TARANAKI taiohi HEALTH STRATEGY

Te Rautaki Hauora Taiohi o Taranaki

Supporting Background Document

November 2012

Young peoples health is important – Kia tika te hauora o ngā taiohi

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The creation of this document, which has supported the development of the Taranaki Youth Health Strategy, is a reflection on the willingness of many agencies and individuals who work to improve the physical, social and emotional well-being of young people in Taranaki. Taranaki District Health Board would like to thank the young people who participated in the consultation processes and whose voices and ideas are clearly heard through this document which helped inform the final Taranaki Taiohi Health Strategy, and the extensive input from the projects Operational Group from Health, Education, Special Education, Secondary Schools, Non Government Organisations, Public Health, Youth Justice, Ministry of Social Development and Council. A list of the participants are included in Appendix 2.

We also acknowledge the willingness of national agencies and local organisations in supplying data to help inform the Youth Profile section of the report, and to the Governance Group in providing direction for the final strategy development.

Defining Youth

Youth, Taiohi, Young People, Adolescents and Rangatahi

There are many definitions for the terms youth, young people, taiohi, adolescents and rangatahi. For the purpose of the development of the Taranaki Taiohi Health Strategy the terms are used interchangeably and refer to young people between the ages of 12 and 24 years.

The age range recognises that the transition from childhood to adulthood is a process rather than a discrete event and that the length of the process varies from individual to individual. It is also recognised that responding to and meeting developmental needs rather than considering chronological age is important in providing good health care for young people.

Within the Youth Profile Section of this document the statistics included varies across age bands between the defined 12-24 years. The information was dependent on the availability of data sets from many sources.

It is acknowledged that taiohi as young as 10 are often identified with complex issues and have the potential to disengage with school at an earlier age. For that reason, the development of youth health teams for Taranaki requires flexibility to pick up at risk young people early.

Defining Youth Health

It was the World Health Organisation in 1948 that succinctly articulated the ideas that health is about more than just a lack of symptoms, stating that *"health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".* When talking about youth health, the concept of well-being is particularly important. Well-being relies on being well in every sense – physically, emotionally, mentally, socially, sexually and spirituality. For any young person, imbalance in one or more of these areas moves us away from a state of optimal well-being.

In New Zealand the Mason Durie Te Whare Tapa Wha model is recognised as incorporating the Māori philosophy towards health is based on a wellness or holistic model of care. The four cornerstones (or sides) of Māori health include whānau (family health), tinana (physical health), hinengaro (mental health) and wairua (spiritual health).

Young people are quick to point out the importance of connectedness to their health and well-being. Solid and trusting relationships with their family/whanau and with peers enables young people to build resilience – the ability to bounce back from difficulties and to overcome adversity or challenges.

Young people remain sensitive to the world around them, responsive to the influences of culture and the behaviours they observe among their peers and adults. Everyone is responsible for the values and attitudes that young people develop.

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Glossary of Acronyms

AoD	Alcohol and Drug
BOT's	Board of Trustees
CAMHS	Child & Adolescent Mental Health and Addictions Services
DAP	District Annual Plan
DHB	District Health Board
DPMC	Department of Prime Minister and Cabinet
ECT	Early Childhood Teachers
ERO	Education Review Office
FGC	Family Group Conference
GPNZ	General Practice New Zealand
HEADSSS	Home, Education, Activities, Drugs, Sexuality, Suicide/Depression and Safety Assessment
HWNZ	Health Workforce New Zealand
MHN	Midlands Health Network
MHP	Māori Health Plan
MOE	Ministry of Education
MOH	Ministry of Health
MSD	Ministry of Social Development
NEET	Not in Education, Employment or Training
NHC	National Hauora Coalition
OHS	Oral Health Service
PHN	Public Health Nursing
PHO	Primary Health Organisation
PHP	Public Health Plan
RCGPNZ	The Royal New Zealand College of General Practitioner
SDB	Special Dental Benefit
SLAT	Service Level Alliance Team
SOC	Social Policy Cabinet Committee
SOI	Statement of Intent
STI	Sexually Transmitted Infection
TDHB	Taranaki District Health Board
YC	Youth Court
YJ	Youth Justice
YMH	Youth Mental Health
YOSS	Youth One Stop Shop

Section 1: Executive Summary and Background

Executive Summary

The Taranaki Taiohi Health Strategy (the Strategy), has been developed from the extensive consultation process with young people and with professionals delivering services to taiohi across a wide range of settings. The strategy has particular reference to cross-agency accountability as no one agency/organisation can achieve improvement in taiohi health outcomes alone. We recognise that for services to be more cohesive and integrated, the implementation of the Strategy will develop a model of care of integrated youth health teams and account for the needs of various geographical differences in North, Central and South Taranaki. There are two strategies, a youth friendly version and an agency version which includes an implementation plan. The final documents requires endorsement from Taranaki DHB Board and the agencies involved. The strategy will be more widely socialised through Taranaki via a communications plan.

The Strategy development received guidance from a cross-sector Governance Group and extensive input from an Operational Group representative of the wide range of stakeholders delivering services to Taranaki Taiohi. Taranaki District Health Board's (DHB's) has a commitment to using Results Based Accountability (RBA) framework as the tool to measure population health outcomes. Monitoring and measuring the success of the Strategy has been built into an RBA framework.

The definition of health recognised in the Taranaki Taiohi Strategy development is broad and improving on the health outcomes for taiohi can be defined by four key domains[1], health behaviours, clinical care, social and economic factors and the physical environment. A stock take of services across the agencies (including NZ Red Cross) showed 49 different services or programmes that are delivered to young people in a variety of settings. This by no means represents the totality of service provision in Taranaki.

Over the last year the New Zealand Government has developed a range of initiatives targeted towards young people. The Government expectations to cross-sector responsiveness is increasingly evident when implementing new programmes and initiatives. As an example, the Prime Minister's Youth Mental Project has been developed with a national multi-Ministry approach, which include the Ministries of Health, Education and Social Development and Te Puni Kokiri. Embedding cross-sector working in policy and framework development is further evidenced in the Mental Health and Addictions Service Development Plan 2012 and The White Paper for Vulnerable Children's Action Plan.

In response to the Prime Ministers Better Public Services Programme a number of papers were developed for the Better Public Services Advisory Group. These papers noted the changes required to the public management system in New Zealand if better outcomes for the population were to be achieved. These included:

- Organisational arrangements structured around the achievement of results
- Leadership that takes a view of the sector as a whole, and looks across agency boundaries
- Decision rights at a sector/system level, rather than at the agency level, supported by a clear mandate and resources.

The Strategy's Operational Group highlighted the need for a new approach to such issues, for example organising sectors around specified results, deliberately tackling complex issues or matters that might fall between the responsibilities of individual agencies. Service requirements that currently allow only parallel working and ad-hoc communication also need to be replaced by a requirement to actively collaboration and for it to become embedded as 'business as usual'.

The responsibility for improving health outcomes for taiohi doesn't rest with one agency alone, which is why it is important for agencies and providers to commit to working together sharing the responsibility. As a result an Alliance Charter has been developed for agencies and organisations to agree the principles of how to work together for the implementation of Taranaki Taiohi Health Strategy. It was recognised early in the strategy development that for young people to truly be at the centre of care, as agencies and organisations we need to provide the necessary leadership and mandate to enable the development of a more holistic and integrated youth health team service delivery model of care.

[1] Willems, Van Dijk and Kushion (2011) Multiple Determinants of Health and the County Health Rankings

Consultation Process

A diverse range of young people were consulted as part of the Strategy's development. Young people frequently reported multiple service options work best for them. For example, while young people access General Practice for medical issues when parents or caregivers are paying, they are more likely to access alternative services for example within schools, youth one stop shops and other nurse led services, for their emotional, mental health and addictions or sexual health issues.

The consultation process also highlighted the significant role of family/whānau and friends play in the knowledge transfer of health information. Knowing what's available and how to navigate through what is currently a complex system is difficult not only for young people and their family/whānau but also for professionals working with the young person. Young people are able to obtain health information in a variety of ways, however they reported most often they use internet, family/whānau or friends first.

It is vital for our community to have an appropriate level of health literacy to enable young people to be empowered, resilient and accountable for their well-being. Re-thinking how best to inform individuals and the community on health information, knowledge sharing and available service options is key to improving health outcomes for Taranaki taiohi.

Information gathered throughout the project from agencies, organisations and professionals working with young people on a daily basis highlighted the increasing complexity of the issues being dealt with. Staff have difficulties navigating through a multi-agency system often resulting in young people falling through the gaps. Counsellors and school nurses who are funded through school budgets are often unsupported and working in isolation.

These professionals along with Public Health Nurses and other nurse led and counselling services dealing with complex issues are often left managing the young person due to the limited options for onward referral. There are service gaps at the mild to moderate mental health and addiction spectrum of care and specialist services struggle to meet demands, leading to long waiting times. The complexity has resulted in professionals having less time to focus on early intervention strategies/programmes which help prevent the escalation of issues.

More detailed information from the consultation process can be found in Section 5 of this document.

Priorities

The final Strategy includes two **transformational change** ideas as prioritised through the project and **three key result areas** mapped into a Results Based Accountability framework. The framework will enable us to measure taiohi health outcomes through indicators across multiple agencies. The two **transformational change** approaches are imperative for ensuring young people are at the centre of care and maximises opportunities to improve health outcomes for Taranaki taiohi. They include:

1. Developing and agreeing an approach to inter-agency/organisation/provider working. This would evolve through the development and sign off of an alliance charter; and
2. The development of a new model of youth health team(s) service delivery which incorporates a range of service providers funded across agencies, and services funded and delivered within the school, alternative education , primary care and other settings.

In profiling the young people of Taranaki, there were a number indicators that required targeted effort to improve health and well-being outcomes and the reduction of rates where taiohi are over represented. Some of these include:

1. Taranaki teen pregnancy rates per 1,000 population for young Māori is 92.0 compared to the national rate of 77.6.
2. Taranaki was the second highest DHB region with reported cased of gonorrhoea within participating clinics reporting through to the Institute of Environmental Science and Research Ltd.
3. Sexual health consultations represented the largest treatment type presenting to Public Health Nurses at 65% and at WAVES 24%. The Primary Health Organisation free sexual health services provided 4,078 consultations for 2,214 young people under 25 years. Female rates are significantly higher, often up to 75% of the overall presentations.
4. Between 2006-2010 admissions for young people for mental health issues had a rate of 7.58 per 1000 population, compared to the national rate of 4.96.

5. The rates of access to the Primary Mental Health initiative decreased from 25% of the total consultations in 2010-2011 to 4% in 2011-2012 (part year vouchers).
6. While our crime rates show a decline, the introduction of diversion programmes has largely impacted on reporting.

These are among a larger suite of indicators that will be attributed to achieving improved taiohi population health outcomes in the following three **key result** areas include:

1. Taiohi are emotionally and mentally well and are achieving their best possible educational outcomes.
2. Taranaki taiohi adopt behaviours that support healthy sexuality and reduces risk taking behaviours.
3. Taranaki taiohi will be better information about the choices they make on accessing health services and choosing healthy lifestyles.

Transformational Change Area 1 – Redefining Multi-agency Governance for Health Services for Taranaki Taiohi

The Strategy has provided the opportunity to propse a Governance framework for doing things differently across agencies and organisations. An alliance leadership team charter has been developed which describes the principles of how we can work together to not only implement the Strategy but as a foundation for continued integrated working into the future. The intention is to define a new way of working through leadership at the governance level. The common service framework threads to achieve a well coordinated and integrated service model include:

- **Shared principles for service delivery** - universal access, focus on outcomes, evidence-based services, integrated approach to service delivery, young person and family/whānau centred approach, partnerships with young people and communities and commitment to working excellence.
- **Common service delivery domains –** health promotion and primary prevention, population health monitoring for young people, early identification of risk and vulnerability and need, early intervention for individuals at risk of compromised health and well-being, ongoing management, intervention and monitoring for those taiohi requiring complex responses, reducing barriers to learning development and restoring well-being.
- **Stronger relationships and partnerships -** well defined framework to strengthen linkages and partnerships, building partnerships and relationships, improving referral pathways to enhance delivery of services to taiohi, participation of agencies and providers to make it work.
- **Effective leadership** – strong leadership and governance structures across agencies, implementing change to create a coherent, coordinated and integrated service system to support workforce through any transition, encourage and support collaboration and coordination through shared vision and principles in practice. Values partnerships, sets high standards, commitment to developing a learning culture

Refer Section 3: Taranaki Cross Agency Governance.

Transformational Change Area 2 – Redeveloping Health Services for Taranaki Taiohi

Re-defining the model of care for young people is largely driven by an agreement from the agencies to sign up to an alliance charter, this provides a baseline for which the common service delivery domains can be mapped out and managed.

Through-out the Strategy development those working at the coal-face with young people continually emphasised the importance of having the young person at the centre of care and the difficulties in navigating through the complex multi-tiered system that currently operates. Often staff are left managing a young persons issues due to the difficulties in timely access to specialist services due to demands on their services. Young people reported they wanted information on what services are available and how to access them and equally providers aren't always aware of what is available.

While young people have access to a range of school based services, there are a cohort of young people who are disengaged with school and in alternative education programmes or other. This cohort do not have access to many of the health services. These are often our most vulnerable and at risk youth.

Guided by the leadership of a multi-agency alliance, the implementation of the Strategy has prioritised the development a robust model of care putting the young person and their family/whanau at the centre of service delivery. The vision for services allows for youth health teams that enables better coordination and integration of service provision and provide reference point for services like counsellors in schools who are often working in isolation.

Although the Gluckman report highlights the need for intervention and prevention at a much early age and work has begun to look to improving the responsiveness to at risk and vulnerable children, the longitudinal effects will likely not be seen for many years. This means, regardless of the rollout of initiatives which focus on addressing issues for younger children and their families/whanau, Taranaki will still need to better meet the needs of our young people now and into the future.

Section 2: National Policy Direction

What Do We Know About Alignment of Policies and National Direction for Youth?

Department of Prime Minister and Cabinet (DPMC)

The Department of the Prime Minister and Cabinet occupies a unique position at the centre of New Zealand's system of democratic Government[2] and provides assistance to the Prime Minister in the following three broad categories:

- Issues that are the direct responsibility of the Prime Minister
- Issues that arise across the full range of Government business
- Administrative support to the Prime Minister

In the DPMC's Statement of Intent 2012-2016[3] one of the key strategic priorities is for leadership of better Public Health Services with a focus on delivering better results for New Zealanders, achieving improved value for money, enhanced use of technology, and realising better leadership of the public sector as a system.

The goal of the Better Public Services programme is to support Government agencies to deliver better results for less by:

- Government agencies working more closely together and in a different way. This includes organising themselves more around results, sharing functions and services, purchasing goods and services, and developing joint systems
- More contestability in service provision and use of alternative providers
- Greater use of technology and a shift to digital channels, so New Zealanders can more easily access services
- Agencies collecting, using and publishing better performance information
- Greater responsiveness to the needs and expectations of New Zealanders, and a willingness to do things differently.

This work is about moving away from being a collection of individual agencies, each doing their own thing, to collaborating on delivering results that matter to New Zealander's. Targets will be developed for each of the results areas and these will be publicly reported on by the end of the year. The purpose is to make agencies publicly accountable for what is being achieved, or not achieved and for the Government to be able to demonstrate its commitment to achieving the results that have been identified as important.

Social Sector Trials

Governance and Management of Social Sector Trials

In 2011 the Government developed a framework for Social Sector Trials with an aim of affecting outcomes for young people by testing a new model of care. Six New Zealand locations were selected to undertake a two year programme from March 2011 to February 2013.

Responsibility for the trials sits with the Honourable Tony Ryall who is the Chair of the Social Policy Cabinet Committee. A Ministerial sub-group provides the oversight and decision making for the trials in consultation with relevant Vote Ministers. The sub-group comprises of the following representatives, Deputy Prime Minister; Ministers of Justice, Health, State Services, Police, Education, Social Development and Employment, Youth Affairs, Community and Voluntary Sector and Whānau Ora.

The day-to-day operation of the Social Sector Trials is the responsibility of Joint Venture Director sitting within the Ministry of Social Development.

At the core of the models were the following:

[2] http://www.dpmc.govt.nz/dpmc

[3] Statement of Intent 2012 – 2016. Department of the Prime Minister and Cabinet

- Either a contracted Non-Governmental Organisation (NGO) or an employed individual in place in these communities to lead a programme of work using cross agency resources.[4]
- NGOs and individuals planning social service delivery for young people, managing relevant contracts and funding that are within the scope of the programme, overseeing resources-in-kind, developing networks, engaging with the community and influencing social services outside of their direct control (like statutory services).
- The establishment of Social Sector Trial local Governance Groups in each location – representatives include iwi, Council, Government agencies, community representatives and social service providers.
- The development of a Social Sector Trials Plan (or a Youth Action Plan) for each location.

The model aims to support decision-making at the local level, build on existing networks and strengthen coordination at every level of Government and within the community and is testing, the effects of transferring the control of resources, decision-making authority and accountability for results from Government agencies to an employed individual or NGO based at the local level. It also provides opportunities to overcome the barriers that exist with cross-agency service delivery.

The programme is focussed on improving outcomes for 12-18 year-olds including the following

- Reduced offending by young people
- Reduced truancy
- Reduced levels of alcohol and other drug use by young people
- Increased numbers of young people in education, training and employment.

What Are the Prime Minister's Priorities for the Youth Mental Health Project?

Mental Health is a significant issue for young people and around one in five will experience some form of mental health problem during this crucial time in their lives. A mild mental health illness can have a big impact on a young person's life and on those around them. Often adolescents and parents do not understand what is going wrong or what to do about it. The Youth Mental Health Project seeks to help to deal with the often complex and challenging issues that need to be addressed.

The Youth Mental Health Project aims to provide earlier intervention and better help for young people with mental health issues, and focuses on the following priorities:

In the Health Sector

Making Primary Care More Youth Friendly

- An additional $11.3 million over four years will be added to existing ring-fenced funding for primary mental health care. It will include expansion to more young people with mild to moderate mental health needs. The funding will be available to General Practitioners, School-Based Health Services and Youth One Stop Shops (YOSS).
- In the interim, the Ministries of Health and Social Development will provide interim support for YOSS. YOSS have been developed in response to young people's preferences. These services have generally been community-driven and have not always had sufficient administrative support or security of funding. The time-limited support will include funding for youth workers and the Ministry of Health will work on service enhancements with effective YOSS.

In September 2012, draft Youth Mental Health service specifications were released to the sector for consultation. The enhanced service is to be based on a stepped care model for service provision. The system allows the delivery and monitoring of treatments so the treatment that is most effective, yet least resource intensive, is delivered first. The approach will help provide young people aged 12-19 years with the most effective mental health care at the lowest price.

The following outlines delivery of evidence-informed interventions in steps 2 and 3 of the Stepped Care Model in the primary care environment.

[4] http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/social-sector-trials/index.html#WhyaretheSocialSectorTrialsinplace3

Stepped Care Model		Percentage of population 12-19 years	Intervention
SUPPORTIVE ENVIRONMENT AND HEALTH PROMOTION eg, NDI, Like Minds, self-care, whānau ora, housing, employment, education, social network	**EARLY IDENTIFICATION OF VULNERABILITY**		
	STEP 1: No disorder or sub-threshold symptoms, distress, adjustment problems	79.30%	Advice, support, psycho-education, self-care, advice and monitoring, social marketing/media
	PRIMARY CARE ENVIRONMENT		
	STEP 2: Mild disorder – brief treatment	6.60%	Monitoring, green prescription self-help books, education
			Extended GP or practice nurse consults
			Brief interventions
			E-therapy
	STEP 3: Moderate disorder – low intensity treatment	9.40%	**Individual Packages of Care**
			Brief interventions
			Pharmaceutical intervention
			E-therapy
			Group Therapy
	SPECIALIST MENTAL HEALTH AND AOD SERVICES		
	STEP 4: Severe disorder – high intensity treatment	4.7%	A range of psychological therapies and pharmaceutical interventions in community and inpatient settings
	STEP 5: Longer term or acute treatment – for chronic and/or complex disorders		

Interventions will include:

Improving waiting times for follow up care

- Greater expectations for access to Child and Adolescent Mental Health Services (CAMHS), and the reduction of wait time targets.
- Currently there is no nationally consistent approach to follow-up care practices for young people discharged from CAMHS. There is a risk of relapse associated with mental health problems particularly in the period immediately following treatment.
- CAMHS will, in partnership with the young person and their family, identify a primary care provider to be responsible for follow-up care. CAMHS will ensure that this provider has access to appropriate documentation and support from CAMHS.
- Young people needing access to Alcohol and Other Drug (AOD) support will receive this sooner as part of a Ministry of Health project to improve access to these services.

Referral pathways

- New Zealand's youth mental health system is complex, with many players. Referrals among these players are currently problematic.
- The Ministry of Social Development will lead a cross-agency review to look at where the referral pathways are not working well, and will recommend practice changes.
- The review is to be undertaken in 2012. It will inform further advice to Ministers on improvements that can be made to the system.

Alcohol and Drug Education Programmes

- Alcohol and drugs are significant factors in youth mental health. Young people are particularly vulnerable to the misuse of substances.
- Access to alcohol for young people is being tightened up through the Alcohol Reform Bill, currently before Parliament.

- In addition, there will be a cross-agency review of Government-funded education programmes to tackle teenagers' drug and alcohol misuse. This review will ensure that funding is being provided for programmes that are in line with best practice.

Family and Community Initiatives

Information for parents, families and friends. A contestable fund that will allow non-Government organisations to bid for funding to provide information to parents, families and friends.

Whānau Ora approach to Youth Mental Health.

- Two Whānau Ora providers with mental health expertise will be contracted to work with 40 Māori and Pasifika 12-19 year-olds and their whānau over a two year period. The young people will be referred by a school-based nurse, Child Youth and Family or the Youth Court following a Family Group Conference.

Training for providers working with truants and disengaged young people. Disengaged young people have very high rates of mild to moderate mental illness.

- Training will be offered to service providers who work alongside disengaged young people so that they can identify mental health needs. Training and resources will be offered to providers who work with truants and young people who are not in education, employment or training (NEET).
- Reconfiguration of the truancy services, and contracting for providers to work with NEET 16 – 17 year-olds for the first time.

Online Initiatives

E-therapy. A proposed E-therapy programme for youth with mild mental health issues will provide a treatment that will focus on the common problems of depression and anxiety.

Improving the youth friendliness of mental health resources. The current range of information and resources to support youth mental health will be reviewed and revamped to ensure it is up-to-date and youth friendly.

Social Media Innovations Fund. The Government will launch a public-private partnership fund designed to help youth providers keep their services technologically up-to-date. $2 million will be invested over four years to create a Social Media Innovations Fund.

School Based Initiatives

Nurses in decile 3 secondary schools. Extra nurses embedded into decile 3 secondary schools, expanding the nurse-led School Based Health Services to a further 18,000 potentially at risk young people.

Youth workers in low decile schools. Youth workers trained in mental health issues will be put into selected low decile schools to work alongside nurses, further strengthening support available to young people. Workers will be contracted by existing community NGO providers through funding by CYF.

Check and Connect. Check and connect will target young people who have disengaged or are risk of disengaging from school. It provides mentoring and monitoring for truants. Trials will be evaluated in 17 schools.

Making schools more responsible for student well-being. The Education Review Office (ERO) will develop indicators of student well-being. Once developed they will be included in the regular review cycle. School charters will be required to respond to the Government objectives.

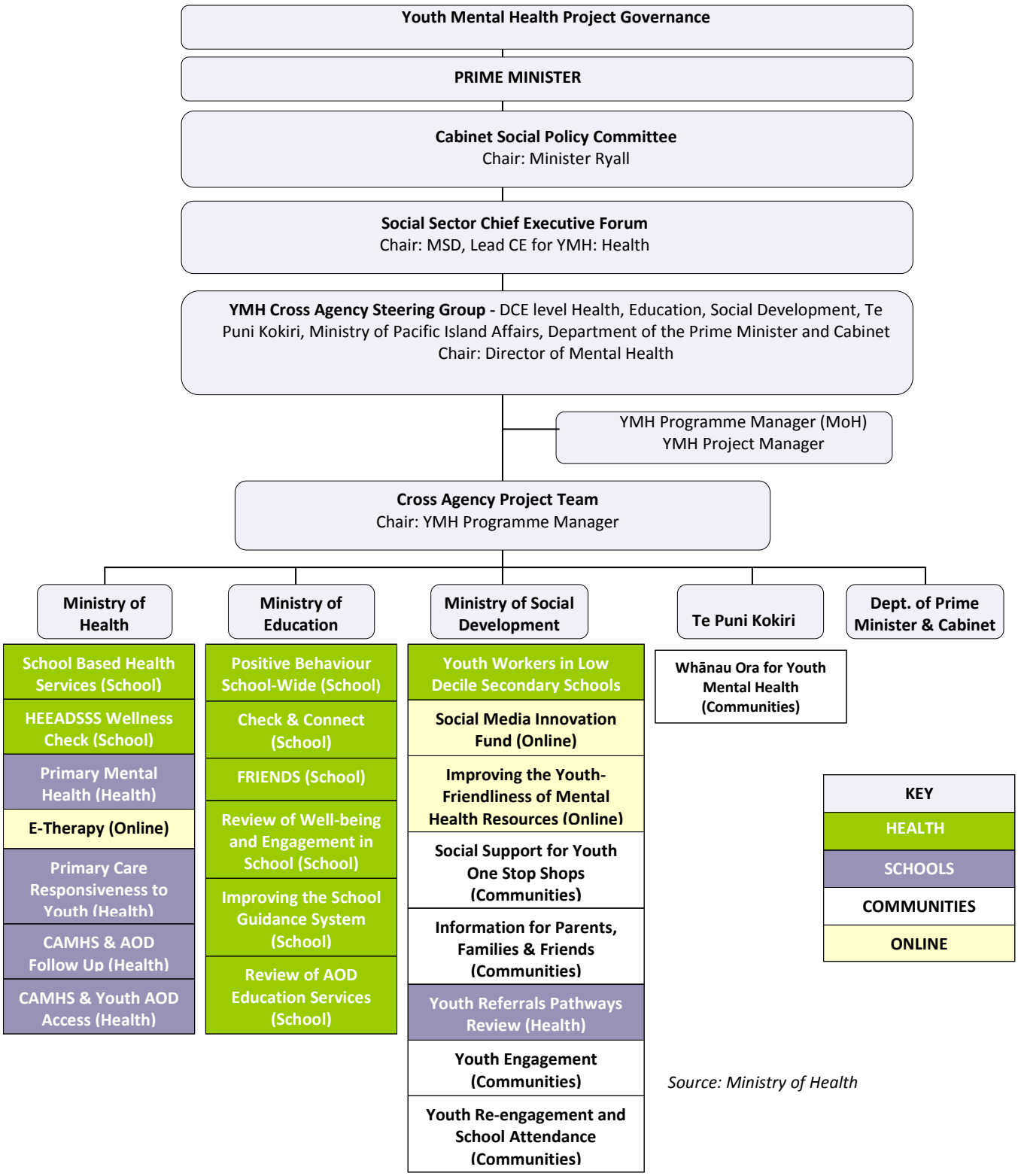
Encouraging positive culture in schools. Training will be provided to help secondary schools implement Positive Behaviour School Wide.

FRIENDS for life. Designed to help students build self-esteem and resilience to help them cope with depression and anxiety. It promotes important personal development concepts and helps young people build positive relationships with peers and adults.

Improving the school guidance system. The Education Review Office (ERO) will review the school guidance system. The review will help establish which practices best support youth well-being and inform. Current funding is around $55 million per year.

Initially led by DPMC, from 1 July 2012 the Ministry of Health is the lead agency for the next implementation phase. A formative evaluation is to be undertaken in two years and a summative outcomes-focused evaluation in four years. The following diagram shows the governance structure for the project.

Governance Structure – Youth Mental Health Project



Source: Ministry of Health

Linking Ministries of Health, Education and Social Development Youth Priorities

The Ministries of Health, Education and Social Development have released their Statement of Intents (SOI) 2012 and beyond. There are a number of youth specific priorities in each of the agencies SOI's in response to the priorities outlined in the Department of Prime Minister's Cabinet Statement of Intent 2012-2014.

The development of the Youth Health Strategy for Taranaki provides an opportunity to align the youth priorities from across various agencies. Often Health, Education and various Ministry of Social Development departments, e.g. Work and Income, Child, Youth and Family and Youth Justice are dealing with a similar cohort of high needs and vulnerable youth. The strategy will enable agencies to connect and be responsive to the most vulnerable youth through an agreed framework.

What are the Ministry of Social Development (MSD) Priorities for Youth?

The Ministry of Social Development Statement of Intent 2012-2015[5] includes young people as a clear priority within welfare reform. Statistics show that those who go onto welfare while young tend to stay on benefits longer than others and as a result have poorer opportunities. In particular those young people (16–17 year-olds) who become disengaged from education, employment and training. Teen parents also tend to stay longer on benefits than those who become parents at an older age. Statistics also show on average a teen mother will spend more than seven of a 10 year period on the Domestic Purposes Benefit. More than a third of those on the Domestic Purposes Benefit became parents as teens and almost half of those have no formal qualifications.

Historically, young people and teen parents have been able to receive a benefit with little support to enable them to have sustainable futures and enabling them to no longer be recipients of the welfare system. As a result the Statement of Intent (SOI) outlines clear initiatives to better support those of greatest need and to maximise positive life choices.

The following are the key strategic focus areas across the Ministry of Social Development for the next three years that relate to youth:

- **Cross agency leadership**. More young people contribute positively to their communities. Ministry of Youth Development providing young people's input into policy development across Government. Participating in, and contributing to policy development.
- **Provide youth development programmes and services for young people**. Fund local programmes and initiatives to connect young people to their communities. Prime Ministers Youth Programme rewards and fosters achievement for young people aged between 14 and 17 who have overcome adversity and to make positive choices for their future. Working across Government to identify common key areas that address youth mental health needs.
- **Reduce the rates of youth crime**
- **More people into work and out of welfare dependency**. Two new benefits - Young Parent Payment and the Youth Payment. Increasing supports for young people who are on a benefit. Contracting specialised youth service providers to be attached to each young person on a benefit to mentor and help them with money management and decision making. New obligations for teen parents to enrol their child with a primary health care provider and complete Well Child/Tamariki Ora checks. A Guaranteed Childcare Assistance Payment for children under five, to ensure teen parents are not prevented from studying.
- **Provide youth focused employment programmes to move young people out of the benefit system.**
- **Introduce stronger obligations for young beneficiaries and work more closely with disengaged youth.**

[5] http://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/corporate/statement-of-intent/2012/msd-soi-2012.pdf

- **More people are in education, training or work**. Early intervention and targeting disengaged 16 and 17 year-olds, helping them get back into education, training or work. Goal to reduce the drift of young people onto welfare at 18 years and increase proportion of 18 year-olds with NCEA Level 2 or equivalent. Intensive support for young people.
- For **young people in care** who are unable to return home, finding a new safe and secure permanent place of their own with extended whānau or a new family. Identify and address immediate **health needs** of children and young people entering residential care.
- **Few children and young people commit crimes**. Work intensively with young people on family group conference (FGC) plans and supervision orders to place them in work, education and training. Identify and address the underlying causes of the young persons offending behaviour. Provide all young offenders in youth justice residences with individual transition plans for re-integration into their communities.

What are the Ministry of Education (MOE) Priorities for Youth?

The Government recognises the role education plays in building a cohesive and prosperous society. The education system is focusing on increasing the proportion of 18 year-olds with NCEA Level 2 or and equivalent qualification[6]. To achieve this; Education will focus on the participation and progression of all young people. The first priority is to improve outcomes for those young people least well-served by the current system, which is Māori and Pasifika learners, learners with special education needs and learners from low socio-economic backgrounds.

The Ministry of Education has a commitment to contributing to the Government's goals to improve youth mental health and better support young people with mental health issues. In addition the MOE acknowledges the contribution to make to the Government's goals to deliver positive change for people with disabilities. This will include cross-Government collaboration in priority areas. This is likely to include making services easy for families and whānau to access and to navigate, working to lift the educational achievement and employment outcomes of young disabled people, and improving the transition from school by trialling the flexible use of funding to support disabled young people's goals.

Other Education priorities include:

- **Strengthening transitions between schools and tertiary education, skills training or the workplace.**
- **Continued implementation of the Positive Behaviour for Learning Action Plan** with a particular focus on low decile schools and parents of Māori and Pasifika children.
- **Utilising the funding from the Governments Youth Mental Health Strategy** to provide further behaviour programmes and initiatives in secondary schools.

what are the Ministry of Health's (MOH) Priorities for Youth?

The Ministry of Health (MOH) has committed to working with other Government agencies on cross-Government initiatives such as supporting youth mental health, suicide prevention and whānau ora. Over the next few years the Ministry of Health will contribute to a cross-agency package of initiatives that will help prevent mental health problems developing, and will improve access to specialist treatment for those who need it.

Other Ministry of Health priorities include:

- **Reducing waiting times for youth alcohol and drug treatment**.
- **Cross Government working**. As a member of the Social Sector Forum, MOH shares leadership of the Forum's work programme, including Whānau Ora; Drivers of Crime; and pilots of new approaches to social service delivery for young people

[6] http://www.minedu.govt.nz/~/media/MinEdu/Files/TheMinistry/2012SOI/2012StatementOfIntent.pdf

Other National Youth Health Priorities

What are the Priorities for Youth Mental Health and Addictions?

