Report to the Ministry of Health

Nursing Services in New Zealand Secondary Schools

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Executive Summary

Nursing services have long been provided in New Zealand secondary schools, but there have been changes over the years in the types of health services provided and in the service providers. In part, these changes have come about in response to broader social changes, including changes in the ways that children and young people are viewed. Over the last couple of decades there has been a new focus on including the views and needs of children and young people in the development of policies and the provision of services designed for them. At the same time, changes within health care have led to an increased focus on primary health care, and in particular to a focus on the critical role of the primary health care nurse in leading these changes.

School nursing services are potential sites for the development of primary health care services as envisaged in the Primary Health Care Strategy, and in some schools such services are currently being provided. However, little is known about the extent of this, about which schools have what sorts of health services, who provides them and how they are funded. This study aimed to explore the role of nursing services in schools, to identify the range of services provided and by whom, and to identify some of the issues for nurses in schools.

The research consisted of a review of the New Zealand literature, interviews with a number of nurses working in schools throughout New Zealand, a survey of secondary school principals, and a survey of nurses working in schools. This summary provides a brief overview of the findings and the key issues identified, and recommendations for the future development of school nursing services.

Summary of key findings

Nursing services provided in schools

- About three-quarters of secondary schools in New Zealand have a nurse in attendance or visiting. Most of these nurses are employed by schools, District Health Boards (DHBs) and public health. Two percent of nurses in schools are employed by primary health organisations (PHOs).

- School health services in the DHB districts in the northern North Island (except Northland) are more likely to have DHB-employed nurses than districts from Taranaki southwards. The South Island overall is less likely than the North Island to have school-employed nurses. The only three districts that appear to have PHO-employed nurses in schools are Bay of Plenty, Tairawhiti and Capital & Coast.

- Most nurse respondents have access to a clinic area within the school, but a sizeable proportion makes use of the school hall or unoccupied offices. Many nurses do not have access to a computer and use paper-based files for clinical notes; those who do have access to a computer are using a variety of databases to record consultations.

- Over three-quarters of nurses are providing personal health services in schools and undertake health education and promotion; about two-thirds undertake HEADSS[1] assessments, and almost half are involved in administering medication where appropriate (eg, the emergency contraceptive pill (ECP), antibiotics, Ventolin) and undertaking home visits. Many also provide first aid services and work with the school on developing the school or other specific health plans. Almost all nurses refer students to other health providers.

- School-employed nurses are more likely to be providing first aid services, and less likely to be providing personal health services, undertaking health assessments or administering medications than public health or DHB-employed nurses. School-employed nurses are less likely than other nurses to make home visits.

- Most nurses undertake fewer than 20 consultations a week, but a sizeable proportion sees more than 120 students a week. These are mostly school-employed nurses, most of whom are available for consultation for more than 25 hours a week in schools. High numbers of public health and DHB-employed nurses hold only brief clinics at schools and are most likely to be seeing fewer than 20 students each week.

- Some nurses, mostly public health nurses, work in more than one school. Of those respondents who indicated that they work in more than one school, most work in two schools, but there are some who work in up to 12 different schools.

Students' use of school health services

- The most common reasons nurses gave for why students use school health services were proximity and because students found it 'comfortable' because they could bring friends and it was familiar. The next most common reason was confidentiality, particularly when students wanted to access health services independently of their families. Over half the nurse respondents indicated that some students used school health services because they did not have access to transport to other services. Fewer than half the nurses (40 percent) indicated that some parents were unwilling or unable to pay for another health service. About a third of nurses indicated that there were students who did not know about other health services, and a third indicated that some did not know how to access other services.

- In interviews with nurses, students' need or desire for confidentiality was frequently mentioned as a reason why students fail to access health services, particularly their family doctor and Family Planning clinics. Nurses employed various methods to protect students' privacy and confidentiality when accessing both school and other health services.

- Nurses indicated that students' use of school health services for reasons of confidentiality, because parents were unable or unwilling to pay, or because the student was unable to use transport to other health services were all more common in lower and mid-decile range schools. However, there also appear to be

[1] HEADSS is a youth health assessment tool referring to home, education, activities, drugs, sexuality and suicide.

reasonably high proportions of students in higher decile range schools who have difficulties with parents being unable or unwilling to pay for other health services and in accessing transport to other health services.

- High numbers of nurses indicated students are referred to school health services by teachers (81 percent) and counsellors or other health professionals (80 percent), and high numbers indicated that students make their own appointments or just queue up. Just under two-thirds of nurses indicated that student attendees may be referred by parents.

Scope of services

- Nurses indicated that the most common reason for students seeking consultations is for advice on sexual health/contraception, and the next most common is for treatment for injuries and general sickness. Just under a third of nurses indicated that students seek help from the nurse for mental health issues such as depression or anxiety, or to talk about family issues. High proportions of nurses indicated that students 'never' or 'hardly ever' seek advice on fitness, weight loss or nutrition, or advice on alcohol and drugs, or smoking cessation.

- For nurses who were employed by agencies outside the school, most often their scopes of service were determined by their employer in consultation with the school. Nurses interviewed described how their role within the school was frequently misunderstood, and they were sometimes regarded as dispensers of 'panadol and band-aids'. Nurses worked to change this image and to develop job descriptions more appropriate to their qualifications and abilities, as well as to the needs of the students.

- About a quarter of the principals surveyed considered that the scope of health services available at their schools did not meet the health needs of their students. Of those principals who indicated they would like extended services, most wanted increased hours for nurses. Other services they would like to see extended included the availability of doctors, sexual health / family planning services, and mental health and counselling services.

Other health services

- Principals indicated that almost all schools have a first-aid-trained staff member and the services of a counsellor. Just over a third indicated hearing/vision testing was available at school and just under a third indicated dental services were available. Schools that have one or more nurses are more likely than schools with no nurses to also have other health services such as counsellors, doctors or Māori service providers.

- Nurses refer students to a wide range of other health providers, particularly counsellors and general practitioners (GPs). About two-thirds of nurses also refer students to Family Planning clinics and over half make referrals to medical specialists. About a third of nurses also refer students to social workers and resource teachers: learning and behaviour (RTLBs).

- School-employed nurses are the most likely to refer students to GPs other than family GPs, and to counsellors, and less likely to refer students to specialists, youth health centres or social workers than DHB-employed or public health nurses.

- Nurses were asked about their schools' levels of need for other health services. The only health providers that a majority of nurses considered their schools have adequate access to were counsellors, and only two-thirds thought access was adequate. This is in spite of the fact that around 92 percent of principals indicated that their schools have counsellors available. More than half the nurses indicated that their schools needed better access to social workers, psychologists and drug and alcohol counsellors, and high proportions also considered there was less than adequate access to sexual health nurses, fitness advisers and family advisers.

- Nurses interviewed described links to local health centres, youth health centres, GPs and PHOs with whom they had developed 'good relationships' and where students could be referred if necessary. They also linked into other health services such as mental heath services; Child, Youth and Family services; Family Planning; paediatricians and other medical specialists; district nurses; public health nurses; physiotherapists; asthma educators; quit smoking programmes; alcohol and drugs services; counselling services; social workers; and dental services; and liaised with teaching staff at school.

- Many principals indicated that they would like extended provision of a range of medical and social services, including mental health services, GPs, and Family Planning services.

Health services and schools

- Most principals indicated that they receive regular reports about clinical activities undertaken by nurses and over half indicated that reports also go to boards of trustees. Most nurses (80 percent) indicated that they report to senior staff within the school, and about a third indicated that they report to boards of trustees. Nurses' reports to boards of trustees were mostly on the types of services offered (38 percent) and throughput (32 percent).

- More public health nurses (41 percent) than school-employed nurses (36 percent) or DHB employed nurses (31 percent) report to boards of trustees.

- Slightly fewer than half (47 percent) of nurse respondents indicated that they are not involved in teaching health classes. Others indicated they are involved in health classes; some are taking health classes alone but more commonly take classes together with a teacher.

- Just over a third of nurses indicated that they provide advice to teachers on health classes. Nurses interviewed indicated that they like to know when a health topic is being discussed in class so that they can provide back-up information to students, and many indicated that they are happy to advise teachers or provide support, particularly for sexual health sessions.

- There are some gaps in school health services during school holidays. Some nurses can be contacted by students during the holidays and some nurses indicated that

they advise students about other services they can use. However, almost a third of nurses indicated that no special arrangements are made for students for the school holidays. Many school-employed nurses are paid for only a 40-week year, and most of the nurses who are available or can be contacted during holidays are public health or DHB-employed nurses.

Professional issues

- Almost all the nurse respondents are registered nurses, and only a small number are enrolled nurses (6 percent). Just over half of the nurses also had family planning qualifications and some had postgraduate qualifications in child or youth health.

