz/service-specifications/current-service-specifications/child-and-youth-health-service-specifications>

Summary of findings

Reviewing and updating the service specifications is an opportunity to set expectations around the quality of care and to create a consistent national model.

4.4. Allocation of resources for equity

The SBHS funding model sees FTE allocations based on the number of enrolled students at each school, with higher FTE to student ratios for lower decile schools, Alt-Eds and TPUs. Many interviewed stakeholders commented on the funding levels and/or the amount of FTE available in each school.

Funding and resourcing of SBHS were major themes in the interviews. Funding based on student ratios did not account for differences in the level of rangatahi need. Higher decile schools could have pockets of very high need and not all low decile schools had similar need profiles. These differences included boarders, refugee populations, 'white flight'¹² and high numbers of Oranga Tamariki (OT) placements.

... there are quite a few boarders there. They are decile one. They have got less than 100 students. So based on the ratios we should only be in, I think, six hours a week or something. Right from the word 'go' at that secondary school we recognised that nearly all students had really complex health needs and social needs. There are quite a few girls that have been placed there by OT ... we have got a nurse in there two days a week plus a nurse practitioner about a good half-day a week. That is far more than the ratio ... there is no way that is going to meet the needs of what those girls need. (Provider)

Overwhelmingly those interviewed, including rangatahi, wanted their clinicians to be available for more hours. Many providers and kaimahi reported that they could use more hours in each school but the funding was not sufficient to meet rangatahi need.

The nurse should come every day. We always have students who come into the office and ask for the nurse and they're not there. (Rangatahi)

Sadly they have very limited resource with us. I think we would be lost without [the nurse] and I think they are only here for two hours on a morning. We could do with them three times a week. (School staff)

The funding per FTE also made recruitment more challenging. Rates of pay were not well-matched with the level of expertise and experience in the nursing sector, creating issues for retention and recruitment (discussed in section 5.5).

¹² Referring to the situation where those who can financially afford to board, can.

But I agree, if I use just school-based health service and keep the nursing FTE just to what that provides there would be nowhere near enough money. (Provider)

Most providers and kaimahi also reported SBHS funding did not cover the cost of administration, reporting, professional development and supervision and the consumable supplies used in routine clinical work.

Funding for supply is something we're constantly fighting because we only get enough money to pay for the nurses and not the things that we can do within the schools. (Kaimahi)

... there are days where they isn't like wraps for your legs or tape or there isn't cough drops or there isn't enough Panadol ... I feel like there should be more feminine hygiene products in there just because there is often times where I go there and there isn't any and I need some. (Rangatahi)

Providers and clinicians may use other sources of funding to cover some of these costs. Sources included:

Additional funding from DHB: Some DHBs topped up the resource for SBHS either by providing funding or contributing some of their staff time, often as an extra role for public health nurses.

ACC funding: Several clinicians reported accessing ACC claims for their rangatahi and using the funding generated to pay for supplies.

Additional funding from providers: Some providers contributed funding to pay for additional FTE and any supplies needed.

We get 1.12 FTE for funding from DHB. Our school tops it up. The school puts in extra to fund us a little bit more. (Kaimahi)

I run a deficit budget on what the DHB gives me. We bring in some ACC money as well. But the school has to put in money. (Kaimahi)

Funding levels for each school and eligibility for SBHS were linked to school decile rating. Interviewed stakeholders pointed out the issues this created for schools with polarised catchments containing a mixture of high and low decile communities. Such schools could have significant numbers of low decile rangatahi but be eligible for no or lower SBHS funding. This issue was not unique to SBHS and those schools could find themselves outside the target group for other school-based services as well. Schools in those circumstances often funded a health service themselves or received a service funded by the DHB.

Linking resourcing to student numbers was difficult for small schools. Time required to meet administrative requirements could take a larger proportion of clinician time where the overall FTE allocation for schools was small.

The only [school] that falls under [SBHS] is [school name deleted]. And because the roll at [the school] is so small [the funding] gives us a few bucks a week ... For

example, the reporting, that nurse in her four hours a week, would just about have to dedicate three of those four hours every week to writing reports. (Provider)

The funding approach was also challenging for schools with issues creating a higher level of demand because of the level of rangatahi need or other factors like rurality. Alt-Eds and TPUs received additional FTE compared to other schools, however resourcing did not meet the demand. There was strong support for finding other ways to define need in the funding model, particularly where there were multiple factors associated with higher need. Kura could also have greater resource demands because of the increased emphasis on SBHS building relationships with other kura staff and whānau.

The other thing is that we just need to better resource schools that have that higher complexity of needs and whose young people are facing a higher intersection in complexity of risks and issues. I would think we would actually need a model that also doesn't just have a blanket 1:700 but actually looks at the decile of the school, the ethnicities in the school, they identify complex issues that the young people are facing and provide a funding model based on that. (Kaimahi)

Summary of findings

Adequate funding is essential to support an equitable service model.

5. Care delivered for rangatahi

5.1. Scope of care

Most clinicians we interviewed felt able to work to the top of their scope of practice and support rangatahi needs. Kaimahi and providers highlighted three enablers for clinician scope of practice: standing orders, the nurse prescriber qualification and access to other specialists within SBHS.

5.1.1. Standing orders

What is a standing order?

A standing order is a written instruction from a GP or nurse practitioner that gives a nurse the ability to administer specified medication under specified circumstances¹³. Nurses must have the competency and training to work under standing orders and are required to keep records on their use of the medication¹⁴. The GP or nurse practitioner who writes the standing order often needs to countersign standing orders or audit their use if countersigning is not required or is infrequently required¹⁵. Many nurses have a range of standing orders they work under.

We've got 29 standing orders so we have quite a large kete of medication that we can use in our space. (Provider)

One of the key intentions of standing orders is to improve timely access to medication. Without standing orders nurses scope is limited and GPs or nurse practitioners need to be involved to access medication. Barriers to accessing GPs outside the education setting or limited GP or nurse practitioner clinics within schools could prevent rangatahi from accessing needed treatment. Standing orders allow nurses to provide treatment immediately.

When I think back to when I first went into school-based nursing there were simple things like skin infections that young people would walk around and you would see them day after day saying, 'You need to get to the doctor'. You'd contact the family but for whatever reason they would not get to the doctor. They would not get that

¹³ Ministry of Health. (2016). *Standing Order Guidelines (2nd edition)*. Ministry of Health. <https://www.health.govt.nz/system/files/documents/publications/standing-order-guidelines-aug16-v2.pdf>

¹⁴ Ibid.

¹⁵ Ibid.

treatment that they needed. With our nurses having standing orders being able to actually contact the family and say, 'Hey, do you want us to treat this right now?' it has made a massive difference. (Provider)

Training for standing orders and partnership with a GP or nurse practitioner also extends nursing scope of practice.

We [GPs] are countersigning those [standing orders] and auditing those. Just the discussion we have around those standing orders means that the nursing scope of practice is extended because they are learning the medications they are giving and getting feedback about the conditions they are treating and sometimes sitting in with us [GPs] and watching us making diagnoses about complex presentations. (Kaimahi - GP)

Others noted the challenges with standing orders, particularly working under standing orders for medication that is readily available in supermarkets and not having access to GPs or nurse practitioners willing to write standing orders or in the right field to write standing orders for youth health.

5.1.2. Nurse prescriber qualification

Nurse prescribers are registered nurses who can prescribe certain medication¹⁶.

There are two types of nurse prescribers:

Primary health and speciality teams: These nurses can prescribe a range of common medications.

Community health: These nurses can prescribe from a limited number of medications.

Registered nurses must have a minimum level of experience in the area they prescribe in along with the appropriate postgraduate diploma to become a nurse prescriber. Similar to working under standing orders the nurse prescriber qualification extends the scope of practice of nurses and allows them to prescribe and treat with a broader range of medication than under standing orders. It also gives nurses an increased ability to offer a nurse-led, independent service.

I'm actually really lucky. I think because of being in this role [nurse prescriber] it's an extended scope. It's really great to be able to do what I'm doing as a nurse prescriber and because it's a service set up to be independent and nurse-led it's really satisfying. (Kaimahi)

¹⁶ Nursing Council of New Zealand. (n.d.). *Registered Nurse Prescribing*. Nursing Council of New Zealand.

https://www.nursingcouncil.org.nz/Public/Nursing/Nurse_prescribing/NCNZ/nursing-section/Nurse_Prescribing

5.1.3. Access to other specialities within SBHS

Having access to other specialties within SBHS benefited the service in that it:

Allowed rangatahi to be supported by staff specialised in their area of need

Gave nurses someone to contact to discuss their treatment decisions

Gave nurses confidence to manage more complex/severe issues knowing they would be able to discuss the case with an expert.

Nurse practitioners have the broadest scope of practice of nurses. They have the education, clinical training and demonstrated competency to prescribe all medication and write standing orders¹⁷.

A lot of us (nurses) would like to upskill. An avenue I'm looking into is perhaps looking at becoming a nurse practitioner one day and hoping to grow our service. Having one nurse practitioner within the school service means I could provide standing orders for common issues like STDs or contraception. (Kaimahi)

When rangatahi could not or did not access GP support outside of the education setting having access to a GP or nurse practitioner within schools broadened the support rangatahi had access to within schools.

We've got a nurse practitioner we have four hours of a week. So whenever we identify somebody that's out of our scope of practice we're either ringing the GPs or talking to the nurse practitioner and getting the treatment that we need to get. (Kaimahi)

Having a GP is essential to allow the nurses to work to the top of their scope of practice. Without a GP on-site, testing, referrals and treatment are difficult ... [With] testing, someone can send off a throat swab on a Monday and by the time the results are back they can start treatment under a standing order. (Provider)

5.1.4. Challenges to scope of practice

By contrast, some clinicians felt unable to work to the top of their scope of practice due to lack of access to the above enablers and/or the presence of:

Lack of support from schools: School support was important for rangatahi to know about SBHS and how to access it. It was also important in allowing clinicians to work with school staff to tailor support to rangatahi need. Most, but not all, clinicians had positive relationships with schools. Reporting back on rangatahi issues and being flexible to respond to referrals from school staff appeared to strengthen relationships.

¹⁷ Nursing Council of New Zealand. (n.d.). *Nurse Practitioner*. Nursing Council of New Zealand. https://www.nursingcouncil.org.nz/Public/Nursing/Scopes_of_practice/Nurse_practitioner/CNZ/nursing-section/Nurse_practitioner

Our time in the school is definitely not prioritised. It's almost an inconvenience us being there. But at the same time we've got so much to do in the school and when we are told that we're not able to use the space or we're given the grottiest place in the school to work from it doesn't look like our services are being valued by the staff ... I don't think the staff really appreciate how much value we add to the school. (Kaimahi)

Restrictions placed by religious special character schools: Many clinicians working in special character schools highlighted their difficulty with working in the sexual health space to support rangatahi. While some provided treatment and tests many struggled with providing contraception. The Board of Trustees could be a more significant obstacle than school staff.

Students are coming to the clinic for sexual health. [The school] allow treatment tests ... I was called to the principal's office many times asking me about sexual health, why am I encouraging the kids? So I had to explain that actually by the time I see the kids they will really have a disease, they already have an infection and we need to help them and treat them. And they were okay with that. (Kaimahi)

Other high schools that I work in currently or I have worked in before my scope has been much larger. I have been allowed to do contraception or STI checks, mental health referrals, just general medical or injury-related stuff: vision, hearing, that sort of thing ... I am not allowed to do anything sexual health-related currently. (Kaimahi)

One kaimahi working in an all-boys school shared they had found ways to provide contraception. This included finding out where their partners went to school and getting them to access contraception, directing them to local services with free contraception or getting them to ask their friends.

... we still have to maintain confidentiality so I'm just like, some of your friends might have some, you know, try hint, hint. (Kaimahi)

Clinicians have limited time: Particularly for those clinicians who work across multiple schools or who have SBHS as one part of their role finding the time to work to the top of their scope of practice could be challenging.

We're jack of all trades but masters of none. If we totally had the time to work with our high schools, there definitely is work there. (Kaimahi – Public health nurse)

5.2. The HEEADSSS assessment

Completion of HEEADSSS assessments with all year nine rangatahi and all Alt-Ed and TPU students is required by the SBHS service specifications.

The HEEADSSS assessment

HEEADSSS is a comprehensive psychosocial assessment tool designed by clinicians to understand the health and wellbeing needs of young people¹⁸. It aims to allow clinicians to identify issues and provide information to assist rangatahi in their development¹⁹, including the socially and psychologically mediated issues, which are the most common causes of rangatahi mortality and morbidity²⁰.

The assessment covers nine areas of importance in rangatahi life: home, education/employment, eating, activities, drugs and alcohol, sexuality, suicide and depression, and safety. These areas are ordered to ease discussion allowing clinicians to build rapport and increase engagement with rangatahi. The non-standardised questions allow clinicians to tailor questions to the needs of individual rangatahi. The intention is that clinicians provide support, information or make referrals to other services to address the identified issues.

This requirement has been implemented in two different ways:

Contracted for HEEADSSS and other health care: Most clinicians were contracted to provide HEEADSSS assessments and any resulting referrals along with other health care.

The contract is that we are contracted to do HEEADSSS assessments but part of our contract where we are doing throat swabbing and there is a small line that talks about having a clinic available that provides sexual health and general first aid. (Kaimahi)

These clinicians were expected to still complete most of their HEEADSSS assessments but spent much of their time offering health care.

In our clinic 30% of our time is HEEADSSS ... and the rest would be clinic. I count clinic as throat swabbing as well. (Kaimahi)

HEEADSSS only: Some clinicians were contracted to provide HEEADSSS assessments to year nine rangatahi and refer them to any other services/supports to address any needs identified. Generally these clinicians were expected to complete assessments with all year nine rangatahi.

I don't do the clinic at the school that I do the year nine assessments at [school name deleted] which sounds a bit strange but I don't really have the capacity to do that so I don't really see any other students outside of the year nine health assessment stuff.

¹⁸ Starship. (2019, November 8). *Adolescent Consultation and the HEEADSSS Assessment*. Starship. <https://starship.org.nz/guidelines/adolescent-consultation/>

¹⁹ Evaluation of HEEADSSS assessments in SBHS. Unpublished – provided by the Ministry of Health.

²⁰ Ibid.

As I said if I do need to follow up on the year nine stuff I'll generally do that during the time allocated for me for year nine. (Kaimahi)

In practice clinicians contracted to provide HEEADSSS assessments only also offered additional support such as first aid or general health support.

If ... the support worker comes in and asks if we can see someone because they've broken an arm they come and get you because you're the nurse on site ... Solely we are going in to do the year nine contract but it doesn't happen like that. (DHB informant)

Some kaimahi were supported with additional funding from providers to increase their FTE and offer this other support.

We do all of the extras: mental health referrals, sexual health issues and all general health needs so we go above and beyond what we're actually contracted to do ... We would spend at least two to three hours on an ideal day doing HEEADSSS assessments ... [Is that funding shortfall from offering a clinic covered by the provider on a voluntary basis?] Yeah. (Kaimahi)

Summary of findings

In practice many but not all of the clinicians working under contracts only requiring HEEADSSS assessments could operate like clinicians working under other contracts.

Many kaimahi and providers noted that while year nine is the youngest age covered by SBHS it was late to be completing a holistic health and wellbeing assessment. Rangatahi faced an increasing number of health and wellbeing issues at a young age and completing the assessment earlier could see rangatahi receive needed support earlier.

I think it needs to happen more in year seven and eight. By the time we've got to year nine we've actually got a lot of students out there who are really starting to use drugs, alcohol. Vaping is a huge, huge thing for us at the moment. I think we need to get on top of the anxiety. (Provider)

One DHB had decided to complete HEEADSSS with year ten students because they wanted to have built trust with rangatahi first.