Mental Health and Addictions Blueprint II

In 2011-2012 the New Zealand Mental Health Commission undertook the development of Blueprint II[7] – Improving mental health and well-being for all New Zealanders – how things need to be and making change happen. For children and young people, resiliency is more important than recovery, and recovery needs to focus on ensuring that developmental milestones appropriate to the children and young people continue to be attained. The principles underpinning Blueprint II include:

Source: Mental Health Commission, Blueprint II

Of the eight clusters covered by the life course approach, two relate to youth/adolescents. The following shows the impact of intervening at these points are:

3. Youth/adolescents with emerging mental health, behavioural and addiction disorders	Youth experience a significantly higher rate of mixed anxiety, depression and alcohol and drug use which has a significant impact on mental health and well-being for this group. It represents an opportunity to intervene earlier and reduce the risk of subsequent adult mental health and addiction issues.
4. Youth/adolescent at high risk (including forensic)	This cluster focuses on youth with significant mental health, alcohol and drug and behavioural disorders and represents an opportunity to intervene in a pathway that has the potential to lead to life-long mental health and addictions issues. It includes youth who are at risk of or already involved with the forensic mental health or justice systems. Interventions for youth with significant mental health, alcohol and drug and behavioural disorders provide an opportunity to reduce the risk of them experiencing life-long mental health and addictions issues.

Source: Mental Health Commission, Blueprint II

[7] http://www.hdc.org.nz/media/207639/bluepring%20ii%20making%20change%20happen.pdf

Blueprint notes that between 40-60% of youth offenders will have mental health and alcohol or drug issues with higher proportions among those remanded. There is a need to develop a nationally consistent stepped system of care for high-risk youth that spans the continuum from early recognition, primary/community level of services through secure youth forensics services that actively support transition back to the community. There is a need to continue to support shared learning, evaluation and research to build understanding of what works for different cultures, particularly Māori youth, and translate this into effective services.

Taking action. Priority 1: Providing a good start – Respond earlier to mental health and addiction issues in children and young people to reduce lifetime impact which focuses on infants, children and young people from vulnerable families and whānau. Actions include:

Increased access and early responses for youth (15-24 years) with emerging behavioural, substance abuse and mental health issues

- Increased access rates for people 15-19 years and 19-24 years.
- **Engagement with young people to find out what sorts of services would improve access and increase take-up.**
- Increased access to effective comprehensive youth health services (for example, **school-based services and youth 'one stop shops').**
- Building skills and knowledge of **staff working in primary care, other general child and youth health services, community and education settings**. This will enable early identification of emerging issues, provision of advice, direction to self-care tools, brief interventions or referral to additional support/services as required.
- Continued development of e-therapies as independent support tools and as part of a programme of support for primary or school-based services that can provide continuity and escalation of support if required.
- Increased **primary and community screening of youth for mental health and alcohol and other drug issues, and assessment of psychological and social functioning**. There will be provision of, or referral to, interventions ranging from brief advice, motivational/problem-solving through to more focused interventions for mental health and dependency issues.
- Continued development of capacity to respond to the **lower prevalence but high risk situations associated with suicide, eating disorders, early psychosis, and severe addiction issues.**
- The prevalence for mental health and addiction disorder in young people is high. Blueprint II reports that 18% of New Zealand 11 year-old children are affected by a mental health disorder. By secondary school 27% of students are affected by depression and anxiety, with 10.6% experiencing significant symptoms, with substantially higher rates for females than males. The period of greatest prevalence is between the ages of 15 and 18 where prevalence peaks at 29% for any mental health disorder and 7% for serious disorders, substantially higher than any other period in life.

Mental Health issues in youth commonly coexist with alcohol and drug problems. The prevalence of hazardous drinking exceeds 50% for 18-24 year-old males. Prevalence rates for cannabis use are approximately 40% for 16-18 year-olds. In addition, conduct disorders or severe anti-social behaviour disorders affect up to 10% of youth and are characterised by aggressive, delinquent, dishonest and disruptive behaviours for which the majority are male.

The prevalence of self harm, suicidal ideation and suicide among young people is high by international comparison, in particular for females. The Mental Health Commission 2011 Child and Youth Mental Health and Addiction[8] report stated that 20% of secondary school students reported self harm in the past 12 months and 4.7% reported a suicide attempt in the same period. In 2009 the suicide rate for males aged between 15 – 24 years is 29 per 100,000, more than four times higher than the rate for females of the same age at 7 per 100,000 and the highest rate in the OECD.

[8] Child and Youth Mental Health and Addictions Report 2011. Wellington. Mental Health Commission

Rising to the Challenge – The Mental Health and Addiction Service Development Plan 2012-2017

In October 2012 the Ministry of Health released for consultation the Service Development Plan[9] (SDP) for Mental Health and Addictions 2012-2017. The purpose of the plan is to set the direction for mental health and addiction service delivery across the health sector over the five years. The SDP has been developed off the back of the Blueprint II documents, Improving the mental health and well-being of all New Zealanders: How things need to be and Making change happen. The document is being consulted on within a tight deadline, with an anticipated final plan available in November 2012. Themes for improving outcomes for young people are peppered throughout the document. Health services are expected to work alongside individuals, families/whānau and communities so that young people have a healthy beginning and can subsequently flourish.

There is an expectation for increased access to service across all age groups in particular while building resilience and averting future adverse outcomes for infants, children and youth. Evidence shows that that mental health problems and substance misuse often first appear in adolescence and 75 percent of problems develop by the age of 24 years (Department of Health 2011).

Young people tend to have a lack of awareness, and reluctance to seek help and under-treatment. Families, schools and communities often lack the tools and information to help young people who are experiencing mental health and alcohol and other drug (AOD) issues. New Zealand continues to have high youth suicide rate relative to other developed countries.

A number of key actions have been reflected in the SDP that focus on intervening early in the lives of young people in order to strengthen resilience and avert future adverse outcomes. The Plan also highlights the need for more flexible and responsive services across all providers, greater cross-agency collaboration and options for earlier intervention to better meet the needs of youth across the full spectrum of health services, including services within schools.

DHB's and NGO providers of specialist youth mental health and AOD services are expected to:

- Enhance responsiveness and flexibility of specialist youth MH&A services
    - Discharge planning that ensures effective hand-over to an identified primary care provider, with provision for ongoing specialist advice as needed.
    - Provision of kaupapa Māori services for Māori communities
    - Delivering services from settings within the local community that are family/whānau and youth friendly, such as schools, youth-specific health services (including one-stop shops) and integrated family health centres
    - Co-location and integration of mental health services and AOD services for youth
    - Obtaining input from young people into planning and delivery of specialist mental health and AOD services
    - Proactively involving and supporting family/whānau and friends
    - Actively working to ensure young people remain engaged with age-appropriate natural community supports.
- Enhance the delivery and integration of specialist MH&A services within primary care, general health services and schools.
    - Urgent assessment for young people and families/whānau in crisis
    - Shared care arrangements that allow young people and families/whānau to move quickly and efficiently between primary care and specialist services as their needs dictate
    - Delivery of specialist services from primary care sites, including youth one-stop shops, in combination with processes to ensure collegial working
    - Discharge planning that ensures effective hand-over to an identified primary care provider, with provision for ongoing specialist advice as needed.
- Support a coordinated multi-agency response for youth with complex inter-agency needs.

[9] Rising to the Challenge – The Mental Health and Addictions Service Development Plan 2012-2017

- Specialist child and youth mental health and addiction services will contribute to a cross-sector response to the delivery of services for youth with high and complex mental health, AOD and other needs. This will include dedicated evidence-informed intensive community services that are flexible and individually tailored to the needs of each young person and their family/whānau, and specific opportunities for young Māori to connect with, and draw strength from, kaupapa Māori approaches and programmes.

Primary Care and Youth health providers are expected to:

- Improve the responsiveness of schools and primary care, maternal, and youth health services
  - Build the skills and knowledge of staff working in primary care, maternity and general child and youth health services and within schools to enable them to recognise and respond effectively to the mental health and AOD issues of infants, children and youth, and their families/whānau. Specific attention will be paid to developing the capacity and capability to enable:
    - early identification of emerging issues (including screening for postnatal depression and use of HEEADSSS wellness checks for youth)
    - provision of advice/brief interventions to address emerging mental health and AOD issues
    - recognition of when specialist advice or referral is indicated and the systems to support this.

Primary Care is expected to:

- Implement youth-centred models of care within primary care
  - Youth-centred models of care will be developed and implemented within primary care services, with the aim of improving the responsiveness and effectiveness of services for youth experiencing mental health and AOD issues, including improving the integration with school based health services, co-location of services in 'youth one stop shops' wherever possible and having the flexibility to respond to 'walk ins'

To enable changes necessary for service priority areas the Ministry of health will either reprioritise existing funding, or funded through a new demographic or funding has been previously approved and allocation for example the Youth Mental Heath Project.

Youth Forensic Services

The Ministry of Health Youth Forensic Guidelines have been consulted widely over the last three years and were released in November 2011. There will be a national allocation of FTE specialist clinicians per year for the next four years to provide the following services:

- Triage, screening, and assessment of youth offenders
- Court liaison services across the country in all youth courts
- Treatment of mental health and alcohol and other drug problems
- Clinical care for youth in Child, Youth and Family (CYF) youth justice residences and youth prisons

Community based services will provide:

- Brief assessments and referrals for youth offenders
- Forensic assessment and follow-up care for youth (aged less than 17 years) with mental health and alcohol and other drug needs in CYF justice residences each year
- Forensic assessment and follow-up care for youth (aged 17-19 years) with mental health and alcohol and other drug needs in prison youth units each year
- Specialist forensic consultation and liaison services for professionals in health services and the justice sector.

Taranaki is the only Midland region that has not had access to Youth Court Liaison/Community Advisor roles, therefore are prioritised for resources with the new funded clinical FTE's. Hauora Waikato will continue to be the regional provider for Forensic services and a regional multi-agency technical advisory group are developing referral pathways and a model of care.

Draft Standards for Youth Health Services

In 2005 Counties Manukau District Health Board commissioned the development of a document called Standards for Youth Health Services[10]. The purpose of the document was to improve the health and well-being of young people by establishing a nationally agreed set of standards for youth health service delivery. The standards remained in draft. In September 2012 the Ministry of Health established an expert advisory group to review and redeveloped standards for School Based Health Services (SBHS). The expert group included a multi-agency approach to its development with Ministry of Education and Ministry of Social Development represented. The standards are likely to generic in as such as they would be usable for health services also funded by the education and broader Youth Health Service Sector for primary care.

Where and How do the Agencies Align?

The following table maps the agencies Statement of Intents and other local planning documents to see where the commonalities in priorities fit.

[10] Draft Standards for Youth Health Services 2006, Counties Manukau District Health Board.

National Agency Priorities

Table 1: Alignment National of Statement of Intent Priorities

Department of the Prime Minister and Cabinet – Statement of Intent 2012 - 2016			
Delivering better public health services that all New Zealanders rely on	**To responsively manage the Government's finances and return surplus in 2014/15**	**Te rebuild Christchurch and the Canterbury economy**	**To build a more competitive and stronger economy**

Delivering Better Public Health Services				
Reducing long term welfare	**Supporting vulnerable children**	**Boosting skills and employment**	**Reducing crime**	**Improving interaction with Government**
1. Reduce the number of people who have been on a working age benefit for more than 12 months.	**2.** Increase participation in early childhood education. **3.** Increase infant immunisation rates and reduce the incidence of rheumatic fever. **4.** Reduce the number of assaults on children.	**5.** Increase the proportion of 18 year-olds with NCEA Level 2 or equivalent qualification. **6.** Increase the proportion of 25-34 year-olds with advanced trade qualifications, diplomas and degrees (at Level 4 or above).	**7.** Reducing the rates of total crime, violent crime and youth crime. **8.** Reduce reoffending	**9.** New Zealand businesses have a one-stop online shop for all Government that advice and support they need to run and grow their business. **10.** New Zealanders can complete their transactions with the Government easily in a digital environment.

Ministries Statement of Intent				
Ministry of Health 2012-2015	**Ministry of Social Development 2012-2015**	**Ministry of Education 2012-2017**	**National Health Board 2011-12**	**Te Puni Kōkiri 2012 - 2015**
1. Health services are clinically integrated, more convenient and people centred - The public can access quality services that meet their needs - The public can access services when and where they need them - Health services are clinically integrated and better coordinated - The health system is supported by suitable infrastructure and workforce	**1. Cross-agency leadership** - Social sector leadership - Leading across Government **2. Reducing long-term welfare dependency** - More people into work and out of welfare dependency **3. Boosting skills and employment** - More young people are in education, training or work - More young people contribute positively to their communities	**1. Improving education outcomes for Māori learners, Pasifika learners, learners with special education needs and learners from low socio-economic backgrounds.** - Raise and sustain participation levels in, and the quality of, early childhood education overall. - Transform the performance of primary and secondary education to increase attainment of core skills and	**1.** A unified system for longer term service planning, funding and provision that is clinically and financially sustainable. **2.** Identify, fund, plan and monitor delivery of health services deemed to be national services. **3.** Support the ongoing development and implementation of RSPs **4.** DHB Planning, Funding and Monitoring. **5.** Capital, IT and Workforce capacity	**1. Whānau Ora: Whānau and Māori achieve enhances levels of economic and social prosperity.** - Whānau Ora policy and service delivery approach - Whānau Ora Social Assistance programme management. - Advice across Government on enhancing the well-being of Whānau and Māori. - Advice across Government on enhancing the well-being of whānau and Māori

- The health system complies with regulations - The public has trust and confidence in the health system **2. New Zealanders are healthier and more independent** - The public is supported to manage their health and independence - Environmental and disease hazards are minimised **3. The future sustainability of the health system is assured** - The efficiency and financial sustainability of service providers is enhanced	**4. Supporting Vulnerable Children** - Fewer children are vulnerable - More efficient and effective allocation of Government resources to meet community needs **5. Reducing Crime** - Fewer children and young people commit crime - Fewer people commit fraud and the system is fair and sustainable **6. Improving interaction with Government** - More people interact with the Ministry in a digital environment **7. Helping Canterbury to recover** **8. Managing in a changing environment** **9. Organisational health and capability** **10. Our Capital Intentions**	qualifications. **2. Maximise the contribution of education to the New Zealand economy** - improve foundation education to ensure all young people are able to gain skills and qualifications. - Strengthen the performance of the tertiary education system and its links to the labour market.	planning and investment supports service plans that are clinically sustainable. **6.** Allocate existing MoH funded non-dept expenditure to be managed at either national, regional or local level. **7.** Reducing waste and bureaucracy and improving productivity of the health and disability system **8.** Encouraging clinical leadership and engagement **9.** Christchurch earthquake recovery **10.** Aged Care.	**2. Te Ao Māori: Māori succeeding as Māori, more secure, confident and expert in their own culture.** - Effectiveness for Māori - Māori language - Māori broadcasting and e- media - Māori cultural practice

Prime Ministers Youth Mental Health Project

In the health sector	Family and community initiatives	Online initiatives	School Based initiatives
1. Making primary care more youth friendly **2.** Improving waiting times **3.** Improving referral pathways **4.** Alcohol and drug education programmes	**1.** Information for parents, families and friends **2.** Whānau Ora approach to Youth Mental Health **3.** Training providers working with truants and disengaged young people **4.** Ensuring young people have a say	**1.** E-therapy **2.** Improving the youth-friendliness of mental health services **3.** Social Media Innovations Fund	**1.** Nurses in decile 3 schools **2.** Youth workers in low decile schools **3.** Check and connect **4.** Making schools more responsible for student well-being **5.** Encouraging a positive culture in schools **6.** FRIENDS for life **7.** Improving the school guidance system

Local Agency/Organisation Strategic Priorities

Table 2: Local Strategic Priorities

Local Agency/Organisation Youth/Rangatahi Priorities						
Health			Education	Ministry of Social Development	Te Puni Kōkiri Te Tai Hauāuru (Whanganui/Taranaki)	
Taranaki DHB (includes DAP, MHP and PHP)	**Midland Health Network**	**National Hauora Coalition**	**Including Special Education (Regional Business Case)**	**Including CYF , Youth Justice and FACS**	**Te Puni Kōkiri Whānau Ora**	**Whānau Ora Regional Leadership Group**
District & Māori Health Annual Plans **1.** Improving access to Mental Health services for youth **2.** Improving waiting time for MH&A Services **3.** Regional collaboration **4.** Improved oral health **5.** Reducing fragmentation of youth health services **6.** Whānau Ora **Public Health Plan** **7.** Increased positive attitude and skills to reduce harm from alcohol **8.** Awareness of health lifestyle messages is improved amongst youth populations **9.** Collaborative working relationships with youth services and health providers (South Taranaki)	**MH&A SLAT Recommendations** **1.** Mental Health and Addictions Stepped Care Model – primary and secondary **2.** Primary Care Toolkit (MH&A) **3.** Enhance accessibility for MH&A, increase engagement and opportunities for intervention **4.** Increase awareness and early detection of MH&A related issues amongst health professionals **5.** Prioritise people who are at risk, disengaged or have significant barriers to services **6.** Progress implementation of health promotion component. **Child & Youth SLAT Recommendations**		More detail from a regional / local perspective	? more detailed priorities in relation to departments of MSD in relation to youth.	1. Provide leadership and coordination across Government agencies and other stakeholders to encourage engagement involvement in Whānau Ora. 2. Te Puni Kōkiri works closely with the MSD and Health to support the implementation of Whānau Ora.	**Roles and Responsibilities** **1.** Leading strategic change for Whānau Ora **2.** Providing positive representation of Whānau Ora at the local and regional level **3.** Fostering excellent communications and relationships within regions **4.** Ensuring the work of the Group is coordinated with other local and regional initiatives and services **5.** Providing high quality advice and recommendations to the Governance Group on the selection of Whānau Ora service providers; the development and implementation of Programmes of Action; regional whānau-centred service delivery and initiatives; priority areas and other issues or areas of advice as determined by the Governance Group **6.** Monitoring and reporting on results, outcomes, best practice examples /models and

<u>Whānau Ora Health Needs Assessment</u> Refer section on consultation.	**7.** Youth health passport (school leavers) **8.** Expert Advisory Group to review youth health services / funding across MHN **9.** IT Platform **10.** Target youth health assessments in Alternative Education and Decile 1 & 2 schools.					implementation issues in their region.

Section 3: Taranaki Cross-Agency Governance

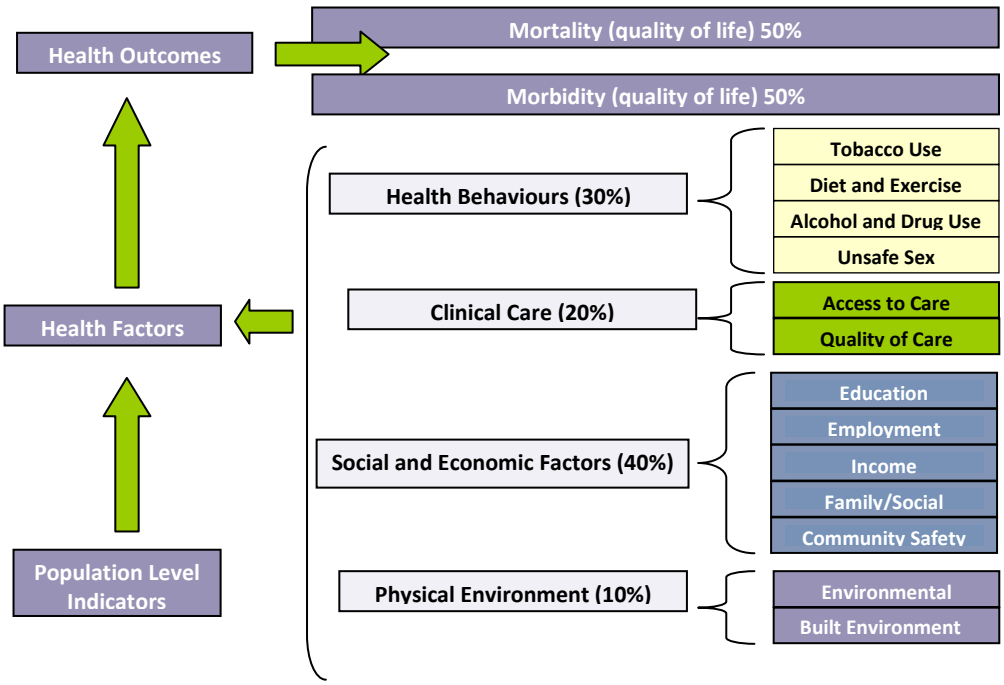
Cross Agency and Provider Governance in Taranaki for Taiohi Service Provision – An Alliance

> The task of the leader is to get his people from where they are to where they have not been.
>
> -Henry A. Kissinger

For the Taranaki Youth Health Strategy to be implemented, agencies will need to commit to working together, agree what needs to be done differently to ensure access and equity, coordination, and integration and alignment quality of service provision. The development of the Strategy has presented the agencies with a unique and timely opportunity to discuss the outcomes desired in strengthening a structure to enable alliance working across agency differences. The development of an alliance charter provides the foundation of strong leadership to encourage future ways of working together.

In trying to understand a whole of system approach to improving health outcomes for young people, it is necessary to understand the broader context of factors that effect health outcomes.

The University of Wisconsin Population Health Institute created a measurement tool[11] that expands the traditional measurements of mortality and morbidity health of a population to include measures that reflect the major determinants of health, eg. health behaviours, clinical care, social and economic factors and physical environment. The fifth determinant, genetics and biology was not included. The model has been used to measure the health of counties in the United States. The following diagram shows how factors affect health outcomes.



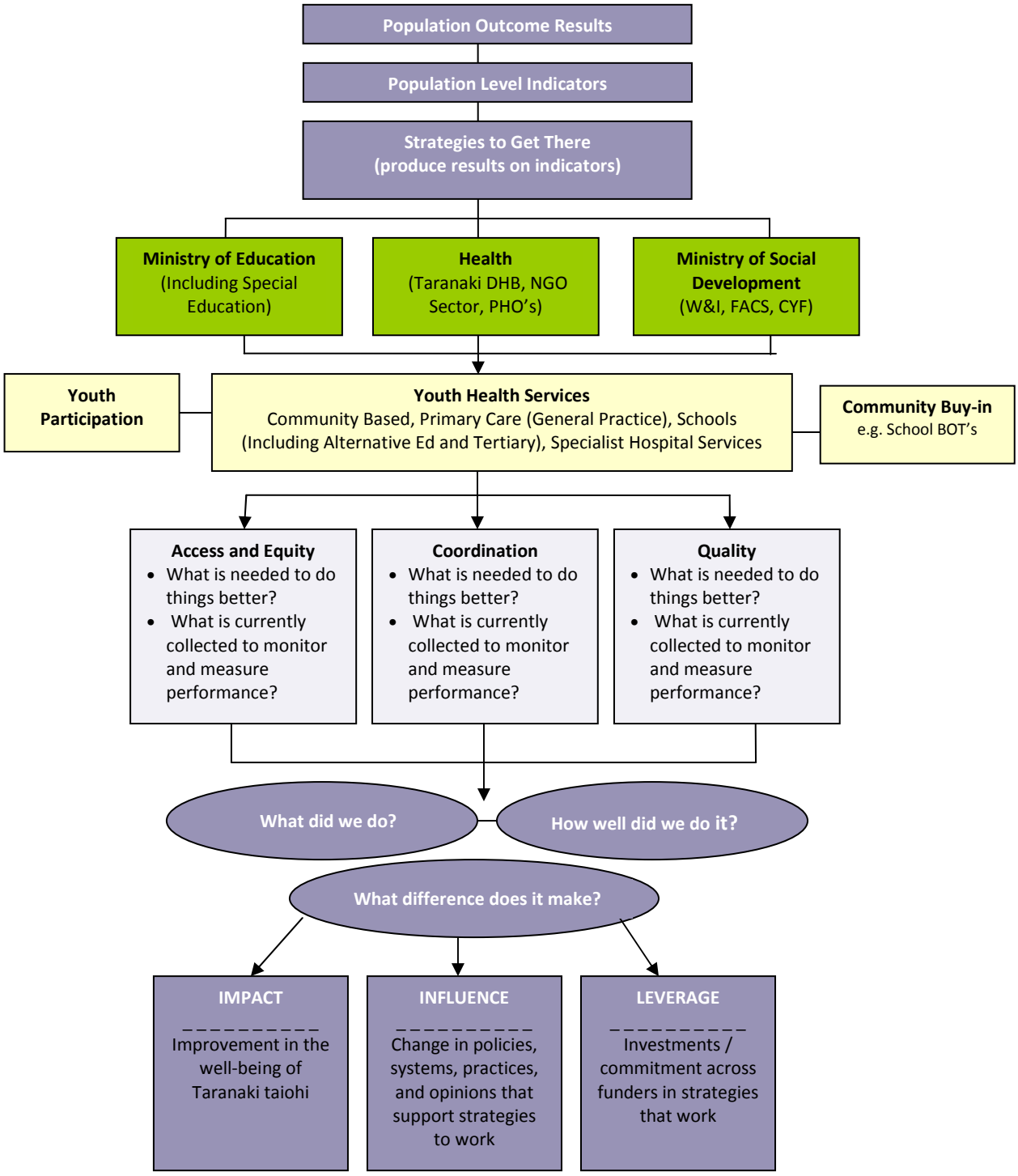
County Health Rankings Model © 2010 UWPHI

[11] Willems, Van Dijk and Kushion (2011) Multiple Determinants of Health and the County Health Rankings

Proposed Governance and Service Structure for Taranaki Youth Health Services

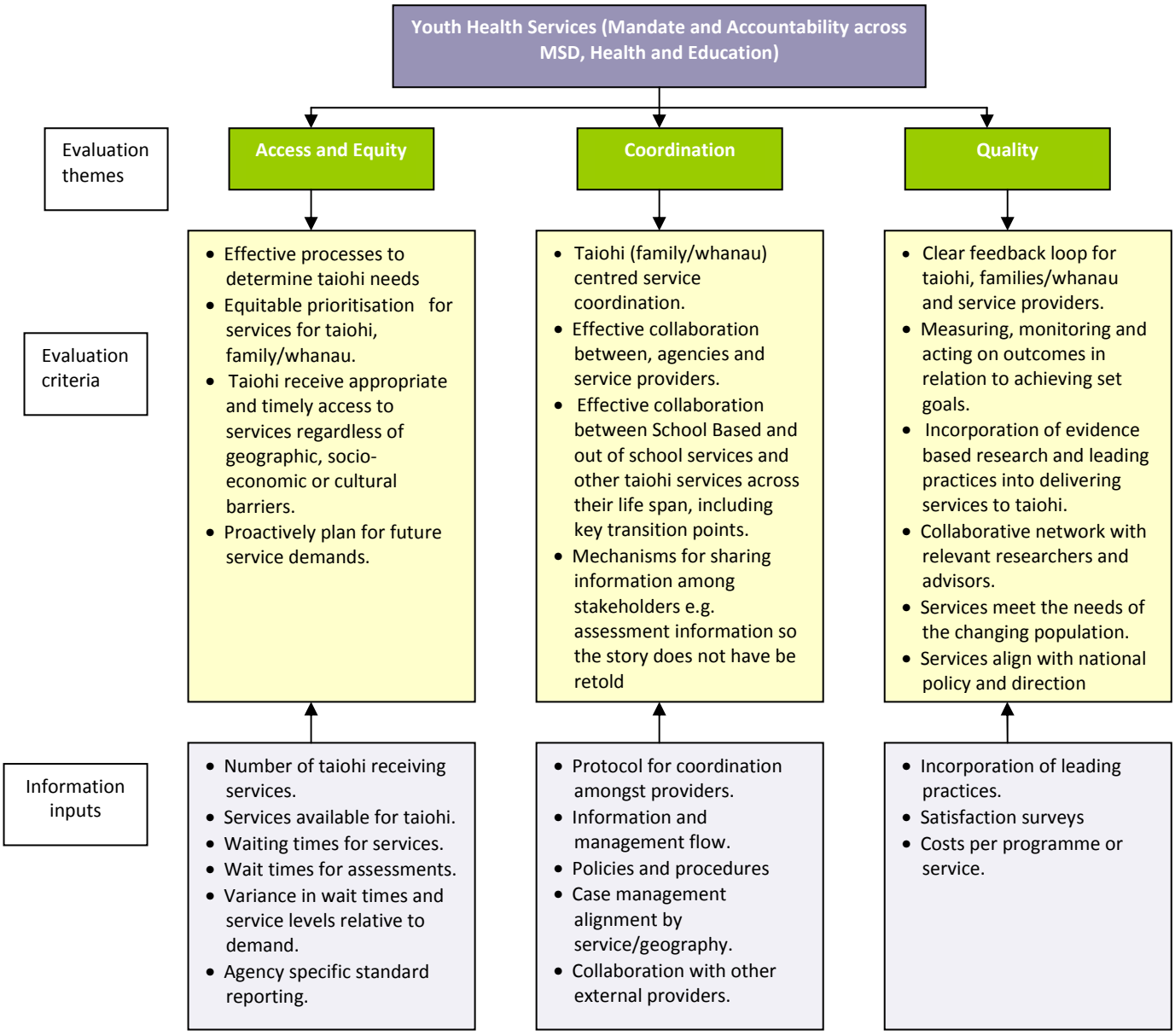
Throughout the project, the operational group felt there were two critical areas for transformational change that would likely have longer term sustainability and improve health outcomes for Taranaki taiohi. Firstly, alignment of the agencies to deliver youth health services and for providers funded by individual agencies to work more closely together through a robust and well defined governance structure. This requires all parties to agree to a model of youth health service delivery that is coordinated, integrated and is able to reduce duplication and more effectively respond to the needs of young people. The second critical area for transformational change is the recognition of the early intervention and prevention evidenced based programmes and the ability to redevelop youth health models of care that challenge the current provision of services across primary/community and secondary based settings, leverages off the success of the nurse led services and integrates better with General Practice.

The following diagram provides an example of the structure that could influence how services for young people can be aligned across agencies to achieve higher level population health outcomes.



A commitment to multi-agency working through an alliance ultimately would have greater influence and ability to put taiohi and their family/whānau at the centre of service delivery, enable change in policies, practices and systems and provide a greater network of clinical and collegial support. Ultimately it could lead to central pooling of funding through mechanisms that allow flexibility to deliver services through the actual needs of taiohi across the region. It is imperative that structures are aligned with and part of the whānau ora vision for longer term gains for multi-agency working.

What Could Access, Equity, Coordination and Quality Look Like for Multiple Agencies?



There are four elements that should define the framework on how we work together, (1) common service delivery domains, (2) share principles for service delivery (3) stronger relationships and partnerships and (4) effective leadership.

The following describes in more detail how the three key areas in defining the governance space for multi-agency space could be consider. This includes aspects associated with mandate and accountability, access and equity and coordination.

Mandate and Accountability

Without a multi-agency agreed mandate for youth health services that is clearly understood by stakeholders, it is difficult to fully define roles and accountabilities for an integrated model of care. The current overlapping involvement of the various sectors/stakeholders and service providers and the differing models that have emerged through historical contracting arrangements

and relationships blur the lines. The following are some key points to consider when looking to set the mandate and accountability for a multi-agency collaborative of taiohi health services for Taranaki.

Mandate and Accountability	
1. Signing of an agreed agency/organisation Alliance Charter	1.1 Agreeing the partners for signing up to an Alliance agreement. 1.2 Agreeing the infrastructure required to establish a new coordinated and integrated model of care. 1.3 Agreeing integrated model of care.
2. Clarification of the scope of services delivered under the mandate of the youth health service collaborative/alliance.	**What outcomes might look like?** 2.1 Establishing a common understanding of proposed model of care, philosophy, purpose and objectives to enable delivery of care that is consistent with direction of whānau ora and recognises te whare tapa wha as central to the well-being of taiohi 2.2 Clarification of roles, responsibilities and accountabilities across all stakeholders and providers. 2.3 Optimal use of resources that are coordinated to meet the needs of taiohi and their family/whānau. 2.4 Alignment of policies and procedures required to support the development and delivery of the services mandate. **How could it be described?** 2.5 Establishing the objectives, scope and intended outcomes of the youth health service alliance. 2.6 Development of a consolidated approach to service delivery. 2.7 Communication strategy on programme mandate, objectives, scope of services
3. Enhancing the cross-sector collaboration to deliver taiohi programmes and services that optimises expertise and resources.	**What outcomes might look like?** 3.1 Common understanding of the programmes and services delivered. 3.2 Facilitation of working relationships, service delivery, planning and coordination among stakeholders and providers. 3.3 Defining taiohi programme accountability, roles and responsibilities and performance expectations that related to taiohi defined health outcomes. 3.4 Promotion of innovative service delivery models that optimise the use of available resources. **How could it be described?** 3.5 Develop or leverage existing cross-sectoral mechanisms to optimise the broader system capacity, focused on collaborative planning, policy development and programme and service monitoring. 3.6 Enable collaboration across stakeholder groups through standardised structures and guidelines. 3.7 Develop shared principles among stakeholders to foster collaboration and dialogue on the delivery of taiohi services for Taranaki, eg: 3.7.1 Performance accountability – shared understanding of performance expectations within stakeholder groups. 3.7.2 Flexibility – shared understanding of enabling human resources and funding flexibility across sectors to deliver effective health services and programmes to taiohi in Taranaki. 3.7.2 Focus on taiohi health outcomes – shared philosophy and standardised guidelines that promote positive taiohi health outcomes resulting from well coordinated taiohi health services.