- Most nurses receive some professional development support in the form of paid study time, and about a quarter can take unpaid study time. Just over half of nurses indicated that their employer meets course costs.

- Most nurses have been working in schools for less than five years, but significant proportions have been working in schools for up to 10 years, and for DHB-employed nurses between 11 and 20 years.

- Most nurse respondents are in age ranges over 30 years, with the largest group in the 40−49 years age range. Some nurses over 40 years of age have worked in schools for 11 years or more, indicating that they have made careers within school nursing. However, the preponderance of nurses in the upper age groups has implications for workforce planning.

- Over a third of respondents who work full time did not answer the question about salaries, but of those who did, almost a third of nurses on full-time salaries earn over $55,000. Almost half of nurses working part time did not answer the question asking about hourly rate, but of those who did, most are earning less than $29 an hour and over a quarter earn less than $24 an hour.

- Nurses employed by schools and working part time are the most likely to be earning less than $24 an hour. Public health nurses are more likely to be earning between $25 and $29 an hour and nurses employed by DHBs are the most likely to be earning between $30 and $34 an hour.

- Of those nurses who indicated they do report to someone in a professional capacity, most report to a senior nurse or another professional in their organisation. Of those who did not report to anyone (16 percent), most were school-employed.

- Two-thirds of nurses indicated that they receive clinical supervision. Of those who indicated that they do not receive clinical supervision, almost all were school-employed nurses. Most supervisors were senior nurses, managers, doctors, trained supervisors or senior colleagues, but a number of nurses indicated that they receive supervision from colleagues, counsellors, or social workers, or from within a local ‘cluster group’.

Prioritisation

- School decile level is commonly a factor in determining what sorts of health services will be provided in schools. The main differences by decile that were found in this research were that:
  - nurses in the lower decile schools are more likely to undertake health assessments, provide personal health services, provide prescribing and vaccinating services and undertake home visits than nurses in high-decile schools, although there is no consistent trend across the low- and high-decile schools for these services
  - nurses in the mid-decile schools undertake more health assessments, and are more likely to refer students to other health professionals, provide personal health services, provide prescribing and vaccinating services, undertake health promotion and education, and develop health plans than nurses in both high- and low-decile schools
  - nurses in high-decile schools are more likely to provide first aid, undertake health promotion and develop a specific health plan than nurses in low-decile schools.
- The provision of personal health services and referrals to other health providers is highest within the mid-decile schools, but remains almost as high for the high-decile schools (deciles 8, 9 and 10) as it is for low-decile schools (deciles 1, 2 and 3). This supports the view that there is a need for school-based health services within schools of all decile ranges.
- Nurses were also asked about the need for other services, including social workers, psychologists, drug and alcohol advisors, sexual health nurses and family advisors. The lower to mid-decile schools appear to have a greater need for all these services than high-decile schools. The need for psychologists and social workers is quite high across all decile ranges.
- From interviews with nurses it appears that school decile is a primary consideration in decisions about the provision of services. However, other needs are also considered, such as rural isolation, a significant transient population, or the needs of specific groups such as Māori, Pacific or other ethnic groups.

Improvements to services

- About two-thirds of principal respondents thought that the scope of nursing services met the health needs of students at their schools. However, over a quarter did not, and most of these thought that more nurse hours were needed. Some principals also indicated a need for increased funding and improved facilities for health services within their schools.
- Some principals commented that they would like to have more doctors available in their schools, and some also mentioned the need for additional sexual health / family planning services, and mental health services, and for the nurse to be able to take part in health education and promotion activities. Some also wanted extended hearing, vision and dental services.
- Nurses interviewed indicated that there were gaps in services, and that extra staff and extended clinic hours were needed in most schools. They also indicated that there were often difficulties in getting outside help for students, particularly from over-stretched mental health and Child, Youth and Family services, and also finding the funding to enable students to use other health services.

Conclusions and recommendations

Health services currently available in schools have evolved from the earlier public health provision, from schools' own initiatives, or from DHBs and PHOs in some districts in response to a perceived local need for a school-based health service. However, the absence of a policy concerning school-based health services and allowing ad hoc development of these services might lead to discrepancies in availability and access to services.

In addition, most nurses employed by schools do not receive clinical oversight and many do not report to anyone in a professional capacity, so their professional isolation is an issue that needs to be addressed. Whichever model for school health services is developed, it needs to ensure there is professional support for all nurses in schools.

There needs to be clarification of the role of the 'school nurse'. The perception held by some of the school nurse as someone who provides 'panadol and band-aids' and who can also assist with some of the administration tasks has helped sustain the low levels of professional support and lack of clinical oversight, and has also helped maintain the low levels of pay of some nurses in schools, part-time nurses in particular.

Developments in youth health education are taking place and it is to be hoped that these will lead to adolescent health career pathways for nurses in schools. The ongoing support from employers that is needed if nurses are to undertake further training, particularly towards an adolescent nurse career pathway, may be more likely to occur if they are employed within health rather than education. However, nurses in schools are working on school sites, supporting students' education through their contribution to students' health and wellbeing, and need the support of school staff to do this effectively. In view of this, there also needs to be a partnership with education.

One way forward might be for DHBs to take responsibility for health services in schools, and to be equitably funded for this. They would need to come to arrangements with schools so that existing structures are not disrupted. Ideally, PHOs would be involved as part of linking to the wider health system. Links need to be made in particular to youth health centres, because not all students or young people are in school. There is a demand for extended GP services that are more accessible to students, as well as other health services, and links with PHOs might also enable nurses in schools to more easily link their students to these other health services.

1 Background to the Research

In recent times, government policies in general have become more child-focused and there has been more emphasis on the participation of, and consultation with, children and young people concerning the provision of services or the development of policies that will have an impact on their lives. This is evident in such policies as the Agenda for Children and the Youth Development Strategy Aotearoa, and in specific youth health policies.[2] There is now also a greater awareness of the links between children's and young people's particular health needs and their educational achievement.[3]

Although health services have always had some presence in schools, they have often been sporadic and minimal. Public health, for example, has long been present, as schools are places where large numbers of children and young people are gathered for a significant part of the day, and so they are ideal places for population-based health measures such as immunisations or screening for hearing and vision. However, broader social changes, including changes in the ways that children and young people are viewed, have led to new developments in the delivery of health services in schools.

There have also been changes in the way health services are delivered. The New Zealand Public Health and Disability Act 2000 initiated population health approaches and an increased emphasis on primary health care. Following on from this Act were two major policy documents, the *New Zealand Health Strategy* (Minister of Health 2000) and the *Primary Health Care Strategy* (Minister of Health 2001). The *Primary Health Care Strategy* had a focus on developing primary health care to play a central role in the health system and identified primary health care nurses as crucial to its successful implementation. As part of this, it established the Expert Advisory Group for Primary Health Care Nursing, which developed a framework for activating primary health care nursing. Within this framework it outlined a vision for primary health care nursing that included aligning practice with community needs, developing innovative models of nursing practice, and developing education and career pathways for primary care nurses. Primary health care nursing was to be delivered in a variety of settings in city, urban and rural areas in partnership with individuals, families/whānau or population groups, and would provide for the case management of individuals across the primary, secondary and tertiary interface (Ministry of Health 2003). Schools are potentially ideal settings for the development of such primary care nursing services, and in some schools these services have already been established.

There are now school-based health clinics in many schools, with a school nurse who provides first-level care to individual students. This may include clinical care, counselling and mediating, support and advocacy, liaison and referral, health promotion and education, and professional management. However, exactly what services are being provided within secondary schools, by whom and how they are funded is not well understood. This research aimed to find some answers to questions about the nursing services available in New Zealand secondary schools. It is a

[2] See, for example, Ministry of Health 2002.
[3] See, for example, Ministry of Education 2006.

component of the wider Primary Healthcare Strategy Evaluation, and as such forms part of an exploration of some of the newer roles of primary health care nurses.

The aim of this study, therefore, was to explore the role of nursing services within New Zealand secondary schools, and to identify the range of school nursing services, who provides these services, how they are funded, and some of the issues for nurses working in schools.

2 Methodology

The aim of this research was to explore the role of nursing services within New Zealand secondary schools. It was an exploratory study aimed at identifying the range of school nursing services and the issues that schools face in relation to school nursing. It was hoped that this exploration would provide answers to questions such as:

- What nursing services are provided in secondary schools?
- How are these services funded?
- How do they link to other health services?
- What are some of the professional issues for nurses working in schools?

There were three parts to this research: a brief literature review, interviews with nurses working in secondary schools, and two surveys, one of all secondary school principals and another of all nurses who work in secondary schools.

