FLEMING & ELVIDGE

Youth Health Services Literature Review

A rapid review of:
School based health services
Community based youth specific health services
& General Practice health care for young people

Peer Reviewed by Dr Peter Watson

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Commissioned by Waitemata District Health Board

ABOUT THIS DOCUMENT

Description	This is a review of New Zealand and international literature in the areas of school based health services, community based youth specific health services and general practice health care for young people aged 12-24.
Purpose	The review was commissioned by Waitemata District Health Board (WDHB) to inform service planning and the implementation of the WDHB strategic plan for youth health.
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Acknowledgements	The support of the Waitemata Youth Team and assistance of Darna Appleyard is gratefully acknowledged.
Method	Search of academic databases, review of identified key youth health websites and documents carried out May-July 2010.
Associated documents	This report should be read alongside Waitemata Health's strategic planning document, 'E Tu Tai Tamariki – Young People Stand Tall: Strategic Directions for Youth Health 2009-2014' and WDHB Youth Advisory Group information (Presented by Youthline 2010).
Disclaimer	We have taken care to ensure the accuracy of information in this report within the project time frame, but the writers cannot accept responsibility for omissions or errors or actions taken as a result of this report. This Youth Health Literature Review was commissioned by Waitemata District Health Board, Planning and Funding Team. The views contained within the document do not reflect the views of Waitemata District Health Board and there is no guarantee of funding or commitment to implement the recommendations contained within. This literature review did not include evidence related to the cost effectiveness, affordability or the relative priority of the recommendations presented. The information contained within this report will now be used to inform future planning work for youth health sector configuration, within the Waitemata district.

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EXECUTIVE SUMMARY

INTRODUCTION

This literature review was commissioned by Waitemata District Health Board (WDHB) to inform service planning and the implementation of the WDHB strategic plan for youth health – 'E Tu Tai Tamariki – Young People Stand Tall: Strategic Directions for Youth Health 2009-2014'. The information from this report will be considered alongside other information including youth input, provider feedback and current opportunities, in order to improve the health and wellbeing of young people aged 12- 24 years in the Waitemata district.

This is a rapid review of published literature relating to the health services for young people aged 12-24, in three focus areas:

- School based health services
- Youth health care in General Practice settings
- Community based youth specific health services

Literature was identified using PubMed, Google Scholar, Embase, CINAHL, and Cochrane library databases, hand searches of key youth health websites and brief Google searches for 'grey' literature (such as reports). Systematic or high quality reviews published in peer reviewed publications within the last ten years were used where available.

In using this report it is important to note its limitations. These include:

1) this is a brief review undertaken in short time frame
2) approaches that have not been evaluated or not been published will not be included
3) approaches that do not come under one of the identified focus areas will not be included
4) much of this research comes from overseas.

Thus in decision making for services this information should be considered alongside other, local information.

KEY FINDINGS

SCHOOL BASED HEALTH SERVICES

There is a large body of literature about school based health services. Most of this comes from comprehensive school clinics which are open for all or most of the school hours throughout the school terms. In this literature:

- School based health services have been shown to increase access to health care, particularly among young people who have poor access to health care outside of the school.
- School based health services have been shown to be more likely to offer youth friendly care than health services that are not specifically for young people are.
- Comprehensive full time or nearly full time school health services have been shown to lead to improvements in school attendance and education outcomes for some students.
- Some studies have found school based health services lead to modest gains in health outcomes for young people – although other studies have not demonstrated improvements in health outcomes.

- Young people generally like comprehensive school health services.

COMMUNITY BASED YOUTH SPECIFIC HEALTH SERVICES

There is little literature that evaluates youth specific health services that are not school based. Available literature suggests that:

- Young people generally want and like youth specific health services.
- Youth one stop shops or community based youth specific health services are good at engaging young people, including young people who are not in school, training or work.
- Young people, providers and stakeholders find youth one stop shops in New Zealand helpful and in general think that they are effective and improve health outcomes for Maori and tauiwi clients.
- Youth one stop shops or community based youth specific health services are likely to increase access to health care, particularly among groups of young people who are not well served by mainstream health services.
- Youth one stop shops or community based youth specific health services within New Zealand and overseas often have a capacity development role, and may support developments to improve mainstream health service responsiveness to young people and to improve the wellbeing of young people in their communities.

GENERAL PRACTICE CARE FOR YOUNG PEOPLE

There is little research regarding the impact of General Practice care for young people. Available evidence suggests:

- Most New Zealand high school students have seen a General Practitioner (GP) within the last year.
- The majority of New Zealand high school students say GPs or family doctors are the main place that they seek health care.
- Where young people do see GPs this is often for short term illnesses and not for issues such as mental health or health risk behaviours. This is the case even when young people do have mental health difficulties and even when they would like help for them.
- GP's often report difficulties in providing youth friendly care (such as lack of training or time).
- Where young people are more familiar with their GP they report fewer barriers to accessing health care.
- GP's who have received high quality training in adolescent health have been shown to be more likely to offer high quality adolescent health care.
- There are a range of actions (such as increased utilization of trained practice nurses, routine psychosocial screening and continuity of care approaches) that may be taken to enhance General Practice care for young people; however few of these approaches have been evaluated.

IMPROVING THE HEALTH OF YOUNG PEOPLE: OVERARCHING THEMES

School based health services, community youth health services and general practice care for young people are all ways for providing primary health care to young people. There is insufficient evidence to support one model of primary health care service provision being the most effective model for all or most young people. Rather,

evidence and expert opinion suggest that a range of opportunities to access health care are needed for different groups of young people and at different times (e.g. covering young people both in and out of school time and in diverse communities) and that critical factors are:

- workforce capabilities (knowledge and skills of providers) and
- service characteristics (the youth friendliness[1] of services).

Reviewing the literature reveals common themes which are important for improving the health and wellbeing of young people within and beyond the health sector. In brief these are: address key risk and protective factors; offer adolescent focused interventions including youth development approaches and utilise comprehensive, multi-level approaches.

The literature reviewed in this document suggests that to improve young people's health the health sector should:

- Provide a range of 'youth friendly' clinical health services, staffed by health professionals who are well trained, skilled and knowledgeable in youth health. These should provide comprehensive and 'joined up' youth friendly care.
- Work across sectors to encourage population, community, school and family level interventions that will improve the health of young people.

SUMMARY OF RECOMMENDATIONS

The recommendations in full can be found on page 47, in brief they are:

1. **To support the co-ordination and ongoing implementation of the following youth health goals it is recommended that a youth health team or 'hub' be established.**

2. **Waitemata DHB should implement a three pronged strategy to improve access to 'youth friendly health care'[2] for young people in the district:**
   - **i) Improve access for the most underserved via a youth specific community based health service and youth health outreach services through agencies that those young people are already engaged with.**
   - **ii) Increase delivery of 'youth friendly care' in General Practices.[3]**
   - **iii) Improve access for school students via comprehensive youth friendly school based health services particularly where students have poor access to health care and have high health needs.**

3. **WDHB should develop a strategy that leads to a workforce with expertise in youth health.**

4. **WDHB should seek opportunities to improve the health of young people in Waitemata from interagency and intersectorial collaboration.**

[1]. The terms 'youth friendly 'or 'adolescent friendly' health care refer to a set of characteristics to improve services appeal and efficacy with young people, these have been well described by the World Health Organisation and others – see Appendix 1.
[2] As note 1.
[3] See Appendix 1, also see page 37 for GP specific models for increasing youth friendly care.

TERMS AND ABBREVIATIONS

Term/abbreviation	Definition
Youth, Young People & Adolescent.	'Young people' was defined by WDHB to be those aged 12-24 years. This is consistent with the definition used by the New Zealand Ministry of Health. In this document 'youth' and 'young people' are used interchangeably. 'Adolescent' often is used more specifically to refer to the teenage years. However all of these terms refer to the developmental period between childhood and adulthood (or the onset of puberty and the attainment of adult roles) and are used interchangeably by many authors.
AHRG	Adolescent Health Research Group
DHB	District Health Board
GP	General Practitioner
MOH	Ministry of Health
PHO	Primary Health Organisation
SBHS	School Based Health Services
YHS	Youth Health Service
WHO	World Health Organisation
WDHB	Waitemata District Health Board
YHS	Youth Health Services
YOSS	Youth One Stop Shop

INTRODUCTION – SETTING THE SCENE

YOUTH HEALTH ISSUES AND ACCESS TO HEALTH CARE

HEALTH ISSUES FOR YOUNG PEOPLE

Most young people in New Zealand are healthy. They report that they have good or excellent health (AHRG 2008a) and they do have less serious physical diseases and are less likely to die than young people in previous generations. However rates of preventable health problems remain high for New Zealand young people compared to other developed nations, and these have considerable cost for young people, whanau and communities, as well as the health sector, both in the short and longer term (Gluckman 2010).

The main causes of death, injury and illnesses for young people in New Zealand in 2010 are related to mental health, behavior and young people's communities or environments, these heath issues include: motor vehicle crashes, suicide, depression, drug and alcohol problems, obesity, inactivity, sexually transmitted infections and unwelcome early pregnancy. Most of these problems are preventable.

Needs for health intervention in young people relate to:

1. Conditions or challenges persisting from childhood. For example babies who are born with a serious disorder, children who endure abuse and neglect, children raised in families that face ongoing hardship and multiple difficulties.
2. Youth specific behaviours. Most young people will be more impulsive and take more risks than adults. Experimenting, trying out new behaviours, making one's own decisions and beginning adult behaviours (such as driving, using alcohol and developing intimate relationships) are normal developmental tasks which sometimes have problem consequences.
3. Establishment of patterns of behavior that persist into adulthood. For example cigarette smoking, substance abuse and patterns of inactivity typically begin or become established in adolescence. Once these behaviours begin they are challenging to change and have significant long term costs.
4. Illnesses that arise in adolescence, for example infections and acne. For a small minority of young people serious illnesses, such as cancer, may begin in adolescence.

Most health services use for young people relates to 4; however the burden of disease is more strongly associated with 2 and 3, and especially for the first group of young people – those who enter adolescence with pre-existing challenges. Redressing this mis-match is an important issue in improving health outcomes for adolescents.

YOUNG PEOPLE'S USE OF HEALTH SERVICES

Young people often utilize a range of health care providers (such as school health, family planning and GP's) rather than having just one medical home (Communio 2009). Most young people say the main place they get health care is from a family doctor, medical centre or GP clinic (AHRG 2008a). About 4% of high school students say they do not go anywhere for health care and the next largest group say their usual place for health care is a school health

centre.[4] The majority of young people have seen a health provider in the last year, however many students have not talked to a health care provider in private and have not been assured of confidentiality (AHRG 2008b).

Many young people, particularly Maori and Pacific young people report that they have had difficulties getting help for problems or were unable to access health care when they needed it. Some of these difficulties relate to issues such as location and cost, however the most common barriers reported by young people are issues such embarrassment, not wanting to make a fuss or concerns about confidentiality (AHRG 2008a, Tylee et al 2007). Young people are often reluctant to raise sensitive health issues and prefer to be asked rather than raising sensitive issues themselves (Haller et al 2007).

YOUNG PEOPLE WITH HIGH HEALTH NEEDS

There are considerable disparities in health status and in access to health care among groups of young people. In planning improved health systems, these groups must be involved or new initiatives risk increasing heath disparities.

In general lower socio-economic status young people have poorer health status than those in communities with more resources (Craig et al 2009).

Maori and Pacific young people frequently have high health needs compared to other ethnic groups in Aotearoa/ New Zealand (Craig et al 2008, Robson and Harris 2007, Clark et al 2008).

Refugees and recent migrants are also likely to have specific health needs (Homans 2003).

Older young people often have higher rates of health problems and more difficulties accessing care than younger adolescents do (Callahan and Cooper 2010).

Additionally specific groups of young people typically have multiple health issues and particular challenges in accessing health care (Homan 2003), these groups include:

- Young people with significant disabilities and or chronic illness.
- Young people who have been abused or chronically neglected within their families including young people who are in care or have graduated from care.
- Young people from transient and/or socio-economically deprived back grounds.
- Young people who are in custody, on probation or involved with justice services or who are affiliated to gangs.
- Young people who are sex working and young people who have high levels of substance abuse.
- Young people who are outside mainstream education or employment. For example those in Alternative Education, on short term courses or unemployed.
- Young people who are attracted to the same sex or both sexes, transgender young people and those questioning their sexuality.
- Young parents.

[4] See Appendix 2 for rates of access to GP care and difficulties getting health care among the 9 107 New Zealand secondary school students in the Youth07 survey. These include gender, ethnic and socioeconomic breakdowns.

HEALTH ISSUES AND ACCESS TO HEALTH CARE FOR YOUNG PEOPLE IN WAITEMATA

E Tu Taitamariki Ma (WDHB 2009) describes the population of young people in Waitemata and key health issues for these communities. In brief Waitemata includes over 114 000 10-24 year olds. This population is reported as 11% Maori, 9% Pacific, 17% Asian and 63% European or other.

In general young people in Waitemata experience similar health issues to the New Zealand youth population with injuries; sexual health; violence; mental health; tobacco, alcohol and other drugs; activity, nutrition and obesity identified as key issues.

Maori and Pacific young people experience poorer health status than New Zealand European young people and Maori, Pacific and Asian young people report higher rates of difficulty getting heath care from existing health services.

In Waitemata in 2009 68% of 10-24 year olds were enrolled in a Primary Health Orgainisation (PHO). As reported in E Tu Taitamariki Ma (WDHB 2009) this varied among different groups with 82% of New Zealand European, 75% of Pacific, 53% of Maori and 42% of Asian young people being enrolled in a PHO.