Access and Equity

Maintaining appropriate and equitable access to taiohi health services is critical to the success of service delivery. Young people are often engaged (or disengaged) in multiple settings e.g. schools, alternative educational or other programmes and it is often difficult to meet the needs of all young people equitably. Prioritisation of resources to where those that need it most requires flexibility, and an understanding of the current and future needs of young people across the district. Scope and practice often varies across communities. Evidence also shows that young people should participate in the development and delivery of services that they use. Improving access and equity is imperative for overall service improvement. The following are some key points to consider:

Access and Equity	
1. Development of access guidelines and tools to guide service delivery.	**What outcomes might look like?** 1.1 Common access guidelines and tools can help achieve equity of service delivery 1.2 Guide planning and coordination of efforts. 1.3 Facilitate tailoring of tools that meet the needs of varying communities, assess the equity of the services currently being provided and develop plans to improve access across various taiohi populations. **How could it be described?** When considering variability across Taranaki service delivery areas, the following could be considered: 1.4 Local flexibility and parameters that impact services – population needs in relation to taiohi health services, number of services required and geography. 1.5 Language and culture – ensuring consistent standards and resourcing when meeting the needs of the Māori population, clarifying roles and accountabilities for various programmes/services when delivering to Māori. 1.6 Functional needs – process that support taiohi who are the most at risk with the highest needs. 1.7 Education sector – addressing variability across boards in relation to standards, processes and roles and responsibilities, clarification of expectations among school health services (e.g. counsellors) to reduce the variability in the individual referral practices. 1.8 Health sector – clarify expected performance of service provision within a coordinated model of care – reducing variability in individual practice. 1.9 Ministry of Social Development Departments – address variability across programme and service provision within various departments. 1.10 Resources – examine ability for cross-sector policies that support improved access to better coordination and sharing of scarce resources across sectors, and alignment of strategies to address access issues related to limited resource availability.
2. Develop formal forums and processes for proactive service planning.	**What outcomes might look like?** 2.1 The implementation of forums that are tasked with proactive planning of service delivery. 2.2 Enhance collaboration across sectors and stakeholders to meet the needs of the taiohi population. 2.3 Create mechanisms across sectors to share information across stakeholder groups to help inform service planning. 2.4 Determine how to address the challenges of service planning among competing initiatives by aligning population needs and sector changes within resource capacity. **How could it be described?** The promotion of regular collaboration among health, education and social services to determine best models and approaches required to manage limited resources across sectors on an annual basis. Objectives of this collaboration could include: 2.6 Determining the impacts of evolving population service demands and any existing or changing legislation or national policy directives.

	2.7 Assess changes in education curriculum and clinical practice etc.. 2.8 Use of cross-sector data and information systems to inform service planning
3. Establish alternative models of service delivery to improve waiting times and access to service provision.	**What outcomes might look like?** 3.1 Develop models of care that focus on early intervention and prevention, and are within a whānau ora framework and recognise te whare tapa wha as essential to the overall well-being of taiohi. 3.2 Optimising of limited resources with better coordinated teams delivering to taiohi, ensuring alignment with best practice guidelines 3.3 Increasing access to specialised expertise to better support taiohi needs in a timely manner. **How could it be described?** 3.4 Protocols to establish alternative models that can be implemented across Taranaki through the following ideas: 3.4.1 Forums with identified experts, to develop alternative models that address challenges in accessing services and meet the unique needs of varying Taranaki populations. 3.4.2 Determining if existing tools, structures and processes that are currently in place that can be leveraged to enhance service delivery 3.4.3 Participation in information sharing processes to communicate successful service delivery models across Taranaki. 3.4.4 Implement ongoing evaluation processes to assess service delivery model effectiveness that will be related to examining overall programme performance. 3.5 Review the skill mix for professionals delivering the services and what is required under a new model of care.
4. Increasing the awareness of the new models of care	**What outcomes might look like?** 4.1 Enhancing awareness of the services available will increase the ability for taiohi, family/whānau, professionals, communities and other stakeholders to identity and access and/or refer to appropriate supports. 4.1.1 Offer relevant information in ways that resonate with them and enhance their understanding of the collaborative services available. 4.1.2 Reduce confusion for everyone in navigating the system by having clearly defined access points. **How could it be described?** 4.2 Develop enhanced communications and tools to increase awareness across schools and the community at large for example: 4.2.1 Brochures and other information medians to provide information to taiohi, family/whānau, schools, communities and other stakeholders on the services available. 4.2.2 Maximise the use of web-based portals for ongoing communication across all agencies, service providers and communities. 4.2.3 Determine additional requirements for taiohi, family/whānau to ease their navigation of the system across health, education and social services for health service provision and implement strategies to support the process. 4.3 Assess feasibility of implementing a single point-of-access for all taiohi health services where referral required.

Coordination

Considering the broad service options available for taiohi, coordination is often complicated and there are multiple entry points into health services delivered by health, education and social services. Communication and coordination is required across multiple stakeholder groups to achieve the benefits of effective coordination and to enable taiohi centred-care.

Coordination	
1. Develop and implement common guidelines to achieve 'shared care and service plans' for each taiohi that engages appropriate services.	**What outcomes might look like?** 1.1 Facilitated shared planning across providers for taiohi who access multiple services. 1.2 Reduced service and knowledge fragmentation. 1.3 Enabled providers, taiohi and their family/whānau to maintain and monitor up-to-date information on progress through services. **How could it be described?** 1.4 Guidelines developed and implemented on a shared care and service plan for each taiohi engaged with multiple services. 1.4.1 Develop mechanisms to support goals as part of a broader holistic approach for taiohi across sectors. 1.4.2 Assess current communication processes and determine mechanisms to enhance and coordinate communications. 1.4.3 Develop taiohi focused and user-friendly reporting protocols that support a consistent and informed approach to the services provided. 1.5 Explore options to implement shared records through existing technology platforms to share outcome information and manage taiohi records. 1.5.1 Assess functionality of an enhanced shared record to link service provider assessments, interventions, communications plans etc.. 1.5.2 As information systems reviewed consider web-based portals that can provide ongoing communication across services.
2. Assess effectiveness of case-management through whānau ora models of care currently being developed in Taranaki.	**What outcomes might look like?** 2.1 By better coordination and collaboration for those taiohi who are accessing multiple services the model can reduce administrative efforts and minimise potential service duplication. 2.2 Limit potential communication delays and reduced related waiting time issues for services. 2.3 Optimise the roles of service providers to increase time spent on direct tangata whaiora service delivery. **How could it be described?** 2.4 Assessing what effective coordinated service provision may be in a mulit-agency alliance for example: 2.4.1 Navigation – provision of a navigation service within a whānau ora type model of care, or the linkage to other services providing a navigation type role. 2.4.2 Various levels of complexity depending on the number of professionalls involved in a young persons life, requiring case reviews and seamless coordination of care. 2.4.3 Agencies and stakeholders exploring the most appropriate role to assume responsibility for service provision by population need and the impact of resources and costs of shifting any accountability.
3. Develop a common protocol for transition processes across	**What outcomes might look like?** 3.1 Transitions between services have been identified as critical areas on which to focus. 3.1.1 Enable seamless coordination and knowledge sharing to facilitate smooth

services.	transitions for taiohi between services and across agencies. **How could it be described?** 3.2 Transition process into, throughout and out of an integrated model of care would enable an improved and seamless pathway of care. 3.2.1 Transition agreements and processes could include eligibility criteria waiting list management for appropriate services information and report sharing and transfer. 3.2.2 Communication protocols to set expectations when taiohi, family/whānau transition across service providers. 3.2.3 Review direct referral processes and the issues with waiting times and how waitlist could be better coordinated. 3.3 Improve provider-to-provider communication and information sharing and coordination to reduce duplicate documentation and assessments
4. Establish navigation support-to-support taiohi in better understanding and navigating services available.	**What outcomes might look like?** 4.1 Empower taiohi, families/whānau to understand the breadth of health support services available and make informed choices about their care. 4.2 Disseminate relevant information to service providers etc. **How could it be described?** 4.3 Explore feasibility of navigation or advocacy support roles (whānau ora). 4.4 Communication channels and forums for taiohi to understand services provided and effectively move through services.
5. Assess, develop and implement mechanisms required to enhance knowledge transfer among service providers in service delivery.	**What outcomes might look like?** 5.1 Through effective knowledge transfer Taranaki Taiohi Health Services can achieve the following: 5.1.1 Build capacity within the system to support the needs of taiohi by reducing the reliance on specialised clinicians and therapists to deliver certain types of support services, and enable them to address taiohi with more complex needs. **How could it be described?** 5.2 The collaborative could incorporate consistent mechanisms to enhance knowledge transfer for effective service delivery. Encouraging improved self-managed care for taiohi with appropriate tools and information. 5.3 Practical strategies for those who continue to deal with taiohi while they are waiting to access other services. 5.4 Support and disseminate evidenced based best practice.

Quality

Continuous quality improvement involves assessing the degree to which goals and objectives have been achieved, as well as determining potential strategies to further enhance service performance. By defining what the Youth Health Services space looks like across the agencies it enables health outcomes for Taranaki taiohi to be measured by all agencies.

The integration of the current demarcated services into a coordinated model of care through an agreed alliance enables sharing, understanding and implementation of leading practices which can then be monitored through ongoing improvement processes. Effective professional development is also required for agencies and providers to demonstrate ongoing quality improvement.

Quality	
1. Assess the 'new model' of care outcomes in achieving its mandate and accountability – through defined indicators and outcomes measurement processes.	**What outcomes might look like?** 1.1 Through assessment of the collaborative services model of care and use of outcomes for service provision monitoring the following objectives could be achieved: 1.1.1 Evaluation of the effectiveness of the services and model of care in achieving the 'mandate' and objectives. 1.1.2 Enhanced accountability of the services with indicators that assess whether the mandate, objectives, roles and responsibilities are being achieved. 1.1.3 Define changes to service coordination to enhance its effectiveness. 1.1.4 Promotion of taiohi (and family/whānau) centred approaches by examining tangata whaiora outcomes and linking to quality improvement plans. 1.1.5 Appropriate outcomes and indicators are used that are meaningful to each part of the sector/agency/service provider. 1.1.6 Setting accountability structures to measure, monitor and act on results of the service outcomes. 1.1.7 Establish guidelines for RBA outcome measurement tools and data reporting. **How could it be described?** 1.2 In order to assess service outcomes, ongoing evaluation of the collaborative should be conducted and include the following: 1.2.1 RBA – define indicators and measurement process to effectively assess collaborative performance against its mandate. 1.2.2 Performance management – determine mechanisms to incorporate ongoing feedback regarding effectiveness of the collaborative. 1.2.3 Each agency/organisation to determine indicators that offer insights regarding the service models impact toward achieving its mandate.
2. Mechanisms to assess tangata whaiora outcomes that are consistent across the service.	2.1 Determine how existing information systems can be used to measure, monitor and asses programme outcomes. 2.2 Determine mechanisms to share and compare results across the province to enhance continuous service improvement.
3. Establishment of a mechanism to objectively review models of care and clinical best practice on an ongoing basis and integrate results into practical delivery of services.	**What outcomes might look like** 3.1 Promotion of taiohi centre goals and outcomes by ensuring best practice that leads to improved tangata whaiora outcomes. 3.2 Build base of evidence and leading practices research to support the service model and enhance service integration. **How could it be described?** 3.3 To be effective best practice models need to be evidence based. 3.4 Determine the appropriateness of holistic goals balanced with the functional needs for taiohi. 3.5 Leverage existing processes that undertake research and development on best practice. 3.6 Establish processes to share and compare data, research findings etc.
4. Establishment of ongoing professional development across services.	**What outcomes might look like?** 4.1 Facilitation of knowledge exchange an capacity building among service providers and across sectors. **How could it be described?** 4.2 Across service providers professional development requirements differ, common education around best practice, system trends, roles and responsibilities is information that could be

	shared on an ongoing basis. 4.3 Define professional development requirements across services. 4.4 Coordinated approach to the delivery of ongoing workforce development and training across sectors to leverage existing knowledge and resources.

Section 4: What the Literature Says

Alliance Partnerships and Implications for Practice

Insanity – continuing to do the same thing and expecting different results – Albert Einstein

Multi-agency working and cross sector leadership has been a priority on the national political agency for some time. A review of the literature shows multi-agency working is complex, and shows empirical evidence on the impact of multi-agency approaches on the professionals involved. While there is substantive literature on the impact to staff there is very little empirical evidence in understanding the impact on service users.

There were a number of key factors that influenced multi-agency working, and the literature review[12] by Atkins, Jones et al. identified:

- **Working relationships** – Key issues over a lack of demarcation of roles, the importance of those involved being committed to multi-agency working and the development of understanding, trust and mutual respect across those participating.
- **Multi-agency processes** – The most common facilitator of good multi-agency working was communication. However, there is a need for the clarity of the purpose of working relationships and establishment of clear and shared aims and objectives.
- **Resourcing multi-agency work** – Resourcing is central to success of multi-agency working, including funding, staffing and time. Although financial certainty was identified as important, where there was inadequate or time-limited funding it often becomes problematic. Other potential risks identified were rapid turn-over of staff, recruitment difficulties and insufficient allocation of time for multi-agency activity.
- **Management and governance** – Leadership is critical in influencing how multi-agencies would work. Evidence shows its is particularly damaging when there is an absence of clear leadership and a lack of support from upper management.

The review explored models that described the extent of multi-agency working. The partnership ladder can be as simple as **information exchange** involving mutual learning, knowledge of what each partner does and could do and a willingness to be open about decision-making processes to new methods of accessing information. It could be as complex as a **collaboration and full partnership** model involving separate and distinct roles but shared values and agenda, pooled resources blurred boundaries, and an ability to continuous development to meet the changing needs. Less powerful partners were being supported to play a role.

In between the extremes a range of differing models can function. For example, **planning action** and collectively agreeing identifying local need within an agreed contribution process, to **implementing projects and service plans** jointly or **coordination and cooperation in practice** which involves active coordination process and draws on partners to help nurture developmental and co-operative culture.

In addition there are other definitions that describe ways agencies can work together as paraphrased below:

- **Autonomous working** – Services remain separate but individual professionals from different disciplines work together to achieve specific goals. Under this example funding and services remain single agency and services separated with very little coordination.
- **Coordinated working** – Professionals from different agencies assess separately the needs of the service user but meet together to discuss findings and set goals. This example of a multi-agency panel or task group provides a focus of the coordination of service delivery. Funding can be single or multi-agency.
- **Integrated working** – Services are 'synthesised' (and coordinated). The approach being more holistic with focus of delivery on the service user. Funding is multi-agency and professionals operate as a team with expectation that roles will be blurred or expanded.

[12] Atkinson M, Jones M, Lamont E, Literature Review, Multi-agency working and its implications for practice: A review of the literature July 2007.

The review also provides an example of effective practice strategies that look at four specific domains; working relationships, multi-agency processes, resources for multi-agency working and management and governance. The full example is included in Appendix 1.

Effective Practice Strategies

Working Relationships	• Clarifying roles and responsibilities • Securing commitment at all levels • Engendering trust and mutual respect • Fostering understanding between agencies
Multi-agency processes	• Ensuring effective communication and information sharing • Developing a shared purpose • Effective planning and organisation
Resources for multi-agency working	• Securing adequate and sustained funding • Ensuring continuity of staffing • Ensuring adequate time
Management and Governance	• Ensuring effective leadership • Establishing appropriate governance systems • Establishing performance management systems

Examples of practical applications of cross-agency working can be found in the New Zealand Social Sector Trials as outlined in Appendix 1.

Taiohi Health Workforce Development

In 2011 the report on the Youth Health Workforce Service[13] was released with a vision for what effective health services for young people in 2020 would be. This vision for young people is:

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

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

By international comparison New Zealand has a poor youth health record in terms of young people's well-being and in terms of the current health services structure and its ability to meet their needs. Comparatively with other OECD countries, New Zealand's young people have among the highest rates of suicide, motor vehicle accidents and STIs. Their health status has made least improvement than any age group over the past 40 years. New Zealand has been slow to address these issues. Historically, response to these issues has been poor, with low rates of training in adolescent medicine among primary care providers, we have few specialist youth health clinicians nationally and few services available that have been developed specifically for young people.

The report included three primary recommendations with supplementary secondary recommendations as follows:

The first recommendation is that services for young people be developed that are appropriate and accessible. The approach being holistic with multi-agency care, which will reduce inefficiencies and provide more cost-effective services.

The second recommendation is ensuring the workforce for young people is trained to be competent and Health Workforce NZ (HWNZ) could purchase post-graduate clinical training to increase the numbers of well trained health professionals. District Health

[13] Report on the Youth Health Workforce Services Review April 2011, Health Workforce New Zealand.

Boards could use contracts as a mechanism to ensure health professionals who do work with young people have the necessary competencies.

The third recommendation is for future clinical leaders and researchers to have the skills to support the workforce and inform service development. Again, using contracts with providers to ensure clinical leadership is evident and service delivery based on research.

The other recommendations highlighted in the report included, effective models of primary health care being developed to meet the specific needs of taiohi, including school based health services, and enhanced General Practice and youth health community based services.

Using contracts as a mechanism to require interdisciplinary and coordinated care with possible longer contracting terms has been used in other parts of the health sector. Politically there is as increasing urgency for greater collaboration with other Government departments, NGO's and voluntary services to deliver holistic care.

Other recommendations:

- **School Nurses** – Inter Ministry work to implement a framework so all school nurses (regardless of who employs them) are competent and skilled to deliver safe, quality nursing care.
- **DHB Mental Health Services** – Shifting resources into supporting those working with youth in the community – resulting in better health outcomes and help break down the primary-secondary service divide.
- **Public Health Nurses** – Employed by primary care and allocated to secondary schools, intermediate and primary schools, delivering school based services and health promotion.
- **Social Media** – More effective use of Social media providing positive public health messages for young people.

In September 2012 the National Youth Health Nurses Reference Group In conjunction with the Society of Youth Health Professionals Aotearoa New Zealand (SYHPANZ), undertook a consultation process on a youth health nursing framework[14]. The knowledge and skills framework was developed to assist registered nurses to recognise the specific needs of youth and be able to adequately provide nursing care and education to young people. The framework recognises three specific areas of practice, Generalist Nursing **(Essential)**, Speciality Youth Health Nurse **(Specialist)** and an **Advanced** Youth Health Nurse.

There are four domains that additional skills are required to inform practice and enhance existing nursing competencies, understanding young people, engaging young people, clinical skills and working with others.

Describing the Period of Adolescence

In May 2001 the Prime Minister's Chief Science Advisor, Dr Peter Gluckman released a report from a scientific perspective about the period of adolescence[15]. The report covers 22 domains looking at both children and adolescents. It provides evidence that shows addressing issues in adolescence is less likely to be as effective as prevention, and that the risk of impulsive and antisocial behaviour is increased by experiences earlier in life.

Dr Gluckman suggests children who do not adequately develop functions like self-control early are more likely to make poor decision during adolescence. A longitudinal study of 1000 children in Dunedin who varied on levels of self-control showed that it predicted an array of life outcomes, including those of physical and financial health and criminal offending up to three decades later. This suggests there is a need to re-direct early childhood programmes, and for intensive investment for higher risk communities.

The Ministry of Youth Development report on young New Zealanders in the transition years[16] emphasises the vital role played by families/whānau and the community at large in promoting resiliency and helping young people to build strengths across the "seven

[14] National Youth Health Nursing Knowledge and Skills Framework 2012, Society of Youth Health Professional Aotearoa New Zealand, National Youth Health Nurses Reference Group.
[15] Gluckman, P, Improving the transition, Reducing Psychological Morbidity during Adolescence May 2011, Office of the Prime Minister's Science Advisory Committee, Auckland New Zealand.
[16] Ten Going on Sixteen: A Profile of Young New Zealanders in the Transition Years 2010. Wellington: Ministry of Youth Development.

C's"; confidence, competence, connectedness, character, contribution, coping and control. Whatever the approach used, researchers agree that this period in a young persons development is one of the most critical stages where the adolescent brain under goes a radical reshaping and where life events have a strong influence on neurological development. The Ministry of Youth Development also describe 6 key principles that underpin positive youth development[17] as follows:

1. Youth development is shaped by the 'big picture'.
2. Youth development is about young people being connected.
3. Youth development is based on a consistent strengths-based approach.
4. Youth development happens through quality relationships.
5. Youth development is triggered when young people fully participate.
6. Youth development needs good information.

Young adolescents (12 – 14 years of age) are often vulnerable due to early childhood problems being made worse by missing out on opportunities.[18] The Green Paper for Vulnerable Children has a range of key indicators of vulnerability in this age group, and they include:

- 8-12% of 13-14 year-olds reported truancy
- 10-15% of 12-19 year-olds reporting heavy and abusive cannabis use
- 7% of female and 3% of male students reporting having had attempted suicide
- In 2009/10 there were 8,000 police apprehensions for 10-14 year-olds
- 34% of 12-17 year olds reporting binge drinking; and
- in 2010 there were 4,552 births to teenagers.

The benefits of intervening early include higher educational achievement, creating employment opportunities; lower involvement in crime; reducing dependence on welfare and improved health.

The report, Improving the transition – Reducing Psychological Morbidity During Adolescence, frames two overarching themes:

- Firstly the need to apply international and domestic evidence about what works which would lead to better outcomes for New Zealand adolescents
- Secondly, that social investment in New Zealand should take more account of the growing evidence that prevention and intervention strategies applied early in life are more effective and provide greater economic returns than do strategies applied later. This will require long-term commitment to appropriate policies and programmes.

While most of our young people cope well with the journey to adulthood, for at least 20% of young New Zealanders the passage through adolescence will have long-term consequences. Given the age of puberty has fallen and the age at which young people are accepted as adults has risen, the journey to brain maturity is not complete until well into the third decade in life. The last functions to mature are those of impulse control and judgment. Early childhood is the critical period in which the basics of self-control are established.

The report provides evidence that the adolescent brain is more sensitive to both alcohol and cannabis, with long-lasting adverse consequences for many young people. It also indicates educational programmes appear less effective than measures that restrict access.

A significant proportion of young people (at least one fifth of young people by the age of 18 years of age), suffer from depression and other mental health disorders, yet the range and capacity of services available to them is inadequate. Given New Zealand's high

[17] http://www.myd.govt.nz/working-with-young-people/

[18] Every Child Thrives, Belongs, Achieves. The Green Paper for Vulnerable Children. 2012. Wellington: New Zealand Government. www.childrensactionplan.govt.nz

rate of adolescent suicide and psychological morbidity, there is a need to address the capacity gap and to raising public awareness of the particularities of adolescent depression.

Depressive disorder mostly starts in adolescence with prevalence rates rising steeply between ages of 15–18 years. It is an important factor in many other problems including school failure, substance abuse and teenage pregnancy. Three quarters of young people with depression get no treatment. Increasing resources to deal with access issues would require training more therapists, funding mental health services for children and adolescents equitably and considering the use of computers and internet to deliver therapy.

Youth Suicide affects about 100 young people below the age of 25 annually in New Zealand and this accounts for a quarter of all deaths in this age group. While the rates have halved over the last 10 years, the rate remains double that of Australia. There has been no decline in the rate for young Māori. There is evidence to support an integrated approach covering many areas ranging from mental health of the individual to the family, school and whole community. Currently suicide prevention is done piecemeal, with interventions to support families but a lack of focus on the high risk group of adolescents with psychiatric disorders, and for those making suicide attempts there are variable levels of ongoing assessment and aftercare.

The sexual health of young people in New Zealand is poor for rates of teenage pregnancy and sexually transmitted infection. The programmes that have been evaluated and found to be more successful are largely overseas, cover a multiple of factors and provide clear messages that address specific behaviours. An example of the many factors involved in the beginning of healthy sexual development include, prevention and intervention programmes, addressing development, family, culture, spiritual, socio-economic, media, school, sexual abuse, alcohol and other drug use and education.

Currently there is little policy and investment focused on sexual and reproductive or youth health. While schools provide sexuality education, it is done so inconsistently. The health curriculum does provide a guide however there are limited sessions and most of the programmes do not have the trademark of effective education as shown by research to be necessary.

Primary Health Care Services

Models of Primary Health Care Delivery

There are communication and management challenges for healthcare providers in maintaining effective clinical relationships while adolescents' transition through the period associated with rapid physical, psychological and social development that often predisposes them to a range of health issues.[19] As a young person enters adolescence parents are largely responsible for their healthcare, by the end of adolescence they have taken over responsibility for this aspect in their lives.

Research in New Zealand suggest 75% of young people access primary health care in any one year, and while most report they are treated with dignity and respect, a large proportions also report barriers to accessing the services they require.[20]

In 2006/2007 New Zealand Health Survey a sample of 1,663 young people aged between 15-24 years, 61.3% said their health was either excellent or very good or 30.8% good. In the same survey, 45.9% of young people reported being diagnosed with a chronic health condition that was likely to last six months or more.

In 2009 a report to the MoH on nursing services in secondary schools[21] identified the most frequent reasons for attending school-based clinics were for advice on sexual matters, contraception and sexually transmitted diseases, followed by treatment of injuries or general sickness like skin conditions, headaches or asthma. Other reasons included mental heath issues, family problems,

[19] Christie D, Vinner R. 2005. Adolescent Development. British Medical Journal 330 (5 February) 301-04
[20] Craig E, Adams J, Oben G, et al. The Health Status of Children and Young People in the Midland Region, November 2011, NZ Child and Epidemiology Service, University of Otago
[21] Buckley S, McDonald J, Mason D, et al. 2009. Report to the Ministry of Health. Nursing Services in Secondary Schools, Wellington: Health Services Research Centre, School of Government, Victoria University of Wellington.

bullying, healthy lifestyles and advice on alcohol and drugs. 16.8% of those surveyed indicated they were unable to access health care when they needed it in the previous 12 months.

General Practice and PHOs

There have been very few formal evaluations of the effectiveness of general practice care for young people. We do know however, utilisation patterns and the barriers young people encounter when accessing care. When compared to the total population the 2006/2007 NZ Health Survey found young people aged 15-24 were significantly less likely to have a health practitioner service they usually went to when unwell. They were also more likely to attend a student health service, accident and medical/24 hour centre than to a GP clinic when first unwell.

While a high percentage of respondents 89.5% indicated they were treated with respect and dignity, and most had used their General Practice in the past 12 months, there were also a range of barriers to accessing the care when they needed it. Including, did not know how to, unable to get an appointment, didn't want to make a fuss, couldn't be bothered, cost too much, no transport, did not feel comfortable, and worried it wouldn't be kept private.

Most common issues cited by young people included perceived confidentiality, privacy, accessibility and cost of General Practice services. Given that the GP generally remains the first point of contact for most young people, improving the quality of care delivered by GPs remains a high priority. Addressing young people's issues around privacy/confidentiality, health screening and preventive counselling would improve quality. Also improving practitioner training in communication and the management of common health issues may increase their confidence and knowledge when dealing with young people.

School Based Health Services

Many school based health services have been developed as local initiatives with parents and local General Practice in collaboration with school principals and boards of trustees (BOTs). We still have a long way to go before we have consistent, comparable, high standard of health service in all schools.[22]

In 2008 the Ministry of Health commissioned a review of nursing services in secondary schools, the range of services, the funding and the issues experienced by school nurses. The review included interviews with nurses *(n=16)*, surveys of school principals *(n=154 or 45% of all NZ's secondary school principals*) and schools nurses *(n=235)*. Of the schools surveyed, 75% had either a nurse in attendance or who visited the school.

Many of the nurses employed through schools do not receive clinical oversight or report to anyone in a professional capacity. The survey highlighted the need for extra staff and extended clinics and often they experience difficulties in accessing outside help for students, for examples over-stretched, mental health and Child Youth and Family services (CYF). Improving the access to social workers, psychologists, drug and alcohol counsellors and access to sexual health nurses were recommended.

The absence of an overarching framework for school based health services (SBHS) and the ad hoc development of services has led to discrepancies in the availability of and access to services. However, comprehensive SBHS have been shown to lead to improvements in school attendance and educational outcomes for students.

The evidence suggest SBHS are viewed positively by students, staff and school health professionals, and that they may increase access to primary health care and other health providers. While the services are available in part for school hours, they are not available after hours, school holidays or weekends. While qualitative evaluations suggest they are an acceptable way to deliver services, with no overarching framework there remains issues around provision of equitable service provision and integrated care.

Winnard, Denny and Fleming in their Best Practice Review[23] described four key components of effective school health services which include the following:

[22] Craig E, Adams J, Oben G, et al. The Health Status of Children and Young People in the Midland Region, November 2011, NZ Child and Epidemiology Service, University of Otago

- **Wide engagement with school and community** – Supporting and working with schools to promote the health and educational achievements of students, closer working relationships and community participation.

- **Youth focus and participation** – Youth friendly staff and facilities, assurance of confidentiality while respecting family values and connections and youth participation in planning and service delivery.

- **Delivery of high quality comprehensive care** – Addressing the importance of culture, multi-disciplinary approach, screening and preventative care, engaging adolescent males, appropriate staffing, facilitating access to other services and safety standards.

- **Effective administrative/clinical systems and governance to support service delivery** – Effective implementation of any service requires appropriate staff, relationships with supportive systems and structures, staff professional development and administration time, appropriate Māori partnership in governance arrangements and evaluation and quality improvement practices.

Youth One Stop Shops (YOSS)

Youth One Stop Shops are community based facilities offering a range of services within a holistic model of care taking into account young people's physical, emotional, mental and social needs. YOSS offer a range of health services including, primary healthcare, sexual and reproductive health, family planning, vaccinations, health promotion and education, counselling, mental health services and alcohol and other drug services. Often other services are also provided including, social work, youth transition services, youth development programmes, mentoring programmes, and advice on accommodation, training and education, budgeting and employment.[24]

Fleming and Elvidge literature review[25] highlighted YOSS are good at engaging young people including those who are not in school, training or work. They often have a role around capacity development, and support developments to improve mainstream health services.

In 2009 an evaluation by Communio of 12 YOSS[26] found that nationally around 28,000 - 34,000 young people were registered with YOSS which represented approximately 10% of the total combined YOSS catchment. Although there was no data available on the effectiveness of the YOSS in improving young people's access to services, the review suggests YOSS are viewed positively by service users and staff and seen as an effective service delivery model including being able to meet the needs of those too old for school based health services, those with more sensitive health issues, and for those who prefer a more youth-focused model of primary care.

In the absence of an over-arching framework, YOSS have evolved in different ways across the country, with a variable range of services and funding and governance arrangements. Sustainability for YOSS is often an issue. As with SBHS there is no national overarching framework which has led to patchy service provision.

Services and Interventions for Women Experiencing Multiple Adversities in Pregnancy

The report on The Determinants of Health for Children and Young People in the Midland Region (2012)[27] covered in depth the topic of services and interventions for women experiencing multiple adversities in pregnancy. The report provides evidence to support

[23] Winnard D, Denney S, Fleming , (2005) Successful school health services for adolescents: Best Practice Review. Kidz First Community Health – Centre for Health.

[24] Bagshaw S. 2006. Survey of the Network of Youth Health Service Providers (NYHSP): Affiliated to New Zealand Association for Adolescent Health and Development (NZAAHD). *New Zealand Medical Journal* 119(1243) 1-7.

[25] Fleming T, Elvidge J. 2010. Youth Health Services Literature Review. A Rapid Review of: School Based Health Services, Community Based Specific Health Services and General Practice Health Care for Young People. Auckland: Waitemata DHB.

[26] McFarlane M, Harris M, Michael S, et al. 2009. Evaluation of Youth One Stop Shops. Wellington: Communio.

[27] Craig L, Dell R, Reddington, et al. The Determinants of Health for Children and Young People in the Midland Region November 2012, University of Otago, NZ Child and Youth Epidemiology Service

investment in the early childhood and the prenatal period has one of the greatest potentials for reducing health inequalities. The period of antenatal care is also considered as an effective method of improving outcomes for pregnant women and their babies. It is also acknowledged that woman, babies and whānau/families in the most socio-economically deprived circumstances consistently experience the worst outcomes.

By OECD standards New Zealand has a high teenage birth rate. In 2008 the number of births per 1,000 women aged between 15-19 years was 22.05 compared to OECD average of 16.34. Research indicates that a combination of access to skills and services and the chance to gain the education and employment needed to succeed in society is associated with lower rates of pregnancy. The factors relating to teenage pregnancy include self esteem and age at first intercourse, education factors such as truancy and lack of qualifications, community factors such as social norms related to sexual activity, childhood poverty, employment prospects and housing and social conditions. The Family Commission has identified preventing repeat teenage pregnancy as a priority area.

Young people who are pregnant are likely to be at increased risk of a number of adversities linked to poorer pregnancy outcomes, including alcohol use, smoking and inter-partner violence. The Christchurch Health and Development Study which followed a cohort of 515 women born in 1977 to age 25 years, found that early motherhood, (defined as having a baby <21 years) was associated with poorer mental health outcomes (depression, anxiety, suicidal ideation and suicide attempts), educational outcomes and economic circumstances. In addition to the adverse outcomes associated with young maternal age, a number of positive outcomes have been linked to teenage parenthood in New Zealand and internationally including, improved family relationships and reductions in risk-taking and self-destructive behaviours.

Young women who have had one unintended pregnancy are vulnerable to subsequent unintended pregnancies. The New Zealand Youth'07 Survey found that students who self-reported pregnancy showed a greater difficulty in accessing healthcare (41.7%). These barriers included concerns about privacy, lack of transport and an uncertainty on how to access services.

As highlighted in Section 7 of this report under Youth Profile, Risk and Protective Factors, the rates of pregnant woman smoking is high and continues to remain high when recorded two weeks post delivery. Taranaki has the highest non-Māori rates across the Midland DHB's and the rates for Māori are higher than the national average. Tobacco smoking in pregnancy is considered the most important potentially preventable cause of a range of adverse pregnancy outcomes. Smoking during pregnancy is associated with placental abruption, miscarriage, still birth, preterm birth and low birthweight. There is evidence smoking cessation interventions during pregnancy reduce the number of women smoking in pregnancy and can improve birth outcomes. It also suggests strengthening staff support and training in smoking cessation may improve uptake of smoking cessation services.