It was going to be year nine health checks but public health nurses found that by doing the year ten health assessment they would tell more information about themselves and we were able to get more of out of them than the year nines. (Providers)

Another provider felt that year nine, being the first year of high school, was too transitional a time to be asking rangatahi about their wellbeing, especially when

HEEADSSS was completed early in the year. Year ten students were more settled into school and HEEADSSS was more reflective of their wellbeing.

What we've learned is that doing the assessment in year nine, particularly early on in the year, creates a range of issues with the data ... It skews it because young people are in a transition time. And then we're asking them health information while they're in the middle of a transition, which is often bumpy ... year 10 seems to be more effective. (Provider)

5.2.1. Benefits of completing HEEADSSS

Many kaimahi and providers saw whakawhanaungatanga as the principal or at least an important side-benefit of completing HEEADSSS.

HEEADSSS gave clinicians an opportunity to introduce themselves and show rangatahi they were welcoming, they cared and they were there to help. For many rangatahi, their year nine HEEADSSS assessment was the first time they met their SBHS clinician.

What I've found with doing some of the HEEADSSS assessments with the year nine students, I will let them know where I'm based and what I can support with. Then they can come back later. It might be year ten they come back; it might be year eleven but they are aware of where to get that support from this service when they require it. (Kaimahi)

The content of HEEADSSS presented clinicians with a way to engage rangatahi in a type of conversation many had never had. That could have a powerful bonding effect between the clinician and rangatahi.

In reality some of these questions these kids have never even been asked before and to show them that attention and give them that time and make that time about them and their health and their wellbeing can definitely increase that level of connectivity to health services. (Kaimahi)

I love doing the HEEADSSS. Other than the fact that we have to do it some of the tools within the HEEADSSS, some of those questions are quite cool because it gives that young person the chance to answer because they have never been asked those questions before. (Kaimahi)

The HEEADSSS content introduced rangatahi to holistic health care and the opportunities they can access to support their health and wellbeing needs.

[HEEADSSS] gives them an introduction to managing their own health needs. Because when they come for a HEEADSSS assessment it's quite holistic and you do ask them a lot of questions, hopefully in a user-friendly way ... I hope at the end of that assessment they go away feeling, 'Hey, that was cool, I could seek out my own health needs going forward'. (Kaimahi)

Some clinicians reported that completing HEEADSSS had led them to identify rangatahi needs that would not otherwise have come to their attention.

[HEEADSSS] is invaluable. The information that we can gather and the services that we can put in place for these young people is quite amazing. (Kaimahi)

Many clinicians worked with school staff to prioritise the year nine students as individuals or as members of a group of students sharing a common profile or characteristic. Other clinicians shared they had issues completing assessments if school staff were not supportive.

At the beginning of the year I get the year nine roll and I have a meeting with the deputy principals, the deans, counsellors and teachers giving me feedback on any students that they're seeing and would like to prioritise the HEEADSSS assessment ... If I do the more complex [ones] I can refer them on. Rather than leaving them until the last term they have a whole year [of support]. (Kaimahi)

Some kaimahi and providers reported reservations about HEEADSSS:

Point-in-time assessment: It is a point-in-time assessment but rangatahi wellbeing can change. As mentioned above, this may be due to year nine (beginning of secondary school) being a transitional period for rangatahi.

I can't tell you how many year nine assessments I did and everything we talked about and how great it was and they've been brought in again and it's a completely different person half a year later. (Provider)

Cultural fit: Some clinicians described adjusting HEEADSSS to be more culturally appropriate. One clinician added culture to the beginning of the HEEADSSS assessment to make it a CHEEADSSS assessment, while another developed a HEEADSSS assessment in te reo Māori.

Nutrition and BMI: It is a poor fit for some assessments such as the nutrition and BMI parts. Kaimahi highlighted the possibility BMI could misrepresent the health and wellbeing of rangatahi who were very athletic and that BMI could change because of the growth that rangatahi experience rather than changes in their health or nutrition.

Outdated vision and hearing tools: Equipping clinicians with appropriate training and equipment to use updated technology allows for better identification of rangatahi health and wellbeing issues.

I think there's a lot of things in this contract that says things like vision and hearing ... a registered nurse, unless she's done additional training, doesn't have that ability to screen ... and testing someone's hearing using a whisper test. That's the stuff that was around when I was trained in 1976 for goodness sake ... we do have proper equipment now that does that sort of stuff. (Provider)

5.2.2. Pressure of meeting HEEADSSS targets

The HEEADSSS targets were a source of workload pressure for many clinicians. They highlighted the pressure they felt to reach their assessment targets, which could reduce its effectiveness. Clinicians said completing the HEEADSSS assessment could be very time consuming when issues are identified. They explained that a basic assessment takes 30-60 minutes and could take significantly longer for rangatahi with high needs. Follow-up work like referrals to external support could add hours to assessments.

There is a massive amount of work [to get all HEEADSSS assessments completed] and because you have unpacked this stuff with the kid there is all of the referrals and follow ups that come out. (Kaimahi)

Inclusion of the HEEADSSS completion percentages in reporting drove clinicians to focus on completion rather than responding to identified needs.

That's one of the real weaknesses of the contract with the Ministry [of Health], that you are reporting on the percentage of students that have had year nine assessments. So when that's a big component of your reporting and you are not having to report on any other good quality outcomes you are focussed on delivering that, making sure that you get that 95%. (Provider)

They call [HEEADSSS] a psychosocial interview, built made for rapport building identification of strengths and resilience building whereas it tends to be used in a way that's not designed to do which is as a target metric, risk assessment thing. But it is not, it's meant to be incorporated in a positive youth development framework. (Kaimahi)

When clinicians offered HEEADSSS alongside other support they ran a continuous balancing act between meeting HEEADSSS targets and supporting rangatahi.

They are contracted to do other things as well and to provide a health service within the schools but the number one metric that they have to aim for is the HEEADSSS. So that often can end up being a conflict in their time availability, especially in schools that only have one school nurse. (Kaimahi)

In the end, it was like just don't do them [all HEEADSSS required]. Provide your care as well. The seniors are all getting pregnant because you're not doing contraception or whatever. (Kaimahi)

For some clinicians, struggling to meet targets resulted in rushed assessments at the end of the year. Others used the support of school staff or workers from other services, even students in one school, to pick up assessments they were unable to complete.

We have always got in our mind how we are going with the contracts and stuff. Checking up ... oh we're 48% now that's awesome. But really at the end of the day

making sure that our most vulnerable students are prioritised over the others is really the aim of the game. (Kaimahi)

Summary of findings

Kaimahi and providers were generally positive about the benefits of HEEADSSS in building rapport and identifying wellbeing issues for rangatahi. However the benefits of the assessment may be lost if clinicians do not have the time to respond to identified issues. More meaningful and outcomes focussed reporting may contribute to increasing the focus on responding to the assessments.

5.2.3. Impact of COVID-19

Some clinicians explained the COVID-19 pandemic meant they introduced a priority system for completing HEEADSSS assessments to ensure rangatahi who needed it most were getting it while schools were open and kaimahi were in schools. Clinicians identified priority students by talking with school staff.

So because of the pandemic we thought we were going to be struggling to get through a lot of our HEEADSSS so we prioritised ... we have asked principals who they've identified who is possibly struggling, not attending school, got things going on that they've got concerned about and we've done them as a priority as well. (Provider)

COVID-19 also reduced the number of schools days in the year available for completing assessments.

So we always used to hit 100% of completion of year nine HEEADSSS assessments. In the last few years we haven't been able to do that. So mostly because of measles and then COVID. (Kaimahi)

Some clinicians, particularly those working in public health, explained that COVID-19 had reduced the time they were available to schools because they had been called on to work on testing and vaccination.

It has been really challenging being able to do this service while we've got [the] pandemic going on because we're public health nurses. So I really, really strongly want to be able to continue on doing HEEADSSS and stuff but it's really, really challenging when we've got other things that we are doing which are really important but it's trying to do that juggling balance ... it's been at the detriment of some of our HEEADSSS clinics with some of the students. (Kaimahi – Public health nurse)

6. The SBHS workforce

6.1. Employment models

While DHBs were the most common employers by school, around half of the total FTE allocated to SBHS were employed by schools (Table 3).

Table 3. Employment models for SBHS workforce (Source: Interviews and DHB SBHS stocktake 2021)

Employer type	Number (%) of schools	Number (%) of SBHS FTE
DHBs: DHBs used the funding to employ and/or allocate public health nurses to clinician roles in schools. Clinicians can benefit from full-time employment by working across a combination of schools. DHBs allocate SBHS schools to public health nurses and supplement their SBHS hours by spreading them across multiple schools or allocating time to other public health nurse roles. DHBs also have access to additional resources and funding pools that enable them to better meet the needs of the workforce.	44%	12%
Primary/community health care services or PHOs: PHOs or primary/community health care services contracted clinicians to work in schools and, sometimes, nurse educators to support clinicians. The clinicians benefit from the support and infrastructure available from within a health care organisation like access to health IT, supervision and internal networks with other health care professionals.	29%	29%
Schools: Schools are funded directly by DHBs to employ a clinician. In this model, the clinician is dedicated to the school and the school controls who works within their school. This enables schools to select clinicians familiar with their community or with similar demographic profiles.	16%	51%
NGOs: Some DHBs contracted NGOs to employ some or all of the clinicians. Examples included YOSSs with other health contracts, kaupapa Māori organisations delivering social services and other health and social service providers. Using NGOs allowed DHBs to fill in gaps in their own coverage, whether they were geographic or related to the clinician expertise (for example contracting a kaupapa Māori NGO to deliver SBHS in kura because they had Māori clinicians fluent in te reo).	11%	8%

The model using schools as employers were concentrated in the larger centres (Auckland, Wellington and Christchurch). Figure 3 shows the distribution of different employer types by school based on the 2021 DHB SBHS stocktake.

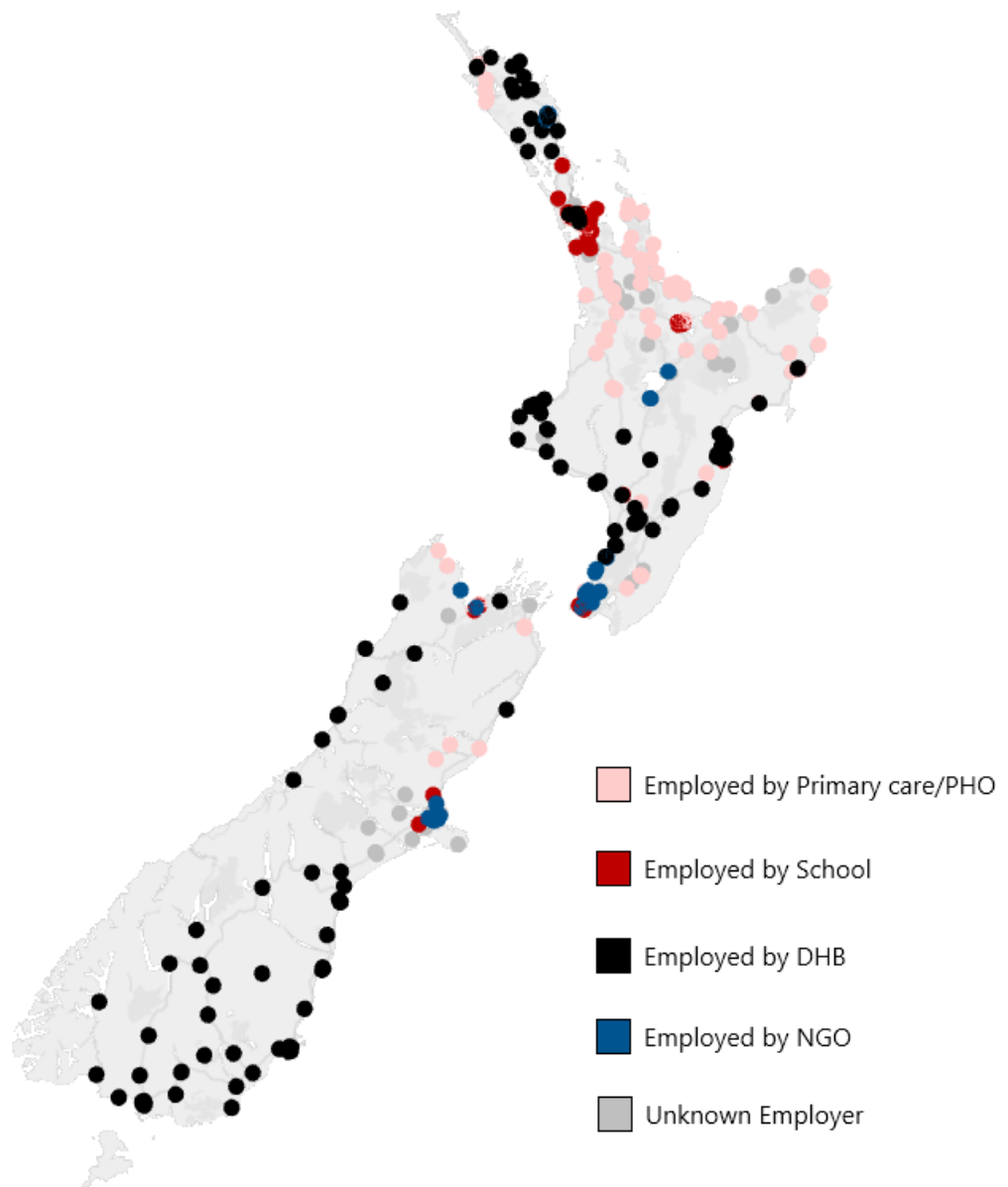


Figure 3. Employer types listed for each school (Source: DHB SBHS stocktake 2021)

6.2. Nurses are the core of the SBHS workforce

From the literature

School-based health services may be better served by nurses with postgraduate education and workforce opportunities that foster the development of a nurse

practitioner role which has increased the effectiveness of school-based health services²¹. Effectiveness is also influenced by adequate resourcing.

The backgrounds of clinicians were varied but most often they brought clinical expertise with nursing qualifications. The 2021 DHB SBHS stocktake found nurses made up the majority of the SBHS workforce. Almost all schools (84%) reported having a nurse (including registered nurses, public health nurses, nurse prescribers and nurse practitioners). Smaller proportions had access to GPs (10%) and mental health professionals (3%). Other roles described by kaimahi and providers included physiotherapists, paediatricians, kaiāwhina navigators/health care assistants and social workers.

Amongst nurses, two-thirds (67%) were registered nurses and just under one-third (30%) were public health nurses. Nurse prescribers (2%) and nurse practitioners (2%) made up a small proportion of the workforce reporting in the stocktake, though qualitative feedback suggested they were more common.

Not all nurses came into youth health after finishing their qualification. They often had backgrounds in other areas of health care including secondary care, emergency department nursing, midwifery, mental health and sexual and reproductive health.

Nurses identified many reasons for entering the SBHS workforce. Some had experience as youth workers or as parents, for others it was their passion for youth that brought them into SBHS.

I really enjoy working with young people ... I think there is a lot of value in working with them earlier on so they can achieve the best out of their lives. (Kaimahi)

²¹ Kool, B., Thomas, D., Moore, D., Anderson, A., Bennetts, P., Earp, K., . . . Treadwell, N. (2008). Innovation and effectiveness: changing the scope of school nurses in New Zealand secondary schools. *Australian and New Zealand Journal of Public Health*, 32(2), 177-180.