2.1 Literature review

A brief review of literature explored New Zealand school health services, adolescent health and health needs, barriers to youth accessing health care, and models of youth health care. A search was made of Victoria University of Wellington's library databases using the key words 'youth', 'adolescent', 'health services' and 'New Zealand'. Material was also obtained from the Ministry of Health library, and key author names were followed up in wider searches for relevant material.

2.2 Qualitative interviews

The qualitative interviews with nurses included a total of 17 interviews: 16 with nurses who worked in secondary schools or youth centres and one with a school counsellor (this was at a school where the nurse and counsellor worked closely together and was conducted in order to obtain the views of an allied staff member about how the health services worked).

The interviews included participants from Auckland, Waikato, Taranaki, Wairarapa, Porirua, Lower Hutt, Christchurch, Timaru and Dunedin.

The interview schedule is attached as part of Appendix 10. The interviews were tape-recorded and transcribed, and entered into Nvivo software. The data were analysed using thematic analysis.

2.3 Quantitative surveys

Survey of principals

The survey of principals was a web-based survey, and emails requesting participation were sent to principals of all 336 secondary schools throughout New Zealand. The schools and school addresses were obtained from the School Directory on the Ministry of Education website (Ministry of Education 2008). From this list, all schools that were of school type 'Secondary Year 7−15' or 'Secondary Year 9−15' were selected. This was a short survey designed to discover the range of health

services being provided in secondary schools, whether there was a nurse attending the school, who employed the nurse, and some information on how health services worked within schools (see Appendix 8 for the principals' survey). There was no personal incentive for completion, but the principals had the option to enter their school's email address into a draw to win a small prize of school supplies vouchers.

An online survey was prepared, which was accessed by clicking a URL in the email. The first page of the survey was an information and consent form. This led to the services question page, which asked about student services available at the principal's school. Two further questions concerned whether the school had a nurse in attendance or not, and if so, who paid the nurse. Subsequent questions depended on the answers to the screening questions.

The survey was conducted in May 2008 and one email reminder was sent after two weeks.

Survey of nurses

Because there are multiple providers of health services in schools there is no list of nurses working in schools. This means there was no sample frame, nor was it known how many nurses work in schools.

The survey was a paper-based questionnaire of 36 questions covering a range of issues concerning the provision of health services in secondary schools. Questionnaires were posted to all 336 secondary schools in New Zealand, selected as described above for the principals' survey and addressed to 'The School Nurse or Health Provider'. In addition, public health nurse managers were contacted and asked if they would participate in the project by distributing questionnaires to all their nurses working in secondary schools. If they were prepared to participate, they were asked to provide the number of nurses who worked in their teams. In response to their requests, another 199 questionnaires were sent to these managers to distribute to their nurses working in secondary schools.

Thus, in total 535 questionnaires were initially sent out. In addition to these, direct requests were received from nurses who were working in secondary schools throughout the country who had heard of the survey and wished to participate. These may have been nurses who had not received the survey via their schools for a number of reasons: it was simply not passed on; there may have been more than one nurse working at the school; they may have been public health nurses who had not received a questionnaire from their managers; and some responded after the reminder had been sent out and requested a new questionnaire because the original had been lost or destroyed, or did not reach them. Of this latter group, there were 18 that we knew were definitely replicas of 'lost' questionnaires, but there may have been others who did not report the first questionnaire had been lost. The final total number of questionnaires sent out was 559 (including the 18 replica questionnaires).

It is presumed that more questionnaires were distributed than there are nurses working in secondary schools. This was partly intentional, because we did not know the size of the population of nurses working in secondary schools so wanted to ensure that there was a high likelihood that all such nurses would have access to the survey. In addition, we believed that although public health nurses may visit schools regularly,

because they are employed by an outside organisation they would be less likely to receive the questionnaires sent via the schools. For this reason, we also approached them via their managers. Other nurses employed by outside organisations (such as PHOs) would be in a similar position. However, because of the large numbers of PHOs and because the numbers of nurses working in secondary schools and employed by PHOs is unknown, it was decided not to approach PHOs separately.

The nurses who had completed the survey by the closing date were invited to enter a prize draw for book vouchers.

Reminder letters were posted to all schools and emailed to public health nurse managers approximately two weeks after the questionnaires were first posted out.

The survey included questions about: consultations with students, other health services, professional issues for nurses, and demographic information (see Appendix 9 for the nurses' survey).

3 Findings from the Literature

A brief scan of the available literature was undertaken. This covered only New Zealand material and recent research investigating adolescent health needs and health services provided in schools. This review briefly covers adolescent health and health needs, barriers to youth accessing health care, models of youth health care, guidelines for developing youth health services, and the benefits of school-based health services.

3.1 Adolescent health and health needs

Youth2000 was New Zealand's first national health and wellbeing survey (Adolescent Health Research Group 2003a, 2003c). This study aimed to determine the prevalence of selected health behaviours and protective factors in a representative population of New Zealand youth who attended secondary school. The sample was Year 9 to 13 youth from 133 randomly selected secondary schools across New Zealand in 2001. Of these, 114 schools agreed to take part in the survey and 75 percent of selected students agreed to participate, for an overall response rate of 64.3 percent. In total, 9579 students completed a multimedia computer-assisted self-interview. The findings of this study cannot be generalised to all youth because they exclude young people who had already left school (known to have high rates of health risk behaviours), and the results may therefore overestimate the health and wellbeing of this age group.

The survey found that most students were healthy (94.2 percent of males and 90.3 percent of females rated their health as good or better). Over half (63.7 percent of males and 54.1 percent of females) reported they were happy with how they got on with their family. Most (84.5 percent of males and 86.4 percent of females) liked school or thought it was OK, and most reported positive connections with their school (having adults at school who care about them, feeling part of their school, usually getting along with teachers, and feeling teachers treat students fairly). Most Māori, Samoan, Cook Island and Tongan youth were proud of their ethnicity and considered it important that their identity be recognised.

The survey also raised a number of areas of concern. Just over a quarter of both male and female students reported riding in a car driven by a potentially intoxicated driver within the last four weeks. Students reported high levels of suicidal thoughts (males 16.9 percent, females 29.2 percent), suicide attempts (males 4.7 percent, females 10.6 percent), and depressive symptoms (males 8.9 percent, females 18.3 percent). A small group of students (11.8 percent) engaged in multiple health-risk behaviours (either five or six of: ever having drunk alcohol, ever smoked a cigarette, ever used marijuana, ever had sex, been in a fight in the last year, or thought of killing themselves in the last year). In contrast, 39.5 percent of students had engaged in none or only one of these behaviours. Although 83.7 percent of males and 80.4 percent of females reported ever having drunk alcohol, the percentage who admitted binge drinking in the last four weeks was smaller (41.4 percent of males, 38.5 percent of females). Of the sexually active students, 63.3 percent of males and 59.7 percent of females reported always using contraception to prevent pregnancy, and 76.5 percent of males and 68.8 percent of females said they had used a condom as protection against sexually transmitted infection the last time they had sex.

Because it was recognised that students excluded from mainstream education would not be included in the national youth health survey, the health of alternative education students was explored in a parallel survey of all 36 alternative education schools in the Northland and Auckland regions in the year 2000 (Adolescent Health Research Group 2003b; Denny et al 2004). Alternative education schools are those that serve students with behavioural problems, repeated expulsions and/or pregnancy or child care responsibilities that preclude them from attending their usual secondary school. They are relatively new in New Zealand (the Ministry of Education having established the Alternative Education Initiative in 1999), and they are limited to students in years 9 to 11 (aged 13 to 15).

The alternative education student response rate was 76 percent. Comparisons were then made between the health and wellbeing of mainstream and alternative education students of the same year groups in the same geographic regions. This showed a higher proportion of alternative education students were male and Māori. They were more likely to come from disadvantaged backgrounds, to engage in risky health behaviours, and to suffer high levels of depressive symptoms. Nevertheless, most of the students reported their health was good, very good or excellent (83.7 percent of males and 78.4 percent of females), the remainder saying it was fair or poor. Alternative education students' positive connections to wider family, school and community were similar to those of secondary school students, and alternative education schools were found to provide supportive and caring environments for their students.

Another source of information about the health needs of alternative education students is the Centre for Youth Health, which provides clinical youth health services to alternative education settings in Counties Manukau (Fleming et al 2004). In the first half of 2004 initial health assessments found that more than 90 percent of these students required follow-up for significant health issues, with about 80 percent having multiple health needs. In addition, many had needs across several sectors, such as health, education, welfare and justice. Few had a regular GP, and high levels of clinician input were required to address their needs (10 or more clinician hours per month for four or more months).