The literature identifies a number of interventions that have shown promise in improving outcomes for vulnerable pregnant women and their babies including:

- Multi-agency approaches targeted at young parents, nutritional programmes as an adjunct to routine care; educational and career development interventions; parenting programmes and access to child care.
- Brief interventions in pregnant women who are not dependent on alcohol or consume alcohol at low to moderate levels and smoking cessation interventions; and
- Group antenatal care for socio-economically disadvantaged women and young women, usually led by a midwife for antenatal care, education and relationship building.

Youth Participation

The Ministry of Youth Development, Te Manatu Whakahiato Taiohi, focus is to promote the interests of young people aged between 12 and 24 years-old[28], by encouraging and assisting them to be involved in social, economic and cultural development of New Zealand.

Effective youth participation requires opportunities for young people to be involved in influencing, shaping, designing and contributing to policy and the development of services and programmes.

[28] http://www.myd.govt.nz/about-myd/index.html

Evidence shows that policies and programmes designed after consultation with users are more likely to be effective. This means services are more likely to be right the first time. Giving young people a place in decision-making enables a broader base of citizen involvement. This balances young people's social rights with their responsibilities.

Research also shows being supported to participate in decision-making gives increased confidence, self-belief and creates a great involvement and responsibility in the future. It also improves attitudes towards understanding young people and leads to a greater awareness in youth issues in organisations.

In summary, youth participation is a right. In 1993, New Zealand became a part of the United Nations Convention on the Rights of the Child (UNROC). UNROC states that all young people under the age of 18 have the right to participate in decision-making, and recognised their rights to express their opinions and to have their views considered in decisions that affect them.

Conclusion

To date the literature has not been able to provide any empirical evidence regarding the effectiveness of one type of youth health service delivery over another. What it does suggest is that a range of opportunities to access health care work better for different groups of young people at different times. There are also common themes across the literatures which are important for improving the health and well-being of young people within and outside of the health sector. These include addressing the risk and protective factors; offering adolescent focused interventions including youth development approaches and utilising comprehensive, multi-level approaches.

As highlighted by Dr Gluckman, there is a growing body of evidence that prevention and intervention strategies applied early in life are more effective shifting outcomes which will lead to more returns over the life course than do preventions and interventions, or disciplinary strategies applied in life.

Furthermore, politically there is an urgency to look to using multi-agency partnerships as an approach to future models of governance and working. In summary the perceived benefits on agencies and services working together are improved/more effective service delivery and joint problem solving, improved communication, improved data sharing and more positive inter-agency relationships. Benefits for health professions include greater personal well-being in the workplace, professional development and identity and more connected working practices.

Section 5: Consultation

Taiohi Focus Group Session's

We cannot always build the future for our youth, but we can build our youth for the future.

-Franklin D. Roosevelt (1882 - 1945)

Seven focus group sessions were held across Taranaki with young people who are leaders and councillors to those that are disengaged in schools, in alternative education and have areas of their lives that are particularly challenging. The demographic profile of the young people participating was as follows:

- There were 74 participants 24 years or under, and were in the following age bands
  - Ages 12-14 years = 8% *(n=6)*
  - Ages 15–18 years = 77% *(n=57)*
  - Ages 19–24 years = 15% *(n=11)*
- 27% of participants were Māori and 73% other ethnicities.
- 55% (*n=41*) were female and 45% (*n=35*) were male.
- 22% of participants were from South Taranaki, 18% Stratford and 61% New Plymouth District.
- 55% of participants were currently in High School, 23% in Alternative Education and 22% reported other.
- 20% reported being on a benefit.

The feedback from young people in Taranaki is largely consistent with other results from consultation processes within and outside of Taranaki. The feedback provides a Taranaki youth voice to the process, and pinpoints the priority areas for taiohi health needs.

Youth health services are complex, siloed and have limited resources dealing with increasingly complex issues. The family/whānau environment for which our young people reside has the biggest influence on the choices they make and the levels by which they view social norms. This is in line with the evidence provided by Dr Peter Gluckman's report which states:

> "Strong families/whānau are the bedrock of society and they provide the foundation for healthy child and adolescent development. . . The early years of life have a unique and formative impact on child health, development and relationships throughout life. Secure mother-infant attachment is an important predictor of resilience in later life including higher self-esteem, reduced anxiety and reduced hormonal responses to stress. . . Even within families with few risk factors, there is growing concern that parents feel unable to establish limits around their children's behaviour. . . a clear need for additional support for families with a history of inter-parental conflict, domestic violence and child maltreatment, as well as for families who are undergoing separation and divorce. It is essential that we identify children who are growing up in risky families; once we do, it is possible to implement a variety of evidenced based intervention programmes that have been shown to improve outcomes in children, adolescents, and adults".

What Young People said are the Issues with Access to Healthcare - What Can We Do Better?

General Practice

- Take time to explain – in our timeframe
- Costs of General practice and prescriptions
- Prescribing anti-depressants and no counselling offered
- Look at computer and not me
- "Been going for years and every time they forget who I
- Stereo-typing young people
- Transport
- Different GP each time I go in. Want to see same person
- Had GP for long time – feel comfortable.
- Gender important (e.g. girls wanting to see

am”
- Access to GP – generally if parents are paying and for medical issues – not sexual or emotional health

female GP or nurse)
- Less big words, too much medical jargon, don’t always understand what is being said

School Based Services

- Easy to get contraception
- Having to wait for next clinic in school – too long
- Great having access in the school that are youth friendly and focused
- Sexual Health Ed is only in year 9, 10 curriculum. Should be for 11, 12 and 13. More likely to take more seriously More education on emotional impact of being sexually active.
- More counselling services.
- Services need to be brought to youth – e.g. schools
- Stigma with accessing counselling – don’t want people to know
- Schools read out in class who has appointment with PHN – stigma that it is sexual health issues – embarrassing

Community Based Services

- Youth specific services / clinics are friendly
- Non judgemental – feel they genuinely care
- Easier having all services under one roof
- Options needed as young people have different services they are comfortable with or not comfortable with
- More caring and helpful
- Easier access, free and able to walk in
- Bus route

General

- More information on what services are available
- Shorter waiting times – CAMHS
- Services where young people are – mobile clinics
- Tailoring programmes for youth
- Scared of Dentist
- Some positive initiatives have ceased – not having services dependent on individuals
- Dental and general healthcare is not a priority when at Uni or other education (post 18) due to the costs
- Trust, confidential and non judgemental
- Weekend services.
- Need to have fun and friendly spaces
- People you can relate to
- Multiple service options work best
- Increase free dental care age – or while at University or in other education

What Young People said about our Family, Friends, Relationships and Communication

Things that Provide a Supportive and Safe Home

- Stable parents
- Stable income
- Communication and talking
- No stress
- Good food, warm home
- Support, love and encouragement
- Boundaries and discipline
- Open-minded parents
- Having own space

Describing Relationships with Family and Friends

- Burning bridges, mending them, building relationships.
- Variable depending on the youth in the focus group. The youth councillor and leaders groups described their relationships very positively, can ask them anything, supportive, happy and fun homes.

- Most at risk youth do not have good relationships with family and were described as: disconnected, close minded, destructive, dysfunctional, don't have a home, broken homes trouble holding down jobs, parents disappearing for a couple of days, parents with drug or alcohol problems.
- Unsafe homes, kids pushing boundaries, youth taking money home but parents using for drugs and alcohol.

Social Media and Communication

- Everyone is at risk
- Hidden messages
- Cyber bullying
- Adds to depression issues
- Gossip pages
- Good way to keep in touch with family and friends.
- Lose the learning about body language
- Things said in texts and facebook would not be said face -to-face.
- Easier to communicate problems rather than talking face-to-face.
- Creates isolation
- Misinterpretation of messages
- Causes arguments
- Too much time spent on Facebook
- Decreases self-esteem
- Lack of supervision
- Losing telephone communication and face-to-face communication skills
- More adverts on Facebook about places you can go for help

How Young People View Nutrition, Exercise and Other Activities

What Contributes (good or bad) to Physical, Emotional and Sexual Health?

- All groups described the positive and healthy things that create good health and well being and recognise the home/family environment (or where you live) as the biggest impact on how their health and well-being is.
- Very few youth didn't view body image as an important part of what they think about. Majority indicated it puts some pressure on your life – for some to the extreme and are conscious about it.
- People who are different often get picked on.
- Majority of the youth said they don't have takeaways everyday, with most who participated stating that food generally was cooked in the home.
- Attitudes, motivation and doing the things you are interested in.
- The more at risk youth do not have the healthy lifestyles in place. Choices of food, substance use, unhealthy sexual activity.

Sexual Health Issues

- STIs, Chlamydia, teen pregnancy
- Substance use, e.g. alcohol and giving into sexual activity
- Drugs and alcohol masking inhibition.
- Contraception – don't want people to know that you are getting it
- Contraception is easy to get
- Not enough safe sex
- Sex just to get a bed to sleep in, not caring about who they sleep with
- Parents should begin talking about sex a lot earlier, so it becomes normalised. The older you get the harder it is to have those conversations
- Being proud of multiple partners.
- Sex taken for granted – acceptable and starting earlier
- Pressure to not use contraception.
- Lesbian sex thought of as safe when it's not necessarily the case
- Morning after pill expensive at Pharmacy
- Increase in transsexuals
- Contraception – don't want people to know that you are getting it

Common Emotional Health Issues

- Depression
- Use of drugs impacts on emotional stability
- Mental Health
- Pregnancy and impact long term on decisions
- Body issues
- Stress
- Family relationships and dramas
- Establish a Taranaki based youth suicide and self harm group.
- Self harm – fad – seen as cool
- Confidence / self esteem
- Girls in general face more issues
- Eating disorders
- Bullying
- Sleep deprivation
- Being in fashion, e.g. bi-sexual
- Sexual health education is only in year 9, 10 curriculum. Should be for 11, 12 and 13. More likely to take more notice

Help for Emotional / Sexual Health Issues

- Counsellors and nurses in schools or other places like WAVES, or Marilyn's clinics in the South.
- Do not often go to GP for emotional and sexual health issues – costs and embarrassed.
- Internet

What Young People View the Substances that are Mostly Used and Abused?

Most Common Substances Abused by Young People

- Alcohol – binge drinking
- Not pot / party pills
- Cigarettes
- Glue, paint, petrol
- P – methamphetamine – older age group
- Cannabis
- Solvents / inhalers
- Prescription drugs
- Energy drinks

Influence of Friends and Family on Substance Use

- Cost is not a barrier
- Alternatives to drinking – how to change the culture and stop the 'drinking to get drunk' attitude
- If parents do, young people more likely to do it. Sends message that it is okay
- Drugs supplied by family members
- More education on how to drink responsibly. Not enough education in high schools on effects of drugs and alcohol on the brain and body
- Wanting to be cool and fit in
- Parties to always have responsible parents policing alcohol and providing food. Sober drivers
- It is fun environment to join in – e.g. drinking games
- Weed more important than food.
- Depressions, mood swings, frustration, family problems

Where Would You Go for Help?

- Teachers you trust
- Family doctor
- Internet
- GP more confidential than school health nurse
- CAMHS
- Tu Tama Wahine
- Salvation Army
- Quitline
- School Health Nurse
- Parents
- Internet
- Helpline
- WAVES
- Family / whānau
- Youth Transition

What Young People see as Contributors to Injuries, Violence and Risk Taking Behaviours?

Types of Things Experienced Putting Them at Risk of Injury, Violence, Motor Vehicle risk, the Law etc...

- Urban exploration – going into unsafe buildings, squatting
- Staying out all night
- Not thinking about consequences
- Girls fighting in junior school.
- Growing up in a rough life and neighbourhood
- Bullying in school, fights, swearing, expelled
- Taking risks makes people take notice of you
- Don't care (disrespect) when kicked out of school
- Drawn into situations where there is pressure to do criminal activity
- Dangerous driving, speeding, drags, no seatbelt, stealing cars, throwing brick from car to car, sideways in car going 120 km
- Experimenting with drugs to see how they affect you
- Family violence
- Smoking in school
- Getting jumped
- Wanting an adrenalin rush
- Rape due to too much drugs and alcohol
- Running from Police
- Binge drinking – alcohol taking – do not care what happen
- Risk – overacting to family, friends, partners violently (no safety net)
- If rules and boundaries not set then at risk of accidents happening

Agencies and Service Providers

What Agencies and Service Providers are Saying?

What are the Opportunities for Doing Things Differently?

- Joint projects between CAMHS, primary mental health services and school system to address the issues and improve outcomes for young people.
- Commitment at Governance level on how Ministry of Social Development, Education and Health will work together in Taranaki to address the issues through an agreed work programme. Dedicated resources to be able to achieve the changes needed. Acknowledging the importance of education, employment and health in a young person's life.
- A need for youth social workers to link with schools and Alternative Education.
- Development of tiered services where the load could be shared and resources better connected.
- Increasing opportunities for mentoring programmes within and outside of school environment.
- Maximising General Practice information technology as an option for addressing demarcation of data for youth services.
- Communication planning and youth services information pack for young people and parents on what is available to enable well informed choices about their health and well-being.
- At a governance level agreeing how youth will participate in the development of delivery of services.
- Confidentiality in school services reviewing and addressing the issues.
- While evidence suggests multiple service options are required they all need to be better connected.
- Development of model of care that provides clinical expertise hub for youth health services that incorporates General Practitioner, specialist youth nursing, and links in Public Health Nursing, Primary Mental Health resources and links in Specialist Mental Health.
- Increasing group work as peers find it easier than talking with their peers. Peer mentoring.

- General Practice – how to do things differently, and removing capitation as the barrier to developing different models of care. How can GP's better support the other youth health services across the sector? Maximising use of standing orders.

What are the Challenges with Integration, Collaboration and Coordination?

- There are fantastic services being delivered by staff that are passionate about the health of Taranaki taiohi, who frequently go beyond what is expected in their roles.
- Alternative Education – too many agencies dropping in to deal with the young people – not coordinated. Need a centralised service to coordinate and be the interface for the huge range of services being provided.
- Alternative Education – lack of programmes offered to young people – e.g. smoking cessation, nutrition, and sexual education. To keep young people engaged often need to be activity based rather then just talking. Some programmes have been person specific and have ceased once person leaves. Need for succession planning for those programmes that work for young people.
- Lack of information on exactly what services are offered and who can access them.
- Referring to agencies and other providers is frustrating – often unable to respond at all or in a timely manner. Resources already over -loaded. Risks associated with managing young people while waiting for appointments.
- General lack of communication between agencies and providers working with youth and lack of opportunity to liaise with each other to discuss issues or concerns relating to interagency working.
- Consider MOU's across services and agencies to better link, communicate and to be clear about how we should all work together.
- Respite services for youth – at times both family and young people need some time out. Agencies like Open Home Foundation etc, have services available via self referral and CYFs. Nothing set up for Health. No crisis respite for youth.
- Relationships between CAMHS and schools and the counsellors is variable, need a consistent approach to expectations of how services are able to support each other.

What are the Benefits of and the Challenges for the School Environment?

- Schools have captive cohort benefits from a 'one stop shop' approach. Providing services at school means less students leaving school grounds.
- Schools are a setting where access can be easy, particularly with the spontaneous nature of needing support for young people.
- Delivery of service/care plans more streamlined in the school community with all personnel involved, including parents.
- School Nurses and Public Health Nurses are often able to pick primary health concerns that could be otherwise missed, and can treat early and refer on if necessary.
- Public Health Nurses deliver clinics within schools as a minimum weekly and up to three times a week in larger schools. Advantage for PHNs being part of a multi-disciplinary team in the Child and Adolescent Service. Added support to the schools with sexual health clinic being run by Doctor. However, model is largely dependent the current resource – succession planning into future model required.
- Limited nursing resources in some schools i.e. access to PHN and Sexual Health Clinics. New Plymouth Girls High School fund their own nurse – the role is isolated, funded from education budget and services provided with minimal medical equipment. There is a lack of opportunities or access to training and professional development. The role would benefit from being under the umbrella of GP for standing orders, clinical oversight and closer working relationships with other health services. Support from Nurse Practitioner once a week has ceased. The role has great insight and knowledge into the lives of the students.
- Core business for schools is learning. Barriers to students learning are often health, social, emotional and mental health issues. Schools are having to resource socio-emotional, care and protection and health/mental health needs which comes out of the curriculum budget.

- When schools fund health professionals e.g. school nurses, often the costs of equipment and consumables are unable to be met.
- Lack of prevention and early intervention for young people.
- Limited supports from health to assist the growing complex needs of the students. Increasing presentations of at risk students, needing higher degree of intervention and ongoing support. Counselling work is becoming increasingly centred on crisis intervention. Increasing numbers of students without adequate food or safe place to be at night.
- Those requiring specialist services e.g. CAMHS – having to manage issues until able to be seen.
- Gap in social work interventions which are required for therapeutic counselling sessions and crisis interventions. Schools would benefit from social workers.
- School environment (counsellors and nurses) are often the first point of call for young people with mental, emotional, physical and sexual health issues, those experiencing domestic violence, sexual and physical abuse, substance abuse, care and protection issues and numerous other health and well-being concerns.
- School funded services - continuum of care ranges from mild support needed to extremely at risk behaviour. To be able to work at the beginning and middle of the continuum of need allows us to work pro-actively and in a preventative manner. Currently high load of work at high risk end of continuum – lack of early intervention creates cycle of mainly crisis management. Major concern is that the service is reactive rather than pro-active.
- Limitations in ability for other agencies to respond to referrals due to demands on service.
- Limited MOH funding and limited delivery of HEADSSS assessments for young people.

What are the Benefits of and the Challenges for Community Based Services?

- Flexibility in the service delivery options that best meets the needs of the different communities, e.g. WAVES – 'one stop shop' and Taiohi Youth Health Service delivered via Outreach model in South and Central Taranaki.
- Volumes of young people accessing services are significant. Services able to take time to build a trusting relationship with young people.
- Services are free of charge and ability for easy access for students. Young people trust and respect those delivering the services.
- Holistic approaches to service delivery – young people's needs are complex and require both general health and mental health response. Available during school holidays.
- Good linkages with a wide range of agencies and providers e.g. Youth Court (YC), Youth Justice (YJ) etc, General Practice, school clinics and PHNs. Able to be responsive to YC and YJ when needed.
- Able to accommodate young people from 10 – 24. Able to be more responsive than General Practice.
- Limited funding and resources to deal with the increasing demands and complexity of needs. More services required for primary mental health and addictions for youth – seeing a lot of mental health issues.
- Ensuring a sustainable model of care long term that is well integrated and supported by a wider clinical network.

What are the Benefits of and the Challenges for General Practice?

- Continuity for the life course of care. Familiarity with family/whānau using same General Practice. 98% of youth between 15 and 24 years have enrolled with a General Practice. The utilisation rate for services is 42% i.e. number of visits as a proportion of the total enrolled.
- Sexual Health initiatives for those under 25 years. Access for all Midlands Health Network GPs. Some provision for free non sexual health consultations.

- General Practitioner supports through WAVES clinics and with Taiohi Oranga Youth Health Services in South Taranaki and Stratford districts. Specialist youth nurses in the South hold clinics in General Practice.
- Access to free services dependent on the decision of the General Practice – will not always know the financial situation of the young person and family. Not well advertised (due to limitations in funding applied to the initiative).
- The way the funding flows for General Practice is a barrier to doing things differently.
- Not viewed as youth friendly. Limitations in the time allocated for consultations. Often young people have numerous issues that need discussing – building trust takes time.
- Length of time for appointments in CAMHS often means by time they see Psychiatrist they say they are fine – re-referred back to GP.

What are the Benefits and Challenges for Specialist Hospital Based Services?

- Public Health Nurses have larger and broader clinical support networks within the DHB, including CAMHS, Public Health and Child and Adolescent Centre paediatric teams.
- Specialist CAMHS services have some good relationships across the sector. Provide crisis support after hours.
- Schools can refer directly to the CAMHS services. There is a marked increase in demand from schools.
- Require consistent approach with working in with all schools. Relationships are variable.
- Child protection issues are growing with an increased amount of reporting required.
- Although funded as mental health service, many other issues are having to be addressed, e.g. ADHD and Asperger's. Developmental disorders are a lot more time consuming.
- Five to six times a week Police or agency showing up at CAMHS with child the service does not know. There is an expectation they will be dealt with then and there. This can take half day to sort out.
- Often where youth have suicidality there is ongoing abuse at home. No place to put these young people. Respite services needed.
- Waiting list long, however families know they can phone for risk assessment if circumstances change.
- All services are seeing an increasing complexity in the needs of young people.
- Primary mental health has limitations on the number of sessions available for young people; this is often not long enough to build up trust and rapport with clinicians.
- Unmet need with 15 – 20% of young people having a mental health issue, CAMHS funded to see top 3% and only seeing top 2%.
- Lack of service provision for children and young people with parents with mental health and/or addictions issues.

Taiohi Questionnaire

What were the Big Ticket Items from the Survey?

A questionnaire was distributed to young Māori in years 12 and 13 from Taranaki High Schools who attended three Incubator Project days held at WITT. The demographic profile of the young people in attendance was as follows:

- 87 participants currently in years 12 and 13 at High Schools across Taranaki, 100% Māori.
- 41% *(n=36)* were male and 59% *(n=51)* were female
- Approximately 72% were from New Plymouth District Schools and 28% from Stratford and South Taranaki Districts.

The following analysis covers each of the questions asked, *Refer Appendix 2 for the Questionnaire*

(Q1) When you feel 'mean as' what are the 3 most important things that keep you happy?

The top three things most commonly identified were, getting on well with family/whānau 66.7% *(n=58)*, having sports and other hobbies 62.1% *(n=54)* and getting on well with mates 58.6% *(n=51).*

The importance of family/whānau on adolescents was evident as the highest response rate for things that most were likely to make them not feel good was also family/whānau as outlined below.

Other responses with ratings over 30% included – being able to talk to friends, internet and texting, doing awesome at school and being busy not bored.

(Q2) When you feel 'crap' what the 3 things that most likely to make you feel that way?

The top three things most commonly identified were, not getting on well with family/whānau 48.3% *(n=42)*, Having nothing to do/bored 40.2% *(n=35)* and falling out with friends 32.2% *(n=28)*.

Other responses noted over 20% were, can't do what I want, being judged, being hungry and having no money.

(Q3) When you are down or depressed and need to see or talk to someone, where do you feel most comfortable going?

When asked the above, there was an overwhelming response for friends and family/whānau. The three most common responses were:

- Friends 85.1% *(n=74)*
- Family/whānau 50.6% *(n=44)*
- Teachers you trust 25.3% *(n=22)*

Most other responses were below 10% except for, don't trust anyone enough to talk about it and school counsellors at 15%.

(Q4) When you want to find health information e.g. sexual health or emotion/mental health where you find it?

When asked where young people would find health information, the three most common responses were:

- Internet/websites 51.7% *(n=45)*
- Family/whānau 46.0% *(n=40)*
- Friends 43.7% *(n=38)*

School Nurses also had large number of responses 34.5% *(n=30)* and for North Taranaki Schools WAVES had 26 responses. The only other response over 20% was for Family Doctor.

(Q5) If you need to see someone about sexual health issues, where do you feel most comfortable going to?

The three most common responses were:

- School Nurses 36.8% *(n=32)*
- Family doctor 34.5% *(n=30)*
- WAVES 31.0% *(n=27)*

The only other response above 20% was Family Planning.

(Q6) For the places you didn't choose, why would you not go there?

When asked why they wouldn't choose other places listed, the 4 most common reasons were:

- Don't know them well enough 33.3% *(n=29*)
- Not private enough people might find out 21.8% *(n=19)*
- Too embarrassed 25.3% *(n=22)*
- Costs too much 20.7% *(n=18)*

The other responses over 15% included, don't trust them to talk about my problems and being judged.

(Q7) What are the top 3 things we could do better?

When asked what we could do better, all responses were quite highly rated as per the following:

- More information on what's available 40.2% *(n=35)*
- Services are more private 37.9% *(n=33)*
- Better Alcohol and Drug Education in schools 35.6% *(n=31)*
- GP Practices more youth friendly 28.7% *(n=25)*
- More help with quitting smoking 37.9% *(n=33)*
- Better sex education in schools 35.6% *(n=31)*
- Nurses / Counsellors more available in schools 28.7% *(n=25)*

Early Childhood Sector

Given the evidence in Dr Gluckman's report that supports the redirection of programmes into early childhood, we took the opportunity to also discuss the strategy with early childhood teachers and the emerging themes within their professional domain. More often the early childhood setting is the area with an understanding of the dynamics within a child's family/whānau environment and early childhood teachers are able to recognise early warning signs for children who are not thriving. As with other service providers engaging with young people, they also experience the impact of limited specialist resources, for example Special Education and Child and Adolescent Centre. The following highlights some of the priority areas identified by the early childhood sector:

- Supporting families with emotional needs eg. Postnatal depression, Mental Health needs etc.
- Bring the support services to the kindergartens, rather than having to send families off to find them for themselves.
- Have a regular Public Health Nurse who visits the kindergarten 2-3 times a week. Someone who becomes familiar to the children and families, and is seen as part of the kindergarten team. Having set dates they attend, so families can plan to talk to them.
- Outreach services for ECT when faced with vulnerable families dealing with crisis situations – other than Crisis Team.
- Information sharing between services – How can ECT connect with other services?
- Proper medication training for ECT, who have children enrolled and need medication administered while at kindergarten.
- ECT linking parents with Public Health Nurses if their child's enrollment form states any medical issues. So that a relationship can be established at the time of enrolment.
- Children who have recurrent admissions/visits to hospital could be linked with Public Health Nurses.

The Early Childhood Education sector has lost links with other services, such as Speech Therapists, Paediatricians, Occupational Therapist's etc. The ECT could work with these specialist services and implement learning techniques specifically designed for a child. Also, Early Childhood Teachers are able to provide the specialists with their day-to-day observations, and the child's family background information.

Children who present with behavioural issues at the early childhood level, mostly do not met the criteria for Special Education and need to be supported for their issues to be addressed early. This will ensure when they transition to primary school they are not lost and 'fall through the gap'. There is no support for children, whose parents are in the Mental Health or Addiction Service.

Early Childhood Teacher's are often the first people who vulnerable families learn to trust, and the Kindergarten is a 'safe place' for them. The teachers then need services that can come in and help provide support to these families. Often the Crisis Team is not available or just refers onto the Police, which in most situations is not appropriate. Often they adopt the roles of a social worker, the centres would benefit from links to such a role.

The Kindergarten environment would make a great hub, where all the services work from, and families can come in and access all the services and advice they need. While space is often limited within centres, having a facility on site at kindergartens which families could visit with different professionals to provide advice and support. This could be for all families in the community not just those in the kindergarten families.

Whánau Ora Health Needs Priorities for Máori Living in Taranaki

What did Whānau, Iwi, Māori Communities and Service Providers say?

The Taranaki DHB Whānau Ora Health Needs Assessment (Ratima M, Jenkins B, 2012) included a consultation process with various whānau, iwi, Māori communities and service providers in relation to their needs. The HNA used this information and drew on existing information from findings from other engagement processes. The three of the four pathways had key areas that specifically related to supporting young people as paraphrased below:

Te Ara Tuarua Pathway Two – 'Máori participation in the Health and Disability Sector

- Increasing the capacity and capability of the Māori health workforce. Succession planning for the longer term sustainability of the professional Māori health workforce.

Te Ara Tuatoru Pathway Three – 'Effective health and disability services'

- Alcohol and drug issues – existing services are substantially inadequate for addressing demand, child and youth services including early intervention programmes in primary schools.
- Mental Health – early intervention services, access to Mental Health services where stringent criteria are not met as Mental Health issues are not deemed to be sufficiently high risk or acute (e.g. 'mild' cases of postnatal depression that require support), major gaps in child and youth mental health services.
- Health services for young men – support for new fathers, mechanisms to facilitate access for young men to primary health care.
- Integration of a life-course approach with an emphasis on provision of specific services for youth (e.g. youth development that takes a multidisciplinary approach and develops the skills and talents of young people, sexual health education, drug and alcohol services).

Te Ara Tuawha Pathway Four – 'Working across sectors'

- Poverty due to debt levels, unemployment, low income and large families and financial barriers to accessing health care and related needs.
- Access to quality housing and concerns raised that families are living in sub-standard rental properties which lack insulation and adequate heating, compounding whānau health issues.
- Financial concerns over education and uniform costs. While educational setting were identified as a positive environment for health promotion e.g. healthy eating and drug and alcohol issues (prior to the development of drug and alcohol problems).

- Increasing educational opportunities for young mothers
- Increasing employment opportunities for communities e.g.
  - Increasing apprenticeships
  - Increased access to childcare
  - Providing parenting support (e.g. young boys with behavioural problems, for single parents and for grandparents who are primary care givers).
  - Addressing family violence and supporting youth (including the provision of youth-focused activities in South Taranaki and a wide range of other health and social services).
- Strengthened intersectoral collaboration with 'health' more involved in intersectoral initiatives.

Public Health Opunake Community Consultation

In August 2011 the Taranaki DHB Public Health Unit completed a report on the community consultation in Opunake[29]. The goal was to identify the strengths and assets as well as issues which impact on community health and well-being.

What were the Key Issues for Young People in Opunake?

Young People – Health and well-being needs of young people, including mental health, drug and alcohol, lack of jobs and tertiary opportunities.

Alcohol and Drugs - Binge drinking the use of marijuana and the introduction of P with in the community are of concern.

Employment – Lack of lack employment opportunities including concern around sustainability of local businesses.

Health Services – Health services are inadequate. Two to three day wait to see the doctor. See different doctor each visit.

Transport – Lack of transport and limited bus service mean it is difficult for people in Opunake to access health and other services.

Other Recommendations

- Develop a youth programme in the High School to address the issues of alcohol and drug abuse, mental health and sexual health.
- Develop a youth 'hangout' or 'space' to provide more activities for young people in Opunake and support parents of teenagers.
- Working more closely with the Police on the issues of alcohol and drug abuse in the community.

Mayor's Task Force for Jobs Forum

In August 2012 the South Taranaki Mayor's Task Force for Jobs held two forums with young people, and adults within the community to get an understanding on what it is like to live in the South Taranaki District.

What Were Some of the Key Issues for Young People in South Taranaki?

Education – Young people dropping out of education, lack of enthusiasm and disconnect between way the teachers teach and the way young people learn.

Employment – Many young people at a loss as to where they could access career, pathway or employment support.

[29] Public Health Unit, *Public Health Community Consultation Results Opunake August 2011*, Taranaki District Health Board

Transport – Biggest barrier to getting work is transport.

Activities – A lot of young people drink and/or get into trouble – bored. Drugs are used more than alcohol as it is easier to get, mainly marijuana. Young people start drinking or smoking around 12 – 15 years of age. Easy to access drugs through family/whānau as everyone knows each other.

Youth Mental Health Project – Survey on Improving Follow-Up After Discharge from CAMHS and Youth AOD Services

In October 2012 the Ministry of Health surveyed District Health Board's, the Royal New Zealand College of General Practitioners and General Practice New Zealand on improving follow-up after discharge form Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and Drug Services. The survey sought information on existing follow-up arrangements for young people and ideas on improving processes.

The most common themes from DHB's included:

- Discharge letters do no necessarily include a follow-up plan for care, but generally include information about the presenting disorder, treatment provided and re-entry process to secondary specialist services should relapse occur in the future.
- Discharge letters were less likely to contain relapse indictors on how to address barriers to access follow-up care.
- Generally follow-up actions requested of GP's in discharge letters are related to medication issues.
- Some form of consultation/liaison services provided to secondary specialist staff are generally available to GPs.
- Barriers to early discharge and follow-up of youth by primary care providers include:
    - Lack of youth friendly environments
    - Lack of clinicians in primary care, including the lack of clinicians specifically trained and experienced in working with youth
    - Limited availability of dedicated mental health initiatives offering brief interventions or counselling sessions
    - The cost of accessing GP services, including co-payment and transport costs.

The common themes for improving follow-up of youth discharged from CAMHS and youth AoD services included:

- Ensuring all clients have a discharge plan that contains follow-up and reengagement processes.
- Sharing the relapse prevention plan, developed in conjunction with the young person and their family/whanau with the primary care provider nominated as providing follow-up care
- Assertive follow-up with youth e.g. text messaging
- Clinical liaison staff located in primary care to ensure better pre and post follow-up occurs
- Youth peer support roles to encourage follow-up
- Increased access points for follow-up in community, schools, drop-in centre, YOSS and mobile services
- More brief mental health interventions
- Psychiatrists meeting regularly with GP's and nurses for consult/liaison/education
- Primary care providers attending interdisciplinary discharge meetings.

Meetings with RCNZGP and GPNZ

Meetings held with RCNZGP and GPNZ also highlighted co-payments as an impediment to youth accessing follow-up care provided in General Practice and many young people would likely seek follow-up at their family GP if the cost barrier was removed. Improving communication and documentation between GP's and secondary care is important and GPs would benefit from having a follow-up care plan. Generally transport costs, employment/training causing time constraints and confidentiality from parents and/or peers are also barriers to accessing care.

Feedback also highlighted the benefits of CAMHS and youth AOD services nominating a clinical primary care provider for follow-up care and being able to transition youth back to their clinical primary care provider at an earlier stage would give specialist secondary care services greater capacity to expand access. It is also recognised that youth friendly and accessible environments, such as school-based health clinics and YOSS are good places for youth to access follow-up care, or arrangements in general practice that give youth more confidentiality.