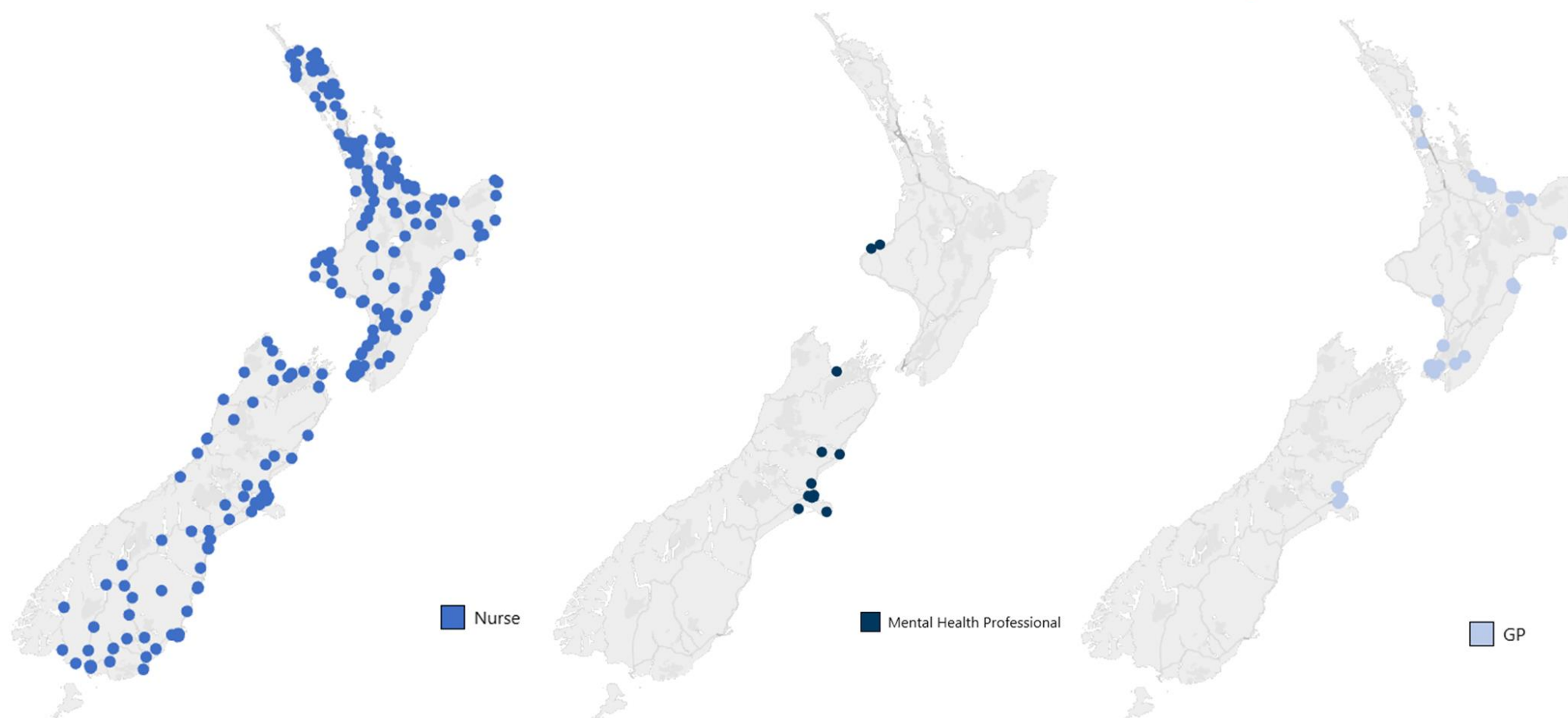


Figure 4. Distribution of schools with nurses, mental health professionals and GPs as their SBHS kaimahi (Source: DHB SBHS stocktake 2021)

6.3. Qualifications and experience

The Te Tatau Kitenga recommendations report emphasises that youth health is a specialist area requiring expertise in mental health, drug and alcohol, sexual health and adolescent development. Clinicians also need the skills to build relationships and rapport within the school settings in which they serve, as well as across the community to enable rangatahi to access external support services they require.

... the specialty area is really important. So you need a nurse [who] knows a lot about mental health, sexual health, drug and alcohol, adolescent development, family systems, community engagement. All those kinds of things are important. (Provider)

Other research has found that it was important to rangatahi that their clinician understood the issues young people experience and had the skills to communicate with them²².

Only a small number of the interviewed kaimahi identified youth health as an area where they had specific qualifications. Some DHBs had developed training about youth health for kaimahi but many had developed their expertise over the years working in SBHS.

There was broad agreement that the independence and isolation of the clinician role combined with the level and diversity of rangatahi needs meant the role was best suited to more experienced clinicians.

When we do recruit we have to fully train them because this service is quite unique. There's not the breadth and depth of youth-focussed or rangatahi-focussed nurses, child and youth health nurses ... Even if we get people that are in fields like mental health or practice nursing, their focus is not on rangatahi, it's on generalist populations ... So we have got a mountain to climb. (Provider)

Support from other health professionals such as doctors, nurse practitioners and mental health services helped fill the experience gap to some extent.

Well good thing is I've got lots of people to talk to. Depends what it is, if it's a mental health question I've got my counsellors who are awesome. If it's a cultural question I've got lots of people around me for that. If it's a sexual health question I can ring our doctors, they are always available. (Kaimahi - nurse)

²² Fleming. (2020). *Youth19 - Youth Voice Brief*. Youth19 Research Group. The University of Auckland and Victoria University of Wellington. <https://www.youth19.ac.nz/s/Youth19-Youth-Voice-Brief.pdf>; Peiris-John, R., Farrant, B., Fleming, T., Bavin, L., Archer, D., Crengle, S. & Clark, T. (2020). *Youth19 Rangatahi Smart Survey, Initial Findings: Access to Health Services*. Youth19 Research Group. The University of Auckland and Victoria University of Wellington. <https://www.youth19.ac.nz/s/Youth19-Access-to-Health-Services-Report.pdf>

In our lowest decile schools, we also have the nurse practitioner or general practitioner clinics. That's someone coming in once a week to see those more complex medical cases. (Provider)

The ability to form relationships and build trust with rangatahi was a critical part of the skillset, regardless of experience and expertise.

... I think it's more the trust and the mana people have ... that will get you through, rather than anything else. (Provider)

Trust and confidentiality are consistent themes in literature that asks rangatahi about what makes successful support services²³. Rangatahi shared that clinicians showing respect, listening to them, being non-judgemental and open-minded and keeping information private were key contributors to their ability to trust them.

Kaimahi and providers consistently identified the ability of clinicians to engage well with rangatahi as a key factor in whether SBHS was rangatahi-centred. For example, a clinician that takes a rangatahi-centred approach is:

Confident to communicate with rangatahi

It's preferred if they have worked in paediatrics or with young people but not a necessity. But they must be able to be youth-friendly and have that open, non-judgemental, warm, able to engage personality and communication skills. (Provider)

Trusted

The other part of what happens is once you have trust with these students and you provide them with what they need, they then often tell you an awful lot more. (Provider)

Non-judgemental

It's a non-judgmental space for them. They can come in here and see somebody and present their problems and they will get support within the guidelines. All the conventions [are] attached to it. Confidentiality and all that. And that, obviously, has better outcomes. (Kaimahi)

Respectful of the rights of rangatahi to privacy and confidentiality

I want to make sure they feel comfortable to come back so I just try and make it a really positive experience as much as I can. I know confidentiality is a really important part of that for young people so that is something I address right off the bat and just being guided by them and making sure it is positive. (Kaimahi)

Willing to advocate for rangatahi if their rights aren't met

It's not the only time that I've helped one of our students make a complaint against health care that they have received, whether it was breaching confidentiality by

²³ Ministry of Health. (2009). *Evaluation of Health Community Schools Initiative in AIMHI Schools*. <https://www.health.govt.nz/system/files/documents/publications/aimhi-08-10-09.pdf>

ringing their Nan or not giving them options, not letting them have their family there to support them. All those kinds of things that they should be doing better but unless we complain [it] doesn't happen. (Kaimahi)

Summary of findings

Experience and qualifications in youth health and a strong understanding of and commitment to diversity are essential for clinicians. DHBs may need national level assistance in developing recruitment criteria and training programmes and disseminating them to providers.

6.4. Workforce demographic profiles

The Te Tatau Kitenga recommendations report emphasised the need for clinicians to be representative of the population and reflect the community in which they are situated. Literature indicates that rangatahi prefer clinicians they feel they can relate to, with match in demographic factors such as age, gender and ethnicity and cultural capability being key contributors²⁴. The SBHS model poses a significant challenge for achieving a representative and relatable workforce. Many schools had one or less FTE, making it impractical to offer rangatahi a choice of clinician. At a regional level, the workforce could represent the diversity of the community but only schools with higher numbers of clinicians could do the same.

While the interviews completed for this phase of the evaluation provided an overview of the workforce, a workforce survey later in the evaluation period will provide a more comprehensive picture of clinician characteristics.

6.4.1. Gender

The NYC feedback report²⁵ emphasised the importance of rangatahi having a choice of gender so they feel comfortable to seek the help they need. Providers, kaimahi and school staff viewed gender representation across the workforce differently. Those with access to both male and female clinicians saw benefit in students being able to select who they were comfortable to engage with. Those with only one option noted many students were happy to engage with them, but some did note specific health needs that would be better supported by male or female clinicians. This has been consistently observed in the literature, with some rangatahi sharing

²⁴ Oranga Tamariki & Office of the Children's Commissioner. (2019). *What Makes A Good Life?* <https://www.occ.org.nz/assets/Uploads/What-makes-a-good-life-report-OCC-OT-2019-WEB2.pdf>

²⁵ School Based Health Services Enhancement Partnership National Youth Committee of School Based Health Services 2021 Report. Provided by Te Tatau Kitenga.

that they would prefer a choice of gender as some issues are easier to discuss with clinicians of the same sex²⁶. Similar to other demographic factors, limitations on the number of FTE available within each school could make it impossible to offer rangatahi a choice of clinician gender.

But all the girls go to [the male nurse]. I don't think they have any qualms about going to him at all because he's so gentle in his approach. He's a really good listener, he's really empathetic, he's not backward in coming forward. So I don't think it's a barrier at all, to be honest. (School staff)

... being a male nurse in a co-ed school I do know that there has been a couple of students who probably would have benefited more from seeing a female nurse and that's totally okay. I have been able to make that happen by getting a female nurse on board but that can just be a challenge perhaps in another setting if there is no other female nurse available ... (Kaimahi)

6.4.2. Ethnicity and cultural capability

A high proportion of those interviewed acknowledged the importance for clinicians to be connected to the rangatahi they worked with. For many this meant ensuring the workforce were locals who were accepted by the community and had a good understanding of the community. The NYC feedback report indicated this creates a safer environment for rangatahi from different cultures and support that better matches their needs.

So I've been basically born and bred here. I love this community ... I worked in the school I went to school in so I knew a lot of the teachers. So actually I was able to slot in really easy because I'm local. (Kaimahi)

It was also important for rangatahi to feel valued and understood culturally and spiritually by clinicians.

If you tell them about your values and beliefs they won't say anything that would disrespect that. (Rangatahi)

With less than one FTE allocated to each school, it was impossible for clinicians to represent the diversity within their school populations. This increased the importance of developing the cultural capability of clinicians so they could provide a safe space for all rangatahi regardless of background.

Providers incorporating these strategies acknowledged the need for services to be by Māori for Māori where possible.

²⁶ Ministry of Health. (2009). *Evaluation of Health Community Schools Initiative in AIMHI Schools*. <https://www.health.govt.nz/system/files/documents/publications/aimhi-08-10-09.pdf>; Oranga Tamariki & Office of the Children's Commissioner. (2019). *What Makes A Good Life?* <https://www.occ.org.nz/assets/Uploads/What-makes-a-good-life-report-OCC-OT-2019-WEB2.pdf>

When we look at recruitment we are mindful that we want Māori for Māori because our cultural split here is 50/50, roughly, and slightly more Māori than non-Māori young people ... So as far as recruitment is concerned we try to recruit Māori staff where possible and young Māori staff. (Provider)

Those interviewed highlighted the priority for Māori and/or te reo speakers to support students in kura. This had not been achieved in all DHBs and some kura and kaimahi described successful models of non-Māori clinicians working effectively in kura where they had invested in connecting with the kaupapa and building relationships with staff, whānau and rangatahi.

The contract wanted a Māori speaking nurse in the kura. [Name deleted] is fluent in te reo so she started off at a wharekura in [place name deleted]. (Provider)

Some of the kura would really like a Māori nurse and in [region name deleted] they're really hard to find ... And of those Māori nurses we struggle to find people who would like to work four hours per week because everybody needs to make a living. (Provider)

In focus groups rangatahi suggested clinicians incorporate key te reo phrases and greetings to begin using te reo in their practice.

If they wanted to they could use more te reo a little bit. Just like greeting themselves or something like that. (Rangatahi)

On the other hand, previous research completed for MoH indicated that by Pacific for Pacific was not a model some Pacific young people preferred²⁷. Some felt unable to fully trust Pacific clinicians as any connection to their wider network could result in “parents and other close relatives [...] being able to ‘quiz’ the health practitioner and press them for more information”²⁸.

Some providers, kaimahi and DHB informants identified cultural competency as a challenge in part due to the workforce profile.

6.4.3. Age

Age was not spoken about widely in our interviews, although research indicates that rangatahi tend to prefer younger clinicians who they feel better understand them and their needs²⁹. Some of those interviewed described potential benefits in younger clinicians who might relate more easily to rangatahi but others considered

²⁷ Ministry of Health. (2009). *Evaluation of Health Community Schools Initiative in AIMHI Schools*. <https://www.health.govt.nz/system/files/documents/publications/aimhi-08-10-09.pdf>

²⁸ Ibid, p.17.

²⁹ Oranga Tamariki & Office of the Children's Commissioner. (2019). *What Makes A Good Life?* <https://www.occ.org.nz/assets/Uploads/What-makes-a-good-life-report-OCC-OT-2019-WEB2.pdf>

older clinicians could bring a sense of parental caring. Participants who spoke about age often saw it more as an issue relating to employment. The part-time roles were often more suited to an older workforce, those with school children or pre-retirement who were looking for reduced working hours. While many noted their clinical expertise was adequate, lack of cultural expertise could be more of an issue for older clinicians.

Summary of findings

The evolving nature of the youth health sector is likely to benefit from a younger workforce and there is a need for a more ethnically and gender diverse workforce. Achieving the recommended workforce diversity requires sustainable employment options with meaningful career progression. The current lack of these is a barrier to diversity.

6.5. Recruitment challenges

The shortage and competing demand for Māori, Pacific and male clinicians was the major challenge in ensuring the right staff were available for the different school and community settings. Providers described a balancing act to ensure diversity across their workforce and the right skills (both clinical and cultural) so they could allocate the best clinicians to the different school and community settings.

... the specialty area of being a nurse in those settings [schools] is really important. Because you gotta know how to work within a community setting. You've got to know how to advocate, how to trust and how to pull back when needed. Let alone your advocacy for young people in terms of what better health care look like for them. (Provider)

Providers also described a lack of applications from the staff they wanted which they attributed to a variety of reasons:

The DHB ... [has] an inclusion policy but [Māori nurses] just don't apply and they don't really exist sometimes. (Provider)

Part-time roles: The way in which clinicians are employed may be a challenge for recruitment and retention. FTE allocation is based on the number of students enrolled in a school. This means not all schools qualify for a full-time clinician so clinicians can be allocated to more than one school or employed on a part-time basis. This is more often a challenge in remote, rural communities.

Clinicians may not be employed during school holidays: For clinicians with children this was seen as a benefit, however, for others this was a challenge. Many non-school employed clinicians were allocated to other areas of nursing to maintain their

full-time employment status. Some identified that school holidays provided a good time for training and development or to catch up on administrative tasks that were often neglected during the term when caring for students was the priority.