NEW ZEALAND MINISTRY OF HEALTH PRIORITIES IN YOUTH HEALTH

The New Zealand Ministry of Health (MOH) Youth Health Action Plan (MOH 2002) specifies a range of objectives and action points for primary health care providers and others to reach young people who do not use existing health services and ensure that health services met the needs of young people. These include:

- involving young people in designing primary health care services for young people
- exploring ways of reaching young people who do not use existing health services
- ensuring health services met the needs of refugee and migrant young people
- encourage family health clinics to become more youth focused and better met the needs of Maori and Pacific young people as well as disabled and deaf young people
- support the extension of school based health clinics, particularly for schools in low income communities.

The Youth Health Action Plan summary of actions for primary health care is included as Appendix 2.

WDHB STRATEGIC DIRECTION IN YOUTH HEALTH

The WDHB vision, strategic direction and priorities in youth health are outlined in E Tu Taitamariki Ma (WDHB 2009). In brief WDHB aims to ensure that young people in the district have

> *"Equitable access to high quality, youth friendly services that are evidence-based and appropriately cater for their diverse needs."*
>
> (WDHB, 2009, p1)

Directions identified in this document are to:

- Improve access to primary health care for the youth population, including enrolment in PHO's.
- Deliver high quality school based health services.
- Consider the need and potential for youth specific community based health services targeted to the most vulnerable populations.
- Ensure that young people are receiving a 'fair share' of health services and that services are configured to improve health outcomes and reduce inequalities in health status.
- Ensure that there is ongoing participation by young people in the design, delivery and evaluation of health services.

THE PURPOSE AND SCOPE OF THIS REVIEW

This review was commissioned to inform youth health service planning by Waitemata District Health Board by providing an overview of published literature regarding 'what works' to improve young people's health and their access to health care in the following specific areas: generic primary care, school-based services and youth-specific health services/youth one stop shops.

'Young people' was defined by WDHB to be those aged 12-24 years. This is consistent with the definition used by the New Zealand Ministry of Health.

INTERPRETING FINDINGS

We endeavoured to carry out a thorough search of the literature within the time frames and focus of the project. However, caution needs to be taken in interpreting the results.

- Some literature comes mainly from overseas, particularly the United States which has quite different health systems and communities from Waitemata.
- There is very little research specifically with Maori and Pacific young people.
- There is relatively little research investigating some important areas of youth health.
- Where there is a lack of evidence to suggest a particular approach is effective this maybe because there has been little research testing that approach, rather than necessarily because that approach is ineffective. A review of the literature only includes what has been published – innovative and effective programmes that have not been written up are not included, and new research after the publication of this report will not be included.

These limitations mean service planning can be informed by the literature but other processes and sources of information will also be important.

METHODS

We reviewed key documents and websites and carried out literature searches as described below.

1) Systematic review

Pubmed, CINAHL Embase and Cochrane Library databases were searched for reviews, meta-analyses, position papers or guidelines for school health services, primary health services and community based youth health services or youth one stop shops published within the last 10 years as well as evaluation studies, trials, multicentre studies or comparative studies published in the last 2 years. Searches were carried out in May and June 2010. The MeSH terms 'School Health Services', 'Primary Health Care', 'Adolescent Health Services' 'Community Health Services' were used with the following limits: (Clinical Trial OR Meta-Analysis OR Practice Guideline OR Randomized Controlled Trial OR Review OR Comparative Study OR Controlled Clinical Trial OR Evaluation Studies OR Guideline OR Multicenter Study) AND English [language] AND MeSH major topic. The 'Primary Health Care' and 'Community Health Services' were limited to 'adolescent' or 'youth', in databases with no 'youth' term the nearest equivalent was chosen e.g. 'young adult' or 'adult', and results checked for relevant studies.

Checks for further relevant publications were made using 'cited by' and snowballing techniques. Key word searches were carried out in Google Scholar for articles or reviews with 'youth' or 'adolescent' and 'health' or care' or 'services' or 'clinic' or primary' in title. Google searches were carried out for 'Youth One Stop Shop', 'Youth Health Service' and 'Youth Health Care' and were repeated with addition of the key words 'evaluation' or 'review' or 'cost benefit'.

2) Hand searches

Searches were also carried out for position statements on youth or adolescent health from the World Health Organisation and youth health professional bodies. Additionally the following key websites were searched:

- New Zealand Aotearoa Adolescent Health and Development (NZAAHD)
- The Auckland School Nurses Group
- The New Zealand College of General Practitioners
- Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health USA.

Limitations and exclusions

Given the timeframes for this project whole of school approaches, health promotion activities, evaluations of impact of interventions on single aspects of health or specific issues and interventions relating to specific diseases which would normally be treated in specialist services were excluded.

3) Key document review

The following key documents were included as part of the literature review.

School health

- Ministry of Health. (2009). Evaluation of Healthy Community Schools Initiatives in AIMHI Schools. Wellington: Ministry of Health: Wellington.
- Buckley S, McDonald J, Mason D, Gerring Z, Churchward M, Cumming J. (2009). Report to the Ministry of Health: Nursing Services in New Zealand Secondary Schools. Health Services Research Centre, School of Government Victoria University of Wellington: Wellington.
- Winnard D, S. Denny, Fleming T. (2005) Successful School Based Health Services for Adolescents: Best Practice Review. Kidz First Community Health – Centre for Youth Health: Auckland.
- Ministry of Health. (2004). Improving the Health of Young People: Guidelines for School-Based Health Care. Ministry of Health: Wellington.

Community Based Youth Specific Health Services

- Communio. (2009). Evaluation of Youth One Stop Shops. Ministry of Health: Wellington.
- Milne and McBride (2008). One Stop Shops: the development of self-evaluation capacity and evaluation framework. Youthline: Auckland.
- Youthline. (2006) Counties Manukau Pacific Youth One Stop Shop: A review of research, best evidence and youth opinion. Youthline & Counties Manukau District Health Board: Auckland.

General Practice Care

- Tylee et al (2007) Youth-friendly primary-care services: how are we doing and what more needs to be done? Lancet. 2007 May 5;369(9572):1565-73.
- Kang M, Bernard D, Usherwood T, Quine S, Aperstein G, Kerr-Roubicek H, Elliott A & Bennett D (2005) Better Practice in Youth Health: Final Report on Research Study: Access to Health Care Among Young People in New South Wales: Phase 2. Sydney: NSW Centre for the Advancement of Adolescent Health, The Children's Hospital at Westmead: Sydney.

Overall

- Department of Health (2007). You're Welcome quality criteria: Making health services young people friendly. Department of Health: London.
- Kidz First Centre for Youth Health and the Youth Health Expert Working Group. (2006). Draft Standards for Youth Health Services. Counties Manukau District Health Board: Auckland.
- World Health Organization. (2002). Adolescent Friendly Health Services, An Agenda for Change. World Health Organization: Geneva.
- Mathias K. (2002). Youth-specific primary health care-access, utilisation and health outcomes. NZHTA Report 2002: 5. NZHTA: Christchurch.

Introduction

School nursing and school based health services (SBHS's) have been expanded over recent decades in New Zealand and internationally to improve access to health care for young people, particularly for those who have poor access to health care or are seen as 'at risk'. Comprehensive SBHS are currently supported by a number of credible organizations as a critical component in improving the health of young people including: the New Zealand Ministry of Health (MOH 2004); the World Health Organization (WHO 2002, Tang et al 2009); the Society of Adolescent Medicine (Pastore et al 2001) and the American Academies of Paediatrics and of Nursing (American Academy of Pediatrics 2008, American Academy of Pediatrics 2001). In New Zealand over 75% of high schools have nursing services or more extensive SBHS's within the school environment (Buckley et al 2009).

There is a comprehensive literature about SBHS and also some literature more specifically focused on school nursing, although as is often the case with community based interventions, there are few randomized controlled trials or systematic reviews (Cowell 2010). Recent New Zealand evidence largely consists of evaluations of health services implemented as part of the AIMHI Initiative[5] (particularly the comprehensive evaluation of AIMHI carried out for the Ministry of Health in 2009) and reviews of literature and expert opinion (Winnard et al 2005, MOH 2004*).* Most international evidence in this review comes from the United States. Caution should be exercised in applying US evidence in the local setting as there are significant differences between the US and New Zealand systems of care. New Zealand evidence is used where available.

Terms*: What are school based health services?*

There is no single model of school based health services (SBHS). However typically SBHS (sometimes called 'school health clinics' or 'school clinics') evaluated in the literature are comprehensive nurse led clinics held in the school for school pupils and sometimes others, to access on their own behalf or via referral. In general they are free of charge; provided through most of school hours; provide routine screening as well as clinical care, and focus on youth friendly services, prevention and early intervention. Most have GP support and have close links to support and health staff within and beyond the school.

Some schools in New Zealand and elsewhere have less comprehensive services provided by a first aider or a school nurse with a more limited role. Others have clinics provided just a few hours per week by a visiting professional. Most of the literature is not based on these less intensive school services.

For the sake of clarity and consistency with the international literature the comprehensive, more intensive services described are referred to in this report as school based health services (SBHS).

[5] The AIMHI Initiative is a multi component intervention designed to improve educational outcomes in nine decile one multi-cultural high schools. The AIMHI interventions began in 2001 and include comprehensive educational/teaching interventions as well as increased health and social support.

SUMMARY OF EVIDENCE

Available evidence suggests comprehensive school based health services that are provided all or nearly all of school hours:

- Increase access to health services, including primary health care, mental health care and other specialist services. Within the United States at least, this is particularly so among those who traditionally have poor rates of access to health care.
- Increase school attendance, school retention and academic achievement and reduce truancy or school absence for some students, e.g. those with chronic health issues.
- Reduce emergency department usage.
- Offer greater access to adolescent focused screening, preventative health care and explicitly confidential care than other primary health care services generally do.
- Are generally seen as helpful and very satisfactory to students, school staff and parents.
- SBHS's have not been conclusively shown to cause gains in health status for young people.

THE EVIDENCE IN MORE DETAIL

INCREASING ACCESS TO HEALTH SERVICES.

In New Zealand SBHS's have been shown to increase access to health care by providing care at the school and by increasing use of other health care including primary care in the community. For example both the AIMHI evaluation (MOH 2009) and Denny et al (2005) reported that students who used the SBHS were more likely to also appropriately use community based primary care. Students who had used the school nurse in the AIMHI evaluation were also more likely to use the services of the school social worker or counsellor (MOH 2009).

Overseas research particularly from the United States also identifies that students who use SBHS have increased use of the family practitioner or GP, reduced use of emergency rooms (Juszczak et al, 2003; Key et al 2002) and increased access to mental health, drug and alcohol and other specialist referrals (Brindis et al 2003). For example Juszczak et al (2003) found adolescents were 21 times more likely to come for mental health service visits at SBHS's than at a community health centre network and SHBS users were four times less likely to use emergency or urgent care than adolescents who did not use a SBHS.

SBHS AND INEQUALITIES

In the US young people from minority ethnic groups, low income young people, rural young people and young people with poor health status have generally higher rates of utilization of school based health services than other students do (Crosby & St. Lawrence, 2010; Silverberg and Cantor, 2008; Jusczak et al 2003, Bradford and O'Sullivan, 2007). This is an often repeated finding. Partly this may be due to the strategic placement of SBHS in communities where there are high levels of needs and the costs of alternatives within the US system.

In New Zealand there is little research specifically on this issue, with the following exceptions:

- Within AIMHI schools the use of the school health or support services by surveyed Maori and Pacific students was approximately proportional to the size of each population within the schools, with Maori students slightly more likely to use the nursing service and Pacific students slightly more likely to use the social worker (MOH 2009).
- Denny et al (2005), in their study of one South Auckland school clinic, reported that Maori and Pacific students were most likely to have used the SBHS in the last 12 months. Specifically 31% of Pacific, 30% of Maori, 17% of New Zealand European and 19% of Asian students had used the service; Maori were the most likely to have used the SBHS as their usual place of health care (10% of surveyed Maori students), although other groups were similar (range of 7-10%).
- Chavesse et al in 1995, reported higher use of a school clinic by Maori and New Zealand European students than Indian and Asian students.

It appears that school clinics increase access for students within that school with some (often small) differences between groups within the school. Once students have used the clinic they are more likely to use it again (MOH 2009), one way of increasing use of the clinic may be of universal health screening of all students.

SCHOOL ATTENDANCE, RETENTION AND ACHIEVEMENT

Comprehensive SBHSs are likely to have positive effects in increasing school attendance, school retention (i.e. staying at school beyond the minimum school leaving age) and academic achievement and reducing truancy or school absence, particularly for those with chronic health issues.

In New Zealand the AIMHI evaluation (MOH 2009) showed improvements in academic achievement, retention of students and truancy associated with the implementation of the AIMHI model; however it is not possible to identify if these effects were due to health services or to other interventions and approaches developed as part of the AIMHI initiative.

In a well controlled longitudinal study of over 2000 ninth graders in the US, Walker et al (2010) reported a significant increase in Grade Point Average (GPA) and a significant increase in school attendance associated with health clinic use. Users of the SBHS had lower attendance and lower GPA's than non users at the beginning of the time period, however using the clinic predicted greater increases in GPA and, after an initial drop in attendance, greater increases attendance over time. They attributed these gains to treatment for illnesses that might have otherwise interfered with attendance, improved preventative health care and increased assistance for emotional and behavioural problems.