Availability of counselling sessions via general practice are limited however having a trained primary care practitioner in general practice who is able to deal with most mild to moderate conditions would alleviate some of the need for consultation/liaison from secondary specialist services.

Responses from District Health Board Questionnaire

A survey of six questions was distributed to DHBs. It was highlighted that GP's were only one of a range of options available for follow-up care and several DHB's noted they work closely with school guidance counsellors on discharge rather than primary care providers. Young people are also likely to access follow-up care with services other than general practice. Where arrangements do work well processes between specialist services and general practice included integrated care, including post discharge.

More commonly actions requested for follow-up with GP's are likely to be related to medication reviews and documented consent was required before sharing information with primary care providers. The NGO sector indicated that they do not necessarily provide information regarding presenting disorders and the interventions provided.

District Health Board's had a range of positive initiatives currently in place or planned for the future including:

- Formalising working relationships with providers of follow-up care
- Mobile services provided by NGOs liaising with GP's
- More share care schemes between secondary services and GP's
- Primary care liaison nurses or case managers working in general practice to attend discharge meetings and quarterly meetings with CAMHS.
- Strengthening links with education providers
- District wide/cross sector/inter-disciplinary discharge and follow-up planning
- Recall of youth discharged to care of GP at six months and 12 months.
- Establishment of youth peer support services.
- Increasing access points in schools, communities, drop-in centres with longer appointments that are free of charge.

Other ideas for improving the effectiveness of the follow-up care arrangements included, general practices forming clusters to make it easier for secondary services to liaise with them on discharge and follow-up issues, attendance at discharge meetings and more education and training for staff working in general practice. It is suggested that consistency should be applied in the use of assessment and screening tools used at key developmental ages more joint planning and shared care arrangements should occur.

Conclusion

Taiohi

Throughout the focus group sessions there was a common theme for better sex education in schools. While evidence supports the introduction of sex education earlier rather than later, young people felt there would be benefit in including it in years 11-13 in the school curriculum, and providing the emotional impacts on being sexually active. This was also a repeated theme in wanting better alcohol and drug education.

There were several areas in particular that requested more help with quitting smoking, including young Māori who undertook the survey and the 15–16 year-olds engaged in the YMCA SYSCO programme who are young men disengaged with the school system and have been in trouble with the law.

The focus group sessions included a wide ranged of young people, including those that are engaged and those who were disengaged with the school system or having trouble in school. Where the engaged students were part of peer mentoring programmes there was a level of empathy and understanding of those struggling within the school environment and their behaviours.

Family/whānau and friends had a significant impact on how they were feeling with their lives and often were the first point of call for finding out health information. This highlights the importance of good health information being available to not only taiohi but family/whānau as well. Having more information on what is available scored the highest response rate in the survey question in understanding "what are the things we could do better?"

Confidentiality is a major factor in where young people access services. The consultation process highlighted that stigma existed across all services for variety of reasons, which is why a range of options work best for young people. Trust in service provision also relates to continuity of care. Often it takes time for young people to build a trusting relationship with a health professional.

The Services

The Operational Group has consisted of a wide number of professionals working with young people and/or managing service provision. It became apparent early in the project the group's priority was to emphasise the importance of the Governance structure of an alliance across the agencies to enable transformational change going forward. There is a sense that unless there is an agreed approach from this level, it would be difficult to make the change that is needed to reduce the demarcation of services that currently exists. There was a recognition and appreciation of the complexity of the work undertaken across all services, the challenges within specialist services to meet increasing demand, the lack of clinical oversight and connectedness for staff employed within the school environment and a willingness to do things differently, by maximising the effectiveness of the resources we have.

Currently there are informal communication pathways for services which hinder opportunities for providers to liaise with each other. Relationships have been built up over time and are often not maintained when there is a turnover of staff.

There is an urgency to look at a model of care that allows a holistic approach to care for our taiohi and the model should reflect the uniqueness of the different Taranaki District. While General Practice is charged with providing more youth friendly options for young people there is also an opportunity for working more closely with other parts of the sector that specialise in youth services.

In conclusion, there is a considerable amount of information available to the project on what is important for our young people in Taranaki and the issues highlighted across the many consultation processes are consistent with the results from the project process.

Section 6: Youth Health Services in Taranaki

A stocktake was undertaken across the Ministry of Education, Ministry of Social Development, Taranaki DHB and NZ Red Cross to identify what services are available to Taranaki taiohi. While the suite of services described will not cover all of what is available, it provides a high level picture from the agencies that are part of the strategy development. In addition, Red Cross was included given the extent of services/programmes they offer.

Youth Health Services and Initiatives via Health Sector

Table 3: Youth Health Services

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service	Targeted Age Group	Intent / Outcomes Funded
1	Oral Health	Adolescent Oral Health Enrolment	Strategic Alliance (Tui Ora Ltd and National Hauora Coalition).	Community Based	Taranaki wide	Adolescent Dental Enrolment Targeting - of hard to reach, out of school teens for dental enrolment - up to 18 years.	year 9 and up to 18 years	The intent of the service is to increase the uptake of access to adolescent oral health service provision.
2	Oral Health	Adolescent Oral health Services	Most Community Dentists plus, Community Oral Health Services (Clinics)	Community Dentists	Taranaki wide	Adolescent Oral Health Services Access to Community Dentists - up to 18 years.	year 9 and up to 18 years	Objective to ensure adolescents are 'dentally fit' by the time they reach 18 and are no longer able to have access to free dental care.
3	General Youth Health Services	Advocacy and support	Taranaki Young Peoples Trust	Taranaki Young Peoples Trust	New Plymouth	Taranaki Young Peoples Trust - Support and Advocacy Service Therapeutic support to child/youth/families that could be at risk of abuse. Provides, advocacy, facilitation and referral, individual support, family/whānau care.	14-16 years - estimate	Taranaki DHB funds small proportion of the funding to the provider who also delivers education programmes for youth out of school.
4	Other Services	General	Multiple providers	Multiple settings	Taranaki wide	Taranaki DHB funds a range of non youth specific services that youth would access, e.g. Mama Pepi Tamariki programmes, whānau ora, pregnancy and parenting programmes, maternity services.	12-24 years	
5	Health Promotion	Health Promotion Youth Programmes	Taranaki DHB Health Promotion	Multiple settings	Taranaki wide	Health Promotion Campaign to promote key youth health messages (sexual, mental, physical, cultural) that are relevant to Māori in South Taranaki.		Awareness of Healthy Lifestyle messages amongst young populations. Increased positive attitude and skills to reduce harm from alcohol.

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service	Targeted Age Group	Intent / Outcomes Funded
6	School based health services	Immunisation / Vaccination	Public Health Nurses and other primary care providers e.g. General Practice, WAVES)	Schools, General Practice, other (WAVES)	Taranaki wide	HPV Nationally rolled out programme - year 8 girls only.	year 8	Decrease in the incidence of Cervical Cancer.
7	Mental Health and Addiction Services (Youth)	Mental Health and Addictions Services (for Youth)	Taranaki DHB - CAMHS services and Tui Ora Limited	Taranaki Based Hospital, TOL	Base and Hawera Hospitals	Specialist Child & Adolescent Mental Health and Addictions Services. Mix of services across NGO and Provider Arm.	Will cover in part the ages for the Youth Health Strategy - 12-18 years.	As per national service specifications.
8	Mental Health and Addiction Services (Youth)	Youth Alcohol and Drug Residential Rehabilitation	Salvation Army (locally) and a range of out of region providers	Within and outside of Taranaki	New Plymouth & Out of region	Residential AoD programmes usually up to 12 weeks for rehabilitation.	Up to 18 years (approx)	As per national service specifications.
9	Paediatric Services	Paediatrics	Taranaki DHB Paediatric Services	Taranaki DHB, Health Centres and Hawera Hospital	Taranaki wide	Covers in part the age groups covered by the Strategy - specialist paediatric services (inpatient, outpatient etc.)		
10	Primary Health Care	Primary Health Care (PHOs) - General Health Services and free sexual	General Practice - Midland Health Network and National Hauora Coalition (PHOs), and unaligned GPs	General Practice	Taranaki wide	0.42 utilisation rate of young people 15-24. 98% of young people in Taranaki enrolled. Free sexual health consultations for young people under 25 years of age.	enrolled population reporting covers 15-24 years	
11	Primary Health Care	Primary Mental Health Initiative	Taranaki Primary Connections (via the Midland Health Network)	Various Counselling options and other services.	Taranaki wide	The youth component of the PMHI provides packages of care for youth at risk that present with psychological problems	16-18 years	Accessing to counselling sessions for youth.
12	School based health services	School based health services	PHNs - High School Health Clinics	High Schools and Taranaki Young Peoples Trust	Taranaki wide	School based health services in high schools and TYPT.	High Schools	School based (and Alt Ed) clinics in all High Schools in Taranaki for health needs of students.

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service	Targeted Age Group	Intent / Outcomes Funded
13	School based health services	School based health services (HEADSSS Assessments)	Public Health Nurses (North Taranaki) and Nurse Practitioner (South Taranaki - via Ruanui Health)	Decile 1 - 3 High schools, Teen pregnancy units, and Alt Ed attached to High Schools	Taranaki wide	HEADSSS Assessments Nationally rolled out programme.	Year 9 or those in other funded education - teen parent units and alternative ed.	Social and Health assessment to provide early indication of unmet needs of year 9 students in decile 1 - 3 schools in Taranaki. (Also include teen pregnancy units and alternative education attached to High Schools).
14	Sexual Health Services	Sexual and reproductive health services	Family Planning & Taranaki DHB Sexual Health Clinics	Family Planning	Taranaki wide	Family Planning / Sexual Health Clinics	Will cover the scope of the Youth Health Strategy - 12-24 years.	Note: the funding allocation has not been split to cover the 13-19 population and is for clients accessing the services. This will skew the cost per client. The internal service level agreement with the Provider Arm funds First Contact Outpatient contacts at $197.56 and Follow-up at $163.65.
15	Sexual Health Clinics	Sexual and reproductive health services	Taranaki DHB – Dr led clinics	Secondary Schools	Taranaki wide	Sexual and Reproductive Health Clinics – Doctor led within selected secondary schools.	Years 9-13	
16	Youth Health Services	Taiohi Oranga - Youth Health Services	Ruanui Health Services	South and Central Taranaki - outreach services and clinics at Ruanui Health	South Taranaki	Taiohi Oranga Youth Health Services (free access to health services). South Taranaki - funding for Nurse Practitioner - services delivered via outreach clinics in various settings/towns in South. Age range 10-24	10-24 years	To enable young people to have access to services to promote their mental, physical, spiritual, emotional and social health.
17	Other non health funded	Youth Health Services	WAVES	WAVES	New Plymouth	Health services including, General Practitioner, Registered Nurse, Nurse Practitioner and Social Work	10-24 years	

Source: Taranaki DHB, Planning and Funding

Ministry of Education (Special Ed.) Services

Table 4: Services Funded Through MOE (including Special Education)

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service.	Targeted Age Group	Intent / Outcomes Funded
18	Special Education	Early Intervention, Severe Behaviour, ORS support for youth in schools	Ministry of Education, Special Education Taranaki	Most Primary, Intermediate, Secondary schools in NP	Taranaki wide	Increasing inclusion of special needs students, with youth focus on supporting those with severe learning needs (ORS); or Severe behaviour service - youth who display severe and challenging behaviour across school/home settings on a daily basis and who are at risk of being alienated from education. Funding for top 1% of population in Taranaki. Age range from 5-14 years.	5-21 years for ORS; 5-14 years for Severe Behaviour	Schools and communities adapting the curriculum to meet the needs of learners with special needs so that they can achieve success. Youth engaged and managing themselves within school settings and relating to others with pro-social skills.

Source: Ministry of Education, Special Education

Child Youth and Family Services

Table 5: Services Funded Through Ministry of Social Development - Child Youth and Family (CYFS)

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service.	Targeted Age Group	Intent / Outcomes Funded
19	Youth Justice	Counselling/ Parenting Support	Family Works	Multiple settings	Taranaki wide	Counselling for young people who offend / Parenting programs for youth offenders who are parents or for parents of teenagers who offend.	10-17 years	Support young people and parents to address issues that impact on their relationships and behaviour; and to encourage young people to develop more socially appropriate behaviour.
20	Youth Justice	Education/ Mentoring/ Court Supervised Camps	YMCA/ SYSCO	YMCA/ Community	Primarily North and Central Taranaki	Education /mentoring programme / Court Supervised camps for youth offenders who have fallen out of education or who would benefit from mentoring support from positive adult role models.	14-17 years	Prevent or reduce re-offending and improve life outcomes.
21	Care & Protection	Gateway Assessments	CYF, Health & Education	Multiple settings	Taranaki wide	Gateway Health & Education Assessments for children and young persons who come into the care of Child Youth & Family or who are referred from a C&P FGC.	0-17 years	Agencies working together to develop plans which best meet CYP's identified needs.
22	Youth Justice	Health & Education Assessments	CYF Approved Health Assessors; Group Specialist Education	Multiple Settings	Taranaki wide	Health & Education Assessments considered for every child offender or youth offender who is at risk of re-offending and who meets agreed criteria.	10-17 years	Developing plans with youth who offend to address health and education issues; to improve their life outcomes.
23	Youth Justice	Rangatahi Programme	Ruanui Iwi Social Services	Ngati Ruanui Tahua	South & Central Taranaki	Kaupapa Māori personal development programme for child or youth offenders.	10-17 years	To prevent or reduce the risk of re-offending and improve life outcomes (limited referrals)
24	Youth Justice	Residential programme for high risk re-offenders	START Taranaki	Kaponga	Nation wide	Three month residential programme for high risk re-offenders, and post residential monitoring back in the community	14-17 years although 16-17 years preferred	Programme for High Risk re-offenders subject to Youth Court Orders aimed to reduce the likelihood of re-offending
25	Youth Service	Social Work Support & Couselling	Taranaki Safer Centre	Multiple settings	New Plymouth	Social work support in the home to support families to modify child/youth anti-social behaviour. Sessions usually take place on a weekly basis and include parenting skills and advocacy. Counselling Service available for youth who display sexual behaviour.	5-14 years	Improvement in young people's behaviour they are less anti-social. Parents and caregivers have the skills to better manage their young person's behaviour.

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service.	Targeted Age Group	Intent / Outcomes Funded
26	Youth Service	Structured Programme	Peoples Activity Centre	Peoples Activity Centre	Stratford	Supervised structured programmes that are goal orientated and constructed in such a way that participants are able to:- share their concerns and issues, take responsibility, manage feelings, problem solve, gain confidence, give praise and encouragement, have fun, be safe and raise their self esteem. Programme is run four times per year and evaluated and reviewed on a regular basis.	5-15 years	To improve young person's confidence and self esteem
27	Youth Service	TXT Programme	Barnardo's	Multiple schools in New Plymouth	New Plymouth	Designed for children who are withdrawn in class, or have difficulty in social relationships with their peers. Delivered through interactive sessions, including games and practical activities; aims to promote a supportive group environment and raise self esteem. Programme run over 6-7 week period.	11-13 years	To improve young person's confidence and self esteem. Re-engagement in school and improved social relationships.
28	Youth Service	Youth Programme & Counselling	Taranaki Young Peoples Trust	Taranaki Young Peoples Trust	New Plymouth	Programmes and Counselling for youth who are at risk of offending and re-offending. Sessions include assessment to ascertain their needs then a programme is developed, incorporating personal goals/plans.	12-20 years	Increase in self esteem and reduction in offending.

Source: Ministry of Social Development, Child, Youth& Family

Work and Income

Table 6: Services Funded Through Ministry of Social Development – Work and Income

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service.	Targeted Age Group	Intent / Outcomes Funded
29	Youth	Limited Service Volunteer	New Zealand Defence Force (NZDF).	Trentham Military Camp	Taranaki wide	Six-week motivational training course. The course takes place in a military environment and uses military facilities. A large part of the course content is led by external providers, and the course has a strong focus on achieving employment-related outcomes for the clients who attend.	18-24 years	The aim of these LSV courses is to increase the number of young job seekers entering employment or training by improving their self-discipline, self confidence, motivation and initiative. These personal qualities are developed through the delivery of training within a disciplined environment.
30	Youth	Outcome Based Programme	U Turn	Level 2 ,Devon Centre, New Plymouth	New Plymouth	Develop job search skills with youth that include creating a CV, interview skills and seeking employment. The provider has extensive labour market contacts that assist the client to secure employment and ensure that these placements are sustainable by delivering post placement support.	18-24 years	Place the client into employment and support them to ensure that the placement in sustainable.
31	Youth	Outcome Based Programme for those clients in receipt of a Sickness or Invalids Benefit or at risk of being Long Term Unemployed.	ECS Connections	At Work and Income	New Plymouth	Develop job search skills with youth that include creating a CV, interview skills and seeking employment. The provider has extensive labour market contacts that assist the client to secure employment and ensure that these placements are sustainable by delivering post placement support.	18-24 years	Place the client into employment and support them to ensure that the placement in sustainable.
32	Youth	Outcome Based Programme for those clients that are in receipt of Invalids and Sickness Benefit that are identified as having a mental illness and/or Psychosocial issues	Workwise	220 Devon Street West, New Plymouth	New Plymouth, Hawera, Stratford and Waitara	Develop job search skills with youth that include creating a CV, interview skills and seeking employment. The provider has extensive labour market contacts that assist the client to secure employment and ensure that these placements are sustainable by delivering post placement support.	18-24 years	Place the client into employment and support them to ensure that the placement in sustainable.
33	Solo Parents	Straight to Work	Taranaki Chamber of Commerce	Taranaki Chamber of Commerce Robe Street	New Plymouth	Short programme aimed at preparing Solo parents to get back into the workforce by giving assistance with CV preparation, Interview skills. The Chamber via its membership will seek to gain paid work experience with	16-24 years	The aim is to prepare Solo parents for entering the work force and obtaining some form of paid employment.

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service.	Targeted Age Group	Intent / Outcomes Funded
				New Plymouth		its members.		
34	All Work and Income Clients	Straight to Work	Engineering Taranaki Consortium	Engineering Taranaki Consortium Robe Street New Plymouth	Taranaki wide	Four week programme preparing people to work within the engineering sector in Taranaki obtaining a Site Safe Certificate for most engineering and petrochemical sites around Taranaki.	16-24 years	Placed into engineering related employment.
35	All Work and Income Clients	Trades Facilitator - Outcome based contract	Employer Chamber of Commerce Central	Taranaki Chamber of Commerce Robe Street New Plymouth	New Plymouth	The Trades Facilitator is working to promote and develop relationships with local schools, ITO and Industry to increase the number of trades related employment opportunities.	16-24 years	The aim is to place a person into an apprenticeship or trade related paid training opportunity.
36	Youth	Training for Work	Taranaki FEATS	64 Centennial Drive, New Plymouth	New Plymouth and Hawera	Training for Work programmes are 13-week programmes that deliver job search skills and training opportunities to up-skill clients in industry related programmes to increase their employability. The provider has extensive networks to broker clients into jobs and support them to be sustainable.	18-24 years	Up-skill the client by delivering training and job search skills so they are more able to secure employment.
37	Youth	Training for Work	Te Whare Wananga O Te Atiawa Development	22 Gill St, New Plymouth	New Plymouth and Waitara	Training for Work programmes are 13-week programmes that deliver job search skills and training opportunities to up-skill clients in industry related programmes to increase their employability. The provider has extensive networks to broker clients into jobs.	18-24 years	Up-skill the client by delivering training and job search skills so they are more able to secure employment.
38	Youth	Training for Work	U Turn	Level 2 Devon Centre, New Plymouth	New Plymouth	Training for Work programmes are 13-week programmes that deliver job search skills and training opportunities to up-skill clients in industry related programmes to increase their employability. The provider has extensive networks to broker clients into jobs.	18-24 years	Up-skill the client by delivering training and job search skills so they are more able to secure employment.
39	Youth	Training for Work	Trade and Commerce	2 Powderham St, New Plymouth	New Plymouth	Training for Work programmes are 13-week programmes that deliver job search skills and training opportunities to up-skill clients in industry related programmes to increase their employability. The provider has extensive networks to broker clients into jobs.	18-24 years	Up-skill the client by delivering training and job search skills so they are more able to secure employment.

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service.	Targeted Age Group	Intent / Outcomes Funded
40	Youth	Youth Services	Tui Ora	Located in NP, Stratford, Hawera and Waitara	Taranaki wide	NEET: To engage and support 16-17 year-olds who are not in education, employment, training or work based learning. YP and YPP: To engage and support 16 -17 year-olds and 18 year old teen parents receiving Youth Payment or Young Parent Payment from Work and Income.	16-17 years	As a result of the service all participants will be expected to have sustained participation in full time education, training or work based learning. Achieved at least NCEA Level 2, have an achievable plan for employment, further education: or training on exiting the service. Not be in receipt of a main Work and Income benefit or serving a custodial sentence within three months of exiting the service.

Source: Ministry of Social Development, Work and Income

Family and Community Services (FAC's)

Table 7: Family and Community Services (FAC's)

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service.	Targeted Age Group	Intent / Outcomes Funded
41	Family Well-being	Family Support Services	Pregnancy Help Inc	Pregnancy Help Inc	Taranaki wide	Promoting family well being in Taranaki by providing social work support and skills development for children, young people and their families. Referrals will be from other statutory organisations as well as self-referrals.	12-20 plus years	• Improved family well-being (achieved through education, health and building family relationships). • Increased parental and child access to, and use of, existing services.
42	Family Well-being	Family Support Services	YMCA - New Plymouth	YMCA - New Plymouth	New Plymouth	Teen Mum's education and life skills programme targeted at 13-19 year-olds. Runs in conjunction with the school calendar year.	13-19 years	• Improved family well-being (achieved through education, health and building family relationships). • Increased parental and child access to, and use of, existing services.

Source: Ministry of Social Development, Family & Community Services

New Zealand Red Cross

Table 8: Services delivered through NZ Red Cross

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service.	Targeted Age Group	Intent / Outcomes Funded
43		Breakfast Mentor Club	NZ Red Cross	Marfell Primary School Patea Area School	New Plymouth / South Taranaki	Provide opportunities for younger children to engage with positive role models and mentors while also having a nutritious start to the day.	Primary students, year 1-8	Improved socialisation with peers, teachers, adults and mentors. More positive interactions in the playground. Better behaviour in classrooms with sustained concentration and better co-operation. Self-awareness and self-confidence improved – value themselves more with less self-defeating statements and behaviour displayed. Improved attendance at school with children more relaxed and willing to come to school. Overall children are happier in the school environment. Funded by NZ Red Cross, Taranaki branches
44		First Aid Training	NZ Red Cross	New Zealand wide	Taranaki wide	First Aid Training to the public, workplaces and schools.	All	Educate people with vital life-saving skills. Note: these courses are offered at a heavily reduced rate to Star and Gateway Programmes for secondary students.
45		No Limits	NZ Red Cross & Various community partners: e.g. NZ Police, SLSNZ, NZ Fire Service, TOA, Taranaki Rescue Helicopter Trust	Taranaki wide	Taranaki wide	A three day programme run twice yearly for vulnerable young people. The programme includes a mix of outdoor education skills and activities as well as targeted modules provided by our community partners.	10-12 years	No Limits facilitates personal development in terms of self-confidence, socialisation and positive inter-generational experiences. Development of skills such as problem-solving, decision-making, communication and teamwork as well as exposing young people to a range of positive role models. Funded by NZ Red Cross, Taranaki branches
46		No Limits	NZ Red Cross & various community partners: e.g. NZ Police, SLSNZ, NZ Fire Service, TOA, Taranaki Rescue Helicopter Trust	Taranaki wide	Taranaki wide	No Limits is a mentoring programme where youth leaders take on the role of "besties" to participants. Opportunities for youth to take on roles within the IT team who do all photography/filming of programme and produce DVD for participants post programme.	16-18 years	Youth leaders become more aware of vulnerabilities that affect youth in our community. Builds upon leadership skills, teamwork, and communication.

	Service Area	Name of Programme, Initiative or Service	Delivered by whom? (Contracted Provider)	Delivered Where?	District	Description of Programme, Initiative or Service.	Targeted Age Group	Intent / Outcomes Funded
47		People Savers	NZ Red Cross	New Zealand wide	Taranaki wide	Free first aid training for year 5-8 students.	8-12 years	Students learn their DRSABC, how to call for help, how to respond to broken bones, poisons, and burns and scalds.
48		Save-a-Mate	NZ Red Cross	New Zealand wide	Taranaki wide	SAM is a non-judgemental programme about harm minimisation decisions which focuses on teaching young people to prevent, recognise and respond to alcohol and other drug related emergencies.	14-19 years	Education and awareness. Save-a-Mate is an interactive workshop, designed to encourage and empower young people to act in real time to "save a mate".
49		School Support	NZ Red Cross	New Zealand wide	Taranaki wide	Provision of uniforms, sports uniforms, first aid kits, sporting activities (eg Moturoa yachting programme, Marfell cricket coaching)	Year 1-13	To enable vulnerable youth to partake in all school activities by removing barriers which may be preventing participation (lack of uniform etc).

Source: New Zealand Red Cross, Taranaki

Section 7: Youth Profile

Demographics

Age

As per the 2011 Census projections there were 13,770 youth aged between 15-24 years in Taranaki, representing 12.5% of the total population. Of these young people 9,120 (66.2%) lived in the New Plymouth District, 1,250 (9.1%) in Stratford District and 3,440 (24.7%) in the South Taranaki District. The proportion of youth in the Taranaki population is projected to fall by 2,870 by 2026. This percentage age group will decrease in the total population from 12.5% to 9.9% by 2026.

The 15–19 year old age group currently represent 54% of the total 15-24 year old population, and 20-24 year-olds 46%. By 2026 this percentage is projected to change to 60% and 40% respectively.

By 2026 the proportion of youth represented within each of the TLA's is expected to change, from 66% in New Plymouth District to 69.1%, and both South Taranaki and Stratford districts will decrease.

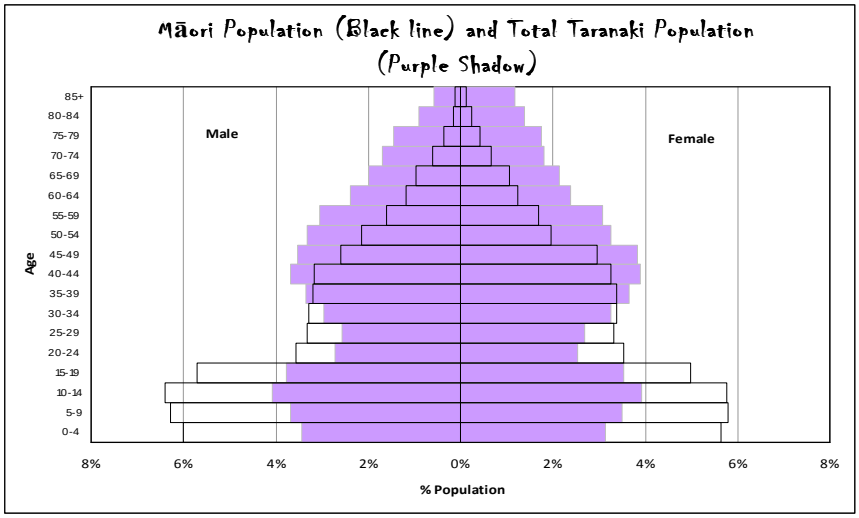
Gender

The Ministry of Youth Development Youth Statistics profile for young people in New Zealand shows there are more males than females in the Taranaki region between the ages of 12–24 years. Males represent 51.8% (*n=9,399)* of the total 18,141 young people and females represent 48.2% (*n=7,742)*, compared to national figures of 50.6% for males and 49.9% for females.

Ethnicity

The Taranaki District Health Board Whānau Ora Health Needs Assessment (WOHNA) reports the Māori population in Taranaki s very young compared to the overall populations as shown in Graph 1 below. 35.9% of the Māori population are under 15 years of age compared to 21.8% of the total population. In comparison only 4.7% of the Māori population in Taranaki are over 65 years of age, compared with 14.8% of the total population.

Graph 1: Age Structure of Taranaki DHB, 2010



Source: Statistics NZ, Estimated Territorial Local Authority Population June 2010

The proportion of Māori between the ages of 15-24 years in the District Health Board catchment is 22% of the age band population, with other ethnicity 78%. 15-24 year-olds in Taranaki represent 13% of the total population (Māori = 3% and other = 10%). As a proportion of the total Māori population of all ages, the 15-24 year old age group represents 18% compared to 12% for other ethnicity.

When comparing Territorial Local Authorities (TLA's), South Taranaki District is disproportionately represented in overall percentage of Māori with 33% of the total living in STD (compared to South Taranaki having 25% of the total 12-24 year olds). 61% *(n=1,716)* of the total Māori reside in New Plymouth District and 6% *(n=933)* in the Stratford District.

In comparing the splits between Māori and other ethnicities in each TLA in the New Plymouth District Māori represented 20% of the age group for 15-24 year-olds (other ethnicity 80%), for Stratford District Māori equated for 14% of the population (other ethnicity 86%) and South Taranaki 28% (other ethnicity 72%).

Social Indicators

Composition of Households in Taranaki

The composition of households for Māori in Taranaki are consistent with national trends, however differ from non-Māori households in ways that may indicate that Māori are experiencing pressures of increased housing costs alongside possible preferences for inter-generational living (Ratima M, Jenkins B, 2012)[30].

Māori are more likely to live in households with three or more residents compared to non-Māori. In 2006, 10.7% of children and young people (aged 0-24 years) lived in crowded households, compared to 16.5% nationally. In comparison 21.9% of Māori children and young people were living in crowded households compared to 6% of European children and young people. Evidence shows crowding is more common in low income households and is associated with health problems like, rheumatic fever, meningococcal disease and mental illness.

Deprivation

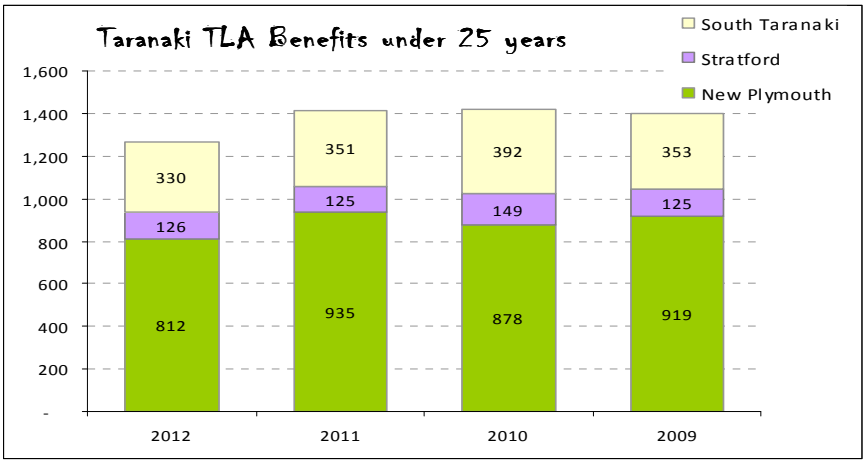
Around 60% of the Taranaki population is in decile 6, 7, and 8 compared to 30% nationally[31]. Non-Māori are over represented in the wealthiest socio-economic deciles and Māori are over represented in the lowest socio-economic deciles. Within Taranaki, 28% of Māori live in the most deprived 20% of areas compared to 10% of non Māori. In contrast, 4.2% of Māori live in 20% of the most affluent areas compared to 12.2% of non-Māori.

Benefits

The number of young people under 25 years of age on benefits (excluding the Independent Youth Benefit) at June 2012 compared to June 2011 decreased by 10%. In June 2011 there were 1,411 young people receiving benefits compared to 1,268 in June 2012.

As a proportion of the population New Plymouth District has less with 64% of the benefits recipients (population proportion 66%) and Stratford and South Taranaki a greater proportion with Stratford with 10% (population proportion 9.1%) and South Taranaki at 26% (population proportion at 24.7%).

Graph 2: Benefits by Territorial Local Authority – under 25 years



Source: Ministry of Social Development, Work and Income

[30] Ratima M, Jenkins B, (2012), Whanau Ora Health Needs Assessment Māori Living in Taranaki (p. 29), Taranaki District Health Board.
[31] Taranaki District Health Board, Annual Plan 2012-2013

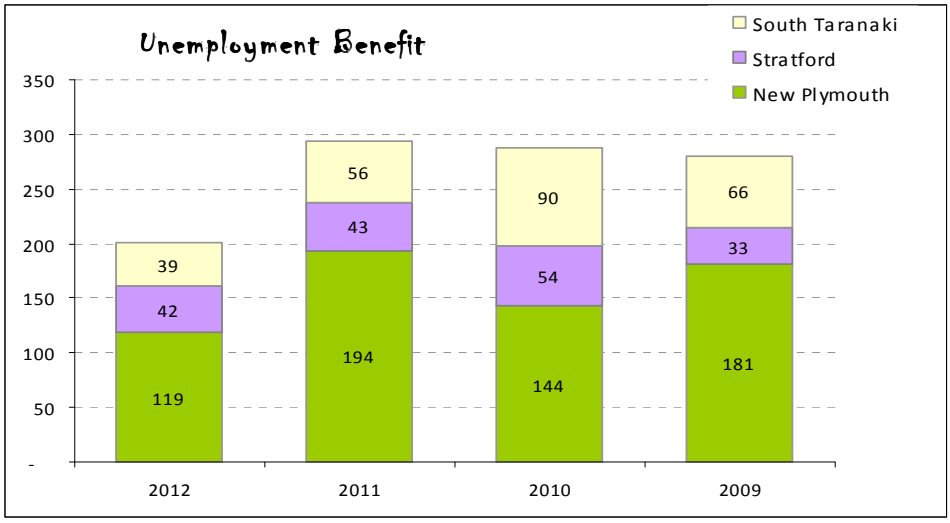
Unemployment Benefit

Over the last four years the Unemployment Benefit has continued to decrease with a significant change in the last year. At June the 2012 figures had reduced by 32%. In June 2012, 200 young people were on unemployment benefits compared to 293 in June 2011.