Sexual health services may be a particular need in secondary schools. A survey and interviews were conducted with principals, boards of trustees and other members of staff involved with health issues in 28 secondary schools in the Counties Manukau area (covering approximately 31,574 students) (Counties Manukau DHB n.d.). In relation to their school-based sexual health services, 7 percent of the schools had a sexual health clinic on site (with a further 14 percent accessing this service off site); 18 percent had a family planning clinic on site (and a further 39 percent access off site); and 28 percent ran a peer sexuality and support programme (PSSP) in school (Counties Manukau DHB n.d.).

The schools identified a number of gaps and problems in sexual health services for their students. These included:

- school nurses − only 68 percent of schools had a registered nurse on site, the remainder having an enrolled nurse or first aider(s)
- off-site services − transportation and safety issues

- sexually transmitted infections and student concerns about confidentiality of treatment
- teenage pregnancies − there was perceived to be a high number of unintended pregnancies in the area
- co-ed sexual health classes − separate classes for male and female students were considered preferable.

Suggestions for improvement included having sexual health services provided on the school site or, in the case of rural schools, having a mobile service. These would enable students to access information, and preventive and ongoing care.

Data from the 2006/07 New Zealand Health Survey indicate that young people are more likely to see GPs outside their normal providers and are more likely to have unmet needs for GP services. Twenty-two percent of women in the age group 15−24 years, and 20 percent of men in this age-group, had seen a GP outside their primary health care provider in the previous 12 months; this is higher than for any other age groups, for both men and women. This survey also indicates that young people are the most likely group to report unmet needs for GP services. Nine percent of young women aged 15−24 years and 8 percent of young men aged 15−24 years reported unmet needs for GP services. For young men in particular, this age group is more likely to report unmet needs for GP services than any other ages (Ministry of Health 2008).

3.2 Barriers to youth accessing health care

Young people identify a number of barriers to accessing health care (Adolescent Health Research Group, 2003b, 2003c; Mathias 2002; Smith et al 2004). These include:

- not knowing how to access health care
- attitudes and feelings (not wanting to make a fuss, can't be bothered, embarrassment, reluctance to admit problems, too scared)
- distance to travel
- inconvenient times
- don't feel comfortable with the health provider
- lack of cultural appropriateness
- lack of privacy
- concerns about confidentiality
- cost of doctor's visit and/or prescriptions is too expensive.

3.3 Models of youth health care

All schools have a responsibility under the Education Act 1989 to provide a safe physical and emotional environment for their students (Ministry of Health 2004b). The Ministry of Health has produced guidelines for school-based health care with suggested steps for setting up a health care service in a secondary school, recognising that there are different models and scales of service at different schools (Ministry of Health 2004b).

In 1912 the first school medical inspectors were appointed within the Department of Education. In 1917 nurses were appointed to the School Health Service, which

transferred from the Department of Education to the Department of Health in 1921, became part of the District Health Nursing Service in 1930 and then joined the Public Health Nursing Service in 1953 (Alcorn 2001).

By 1991 there were many different organisational arrangements for health services in schools and some confusion over what sort of model of health services should prevail (Lungley and Barnett 1991). Public health nurses continued to be available to school, but their role also extended to the wider community. In addition, some schools employed their own nurses and developed school health services (Alcorn 2001). However, the ad hoc development of services has led to differing provision, standards and school nurse salaries, and difficulties for nurses' continuing professional development and career pathways (Alcorn 2001; Bennetts 2005). The Primary Health Care Strategy may provide 'an opportunity to revise the way we have met the needs of our young people while at school and develop a framework to support and develop the nurses in these roles' (Bennetts 2005:13). This may be easier for schools in an area covered by a single PHO: managing funding and 'clawbacks' where a student population is covered by more than one PHO can be challenging (Bennetts 2005).

Models of youth health care, both in schools and in the community, include:

- intensive and comprehensive (or wrap-around) services
- comprehensive healthy school environment or co-ordinated school health programmes
- comprehensive school-based clinics
- community-based school-linked youth health services
- primary health care
- school nurse only
- suitcase/mobile clinics
- family−school−community collaborative model (Fleming et al 2004).

Some New Zealand schools have adopted the World Health Organization's Health Promoting Schools model, which is a whole-of-school approach to promoting student, staff and community health and wellbeing (Ministry of Health 2004b). This aims to help schools to:

- connect the physical, emotional, social, spiritual and environmental aspects of health
- create the best possible learning environment for students
- create a pleasant and healthy workplace for staff
- strengthen school−community links
- empower community members to participate actively in the school (Ministry of Health 2004b:3).

AIMHI (Achievement in Multicultural High Schools) is a Ministry of Education programme established in 1995 in nine low-decile secondary schools in the Porirua, Central Auckland and Counties Manukau regions with the aim of raising the achievement levels particularly of Māori and Pacific students (AIMHI n.d.). In 2001 these schools received additional funding from the Ministry of Education to support the development of 'full service facilities'. This involved co-locating a range of

services (including health services) on site at the schools and connecting community aspirations and goals with those of the schools.

School health services may not address all the health needs of young people. They are not available in all schools, they may not operate during school holidays, high-risk students often leave school early, and young people between 16 and 24 still have developmental needs that are not well met by adult-focused health care (Bagshaw 2006). Youth-specific services have therefore developed in the community too. In 2005 there were approximately 14 such services in New Zealand, which were surveyed regarding their funding and services (Bagshaw 2006). Nine services responded. These services were open for between 30 and 50 hours per week and were providing free services for young people aged between 10 and 25 years (with some variation at the top and bottom of this age range). All had a contract with the Ministry of Health or their DHB, four had additional contracts with their local PHO, and all had other sources of funding too. Five of the services had young people working there; all but one employed a nurse (mostly full time); all but one had a doctor (mostly part time); four had counsellors; and five had social workers.

A more recent survey of DHBs and PHOs (McKay and Bagshaw 2008) found that of the 14 (of 21) DHBs that responded to the survey, six DHBs funded a school health service either via a PHO or directly, and five provided services in schools via funding for public health services or one-stop-shops. Six DHBs also provided funding to youth-specific community youth health services or one-stop-shops. Of the 82 PHOs listed, 33 responded to the survey. The report found that these responses did not provide sufficiently clear data for analysis, but it did note that 11 PHOs have contracts with health providers to fund doctors and registered nurses to provide health services in schools. Most of the funding for these was through Services to Improve Access (SIA).

3.4 Developing youth health services

A 2003 Ministry of Health-sponsored workshop to develop guidelines for school-based health services identified six key operating principles for an excellent youth health service. These were:

- promote a youth development philosophy with a focus on keeping students well and building on their strengths
- actively involve students in all aspects of the service − its design, governance and service delivery
- work with the school community to develop a health-promoting environment for students and staff
- integrate the health messages promoted in the health centre with what is being taught and learnt in the classroom
- encourage the professional development and ongoing learning of the centre's staff
- take care to see that the service's policies and practices contribute to reducing, not increasing, health inequalities (Ministry of Health 2004b:23−7).

Eleven steps for setting up a health care service in a secondary school were described:

1. identifying need
2. consulting with stakeholders
3. working out what is feasible
4. finding a suitable location
5. recruiting staff
6. developing practice policies
7. protecting records
8. developing protocols with other practices
9. clarifying governance issues
10. promoting and launching the service
11. devising a monitoring system (Ministry of Health 2004b:6−22).

Building on these guidelines, a literature review was undertaken to identify critical success factors for adolescent health services delivered in schools (Winnard et al 2005). Evidence was sought for the influence of variables related to school health services on equity of access, health outcomes, patient satisfaction and continuity of care. Four important components of effective school health services were found:

1. wide engagement with school and community:
    a) engagement with school
    b) engagement with community
2. youth focus and participation:
    a) youth-friendly staff and facilities
    b) assurance of confidentiality while respecting family values and connections
    c) youth participation in planning and service delivery
3. delivery of high-quality comprehensive care:
    a) addressing the importance of culture
    b) a multidisciplinary approach
    c) screening and preventive care
    d) engaging adolescent males
    e) appropriate staffing
    f) facilitating access to other services
    g) safety standards
4. effective administrative/clinical systems and governance to support service delivery:
    a) administrative/clinical systems
    b) staff professional development and administration time
    c) governance
    d) evaluation and quality improvement practices (Winnard et al 2005:4−6).

In terms of providing health care to young people outside mainstream school settings, there is no single best model, but evaluation of various models suggests that the most promising outcomes for significant, long-term health gains are from intensive, integrated services with continuity of care (Fleming et al 2004). Services also need to be youth friendly, culturally sensitive, easy to access and able to address multiple issues and systems (Fleming et al 2004).