What we do see sometimes are nurses who are attracted to the school hours because they've got kids but their background sometimes is non-relatable to some of the schools that we go and provide nursing services to. Somebody terribly middle class wouldn't always be the greatest fit for some of the schools of lower decile schools that were going into. (Provider)

We don't get a lot of applications for school-based health services ... mostly that is due to not being paid in the school holidays ... I did have to explicitly say, 'This means you would get paid for 40 weeks a year. And then you would get your four weeks annual leave over Christmas. So you're eight weeks unpaid.' And a lot of people were like, 'Oh, can I pull my application?' So we went from about 15 to about four [applications]. (Kaimahi)

Remuneration is considered low: Some providers, kaimahi and DHB informants noted the level of pay has not kept up with the increasing skills needed.

... when the model was set up, so for us it was in 2002, the amount of money that was given per FTE was probably reasonable in that we didn't have a fully trained workforce ... And people weren't coming in necessarily very skilled in youth health. As we've progressed our nurses have become more and more skilled and we've asked for more skills for those nurses. I don't believe that the funding model has kept up. (DHB informant)

Pay is obviously a big factor. We pay reasonably well but I know some of the NGOs struggle to pay the same amount for the nurses. So pay rates and also opportunities to grow their practice is very important for retention. (Provider)

If you look at like the nursing pay contract for the DHB, ours [non-DHB] are meant to be aligned with it, except for some major issues. The first one is that, depending on the level of nurse that you are, which is 1,2,3,4, you get a higher pay rate. But our contract only pays up to level 3 for the school nurses, which is a below expert level. But actually the work that they're doing is above expert level ... Then you add in the annualized pay because they often don't get paid over this holiday period you end up squashing it down so that you have these people who need to be highly skilled need to have huge amounts of knowledge need to be able to operate autonomously, which is a high expectation, and then getting paid less per annum than a new nurse would. It's just not a good model. (Kaimahi)

Lack of career progression: This impacts on recruitment, retention and sustainability of SBHS and continuity of care within school environments. The Te Tatau Kitenga recommendations report speaks to a need to strengthen career pathways as part of the enhancements programme.

... there [are] no real opportunities for the few of us who are in school nursing to progress to that next step or the clinical educator role. Going forward that is something they would have to invest in to ... They are going to lose so many of us in

the next couple of years and they will not be replacing us with people who have the same passion or drive ... (Kaimahi)

The result of recruitment challenges is the appointment of people who do not have the necessary skills, cultural capability and experience. Some schools have such a great need for support that they are often willing to focus on filling the role rather than waiting for the right person for the role.

... sometimes there are positions that are advertised and there are very few suitable candidates that apply for those roles. And the school's teachers go, 'oh, we just want someone in the role', rather than going, 'we need the right person in the role', and so that has led [to] challenges for our team as well, in terms of clinical oversight. (DHB informant)

DHB informants and providers are finding innovative ways to try to bring more Māori and Pacific into the SBHS space to meet the needs of young people. This included specifically targeting recruitment strategies to attract Māori applicants or ensuring all Māori applicants were interviewed. These mechanisms need to be supported by clear career progressions and professional development support.

We couldn't find Māori and Pacific so we took on a health care assistant who happens to be Pacific and Māori and we are needing to look at how we pathway them differently. This is our first step into this space to do it differently. It is really difficult to recruit the right diverse staffing but we are doing what we can. It takes us 18 months to train a new graduate into all of public health nursing and youth health is more tricky because they need more in their tool kit to be able to respond appropriately. (DHB informant)

6.6. Professional development

Providers have faced challenges with recruiting clinicians with the qualifications and training to meet the needs of rangatahi. Workforce development is therefore important both to develop clinician skills and give them confidence to work to the top of their scope of practice and to provide career pathways which will contribute to retention.

I'm really aware that workforce development is one of the critical issues in terms of improvement ... It does require quite a high level of expertise to be able to walk into a school and to be able to autonomously operate as a health professional in an education environment. (DHB informant)

The other big gap of course is we have had to provide a lot of training once they are in the role. They might be really experienced primary care nurses, they have either come from a Māori health provider or primary care, from GP practices, but not specifically youth health. Occasionally we have got a highly skilled youth nurse that has come on board and that has been brilliant but that doesn't happen very often. (Provider)

Availability of youth health training was an area that providers and DHB informants felt needed strengthening. Some DHBs and providers had developed their own youth health training programme but this was not consistent across the country. With the timeframe to train clinicians taking up to 18 months there was a need to ensure retention was a focus for providers.

Some clinicians were, however, very positive about the support available to them in their roles. Having a team member in a coordination role with a focus on supporting the clinicians with management, supervision and professional development helped to connect clinicians with each other.

I feel really supported, more so in this role than other roles. With [the] DHB if I have ideas they are really supportive and provide the training necessary. Professional development is built in and the DHB is very supportive. (Kaimahi)

Nurses in rural communities, isolated communities or those without access to many other services highlighted the need for nurses to gain further qualifications to enable them to better meet the needs of their communities. Being a nurse prescriber was one of the examples given. Those who had this qualification found it helpful while those without access to a nurse prescriber spoke of that being a barrier.

There is this [nurse prescribing] course out there but the DHB has to apply to the nursing council to run a course and to support the nurses. So these community nurses are at a different level and it is not a post-graduate qualification. And I think if we had that, that would break down a lot of barriers for us for [the] provision of contraception and sexual health in the schools. (Provider)

Clinicians found it difficult to juggle the demands of their role with the need for ongoing training, development and supervision. Examples were provided where if clinicians attended professional development there was a reduction in service provision for that week. Having professional development opportunities online reduced the time commitment required and could make access easier, particularly for rural clinicians, but could lose some of the benefits around networking and connecting with peers.

I think we do definitely notice that [name deleted] must have been on PD last week. So she had three days off so we only had nurses in two days and you definitely notice when they are not here every day because that's when there's a massive backlog or things like that. (School staff)

There is lots of different training things we could do to upskill ourselves, perhaps to make the health assessments more comprehensive. But then again we only have so much time. It's finding that balance. (Kaimahi)

Clinicians employed by schools appeared to be more likely to face challenges in accessing paid time for professional development.

The other thing with the nurses being employed as support staff, often they have to fight to be allowed to go in on a teacher only day or to actually access PD that they require to keep up with their registration requirements. Schools sometimes don't have an understanding of those things as well. (Provider)

Summary of findings

Regional networks connecting clinicians with each other and resources for professional development through funding for courses or a nurse educator could reduce the risk of isolation while upskilling the SBHS workforce.

Examples

Some providers continued paying for clinician time over school holiday periods and dedicated it to professional development. Doing so also helped retain clinicians in roles by providing a continuing income over the holidays.

In one DHB with a combination of NGO, primary care and school employed clinicians, the DHB contracted an NGO to develop some of the professional development and support infrastructure kaimahi might have in place if they were all employed by a single organisation. This approach led to a consistent set of standards for all clinicians regardless of employer and helped share good practice around the region.

6.7. Supervision – clinical and cultural

From the literature³⁰

A number of benefits for nurses, midwives and their respective professions have been demonstrated through the implementation of high-quality supervision. These benefits include: improved worker retention; improved motivation and commitment to the organisation; maintenance of clinical skills and quality practice; improved communication among workers; increased job satisfaction; self-critique of clinical and cultural practice in a safe environment; development of strategies to address issues raised as part of critiquing and reflecting on practice; identification of strengths in nursing and midwifery practice; identification of

³⁰ New Zealand Nurses Organisation. (n.d.). NZNO Practice Fact Sheet: Supervision. https://www.nzno.org.nz/LinkClick.aspx?fileticket=d7lqZCfjC_M%3D&portalid=0

learning opportunities to enhance further development of nursing and midwifery practice; prevention of burnout; and nursing leadership development.

The College of Nurses Aotearoa NZ supports registered nurses to access professional supervision to enhance and support practice³¹. The Te Tatau Kitenga recommendation report acknowledged the critical role that supervision plays in SBHS and they have recommended that “supervision is made available and accessible to all professionals working in SBHS and aligned to best practice” as part of the enhancement programme.

Access to and support via supervision was applied differently across DHBs and providers. Notably, some DHB regions employed an individual (for example a nurse educator) or in some cases an organisation to provide supervision, clinical support and professional development. These roles could reduce the risk of isolation, create opportunities for sharing good practice and increase the consistency of SBHS.

[We] are contracted to provide one face-to-face, one-on-one professional supervision session per month for our school nurses. Once a month we do cluster groups so we bring all of the school nurses together for professional development opportunities, like strengthening their connections because they're often quite isolated but also giving opportunities for that group supervision, peer review, case review kind of studd to happen. We also facilitate ... portfolio stuff as well as facilitating connecting up to existing training options or setting up the training options, brining people in house to train our school nurses and occasionally I'll go out and do on site in clinic support around education training ... (Kaimahi – Nurse educator)

There was a mixed review from the current workforce as to the quality of supervision provision. Like professional development, having time to commit to supervision was an issue for some kaimahi. Some kaimahi also faced barriers within their DHB.

I guess that's something I would really like to see in the contracts with the Ministry of Health, that it is expected that supervision is provided to these nurses because this DHB has a very archaic policy in that the DHB only pays for supervision for those who require it for the registration. So people who work in mental health require it for the registration. Doctors require it, occupational therapists require it. That is about it. (Provider)

³¹ College of Nurses Aotearoa NZ. (n.d.) *Nursing Supervision Provided by Nurses for Nurses*. <https://www.nurse.org.nz/professional-nursing-supervisors.html>

6.8. Workloads

SBHS clinicians described managing increasing workloads. They were contracted to deliver in three areas:

HEEADSSS assessments: The HEEADSSS assessment takes up a significant proportion of nurses time particularly for those who are only in a school on a part-time basis. Youth health needs were becoming more complex and mental health was a large emerging area.

Physical health needs: Meeting the physical health needs of young people including referrals.

Health promotion: Health promotion was under-prioritised because there was minimal time left for this to be completed.

Clinicians and providers identified burnout as an area to be addressed across the workforce. They also noted evolving and complex increasing needs of young people.

... I know the ratio is one to 750. And that's ridiculous ... knowing that there is, from a nursing perspective, community prescribing, putting the rods in, we can add more and more to what the skill set of the nurse does. But actually there isn't capacity to do all that to be that one stop shop kind of thing. (Provider)

Clinicians were making trade-offs between supporting the health and wellbeing needs of the young people they supported with their own health and wellbeing needs. This was often caused by a lack of time or availability of staff cover more so than a lack of access to supervision.

I think that nurses are close to burnout. I think a lot of them are close to falling over at the moment. It's the biggest thing for me, we've got a lot of very stressed young people and very stressed and overwhelmed nurses as well. (DHB informant)

Because of the socioeconomic group of people that we work with and the high end that we deal with on a daily basis and having a nurse in a space for 25 hours a week, the day-to-day stuff from self-harm to suicide, abuse, sexual abuse, court cases, the whole rigmarole, it is physically and emotionally draining. (Provider)

Summary of findings

The SBHS role is demanding and requires experienced kaimahi with youth health qualifications. There are identified barriers to developing the diverse workforce needed to enhance SBHS including employment models, remuneration, career progression, workloads, supervision and support. Addressing the identified barriers and strengthening the workforce underpins the ability to improve outcomes for rangatahi.

Many stakeholders described clinicians working longer hours than SBHS funding resourced. Providers and clinicians themselves complemented the SBHS funded hours with their own resources. Different fundings streams has the potential to contribute to inequitable access to SBHS because different communities have different abilities to make up funding shortfalls.

7. Rangatahi-centred service

7.1. Overview of youth needs

Interviewed stakeholders across the country in all settings portrayed the range, complexity and depth of rangatahi need being addressed by SBHS.

You can have a student that's fallen over and you're putting a plaster on their knee and talking to them about home and bits and pieces and then you'll glance down at their arm and they might have been cutting and then you've moved off into a whole different thing. You really don't know what you're going to get. You could have the ambulance in your school half an hour from now. (Kaimahi)

Past work on SBHS has found rangatahi most often seek support for sexual health and contraception advice, treatment for injuries and general sickness and for mental health issues including anxiety or depression³². Providers and kaimahi identified those same issues as the most common within SBHS but also reported constant change in the detail underlying those needs.

You are playing catch up mode half the time because we're so far behind the youth. They've discovered something three weeks ago and we are only hearing about it now. That presents challenges and makes you learn and grow and develop as a person and then walk alongside them a bit to guide them around how that looks. (Kaimahi)

Table 4 uses the Te Whare Tapa Whā³³ framework to provide an overview of the issues kaimahi and other stakeholders identified as common for the rangatahi they support.

³² Buckley, S. et al. (2009). *Nursing Services in New Zealand Secondary Schools*. Ministry of Health.

³³ Ministry of Health. (2017). *Māori health models – Te Whare Tapa Whā*. <https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha>

Table 4. Rangatahi needs most often identified by SBHS kaimahi, rangatahi and other stakeholders (Source: All interviews)

Taha Wairua	Taha Tinana	Taha Hinengaro	Taha Whānau
<ul style="list-style-type: none"> The Pacific young people's focus group shared the importance of their spirituality for maintaining or restoring balance and harmony within their wellbeing. <p><i>It would be great if someone were to talk to me about the spiritual side, that's a deep thing for me. That's something that isn't bought up. Like have a youth pastor - scripture of the day etc. Hold fellowship sessions during the breaks etc. (Pacific young person)</i></p>	<ul style="list-style-type: none"> Sexual health including pregnancy tests, contraception, STI tests and treatment <p><i>[Students] love having the choice of contraception made available to them in school so that they don't have to try and get somewhere after school, particularly in those rural areas. (Provider)</i></p> <ul style="list-style-type: none"> Puberty education Rainbow rangatahi – sexual and gender identity and transitioning support and gender affirming care <p><i>[We need] nurses being educated on trans people such as just having a basic education in things like binding and binder safety. (Rainbow rangatahi)</i></p> <ul style="list-style-type: none"> Other physical health conditions including skin conditions, chronic conditions (asthma, diabetes, obesity), physical disabilities <p><i>[It is] not just normal overweight kids, we talk about BMI 40-50 [where] they really need some help otherwise they will have some health risk. (Kaimahi)</i></p> <ul style="list-style-type: none"> Developmental disabilities Physical activity and sleeping Vaping, smoking and other substances <p><i>Smoking cessation, vape cessation, we're seeing a lot of at the moment. (Kaimahi)</i></p>	<ul style="list-style-type: none"> Eating disorders Anxiety Depression <p><i>We have had parents who have just been told basically by the hospital just to ring the school counsellor because there is nothing else. (Kaimahi)</i></p> <ul style="list-style-type: none"> Panic attacks Behavioural support Suicidal ideation and self-harm <p><i>We had a [student] suicide this year and we've had quite a few students attempt suicide this year. (Kaimahi)</i></p> <ul style="list-style-type: none"> Coping with trauma and abuse - intergenerational <p><i>I think there's a huge percentage of students who have experienced considerable trauma, family trauma, sexual trauma, the trauma of moving from place to place, the trauma of multiple adults in their family life, the trauma of violence, the trauma of alcohol and drug use. (School staff)</i></p>	<ul style="list-style-type: none"> Support to manage the impact of complex home environments including family breakdowns, whānau in recovery Impacts of economic difficulty at home particularly in the wake of COVID-19 <p><i>Parents who are in rehab or you're second or third generation of unemployment. Second or third generation of parents who are [in]...rehab. (School stakeholder)</i></p> <p><i>Parents, whānau who are adamant and angry and it usually comes from a base of fear because something sure as hell is going on in that house, and they don't want the kid to say anything. (Provider)</i></p>

The rangatahi we interviewed were positive about SBHS. They said:

That the services were useful

I feel like there should just be more funding towards the services because they do help a lot and they are very useful when people get to know them. (Rangatahi)

They saw their clinicians as a gateway to the medical system

You come in with a health concern and then he'll usually point you in the right direction ... I think he's a good way to get into the medical system. (Rangatahi)

They were comfortable talking with their clinician about different aspects of their wellbeing

I think throughout time ... people are more used to talking to them and not just about your physical health but their mental health and stuff like that too. (Rangatahi)

Even during COVID-19 they could access some SBHS

We have a doctor here. She comes in every Thursday. With COVID, she cannot come in. She does [it] online. (Rangatahi)

How they felt treated by their clinician potentially influenced if they asked for help

Sometimes if you need to see her or get something she asks too many questions about it. Like if you needed a morning-after pill or something ... she won't give it to you unless you answer these certain questions about it and it just makes you feel more embarrassed about what you did. (Rangatahi)

7.2. Promoting SBHS

The NYC feedback report and interviews with kaimahi and rangatahi highlighted that raising awareness of SBHS was important to make it accessible. Approaches described in interviews included:

Engaging with school staff to build their understanding of SBHS and encouraging referrals.