The recipients of the Unemployment Benefit across the three Taranaki Districts are disproportionate to the population splits. With Stratford having 21% (pop. 9.1%), South Taranaki 19% (pop. 24.7) and New Plymouth 60% (pop 66%).

Decreases in recipients in the last year were in New Plymouth and South Taranaki Districts only.

Graph 3: Taranaki Unemployment Benefit 2009-2012



Source: Ministry of Social Development, Work and Income

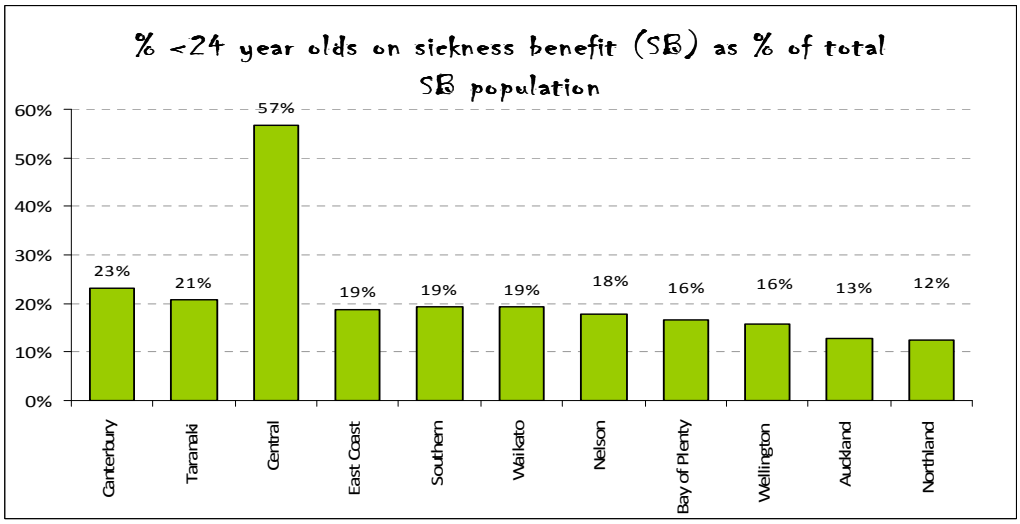
Domestic Purposes Benefit

For the Domestic Purposes Benefit, numbers decreased marginally by -4% (n=21). The decreases were across the three Districts.

Sickness Benefit

For the Sickness Benefit the numbers remained the same (n=209). However the decrease in New Plymouth numbers were offset with an increase of 10 in South Taranaki.

Graph 4: < 24 Year-Olds on Sickness Benefit 2012



Source: Ministry of Social Development, Work and Income

Invalids Benefit

For the Invalids Benefit the numbers remained static across the three districts (n=201).

Not in Education, Employment or Training (NEET)

The rates for young people who are not engaged in education, employment or training[32] in 2006 were above the national average and in 2011 below. The national average in 2011 was 13.3% compared to Taranaki at 11.8%. The highest District was New Plymouth at 12.4%. The biggest decrease across the five year period was for South Taranaki, from 16.3% to 11.2%.

Table 9: NEET Rates for Taranaki Region

	National	Taranaki	New Plymouth	Stratford	South Taranaki
NEET % 15 -24 years 2006	12.5%	13.6%	12.6%	14.0%	16.3%
NEET % 15 -24 years 2010	13.3%	11.8%	12.4%	9.3%	11.2%

Source of data: WITT Youth Health Strategy 2012-2015

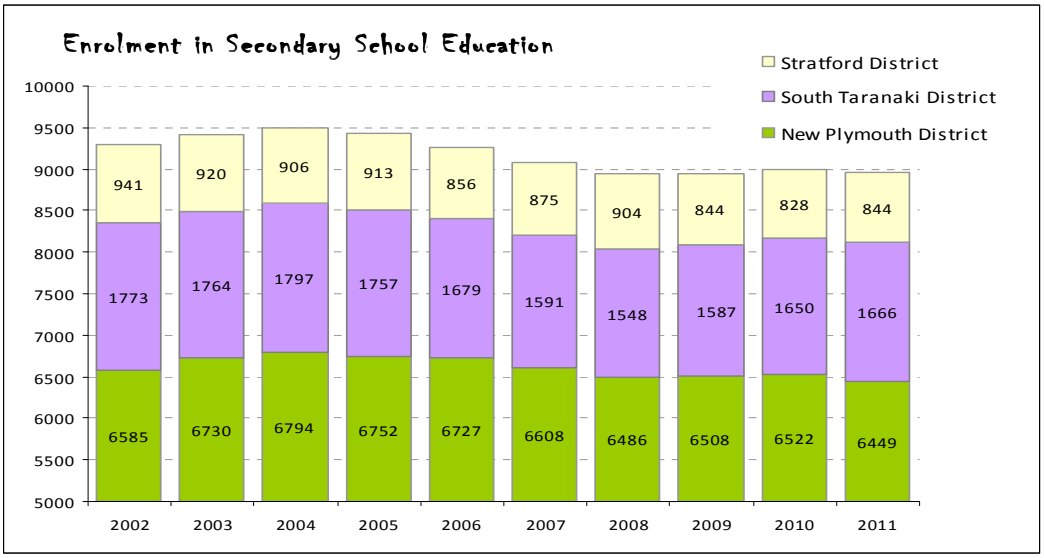
Education

Enrolled in School (12 – 24 years)

Over the last five years, the total students enrolled across Taranaki has decreased by -1.3% (*n=115)* and in the last 10 years enrolments have decreased by -3.7% (*n=340).*

While New Plymouth and Stratford Districts have experienced decreases in the last five years of -2.4% (*n= 159*) and -3.5% (*n=31*) respectively, South Taranaki District increased enrolments by 4.7% (*n=75*) but over the last ten years have decreased by -6.7% (*n=107*).

Graph 5: Taranaki Secondary School Enrolment



Source: Statistics New Zealand

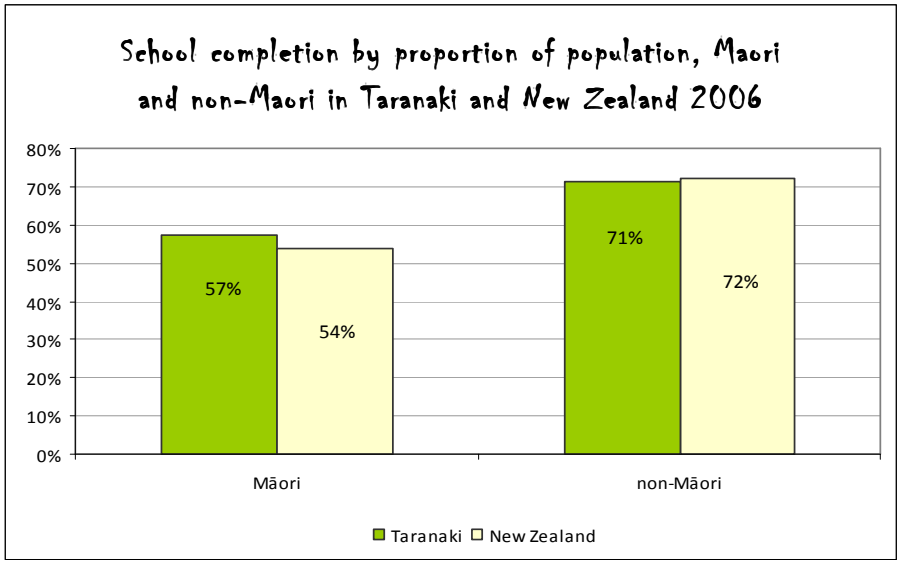
It is likely there will be an impact longer term in the increased birth rate in Taranaki over the last five years with a 10% increase. The rates have gone from 1250 to 1600 per annum.

[32] WITT Youth Strategy 2012-2015, New Plymouth, Western Institute of Technology at Taranaki

School Completion and Educational Attainment

Education is a key social determinant of health with increasing education levels corresponding in health status (Ratima M, Jenkins B, 2012). The Business Economic and Research Limited Report showed in the Taranaki region 57% of Māori completed High School compared to 71% of non-Māori (Graph 9).

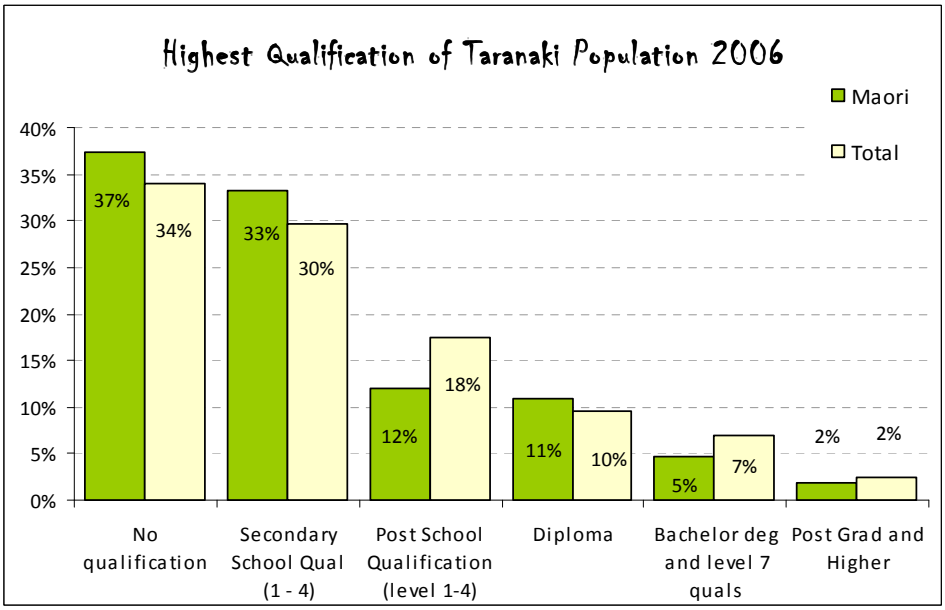
Graph 6: School Completion Rates



Source: Census 2006

At the time of the 2006 Census, the highest % for education attainment for Māori in Taranaki was 43% having no qualifications, 30% a secondary school qualification (Level 1, 2, 3 or 4), 17% a post school qualification (Level, 1, 2, 3, or 4), 5% held a diploma, 7% a bachelors degree and 1% held a post graduate degree or higher.

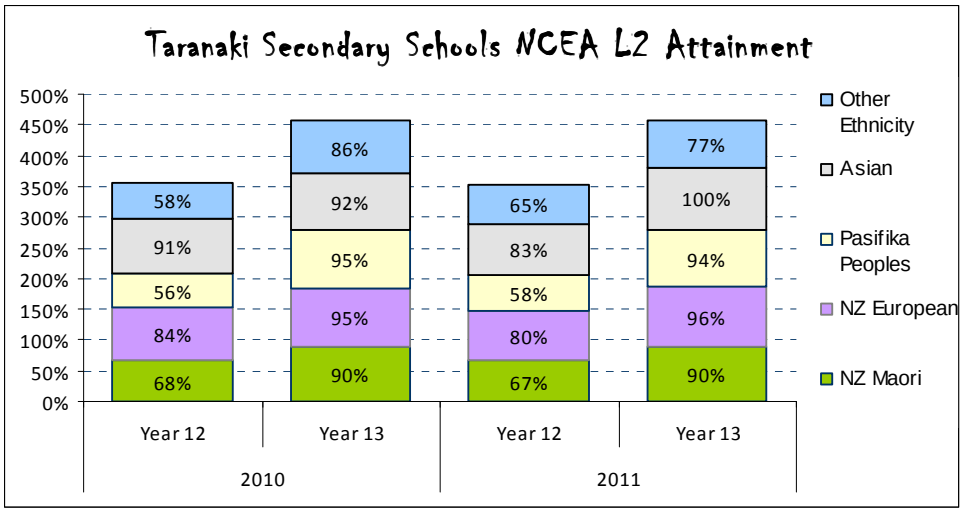
Graph 7: Highest Qualification of Taranaki Population 2006



Source: Census 2006

The Government has set a target for 85% of 18 year olds achieving NCEA Level 2 or equivalent qualification by 2017. A number of initiatives are being rolled out through the Ministry of Education with key actions to help reach the target.

Graph 8: Taranaki Secondary Schools NCEA Level 2 Attainment



Source: Ministry of Education Website

In 2011 there were 11.7% of Taranaki students that left school with no formal qualifications, as compared to other the other Midland DHBs with 17.1% Waikato students, 13.9% Bay of Plenty students, 18.8% Tairawhiti students and 15.5% of Lakes students.

School Stand-downs, Suspensions, Exclusions and Expulsions

In New Zealand schools, stand-downs, suspensions, exclusions and expulsions are ways in which the system deals with student behaviour that disrupts the learning and well-being of other students or staff[33]. The levels are indicative of an absence of engagement with learning. Nationally the highest number of suspensions by behaviour type was, continual disobedience (25.7%), Drugs including substance abuse (22.6%), and physical assault on other students (18.9%).

In 2011 Taranaki secondary schools had slightly higher rate of stand-downs, suspensions, exclusions and expulsions than the national average. This is also reflected in statistics for Máori. The rates for Taranaki are approximately 32 per 1000 population.

Truancy and Unjustified Absences

Unjustified absences are relatively infrequent during primary school years (Years 1-6), but increased progressively during secondary school (Years 9-13), with the highest rates being seen in those in Year 13+. In Taranaki in 2011 the total unjustified absence rates was 2.4 days per 100 students. This is slightly higher than the national rate of 2.3 days. For the remainder of the Midland regions Bay of Plenty was 3.2 days, Lakes 3.3 days, Tairawhiti 4.2 days and Waikato 2.9 days per week per 100 students.

Truancy tended to decreased as the degree of deprivation of the school catchment decreased. Rates for Māori are also higher than European students.

Special Education Statistics 2011-2012

Special Education provides a range of services across the sector for young people with the greatest need. The following services were delivered by Special Education in 2011-2012:

Table 10: Services Delivered by Special Education 2011-2012

	Service Description	Volume
1.	Education Assessments for Youth Offenders	13
2.	Specialist services to ORS and High Health funded students	169
3.	Specialist services to students with moderate hearing loss	29
4.	Specialist services to students with physical disability	22
5.	Assistive technology equipment requests	21
6.	Specialist services to infants and young children requiring intervention in early childhood sector	289

[33] Craig L, Dell R, Reddington, et al. The Determinants of Health for Children and Young People in the Midland Region November 2012, University of Otago, NZ Child and Youth Epidemiology Service.

	Service Description	Volume
7.	Specialist services to students with communication disorders and delays	206
8.	Language and Learning Intervention service	26
9.	Specialist services to students with severe behaviour challenges	61
10.	Individual crisis response	2
11.	Intensive wrap-around service for students with severe behaviour challenges	1
12.	Response to Traumatic Incidents	4
13.	Workshops/training courses for educators and providers	6
14.	Specialist Services to Supplementary Learning Support students	40
15.	Incredible Years courses for Parents	5 courses (SE and NGO)
16.	Incredible Years courses for Teachers	4 courses (SE and RTLB)
17.	Support for School Wide framework in a total of 11 schools as well as induction of three new schools into programme.	

Source: Special Education Taranaki

Western Institute of Technology (WITT)

The Taranaki WITT Youth Strategy 2012-2015[34] shows the numbers of students enrolled at June 2012 was 1,585 which represent approximately 13% of the total Taranaki population cohort.

Between 2011 and June 2012 the numbers enrolled decreased by 12%. The 16-17 age group increased by 67% and 18-24 age group decreased by 21%.

Table 11: WITT Enrolment Trends 2009 - 2012

	2009		2010		2011		2012	
Age	Number	% Total	Number	% Total	Number	% Total	Number	% Total
16 – 17 years	54	3%	217	10%	189	11%	315	20%
18 – 24 years	1,862	97%	1,938	90%	1,606	89%	1,270	80%
Total	**1,916**		**2,155**		**1,795**		**1,585**	

Source: WITT Youth Strategy 2012-2015

Risk and Protective Factors

Smoking

The Taranaki DHB Tobacco Action Plan[35] reports that Māori rates of smoking are consistent with national rates, with prevalence being much higher (44.5%) than with non-Māori (22.4%). This suggests smoking cessation intervention provides an opportunity for action to reduce health inequalities.

In 2008 the 13 years old was the average age for young people surveyed between 15—19 having had their first cigarette.[36] This finding suggests young people are starting smoking before they reach High School age. Māori in Taranaki have a youthful population structure compared to non-Māori, and therefore make up a relatively high proportion of the local population of children and young people. Māori children and young people experience greater exposure to risk factors and poorer health outcomes than non-Māori children and young people.

The prevalence of regular smoking (smoking daily, weekly or monthly) in Taranaki Year 10 students (14-15 year-olds) in the Action on Smoking and Health Survey 2008[37] was 10.2% compared to statistics for 2011 of 7.1%.[38]. The survey shows boys are more likely to have never smoked, 69.8% (35.7% in 1999) compared to girls, 65.2% (33.6% in 1999). Girls are also more likely to be daily or

[34] WITT Youth Strategy 2012-2015, New Plymouth, Western Institute of Technology at Taranaki

[35] Tuautoko I Rerenga a Tupeka Kore Taranaki, Supporting the Journey to a Tobacco Free Taranaki – Overview and Action Plan July 2011, Taranaki DHB.

[36] Ministry of Health. (2009). Tobacco Trends 2008: A brief update of tobacco use in New Zealand. Wellington: Ministry of Health.

[37] Paynter J. 2009. *National Year 10 ASH Snapshot Survey, 1999-2008: Trends in tobacco use by students aged 14-15 years.* Report for the Ministry of Health, Health Sponsorship Council and Action on Smoking and Health, Auckland, New Zealand.

[38] Action on Smoking and Health 2011. DHB.< http://www.ash.org.nz/>

regular smokers, 3.7% and 9.3% (in 1999, rates were 12.8% and 22.4%) compared to boys, 2.5% (daily) and 6.3% (regular), (in 1999, rates were 11.6% and 19.1%).

Comparing 2010 and 2011 survey results the overall percentage decrease for Taranaki youth who reported daily and regular smoking was -2.9% and -2.1%, and an increase in the percentage of those who never smoked, 4.6%.

Taranaki statistics shows the number of youth smoking on a daily basis is -2.0% below the national average, for regular smoking, -2.2% below the national average and similar to the national average for never smoked rates.

Although 2011 ethnicity data was not available by DHB some of the key findings of the national survey showed:

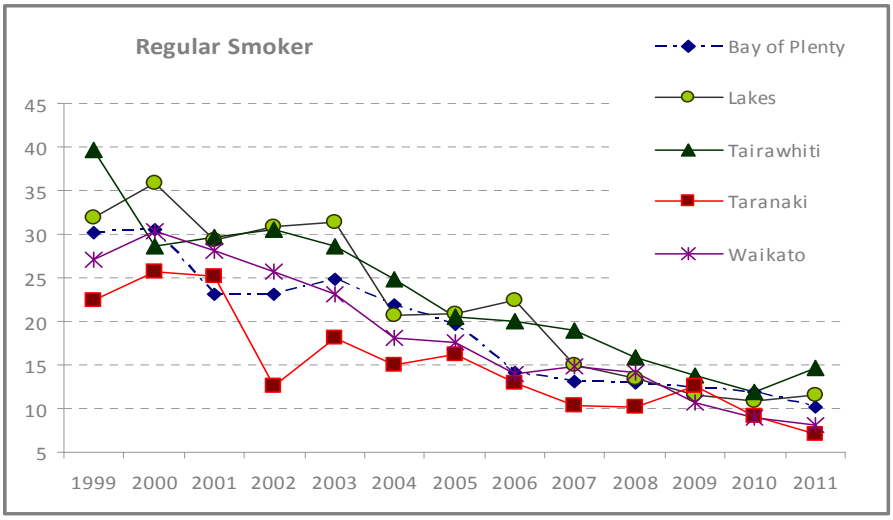
- 2.4% of European, 10.3% of Māori, 5.9% of Pacific and 1.2% of Asian students were **daily smokers** in 2011.
- Māori students had the biggest decline in **daily smoking** compared to other ethnicities with change from 14.1% in 2010 to 10.3% in 2011.

Similarly, youth smoking by socio-economic status was not available by DHB, however key findings from the national survey show:

- 9.6% of students from low decile, 4.6% from medium decile and 1.9% from high decile schools were **daily smokers** in 2011.
- 13.8% of boys and 19.4% of girls from low decile schools were **regular smokers**, compared to 4.1% of boys and 4.9% of girls from high decile schools.
- 53% of students from low decile, 67% from medium decile and 79.6% from high decile schools had **never smoked**.

Compared to other DHB's, Taranaki ranked 11/20 for never smoked, third lowest for **daily smokers** and fifth lowest rates for **regular smokers**.

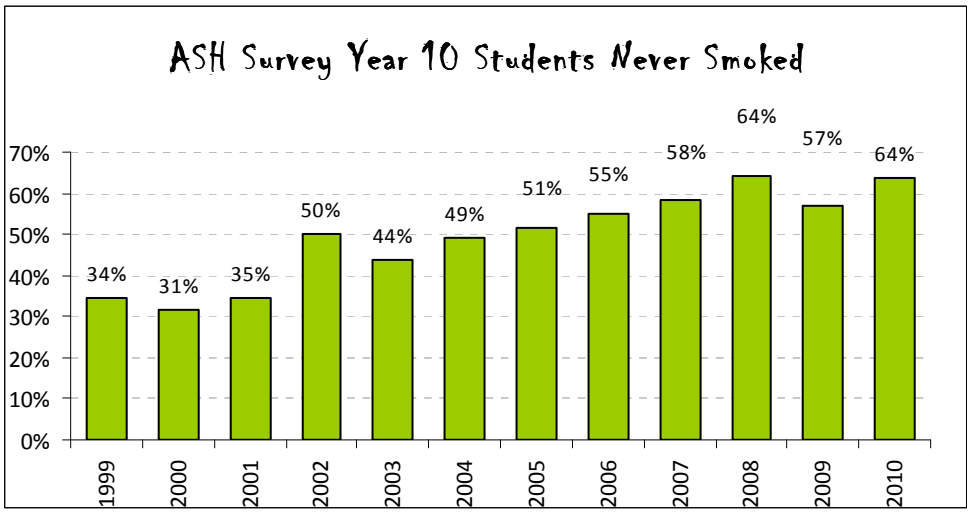
Graph 9: Midland DHB Comparison Regular Smokers



Source: National ASH Survey

Māori in Taranaki have a youthful population therefore make up a high proportion of young people in the region. Māori young people experience greater exposure to risk factors and poorer health outcomes than non- Māori.

Graph 10: Taranaki Year 10 Students Reporting 'Never Smoked'



Source Data:Tautoko I Rerenga a Tupeka Kore – Taranaki. Taranaki DHB Tobacco Overview and Action Plan

Smoking in Pregnancy

Tobacco smoking during pregnancy is link to adverse health effects for woman and babies. It is the most important potentially preventable cause of a range of adverse pregnancy outcomes.

In Taranaki the proportion of babies whose mother was not registered with an Lead Maternity Carer (LMC) at delivery was significantly lower than the New Zealand rate[39]. In Taranaki 2.3% per 100 babies were not registered compared to the New Zealand rate of 16.3%. Similarly the four other DHB regions were also significantly under the national rates for example, Tairawhiti with 1.5% and Bay of Plenty 0.7%.

The proportion of babies born to Mothers who smoked at first registration with a LMC were significantly higher across the Midland Region than the New Zealand rate amongst babies whose maternal smoking status was known. The New Zealand rate was 16.5% in Taranaki it was 21.4%. Of those that smoked, 8.21% smoked more than 10 cigarettes a day and 13.19% smoked less than 10 cigarettes per day.

By ethnicity, nearly 40% of Māori mothers identified as smokers at first registration compared to 14% of European mothers. The Taranaki rates for European are highest in the Midland region and 4% higher than the New Zealand rate.

Second-hand Cigarette Smoke Exposure

National Maternity Collection data for babies whose mother's smoking status was known, 84.4% had a non-smoking mother, while 9.7% had a mother who smoked less than 10 cigarettes a day and 5.6% had a mother who smoked more than 10 cigarettes a day.

In all Midland DHB regions during 2009-2010, maternal smoking status at two weeks after delivery recorded in the National Maternity Collection varied were significantly higher than the New Zealand rate. Taranaki recorded 21.4% of mothers smoking, Waikato 19.5%, Lakes 25.8%, Bay of Plenty 24.2%, and Tairawhiti 35.6%. The New Zealand rate was 15.2%.

The % those smoking by age and ethnicity shows a decrease in the age of Māori reporting smoking from 24 years of age, for non-Māori the decrease shows from 19 years onwards.

The rates for non-Māori smoking at two weeks post delivery were also the highest in Taranaki compared to the other Midland DHBs. The proportion of pregnant mothers smoking shows Māori rates of smoking show a marked decrease from 23 years of age and at 18 for non-Māori. At 24 years of age 40% of Māori were smokers and between ages of 30 and 45 the figure drops between 30-33%. For non-Māori at 24 years 15% were smokers and between the ages of 30 and 45 between 5-8% recorded being smokers.

Alcohol

Young people aged 12-24 years[40] make up 19% of New Zealand's population. Over 50% report themselves as non drinkers, which mean 50% do consume alcohol. Among all age groups who drink, young persons are more likely to report themselves as drinking

[39] Craig L, Dell R, Reddington, et al. The Determinants of Health for Children and Young People in the Midland Region November 2012, University of Otago, NZ Child and Youth Epidemiology Service.

[40] New Plymouth District Alcohol Strategy 2009-2014

large amounts of alcohol during a single occasion. This pattern of young drinkers is correlated by the experience of adolescents and young adults in other countries. Student drinking is substantial with 34% reporting an episode of binge drinking in the past four weeks.

In 2007 the University of Auckland was commissioned by the Alcohol Advisory Council of New Zealand to undertake a survey of young people attending mainstream secondary schools. The survey provided information from 9898 students. The Youth' 07 report on young peoples use of alcohol[41] indicates just over a third of students (37.4% of males and 33.1% of females) thought it was okay for people their age to drink alcohol regularly, and just under two-thirds (62.9%) report that their parents drink.

Compared to the results in 2001 there was a significant decline in the proportion of students who thought it was okay for people their age to drink regularly (from 49.1% in 2001 to 35.4% in 2007).

In 2007, 71.6% of students reported having ever drunk alcohol and 60.6% reported they currently drink. This represented a decline from 2001, when 81.9% of students reported having ever drunk and 70.1% reported they currently drink. There was no significant change in reporting of binge drinking (consuming five or more alcoholic drinks in one four hour session) in past four weeks, 32%–34%.

In the younger age group (13 years or under) more male students 54.1% in 2007 than females 47.0% had tried alcohol but by age 17 and older, however there was no difference in gender reporting they had ever drunk. The proportion of students that currently drink was 60.5%.

There was a significant variation between students from differing ethnic groups. Students from more deprived neighbourhoods were less likely to be current drinkers (high deprivation 56.2%, medium deprivation 61.3%, and low deprivation 62.6%).

There were differences by sexual attraction, with same/both-sex-attracted students were more likely to report having ever drunk alcohol (85.1%) compared with opposite-sex-attracted students (73.8%) and more likely to current drinkers (74.7%) compared with opposite-sex-attracted students (63.1%).

Alcohol-Related Hospital Admissions

Research suggests that alcohol use in young people is associated with a wide range of short and long term effects, including increased risk of motor vehicle accidents, risky sexual behaviour, sexually transmitted infections (STI's) and pregnancy, victimisation by or perpetration of violence and sexual assaults; obesity and increased risk of other substance use.[42]

In New Zealand during 2007-2011 alcohol was listed as a contributory cause in a large number of hospital admissions. Only 8.8% of these admissions had acute intoxication or the toxic effects of alcohol listed as the primary diagnosis. In 36.5% injury was the primary diagnosis and 32.2% of admissions had a mental health condition (including alcohol dependence) listed as primary diagnosis. These figures represent the more severe end of the spectrum as it is likely many cases of acute intoxication or minor injury were dealt with in the Emergency Department setting.

Between 2007-2011 Taranaki had the second lowest rate of alcohol-related hospital admissions in young people aged between 15-24 years in the Midland Region but the rate of 1.24 was still higher than the New Zealand average of 1.00. Tairawhiti DHB rate was the highest at 2.54 and Waikato was the lowest of the 5 DHB's with 1.02.

Drugs

Use of any drug for recreational purposes

Among people who had ever used any drug, one in three (34.6%) had first used drugs when aged 15–17 years, and 27.8% had first used drugs when aged 18–20 years.

[41] Amerataunga,S., Waayer, D., et al. *Youth' 07: The Health and Well-being of Secondary School Students in New Zealand. Young People and Alcohol.* Auckland, New Zealand: The University of Auckland, Adolescent Health Research Group.

[42] Craig L, Dell R, Reddington, et al. The Determinants of Health for Children and Young People in the Midland Region November 2012, University of Otago, NZ Child and Youth Epidemiology Service.

Cannabis

Of those people who had ever used cannabis, one in six (16.2%) had first tried it when aged 14 years or younger, and one in three (35.7%) had first tried it when they were aged 15–17 years

Trends by age group

Generally, past-year drug use was higher in the younger age groups (16–17 years, 18–24 years, and/or 25–34 years) than in the older age groups.

For both men and women, those aged 25–34 years were significantly more likely to have ever used drugs than people in other age groups.

People aged 18–24 years also had generally higher rates of past-year drug use. Four in 10 (38.1%) men aged 18–24 years had used any drug (excluding alcohol, tobacco and BZP party pills) for recreational purposes in the past year, and three in 10 (29.8%) women in this age group had done so.

Trends by ethnicity

Among those people who had used cannabis in their lifetime, Māori and non-Māori had similar rates of first starting cannabis when aged 15–17 years, but Māori were significantly more likely than non-Māori to have been aged 14 years or younger when they first tried cannabis (age adjusted).

Crime statistics

The statistics for crime rates in Taranaki show a considerable drop in the young age group 17–19 over the last two years. One of the key catalysts to reducing crime and the impact that it has on a community is by investing more time into addressing lower-end risks with our youngsters. [43]

Apprehensions have also reduced among those aged between 14-16 years of age. Most successful youth apprehensions are dealt with through alternative processes as opposed to the judicial system. Stratford area has developed a successful youth intervention programme that has resulted in a number of positive outcomes in regards to reducing youth offending and improving the behaviour and attitude of young offenders.

Police and key Government agencies cannot do this alone and it is important that approaches are aligned with other community groups, both Government and non-Government in order to achieve a positive outcome with child offenders and victims.

Graph 11: Crime Statistics 17 to 24 years

Source: Statistics New Zealand

[43] http://www.stuff.co.nz/taranaki-daily-news/news/south-taranaki-star/7225487/Early-intervention-best-way-to-prevent-crime

Youth Health Services

Taiohi Youth Health Services, WAVES and Public Health Nursing

Three specialist community based youth health services operate in Taranaki. Two models utilise Youth Nurse Practitioner's and Registered Nurses and General Practitioners to support service delivery and the other is delivered by the Public Health Nursing Team based at the Taranaki DHB.

Taiohi Oranga and HEADSSS

A significant number of young people choose to use the community based services in South and Central Taranaki the Taiohi Oranga Youth Heath Services, WAVES in North Taranaki, and Public Health Nursing in schools as an alternative to General Practice.

In 2011 the Taiohi Oranga and School Based Health Services for South and Central Taranaki saw 1,272 young people and conducted a further 73 health and HEADSSS assessments. The largest cohort of young people accessing the services is 15–19 year-olds, ranging from 53%–66% across quarters.

Māori utilising the service ranges from 42.2% to 54.8% across quarters. 80% of service users are female and 20% male.

Do not attend rates are small with only 14 young people not attending. This shows the effectiveness of taking services to young people.

WAVES Youth Health, Development and Support Services

The current registered clients at WAVES are 3,132. These are young people who have accessed the services over the last three years.

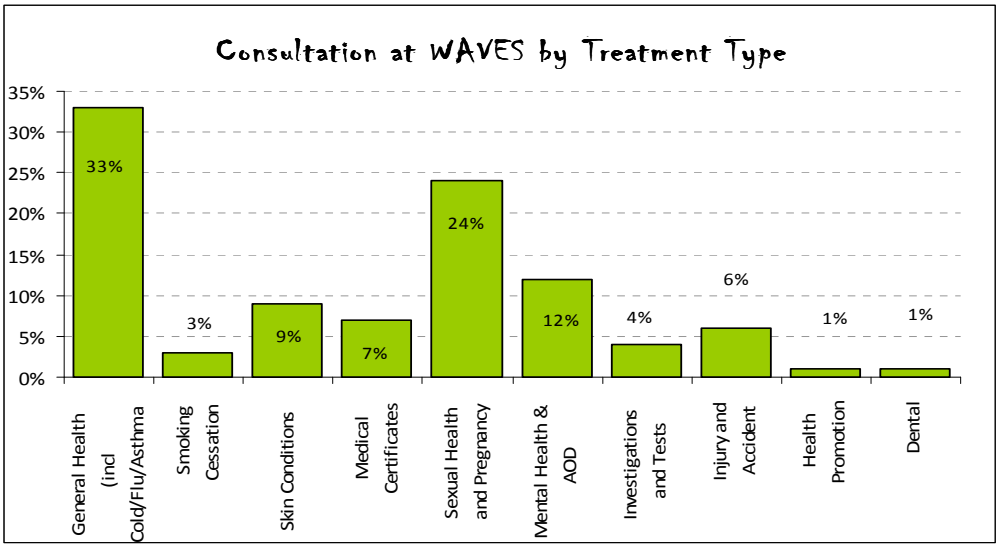
The number of clinical appointments seen in the last 12 months was 5,418. This averages 104 clients per week accessing health services. Numbers of outward laboratory tests were 1,542 and numbers of prescriptions made were 5,453. There were 242 referrals to other providers.