3.5 The benefits of school-based health services

School-based health services can reduce a number of barriers to care identified by young people (Winnard et al 2005). An evidence-based review of the effectiveness of youth-specific primary health care found that these services clearly enhanced access and utilisation (Mathias 2002). Some showed particular benefit for young people who are socioeconomically disadvantaged, female and at risk; the evidence as to whether access for ethnic minorities is increased was not consistent. For youth using school-based health clinics, there was increased access for rural youth compared with urban youth (Mathias 2002).

A number of benefits of accessible, high-quality primary health care for young people within school health services have been identified (Alcorn 2001; Winnard et al 2005). These include:

- improved child and adolescent health outcomes
- improved health outcomes of communities
- the potential to enhance student educational outcomes by improving their physical and mental health, thereby removing barriers to learning
- promoting long-term healthy behaviours.

School-based health care may address previously unmet health needs. A survey of students at a secondary school where a school-based health centre had been established the previous year found most students (79 percent) reported using their family doctor as their usual place of health care, and most (80 percent) had been to this doctor in the previous 12 months (Denny et al 2005). This result was similar to findings from the national survey of youth health. In addition, almost 40 percent of students had attended the school-based health centre in the previous 12 months, and for 9 percent of students it was their usual place of health care. These findings suggest school-based health care does not displace accessing a family doctor, but is additional to it (Denny et al 2005).

The AIMHI Healthy Community Schools initiative has incorporated social services and nursing services, including a comprehensive and holistic health assessment for all Year 9 students and the follow-up of any identified needs (Sinclair and Greenwood 2005). Improving the health, education and social service outcomes for young people within AIMHI schools has been most successfully demonstrated across the following areas:

1. educational achievement:
    - the improved ability to learn
    - improved levels of educational achievement of students
2. access to health and social services:
    - improved student access to primary health
    - improved student access to social support
    - improved student access to specialist services
    - an improved approach to health, education and welfare services to ensure improving accessibility of services by a systems approach or service shifts
    - improved management of students requiring chronic care

3. health of students:
    - the developing resilience of young people
    - reduced numbers of sports-related injuries
    - improved sexual health
    - improved knowledge of nutrition, exercise and weight
    - improved hearing and vision of students
4. development of school-based health services:
    - developing a culturally competent service
    - the development of and advancement of the role of the school nurse
    - the development of school-based health centres (Sinclair and Greenwood 2005).

The health needs of younger children, and of the communities to which they belong, may also be addressed through school-based health care. An Auckland study aimed to determine the feasibility of establishing a nurse practitioner-led, family focused primary health care clinic within a primary school environment as a means of addressing the health needs of children and families (Clendon and White 2001). A community needs analysis was undertaken, using demographic data, 17 key informant interviews and two focus groups. A range of health issues were identified, the most prominent being the prevalence, management and control of asthma in the community; poor nutrition of children; poor or inappropriate parenting skills; the need for more health education for parents; high refugee and migrant population health needs; the lack of readily available health information; and concerns about poor access to health services.

The study resulted in the development of a plan to establish a nurse practitioner-led, family focused primary health care clinic based in a primary school in Central Auckland. Such a clinic was subsequently set up in another Central Auckland community with high health needs and low socioeconomic status, offering health promotion, health education, assessment, referral and the treatment of minor illness and injury to children, families, school staff and the community (Clendon 2003). The most common reasons for contact with the clinic were skin conditions, health education/promotion, ear conditions and asthma/respiratory conditions. Specific intervention initiatives were targeted at individual, family and community levels for those with skin conditions, asthma and ear problems.

Comparing data for children from the clinic area who visited Starship Hospital before and up to 18 months after the clinic was established showed decreases over that time in the number of visits (inpatient, outpatient and emergency) for general paediatrics, surgery, and ear, nose and throat (ENT), although only the ENT results were significant at the $p = < 0.05$ level (Clendon 2004/2005). These results could also have been influenced by other community factors such as the establishment of a GP clinic in the neighbourhood and changes in the demography of the community. Nevertheless, the author of the evaluation considered the findings showed the school clinic was improving health outcomes for children with the particular health needs that had been targeted for care (Clendon 2004/2005).

The milieu of the clinic was also shown to have significantly influenced participants' perceptions of effectiveness. This included consideration of the cultural context in which the clinic was situated; understanding health problems in relation to individual

life circumstances; and communicating in a non-judgemental manner, in language that was easily understood (Krothe and Clendon 2006). These factors were important in influencing clients to take greater responsibility for their health (Krothe and Clendon 2006).

An evaluation of nursing innovations across a number of sites included one where the innovation aimed to improve the local rural health services though the provision of free self-referral drop-in nursing clinics in locations that could be conveniently accessed by targeted client groups. One of these was at the local college and included four clinics a week: three nurse-only and one with a GP. The evaluation found that over time there was evidence of an increased uptake of health services by students, and in particular by male students. School representatives reported the promotion of youth 'ownership' of the school clinic, student comfort with nursing practice, and the integration of care across clinics and home as key success factors (Ministry of Health 2007).

3.6 Summary of the literature

Most young people consider themselves to be healthy, but their engagement in known health-risk behaviours raises concerns for their health and wellbeing. In addition, young people identify a number of barriers to accessing traditional health care.

To better meet their health needs, school and community-based services for young people have been developing in New Zealand over the last 10−15 years. These are continuing and expand the tradition of school and public health nursing which has existed in various guises since early last century. A variety of models of youth health care exist, including traditional general practice services, school-based clinics (providing varying levels of service), visiting nurses and other professionals, school health education programmes, community-based youth health clinics, and family−school−community collaborative ventures.

Effective school health services need to have:

- wide engagement with their school and community
- a youth focus and participation
- delivery of high-quality comprehensive care
- effective administrative/clinical systems and governance to support service delivery.

Youth-specific primary health care has been shown to enhance access and utilisation of services, and to improve education and health outcomes.

4 Findings from the Interviews and Surveys

4.1 Response rate

The survey of principals

This survey attempted to contact every secondary school principal in New Zealand. Three hundred and thirty-six emails were sent out and 154 valid responses to the survey were received. A small number of email addresses were returned 'invalid'. There was thus a response rate of 154 valid responses from 336 secondary school principals, or 46 percent. This rate is not unexpected for a group of busy professionals who have been contacted via email. It is also probable that some principals might have little interest in taking part in a survey of health services in their schools.

The survey of nurses

We attempted to locate all nurses working in secondary schools and sent forms to all 336 secondary schools as well as to public health nurse managers, but with no way of knowing the number of nurses in schools we could not be sure how many responses we would get. Of the total 559 questionnaires that were sent out, we received back 267. Of these, 32 were completed by the 'first aider' at the school, usually either a teacher or administrative staff member trained in first aid. These surveys were removed from the analysis, although some data from them were analysed separately. This left a total of 235 surveys, all completed by nurses working in secondary schools. We do not know the size of the population of nurses working in secondary schools so cannot provide a response rate.

Some nurses − public health nurses in particular − work in more than one school, and there are a few schools that have more than one nurse. The relationship between the number of nurses and the number of secondary schools is therefore not one-to-one. However, as there are 336 secondary schools, and we received responses from 235 nurses, it would seem that we have reached a high proportion of the total potential number of nurses who work in secondary schools.

4.2 Findings

The findings from the principals' survey, the nurses' survey and the interviews with nurses are reported together under the main theme areas or topics. The sources of data from each part of the research (the two surveys and the qualitative interviews) are identified within each topic section.

4.2.1 Background to clinics

Although there is a long history of the presence of nurses in schools, it is only relatively recently that there have been on-site comprehensive health services. These are regular, on-site clinics with nurses and sometimes visiting GPs and other health providers; in some areas these are administered through the public health divisions of DHBs and in other cases by a local PHO; sometimes they are extensions of local youth health centres; some are AIMHI schools;[4] and in others the school itself

[4] The AIMHI schooling improvement programme includes nine decile 1 urban secondary schools, eight in Auckland and one in Wellington, with high proportions of Pasifika and Māori students. The AIMHI

organises and funds the clinic, or obtains funding from a charitable trust, as a consequence of the recognition within a school that students' health needs were not being met.

Legally, schools are required to employ a first aid-qualified staff member to deal with incidents and injury, and most schools comply, with 93 percent of principals stating there was a staff member with first aid training at their school. From the survey of principals it appears that around three-quarters of schools also have a nurse on the staff, some undertaking administrative tasks as well as nursing activities.

Public health nurses have long had a presence in schools, both visiting regularly and attending on request for health issues identified by teachers. Schools were also the places where immunisations took place, as most young people could be located there. In some cases, when asked about the origin of the nursing services in the school, nurses interviewed would say that they had 'always been there' but often in quite a different form; for example, the tasks of the earlier school nurse might be 'putting on band aids', the nurse being 'in the job for 25 years' but not undertaking any professional development. The nurse was also often seen as an administrative assistant. In some cases nurses were still working to change these job descriptions.