STUDENTS, SCHOOL STAFF AND PARENTAL SATISFACTION

The AIMHI evaluation (MOH 2009) included satisfaction surveys of parents, school staff and young people:

- Most (75%) of the 784 students who participated in the survey had used the services of the nurse or GP. Students were generally very positive about the school nurse/GP service and found them helpful and easy to talk to.

- Most parents did not provide feedback, however the 68 parents who did, were pleased the school had a health service, felt that it had improved the health of their children and did not express any concerns about the service.
- 245 staff at AIMHI schools responded to surveys, most (81%) were teachers. Staff were generally very positive about the health and social support services, felt that they were effective and felt that these services made their own jobs easier. Satisfaction among staff with these services appeared to have gradually increased as services had been in place longer. Staff were generally comfortable referring students to the services.

These findings are consistent with USA findings which also report that SBHS are rated highly by young people (Benkert et al 2007; Scudder et al 2007).

SCHOOL BASED HEALTH CARE AND 'ADOLESCENT FRIENDLY' CARE.

Comprehensive school based health services typically are youth specific and designed to be adolescent friendly (Gustafson, 2005). New Zealand (Denny et al 2005) and international studies (e.g. Klein et al 2007) have found that SBHS are more likely to offer preventative screening and anticipatory guidance (for example regarding issues of sexual health, mental health, substance use) than other health services are. In addition teenagers using SBHS were more likely to report that they had spoken with a doctor or nurse in private and had had confidentiality explained to them than students accessing traditional primary health care in New Zealand (Denny et al 2005) and overseas (Klein et al, 2007).

GAINS IN HEALTH STATUS?

There have been some studies which have found gains in health status associated with SBHS, for example Ricketts and Guernsay (2006) found reduced rates of pregnancy among African American students attending schools with SBHS's. However others report no significant findings or small effects (Silverberg and Cantor, 2008; Lear et al 2002; Kirby 2002). This lack of evidence is likely to be due to both methodological challenges and the reality that there are multiple determinants of health status among young people, of which access to health care is only one (Silverberg and Cantor, 2008).

SCHOOL BASED HEALTH SERVICES - SERVICES OFFERED AND MODEL OF PRACTICE

There is no single model of school based health services, indeed responsiveness to local environments is seen as key (Gustafson, 2005). However there are common features associated with success in New Zealand and internationally. These have been described with a high level of consistency in the international and New Zealand literature. Rather than attempt a comprehensive review here we have outlined the key points for success from the recent review of AIMHI services (MOH 2009). This document is selected as it explicitly sets out to identify ways forward for school health services in New Zealand and builds on both the MOH guidelines for school based health services (MOH, 2004) and the New Zealand review of best practice for school health services carried out by Winnard et al (2005). This document is also highly consistent with international literature.

Key factors in the effectiveness of school-based health services
Ministry of Health (2009)

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

From Ministry of Health (2009) Evaluation of Healthy Community Schools Initiative in AIMHI schools page xviii.

Requirements for an effective school-based health service
***Success factors*, Ministry of Health (2009)**

Previous research and the results of the evaluation of the HCS initiative in AIMHI schools indicate that there are nine inter-related success factors (the 9Cs) to consider when developing and implementing a school-based health service in a low-decile school. These are:

Community,
Communication,
Capital requirements,
Contract
Connectivity
Clarity,
Commitment,
Culture
Capability

From Ministry of Health (2009) Evaluation of Healthy Community Schools Initiative in AIMHI schools page 75-76.

SERVICES OFFERED BY SBHS

Descriptions of service components of SBHS are provided by the AIMHI evaluation (MOH 2009); the Service Specifications for School Based Health Services (Sinclair, 2006) and by many international sources including American Academy of Paediatrics (2008). These generally include:

- A mix of walk in (no appointment required), or booked nurse appointments for personal health issues. These appointments are likely to include screening, preventative care, assessment and referral for a range of health issues and risks. At times liaison with families or other providers or case management activities are required.
- GP appointments available for one or more sessions a week.
- Planned screening programmes. In the AIMHI schools comprehensive physical and psychosocial health assessments are carried out for all consenting students in Year 9. Additionally the HEADSS assessment may be used opportunistically when students visit the clinic. In the USA annual comprehensive biomedical and psychosocial checks for adolescents are currently recommended by the American Academy of Pediatrics (American Academy of Pediatrics 1995) and the US Maternal and Child Health Bureau (Green 1994).[6]
- Physiotherapy, social work, mental health or counselling services or related services such as alcohol and drug counselling or FPA services are offered from the clinic in many schools.
- SBHS often offer support with medication or management of symptoms for young people with chronic illnesses.
- Leadership, advice or support to the school for health education, student health council, health promotion or whole school approaches to support health and wellbeing of students.

SBHS CLINIC HOURS

In New Zealand there is considerable variety in the number of hours school health services are available, the AIMHI comprehensive SBHS are generally available for the school opening hours (MOH, 2009), whereas some schools have clinics provided by visiting professionals and open only a few hours a week (Bulkley et al, 2009). Most of the research demonstrating the effectiveness of SBHS tests comprehensive models that are open throughout school time and sometimes beyond. The Ministry of Health Guidelines (2004) suggest SBHS's need to be open at least 20 hours per week "to establish themselves in students' consciousness" (MOH, 2009, p 10). The guidelines available for school nurse to pupil ratios suggest a minimum of 1 fulltime nurse per 750 students (see next section). This would suggest that most Auckland secondary schools could expect to have fulltime nursing coverage.

The only research identified that directly tests impact of SBHS opening hours were US studies by Telljohann and others (Telljohann et al 2004a and Telljohann et al 2004b). These suggested that there were benefits in having clinics open throughout school time. They reported that in schools with nurses available 5 days per week 21 of 30 health service activities were accessed by students more than 2.5 times the rates that they were accessed in schools that had nurses for two days per week (Telljohann et al 2004a).

[6] See page 38 for more information on comprehensive health screening in adolescent health care.

SBHS NURSING – STUDENT RATIOS

The United States Department of Health and Human Services recommend at least 1 nurse per 750 students in healthy populations, with higher ratios for students with known disabilities or high health needs (Healthy People 2010, 2000). The US National Association of School Nurses also recommends a minimum of 1 school nurse to 750 students in healthy populations and:

- One nurse for no more than 225 students in the mainstreamed population
- One nurse for no more than 125 students who require complex heath care or are severely chronically ill or developmentally disabled (Association of State and Territorial Directors of Nursing 2008).

In New Zealand AIMHI schools were provided health funding for one FTE nurse per 750 students, however 6 of the 9 AIMHI schools provided additional nursing hours which they funded via other sources (MOH 2009).

SCHOOL BASED HEALTH SERVICES, LIMITATIONS AND CAVEATS:

The literature regarding school based health services is largely positive. Key caveats or limitations include:

Relationship with Primary Health Care

The majority of students access primary health care via a GP or family practice. SBHS also provide primary care. If the role and relationship of the SBHS to regular primary health care is not clear and supportive there is potential for problems associated with having two different systems providing similar services.

Support for students during holidays and after school and support for young people who are not enrolled in school

Some SBHS's are linked to Primary Health Care Organisations or/and explicitly seek to build links with the primary health care providers and encourage use of other providers outside of the clinic. If this is not done effectively then the part-time, school term only, availability of the SBHC is a weakness of the model.

Further, school clinics do not usually provide access for young people who are not at any school or who have left school. Again, this is a weakness if SBHS's are expected to be the major tool in promoting the health of young people. Utilisation of health care may be lower for older youth than school aged adolescents (Callahan and Cooper, 2010) and is poorer for those who leave school early than those who remain in school (Denny et al 2004, Fleming 2006). In the US some SBHS's are accessible to young people who are not students at the school (Berti et al 2001), or are placed on the boundary of the school property and can be accessed from inside or outside the school hours (Berti et al 2001).

Sustainable funding

In New Zealand primary health care is generally funded via General Practices which are part of Primary Health Care Organisations. Sustained funding for school health services may be problematic.

Potential for isolated practitioners

School clinics are often provided by one lead nurse. If the nurse is not well trained and supported by health and other staff within and beyond the school, there is potential for difficulties and risks associated with working alone in a complex role (Buckley et al 2009). School nurse turnover has been high in many clinics (MOH 2009) and nurses frequently report feeling professionally isolated (Buckley et al 2009). Actions such as employing nurses with a high

level of expertise; clear job descriptions and expectations; managerial and collegial support within the school; regular clinical supervision; peer supervision or support; GP or other medical support and specialist youth health training have been identified as reducing risk in this area and promoting effective services (Buckley et al 2009, MOH 2009).

WHAT DOES THE LITERATURE TELL US ABOUT COSTS, RELATIVE IMPORTANCE OR PRIORITY OF THIS AREA?

There is a lack of specific comparative data or cost benefit analyses. However school based health services have been supported by a range of professional bodies and are supported by the New Zealand Ministry of Health as a way forward for improving adolescent health. In New Zealand the MOH has prioritized the development of school based health services in decile 1-3 schools.

An estimate of costs is beyond the scope of this review. However it should be noted that CMDHB have undertaken some modelling exercises. CMDHB modelling (Sinclair, 2006) recommends in addition to existing school nursing services, for every 750 students, comprehensive school based services should have:

- 1 FTE registered nurse (funded by Health)
- GP session 5 hours per week (funded by a Primary Health Care Organization)
- 1 Guidance Counsellor (funded by Education)
- A Health and Safety person providing first aid, providing triage, follow up of lab tests, statistics and admin support working under the direction and supervision of the nurse (funded by Education).
- A reception and administration person at 40 hours per week during school terms (funded by Education).
- 1 Physiotherapist (funded by ACC)
- 2 Social workers/Community workers to work mainly with families of high risk students (funded by the Ministry of Social Development)
- Community liaison offices – focus on attendance and truancy (funded by Education).

FINDINGS 2: COMMUNITY BASED YOUTH SPECIFIC HEALTH SERVICES

INTRODUCTION

This section of the report reviews literature regarding community based health services for young people. We focused on services that are specifically for young people, provide comprehensive, youth friendly primary health care and sometimes other services, and can be accessed directly by young people without referral.

Terms*: Youth Specific Community Health Services, Youth Health Service, Youth One Stop Shops*

There is no single model of community based youth specific health services.
However typically community based youth specific health services, or more simply, youth health services (YHS) reported in the literature are:

- Specifically for young people
- Offer comprehensive youth friendly health care
- Based on youth development approaches and youth participation in service planning, delivery and evaluation
- Take a flexible, youth centred approach to ensure young people's health and wellbeing needs are addressed in concordance with the young person's wishes
- Aim to address multiple issues in a seamless and integrated way
- Often offer social, educational or other support
- Are provided from a youth friendly environment
- Often offer recreational or arts activities and may or may not offer drop in or hang out space
- Are provided at little or no cost to clients
- Have strong links to other providers and their local communities
- May offer outreach services

In New Zealand such services are often called Youth One Stop Shops (YOSS), although at times the term YOSS is used to include services that do not have a significant health component.

YOUTH ONE STOP SHOPS IN NEW ZEALAND

In New Zealand youth one stop shops have developed since 1994 in response to identification of young peoples health needs; acknowledgement that these needs are not well met by traditional health care services; understandings regarding barriers and facilitators of access to health care for young people and young people's preferences (Bagshaw 2006). Often these services were established on minimal budgets and in response to local needs and advocacy. In 2009 New Zealand had at least 14 services identified as a youth one stop shop (YOSS) (Communio 2009). These included 12 YOSS services which had a health focus (Communio 2009).

OVERSEAS MODELS

There are similar but varied initiatives in other counties around the world (Bennett and Tonkin 2003). For example in Australia there were 15 youth health services in 2005 in NSW alone (NSW CAAH 2005, Kang et al 2006). Since 2006 30 new community based youth specific health services have been established in Australia under the Headspace Initiative with more planned. Headspace services are designed to improve mental health and wellbeing however they provide help without referral from a single, youth friendly location for general health, mental health and counselling, education, employment and other services, alcohol and other drug needs. Headspace services do not usually include hang out space or a recreational focus, young people would usually only access them if they were seeking help. The centres are staffed with a range of youth friendly health professionals and are supported by national research and development functions (Hodges et al 2007)

Other models, such as 'Headstrong' in Ireland, also take comprehensive, youth specific approaches although this is perhaps better described as a 'hub and spoke model' with services directly accessible to young people provided in partnership with others and a strong community development, capacity building focus (Craig Hodges, Director of Service Development, Headstrong, personal communication July 2010, Melbourne).

AVAILABILITY OF EVIDENCE

Youth one stop shops and other community based youth health services such as youth health hubs are relatively recent service models and there is little empirical research in the area. The literature search identified no trials, systematic reviews nor cost benefit analyses of community based youth health services or youth one stop shops. Most of the research identified was descriptive, called for further research or advocated for services of this nature based on expert or youth opinion (Dewart and Zaengle 2000, Collins Management Consulting and Research 2002, Bennett and Tonkin 2003, Dempsey-Steward 2003, Detscher 2004, Kang 2005, Milne and McBride 2008).

However there is recent New Zealand literature which includes evaluative information mainly based on youth, provider or stakeholder opinions regarding existing or planned Youth One Stop Shop Services. Documents produced within the last five years are:

1) An evaluation of youth one stops shops for the Ministry of Health (Communio, 2009). This document reviews New Zealand health focused youth one stop shops using interviews and surveys with YOSS service management, stakeholders and 252 young people who had used YOSS's. It includes reports of service utilization and funding levels.