28% of clients accessing services are Māori; however the percentage of Māori participating in Youth Development programmes is considerably higher at approximately 75%. Similarly to the South and Central Service a higher proportion of females access the services at 74%.

The age of those presenting the most were 17 and 20 year-olds with over 800 consultations each in the last 12 months, This was followed by 18-19 year-olds between 690 and 750.

A snap shot of the three months to April 2012, shows the following proportion of treatment provided.

Graph 12: WAVES Consultations by Treatment Type



Source: WAVES Youth Services

Public Health Nursing - TDHB

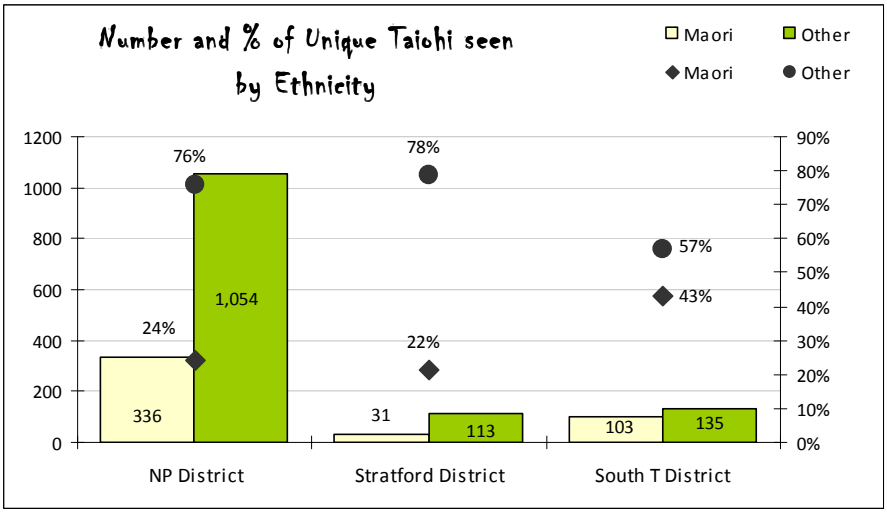
Taranaki DHB deliver the Public Health Nursing services across Early Childhood Centres, Kohanga Reo, Primary, Intermediate and Secondary Schools; and alternative education facilities.

The following statistics provide a snap shot of consultations completed in the 2011 calendar year; this excludes the HEADSSS assessments and sexual health Doctor led clinics.

In New Plymouth and Stratford Districts the percentage of unique Māori clients accessing Public Health Nursing services was 24% and 22% respectively. South Taranaki was considerably higher with 43%.

As a proportion of the District, 78% of unique taiohi were seen in the New Plymouth District, 8% in Stratford and 13% in South Taranaki.

Graph 13: Public Health Nursing Unique Taiohi by Ethnicity

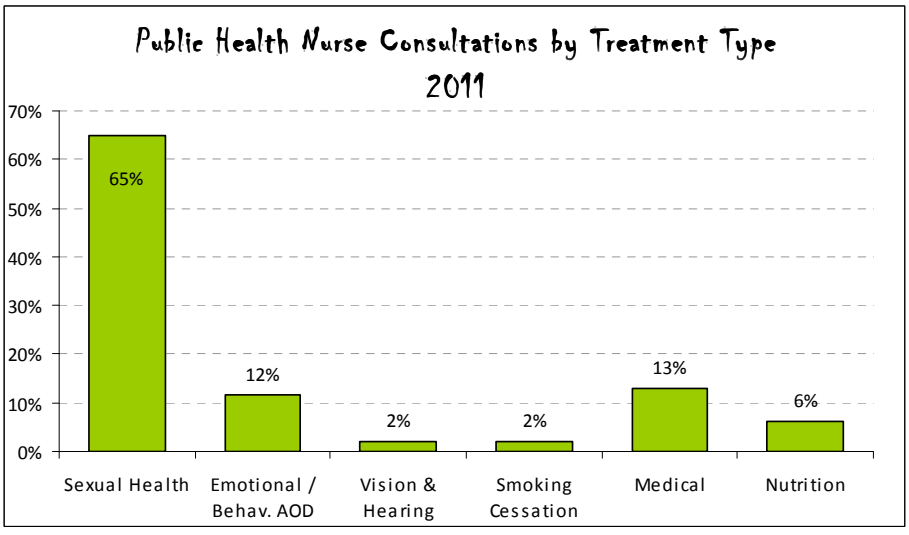


Source: Taranaki DHB, Pubic Health Nursing

The Public Health Nurses (PHN's) completed 2,691 consultations in 2011 and 65% *(n=1750)* were sexual health related, 13% *(n=350)* for general medical and 12% *(n=315)* for emotional/behavioural or alcohol and/or drug issues (AoD).

As a percentage of the total Taranaki sexual health consultations, South Taranaki had the lowest with 4% *(n=71)*. This is likely offset with the Taiohi Oranga Youth Health Service also delivering in South Taranaki. For the total consults in South Taranaki, sexual health and general medical each made up 30% of the total. Compared to the Stratford District, 66% *(=144)* were for sexual health and 21% *(n=45)* for emotional/behavioural or alcohol and/or drug issues.

Graph 14: Public Health Nurse Consultations by Treatment Type



Source: Taranaki DHB, Pubic Health Nursing

Primary Care

Primary Health Organisation (PHO) Enrolled Population's

The General Practices aligned to Primary Health Organisations (PHOs) in Taranaki report a combined enrolled population of 13,498 for young people aged between 15–24 years. This represents 98% of the 15–24 year population in Taranaki. The numbers and utilisation rates across mainstream and kaupapa Māori PHO's is as follows:

Table 12: PHO Enrolments and Utilisation

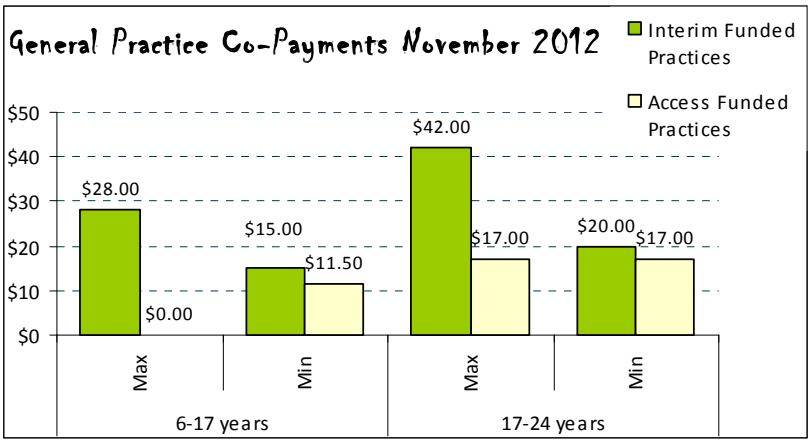
15 – 24 yrs	Patients	General Practitioner		Nurse/Other		Total	
	Total	Visits	Utilisation Rate	Visits	Utilisation Rates	Visits	Utilisation Rates
Mainstream PHO	12,512	3,893	0.31	1,223	0.10	5,116	0.41
Kaupapa Māori PHO	986	281	0.28	222	0.22	503	0.51
Total	**13,498**	**4,174**	**0.31**	**1,445**	**0.11**	**5,619**	**0.42**

Source: Midlands Health Network and National Hauora Coalition

The proportion of Māori enrolled with the service is 18% for the Mainstream PHO and 65% for the Kaupapa Māori PHO. Young people as a percentage of the total enrolled population are 13% mainstream PHO and 16% Kaupapa Māori.

The average co-payment for interim funded practices in Taranaki for age groups 16-17 years is $23.00 and for 18-24 years $32.00. Only one practice in South Taranaki has free consultations for 6-17 years.

Graph 15: General Practice Co-Payments November 2012

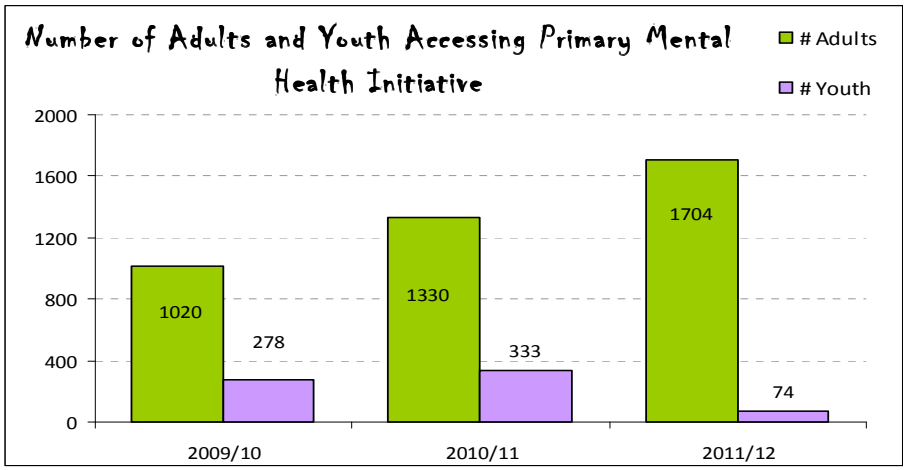


Source data: Midlands Health Network and National Hauora Coalition Websites

Primary Mental Health Initiative (through PHO's)

In 2011/12 the PHO's changed the way youth were accessing the Primary Mental Health Initiative. For the 2009/10 and 2010/11 years funding was allocated via an FTE for psychology. This was then changed to General Practice (and WAVES) having access to counselling vouchers based on the demographics of the enrolled population. The numbers are lower also due to the youth vouchers not being in place for the full year.

Graph 16: Primary Mental Health Initiative Statistics



Source: Midlands Health Network

Free Sexual Health for Under 25 Year-Olds

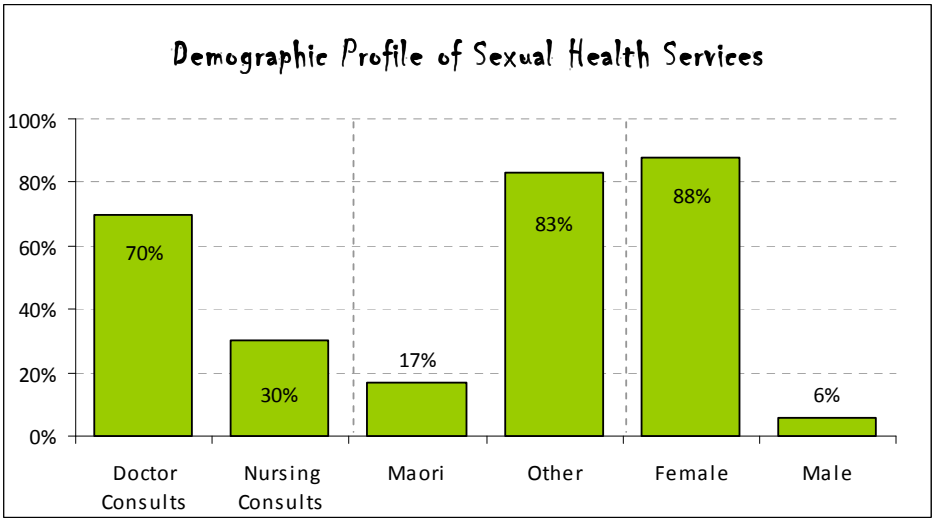
The Midlands Health Network deliver free primary care based sexual health and contraception services for under 25 year-olds. The contracted General Practitioners and their practice nurses accept self referrals and provide the following:

- Assessment, diagnosis and treatment of sexually transmitted infection (STI) related problems
- Health Promotion and disease prevention advice
- Contraception advice
- Screening and testing services
- Treatment
- Contact tracing
- Referral to specialist sexual and reproductive services, if required
- Referral to sexual abuse and assault services, if required.

In 2011-2012 the free sexual health service delivered a total of 4,078 consultations to 2,214 patients. The average consults per patient was 1.84.

The 18-21 year-olds were the largest group accessing the service at 49% of the total *(n=2014)*, age groups <=17 years of age and 22-24 years of age both were 26% of the total.

Graph 17: Sexual Health Services Primary Care



Source: Midlands Health Network

Māori were under represented in the statistics compared to their population percentage at 17% *(n=683).* The female to male ratio is significantly disproportionate with 88% *(n=3,586)* female and 6% *(n=241)*.

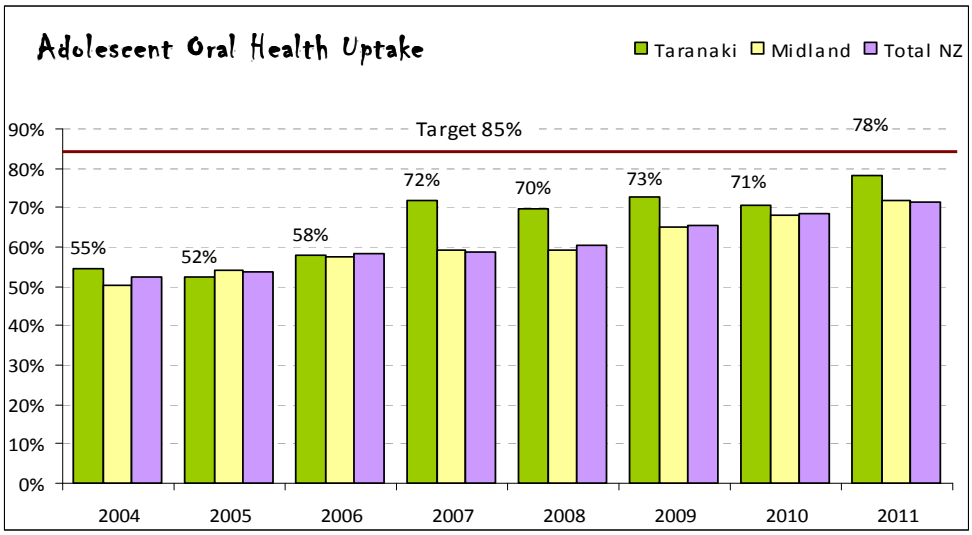
The majority of consultations were undertaken by a General Practitioner at 70% *(n=2,851)* and 30% *(n=1,227)* Nurse consults.

Other Health Statistics

Adolescent Oral Health

Taranaki DHB contract with Community Dentists for Adolescent Oral Health services to taiohi under 18 years of age. The utilisation of the service has increased over the last year to 78%, compared to the Midland Region average rate of 71.9% and the New Zealand average of 71.6%.

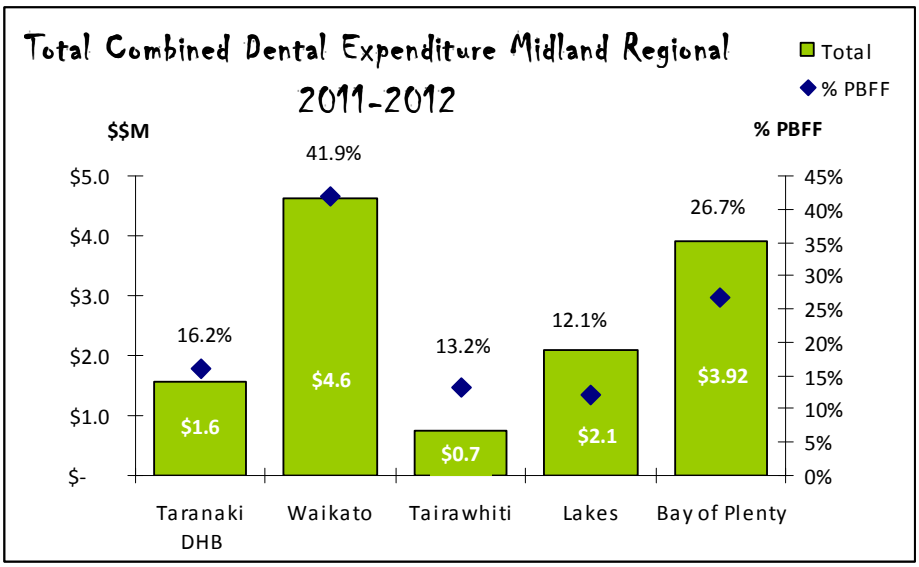
Graph 18: Utilisation of Adolescent Oral Health Services



Source of data: Health Improvement and Innovation Resource Centre (HIIRC)

There are two services available, Oral Health Services (OHS) and Special Dental Benefits (SDB). A third service, low income dental, is available to the whole population some of which would cover those 24 years and under. In comparing the expenditure against other DHB's in the Midland Region to the overall population based funding formula percentage (PBFF), Taranaki's actual expenditure for 2011-2012 is 10.6% compared to a population of 16.2% of the total Midland Region, (based on total population, not adolescent cohorts).

Graph 19: Adolescent Oral Health Services Expenditure 2011-2012



Source data: Midland Oral Health Regional Coordination and Monitoring Services

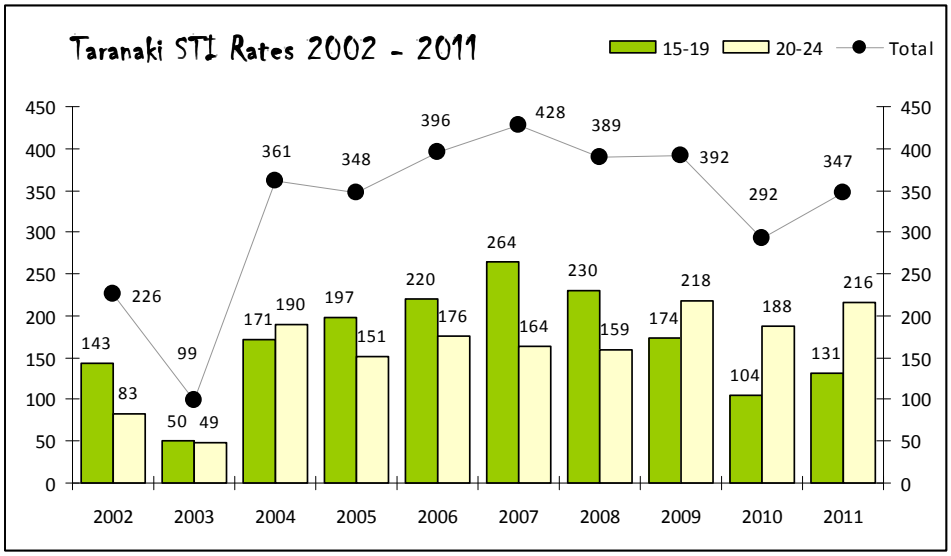
Work and Income also fund oral health services through their benefits schemes. The expenditure associated with the cohort of under 24 years of age for the last 12 months was $86k. 77% of the expenditure related to the New Plymouth area and 12% for both Hawera and Stratford areas.

Sexual Health

Overall Rates of Sexually Transmitted Infections (STI's)

The overall rates for Sexually Transmitted Infections (STI's) increased in 2011 from 2010. Trends also show the numbers presenting in the 15-19 year age group has decreased over the last five years, while the proportion of 20-24 year-olds continues to increase.

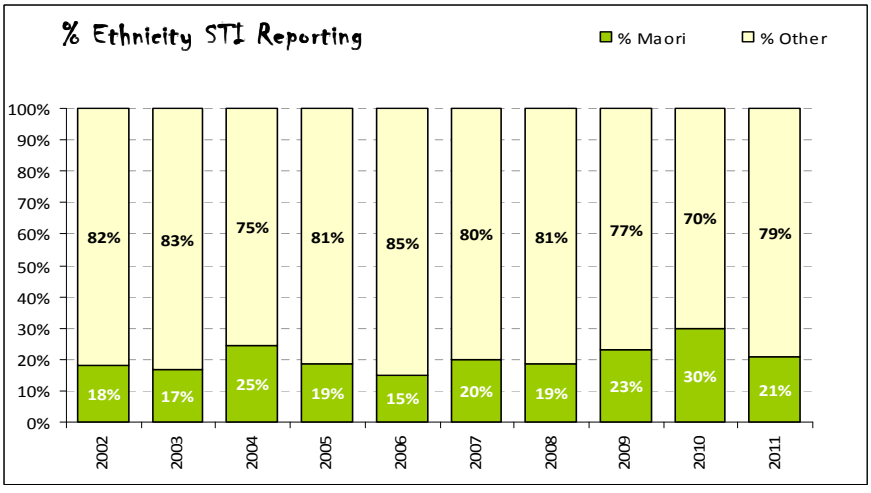
Graph 20: Taranaki STI Rates 2002 - 2011



Source: Institute of Environmental Science and Research Ltd

When comparing rates by ethnicity, Māori representation is proportionate to their percentage of the overall 15-24 year old population of 22%.

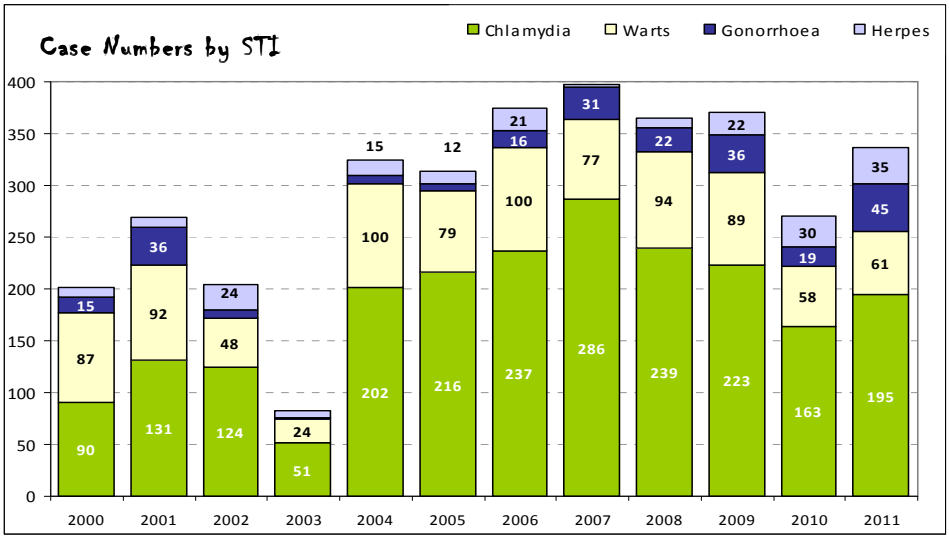
Graph 21: STI Reporting by Ethnicity 2002-2011



Source: IInstitute of Environmental Science and Research Ltd

The highest number of cases for STI's for the 15-24 year-old age group is Chlamydia followed by Genital Warts. Gonorrhoea however has seen the largest increase in reported cases over the last five years.

Graph 22: Taranaki Case Numbers by STI Type



Source:: Institute of Environmental Science and Research Ltd

Chlamydia

In 2011, genital chlamydia infection was the most commonly reported STI in New Zealand[44] and is asymptomatic in approximately 25% of male cases and 70% of female cases. It is most commonly diagnosed in females 15-19 year age group and in males in the 20-24 years age group in both the laboratory and clinic settings.

In Taranaki, the rate per 100,000 for test-positive chlamydia is less than the national average. For 15-19 year-old age group the rate is 2,287 compared to 3,798 nationally, for the 20-24 year-old age group it is 2,747 compared to 3,826. The DHB areas which have significant outliers to the national average are Tairawhiti and Lakes.

Taranaki has the national average for the total number of tests per 1000 population at 90, and slightly lower than the national average of 8.4% positive tests compared to 9.0%.

Gonorrhoea

In 2011, the estimated national gonorrhoea rate was 67 cases per 100,000 population. Taranaki's rates overall were slightly higher than the national average at 68. However, there was a marked difference in the rates per gender, with males testing positive at a rate of 57 per 100,000 (national average 79) and females 77 (national average 55).

Taranaki also reported poorly in the younger age groups, with the 15–19 year age group reporting a rate of 246 per 100,000 (national average 244) and for 20–24 year age group rates at 458 compared to 306 nationally.

Gonorrhoea cases not seen in the participating clinics are likely to be diagnosed in primary care. The highest proportion of gonorrhoea cases seen within a participating clinics was in West Coast DHB (77.8%), followed by Taranaki (77.3%) and Waikato (52.9%).

Genital Herpes & Genital Warts

Over the last six-year period the Taranaki region has continued to show an increase in the case numbers of genital herpes. Genital warts case numbers have remained static

At Risk Groups

[44] The Institute of Environmental Science and Research Ltd. Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2011 Porirua, New Zealand.

Those aged less than 25 years showed a disproportionate burden of STI's in 2011. The highest numbers and rates for each STI nationally were consistently in the 15–19 years and the 20 –24 year age groups both in clinic and surveillance data.

In comparing New Zealand data with other countries, the rates for Chlamydia are two to three times higher than what is published i.e. 786 per 100,000 population (NZ) and 319 Australia, the UK 349, and USA 426. For gonorrhoea the NZ rate at 67 was also higher than Australia 44 per 100,000, UK 30 but lower than the USA with a rate of 101.

Teenage Birth Rates and Terminations

Birth Rate

For the year ending June 2011 the Taranaki female population giving birth under 20 years of age is 34.2 per 1000 population compared to the national average of 27.4. For mothers of Māori ethnicity the rate is 92.0 compared to 77.6 nationally. For non-Māori mothers the Taranaki and national rates are similar, 15.8 and 14.0 respectively.

According to the 2006 Census the percentage of 15–24 year-olds in Taranaki that had no children was 75.2% compared to the national average of 79.3%. The percentage of 20-24 year-olds with one child is 6.4% higher than the national figure.

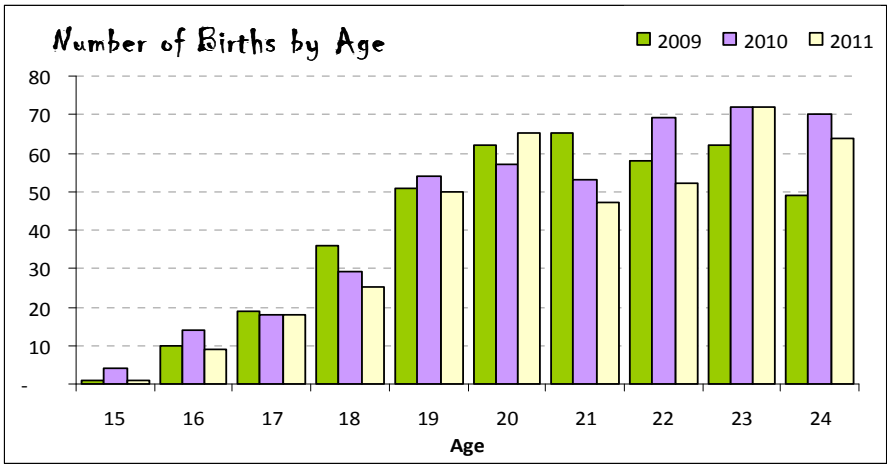
Table 13: Birth Rate Comparison

	Taranaki DHB			New Zealand		
	Live Births for Under 20 Year-Olds - By Ethnicity of Child	Female Population 15 - 19 Years by Ethnicity of Mother	Rate per 1000	Live Births for Under 20 Year-Olds - By Ethnicity of Child	Female Population 15 - 19 Years by Ethnicity of Mother	Rate per 1000
Māori	81	880	92.0	2,528	32570	77.6
Non Māori	44	2,780	15.8	1,719	122,520	14.0
Total	**125**	**3,660**	**34.2**	**4,247**	**155,090**	**27.4**

Source: Statistics New Zealand

The number of births for ages 15-24 years have fluctuated from 413 in 2009, 440 in 2010 and 403 in 2012. Māori mothers represented 45% of the total births in 2009 and 38% in 2011.

Graph 23: Taranaki births by Age by Year



Source: Taranaki HB Patient Management System

Termination of Pregnancy

The statistics for inpatient terminations of pregnancy (Top's) have decreased over the last three years. In 2009 there were 230 terminations, in 2010 there were 198 and 2011 had 196. This is a 15% decrease since 2009. The numbers of Māori as a percentage of the total also decreased, in 2009 to 39.7% (*n=89*) compared to 2010 at 31.3% (*n=72*) and 23.5% (*n=54*) in 2011.

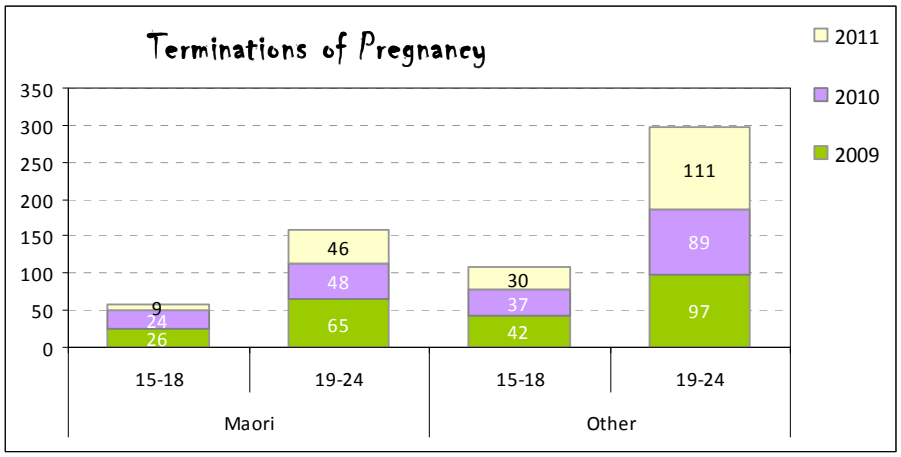
By comparison, New Zealand/Pakeha volumes have remained static with 116 terminations in 2009 and 119 in 2011.

The number of terminations for the 15–18 year group also decreased over the three years, with 68 terminations in 2009 compared to 39 in 2011, -42.6%. The numbers for the 19–24 year age group while showed a decrease from 162 terminations in 2009 to 157 in 2011, -3.1% (*n=5*), there was an increase of 14.6% (*n=20*) between 2010 and 2011.

In comparing the domicile code of residence for those accessing TOP services the biggest decrease in terminations were for those in Stratford and South Taranaki Districts between 2009 and 2011 of –33.9% (*N=11*) and -55.0% (*n=19*) respectively.

Taranaki's statistics for the 2006–2010 period for terminations was almost double the national rate per 1000. With Taranaki reporting 30.8 per 1,000 for Taranaki compared to the national average of 15.89.[45]

Graph 24: Taranaki Terminations of Pregnancy (TOPS)



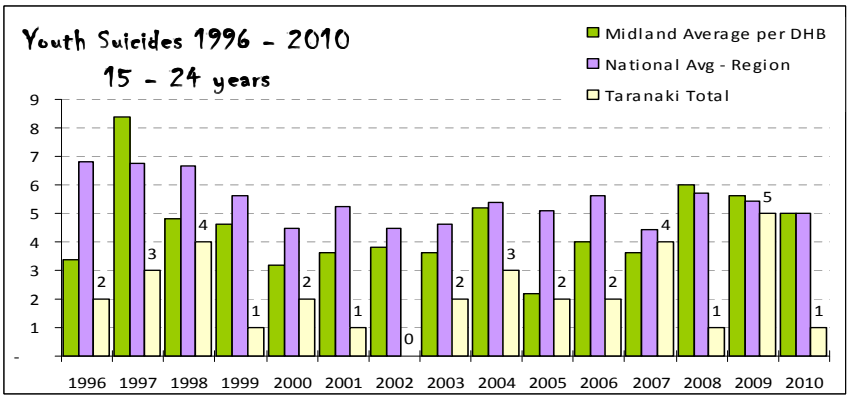
Source: Taranaki HB Patient Management System

Mental Health and Addictions

Youth Suicide 15–24 Years

In Taranaki between 1996-2010 there were 32 suicides for young people aged between 15-24 years. Sixteen percent of those were Māori *(n=5)*. The rates per annum across this period ranged from 0 in 2002 to 5 in 2009. The provisional numbers for 2010 are one suicide for the region. In 2010 the % of youth suicide was 6% of the total for the region. This is the second lowest in New Zealand, nationally 22% of total suicides were youth, and the Midland Region was 21%. However, in 2009 42% *(n=5)* of Taranaki suicides were youth for which three were male and two female.

Graph 25: Youth Suicides 1996 - 2010



Source: Ministry of Health

[45] Craig E, Adams J, Oben G, et al. The Health Status of Children and Young People in the Midland Region, November 2011, NZ Child and Epidemiology Service, University of Otago

Hospital Admissions for Young People with Mental Health Diagnosis

For the Midland Region DHB's between 2007-2011 the most common reasons for hospital admissions with mental health diagnoses in young people were schizophrenia, shcizotypal/delusional disorders, depression, the mental health effects of drugs and alcohol and stress reaction/adjustment disorders.