The schools covered in this study included every type of health service arrangement listed above. In the survey of principals, about a third of principals indicated that the nurse in their school was employed and paid by the school; a further two-thirds indicated the nurse was paid by some other agency. In the nurses' survey, just over one-third of nurse respondents indicated that they were employed by schools. About a quarter were employed by public health, and in about one-third of schools nurses were employed by DHBs.

In some cases nursing services have come about in response to a case being put to the board of trustees to alleviate an extremely over-extended school administration staff member with a first-aid certificate. In other areas the school clinics are administered and funded by local PHOs, developed as a consequence of awareness that youth health needs in a geographic region were not being met − sometimes because local practitioners realised they were not seeing young people, sometimes as a result of a study of heath services uptake. However, it appears that only a very small proportion of nurses in schools are employed by PHOs (around 2 percent of nurses surveyed).

Funding for the school health services comes from a variety of sources, including regional public health; DHBs (in addition to public health); the AIMHI schools, with funding from Healthy Community Schools (HCS); as well as the DHBs' and the schools' own funds. Others are paid through the schools' operations grants, sometimes backed up by funding for international students, and in some cases they are funded by community or other grants. Some are funded by PHOs.

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group of schools was established in late 1995, and from 2002 onwards the AIMHI Healthy Community Schools initiative was established to co-locate community health and other services on school sites.

4.2.2 Employment of nurses in schools

Principals surveyed were asked whether there was a nurse in attendance or visiting their school, and 75 percent indicated that there was.[5] In addition, 29 principals indicated that more than one nurse attended or visited their schools (out of a total of 154).

They were asked further whether the nurse was a 'school nurse',[6] employed and paid through the school, and 35 percent of principals responded positively.

Table 1: Health services in school
(Principals' survey)

	Yes	No	Null
Does your school normally have a nurse in attendance (or visiting)?	112	37	5
	75%	25%	

Note: Null responses indicate respondent did not answer question or response was invalid

Table 2: Numbers of school nurses
(Principals' survey)

	Yes	No	Null
Is your nurse a 'school' nurse − employed and paid through the school?	50	92	12
	35%	65%	

A total of 37 of the principals who responded indicated that there was no nurse at their school (out of a total of 154). However, for some of these schools, at least, there are some health services available, including nurses, doctors and counsellors (see section 2, Appendix 3). For those principals who indicated that there were nursing services available, the 'first' nurse at the school was equally commonly either a public health nurse or a school-employed nurse. However, if the school had more than one nurse in attendance or visiting, the 'second' nurse was most often a school-employed nurse.

Table 3: Who employs the nurses at your school?
(principals' survey)

	Public health	School	PHO	GP	Youth health	Not sure
First nurse employed by	45	44	8	5	3	2
Second nurse employed by	8	16	6	1	1	0

[5] These data corroborate the survey findings by Smith et al (2004) that about three-quarters of students and staff in secondary and composite schools report that their school has a school health nurse.
[6] Note that the term 'school nurse' used in this document refers to nurses working in schools who are employed by the school. Nurses working in schools who are employed by other agencies, such as public health, are not referred to as 'school nurses'. This reflects the understanding of this term by nurses who work in schools.

Nurses surveyed were also asked to name their employer. These data indicate that more nurses are employed by schools than by either public health or DHBs, although public health and the DHB combined employ the greater number of nurses.[7] Two percent of nurse respondents were employed by a PHO.

Table 4: Who is your employer?
(nurses' survey)

The school	Public health	The DHB, but not public health	A PHO	A youth health centre	Other
39%	25%	30%	2%	Less than 1%	3%

Note: N = 233

'Other' employers named by the nurses were commonly DHBs, sometimes in partnership with another organisation such as a PHO or a youth health service, and community trusts.

Nurses interviewed often expressed a preference for combined funding for school health services (from both health and education) because they see themselves as part of the school community. They also see themselves as making a contribution to education, expressed in the idea that a 'healthy student' is better able to learn and teachers are better able to teach when students' health, behaviour and welfare needs are being met. Some thought that their funding should come through health, but that they were 'on their property dealing with the kids so there needs to be partnership with the schools'. Where the school nurse is paid through the school's operations grant, there was occasionally resentment expressed by school staff that education money was being spent on a health service.

[7] Note that in response to the question 'What is your job title?' almost all the nurses employed by DHBs called themselves 'public health nurses' (see Appendix 5, Table A16).

DHB districts and employers

Nurses surveyed were asked which DHB district they worked in, and these data were compared with the types of employers. The full data are available in Tables A5 and A6, Appendix 5, but are summarised below in Table 5.

Table 5: Type of employer, by DHB district

DHB district	Employers of nurses in schools in order of most common to least common*
Northland	Public health, DHB, the school
Waitemata	The school, public health = DHB
Auckland	The school, DHB, public health
Counties Manukau	The school, DHB, another organisation
Waikato	The school, DHB, public health, another organisation
Bay of Plenty	The school, PHO
Lakes	The school = DHB = youth health centre = another organisation
Tairawhiti	The school = PHO
Taranaki	DHB, the school = public health
Hawke's Bay	Public health, DHB, the school, another organisation
MidCentral	Public health, the school
Whanganui	Public health, the school
Hutt	Public health, the school
Capital & Coast	Public health, the school = PHO = another organisation
Wairarapa	The school = DHB
Nelson Marlborough	Public health, the school, DHB
West Coast	Public health
Canterbury	DHB, public health, the school, another organisation
South Canterbury	DHB, the school
Otago	Public health, DHB
Southland	DHB

* The symbol '=' indicates the two employers are equally common in that region.

Table 5 lists the DHB districts with the employers of nurses in schools arranged in order of most common in that region to least common. One of the main differences is between the North and South Islands, with South Island schools much less likely to have school-employed nurses. Within the North Island the northernmost regions (except Northland) are more likely to have nurses employed by schools than the regions from Taranaki southwards. Schools in only three DHB districts appear to have nurses employed by PHOs (Bay of Plenty, Tairawhiti, Capital & Coast).

4.2.3 Clinic facilities

Table 6: Availability of clinic facilities at surveyed schools

Clinic facilities available	Number	Percent
A school-based health centre with clinic area for nurse	114	49
A room that is used only for health services	88	37
Use of a non-health room such as school hall changing rooms	24	10
Use of some other non-private area (eg, part of school hall)	5	2
Other	42	18

Notes: N = 181. The total number sums to more than 181 as some respondents selected more than one response category.

Slightly less than half the nurse survey respondents had a clinic area for the nurse (49 percent); however, a further 37 percent had use of a room that was used only for health services, such as counsellors. Ten percent of respondents used another room at the school, such as the school hall changing room, and 2 percent stated that they used a 'non-private' area such as part of the school hall. A sizeable proportion of respondents selected 'other' and were using spaces such as the 'sick bay if no students were there', 'whichever room that is available at that time', 'careers room, any empty office available' and 'store room'.

Nurses interviewed described a school cloakroom, a little office, the school hall dressing rooms, the counsellor's office, and the sick bay, while in some schools a dedicated clinic was established. Some of the difficulties nurses described concerning non-dedicated rooms, such as a small office off the school hall, were: the lack of privacy, both in the clinic itself but more often with students having to queue up where they could be easily seen; having to share with other health staff, making clinic time limited; and having inadequate treatment facilities in the non-dedicated room. Nurses also commented that they preferred to be situated near other health staff, particularly school counsellors, because they liked to work as a team. In some cases there were other visiting health providers such as GPs, physiotherapists, Family Planning clinic staff, dieticians and speech therapists, and nurses might need to offer their own clinic space to these providers. In other cases there were excellent facilities available for the nurses' clinic and separate rooms available for visiting providers. Some of the principals surveyed also mentioned the lack of available space as making confidentiality difficult.

Nurses talked about the importance of school staff consulting with the school health team when developing facilities so that appropriate facilities could be provided. These included such things as an adequate treatment room, but also the need to situate toilets where students could come and go privately, and the need for a private waiting area that was screened off from view by the rest of the school.