Clearly communicating with rangatahi and whānau about SBHS – what is it, where it is, who it is for and how can they access it. Clinicians employed a range of communication tools. The most common was clinicians promoting SBHS during assemblies, at year nine orientation or when they visited each class and introduced themselves. School staff also promoted SBHS through referrals.

At the start of the year I go to the junior and senior assemblies and just give them sort of like a brief chat about what the services are, that everything's confidential. (Kaimahi)

Rangatahi have shared that this should not happen only once³⁴.

Communication with rangatahi and whānau should occur more frequently to remind them the support is available.

Visibility during break times supported an informal drop-in model. Some clinicians described 'roaming' the school grounds during lunch breaks or before and after school where rangatahi were able to access the nurse and casually ask health-related questions informally.

I walk around during lunchtime and that is where I get the males. They ask a question in passing. They don't really come to me [in my room] so I try and get out there at lunchtime once a week for an hour and walk around. I will see very different people when I walk around at lunchtime to what I see in a normal day. (Kaimahi)

When asked how support services could be improved, rangatahi shared the positives of clinicians being visible during break times, explaining that the casual setting encouraged those who may be put off by booking appointments³⁵.

Being part of the community.

When I went to [school name deleted] college I thought I really want to get involved in this community. For me that was turning up to some school events, to a rugby game or to the dance competition or whatever and supporting the school. That way you actually feel really connected and the kids feel connected to you as well and it is a great way of getting to know the other staff members as well. (Kaimahi)

The nurse is very well known. They are both very open and they both want to hear what's wrong or your worries or your health concerns. I definitely think if they are more known ... then they will have a lot more potential and I think people would be like, 'Oh, okay, these guys are great'. (Rangatahi)

Summary of findings

Raising awareness of SBHS is a step towards accessibility. MoH and MoE have a role to play in explaining and promoting the value of SBHS to schools and their communities.

³⁴ Oranga Tamariki & Office of the Children's Commissioner. (2019). *What Makes A Good Life?* <https://www.occ.org.nz/assets/Uploads/What-makes-a-good-life-report-OCC-OT-2019-WEB2.pdf>

³⁵ Fleming. (2020). *Youth19 - Youth Voice Brief*. Youth19 Research Group. The University of Auckland and Victoria University of Wellington. <https://www.youth19.ac.nz/s/Youth19-Youth-Voice-Brief.pdf>; Peiris-John, R., Farrant, B., Fleming, T., Bavin, L., Archer, D., Crengle, S. & Clark, T. (2020). *Youth19 Rangatahi Smart Survey, Initial Findings: Access to Health Services*. Youth19 Research Group. The University of Auckland and Victoria University of Wellington. <https://www.youth19.ac.nz/s/Youth19-Access-to-Health-Services-Report.pdf>

7.3. Rangatahi-centred care

Clinicians strived to deliver rangatahi-centred care to improve outcomes for young people and their whānau. Rangatahi-centred care acknowledges rangatahi are the experts in their own lives and needs and they can identify solutions that best fit their circumstances. Clinicians shared their intention for rangatahi to drive their own support, consistent with the Te Ūkaipō value of 'Rangatiratanga'.

So as a young person comes in, after a couple of minutes of conversation you can kind of understand a little bit more about that young person. And every young person is different. No one fits a certain mould. So it's been quite adaptive in the way that we engage with those young people and approach them. (Kaimahi)

Approaches to rangatahi-centred care focussed on rangatahi participation, meeting the needs of rangatahi, improving health literacy, workforce competency and whānau involvement.

7.3.1. Empowering rangatahi

Empowering rangatahi is key to delivering rangatahi-centred care. A key theme in our discussions was how clinicians adjusted support to suit rangatahi and their needs rather than imposing a set plan for all rangatahi.

[What I would like them to do] They don't just like say, 'Go to see a doctor' or something. They would break it down, I guess, like they just listen and see what you want to do. (Rangatahi)

They always ask if you are comfortable and they never tell you to say something. They ask you to say something and that always makes me feel like I'm in control of the conversation and that I'm not getting forced to say anything. (Rangatahi)

Some of the adapted support included:

Removing limits on the number of sessions to allow support to continue for as long as rangatahi need.

Working with whānau when rangatahi are comfortable for them to be involved or not including them when it is not something rangatahi want. This is discussed in further detail in the next section.

He doesn't judge you on your family or what's happened in the past. He just judges you on how he knows you and how you are connected with him. He likes to know about your past if that's what you need to talk about but he won't ever judge you on your family. (Rangatahi)

Giving rangatahi all appropriate information and options so they can make informed decisions about their care.

Consulting with rangatahi about any need for referrals to ensure they understand their options and are supportive of referrals. Many clinicians work with rangatahi to identify and remove barriers to accessing this support.

Many clinicians sought to empower rangatahi (and whānau) by incorporating health promotion activities into SBHS to improve health literacy. They hoped to enable rangatahi to be more knowledgeable about their health and to know where and how to access other health and social services. Some clinicians undertook health promotion themselves, some schools engaged external providers to deliver health promotion activities, and some clinicians *have no time to do any health promotion stuff*. (Provider)

Health promotion activities described included:

Educating rangatahi about how to look after their health for today and for the future. Sometimes this took place informally within SBHS. Other times this occurred formally within a classroom setting.

If we're giving them antibiotics it's about finishing the course [or] talking to them about antibiotic resistance, [explaining] why we're not giving them antibiotics. So it is lifelong education that they are going to take into their adulthood. (Kaimahi)

I have a good relationship with the teacher so they will ask if I can come in and support them with different learnings. (Kaimahi)

Informing rangatahi about external services and supporting them in building their skills and confidence in navigating the services themselves.

I find that if they're wanting to access an outside service, they'll say, 'Miss, can you ring them?' And I'll say 'Yep, okay, I'll ring the number'. And then I'll say, 'You have to talk to them now', and they're like 'Why?', and I say 'Because they're gonna ask you a whole lot of questions that I can't answer, like what's your phone number and stuff like that'. (Kaimahi)

[The nurses] show you connections to other services so you can be helped after you leave school. (Rangatahi)

Educating rangatahi about the health system, such as informed consent and their rights to information, privacy and confidentiality.

... my role is trying to educate them about how this health system is supposed to work for them. I start every consultation where I meet a new student, I explain to them who I am, what my role is. I explain to them the rights to have support, the rights to have options to be explained things in a way that they understand. I also tell them once you turn 16 you're considered an adult. You make all the decisions. (Kaimahi)

Conversations with rangatahi beyond the scope of their school's health curriculum content.

[The school health curriculum] is not enough, they want more. I had a chat to [the health teacher] last time we were here, and I said, 'Look, you have to probably stick to your curriculum within your school boundaries, but I can talk about anything'. [They were] like, 'Oh, that's great'. (Kaimahi)

Advocating for young people within school.

One of the other things we had a bit of a push around because in the technology [there were a lot of] injuries. We went to the principal, we said, 'We are seeing a lot of injuries, why?' It turned out that the classes were actually too big. They have now got teacher aid support in there. (Kaimahi)

7.3.2. Involving whānau in decision making

Whānau involvement provided clinicians with a better insight into rangatahi lives and supported a holistic approach to wellness through educating the wider whānau on health-related issues and needs. While many clinicians involve whānau to the extent rangatahi agree to it and their time enables them to, SBHS is focussed on supporting rangatahi rather than supporting their whānau and their general health needs.

Often if you're working with one member, the rangatahi, they've usually got a little brother or little sister that probably needs some services as well. So how do we make our approach more whānau centred rather than focussing just on rangatahi? (Kaimahi)

You can't just educate that child in front of you. You need to be able to educate the wider whānau. Because ultimately, whānau are responsible for whānau. (Kaimahi)

[Whānau involvement] is invaluable as it provides an opportunity to assess the students' lived experience as well as increasing a coordinated approach to care through increased whānau centred, improved health literacy. (Kaimahi)

Many kaimahi and providers acknowledged the role of whānau in ensuring rangatahi care plans were managed, medication was administered and informed decisions were made. Kaimahi, providers, rangatahi and school staff discussed the role of whānau in the following circumstances:

Clinicians built relationships with whānau of rangatahi with diabetes to ensure the right care plans were in place for rangatahi and whānau.

We have to build up a rapport with the parents [of diabetic students] ... We do connect with [name deleted] diabetic centre so that they can be aware of what we experienced. And it's a really good relationship once we've established that and work together for care plans for our students. (Kaimahi)

Whānau worked alongside clinicians and specialist staff to support rangatahi with medication.

... we have a few students with ADHD and also with poor adherence of medication. So we have to work with paediatricians, parents just to make sure we're all on the same page helping students. (Kaimahi)

Whānau involvement was crucial when rangatahi were unable to make informed decisions. Whānau were informed about services and supported rangatahi who were unable to verbalise consent.

We have relationships with whānau ... especially for special alternative education ... so they know what is happening with their child because sometimes the students can't verbalise themselves. (Provider)

Clinicians acted as a bridge between whānau and rangatahi when rangatahi felt unable to communicate about their health and wellbeing with whānau.

Personally I would talk to the nurse if I wanted my mum to know and I didn't want to say myself. Stuff that I don't feel comfortable telling my mum I would like him to say something. I feel like its better coming from the nurses. (Rangatahi)

Clinicians worked with whānau and vulnerable students. Clinicians noted it was particularly valuable to have whānau involved when external services were needed to ensure whānau could support rangatahi to go to the services.

With his most vulnerable students that see him, [he] definitely [works with the whānau]. I think he's got a really good relationship with them and often he will meet with them, contact them regularly ... In terms of accessing outside services ... he can go directly to them and explain why [the student needs the service]. (School staff)

Though many kaimahi and providers emphasised the importance and value of whānau input they discussed the importance of still centring care on rangatahi and the challenges that arose with whānau in some circumstances:

And [I] only get parents involved if we've got the buy-in from the student and if we really need to get that buy-in. Otherwise it's all kept private and confidential. (Kaimahi)

Some kaimahi and providers noted the tension around whānau involvement when the main contributing factor to rangatahi unwellness stemmed from the home environment.

When it's serious cases we contact parents for mental health issues. That is required and it's good to have the whānau on board as well. But sometimes the whānau are part of the cause and it makes it really hard for the young person so it's about working with them. (Kaimahi)

Parents, whānau who are adamant and angry. It usually comes from a base of fear because something sure as hell is going on in that house and they don't want the kid to say anything. (Provider)

Unless it's needed it can be good to not ask about your family. Just focus on the problem they have in front of them. (Rangatahi)

Parental consent for mental health support is required for rangatahi younger than 16. Some kaimahi and providers felt this process negatively impacted rangatahi care, especially when rangatahi did not want to disclose the magnitude of self-harm and mental illness.

I might have a young 14-year-old girl come that's really suicidal or she's a chronic self-harmer and really depressed but doesn't want her parents to know ... A lot of students refuse [asking for parental consent] because they don't want their parents knowing. (Kaimahi)

7.4. Equity and non-discrimination

SBHS has a clear mandate to reduce inequities by ensuring groups that are less visible, socially marginalised, stigmatised or do not have advocates have equitable quality of and access to health services they need. This is captured in the Te Ūkaipō value ‘Ōritetanga’.

In their feedback report, the NYC highlighted the importance of SBHS being a service that is not ‘one size fits all’. While clinicians said they tailored support for each rangatahi many also shared how they adapted their care to match specific groups of rangatahi to ensure they felt comfortable and safe within SBHS:

Māori and Pacific students: Many kaimahi and providers acknowledged they could do more to offer culturally appropriate care for Māori and Pacific students. Examples included: having resources available in Māori and Pacific languages, working with school staff who are fluent in te reo Māori or a Pacific language to connect with or represent whānau, utilising cultural diversity within multi-disciplinary teams to ensure care is culturally appropriate, connecting with Māori and Pacific providers and offering whānau-centric care.

Culturally there are different approaches. Not just like Pacific, Māori or Fijian Indian kids but even Tongan, Samoan there are differences. One of the reasons we do our case management meeting weekly is because we have everybody across all ethnicities and we can make sure we are on the right track if we're dealing with somebody. (Kaimahi)

We also have Māori and Pacific providers who provide support as well. I've heard of an example where nobody knew what to do with this young person and they went to [the Māori health provider] and got support as somewhere to go. [The provider] made the student feel connected, supported and cared for them during difficult times. (DHB informant)

For some clinicians this also means understanding the role of cultural medicine in supporting rangatahi, combining both cultural and western practices to support rangatahi.

A lot of Pasifika students do a lot of non-western medicine so a lot of plants on their boils. It's trying to get alongside them, asking if they've found it to be helpful, does it take away any pain, does it feel better or worse. And getting them to be like, it has been a week now and it hasn't really helped, and so I would introduce other ways. I'm trying to utilise a bit of western with a bit of a naturopathic, homoeopathic vibe. (Kaimahi)

There's the odd kawakawa coming into play. And I'm still supportive of that. But my kōrero or whakaaro around that with our nana's and papa's is it's past that now, they need to have a medicine to clean it out. And then when it's no longer like that then you can go back to using the kawakawa. (Kaimahi)

One kaimahi noted that this enabled them to build rapport with whānau, increasing compliance and leading to better health outcomes for rangatahi.

It's the same with whānau Pasifika. Some, they drink a whole lot of leaves which is all mashed up, grinded up and then they drink that when they have sore puku and stuff. I'm not 100% sure on what that is. But then I'll go to the senior teacher and say, 'Hey, this kid told me this, what is it?' And then I do my research and then go back to the whānau with the support of the teacher to be able to give the whakaaro on why we need to take it to the next level without disrespecting the values and beliefs. Just by being able to do that helps the rapport with the whānau and the compliance. (Kaimahi)

Summary of findings

Part-time roles and recruitment challenges meant that supporting rangatahi Māori and Pacific young people with Māori and Pacific kaimahi is often not feasible. This highlights the need for cultural capability training for all kaimahi. Although this is not a MoH role, service specifications could define requirements and specify training needs.

Rainbow rangatahi: Rainbow rangatahi have shared that acceptance and greater awareness of issues specific to their community are important in creating a safe space that they felt able to relate to³⁶. Using pronouns, promoting acceptance and lack of judgement, highlighting confidentiality and privacy and connecting with rainbow friendly services is how most clinicians created rainbow friendly services. In some cases, clinicians initiated conversations with whānau about support. In other cases not involving whānau created a rainbow friendly space for rangatahi.