2) A report for Counties Manukau Health to inform planning for a Pacific youth one stop shop (Youthline 2006). The document includes information from Pacific young people from the district who visited YOSS's, participated in 2 youth focus groups and a survey of 125 Pacific young people and reviewed proposed key success factors for a Pacific focused youth one stop shop. The report also includes a literature review and information from interviews with YOSS providers and youth service providers in Counties Manukau.

3) A survey of New Zealand youth one stop shop services reviewing literature and reporting survey findings from one stop shops regarding services provided, key contracts held, funding, staffing and future plans (Bagshaw 2006).

SUMMARY OF EVIDENCE

- Young people generally report that they want and like youth specific health services.
- Youth one stop shops or community based youth specific health services are good at engaging young people, including young people who are not in school, training or work.
- Young people, providers and stakeholders find youth one stop shops in New Zealand helpful and in general think that they are effective and improve health outcomes for Maori and tauiwi clients.
- Youth one stop shops or community based youth specific health services are likely to increase access to health care, particularly among groups of young people who are underserved by mainstream health services.

Additionally:

- Youth one stop shops or community based youth specific health services in New Zealand and overseas often have a capacity development role and may facilitate developments to improve mainstream health service responsiveness to young people and to improve the wellbeing of young people in their communities.
- There are a number of descriptions of YOSS's in New Zealand (Communio 2009, Bagshaw 2006, Youthline 2006, Pinfold 2007).
- Opportunities to improve the evaluation capacity of youth one stops shops have been described (Communio 2009, Milne and McBride 2008).
- Critical success factors, operational challenges and opportunities for New Zealand youth one stops shops have been described (Communio 2009, Youthline 2006, Bagshaw 2006).

EVIDENCE IN MORE DETAIL

YOUTH PREFERENCES

There have been a number of projects asking young people via youth advisory groups, focus groups, hui and surveys what kind of health services they would prefer (including Youthline 2010, Fleming et al 2008, Milne and McBride 2008, Youthline 2006). These projects identify unmet health needs and barriers to health care. There is no one way forward indicated by all consultations – however generally young people in New Zealand report that they want services to be youth focused or youth friendly, have skilled staff, cheap or free services that are appealing or easy to access, have youth participation or governance and often have (or be located with) fun, cultural or recreational activities.

It is important to seek the input of young people local communities and from young people who have current health needs. People's perspectives of the kinds of help they want have been shown to be quite different when they are actually seeking help, from when they are just talking about it (Rickwood et al 2005, Wilson and Deane 2010). For example, young people who are not currently help seeking usually report that they want help through family, friends and people that they know, however when they want help for a current health problem some are more likely to say that they would like professional help (Wilson and Deane 2010).

Youth participation in the design and ongoing management of youth heath services is acknowledged as critical for their success (Communio 2009, Youthline 2006, Ministry of Health 2002). Ongoing participation is essential as young people's needs and perceptions of what will be most effective develop over time.

Three recent Auckland youth consultation projects have been carried out addressing these questions within the last five years. These are briefly described in the boxes below.

Waitemata District Health Board Youth Advisory Group: This culturally diverse group of young people from the Waitemata district was organised and trained by Youthline Trust. They participated in focus groups and a survey of 227 Waitemata young people re barriers to health care and opportunities to make health care appealing and effective for young people. It is recommended that this report (Youthine, 2010) be read alongside this literature review as it provides local and contemporary opinions. In brief, participants expressed a preference for:

- making health services youth focused and less clinical in how they present to young people;
- having youth specific services;
- understanding, skilled staff;
- having fun activities available onsite;
- have free or cheap comfortable services that are easy to get to, offer extended hours and are perhaps close to other facilities that young people use.

CMDHB Pacific Youth Consultation: This process and report was also facilitated by Youthline (2006). Pacific young people from Counties Manukau participated in focus groups and a survey regarding barriers to accessing health care and ways to increase access by Pacific youth. They reported that:

- staff skills and characteristics were critical
- a community-based youth health service should provide recreational activities and services including a drop in centre, counseling, youth law, health and other services
- some but not all young people thought that a service should be exclusively for young people
- some young people said it was important that staff were Pacific while other young people preferred to have staff members from outside their culture.

In the focus groups factors that were identified as most important were:

- that staff that make you feel respected; that they are experienced working with young people; that they have time to hang out with you and that they listen to your views.

In the questionnaire of young people the most important aspect of service delivery was that:

- it be a health centre just for youth and that centre have recreational activities including youth and cultural groups and that the centre be free or cheap, be easy to get to and involve young people in setting up the service.

Otarians health and wellbeing: This project investigated the opinions of young people in Otara regarding what would improve the health and wellbeing of young people in Otara (Fleming, King and Tregonning 2008). Most of the young people involved were Pacific although there was a substantial minority of rangitahi Maori. Youth opinions were sought via a steering group, a youth leaders group, interviews and a survey. To improve the health and wellbeing of young people in their community participants expressed needs for:

- environmental changes (such as having places to buy healthy food and safe places to cross busy roads)
- healthy behaviour being role modeled by youth leaders, families and others in their community (to achieve this suggestions included health providers working closely with youth leaders and family/community festivals, campaigns and challenges)
- improvements to existing health care services (such as shorter waits at GP services and friendly GP's)
- the establishment of youth health services to be provided via a new Otara specific youth café or youth centre or via existing Otara youth services.

ENGAGING YOUNG PEOPLE

The international and New Zealand literature suggests that youth health services or youth one stop shops are to be good at engaging young people (Kang 2006, Communio 2009). Such services typically have multiple access points or reasons to come to the service (such as general health care, sexual health, sometimes recreation, cultural or arts activities, sometimes social services) and make multiple efforts to reduce barriers to care; such as offering extended opening hours, outreach services, free services, youth friendly reception staff, welcoming environment, clear confidentiality policies and friendly accepting staff members (Communio 2009, Bagshaw 2006, Youthline 2006).

New Zealand youth one stop shops see large numbers of young people and have high demand for their services. The Communio evaluation of New Zealand youth one stop shops (2009) details that the 12 health focused youth one stop shops reported 137 163 occasions of service in the last year with a mean of 11 430 per YOSS. These YOSS's had 1000- 5000 registered clients as well as casual visits. Numbers of registered clients vary by size of catchment area, service model, length of time established and other variables.

Young people using youth one stop shops services report that they like the services, and that services are accessible, appropriate and acceptable (Communio 2009).

WHO USES YOUTH HEALTH SERVICES OR YOUTH ONE STOP SHOPS?

Various youth health services do have different target groups, for example Frontyard (Melbourne) and Cellblock (Sydney) target homeless young people, the Otago Youth Wellness Centre (Dunedin) was established to target young people who were truant from school. The Headspace centres in Australia target young people with mental health or drug and alcohol concerns.

Most of the YOSS's in New Zealand have specific relationships and strategies to encourage the participation of taitamariki Maori and Pacific young people via staffing and governance, service relationships, activities offered, location and promotion.

Most have an inclusive youth focus rather than targeting a single risk group, although they often target young people who have high needs via:

- the range activities and services offered (e.g. programmes for young parents, sports programmes)
- location
- outreach clinics to services which involve young people with high health needs (e.g. justice and alternative education programmes)
- diverse staffing
- relationships with other providers (such as migrant and refugee services, sex workers groups).

According to the Communio 2009 report, the majority of clients for most youth one stop shops are female and most are aged 15-24 with just over half being 15-19 years old.

Some YOSS clients are school students. Many are over the school leaving age and, as Bagshaw (2006) highlights, still have developmental needs best met within a youth focused service. Additionally youth specific health services can be one of the only low or no cost youth friendly health services that young people who have left school early and are not in work or training can easily access.

MAORI YOUNG PEOPLE

Nationally Maori make up 30% of health YOSS clients (Communio 2009). In some areas (e.g. Rotorua and Hamilton) 50% of young people seen are Maori (Pinfold 2000, Communio 2009).

Maori clients surveyed (Communio 2009) reported that they thought the YOSS was effective or very effective at providing them with access to the health services that they need. They reported that the reasons they used the YOSS's were the staff, location and youth friendliness of the service.

More than half the stakeholders surveyed as part of the Communio evaluation thought that youth one stop shops were effective in meeting the needs of rangitahi Maori. All YOSS have at least some links with one or more iwi providers/ Maori organizations although the Communio report (2009) notes that in some areas links could be strengthened and there is scope for increased collaboration.

PACIFIC YOUNG PEOPLE

Nationally Pacific young people make up a small proportion of YOSS clients, with the YOSS managers survey identifying 3% of clients as Samoan and 3% of YOSS clients as other, including other Pacific ethnicity (Communio 2009). Again, this varied among the services with several one stop shops reporting rates of about 20% of clients being Pacific.

One YOSS met with Pacific leaders to investigate why the service was not highly used by Pacific young people when it was established (reported in Youthline 2006). The leaders suggested that they did not want young people going there as it was 'where the naughty kids go'. Progress was made by strengthening links with Pacific communities.

Cultural activities and outreach services going into churches and communities were also seen as increasing participation by Pacific young people (Youthline 2006). The Youthline (2006) report specifically investigates the concept of a YOSS for Pacific young people in the Counties Manukau district. Based on Pacific youth input, stakeholder consultation and literature they identify that critical factors are:

- Location and physical environment
- Staff
- Funding and cost
- Youth driven
- Youth friendly service provision
- Coordination and collaboration
- Community involvement
- Reliability and consistency.

YOUNG PEOPLE'S USE OF YOUTH ONE STOPS SHOPS, SCHOOL HEALTH SERVICES AND GP CARE

Estimates of the proportions of YOSS clients who are enrolled in PHO's varies widely. Among YOSS clients surveyed as part of the Communio evaluation (2009) 43% said they were not enrolled in a PHO and 15 % said they were not enrolled and 42% did not know. Some of the YOSS clients did sometimes use GP care, but came to the YOSS for some health care, especially for more sensitive issues.

An analysis carried out in Rotorua found that the implementation of a YOSS service was not associated with a decrease in young people's use of traditional GP services in the area (Pinfold 2007). This finding is consistent with studies of school based clinics which have found that rather than competing with traditional primary care, providing convenient youth friendly care actually increases young people's appropriate use of other health care services.

Some YOSS clients are at school, for those who do have access to school based health services the YOSS may be particularly important during holiday periods (Bagshaw 2006).

YOUTH ONE STOP SHOPS OR COMMUNITY BASED YOUTH SPECIFIC HEALTH SERVICES APPEAR TO BE EFFECTIVE MODEL FOR INCREASING ACCESS PARTICULARLY FOR 'UNDERSERVED' OR 'HIGH-NEEDS' YOUNG PEOPLE

Many youth one stop shop clients are not enrolled with a general practitioner or choose not to attend a general practitioner for all their health needs (Communio 2009). Some YOSS clients (14% of those who participated in the Communio survey) said that without the YOSS they would not access any health care. These clients tended to be

those with higher health and social needs (Communio 2009). 30% of users of the Christchurch YOSS in an earlier evaluation reported that without the YOSS they would not get any care (Geddes 1997, cited in Mathias 2002).

The Communio surveys indicated that young people and most stakeholders believe YOSS's do well supporting vulnerable young people (Communio 2009).

YOUTH ONE STOP SHOPS AND HEALTH OUTCOMES

No studies were identified that could show whether or not YHS and YOSS's improve health outcomes. However New Zealand providers of YOSS services, stakeholders and clients have high levels of belief that YOSS's are effective and improve health outcomes for Maori and for tauiwi clients (Communio 2009).

YOUTH CENTRES

There is some international literature regarding youth centres. The Youthline 2006 report provides a brief overview of this. They outline research investigating why many young people do not use particular youth centres. The identified barriers include: off putting locations; youth and or parent perceptions of who uses the centre; the centre being seen as being taken over or belonging to particular youth sub cultures only and bullying within centres.

Some literature finds that unstructured time at youth centres may increase antisocial behavior among young people who use the centre (reported in Youthline 2006).

MODEL OF PRACTICE

There is no single model of practice of community based youth health services. Like school based health services, responsiveness to communities and flexibility are seen as key elements for success. Common key features of youth health services have been outlined in the 'terms' box on page 22.

There is considerable variation in youth one stop shops and youth health services in how much they are a place young people go to when they are seeking help versus. how much they are a centre to spend time or engage in recreational activities. Some YOSS's in New Zealand are primarily a health service for young people with a friendly welcoming environment and things to do while you wait. While others (e.g. the Palmerston North YOSS) began as a youth centre and later added a health component. Some (e.g. Rotovegas in Rotorua) provide a youth health service which is in the same building as a youth centre but can be accessed via a separate door.

Additionally some youth health services provide outreach services and satellite clinics (e.g. The Vibe based in Lower Hutt provides clinics in schools, in Alternative Education schools, and in more remote parts of the area), whereas others provide most of their services from a single site.

Communio (2009) analyze how existing New Zealand YOSS provide services and work with other providers. Their analysis included interviews with 94 providers who work with OSS services. They conclude

> *'The way in which Youth One Stop Shops provide services is unique and highly valued by other providers in the sector. While the Youth One Stop Shops do not provide any services that are not available elsewhere the integrated and youth –specific model of care increases access by youth, particularly those who have higher need.'*

There is currently a diversity of aims of youth health services and communities that they serve. There is not currently literature to point to a single ideal model for all of these.

YOUTH SPECIFIC COMMUNITY BASED HEALTH SERVICES – LIMITATIONS AND CAVEATS

Evidence

There is little empirical evidence for community based youth specific health services, although strong rationales and positive feedback exist. There are risks with a youth centre approach, although many youth health services do not use a youth centre model and potential difficulties associated with youth centres may be addressed.