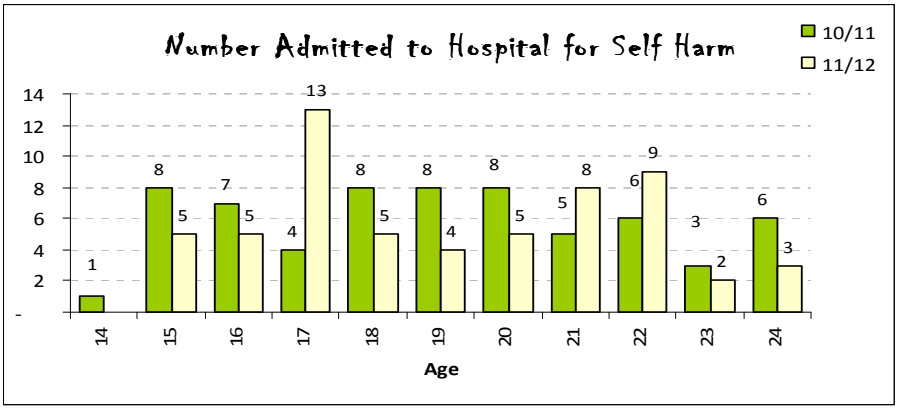
For the 2007-2011 years Taranaki DHB has the second highest rate of admissions for young people aged 15-24 years by primary diagnosis. The rate is 754.06 compared to Tairawhiti 962.03, Lakes 471.13, Bay of Plenty 645.14 and Waikato 532.62. For Taranaki the highest diagnosis for admissions was depression which was 22.1% of the total (166.89 per 100,000 pop), by comparison Tairawhiti and Lakes it was for schizophrenia with 30.3% (291.14 per 100,000 pop) and 30.4% (143.26 per 100,000 population) of admissions retrospectively, Bay of Plenty was also for schizophrenia with 18.5% (119.44 per 100,000 pop) of admissions and for Waikato both depression and schizophrenia recorded 17.5% of the total admissions (93.37 and 92.99 per 100,000 pop).

Self-harm Hospitalisations

In 2010 the total admissions for the Taranaki were 100. This represented 3.54% of the total in New Zealand. Admissions for age group 14-18 remained static at 28 for both 2010/11 and 2011/12. For the 19-24 year age group the numbers decreased by 5 to 31 in 2011/12. Admissions for Māori increased by 25% of the total in 2010/2011 to 32% of the total in 2011/12. For those domiciled in the New Plymouth District the proportion of Māori increased from 18% of the total in 2010/11 to 38% of the total in 2011/12.

Admissions for patients domiciled in the New Plymouth District decreased from 44 to 29 between both years. For Stratford there was an increase from 1 to 8 and South Taranaki decreased from 16 to 10.

Graph 26: Hospitalisations for Self-harm

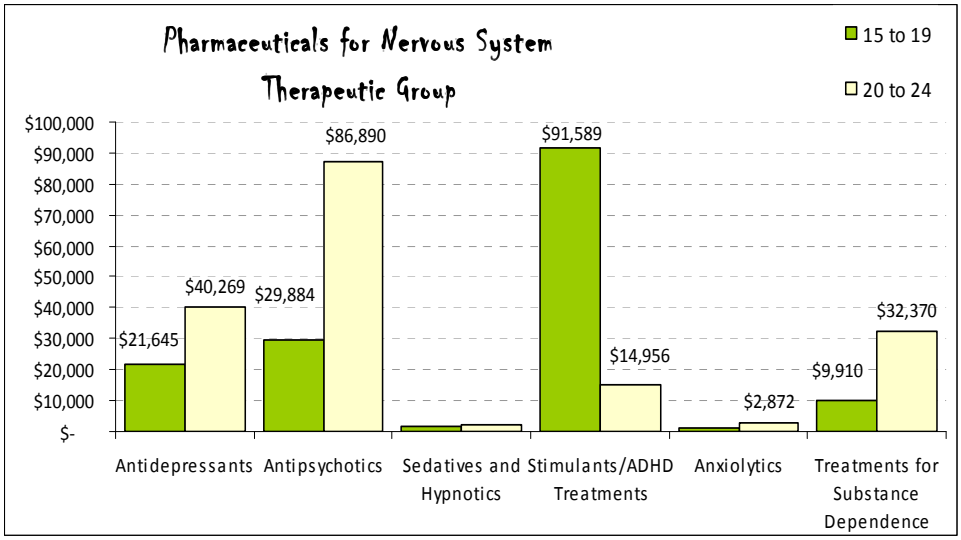


Source Data: Taranaki DHB Patient Management System

Pharmaceuticals – Mental Health

For the 2010-11 financial year there was $120K spent on antipsychotic drugs for young people aged between 10–24 years. This was 6.1% of the total expenditure. For Antidepressants 4.9% ($63,221 and 2,532 scripts) were prescribed, 82% of Stimulants/ADHD treatments were for young people which was $289K (4,839 scripts). The following graph shows the break down for age groups (excluding 10-14 years) for various Nervous System Therapeutic Group drugs.

Graph 27: Pharmaceutical Expenditure for Nervous System



Source: National Pharmaceutical Warehouse

Hospital Data

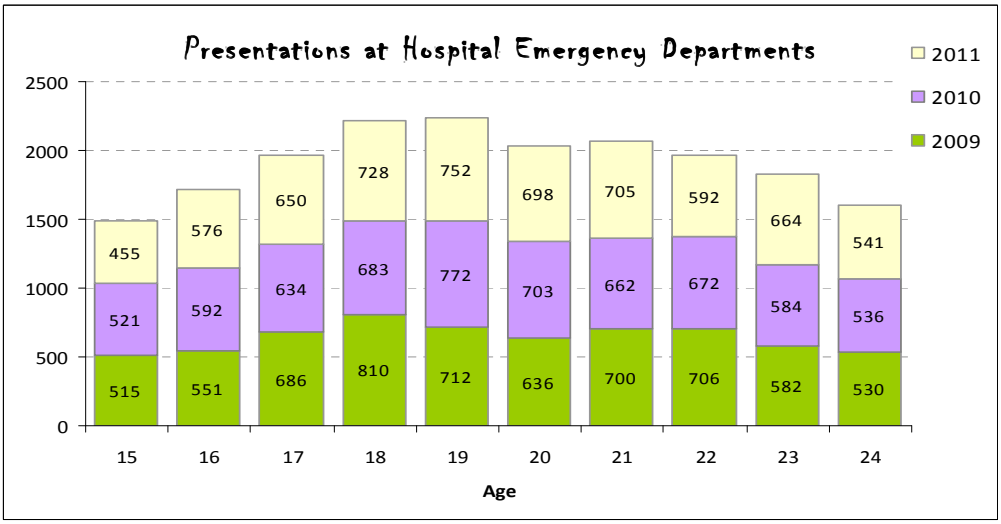
Emergency Department Use

In 2011 there were 6,191 presentations to the Taranaki DHB Emergency Departments (ED) for ages from 15–24 years. This represented 18% of the total 34,333 presentations. In comparing the statistics by domicile and TLA, 52.4% of presentations were for patients residing in New Plymouth District, 6.7% for Stratford District and 37.4% for South Taranaki District. A further 3.5% were from out of the region or from overseas. These figures are disproportionate compared to the age group population splits by TLA, which are 66.2% residing in New Plymouth District, 9.1% Stratford and 24.7% South Taranaki Districts.

Of those presenting 24.4% were Māori.

The highest numbers of presentations were for the 18–21 year age groups. Presentations by gender are relatively similar to the proportion of the population, 49.4% for females and 50.6% for males.

Graph 28: Emergency Department Presentations



Source: Taranaki DHB IBA Patient Management System

Most Frequent Reasons for Hospital Admissions by Type

The 2011 Health Status of Children and Young people[46] report identified the most frequent rates of admission to hospital for young people aged 15-24 years compared against national data.

As highlighted in the section on teen births Taranaki DHB's rates for young people giving birth are significantly higher than the national average. This is also the case for abortion rates which are almost double the national rate with 30.8 per 1,000 for Taranaki compared to the national average of 15.89.

The most common hospital admissions in young people aged 15–24 years by Admission Type for Taranaki from 2006-2010 is as follows:

Table 14: Common Hospital Admission Comparison

Primary Diagnosis/Procedure	Number Total 2006-2010	Number: Annual Average	Rate per 1,000	Percent (%)	National rate per 1,000
Reproductive Admissions by Primary Diagnosis					
Pregnancy/Delivery/Postnatal	3,175	635.0	94.1	72.1%	74.26
Therapeutic/Other/Unspecified Abortion	1,039	207.8	30.8	23.6%	15.89
Spontaneous Abortion/Other Early Pregnancy Loss	190	38.0	5.63	4.3%	5.74
Total Reproductive Admissions	**4,404**	**880.8**	**130.5**	**100.0**	
Acute Admission by Primary Diagnosis					
Injury / Poisoning	1,061	212.2	15.1	20.1%	14.12
Mental Health	531	106.2	7.58	10.0%	4.96
Abdominal / Pelvic Pain	398	79.6	5.68	7.5%	5.17
Skin Infections	242	48.4	3.45	4.6%	3.24
Appendicitis	173	34.6	2.47	3.3%	2.28
Gastroenteritis	152	30.4	2.17	2.9%	2.23
Urinary Tract Infection	111	22.2	1.58	2.1%	1.85
Total Acute URTI	100	20.0	1.43	1.9%	1.38
Asthma	93	18.6	1.33	1.8%	1.35
STI / Pelvic Inflammatory Disease	81	16.2	1.16	1.5%	1.17
Other Diagnoses	2,348	469.6	33.5	44%	24.42
Total Acute Admissions	**5,290**	**1,058.0**	**75.5**	**100.0%**	
Arranged Admission by Primary Diagnosis					
Neoplasm / Chemotherapy / Radiotherapy	104	20.8	1.48	6.2%	1.90
Injury / Poisoning	60	12.0	0.86	3.6%	1.16
Removal if Internal Fixation Device	50	10.0	0.71	3.0%	XX
Mental Health	17	3.8	0.27	1.1%	0.53
Other Diagnoses	1,445	289.0	20.6	86.1%	13.03
Total Arranged Admission	**1,678**	**335.6**	**24.0**	**100.0%**	**17.4**
Waiting List Admissions by Primary Procedure					
Gastrointestinal Procedures	313	62.6	4.47	18.9%	2.17
Dental Procedures	313	62.6	4.47	18.9%	1.20
Musculoskeletal Procedures	211	42.2	3.01	12.7%	2.67
Tonsillectomy +/- Adenoidectomy	143	28.6	2.04	8.6%	1.32
Procedures on Skin/Subcutaneous Tissue	113	22.6	1.61	6.8%	1.32
No Procedure Listed	83	16.6	1.18	5.0%	0.78
Procedures on Nose	55	11.0	0.79	3.3%	0.40
Inguinal Hernia Repair	25	5.0	0.36	1.5%	0.21
Myringoplasty	19	3.8	0.27	1.1%	0.20
Grommets	13	2.6	0.19	0.8%	XX
Other Procedures	368	73.6	5.25	22.2%	4.40
Total Waiting List Admission	**1,656**	**331.2**	**23.6**	**100.0%**	**15.1**
Taranaki Total	**13,028**	**2,605.6**		**100%**	

Source: Statistics NZ Child and Epidemiology Service

[46] Craig E, Adams J; Oben G, et al. The Health Status of Children and Young People in the Midland Region, November 2011, NZ Child and Epidemiology Service, University of Otago

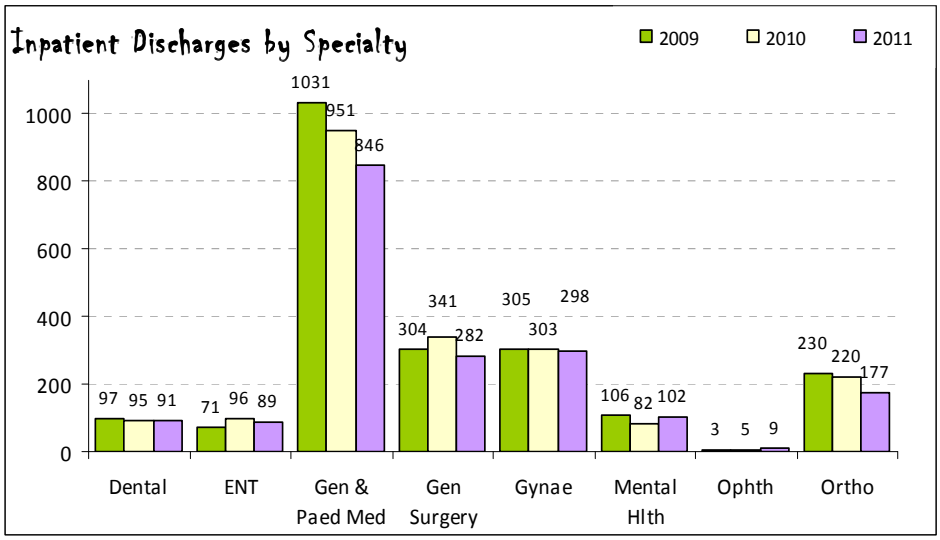
The most significant rates between Taranaki and national were for Pregnancy/Delivery/Postnatal, Therapeutic/Other/Unspecified Abortion, Mental Health, other acute admissions (other diagnoses) and other arranged admissions (other diagnoses).

Inpatient Discharges by Speciality

Over the last three years the discharges for age group 15–24 years has decreased by 12% (excluding Maternity Services). The specialities with significant change between 2010 and 2011 were, Mental Health increase of 24% *(n=20)*, General Surgery -17% *(n=-59),* General and Paediatric Medicine -11% *(n=-105)*, and Orthopaedics -20% *(n=-43).*

For those patients identified as Māori, the discharges decreased by -13% *(n=78)* in 2011.

Graph 29: Inpatient Discharges by Speciality Group



Source: Taranaki DHB

Pharmaceuticals

Pharmaceutical Use

Pharmaceutical Use

Tables 15 shows the use of pharmaceuticals by young people, by therapeutic drug group and ethnicity.

The total pharmaceutical cost for youth 15–24 years of age in the 2010-2011 financial year was $1.3 million, which represents 4.3% of the overall Taranaki DHB Pharmaceutical expenditure. The cost per head of population is $97.29 in the 15–24 year age group. This compares to $66.80 per person in the 0-14 age group and $393.43 per person in the over 25 year age group. Drugs for nervous system disorders were the highest cost followed by respiratory systems and allergies.

Table 15: Pharmaceutical Use for Youth, Taranaki 2010-2011

Type	No. Scripts	Reimbursement Cost (excl GST)
Alimentary Tract and Metabolism	5,439	$113,105
Blood and Blood Forming Organs	1,430	$19,909
Cardiovascular System	348	$67,720
Dermatological	17,792	$62,581
Extemporaneously Compounded Preparations and Galenicals	749	$31
Genito-Urinary System	3,911	$112,226
Hormone Preparations - Systemic Excl. Contraceptive Hormones	3,647	$38,581
Infections - Agents for Systemic Use	28,400	$85,081
Musculoskeletal System	6,919	$82,281
Nervous System	26,658	$485,498
Oncology Agents and Immunosuppressants	499	$68,450

Type	No. Scripts	Reimbursement Cost (excl GST)
Respiratory System and Allergies	15,405	$182,102
Sensory Organs	4,237	$8,227
Special Foods	510	$14,149
Unknown	821	$3,472
Various	13	$90
Total	**116,778**	**$1,343,503**

Source: National Pharmaceutical Warehouse

Table 16 shows that by cost Māori were prescribed a lower proportion of pharmaceuticals (14.6%) compared to their proportion of the population. In comparison Māori 0-14 years represents 22% of the overall costs. The average cost per script for Māori was $3.15 less than overall average cost. In contrast, the average cost per script for all age groups was for Māori is $31.99 which is $1.80 higher than the overall average of $30.19.

Table 16: Pharmaceutical Use by Youth, by Ethnicity, Taranaki 2010-2012

Ethnicity	No. of Scripts	Reimbursement cost (excl GST)	% Cost	Avg Cost per Script
Māori	9,525	$195,634	14.6%	$20.54
Other	46,595	$1,137,531	84.7%	$24.41
Pacific Island	588	$10,038	0.8%	$17.58
Total	**56,708**	**$1,343,503**		**$23.69**

Source: National Pharmaceutical Warehouse

List of Graphs

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Appendix 1: Alliance Working

Summary of the Impacts of Multi-Agency working[47]

Impacts on Professionals	
Personal well-being	• Professionals found multi-agency working to be rewarding, stimulating and enjoyable • Increased job satisfaction • Opportunities for creativity and autonomy • Increased professional confidence
Professional development	• Increased knowledge and understanding of the roles of other agencies • Increased knowledge and understanding of cross-disciplinary issues • Changed professional understanding and practice • Expansion of roles and the development of new ones
Professional identities	• Increased accountability • Confusion over roles and professional identities • Questioning of individual roles • Uncertainty over professional status
Working practices	• Improved communication between agencies/services • Improved interaction amongst professionals • Increased accessibility of other agencies • Improved accessibility to information from other agencies • Greater opportunities for information sharing and problem solving • Increased workload on individual professionals • Potential for duplication
Impacts on Service Users	
Improved services for service users	• Easier/quicker access to services • Referral to appropriate agencies/services • Increased focus on prevention/early intervention and reduced need to access specialist services • Reduced stigma attached to accessing services
Improved lives	• Enabled children and young people to remain in their local community, i.e. live at home/attend the local school • Improved support for children and young people • Improved educational attainment
Impacts on Agencies/Services	
Impacts on Agencies/Services	• Increased demand placed on services/agencies • Reduced demand made on services/agencies • More positive inter-agency relationships • Improved communication between agencies • Improved data sharing • Efficiency savings

[47] Atkinson M, Jones M, Lamont E, Literature Review, Multi-agency working and its implications for practice: A review of the literature July 2007.

Factors that Facilitate and Challenge Multi-Agency Working[48]

Facilitating Factors	Challenging Factors
WORKING RELATIONSHIPS	
Role Demarcation	
• Clarity over roles of agencies • Clear role boundaries • Acknowledging professional differences • Status issues/hierarchies addressed • Understanding of each other's responsibilities	• Status issues/power struggles • Professional hierarchies • Lack of equal representation • Blurring of professional boundaries • Role ambiguity • Redistribution of specialist skills
Commitment	
• Willingness to work together • Commitment form all staff • Strategic commitment	• Lack of commitment • Inappropriate levels of representation • Competing priorities
Trust and Mutual Respect	
• Positive regard for workers from different agencies	• Lack of trust between individuals and agencies
Understanding Other Agencies	
• Awareness of what other agencies can contribute • Appreciation of different agency contexts • Understanding the range of perspectives involved • Development of a partnership culture	• Stereotypical thinking • Ignorance of other services • Failure to recognise the contribution of others • Different professional models and beliefs • Conflicting professional and agency cultures
MULTI-AGENCY PROCESSES	
Communication	
• Transparent structures for communication • Maintaining constant communication • Adequate IT systems	• Lack of clear channels of communication • Poor interagency communication
Clarity of Purpose	
• Establishing clear and realistic aims • Aims understood and agreed by all agencies • Developing a shared vision based on jointly held values • Appropriate targets • Clear justification for partnership	• Lack of clarity about the rationale for multi-agency work • Divergences in objectives
Planning and Consultation	
• Inclusive planning systems • Consulting service users • Conducting a needs analysis • Extensive consultation	• Lack of consultation with key stakeholders
Organisational Aspects	
• Effective systems, protocols and procedures • Establishing formal protocols • Clearly defined structure or model • Continual reassessment of processes and procedures	• Failure to address temporal aspects of partnerships • Competing policies and procedures • Complex and time consuming negotiations • Organisational restructuring • Different targets and incentives •

[48] Atkinson M, Jones M, Lamont E, Literature Review, Multi-agency working and its implications for practice: A review of the literature July 2007.

Information Exchange	
• Establishing clear protocols for information exchange • Accurate and up to date shared data between agencies	• Confidentiality issues • Different rules and protocols around information sharing • Legal, ethical and practical obstacles
RESOURCES FOR MULTI-AGENCY WORK	
Funding	
• Adequate funding with shared access • Financial certainty • Equity between partners • Explicit agreements about the pooling or sharing of resources • Sufficient administrative support	• Conflicts over funding within and between agencies • Inadequate funding • Time-limited funding • Management of a variety of funding streams • Lack of joint budgets
Staffing	
• Recruitment and retention of staff • Effectiveness of particular personalities • Adequate staff • Co-location of staff	• Staff turnover and recruitment difficulties • Lack of qualified staff • Salary differentials • Variations in conditions of services
Time	
• Dedicated time for start-up • An incremental approach to joint working	• Lack of time to devote to joint working • Time involved in developing and sustaining relationships

Effective practice strategies: A summary[49]

EFFECTIVE PRACTICE STRATEGIES	
Working Relationships	
Clarifying roles and responsibilities	• Take time initially to clarify roles and responsibilities of all parties • Each worker should have a clear role and sense of contribution • Recognise and value differences, value diversity • Joint training can help to clarify roles and shared learning in groups can reduce stereotypes • Provide time to allow professionals to reflect on their new professional identities • Reduce 'turf issues' by pre-planning and highlighting the positive outcomes of collaboration and disseminating those from other service collaborations • Ensure parity in the perceived seniority of representatives from different organisations • Foster respect for specialist expertise combined with a willingness to explore and celebrate professional diversity • Boundary crossing can lead to a renegotiation of professional practice
Securing commitment at all levels	• Multi-agency work requires commitment at both strategic and operational levels • Foster personal commitment rather than professionals being directed to work in a multi-agency way • Ensure that the professional involved can see the benefits of multi-agency work as this secures greater commitment and stops it from floundering • Provide opportunities for sharing goals and visions, establishing trust and mutual responsibility as this helps secure commitment • Creating opportunities for decision making, and effectively chairing meetings encourages attendance • Ensure that part-time, peripheral or seconded staff feel included • Consult with professionals and clients from the beginning to secure commitment • A strong history of collaboration raises levels of commitment • Commitment should be underpinned by resources

[49] Atkinson M, Jones M, Lamont E, Literature Review, Multi-agency working and its implications for practice: A review of the literature July 2007.

	• Leadership modelling commitment heightens commitment levels
Engendering trust and mutual respect	• Development of close working relationships aids honesty and encourages open discussions of problems • Sharing skills and expertise develops trust, as does a willingness to be honest regarding knowledge gaps • Shared visions and equal resource distribution develops trust
Fostering understanding between agencies	• Joint training and forums can help to foster understanding between agencies • Recognition of the unique roles of individuals and utilisation of all skills • Work shadowing schemes can enhance understanding • Key players should be given time together to foster mutual understanding and informed dialogue • Accessible, practical guides to working with different sectors • Appointing a leader with 'cultural intelligence' who can identify the different cultures and construct an appropriate response • Provide opportunities to cross-boundaries, to examine current practice for each agency and to rethink the multi-agency philosophy • Give the culture of partnership and collaboration high priority • Basing strategic level staff in a reluctant department can raise the profile of multi-agency working • Take time to learn and understand each agency's mission, priorities and technical language • Staff secondments into partner agencies or presentations from different agencies at the start of collaboration can help to break down barriers
Multi-Agency Processes	
Ensuring effective communication and information sharing	• Create transparent lines of communication with clear protocols • Increased contact through meetings, working groups or training etc, results in greater inclination to seek further communication • Create frequent opportunities for communication, discussion and debate • Face-to-face meetings and a mix of formal and informal modes of communication • Develop personal connections to promote working relationships and informal links • Co-locate services where possible • Provide accessible, written updates, particularly at early stages of multi-agency partnerships • Have a pro-active approach to communication and embed into working practices • Formalise processes for information sharing and establish clear protocols • Provide joint training to facilitate information sharing and the exchange of good practice • Ensure that all representatives understand all terms or acronyms and provide definitions of the most common terms • Explore any differences in terminology as a group and consider any different understandings • Key players in multi-agency groups might benefit from more time together to foster informed dialogue • Team activities and service development should allow for creation of a shared language
Developing a shared purpose	• Develop a shared vision to define the scope and purpose of the partnership and use this as a reference point • The shared vision should be inspirational and based on jointly held values • Develop a shared understanding • Have a clear justification for partnership and demonstrate value for money • Develop clarity of roles and responsibilities (role demarcation) • Ensure targets and objectives are relevant and shared across agencies • Clearly articulate goals and outcomes • Develop guidelines to show how services are coordinated • Provide joint training or staff development • Set up a steering group to identify problems, key issues and different cultures • Conduct a needs analysis to create a picture of existing provision and boundaries of provision

Effective planning and organisation	• Consult service users on needs, issues and priorities in a way that empowers them and is sustainable • Use well designed consultations, good instruments and strategies etc • Develop shared protocols and written commitment to inter-professional working that are reviewed regularly • Develop a clearly defined and well documented structure/model to explain multi-agency operation and make this available to service users • Set up systems and structures to support joint working, such as service level agreements, coordinating bodies and multi-professional groups • Understand and cater for distinctive working conditions and the aims and objectives of different sectors • Disseminate good practice • Provide joint training to develop common ways of working • Use task groups to transform strategic plans into operational action • Adopt pro-collaboration policies and inform frontline staff • Select representation purposefully, ensuring equal representation • Balance the need to involve all organisations with the need to deliver partnership objectives efficiently and involve all relevant agencies early • Use a checklist of all agencies involved with the client group • Ensure representation of service users where relevant • Deliver any new functions through existing partnerships wherever possible • Assess the variability of members' history of collaboration when bringing a multi-agency group together • Provide training to those inexperienced in multi-agency work • Where there are few inherited linkages, proactive networking at strategic levels could counter-balance this
Resources for Multi-Agency Work	
Securing adequate and sustained funding	• Pooled budgets or joint funding • Identify and use alternative sources of funding • Avoid asking individuals to be involved in multi-agency work without additional funding, i.e. whilst still being held accountable for their full workload • Ensure stability of funding and distribute resources equally across agencies • Produce and agree clearly written agreements for funding arrangements • Recognition by senior managers of the importance of shared resources and the need to act as champions for funding arrangements at strategic/operational levels • Ensure dedicated resources to keep everyone engaged • Resources should be available to support management and administration
Ensuring continuity of staffing	• Support leaders and delegate responsibility to alleviate problems with staff turnover • Consider capacity issues to ensure continuity of representation over time • Facilitation through co-location, a joint location or a change in location
Ensuring adequate time	• Build in time for planning, developing and implementing arrangements • Sufficient groundwork on team building and developing trust • Create time for reflecting on new professional identities • Have a project start up phase for planning and development
Management and Governance	
Ensuring effective leadership	• Senior positions have more clout than junior staff in management roles • Leaders require shared vision and tenacity to drive the agenda as well as full commitment, strong entrepreneurial skills and networking • Partnerships needs sustained input from leadership and leaders need time and resources for their role • Reorganise work to ensure that managers can get time to get involved • Leaders should consult with and provide support for frontline staff, as well as addressing service conditions and staff welfare

	• Provide support networks for leaders and some delegation to other staff to relieve pressures • Leaders should model commitment to maximise collaboration
Establishing appropriate governance systems	• Processes/structures of accountability need to be appropriate to the type of partnership and make sense to frontline workers • Have clear roles and responsibility for the accountable body • Give accountability to external stakeholders and be accountable to service users • Consistency of governance structures with the vision and approach the partnership is taking, and facilitate efficient and effective decision-making
Establishing performance management systems	• Clear aims and objectives and joint performance indicators • Performance management systems that reflect the complexity of partnership working, capture a range of activity and have a clear focus on outcomes • Have joint review and evaluation procedures (e.g. team away days)

Appendix 2: Participants in Taiohi Health Strategy Development

Youth Health Strategy Governance Group	
• Sandra Boardman, Taranaki DHB, Planning & Funding • Ngawai Henare, Taranaki DHB, Māori Health • Gloria Campbell, Ministry of Social Development • Margaret Carville, Ministry of Education, Special Education • John Macaskill-Smith, Midlands Health Network	• Hayden Wano, Tui Ora Limited • Warren Nicholls, National Hauora Coalition • Rosemary Clements, Taranaki DHB, Hospital Services • Jenny James, Taranaki DHB, Planning & Funding
Operational Group	
• Warren Nichols, National Hauora Coalition • Lisa Parker, Special Education • Leigh Cleland, Taranaki DHB, Child and Maternal Health • Pauline Cruickshank, Midlands Health Network • Mary Lawn, Taranaki DHB, Public Health Nursing • Marilyn Chittenden, Ruanui Health • Jo Van Leeuwen, Taranaki DHB, MH&A • Janet Young, Taranaki DHB, CAMHS • Andrew French, CAMHS • Sarah Wood, Midlands Health Network • Rewatu Carr, Taranaki DHB, Health Promotion • Hinenui Knock, Taranaki DHB, Health Promotion • Mark Bowden, Spotswood College • Craig Campbell-Smart, New Plymouth District Council and WAVES	• Garth Clarricoats, WAVES • Linda Cox, YMCA • Hellmuth Hartung, YMCA • Mana Lawrence, Youth Justice • Yvonne Van Lent, New Plymouth Girls High School • Katherine Clement, New Plymouth Girls High School • Wendy Payne, Inglewood High School • Carol-Moana Rosser, Taranaki Young Peoples Trust • Samm Faami, Taranaki Young Peoples Trust • Ellen Hall, Stratford Youth Services • Tanya Anaha, Taranaki DHB, Māori Health • Dorothy Horwell, Taranaki DHB, Public Health Nursing • Jill Jones, Taranaki DHB, Public Health Nursing • Jenny James, Taranaki DHB
Clinical and Results Based Accountability Workshops	
• Warren Nichols, National Hauora Coalition • Mary Lawn, Taranaki DHB, Public Health Nursing • Leigh Cleland, Taranaki DHB, Child and Maternal Health • Louise Roebuck, WAVES • Jo Van Leeuwan, Taranaki DHB, MH&A • Yvonne Van Lent, NPGHS • Kathleen Clement, NPGHS • Craig Campbell Smart, NPDC & WAVES • Linda Cox, YMCA • Rewatu Carr, Taranaki DHB, Health Promotion • Wendy Payne, Inglewood High School. • Chris Nganeko, WAVES	• Pauline Cruickshank, Midlands Health Network • Janet Young, Taranaki DHB, CAMHS • Steve Harvey, Taranaki DHB, CAMHS • Marilyn Chittenden, Ruanui Health • Deb Harding, Tui Ora Limited • Dr Janet Mills, General Practitioner, MHN • Jenny James, Taranaki DHB, P&F • Megan Jackson, Family Works • Lisa Parker, Special Education • Barry Bublitz, National Hauora Coalition • Mana Lawerence, Youth Justice • Garth Clarricoats, WAVES

Focus Group Sessions and other one on one interviews	
• Stratford District Council - Youth Councillors • New Plymouth District Council – Youth Councillors • YMCA – Young Achievers • YMCA, SYSCO Programme • South Taranaki, Alternative Education, Hawera and Patea High Schools	• Taranaki Young Peoples Trust • WAVES, Transgender, Bi-sexual, Gay Group and window washers. • Dr Pat Boulton • Questionnaires, Incubator Programme

Appendix 3: Youth Questionnaire

Answer this survey to …

be in to WIN 1 of 4 $50 Centre City Vouchers

Making Health Services for young people Awesome!

Are you? Tāne/Male Wahine/Female **What school do you go to?** _____

First Name:_____ **Telephone Number**_____

(Q1). When you feel mean as  **what are the 3 most important things that keep you happy?**

Get on well with my family/Whānau
Doing awesome at school
Being busy and not bored
Feeling supported and encouraged to do things
Get on well with my mates
Doing sports or other hobbies
Talking to friends on internet or texting

Other _____

(Q2). When you feel crap  **what are the 3 things most likely to make you feel that way?**

Not getting along with family/whānau
Not allowed to do what I want
Bullying, school, cyber or text
People judging me
Getting in trouble at home
Getting in trouble at school
Don't know why I felt like that
Falling out with friends
Nothing to do
Drinking and/or taking drugs
Being hungry
No money
Something happened, don't know who talk to

Other _____

(Q3). When you're feeling down or depressed  **and need to see or talk to someone, where do you feel most comfortable going?** (tick as many boxes as apply)

School Counsellor
Teachers you trust
Nurses in schools
Friends
WAVES
Don't trust anyone enough to talk about it.
Family Doctor (GP)
Family/whānau
Other counselling services
Youthline or Healthline
Youth health services eg. Hawera Hub/E-Town
I don't know what's available

Turn the page ow!

Other _____

(Q4). **When you want to find health information e.g. on Sexual Health & Emotional/Mental health where would you find it?** (tick as many boxes as apply)

Internet/websites
Family/Whānau
Teacher's you trust
Youthline or Healthline
WAVES
I don't know what's available
Friends
School counsellor
School nurses
Family Doctor (GP)
Youth health services eg. Hawera Hub/E-Town

Other_____

(Q5). **If you need to see someone about Sexual Health issues, where do you feel most comfortable going to?** (tick as many boxes as apply)

School counsellors
WAVES
Family Planning Clinic
School Nurses
I don't know what's available
Family Doctor (GP)
Youth health services eg. Hawera Hub/E-Town
Dr Boulton's sexual health clinic
Pharmacy

Other_____

(Q6). **For the places you didn't choose why would you not go there?**

Costs to much
Not private, people might find out
They use too many big words I don't understand
Cant get appointment when I want
Don't trust them to talk about my problems
Have to see different people all the time
No transport
Being judged
Too embarrassed
Don't know them well enough
Not youth friendly

Other _____

(Q7). **What are the top 3 things, we could do better** 

Better Sex Education in schools
Better alcohol and drug education in schools
More help for young people to quit smoking
Make nurses/counsellors in schools more available
Make GP Practices more youth friendly
Bring services to where young people are
Make services more private
More information on what's available

Do you have any other ideas? _____

Nga mihi – Thanks for your help