We offer rainbow friendly support, maintaining confidentiality and have initiated some conversations amongst whānau in regard to support going forward. We also connect them to our YOSS or to rainbow friendly GPs who are able to provide gender affirming care, including puberty blockers and hormone replacement therapy. (Kaimahi)

One of our nurses is very relational with the rainbow community because her child is transgender so she has been really helpful in three scenarios where whānau have struggled with surgery and change and identity of their child. (Provider)

Some clinicians set up rainbow youth groups. Others advocated within the school for the needs of rainbow rangatahi.

I've set up a rainbow youth group now and we meet every fortnight which they've never had. And we're pushing for a gender-neutral toilet and just lots of things like that. It's just all about creating that positive change where it's never been. It's always been pushed under the carpet or you never talk about things out loud. (Kaimahi)

³⁶ Oranga Tamariki & Office of the Children's Commissioner. (2019). *What Makes A Good Life?* <https://www.occ.org.nz/assets/Uploads/What-makes-a-good-life-report-OCC-OT-2019-WEB2.pdf>

Refugee students: For many refugee students accessing health care and talking with clinicians about their health and wellbeing can be difficult and takes more effort. One clinician tailored her support to be more respectful to acknowledge this effort and language and cultural differences.

My main variation would be with refugee students. My humour is not for everyone and with my refugee students I am very aware of what I'm saying and how I'm saying it. I'm a lot more professional so not as joking and conversive as such. Just being really respectful that for them to come and see someone and talk about stuff is a huge deal for them. (Kaimahi)

Different ages: Many clinicians described adjusting how they spoke to younger rangatahi compared with older students to make their support more accessible for rangatahi.

I may change my lingo a little bit from a younger person to an older person, but not by much, and that's just out of making things nice and easy for everybody to understand not because there's any need to. (Kaimahi)

Being accessible to students via text, email or social media worked better for older students who were more able to understand written communication.

The older kids can understand really well via text but some of the younger ones might get confused so I find it better to do it in person with them. But it's definitely a reliable way to work with the older ones. (Kaimahi)

Disabled rangatahi: Many clinicians discussed relationships with learning support units within schools to facilitate equitable access to care for disabled rangatahi. For some clinicians these relationships were based on their involvement in pastoral care teams and discussions within those teams about at-risk students. For others the relationships were based on referrals from learning support or clinicians completing health promotion within the learning support area. Rangatahi in learning support units were also often a priority for HEEADSSS assessments.

I have good relationships with learning support. If they have somebody that they're working really closely with and they disclose something they will bring the student over if it's all good and we talk about confidentiality and then we go down [a care pathway]. (Kaimahi)

Rangatahi in care: In most cases rangatahi in care were identified as at-risk students by school staff and clinicians. This generally made them a priority for a HEEADSSS assessment, allowing them to receive support within the school as early as possible.

Summary of findings

Specific training, technical assistance and advocacy is needed to enable further support for different rangatahi groups.

7.5. Giving rangatahi choice in how they want to engage

Clinicians wanted to make the process seamless, easy, accessible and suitable for rangatahi. Many kaimahi and providers noted it was important to have a variety of options for accessing SBHS that were appropriate for rangatahi with different preferences.

DHB informants, providers and kaimahi noted the use of both drop-in and booking approaches. Some clinicians prioritised a drop-in clinic based on school needs while others concentrated on appointment bookings.

[Rangatahi have] multiple points of communication so they can email appointments or text an appointment or just drop in which is good. Or they can do it via a teacher or via a parent. Accessibility is easy. (Kaimahi)

Some clinicians noted the usefulness of a multiple access approach and being able to pivot between the two approaches.

I try to have an open-door policy as much as I can while also having appointments for the ones who need them. If something is going on they can knock on my door and I will say come back in an hour or come back at this time or if it's urgent I will see them then. (Kaimahi)

7.5.1. A structured appointment booking system

From the literature

Research has shown that young people described the ease of making appointments and ability to schedule their own appointments as one of the main reasons they sought health services at a school-based health service instead of at their general practice³⁷.

An appointment booking system encouraged structured access, arrival and use of time. Some clinicians noted the use of a receptionist who supported the booking system. Some clinicians utilised a 'school runner' who presented a wellbeing slip to

³⁷ Daley, A. M., Polifroni, E. C., & Sadler, L. (2020). "Here I Don't Feel Like a Stranger": Adolescents' Perspectives on School-Based Health Centers. *The Journal of School Nursing*, 1-10. doi:<https://doi.org/10.1177/1059840520979661>

the teacher for student release. However some clinicians raised concerns around confidentiality and student privacy using a school runner.

Some clinicians and providers described the use of technology and provided text booking appointments for rangatahi to access SBHS to avoid some of the privacy issues of other approaches.

I think that's how the youth work. They want it now they want it here. That's how it is so that's why we moved to that text to book because that's how they work.
(Provider)

Many clinicians and providers highlighted the benefits of structured appointments particularly for following up on immunisations, sexual health and any existing cases. Some school staff and clinicians also noted the booking system minimised the risk of students wandering during class time.

... there is a system where we send out appointments to students. They might be due for their next injection, they're booked appointments. (Kaimahi)

... we do schedule our work so we make our own appointments to recall students as well. (Kaimahi)

One rangatahi described the simplicity of appointments and reduction of waiting time based on allocated appointment slots.

When I saw the nurse I booked an appointment because we are supposed to and also it, I think, helps so you're not sitting there and waiting around. You can go off and do everything else ... I find making an appointment much easier because you can take a spot. (Rangatahi)

7.5.2. Drop-in models

An informal drop-in model supported accessibility in a way that better suited some rangatahi. Drop-in clinics enabled rangatahi to see a clinician when they wanted and removed the structured appointment approach which did not work for all rangatahi.

Because we've got nurses in the schools they've set up in clinics ... kids are just dropping in when they need ... for a variety of things, none of which we were contracted to do. But because of the need we will provide that service because the kids are motivated to come and visit and it takes a lot for these kids to come to a nurse, to come to a professional to seek some assistance in whatever they need.
(Provider)

Young people have to be able to fall through the door ... you have to make it really easy for them. (Kaimahi)

I'm just an open space so they can drop in at any point. If I'm not here on the other days they go see the admin team and leave a note for me and then I'll go and find them ... (Kaimahi)

However a drop-in clinic requires a designated confidential area and waiting room for rangatahi. Clinicians also noted the importance of school staff buy-in and support of SBHS for the drop-in model to be successful.

7.6. Physical space

From the literature

Common challenges working in the school setting include lack of access to a clinical area reducing the confidentiality of the services³⁸ and human resource difficulties such as high staff workload and lack of professional development³⁹.

Confidentiality is one of the key concerns for rangatahi accessing health care⁴⁰, therefore best practice for SBHS includes a private, confidential and comfortable physical space⁴¹. This was supported by rangatahi, kaimahi and DHB informants interviewed, along with Te Tatau Kitenga and the NYC.

... we had a year 10 student come and see me because they thought they had an STI and they couldn't go to the clinic because aunty was there and would have told mum about it. (DHB informant)

I have a good space at my school ... we have a small waiting area which is vital, I have a toilet which is really great because at other schools we have to send girls with swabs down their tops and pockets to run down hallways to take tests. Ideally if we can have privacy, room for a bed and a room with a curtain around a bed our own toilet, running water ... (Kaimahi)

The physical location and layout of SBHS is also important in creating an environment that fosters positive experiences and engagement for rangatahi. In the 2021 MoH stocktake of SBHS physical spaces⁴², 87% shared they had adequate physical space to deliver SBHS. The remaining 13% did not have adequate physical space, were in the process of setting up a physical space or did not provide a response.

³⁸ Buckley, S. et al. (2009). *Nursing Services in New Zealand Secondary Schools*. Ministry of Health.

³⁹ Baltag, V. P. (2015). Global Overview of School Health Services: Data from 102 Countries. *Health Behaviour & Policy Review*, 2(4), 268-283.

⁴⁰ Daley, A. M., Polifroni, E. C., & Sadler, L. S. (2019). The Essential Elements of Adolescent-friendly Care in School-Based Health Centers: A Mixed Methods Study of the Perspectives of Nurse Practitioners and Adolescents. *Journal of Pediatric Nursing* vol. 47.

⁴¹ Committee on School Health. (2004). School-Based Mental Health Services. *Pediatrics* Vol. 113(6).

⁴² MoH stocktake of SBHS physical spaces 2021. Unpublished – provided by the Ministry of Health.

Of those with adequate physical space, 34% had a clinic facility, 53% had a space they shared with others and 13% had some other facility. Adequate physical spaces looked like:

A pre-existing health and wellbeing hub

Rooms spread across multiple locations (including SBHS located in a different part of the school to guidance counsellor, social worker, etc.)

An old room (i.e., classroom, dental clinic)

Sports courts

Space in a YOSS

Available rooms/spaces close to the staff room or main school office

Hot-desking (i.e., using guidance counsellor's office when they were on lunch break).

The most positive feedback was about wellbeing hubs. In a hub the health and wellbeing professionals are in one location and there is a clear first point of contact (receptionist) with a large waiting area for rangatahi. This was the preferred physical space for SBHS in the NYC feedback report, as wellbeing or student hubs create a private space for rangatahi to seek health, wellbeing and school support. This removes the stigma around being seen by other students as going to see the nurse, is a private space and it becomes a familiar space for rangatahi.

Many schools did not have a space available that could be dedicated to wellbeing.

We have a cool set up at student services. We have a big room that they come into where the receptionist is. Off the room are all of our rooms. The nurses are close together, opposite me is the guidance counsellor, the social worker, the doctors, physio and external agencies can use. The community liaison officer is nearby and there are a couple of other rooms. (Kaimahi)

Clinicians and rangatahi from a small number of schools mentioned that their wellbeing hubs became a place where rangatahi *hang out* as it was socialised around the school and over the years became a place where all rangatahi could access the water cooler, free food and sanitary products.

Some schools and clinicians created spaces for rangatahi to feel comfortable in by having couches, beanbags, games and resources that embraced the diversity and reflected trends.

... often we don't have any control about our environment. But if you have a cool space for young people ... what they think is cool ... I put a couch in there, I brought in a stereo ... [they come in and jam] in my two-seater couch. Things like that make a big difference. (Kaimahi)

These rooms reflect who we are. They have karakia [representing Māori] on the walls and fine mats [for Pacific]. We have a family room here and a kitchen. We can just come and hangout. (Rangatahi)

While some kaimahi and providers were positive about the type of physical spaces available for SBHS, some clinicians were working in spaces which were not readily available in all schools. Challenges across the motu included:

The lack of space to deliver services and engage with rangatahi: Some kaimahi, providers and DHB informants noted that the lack of dedicated space had been a *real challenge* for schools and clinicians. Some schools did not have the space/resource and a small number of school staff noted that schools were expected to provide appropriate, well-resourced spaces for SBHS without additional funding or support.

Everyone is scrambling to find enough room for the services that they provide in schools. Unless they prioritise a space for us and value our services that could become a barrier to us being able to deliver the services in the school setting, which is the ideal setting for the student. (Provider)

... they're working out of shoe boxes. One of our nurses ... works out of the squash courts upstairs at the school. Just wherever we can jam them in. So even that hasn't been looked at in the big scheme of things. (Provider)

An additional challenge for some clinicians was the spread of the health services/team across multiple, disjointed buildings. This made it difficult for the ease of flow for rangatahi to access other health and wellbeing professionals.

It's very hard working out of three different buildings which are not connected. You've got an umbrella because it rains a lot ... when you're running between buildings ... we don't see each other all day unless we have an emergency then we both go and support each other. (Kaimahi)

Inadequate access to infrastructure and resources: Some clinicians described having access to a sink, running water, sufficient storage and/or lockable cabinets for medication. However, more commonly, clinicians described working within small, confined spaces that were outdated without temperature regulation and beds.

We've got students who have anxiety and we're put into spaces where there are no open windows, very closed little boxes, extremely hot or very cold. We've got to make use of what we've got ... [The space is] absolutely not [youth-friendly], so you know why they're not coming to see you. (Kaimahi)

It's kind of like a cupboard ... I've got a toilet, which I needed, but it's not that confidential ... you've got this waiting room. And to the right of that is my office and that's it. Just a space with a couple of chairs, there's no bed or anything. (Kaimahi)

Lack of privacy: The lack of privacy was a profound concern for many kaimahi, providers and DHB informants. Interviewed rangatahi noted this as a barrier to engaging in SBHS. Some schools were furnished with areas that were *soundproof* and *confidential* such as offices, breakout rooms and bathrooms that allowed clinicians to interact with rangatahi.

Our students can come in from the waiting room into a room through a door and then they go left or right into the nurse or doctor or they can go from one to the

other without anyone in the waiting room seeing them. They can go into the bathroom where they do all their own STI screening, pregnancy tests. (Kaimahi)

My girls who are doing a pregnancy test or having a swab, they have to throw everything under their jacket to come back into my office ... And that can put girls off. That can stop them coming to me. (Kaimahi)

In some schools, they *removed the doors* from the rooms to maximise the use of small spaces which in turn compromised the privacy or information shared between clinician and rangatahi.

We are delivering a health service generally in an environment that is not set up to deliver health care services. We make the best of it but we often trade off a waiting room or privacy. So generally we don't get a purpose-built facility and sometimes we don't even get a perspective when facilities are being built. (Provider)

Summary of findings

The space SBHS is delivered in affects accessibility for rangatahi and the quality of care able to be offered. Better spaces are needed in many schools for SBHS to realise the potential it has to offer rangatahi. MoH and MoE could provide guidance to DHBs and schools about the physical space requirements to enhance rangatahi access to SBHS.

7.7. Clinician availability

From the literature

One school-based health services characteristic linked to positive mental health outcomes is increased nurse and GP time in schools⁴³. School-based health services are associated with fewer pregnancies among students but only when the availability of staff nursing time exceeded 10 hours per 100 students per week⁴⁴. A possible explanation for this is that higher nursing and GP hours allow for more comprehensive care without the pressure of time limitations⁴⁵.

Clinician time is an important aspect of accessibility for rangatahi in two ways: being accessible for a higher proportion of school hours and having more time to spend

⁴³ Denny, S., Howie, H., Grant, S., Galbreath, R., Utter, J., Fleming, T., & Clark, T. (2018). Characteristics of school-based health services associated with students' mental health. *Journal of Health Services Research & Policy*, 23(1), 7-14.

⁴⁴ Denny, S., Farrant, B., Cosgriff, J., Hart, M., Cameron, T., Johnson, R., . . . Robinson, E. (2012). Access to Private and Confidential Health Care Among Secondary School Students in New Zealand. *Journal of Adolescent Health*, 285-291.

⁴⁵ Ibid.

with each rangatahi. Aspects of accessibility discussed above (for example, empowering rangatahi and involving whānau) take time. Clinicians need sufficient time available to support rangatahi to lead their care.

All DHB informants, providers and kaimahi said they would like to see the services delivered under SBHS extend their hours of availability to better meet the needs of rangatahi. The current time available within schools was not sufficient to meet student demand.

I think the shame for us is that we can't have a nurse in the school at all times because what happens on a Monday may not happen on a Tuesday or a Wednesday or Thursday. So if we're only there four hours, twice a week, then we're not capturing what's happening for the kids if there's a need on the other days as well. (Provider)

The days and hours that clinicians were available varied greatly across the motu but the vast majority were only available within school hours. Where schools received a small fraction of an FTE it was impossible for SBHS to be available across all school hours. Larger schools, who were also more likely to employ clinicians, were more likely to have full FTE or multiple FTE and so could have SBHS coverage for their school hours.

Generally when SBHS was available throughout the day and week, i.e., Monday to Friday, 8am-4pm, the school directly employed clinicians. By contrast when SBHS was only available during some school days or hours often clinicians were DHB, PHO/primary care or NGO employed.