Relationship with Primary Health Care

Many young people access a GP or family practice for some of their health care. If the role and relationship of the service to regular primary health care is not clear and supportive there is potential for problems associated with having two different systems providing similar services.

Sustainable funding
In New Zealand sustained funding for youth one stop shops has been a major challenge. Insufficient funds have limited services abilities to respond to identified needs and has forced the closure of some services.

Workforce
There are currently few youth health trained professionals in New Zealand.

WHAT DOES THE LITERATURE TELL US ABOUT COSTS, RELATIVE IMPORTANCE OR PRIORITY OF THIS AREA?

There is a lack of specific comparative data or cost benefit analyses. However community youth specific based health services are likely to be particularly important for:

- young people who are not well served by GP care or school based health care, and
- those who have sensitive health issues concerns or multiple health needs.

An estimate of costs is beyond the scope of this review. However it should be noted that specific YOSS service funding levels and output information is available in the 2009 Communio review.

FINDINGS 3: GENERAL PRACTICE CARE FOR YOUNG PEOPLE

INTRODUCTION

Most young people in New Zealand have seen a General Practitioner (GP) within the last year and see the GP or family doctor as the main place they get health care. However, many young people report barriers or problems (such as cost, embarrassment, not wanting to be bothered or concerns regarding confidentially) to seeking health care. Often barriers are found to be particularly high for taitamariki Maori, Pacific young people and sometimes Asian or other migrant groups; young people in higher deprivation communities and same sex attracted young people.

Additionally when young people do see GP's this is often for short term illnesses or difficulties (especially respiratory or skin care issues) not for issues that represent the main burden of disease in this age group (such as mental health and behavioural issues).

There is a lack of robust evaluation of General Practice care for young people; however there is a large body of literature calling for youth friendly services. In addition, available research suggests:

- young people often seek care from more than one provider or 'medical home'
- GP's report difficulties in providing 'youth friendly' care
- where young people are more familiar with their GP they are less concerned about barriers to care.

When youth specific services have been compared to non-youth specific services such as traditional GP services, in general:

- young people prefer youth specific services
- young people who have access to youth specific services have increased use of primary health care
- youth specific services are more likely to offer 'youth friendly care'[7].

However it should be noted that:

- General Practice based primary health care is a key component of the New Zealand health system and of efforts to improve the health status of communities
- many of the barriers which reduce young people's use of General Practice care can be addressed.
- there are many models of providing youth friendly primary care by GP organizations although few of these have been robustly evaluated.

This section of the report explores the evidence, models of service and opportunities for improving youth health via community based General Practices that are not youth specific services.

[7] The term 'youth friendly' health care or services refers to a set of characteristics to improve services appeal and efficacy with young people, these have been well described by the WHO and others – see Appendix 1.

Terms

'General Practice', 'Primary Health Care' and 'Family Doctors' are often used interchangeably. However School Based Health Care and Community One Stop Shops are also examples of Primary Health Care. This section focuses on care for young people delivered by General Practices that are based in communities and are not specifically focused on young people. Although these services may be provided by a range of professionals they are often referred to as General Practices or Family Doctors. To avoid confusion the following terms are used here:

General Practitioners or GP's – to refer to the doctors themselves (doctors who are vocationally registered as General Practitioners)

General Practices – to refer to primary health care practices, based in the community, which are not set up specifically for young people. These practices typically include doctors, nurses and others.

THE EVIDENCE

UTILIZATION OF PRIMARY HEALTH CARE

a) The majority of young people see a GP at least once a year

75% of male and 79% of female of New Zealand secondary school students who participated in the Youth'07 Adolescent Health Survey had seen a GP within the last year (AHRG 2008a). Most (88%) of the nearly 10 000 students in the survey said the place they would usually seek health care was a family doctor, medical centre or GP (AHRG 2008b).[8] This is in keeping with international findings that in developed countries, 70-90% of young people contact primary health care services at least once a year (Tylee et al 2007).

There are differences among different population groups within New Zealand, with Asian, Pacific and Maori young people and young people in more deprived areas in the Youth'07 survey reporting lower rates than others of having seen a GP/Family doctor in the last year (see Appendix 2 for details and a brief description of the Youth07 survey of high school students).

b) Young people often use more than one health care provider

Young people often use more than one health care provider (Communio 2009, New Zealand Association of Adolescent Health and Development 2006). As children, many young people will have had a family primary health care provider. As adults many of them will not have the same provider. During the adolescent years young people often seek help from range of providers. A comprehensive study of young people attending General Practices in

[8] After the 88% who picked 'Family doctor, medical centre or GP clinic as the place they usually went for health care, the next most common response 'I don't go anywhere for health care' which was selected by 4% of participants; and then a school health centre (reported by 3%).

Australia (Haller et al 2007) reported that only half of participants waiting to see a GP were attending their usual practice.

c) Many young people report difficulties getting help for health issues

The Youth'07 survey also explored difficulties getting health care. 77.5% of the students in the least deprived communities and 58% of students in the most deprived communities reported that they had not had difficulty getting help for health issues when they needed it in the last year. Again there are differences among communities, with students in the least deprived communities, highest decile schools and New Zealand European and Asian students reporting the least difficulty getting help (see Appendix 2). Students who are same-sex attracted report high rates of having wanted to see a health professional but not being able to (26% compared to 16% of opposite sex attracted students) (Rossen et al 2009).

Young people report many barriers to GP health care. These include cost, opening hours, location, waiting times, attitudes or friendliness of reception and clinical staff, concerns about confidentiality and privacy, embarrassment and reticence, not wanting to be bothered, short appointment times and not knowing that there was help available or that the health professional could help with the issue (Youthline 2010, Adolescent Health Research Group 2008, Fleming et al 2008, Bernard et al 2004, Booth et al 2002). In general young people are more concerned about personal barriers - confidentiality, trust, embarrassment, shame and fear of being judged than they are about structural barriers (such as cost, location and hours) to health care (Bernard et al 2004). Bernard et al (2004) report that these personal barriers are lower for young people when they get to know their GP well.

d) General Practitioners also report barriers to proving care to young people

GP's perceptions of barriers for them to providing youth friendly care include: lack of time; lack of training with dealing with behavioural health issues; lack of specialty care to deal with behavioural issues; issues relating to parental time and income; concerns about using stigmatising labels or stigmatizing normal behaviour; difficulties relating to clinical organisation and management including privacy and cultural differences (Bitar et al 2009).

e) Young people typically do not raise mental health or behavioural issues with the GP

International research suggests that when young people do access health care this is most often for short term physical health concerns – especially dermatological and respiratory issues (Haller et al 2007; Tylee et al 2007). This contrasts with the burden of disease in adolescents (predominantly associated with emotional and behavioural issues) and the importance of preventative care in this age group.

A range of research has reported that young people would welcome a discussion on health issues such as substance use, sexual health, relationships or mental wellbeing and see their doctor as a reliable source of advice however on many occasions young people do not disclose these concerns unless prompted (Tylee et al 2007, Fleming et al 2008, Walker and Townsend 1999). In an Australian study of 450 young people who were interviewed before they saw their GP Haller et al (2007) identified that most of the young people did not consider that they had an illness, yet they were worried about a particular health issue. More young people were prescribed medication than expected to receive it. Many of the participants simply wanted reassurance or advice.

In the same study (Haller et al 2007) the authors identified that although only 10% of the participants were seeking help for a psychological issue, 24% thought that they currently had a mental disorder and on pre-appointment screening 36% had scores suggesting a mental disorder. Mauerhofer et al (2009) in a cross sectional survey of 7429 Swiss young people reported that the large majority of young people needing help for psychological problems did not seek help, even though they regularly consulted their GP.

f) Summary: young people's utilization of GP care

Taken together, these findings suggest there are a range of issues to address that can be addressed to enhance the impact on youth health of primary care, these should include not only efforts to increase enrolments in PHO's or the number of times young people see GP's, but should also include efforts to better match the kind of services young people do get from the GP to their health needs.

EVALUATIONS OF PRIMARY HEALTH CARE FOR YOUNG PEOPLE

This review identified little evidence regarding the effectiveness of primary health care for young people. Most of the published research evaluates the impact of youth specific primary health care, particularly of school based health services, or occasionally, community based youth heath services such as youth one stop shops (Tylee et al 2007; Mathias 2002). These findings are referred to in more detail in the sections on school based services and community based youth specific services. However relevant conclusions are

- Young people without access to youth specific services use primary health care services less than young people with access to youth-specific services do (Mathias 2002; Brindis et al 2003) and have higher rates of use of emergency care (Juszczak et al, 2003; Key et el 2002).

- Non-youth specific providers of primary care are less likely to offer young people preventative screening and anticipatory guidance, are less likely to see the young person in private and are less likely to explain the confidentiality of services to young people than youth specific health services are (Denny et al 2005, Klein et al 2007).

- In youth satisfaction surveys or investigations of health preferences young people typically express a preference for youth specific services over a family doctor or GP (Mathias 2002). 30% of clients of the Christchurch youth health service said they would not have used other health services had that youth service not been there (Geddes 1997 cited in Mathias 2002).

EVALUATIONS OF 'YOUTH FRIENDLY' PRIMARY CARE INTERVENTIONS

Where health providers have tested primary health care interventions specifically aimed to appeal to young people or increase access among young people these have been promising. In 2007 Tylee and others carried out a systematic review of 'youth-friendly' primary care services. They reported that:

a) Most of these studies were observational, however the available data did suggest youth friendly interventions do increase access to health care.
b) The only two randomised controlled trials reported did show an increase in access to care associated with nurse led wellness clinics in the UK and with youth friendly pharmaceutical advice in Bolivia.
c) Five studies measured the effect of youth friendly health services on young people risk behaviours. These generally reported modest positive changes:
   - There were small but positive effects on health risk behaviours in a randomized trial of nurse-led wellness visits in UK general practices.
   - In three youth friendly interventions aimed at sexual risk taking there were improvements in sexual-risk behaviours among girls only in one study and among boys and girls in the others.
   - In a UK quality improvement intervention for the management of youth depression in primary care (involving expert team leaders; care managers; youth and provider choice of treatment) there were improvements in symptoms of depression for young people.
d) Provider performance in addressing youth health issues can be improved with appropriate training. A comprehensive adolescent health training package for GP's was tested in a robust trial in Melbourne. GP

knowledge, attitudes and self-reported behaviours were improved following the training and were maintained at a five year follow up (Sanci et al 2005).

In New Zealand Morgan and Haar (2009) reported that free general practice sexual health visits for registered adolescents was associated with an increase in Chlamydia testing among under-25 year olds at the intervention practices, and that the free GP visits for under-25 year olds living in rural and lower socioeconomic areas in New Zealand was associated with a significant increase in testing and detection for Chlamydia trachomatis in the target group.

MODELS OF CARE: IMPROVING GENERAL PRACTICE FOR YOUNG PEOPLE

A range of models to increase the effectiveness of General Practice care for young people have been described or are suggested by the needs and barriers identified in this review. Few of these have been evaluated although there are some projects underway (Melissa Kang, University of Sydney, personal communication, June 2010).

Kang et al in their extensive 2005 review identify the following models which aimed to increase youth friendliness of GP care in New South Wales:

- **GP education within schools**.

This involves GP's talking with classes of students about using GP services. This model was popular among Divisions of General Practice and the schools that they worked with. One such programme had demonstrated increased intention to seek help among students, and further evaluations were planned.

- **GP clinics in existing youth services**.

This involves GP's travelling from their usual practice to a service which young people were already using and seeing them there. This was particularly aimed at marginalized young people and partly aimed to encourage the young people to access GP's via their usual clinic once they had a relationship of trust. Some of these clinics had demonstrated an increase in utilisation of services and all demonstrated an increase in the GP's confidence and knowledge. Some had not been sustainable due utilisation rates and funding issues.

- **School based clinics**

This is where GP's provide a clinic in a school or support an existing school based health service with GP hours. One evaluation reported the service was well utilised but needed excellent collaboration with the school.

Other possible models of General Practice service delivery or developments to support youth health include the following:

- **Youth health standards and frameworks for 'better practice' within existing General Practices.**

Standards or frameworks for youth health care have been developed for Primary Care and other providers in numerous settings. In New Zealand the College of General Practitioners publishes a guide for GP's in working with young people (RACGP, 2006). This has been developed and reviewed by New Zealand practitioners and provides practical guidance for communication, screening, managing key adolescent health issues. Additionally there are local draft standards for youth health services (Kidz First Centre for Youth Health and the Youth Health Expert Working Group 2006). Other frameworks include the WHO Principles for Adolescent Friendly Care and the New South Wales Centre for the Advancement of Adolescent Health Youth Health Better Practice Framework (2005), extracts from each of these are included in Appendix 1.

- **Training of primary health care providers**

A multifaceted educational programme (2.5 hours per week for 6 weeks) in the principles of adolescent health care, followed 6 weeks later by a 2-hour session of case discussion and debriefing was developed and evaluated in a randomized controlled by Lena Sanci and others in Victoria. Sustained, large improvements in GP knowledge, skill, and self-perceived competency were reported (Sanci et al 2005).