Many nurses kept their clinical notes as paper files, locked in a cabinet either at the school or at the office if they were public health nurses. Others had access to computers and a variety of different databases, including MedTech 32, the AIMHI database 'Pupil', or one of the school-based systems such as e-Minerva, Integris or

KARMA. However, nurses described difficulties aligning their records with the school systems:

> *[And if the school roll changes they] have to update it because it hasn't been updated since the beginning of the year, so new students coming in, I just to add on [to my database] which is a pain. And they won't [edit the database at the beginning of each year] until week four or five when everything settles down, so of course I've seen 50, 60, third formers by that stage. It's hopeless.*

The availability of computers or suitable software with which to record notes varies:

> *So I'm just getting these statistics down, attendees and follow-up visits, and it will be a big learning curve ...But I've not got my own computer. It's just the one I log on to. So hopefully we can pull out some stats and it will show trends and how popular, and which years are actually accessing the clinics.*

> *At the moment I'm using the truancy officers' database. What we've got is it's loaded onto my computer only, so I'm the only one who's got access to it, and I've just altered it. It's kind of a very, very basic, backwards step from MedTech32. That's what I was used to using, and then I thought about trying to invent a database, and then someone said try this one. That's one thing that would be good: if they could make up a really good system for data entry ... for school nurses. Like MedTech is ideal, but the cost of that ... I think it's free to schools, but then you've got to pay an annual fee of, like $2,500 or something.*

Public health nurses in particular were concerned that there was inadequate sharing of information on children's and young people's health status. For instance, a child might come to their attention and referrals made concerning the child's broader health and social situation. The child might then be admitted to hospital as a result of his or her home conditions, but the paediatrician will not have the information that the public health nurse has been involved and could provide some contextual information:

> *Even if the paediatrician could see, oh, the public health nurse saw them yesterday, I'll give her a call. I mean, we're in the home. When you go into a home and glance around, you get so much information from just those things ...So ideally it would be that every nurse has a laptop and records that are electronic, that are linked into a central child health database.*

4.2.4 Services provided

In the survey nurse respondents were asked to indicate the range of services they provided. Just over three-quarters of nurses provide personal health services and slightly less than three-quarters undertake health assessments. A similar proportion is also involved in providing information to school staff about health. High proportions of nurses refer students to other health providers and undertake health education and health promotion activities.

Table 7: Health services provided

Services	Number	Percent
Refer students to other health providers	212	90
Health promotion	193	82
Health education	184	78
Educating staff on health issues	178	76
Personal health services for students	178	76
Health assessment	166	71
HEADSS[8] assessment	156	66
First aid	133	57
Works as nurse with school to develop a specific health plan	114	49
Home visits	114	49
Prescribing, where appropriate (eg, ECP, antibiotics, Ventolin	108	46
Works as nurse with school to develop a school health plan	102	43
Vaccinations and immunisations	74	32
Other	37	16

The 'other' tasks described by nurses (Table 7) included liaising and/or attending meetings with counsellors, Child, Youth and Family (CYF) services, paediatric care, and Resource Teachers: Learning and Behaviour (RTLBs); running healthy and peer support programmes; and research.

In interviews with nurses, some described providing regular primary care clinics in which they undertake assessments, tests and referrals; prescribe medication; provide education in health-related matters, health promotion and counselling; apply dressings; and so on:

> *I'm seeing an average of about 31 students a day. And that can be anything – headaches, injuries, dressings, medical stuff like coughs, colds, generally being unwell. Lots of sexual health. There's the mental health side of things, drug and alcohol, period pains … And sometimes it's just questions as well: "I'm thinking about having sex but I don't know", things like that. There are things like hygiene as well. I get referrals from teachers to talk to students about hygiene. There are students that come in just for their medication each day.*

[8] HEADSS is a youth health assessment tool referring to home, education, activities, drugs, sexuality and suicide.

I just do basically the looking after the kids if they're injured or become sick at school. We also act in the liaison role with outside services. We've got a really close relationship with the health centre just up here, so it's like a three- or four-minute walk for the kids, so that's really great … And for the Mental Health Unit, and we do a lot with Child, Youth and Family. And we also act as liaison with other staff in the school for students, especially with deans and things like that.

Services …right across the board with everyone … injuries depends on the season, in the rugby season our injuries go up … I do quite a lot of sexual health things, a lot of injuries, quite a lot of skin things like boils, impetigo… asthma… the Chlamydia rate is very high in this area.

The care we give is very much the same as they would receive if they came to their GP. So they would access me two of the sessions and we can do a whole ACC assessment, we now can claim through ACC…I do their dressings. If the doctor's there we sometime suture them. With the GP we do small operations like ingrown toenails, removal of lumps and bumps sometimes, they get laboratory services. So if we need blood tests done I do the bloods. We do sexual health care. We do swabs and any testing and things like that. We do a little bit of − we're probably one area that we know that we're not good in and I'm speaking for myself and the two colleges I work in, is the mental health area because we don't always seem to have a lot of time.

I mean it's a primary health care service, so it's the full everything you'd expect in primary health care for a young person would be accessible through the health service. So everything, from skin, to asthma, to mental health, alcohol and drugs, sexual health, contraception, accident and injury, chronic disease, all those things that young people aren't necessarily accessing through their PHO.

The data on services provided from the survey of nurses are combined into groups in Table 8. These groups indicate the level of health service; for example, the more 'hands-off' service providing referrals, health education and promotion, or a more 'hands-on' primary health care service, including personal health services, prescribing and so on.

Table 8: Services provided by nurses' employer

Service	Employer (%)		
	The school	Public health	DHB
First aid	98	22	25
Health assessment, HEADSS assessment	58	72	77
Refer students, health promotion, health education	81	83	87
Personal health services	69	78	82
Prescribing, vaccinations	26	49	46
Home visits	15	79	73
Develop school health plan, specific health plan, education	53	66	55
Other	19	19	11

Note: N = 235

Many more nurses employed by schools are involved in providing first aid than nurses employed by other agencies. This is not surprising given they are more likely to be on hand during the week (see Table 11), and therefore likely to take on any first-aid tasks. School-employed nurses are less likely to be undertaking health assessments or personal health services, or to be involved in providing vaccinations or administering medications, than DHB-employed or public health nurses. They are also much less likely to undertake home visits than both public health nurses and DHB-employed nurses. There is not much difference between nurses employed by the different agencies in terms of their likelihood to make referrals to other health providers or to develop health plans.

In some clinics the emphasis is on assessment and referral, with very minimal hands-on care for such things as dressings or tests. Nurses interviewed indicated that decisions regarding the level or type of care depend on a number of factors, sometimes depending on who the service provider is, sometimes depending on resources. For example, nurses in schools who are employed by public health work on Well Child and Enhanced Youth Health specifications. While nurses from public health have job descriptions and scopes of practice decided by their employer, other nurses' job descriptions are not always clear − and not necessarily appropriate.

> *I really don't think that they really thought too hard and in-depth as to what a nurse does …they needed a registered nurse to deal with the on-going issues that are in the school …I don't think they gave it any really in-depth thought because they don't know, they are not medical people.*

Many of the nurses interviewed spoke of the advantages of HEADSS assessments. Often nurses would use this assessment tool with students who visited the clinic, and many spoke of their wish that all Year 9 students could undergo a HEADSS assessment. They maintained that the need for HEADSS assessments was:

> *not a decile thing … that every young person [should] have the ability to have that assessment, see what health is about, where am I right now.*

This would not only identify health needs that students have that are not being addressed, but would also provide contextual information about students who may present with health issues in later years.

Moreover, the students' initial visits for assessment would allow them to familiarise themselves with the clinic, meet the nurse, and help overcome any reluctance they might have had to visit the clinic when they needed it. This also arose in comments by principals:

> *[We need] more hours, AIMHI Year 9 health screening to broaden our data base and build confidence to attend [the] health room in the Year 9 age group for future years.*

For nurses, the main factor inhibiting full assessments was time:

> *It's time constraint. I'd love to do a full HEADSS but to do a full HEADSS assessment you [need at least] 40 minutes.*

A nurse in a school with 360 Year 9 students who was undertaking HEADSS assessments noted that by May they had 'only just started on the Bs: If you do 300 a year that is a full-time job'. In some cases the time available was restricted by the school:

> *We do HEADSS assessments ... but it's not always appropriate because you've only got a few minutes with them really. The colleges have said, 'Hey, yeah, great, come on, welcome, but you're not having any school time. It will have to be lunch time'.*

There are some barriers to nurses being able to provide some sexual health services; for example, when boards of trustees are not willing for the nurse to provide the emergency contraceptive pill (ECP):

> *even though surveying the students and that survey demonstrates what the students are wanting, that voice isn't actually heard, and so it's really difficult to get the students' voice heard to the board of trustees.*

Nurses also noted the perception by some within the school community that if the nurses arrange for students to access family planning through the school, or make ECPs or other contraceptives available to students, it is 'encouraging the kids to have sex'. They also described the lack of funding to test girls for Chlamydia, although nurses may prescribe antibiotics once it is detected.