[SBHS has] mostly part-time hours [in] each school, depending on the size of the school ... some nurses might cover more than one school. (DHB informant)

Rangatahi health needs were not limited to school hours. As identified by Te Tatau Kitenga, ideally the SBHS model would extend to cover after school, weekends, school holidays and lockdowns. This was a recommendation that was widely supported by those interviewed.

My big dream would be to see some youth health hubs that operate out of high schools in the school holidays. So those young people can still access services (Provider)

Some of the ways clinicians had sought to align their times of availability with rangatahi needs included:

Being available on school days but outside non-teaching hours

I do the eight hours so kids can drop in to see me before school starts for some of the ones who don't want to miss classes and I also offer an after school clinic and break time clinics. (Kaimahi)

Being available outside of their usual (contracted) hours

Sometimes we [are] called in not on the day of work that we're there because there's a need for a young person ... But because funding is so limited you can only choose

one day of the week to be there. So we do go over our allocation to be able to meet the needs of those young people. (Provider)

Embracing telehealth, particularly during COVID-19 lockdowns

[The clinicians] implemented a text service during COVID. So they have a cell phone available for a public health nurse. And while the kids were in lockdown they could text that number and know that they could access health services that way ... And I know that they would really like to explore telehealth further. (DHB informant)

Summary of findings

Schools allocated less FTE than required to be available for school hours each day of the week did not always have a clinician available when rangatahi needed support. Resourcing should consider how much time the clinician should be present in the school as well as the time needed to provide support.

8. Connections with other staff and services

Clinicians take a holistic focus but need to work with others to provide support for the breadth and/or complexity and/or severity of issues they might identify for rangatahi. Limitations on time and the impossibility of having expertise in all areas rangatahi might have a need for support necessitate a multi-disciplinary approach that extends beyond SBHS into the community.

Clinicians, who are considered autonomous in their roles within schools, highlighted the important of developing strong relationships within the school as well as identifying and forming relationships with other services that support youth health and development across the school community. The collaboration across services has the potential to reduce the gaps that young people fall through and improve service delivery through sharing knowledge.

One of the reasons we do our case management meeting weekly is because we have everybody across all ethnicities and we can make sure we are on the right track if we're dealing with somebody. I guess we have slightly different approaches but in the end we are providing health care which is pretty similar, probably. (Kaimahi)

8.1. Wellbeing in education settings

Wellbeing in schools is an increasingly important part of MoE's work with schools. SBHS supports the intent and delivery of wellbeing in school settings by offering health services within decile one to five secondary schools.

8.1.1. Connections with school staff

School staff felt a sense of relief knowing that clinicians would be at school on a designated day or a text and phone call away should they need health support.

They have a clear skill set that [school] staff don't possess. It's so reassuring that I know every Tuesday I have a registered nurse who is coming in to do the heavy lifting of the wants and needs of our young people that otherwise we would find really difficult to meet their needs. (School staff)

Many kaimahi and providers highlighted the strength of a multi-disciplinary team in the school setting. The team provided extra resources and wrap-around services to rangatahi at high risk. Some clinicians who worked in a wellbeing team acknowledged the coordination between health care services and wider wellbeing.

Sometimes school is the safe place. Let's just make this happen for you while you're at school so it's not too dangerous at home. (Kaimahi)

This morning we had our case management [meeting] with the nurses, the social workers, the school guidance counsellor who is employed by the school and the psychologist is employed as part of the enhanced school-based health service contract. We case manage weekly all those young people that are high risk. Anyone

that's under Oranga Tamariki or who is under secondary mental health services or who have really complex needs that we're all working with. (Kaimahi)

Schools have shown an active interest in being part of the decision making around who gets to work in their school. The relationships developed between clinicians and school staff enable this dialogue and schools have felt more empowered when they have been part of those decisions.

SBHS offers more than supporting rangatahi with health needs. Relationship management within schools is an important role requiring adequate time commitment. Good communication is critical to ensure everyone is on the same page and reduce the gaps for rangatahi to fall through.

Some clinicians offered staff training as part of their work within schools and educated staff about services available and how to access them if they are not available on a particular day. This is not a common feature of the role but has been adopted by some clinicians in observing the needs of their school community.

They have got really good staff there now and I have actually given them all the agencies and pathways if anything comes up and what to do and they have taken it and it has empowered them to actually go and get that help for them straight away. But if they have ones that they are worried about they'll email me and sometimes it might be like one parent hasn't bought the child's Ritalin and they just need a reminder. We keep in contact like that. (Kaimahi)

Strong relationships within the school and having an active presence around the school reduced barriers to engagement. Strong relationships between SBHS and wider school staff enabled teachers to refer rangatahi to SBHS for support.

... it has been the best year. Teachers are referring, we are getting into a great system when they will mention something or see an alarm bell and tell them to go and talk to the nurse. I will have a list of people the teachers will email me and I will try to catch students. (Kaimahi)

The benefits of inclusive practice in schools included teachers feeling comfortable to refer students and identifying needs earlier, school leadership including the clinician in leadership meetings and students feeling comfortable to see the clinician. It was important in many of the schools that the clinician became part of the wider school community.

[The clinician] is definitely a member of staff, not an external person who's coming in ... You wouldn't know the difference [that the clinician is not employed by school]. (School staff)

Time has been identified as a limitation to creating meaningful relationships within and across the school community. Those employed by schools were naturally part of the school community so forming relationships with wider staff was not as challenging. For some they had previous relationships with the school or school community that enabled them to transition into the role more easily.

Clinicians that were only in schools part-time or those who belonged to an external organisation needed to dedicate time to building rapport with school leaders, staff and rangatahi. Clinicians who were dedicated to one school found it easier to build relationships because they were regularly present in the school.

The relationships with the schools has strengthened because we have got a nurse in there more time so it makes joining up together much easier. There's much more presence which is really important. (Provider)

The nurses are autonomous practitioners. If they see a need and they want to develop relationships with their schools ... then from my perspective they are free to do that ... Obviously, there might be pressures around workload as whether you feel like you've got the time sometimes to spare to do that important work. (Provider)

Not all providers and kaimahi noted an open working relationship with schools. There were some schools where clinicians were restricted in how they were to deliver within the school. These schools seemed to be in the minority.

The board have agreed that the school-based health assessments can go ahead. But that's the bare minimum, that just the nurses go and do their assessments and leave again. (Provider)

8.1.2. **Connections with other services working within schools**

SBHS is not the only support service available within schools. Other services that SBHS is connected to within schools include:

Student support/health team

Pastoral care team (including youth workers, counsellors and Special Education Needs Coordinators (SENCOs))

Learning support team (including Learning Support Coordinators (LSCs), Resource Teacher – Learning and Behaviour (RTLBs))

Guidance counsellors

Pacific and Māori youth workers

Social workers

Mental health workers.

Kaimahi and providers highlighted the benefits from knowing and developing relationships with other youth-focussed services both within schools and external providers. These relationships offered wrap-around support to rangatahi enabling warm handovers between clinicians and other support. This also enabled clinicians to focus on the health needs of young people while brokering support to other areas of identified need or expertise in a particular area.

I think working with education is working well. Working with learning support structures and the Kāhui Ako [cluster] is working well. It's still fairly new so we are still developing that but working also with other support structures because not all of

the schools have those either has seemed to work really well and the better the communication with them the better outcomes there are. (Provider)

8.2. Connections to primary care

SBHS can also act as a bridge for rangatahi to access health care in the community⁴⁶.

Clinicians referred and worked alongside GPs in multiple ways often linking when issues were outside of the clinician scope of practice. They also noted the importance of connection to GPs when rangatahi presented with complex needs.

Some clinicians focussed on creating a link between rangatahi and primary care so they would have a health care connection that could be sustained after they left school. A few clinicians shared examples of empowering rangatahi to access their own GP, particularly senior students transitioning out of the schooling system.

One of the big things is to try and empower these young people to find a GP or primary care practitioner that they do feel comfortable with and don't charge them and listen to them and give them the space and be confidential. (Provider)

We are also getting every year 12 and year 13 female [in to the clinic] and we are going through contraception [asking] if they have booked in with a GP for next year and again going through what it is to be waiting for a GP or waiting for a sexual health service. [We try and educate the students] that they can book online or making an appointment is really important. (Kaimahi)

Some clinicians were mindful of smaller communities and the risk of compromising rangatahi confidentiality. Some noted the importance of an established relationship and clear communication with GPs to discuss cases and in some instances treat rangatahi at the school clinic with the support of the GP.

I become a link for the young people to the GPs purely because they don't want to walk through the front door because they know everyone there ... I do the ECPs and the STI checks here. If it's a script for any medication, predominantly the contraception ... the GPs are really receptive at [name deleted] for me to go to them and say, 'This person needs the pill, blood pressure is fine' ... So that has made things a whole lot better and more accessible for the young people. (Kaimahi)

8.3. Referral pathways

Support from national connections could help establish and/or strengthen relationships. It was important for all kaimahi to have a good understanding of services provided in the community, particularly for rangatahi who required

⁴⁶ Peiris-John, R. F. (2020). *Youth19 Rangatahi Smart Survey, Initial Findings: Access to Health Services*. Youth19 Research Group, The University of Auckland and Victoria University of Wellington.

intensive and specialist support. Many kaimahi acknowledged the importance of having a strong relationship with services in the community and knowing what was available should rangatahi require a range of services. Good relationships required on the ground contact between clinicians and other services. However services and organisations available varied from community to community, even within DHBs.

Knowing your youth services agencies out there and getting all on board [about] what they provide is key. The spaces that are available, the youth-friendly spaces ... because we might say access your counsellor but if they don't have one or they're not [appropriate] it's really difficult. (Kaimahi)

Some providers and kaimahi noted the establishment of professional development hubs to encourage socialisation between clinicians and community health practitioners. The hubs provided an opportunity to gather, share ideas, discuss trends, seek advice and acquire new information on referral pathways. They noted the importance of the hubs as a means of weaving clinicians together, particularly those who were isolated in schools. Some also felt the professional development model facilitated a space for a variety of nursing expertise to discuss all things related to SBHS.

At our cluster group meetings we will also bring in people from some of those different community organisations that referrals would be sent to, partly so that people have a face that they're familiar with, partly so they can understand the referral process. (Kaimahi)

Many kaimahi and providers had strong relationships with external health and social services in their regions. Clinicians referred rangatahi out to external services if they required support that was outside of their scope of practice.

And so anything that we can't deal with as far as infection wise or health wise, that isn't under our scope of practice, we can either refer to their own GP or if that's not possible because they don't have a GP or there's no time or parents are working we can refer to the school GP. (Kaimahi)

8.3.1. Rangatahi referrals to external services

The referral process generally encompassed:

Clinicians supported rangatahi and informed them a referral was to be made.

If rangatahi had an existing GP, clinicians would check that the GP agreed that a referral was the best course of action for the rangatahi.

For our students with complex [health issues] or who has other health issues, if I think that it's something simple I'll always make contact with the GP to see if they are happy for me to treat them or if they prefer to see the student. (Kaimahi)

Clinicians made direct contact with external services and provided a warm handover of rangatahi.

Rangatahi referrals to community-based mental health services were a common referral pathway. The ongoing relationships and communications between kaimahi and external services were important for providing continuity of care for rangatahi.

We will refer them offsite ... or we find external counsellors that are happy to come in. There are a few that do come in under the ACC counselling but generally it's harder to find mainstream counsellors to support young people [if they aren't in severe space]. (Kaimahi)

... it does require quite a lot of navigation and a lot of support to get young people connected with the right service. So it's not just about referring them to mental health service. This needs to be the right service and there needs to be a proper connection made. (DHB informant)

To a lesser extent, clinicians made referrals to services to support oral, hearing and vision.

We are finding oral health is really important and vision and hearing, they may have had glasses but need to have a reassessment. (Provider)

Clinicians leveraged their personal connections and professional relationships to work with other services for rangatahi:

Bringing services into school (i.e., audiologists, dentists and mental health specialists)

I'm the only school in the whole area that the ear nurse comes to because I've known her for 20 years. And she knows how hard it is for some of our kids to get to their appointments. So I just round them all up at school and she comes in and sees them all. (Kaimahi)

Providing transport and accompanying rangatahi to their appointments

Dental visits, taking them to GPs ... I have transported students for physio, lots of students going to Specsavers as well for eye checks and for organising glasses because whānau are unable to get them there ... doing a lot of transport to counselling to ensure students get there because otherwise they won't get there. (Kaimahi)

As mentioned, establishing a relationship with rangatahi GP and/or their medical practice.

8.4. Information sharing

A key part of referrals is sharing information about the rangatahi and the reasons for referral. Our conversations highlighted this was particularly important for disabled rangatahi who were connected to support services within schools to avoid frustrations from retelling information they had already shared with people in the school setting.

Clinicians used a wide range of systems for case management, including Excel and paper-based record keeping (Table 5). Some were capable of hosting information in a way that could be accessed by other health providers while others made sharing information a completely manual process.

Table 5. Different systems used for case management (Source: DHB SBHS stocktake 2021)

System	%
MedTech	29%
PMS	20%
Web Pupil	16%
Indici	13%
Excel	9%
Paper-based system	8%
Other (Kamar)	5%

One provider noted their region had the infrastructure and resources at the start of SBHS to develop and inform clinical pathways, set up electronic systems for referrals and provide professional development for staff on referral processes.

When we first set up school-based health service we had a clinical advisory group which set up all those clinical pathways ... We are pretty lucky with our systems, that all happened at about the same time that school-based health services was rolled out. (Provider)

Summary of findings

Information sharing systems would enable more effective referrals and rangatahi support between SBHS and other services outside SBHS.

9. Summary of findings

The table below provides a summary of findings against the evaluation framework headings.

Areas of variation	Differences across regions
Rangatahi voice	
Rangatahi voice in national and regional leadership	<ul style="list-style-type: none"> A strong rangatahi voice, influential at all levels, is one of the focus areas of the Youth Action Plan and the recommendations of Te Tatau Kitenga. The National Youth Committee is now in place to be the national rangatahi voice in SBHS leadership. While few stakeholders described systematic rangatahi contribution to governance and/or service design at a regional level, some clinicians described working with student wellbeing groups or similar to design and refine SBHS at the school level.
Feedback from rangatahi as SBHS users	<ul style="list-style-type: none"> The annual rangatahi surveys providers are required to complete were most often mentioned as approaches to seeking rangatahi feedback. Rangatahi voices may be more meaningfully included at school level where rangatahi know the school context and can be empowered to have a voice. However it will be important to ensure representative from all rangatahi groups are included. Good data on rangatahi experience and rangatahi outcomes is needed to inform practice and service improvements. A robust and consistent approach to collecting the data is needed, especially in the absence of a single joined-up SBHS IT system.
Leadership	
National SBHS leadership	<ul style="list-style-type: none"> MoH recognised the importance of SBHS having strong connections to education and the wider youth health and wellbeing sector by taking a partnership approach to SBHS leadership.
Regional leadership	<ul style="list-style-type: none"> In most areas national connections between MoH and MoE were not evident at the regional level where many MoE staff were not aware of or involved in SBHS. Some regions had regional leadership groups bringing together professionals with different backgrounds. Supporting regional leadership could strengthen connections between kaimahi and other services, facilitating multi-disciplinary approaches to rangatahi wellbeing.
Service specifications	<ul style="list-style-type: none"> The service specifications are an important mechanism for translating policy and intent into practice. Reviewing and updating the service specifications is an opportunity to set expectations around the quality of care and to create a consistent national model.
Allocation of resources for equity	<ul style="list-style-type: none"> There was strong support for reviewing the funding model with insufficient resource to meet demands a theme across regions. Adequate funding is essential to support an equitable service model.