- **Building relationships and trust**

Bernard et al (2004) carried out an in-depth investigation of general practitioners and young people's perceptions of barriers to health care for young people. They concluded that young people's most significant concerns related to concerns about confidentially and trust, fearing the providers might tell others about their issues, being seen accessing the health services, feeling embarrassed and concerned about being judged negatively by the provider or not knowing what the provider could offer. In this study young people felt if they got to know the provider many of these barriers would be reduced. These findings are consistent with attitudes expressed by young people in qualitative work in New Zealand (Youthline 2010, Milne and McBride 2008). This information suggests that there may be simple opportunities for improvements in General Practice care for young people involving an emphasis on building relationships between the providers and young people, explicitly addressing confidentiality and embarrassment and helping young people to feel more comfortable about disclosing personal information.

- **Viewing adolescents as new users of health services**

The UK Royal College for Paediatrics and Child Health paper on Health Care for Adolescents (Royal College for Paediatrics and Child Health 2003) suggests that young people should be regarded as new users of health services and offered a specific appointment to met their GP and discuss and negotiate their general practice service. This could include a discussion regarding confidentiality; the range of issues addressed by the GP and other professionals in the practice and having an opportunity to decide whether to continue with their parents GP or chose their own. If this is offered as a routine process to young people as they grow up and is explained to parents and young people in advance, such an introduction appointment could potentially address many of the identified barriers to high quality GP care for young people.

- **Extended role for nurses or other non medical professionals in General Practices**

School based health services and youth health centres have been identified as often providing more satisfactory care to young people than General Practices do. The former services are typically provided by youth health trained nurses or social workers, youth workers or peer supporters in the first instance. A minority of clients are then seen by a doctor if this is indicated. Providing a well trained and supported member of staff who is not necessarily a GP may represent an opportunity for General Practices too.

- **Extended appointment times**

Extended appointment times are suggested as part of providing youth friendly health services by the WHO (2002) and others. Extended appointments can allow time for explaining confidentiality, relationship building, screening and following up sensitive heath issues. This might be done by funded appointments and or by utilising non medical health staff.

- **Free appointments**

All appointments being free or a schedule of free appointments (e.g. for an annual visit) might increase young people's use of health care. This approach was effective for a Chlamydia screening initiative reported by Morgan and Haar (2009). It is critical that people know that the appointments are free (Fleming et al 2008).

- **Screening**

There is considerable advocacy for routine screening for sensitive health issues among young people. This is on the basis that young people do not typically proactively disclose sensitive behaviours to health providers and yet they are often willing to, or indeed want to discuss them. Further many of these behaviours can have significant health consequence or interact with other health problems, for which the young person may be being treated.

The American Academy of Paediatrics, American Association of Family Physicians, American Medical Association (AMA), the Society for Adolescent Medicine, the US Preventative Services Task Force and others recommend routine preventative health screening for biomedical and psychosocial aspects of health for adolescents (Park et al 2001). Most recommend annual visits, de-emphasise screening for rare disorders and encourage anticipatory counselling and a preventative approach (Park et al 2001). Solberg et al (2009), suggest there is currently a lack of evidence to support some components of screening on such a regular basis. However the recommendations are based on the rationale that:

1) risk behaviours change rapidly and unpredictably through the adolescent years and

2) timely personalized anticipatory counselling and early intervention seems to be effective and have a positive cost benefit ratio (i.e. saves more than it costs) (Elster and Kuznets 1994 ; Parks et al 2001).

In New Zealand the year 9 assessments and opportunistic youth health screens when young people return to school clinics have been reported as a key part of the success of the AIMHI initiative (MOH 2009).

Parks et al (2001) report an estimate of $130 per year (2001 US dollars) per young person to provide the routine preventative services recommended for adolescents by the AMA. They quote a range of estimates suggesting that for every dollar spent on screening in adolescence long term health costs are reduced by a greater amount.

Routine screening within clinical appointments takes time. Pen and paper or computer based questionnaires regarding current health behaviours and concerns prior to consultation with the provider may feasible. Lewin et al (2009) reported that a pre-visit questionnaire for adolescents tested in a Canadian clinic increased the rate of psychosocial issues being addressed and reduced the number of medical interventions by 43% - this included fewer prescriptions being written and fewer medical tests and investigations.

GENERAL PRACTICE CARE FOR YOUNG PEOPLE – LIMITATIONS/ CAVEATS

There are low rates of enrolment among Maori, Pacific and Asian young people in Waitemata in primary health care organisations. GP care would need to be engaging and effective for Maori, Pacific and Asian young people as well as other groups of young people in order to support their health needs and to reduce disparities.

There are significant barriers for many young people seeing GP's or seeing them about important issues. There are a range of possible ways to address many of the specific concerns young people have about GP care however many of these require considerable efforts by General Practices and at the current time there little evidence to show that these approaches are effective or little training to support such changes.

WHAT DOES THE LITERATURE TELL US ABOUT COSTS, RELATIVE IMPORTANCE OR PRIORITY OF THIS AREA?

There is a lack of specific comparative data or cost benefit analyses however the development of school health or youth specific community services requires significant investment. Investment in GP care may also yield gains.

As the key component of the primary health care system in New Zealand, the main place that many young people go for health care, and the place that young people are likely to get care before and after the years when they are able to use school based or youth specific services, GP care should be an important part of a strategy to improve youth health in the district.

FINDINGS 4: IMPROVING THE HEALTH OF YOUNG PEOPLE - OVERARCHING THEMES

WHAT WORKS TO IMPROVE YOUNG PEOPLE'S HEALTH?

Youth health centres, one stop shops, school based health services and community based General Practices are all ways of providing primary health care to young people. Reviewing the literature for each of these areas reveals many common themes and challenges. This section of the report explores evidence, needs and opportunities to improve youth health for all of these and other models of service delivery.

There are key developments in adolescent health research and practice which are important for improving the health and wellbeing of young people across a range of sectors and interventions. These themes are based on new understandings of adolescent health and development and on the kinds of interventions that have been successful in this age group. These key themes underlie a broad range of contemporary best practice interventions, in brief they are:

- **Address key risk and protective factors.** As with other age groups the factors which have the biggest long term impact on young people's health status are not usually related to health services, but to the context in which young people live –families, access to resources, current and future connections with society (e.g. connectedness to family, having skills for work and having hopes for the future) and safe environments (such as safe roads, limited availability of drugs and guns) (Centers for Disease Control and Prevention et al 2004, Blum 1998).

- **Provide adolescent focused interventions**. Adult or child focused services have met with limited success for teenagers. Rather, interventions should specifically seek to engage youth and consider the specific risks and opportunities for working with young people within their culture and communities This includes youth development approaches (Centers for Disease Control and Prevention et al 2004).

- **Utilise youth development approaches.** Youth development interventions aim to address key risk and protective factors and provide developmentally and culturally appropriate interventions to enhance young people's skills, strengths, sense of belonging, ability to contribute to their communities now and in the future. Youth development approaches typically build on strong relationships with young people and focus on developing young people's strengths rather than, or rather than only, focusing on reducing health problems and risks. Where youth development approaches are utilized alongside interventions to address health risks these can be effective in promoting young people's strengths and abilities and protecting young people against multiple risk outcomes (Kirby 2009, Denny 2004).

- **Include comprehensive, multi-level approaches.** Recent research has highlighted that: there are common antecedents to diverse adolescent health problems; risk behaviours tend to cluster and engaging in one risk behaviour often contributes to other negative health outcomes. Secondly, individual, family and social level factors are important in adolescent health. For these reasons comprehensive, multilevel approaches are important in efforts to improve the health and wellbeing of populations of young people (Centers for Disease Control and Prevention et al 2004).

WHAT DO THESE THEMES MEAN FOR HEALTH SERVICES?

In terms of clinical service provision these themes suggest services should:

- Urgently focus on workforce development. The orientation of a workforce to effectively engage young people and positively intervene to reduce negative health outcomes and promote healthy development requires a workforce that is skilled and knowledgeable in this emerging field of health care..

- Provide 'youth friendly health services' (see Appendix 1). This includes an emphasis on good quality relationships; providing explicitly confidential services; routinely screening for a broad range of biomedical and psychosocial issues; emphasising prevention; discussing sensitive health issues and providing individualized support and follow up.

- Utilise approaches that are comprehensive, holistic and 'joined up' over narrow specialist roles and multiple referrals for different issues.

- Work with a variety of partners when young people have complex needs beyond the individual services competencies. This may include having information sharing protocols, common assessment frameworks, clearly identified lead professionals in complex cases and includes utilizing and having input into existing intersectorial collaboration mechanisms.

- Work across sectors to encourage population, community, school and family level interventions that will improve the health of young people. For example:
    - Supporting youth development projects that enhance whanau connections, young people's skills, community connections etc.
    - Supporting preventative interventions undertaken by other agencies (such as liquor licensing, road safety etc).
    - Supporting interventions that improve youth health that are offered by other agencies such as whanau ora programmes, pharmacy interventions etc.

FOR WHICH YOUNG PEOPLE?

Young people from a range of cultural and socio-economic back grounds report very similar barriers to traditional health care and report similar preferred ways of increasing access to health care; however, there are disparities in both health outcomes and access to services between different populations of young people.

National and international literature and the WDHB youth health strategy suggest interventions to improve the access of all young people to health care as well as specific targeted interventions for young people who have higher health needs. Groups of young people who have high health needs are listed on page 9.

IMPROVING THE HEALTH OF YOUNG PEOPLE –WHICH MODEL IS BEST?

No literature was found that compared the impact of school based services, youth specific community based services and general practice care as strategies to improve young people's health, however it is clear that:

- School based health services can have a positive impact for those at school.
- General Practices are the first point of contact most young people seeking health care, and there are opportunities for General Practices to better meet the needs of young people.
- Youth specific community health services are likely to have an impact, particularly for those who are not well connected to school based care or general practice care.

There are other services types that may also improve the health of young people (Kang et al 2005, Tylee et al 2007). These are described in the table below.

Models of service provision aimed at improving access to or quality of health care for young people other than: school based health services, youth specific community based health services and youth friendly primary care (after Kang et al 2005, Tylee et al 2007)

Maori and Pacific specific models

Multiple sources suggest that the needs of Maori and of Pacific young people have been poorly met by mainstream health services. No literature for Maori or Pacific specific models except for a Pacific focused youth one stop shop was identified as part of this review. This is a gap in the literature.

Existing youth consultations suggest cultural skills and connections of staff and community connections are critical and that young people might want to be able to access care both within and outside of their communities. The Youthline 2006 consultation reported that Pacific young people wanted to be offered the option of Pacific centred care and Pacific or non-Pacific staff members. A consultation carried out by Te Puni Kokiri (1994) (cited in Mathis 2002) of taitamariki suggested that Maori staff were important but they should not be too close in age or too closely related. In the Otara youth consultation (Fleming et al 2007), young people wanted both family centred and youth specific interventions.

Outreach clinics and mobile services

Outreach and mobile services may be provided as stand alone services or part of a youth health centre, general practice or other programme. They are particularly used to reach young people who are marginalized from regular health services.

Integrated clinical services

Young people who have multiple needs are often involved with many agencies, often with serial referrals, ineffective engagement and a lack of co-ordinated effective care (Fleming 2007, Auckland Youth Support Network 2006). There are a range of approaches including Strengthening Families, High and Complex Needs and Whanau Ora which are designed to reduce gaps and improve the effectiveness of existing health services. In the UK "Making it Happen" (Department for Children, Youth and Families 2008) details a child and youth orientated reform package aimed at integrating systems and processes. This includes common assessment frameworks, information sharing protocols, shared training and case reviews and clearly identified lead health professional for young people with multiple issues. In New Zealand there have been local improvements described associated with interagency reviews of shared complex cases and shared training processes.

Models of service provision aimed at improving access to or quality of health care for young people other than: school based health services, youth specific community based health services and youth friendly primary care *continued* (after Kang et al 2005, Tylee et al 2007)

Area based youth health co-ordinators

As described by Kang et al (2005) these co-ordinators aimed to:

- facilitate and support activities and projects that assisted in the strategic development of youth health care within the area
- develop and maintain a co-ordinated approach to youth health care within the area
- Work in collaboration with key stake holders, relevant agencies and young people to enhance access to services by youth.

Kang et al (2005) report that this approach appeared to have been effective in improving service co-ordination in some areas and recommended this as a useful strategy.

Hospital based adolescent health centres

Hospital based adolescent services have been important in some urban centres, providing inpatient and outpatient secondary care and often supporting broader sector development.

Community services that are not youth specific

For example Maori health providers, Pacific health providers, Family Planning units, pharmacies and some shops may undertake interventions to improve young people's health.

Internet and technology based services.

There are a number of internet and telephone based services where young people may access advice, information or support. These are typically implemented nationally or regionally rather than at district level.

Current best evidence suggests culturally appropriate, youth friendly services provided using range of models are needed to increase access to health care for young people. This should include improvements in 'mainstream' (non–youth specific) services for young people as well as the development of youth specific services.

The World Health Organization (2002) and others including the Society for Adolescent Medicine (2004, 2009) the Royal College of Paediatrics and Child Health (2003) and the New Zealand Association of Adolescent Health and Development (2006) emphasize that that young people need a variety of health services to meet their needs and that accessible youth friendly health services should not be restricted to a particular model but address critical issues across a range of settings. Writing for the World Health Organisation, Homans (2003) reports:

> "*Whilst there cannot be global consensus on the ideal model for service delivery for young people (as they are a diverse group with varying needs), there are varying factors which are generally agreed to facilitate the responsiveness of services to young people's needs. These factors were identified at the WHO Global Consortium on Adolescent Friendly Health Services."*
>
> Homan, 2003, p 3.

CONCLUSIONS

The evidence reviewed in this report suggests that:

A) No one initiative will improve access to health care for all young people in Waitemata. Rather:
- The majority of young people who are at school are likely to benefit most from GP or school based initiatives.
- The majority of young people who have left school are likely to benefit most from GP, student health services in tertiary institutions and youth specific health services that they can access in the community.
- Young people who under 16 or 17 years old and are underserved[9] are likely to benefit most from health support of agencies that are currently effectively engaged with them and from initiatives to improve collaborative work between agencies.
- Young people who are over 16 or 17 years and are underserved, are no longer eligible for many comprehensive services (such as Youth Justice, Child Youth and Family, Alternative Education support) and are likely to benefit from youth specific health services that they can access in the community.

To implement such a range of initiatives will require time, funds and ongoing training. For these reasons longer term goals and initial steps are suggested in the recommendations section and workforce development is a key recommendation.

B) There are considerable youth health gains that may be made by interagency and intersectorial efforts. Such efforts will require ongoing investment in partnership development, information sharing and leadership.

[9] Have high health needs and yet typically have low rates of utilization of mainstream preventative health care services.

SUMMARY OF RECOMENDATIONS

1. **To support the co-ordination and ongoing implementation of the following youth health goals it is recommended that a youth health team or 'hub' be established.**

2. **Waitemata DHB should implement a 3 pronged strategy to improve access to 'youth friendly health care'[10] for young people in the district:**
   - iv) **Improve access for the most underserved via a youth specific community based health service and youth health outreach services through agencies that those young people are already engaged with.**
   - v) **Increase delivery of 'youth friendly care' in General Practices.[11]**
   - vi) **Improve access for school students via comprehensive youth friendly school based health services particularly where students have poor access to health care and have high health needs.**

3. **Waitemata DHB should develop a strategy that leads to a workforce with expertise in youth health.**

4. **Waitemata DHB should seek opportunities to improve the health of young people in Waitemata from interagency and intersectorial collaboration.**

RECOMMENDATIONS & FIRST STEPS

Recommendations are made based on the youth health literature and should be considered alongside youth, community and provider feedback and WDHB goals and opportunities.

RECCOMENDATION 1

To support the co-ordination and ongoing implementation of the recommendations in this report it is recommended that a youth health team or 'hub' with clinical expertise is established. Such a team or hub should: provide youth health clinical services particularly to young people who have high health needs and are underserved by existing services; provide clinical youth health expertise to support other services and support the development of youth health capacity in the district.

[10] 'Youth friendly care' or 'adolescent friendly health care' refers to service characteristics as described in Appendix 1.

[11] See Appendix 1, also see page 36 for GP specific models for increasing 'youth friendly care'.

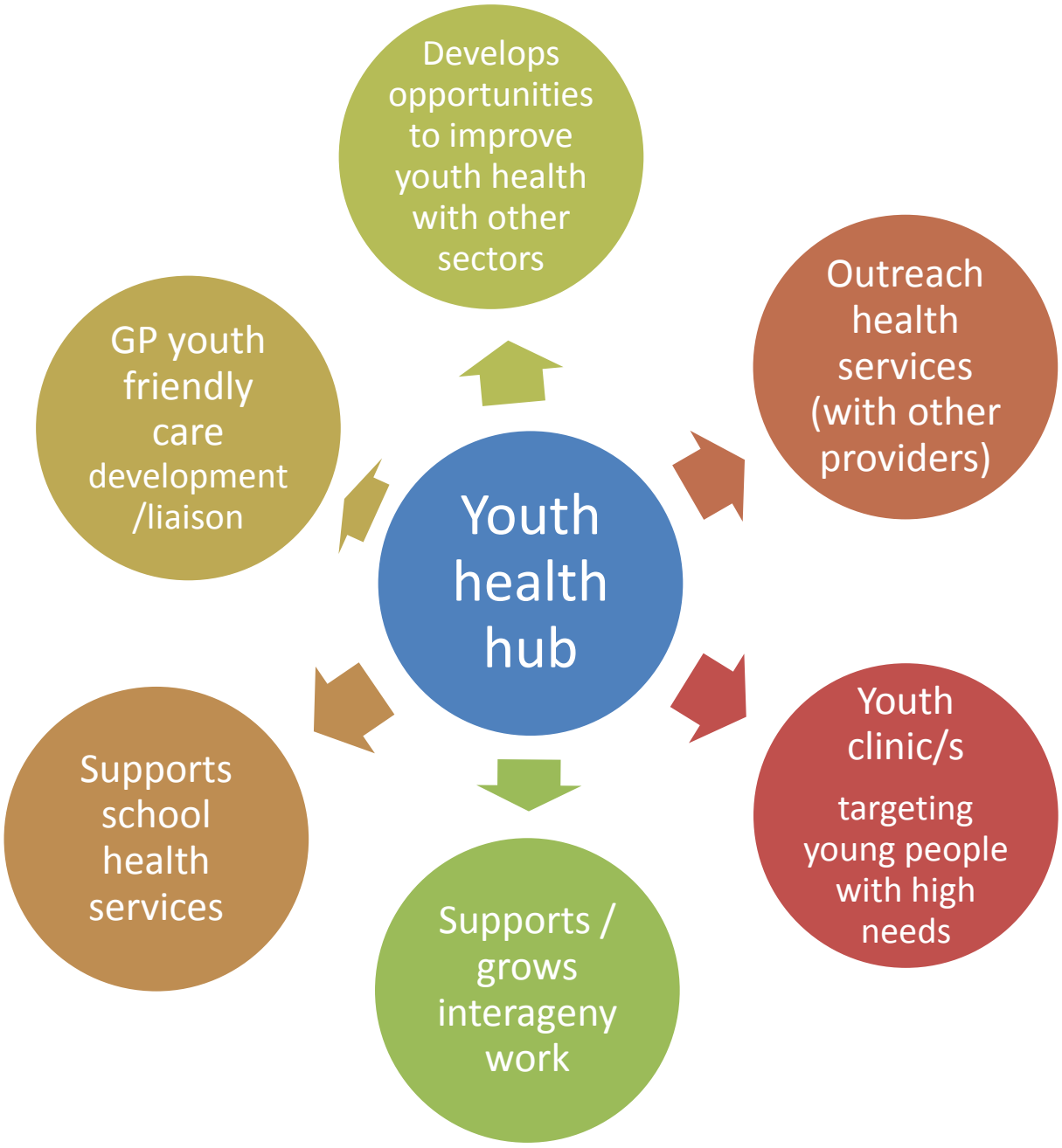
Specifically a hub should:

1. Improve access to youth friendly health care for young people who have high health needs and poor access to care via:
   - the provision or support of outreach services
   - the provision of a youth specific community ' youth friendly' health service that young people can access directly when they wish to.

   Some or all of these clinical services might be offered in collaboration with other providers.
2. Support school health services.
3. Support the growth of General Practice youth friendly care via development/liaison roles.
4. Provide or ensure the provision of training and development to improve workforce capacity and youth friendly health care available in other settings.
5. Facilitate interagency collaboration to improve services for young people who have high health needs (e.g. via information sharing protocols and shared processes).
6. Actively seek and develop opportunities to improve youth health with other sectors (e.g. city council, police and community agencies).

Such a hub would require a high level of skill in working with young people and with other providers. See over for a suggested model.

Youth Health Hub example:



RECOMMENDATION 2

Waitemata DHB should implement a three pronged strategy to improve access to youth friendly health care for young people in the district

i) YOUTH HEALTH SERVICES TO UNDERSERVED YOUNG PEOPLE

It is recommended that WDHB:

- Support the delivery of existing quality services which currently meet the needs of underserved[12] young people by:
  - providing youth health support for agencies who are already engaged with targeted young people
  - providing outreach clinics to sites where vulnerable young people are regularly located (such as justice services or training courses).
- Develop a community based youth specific health service in one or more locations and targeted towards underserved young people.

These activities could be delivered and or supported by a youth health team or hub with responsibility to work with a range of providers to ensure that the needs of underserved young people are met.

ii) YOUTH FRIENDLY CARE IN GENERAL PRACTICES

WDHB should discuss opportunities to increase youth friendly primary care with PHO's.

- Ideally all GPs would provide 'youth friendly health care'.[13]
- As a medium term goal WDHB should aim to have youth friendly care available via at least one practice in each locality.
- In the short term key youth friendly practices, demonstration sites or a process to develop youth friendly practice should be provided. Initiatives such as:
  - 'new health consumer' adolescent appointments;
  - nurse led appointments;
  - fully funded consultations
  - extended consultations and
  - routine screening

  should be considered.

Developing new styles of service requires time, training and expertise. As a first step it is recommended that WDHB develop a General Practice youth health development position. This could be located within a youth health team or hub.

[12] Underserved young people refers to young people who have high health needs and yet are typically not well engaged in primary health care services. Groups of young people who frequently have high health needs compared to others in New Zealand and are frequently 'underserved' are listed on page 9.

13 See Appendix 1, also see page 36 for GP specific models for increasing 'youth friendly care'.

iii) SCHOOL BASED HEALTH SERVICES

WDHB should support comprehensive school based health services. Ideally all schools would have multidisciplinary health teams, providing youth friendly care, available through most of the school week.

As first steps it is recommended that WDHB:

- Extend comprehensive school based services (utilizing nurses with a broad role and range of skills and multi-disciplinary support, available through most of the school week) in communities where students have poor access to health care and have high health needs.
- Ensure all school based health services:
  - Are well supported in terms of youth health training, supervision and professional standards.
  - Have explicit processes to link young people to other providers outside of school time and when they leave school.
  - Are well linked to the other support structures within and around the school.

MODELS OF PRACTICE

In each of these settings 'youth friendly health care' as described in Appendix 1 should be provided.

RECOMENDATION 3

WDHB develop a strategy that leads to a workforce with expertise in youth health

To ensure that all young people in Waitemata have access to youth friendly health care, workforce development will be required. As a first step WDHB should acknowledge the need for workforce development. Secondly a strategy for development should be initiated; this could potentially be led by a youth health team or hub. There are opportunities for this to occur alongside national developments with the Society of Youth Health Professionals Aotearoa New Zealand (SYHANZ) and others.

RECOMENDATION 4

WDHB should seek opportunities to improve the health of young people in Waitemata from interagency and intersectorial collaboration.

Youth health gains can be made from effective interagency collaboration and from intersectorial interventions that support the wellbeing of young people. These may be activities that health can support or help to initiate without necessarily taking a long term role or large investment. Some co-ordination and leadership is however required.

Interagency interventions include:

- supporting existing interagency processes (for example Whanau Ora and Strengthening Families)

and can include providers who work with the same groups of young people:

- having clear information sharing protocols;
- utilising shared case review process and shared training
- the development of clearly identified lead professionals and referral process
- collaborative work processes.

Intersectorial efforts can address needs that are not the sole responsibility of health sector but have positive health outcomes. Needs can be identified through local review and planning process including High and Complex Needs processes, mortality review, community, youth and stakeholder consultation. Examples of areas where there can be youth health gains in this way include:

- The provision of high quality programmes for taitamariki which develop leadership, cultural and whanau connectedness and healthy activity
- The provision of emergency contraception via 'youth friendly' pharmacies
- The development of community wide interventions to reduce truancy or youth offending.

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APPENDIX 1: 'YOUTH FRIENDLY' HEALTH SERVICES

Appendex 1 **Characteristics of adolescent friendly health services.** World Health Organization 2002.

Appendix 1b **Specific Youth Health Service Standards - Summary.** Kidz First Centre for Youth Health and the Youth Health Expert Working Group, 2006. This is an Aoteraoa/New Zealand specific resource.

Appendix 1c: **Youth Health Better Practice Framework.** From the New South Wales Centre for the Advancement of Adolescent Health fact sheets for providers 2005.

Appendix 1 d. **'Youth friendly health care' a brief summary of essentials.**

Appendix 1a: Characteristics of adolescent friendly health services

From: World Health Organization 2002 Adolescent Friendly Health Services —An Agenda for Change,

Adolescent friendly health services need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient. They require:

1 Adolescent friendly policies that
- fulfill the rights of adolescents as outlined in the UN Convention on the Rights of the Child and other instruments and declarations,
- take into account the special needs of different sectors of the population, including vulnerable and under-served groups,
- do not restrict the provision of health services on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age,
- pay special attention to gender factors,
- guarantee privacy and confidentiality and promote autonomy so that adolescents can consent to their own treatment and care,
- ensure that services are either free or affordable by adolescents.

2 Adolescent friendly procedures to facilitate
- easy and confidential registration of patients, and retrieval and storage of records,
- short waiting times and (where necessary) swift referral,
- consultation with or without an appointment.

3 Adolescent friendly health care providers who
- are technically competent in adolescent specific areas, and offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances,
- have interpersonal and communication skills,
- are motivated and supported,
- are non-judgmental and considerate, easy to relate to and trustworthy,
- devote adequate time to clients or patients,
- act in the best interests of their clients,
- treat all clients with equal care and respect,
- provide information and support to enable each adolescent to make the right free choices for his or her unique needs.

4 Adolescent friendly support staff who are
- understanding and considerate, treating each adolescent client with equal care and respect,
- competent, motivated and well supported.

5 Adolescent friendly health facilities that
- provide a safe environment at a convenient location with an appealing ambience,
- have convenient working hours,
- offer privacy and avoid stigma,
- provide information and education material.

6 Adolescent involvement, so that they are
- well informed about services and their rights,
- encouraged to respect the rights of others,
- involved in service assessment and provision.

7 Community involvement and dialogue to
- promote the value of health services, and
- encourage parental and community support.