Areas of variation	Differences across regions
Monitoring and reporting	<ul style="list-style-type: none"> Stakeholders at all levels wanted to move towards more meaningful, outcome-based reporting. Sharing useful reporting with schools has the potential to help schools promote rangatahi wellbeing.
Care delivered for rangatahi	
Scope of care	<ul style="list-style-type: none"> Most clinicians we interviewed felt able to work to the top of their scope of practice and support rangatahi needs, enabled by some or all of: standing orders, the nurse prescriber qualification and access to other specialists within SBHS.
The HEEADSSS assessment	<ul style="list-style-type: none"> In practice, many but not all of the clinicians working under contracts only requiring HEEADSSS assessments could operate like clinicians working under other contracts. Kaimahi and providers were generally positive about the benefits of HEEADSSS in building rapport and identifying wellbeing issues for rangatahi. However the benefits of the assessment may be lost if clinicians do not have the time to respond to identified issues. More meaningful and outcomes focussed reporting may contribute to increasing the focus on responding to the assessments.
The SBHS workforce	
Employment models	<ul style="list-style-type: none"> By school, DHB employment was the most common model but schools were responsible for employing more than half of the SBHS FTE. The type of organisation employing kaimahi could influence the time and support for non-clinical work (e.g., professional development) and the infrastructure (e.g., access to patient management systems, colleagues for consultation) available to support clinicians.
Nurses are the core of the SBHS workforce	<ul style="list-style-type: none"> Nurses made up the majority of the SBHS workforce. Almost all schools reported having a nurse (including registered nurses, public health nurses, nurse prescribers and nurse practitioners). Other schools had access to GPs, mental health professionals, physiotherapists, paediatricians, kaīawhina navigators/health care assistants and social workers.
Qualifications and experience	<ul style="list-style-type: none"> Experience and qualifications in youth health and a strong understanding of and commitment to diversity are essential for clinicians. DHBs may need national level assistance in developing recruitment criteria and training programmes and disseminating them to providers
Workforce demographic profiles	<ul style="list-style-type: none"> The evolving nature of the youth health sector is likely to benefit from a younger workforce and there is a need for a more ethnically and gender diverse workforce. Achieving the recommended workforce diversity requires sustainable employment options with meaningful career progression. The current lack of these is a barrier to diversity.
Professional development and supervision	<ul style="list-style-type: none"> Kaimahi draw support from the organisations they sit within. Kaimahi employed by health organisations (DHBs, PHOs, primary/community health care services, NGOs) appeared to have greater access to health information systems and support from other staff members. Many seemed narrower in their scope, focussing more on health issues and less on wider wellbeing. Kaimahi based in social sector organisations had easier pathways for referral for wider wellbeing issues. It was hard for kaimahi to manage professional development with the demands of day-to-day work but paid time in the school holiday periods

Areas of variation	Differences across regions
	<p>could provide time and space for professional development without impacting other aspects of the role.</p> <ul style="list-style-type: none"> Clinical and cultural supervision both support practice. Arrangements varied by DHB. Kaimahi supported including professional development and supervision in contracts.
Workloads	<ul style="list-style-type: none"> The SBHS role is demanding and requires experienced kaimahi with youth health qualifications. There are identified barriers to developing the diverse workforce needed to enhance SBHS including employment models, remuneration, career progression, workloads, supervision and support. Addressing the identified barriers and strengthening the workforce underpins the ability to improve outcomes for rangatahi. Many stakeholders described clinicians working longer hours than the SBHS funding resourced. Providers and clinicians complemented the SBHS funded hours with their own resources. Different fundings streams have the potential to contribute to inequitable access to SBHS because different communities have different abilities to make up funding shortfalls.
Rangatahi-centred service	
Youth needs	<ul style="list-style-type: none"> Interviewed stakeholders identified rangatahi needs across the four domains of Te Whare Tapa Whā. Feedback from providers and kaimahi was consistent with the most common issues identified in the literature (sexual and reproductive health, mental health issues, general sickness and injuries.
Promoting SBHS	<ul style="list-style-type: none"> Raising awareness of SBHS is a step towards accessibility. MoH and MoE have a role to play in explaining and promoting the value of SBHS to schools and their communities.
Rangatahi-centred care	<ul style="list-style-type: none"> Kaimahi strived to deliver rangatahi-centred care to improve outcomes for young people and their whānau. They adjusted the support they offered to suit rangatahi and their needs. Involving whānau in decision making could strengthen the care offered and ensure it continued in the whānau environment but could also be a barrier to change. Though many kaimahi emphasised the importance and value of whānau input, they discussed the importance of still centring care on rangatahi.
Equity and non-discrimination	<ul style="list-style-type: none"> Part-time roles and recruitment challenges meant that supporting rangatahi Māori and Pacific young people with Māori and Pacific kaimahi is often not feasible. This highlights the need for cultural capability training for all kaimahi. Although this is not a MoH role, service specifications could define requirements and specify training needs. Specific training, technical assistance and advocacy is needed to enable further support for different rangatahi groups.
Giving rangatahi choice in how they want to engage	<ul style="list-style-type: none"> It was important to have a variety of options for accessing SBHS that were appropriate for rangatahi with different preferences. Structured appointments with different options for making bookings and informal approaches both had strengths.

Areas of variation	Differences across regions
Physical space	<ul style="list-style-type: none"> The space SBHS is delivered in affects accessibility for rangatahi and the quality of care able to be offered. Better spaces are needed in many schools for SBHS to realise the potential it has to offer rangatahi. MoH and MoE could provide guidance to DHBs and schools about the physical space requirements to enhance rangatahi access to SBHS.
Kaimahi availability	<ul style="list-style-type: none"> All DHB informants, providers and kaimahi said they would like to see the services delivered under SBHS extend their hours of availability to better meet the needs of rangatahi. The current time available within schools was not sufficient to meet student demand. Issues with clinician availability not meeting rangatahi need could be addressed by lowering the clinician to rangatahi ratio to allow for greater FTE at each school.
Connections with other staff and services	
Wellbeing in education settings	<ul style="list-style-type: none"> Wellbeing in schools is a focus for MoE so there is good reason for there to be a strong connection between SBHS and school staff. Having good connections between kaimahi and teachers and being an active presence in the school reduced barriers to engagement with rangatahi.
Connections to primary care	<ul style="list-style-type: none"> Clinicians referred and worked alongside GPs in multiple ways often linking when issues were outside of the clinician scope of practice.
Referral pathways	<ul style="list-style-type: none"> Support from national connections could help establish and/or strengthen relationships. It was important for all kaimahi to have a good understanding of services provided in the community, particularly for rangatahi who required intensive and specialist support.
Information sharing	<ul style="list-style-type: none"> Information sharing systems would enable more effective referrals and rangatahi support between SBHS and other services outside SBHS.

Appendix 1: Evaluation approach

<p>Te Rapunga</p> 	<p>This stage relates to the preparation of one's journey - planning is imperative. This is the part of the process where you assess all that is needed to ensure a safe and successful journey. We aim to build a clear understanding of the goals and purpose of the evaluation, intended outcomes, resources and expertise required to deliver. This stage includes processes to examine the current state and determining the direction toward the goal/s.</p>
<p>Te Kitenga</p> 	<p>The focus of this stage is on gathering insights throughout the journey. It includes developing processes for collecting/accessing data, information and knowledge from stakeholders including MoH, providers, schools and others. It also includes understanding the environmental cues that exist in each community, how these may differ across communities, what responses may be required, and how these may vary across different communities.</p>
<p>Te Whāinga</p> 	<p>The priority is to ensure we are on the correct path through a process of evaluation. During this stage there is the opportunity to obtain feedback, input and ideas about the journey thus far. In Te Whāinga we ascertain the success of the current pathway and refine the plan toward achieving the goal. In this stage it is imperative to connect with co-researchers and key stakeholders to ensure all insights and perspectives are gathered and being used to inform the outcomes of the journey thus far.</p> <p><i>“Central to wayfinding is the discipline of reading the signs in an unfolding, constantly moving reality, one in which the wayfinder stays open and responsive to changing conditions” (Spiller, Barclay-Kerr & Panoho, 2015, p. 128).</i></p> <p>If Te Whāinga indicates that goals and outcomes are not being met, we return to Te Rapunga and complete a process of recalibration. During times of navigation this is where the waka would be placed into a spin to enable navigators to reflect, reinterpret and review environmental cues. These environmental cues would then be used to support decision making regarding a new path or course of action. If the pathway one is following was tika and pono, correct and true, then the process would continue on to Te Whiwhinga.</p>
<p>Te Whiwhinga</p> 	<p>Te Whiwhinga is a point in the journey of assessing whether initial goals have been reached, what was successful and how this was reached, and what learnings have been gained to improve future journeys. This stage provides opportunities to reassess whether there may be a need to reset and return to Te Rapunga.</p> <p>Evaluation considerations include providing opportunities to reflect on evaluative processes with MoH, SBHS providers and stakeholders to inform ongoing data collection and ensure information that is gathered is meaningful and useful. Iterative shared learning, close relationships with co-researchers and communities, open and clear communication and reflective practice are critical to the evaluation. Te Whiwhinga is reflected in the progress and achievement of evaluation outcomes.</p> <p>Before presenting the fifth stage of this process, it is important to indicate that while Te Whiwhinga reflects a successful outcome towards achieving the intended goal, learnings, data and information can be derived from this process that may require us to return to Te Rapunga with a need to review the evaluation plan.</p>

Te Rawenga



During this stage all indicators, measures and data would suggest that we are on track in regard to our journey. Te Rawenga provides an opportunity to reflect on key drivers and enablers of success, and more importantly allows us an opportunity to celebrate this success with our communities and co-researcher groups. We see this as an integral part of creating trusting and ongoing relationships within the three-year timeframe of this piece of work.

While it may seem that Te Rawenga indicates the end of the process, as with navigation the journey is seldom complete. Even at the stage of Te Rawenga there are opportunities to reflect on and review learnings taken from a successful outcome and return to Te Rapunga to understand how these can contribute to further outcomes in other areas.

Appendix 2: SBHS logic model (June 2021)

We developed the SBHS logic model to guide the evaluation and in a way that connects with the evaluation approach (Te Rapunga), the Ministry's enhancement programme and the work of Te Tatau Kitenga and Te Rōpū Mātanga o Rangatahi in developing Te Ūkaipō, the values framework for SBHS. The logic model is a living document for the evaluation and will continue to be reviewed and revised with partners.

Values - navigating the SBHS journey
In traditional navigation, the stars, moon, tides and environmental cues help determine whether we are on track. Te Ūkaipō guides the SBHS mahi and is relevant for all services working in youth development.

Destination - positive change for rangatahi

The destination of the SBHS journey is positive change for rangatahi, visible at the individual and population levels. Outcomes for schools, services and the community are valuable in their contribution to achieving positive rangatahi outcomes.

Waypoints - outputs, service outcomes

Steps towards reaching the destination, necessary but not sufficient in themselves. They focus on how services are delivered and the rangatahi experience of those services. Equitable access to participate in SBHS for all rangatahi including the priority groups underpins the waypoints and outcomes.

SBHS waka

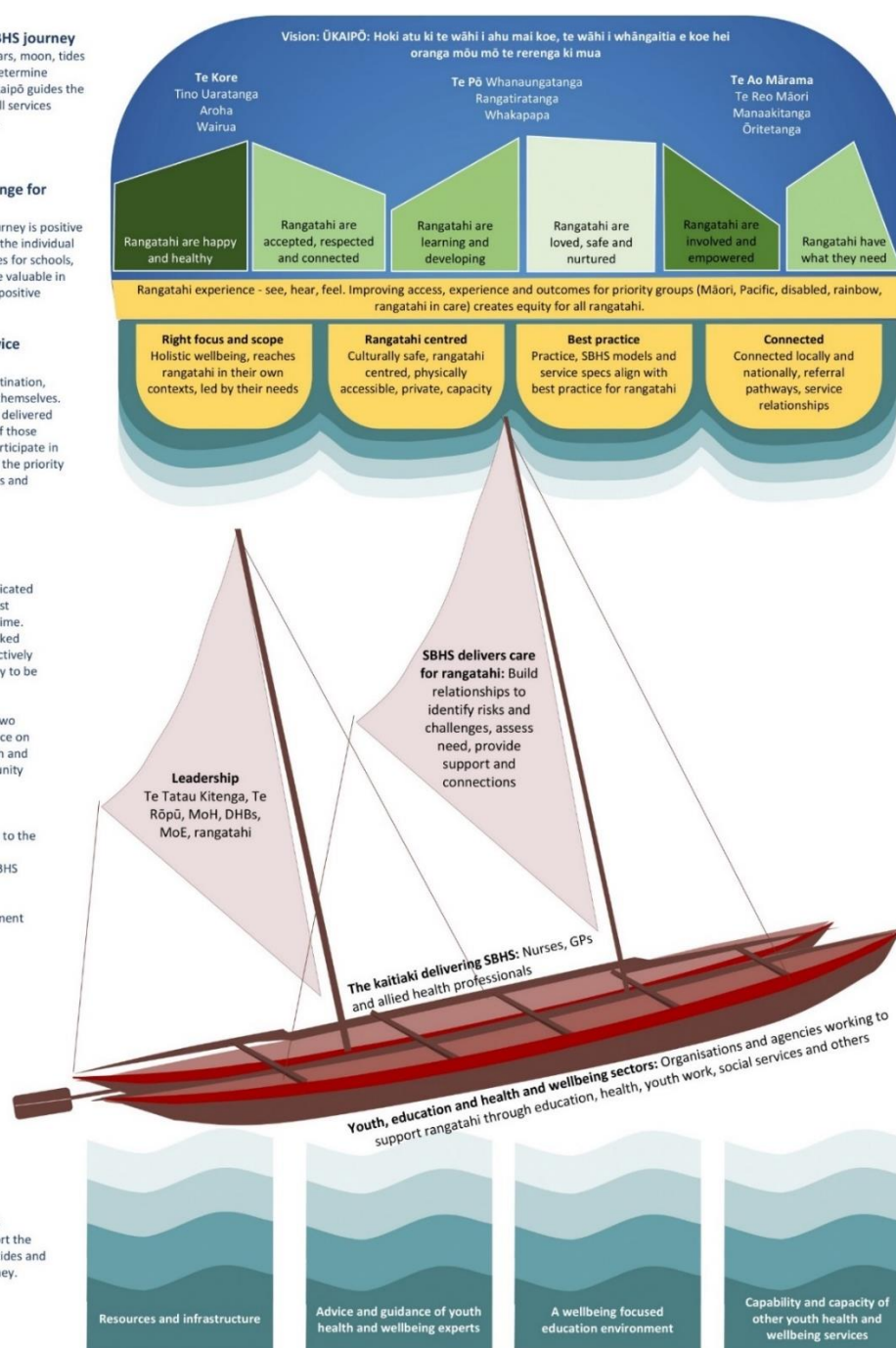
Double hulled waka are sophisticated vessels made for journeys of vast distances over long periods of time. They are made of many interlinked parts which must all work collectively and in alignment for the journey to be successful.

The connections between the two hulls represent SBHS dependence on the youth, education and health and wellbeing sectors in the community to support rangatahi and complement SBHS.

The rigging connecting the sails to the hulls represent the lines of communication between the SBHS workforce, governance and management through service specifications, quality improvement programmes, monitoring and evaluation.

Resources and conditions

The resources needed to support the journey and the environment, tides and currents, which affect the journey.



Appendix 3: Evaluation frameworks

School-Based Health Services: Process and outcomes evaluation framework overview

This evaluation framework is designed to provide structure for the evaluation through bringing together the Te Ūkaipō values, Te Tatau Recommendations for the SBHS enhancement programme and outcomes measures. It will be used to guide the evaluation planning, data collection, analysis and reporting. We expect it to evolve throughout the evaluation as the enhancement programme is developed and implemented.