8 Community based, outreach and peer-to-peer services to increase coverage and accessibility.

9 Appropriate and comprehensive services that
- address each adolescent's physical, social and psychological health and development needs,
- provide a comprehensive package of health care and referral to other relevant services,
- do not carry out unnecessary procedures.

10 Effective health services for adolescents
- that are guided by evidence-based protocols and guidelines,
- having equipment, supplies and basic services necessary to deliver the essential care package,
- having a process of quality improvement to create and maintain a culture of staff support.

11 Efficient services which have
- a management information system including information on the cost of resources,
- a system to make use of this information.

Appendix 1b: Specific Youth Health Service Standards - Summary

From: Kidz First Centre for Youth Health and the Youth Health Expert Working Group, 2006. Draft Standards for Youth Health Services

Engagement with Community	Youth Focus and Participation	High Quality Comprehensive Clinical Care and Practice	. Health Promotion/ Public Health Activities	5. Administrative/ Clinical Systems to Support Service Provision
1.1.1 U nderstand the community 1.1.1 Needs analysis 1.1.2 Scope existing services 1.1.3 Understand local systems and drivers in the community 1.1.4 Build comprehensive picture of the community	**2.1 Youth friendly** 2.1.1 Youth friendly staff 2.1.2 Youth friendly facilities 2.1.3 Respect for young people and all of their cultures 2.1.4 Developmentally appropriate care 2.1.5 Facilitation of access for groups identified as underutilising the service	**3.1. Recognise importance of positive youth development, strengthbased practices and multidisciplinary care** 3.1.1. Informed by positive youth development 3.1.2. Facilitation of collaborative practice and multidisciplinary care 3.1.3. Transition issues / facilitation of access to a broad range of other services	**4.1 Committed to development of public policies that support the healthy development of young people** 4.1.1. Contribute to development and implementation of policies supportive of health promoting choices for young people	**5.1. Organisational structures** 5.1.1. Clear organisational structure with MoUs where appropriate
1.2 E ngage and consult with the community 1.2.1 Forming and maintaining relationships 1.2.2 Ongoing working relationships 1.2.3 Community stakeholder participation 1.2.4 Intersectoral collaborative decision-making 1.2.5 Regular and ongoing networking with relevant professional communities	**2.2 Confidential and Private Care** 2.2.1 Young people and adults are assisted to understand the Code of Health and Disability Consumer Rights, and the Privacy Code as they relate to young people 2.2.2 Client information is treated as confidential and private 2.2.3 Staff understand legal issues related to providing care for young people 2.2.4 Physical privacy is respected	**3.2 Provide core clinical care and minimum youth health services** 3.2.1 Identification of key clinical issues, and management of chronic health conditions common in young people 3.2.2 Ability to provide primary care level assessment of mental health, sexual and reproductive health, and drug and alcohol issues 3.2.3 Clinical contacts viewed as opportunities for screening, preventive care and health education	**4.2.2 Contribute to creation of supportive environments for the well-being of young people** 4.2.1 Work in the community to contribute to the creation of supportive environments for the well-being of young people	**5.2 A dministrative/clinical systems** 5.2.1 Standardised templates for data collection and reporting 5.2.2 Clinical records and information, integrated with other providers while protecting data 5.2.3 Prompting/recall systems
1.3 F eedback to the community 1.3.1 Reports, information about services 1.3.2 Appropriate dissemination pathways 1.3.3 Inform community about youth health issues	**2.3 Youth participation in** 2.1.1 Planning/development 2.1.2 Service delivery 2.1.3 Own and whanau/family health care	3.3 **Staff with appropriate training and skills in youth health** 3.3.1 Specific training in youth health and development 3.3.2 Basic youth health skills	**4.3 Committed to strengthening community action to enhance the well-being of young people** 4.3.1 Assist young people in the community to develop skills and resources to take effective action to support their well-being. 4.3.2 Equip parents and those working with young people to build quality relationships with young people	**5.3 Clinical quality improvement processes** 5.3.1 Guidelines/ accepted best practice (local & international) 5.3.2 Commitment to evaluation
		3.4 Importance of culture in service provision and planning 3.4.1 Recognition and response to cultural values and beliefs of Maori young people and their whanau, and other ethnic cultural groups 3.4.2 Importance of collecting accurate ethnicity data 3.4.3 Holistic cultural models of health influencing practice	**4.4. S upport population level health promotion and protection initiatives targeting young people** 4.1.1 Promote national immunisation initiatives that impact on young people 4.1.2 Support health promotion campaigns targeting young people and youth issues	**5.4 F acilitation of professional development and administration responsibilities** 5.4.1 Orientation 5.4.2 Continuing education 5.4.3 Supervision 5.4.4 Resources and time for collaborative work

Appendix 1c: Youth Health Better Practice Framework

From: NSW CAAH 2005 ACCESS Study: Youth Health - Better Practice Framework Fact Sheets

The New South Wales Centre for the Advancement of Adolescent Health published a youth health better practice framework and easy to use fact sheets for providers in 2005. Based on provider interviews and literature reviews they identified the following principals of good practice:

Accessibility – Accessibility describes a flexible, affordable health service which is relevant and responsive to the needs of all young people (regardless of age, sex, race, cultural background, religion, socio-economic status or any other factor). Better practice in this area includes services having a promotion strategy for targeting young people and a confidentiality policy widely publicized to target group; services actively seeking to understand and respond to young people's concerns and needs; services provided free, or at a cost affordable to young people; a location that is easy for young people to get to; being open after hours/ when young people can get there; drop in as well as appointment based systems; flexibility around consultation times, and the capacity to offer longer sessions to deal with complex issues and staff provided with training, supervision and support to maintain the knowledge and skills required for working with young people.

Evidence based approach - An evidence-based program is able to demonstrate that its development has been based on a reliable assessment of need derived from a range of information sources ('evidence'), and also that its strategies were designed according to good practice standards determined by local, national and international guidelines.

Youth participation - Youth participation describes young people's active involvement in developing, implementing, reviewing and evaluating services and programs intended for their benefit. It requires designing formal structures and youth-friendly mechanisms through which young people can express their opinions and exercise decision-making power. Young people's participation increases mutual respect between service providers and adolescents, and increases the latter group's sense of ownership and involvement in programs.

Collaboration - Collaboration occurs when service providers develop internal and external working relationships with other agencies that share similar service goals and target groups. Actions include communicating, networking and working together, both within and beyond the service's immediate sector (e.g. health, education, welfare, drug and alcohol, recreation). Collaborative partnerships often involve cooperatively working together in service planning, implementation, review and evaluation. Working in collaboration optimizes resources, reduces duplication of effort and encourages holistic service delivery to young people

Professional Development - Professional development involves developing workers' knowledge, skills and attitudes in order to ensure that they can work confidently and effectively with young people. This includes providing training, mentoring and supervision opportunities, as well as creating and maintaining organizational structures which support both individual and team performance. Proactive professional development ensures the creation of a learning culture in the workplace, increasing individual and team competence, confidence and morale, thus resulting in a more effective service.

Sustainability - Sustainability describes continuing programs which eventually become self-maintaining in the longer term. It can also refer to programs, activities and effects which continue to happen, even after initial funding has been discontinued and the original implementing agency has withdrawn. Sustainability requires a long-term vision where program longevity is supported through identifying alternative income sources, investing in strategic advocacy, adopting good practice and developing partnership capacity so that other agencies or communities can integrate the activities into existing frameworks. Sustainable programs support long-term improvements and outcomes to the health and well-being of target populations, and reduce the vulnerability of having short-term, stand-alone interventions

Evaluation - Evaluation is a process undertaken in order to review a service's or program's results. It involves determining what was done (inputs, outputs), how it was done (the process) and how well it was done (quality), as well as which changes or results were achieved (impact, outcomes) as a result of the program or intervention.

Effective evaluation engages workers, program consumers and other stakeholders in a participatory process, providing avenues for feedback and thus enabling service improvement. Undertaking regular evaluation enables services to systematically assess results, identify what has been most effective (developing 'evidence'), strengthen programs and demonstrate accountability. As such, evaluation plays a crucial role in quality assurance. Evaluation contributes to evidence-based practice by highlighting what works and why. It provides a valuable opportunity for services to identify which strategies work best, enabling services to adapt and choose the most effective approaches.

Appendix 1 d: 'Youth friendly health care' a brief summary of essentials

'Youth friendly health care' essentials:

Strengths in developing relationships and communicating with young people.

Routine comprehensive screening and an emphasis on preventive and holistic care.

Culturally appropriate, confidential services that young people know about, can get to and can afford

Youth participation in service development and delivery

Skilled and knowledgeable staff who provide effective evidence based care and work effectively with other providers in their community.

APPENDIX 2: ACCESS TO GENERAL PRACTICE SERVICES AND DIFFICULTIES GETTING HELP: FINDINGS FROM YOUTH07.

This appendix provides data from Youth07 regarding participants reports of having seen a GP within the last 12 months and difficulties getting help for problems. Youth07 is a comprehensive national adolescent health and wellbeing survey designed and delivered by the Adolescent Health Research Group at the University of Auckland. The survey was carried out on hand held computers, 9107 students in Years 9-13 from 96 secondary schools around New Zealand took part. Findings are publically available (see youth2000.ac.nz), however these detailed figures were provided on request by the AHRG in 2010.

1) Youth'07 data provided by AHRG 2010: Rates of access to GP in the last 12 months among secondary school students

Total	**Percent**	**95% CI**
Total	76.8	75.5-78.1
By Sex	**Percent**	**95% CI**
Male	74.8	73.4-76.3
Female	79.1	77.4-80.8
By NZDep Index Decile[14]	**Percent**	**95% CI**
1 (least deprived)	81.8	79.6-84.0
2	78.5	75.7-81.3
3	79.3	76.7-81.8
4	77.8	75.3-80.3
5	76.4	73.1-79.7
6	78.2	74.7-81.7
7	72.5	69.1-75.8
8	75.7	71.8-79.7
9	73.7	70.2-77.2
10 (most deprived)	71.3	67.8-74.7
By School Decile	**Percent**	**95% CI**
1 (most deprived)	74.9	70.7-79.1
2	70.4	61.9-78.8
3	77.1	72.4-81.8
4	76.1	72.7-79.5
5	77.6	75.5-79.7
6	75.2	71.0-79.3
7	75.4	70.2-80.6
8	78.1	75.4-80.9
9	80.2	77.3-83.1
10 (least deprived)	76.9	75.5-78.3

[14] The NZDep or New Zealand Deprivation Index is calculated from 9 variables (including household income, home ownership, single parent families, employment, qualifications, overcrowding and access to a telephone and car) from the 2006 census data for each meshblock or neighbourhood area (Adolescent Health Research Group, 2008).

By Prioritised Ethnicity[15]	Percent	95% CI
Māori	75.3	73.0-77.7
Pacific	70.6	67.1-74.1
Asian	66.1	63.2-69.0
Other	78.0	74.8-81.2
New Zealand European	80.9	79.5-82.3

2) Youth'07 data provided by AHRG 2010: Rates of secondary school students reporting that they haven't had any difficulty getting the health care in the last 12mths.

By NZDep Index	Percent	95% CI
1 (least deprived)	77.5	74.9-80.0
2	73.8	71.3-76.3
3	74.8	72.3-77.4
4	71.0	67.5-74.5
5	71.7	68.2-75.1
6	70.3	67.1-73.4
7	72.2	68.6-75.8
8	65.9	62.5-69.3
9	61.7	58.5-64.8
10 (most deprived)	58.6	54.1-63.2
By School Decile	**Percent**	**95% CI**
1 (most deprived)	53.1	47.8-58.4
2	61.1	58.1-64.0
3	61.1	54.6-67.5
4	68.9	66.2-71.5
5	70.8	66.1-75.6
6	71.5	68.0-75.1
7	71.4	67.9-74.8
8	74.3	70.8-77.9
9	72.9	69.9-75.8
10 (least deprived)	74.4	72.7-76.0
By Prioritised Ethnicity (13)	**Percent**	**95% CI**
Maori	62.0	59.1-64.9
Pacific	59.6	55.5-63.8
Asian	72.0	69.2-74.8
Other	69.6	66.0-73.2
New Zealand European	75.1	73.7-76.5

[15] Using the New Zealand census ethnicity prioritization method.

APPENDIX 3: SUMMARY OF ACTIONS FOR PRIMARY HEALTH CARE FROM 'YOUTH HEALTH A GUIDE TO ACTION' THE MINISTRY OF HEALTH.

'Youth Health – A Guide to Action.' Summary of Actions for Primary Health Care (GPs, public health nurses, family planning, etc)

Ministry of Health, 2002, p4

- Actively involve young people in designing primary health care services for young people.
- Explore ways of reaching out to those young people who don't use existing health services, through:
    - youth-specific health services
    - mobile clinics at sports events, marae, dance parties, central city and rural locations
    - extending the role/reach of public health services and practice nurses
    - supporting Maori and other communities to develop their own services.
- Ensure that health services meet the needs of refugees and migrant young people.
- Encourage family health clinics to look at how they could become more 'youth focused' – taking account of young people's expressed desire for privacy and confidentiality. Look at how user friendly they are for Ma¯ori and Pacific young people, and from the perspective of disabled and deaf young people.
- Support the extension of school-based health clinics, particularly for schools in low-income communities.
- Compile a web-based directory of health services for young people.
- Review consistency of eligibility of young people to access to health and other social services.
- Develop youth-focused guidelines to assist health workers to recognize early signs of mental illness and alcohol and drug abuse.
- Ensure that admissions and transfers of young people in hospital are based on the best interests of the young person.