Nurses are often asked to contribute to health and safety measures at the school, and to undertake tasks such as pandemic planning, holding the chemical hazards register, advocating for cleaner toilet facilities for students, and sometimes undertaking administrative tasks such as reception or late attendance monitoring. Some of the nurses interviewed described their upcoming responsibility for the Healthy Eating − Healthy Action project that DHBs were developing in their districts. Responsibilities such as these often meant staying late at school (eg, for meetings of health and safety committees, for which they were not paid). Often the nurses spoke matter-of-factly about accepting these broader and often thankless tasks, seeing their relevance or value, and also recognising the importance of maintaining good, positive relationships with other school staff.

Some of the nurses interviewed mentioned that the MeNZB (Meningococcal B) campaign had taken a lot of time and resources. One nurse explained that they had been told regularly that MenzB had 'gone over' its funding, but it was always being prioritised over their other work.

Nurses interviewed also noted other different needs that were represented within different regions, deciles, communities and schools. For example, the different communities of need would be described:

> *One of our schools is a Catholic school and that gave us a sort of different dynamic from what sort of services we could provide and also they start quite young ... Year 7 right up to Year 13. So you were looking at a different, a broader community of young people and different needs really…and it meant you could collect their information locally. The extended community was*

similar, so what happened in their schools and what they needed in their schools was quite different.

Nurses who worked in schools where there were rural students emphasised the extra difficulties these students experienced in trying to access health care. They are reliant on parental transport, potentially compromising students' needs for privacy and confidentiality, and have to drive long distances, all of which are barriers to their access to health services.

4.2.5 Numbers of consultations

Although the majority of nurses are seeing fewer than 20 students each week, there is a reasonably high percentage seeing over 120 students a week (see Table 9).

Table 9: Number of consultations each week

Number of consultations	Number	Percent
Less than 21	118	50
21–40	28	12
41–60	13	6
61–80	13	6
81–100	9	4
101–120	5	2
120 +	37	16
'Skipped' question	12	5

Note: N = 235

Table 10 shows the numbers of consultations per week, by nurse employer. The low number of consultations undertaken by some public health and DHB-employed nurses reflects the brief clinics they hold at schools – such as one lunch-hour visit at a school every week. In contrast, the large number of consultations undertaken by some school-employed nurses reflects the full-time availability of some of these nurses (see Table 11).

Table 10: Type of employer by numbers of consultations

	Employer (%)*			
Number of consultations	**The school**	**Public health**	**DHB**	**A PHO**
Less than 21	3	22	26	1
21–40	5	3	4	1
41–60	4	0	1	0
61–80	6	0	0	0
81–100	4	0	1	0
101–120	2	0	0	0
120 +	15	0	0	0

* Cross-tabulation percentages

Table 11 shows the hours nurses are available to students for consultation, by nurse employer. Nurses employed by the school are the most likely to be available for over 20 hours per week. High proportions of nurses available for consultation for more than 35 hours a week are 'school nurses' and a reasonably high proportion are DHB-

employed. Most DHB-employed nurses and public health nurses are available for consultation for less than 5 hours each week.[9]

Table 11: Hours available for consultation, by type of employer

	Hours (%)*							
Employer	**0−5**	**6−10**	**11−15**	**16−20**	**21−25**	**26−30**	**31−35**	**Over 35**
The school	6	2	1	2	4	10	7	9
Public health	14	3	2	2	1	1	1	1
DHB	19	2	1	2	1	11	1	3
PHO	1	0	0	0	1	0	1	0
Youth health centre	0	0	0	0	0	0	0	0
Other organisation	1	0	0	0	0	0	2	0

* Cross-tabulation percentages

Not unexpectedly, nurses who are available for consultation for less than five hours are the group most likely to see fewer than 20 students. Similarly, nurses who are available for over 25 hours are the most likely to see 120 students or more each week (Table 12). However, some of the nurses seeing large numbers of students each week are available for less than five hours. This appears to indicate there are quite high proportions of brief consultations with students. Conversely, there are also high proportions of nurses available for more than 35 hours a week who are seeing small numbers of students. This may indicate some long consultations, or it may be that some nurses (such as public health nurses) are available for consultations for most of the week, but not necessarily on-site (they can be contacted by students if necessary).

Table 12: Nurses' availability, by number of students seen

Number of students seen	**Hours available for consultation (%)***							
	0−5	**6−10**	**11−15**	**16−20**	**21−25**	**26−30**	**31−35**	**Over 35**
Less than 21	33	5	2	1	1	3	1	3
21−40	2	1	0	2	2	1	1	3
41−60	3	0	0	1	1	11	1	0
61−80	2	1	0	1	1	1	1	1
81−100	0	0	0	0	0	1	1	2
101−120	1	0	1	1	0	1	0	0
120+	2	1	1	0	2	5	6	4

* Cross-tabulation percentages

When the hours available for consultation are compared with hours of work in the school per week, there is the expected increase in hours available for consultation with hours of work per week. However, there is a fairly high proportion of nurses who indicated that they work for fewer than 20 hours per week who also indicated that they are available for consultation for more than that time – up to and over 35 hours per week (see Table A3, Appendix 5). One explanation for this is that there are some nurses who are available for consultation outside 'working hours.' In both the survey and interviews, some nurses indicated that they were 'on call' outside clinic hours,

[9] Note that when 'type of employer' was compared with 'job title', it was found that most of the DHB-employed nurses called themselves 'public health nurses' (see Table A16, Appendix 5)

could be contacted by cell-phone, or were sometimes approached out in the community.

Table 13: Number of nurses working in multiple schools

Number of schools	Nurses working in this number of schools
2	15
3	5
4	2
5	1
6	4
7	1
8	0
9	2
10	0
11	1
12	1

Note: N = 265

In the survey, nurses were asked to provide the decile rating of all the schools they worked in. This data provided an estimate of the number of nurses working in multiple schools. Some respondents (142 out of the total of 265) did not provide a decile rating. Table 13 shows the spread of nurses working in more than one school across the numbers of schools. This shows that most nurses who worked in more than one school worked in two schools, but some nurses were working in up to 12 schools. Of those who worked in more than one school, all except two described themselves as public health nurses (one provided the job title 'clinic nurse' and one 'school nurse').

4.2.6 Students' use of school health clinics

Nurses were asked why they thought students used school health clinics rather than another health service.

Table 14: Most frequent reasons why students choose to visit school nurse rather than another service

Reason	'Very Often' or 'Often' (%)	'Sometimes' or 'Never' (%)
For reasons of confidentiality	68	27
Because the school nurse is close by (handy) at the time	82	13
Parents are unwilling or unable to pay for GP or other health service	40	53
Student unable to use suitable transport to other health services	58	43
It's 'comfortable' (friends can come too, it's familiar, etc)	84	12
Student doesn't know any other health service	33	61
Student doesn't know how to access another health service	34	60
Student is referred to you by a teacher	36	60
Don't know	2	0

Note: N = 235

The most common reasons nurses gave for why students use school-based health services rather than another service were for reasons of 'accessibility' – in terms of both proximity and comfort. The next most common reasons were 'confidentiality' and 'lack of suitable transport' to another service. A reasonably high proportion used school services because their parents were unable or unwilling to pay for another service, although for over half the nurses this was 'hardly ever' or 'never' a reason. Only a third of nurses thought students accessed school services because they did not know of, or did not know how to access, other health services.

Accessibility

A common reason for students' preference for school health services is their accessibility. This includes students not needing to find and pay for transport, but also the clinic being at school makes it more a part of their everyday lives and so more 'student-friendly'. Other attractions for students are that it might enable them to 'escape' from class, or might provide some respite from bullying classmates. Proximity, as well as the suitability of the clinic, also means that students can bring along friends if they wish.

Confidentiality

The nurses interviewed frequently mentioned confidentiality as a reason for students' choosing school health services. Although the nurses always worked with students' families as far as possible and encouraged students to talk to their families, they indicated that often students prefer to access services independently of their families. This may be for reasons of privacy; for example, students would not want to be seen by family or family friends at the local GP's rooms or the Family Planning clinics.

> *But often their parents go there [Family Planning clinic], or their aunts and uncles, and they don't want to be seen at them.*
>
> *…often these young people don't want to be seen in the doctor's waiting room, because an aunt or something might see them and then say, 'What's your daughter doing? I saw her at the doctor's'…*
>
> *And some of the information they give you, you know they're concerned that the teachers might find out, so once we explain what confidentiality means in our context they are actually quite relieved and they will talk about things and get things done.*

Nurses' concerns regarding students' need for assurance about confidentiality corroborate findings from the study undertaken by Smith et al (2004), which indicate that less than half the students surveyed were confident about the privacy of their information.

Table 15: Reasons for using school clinics, by school decile

	Reason (%)*		
Decile	**Confidentiality**	**Parents unwilling/unable to pay for a GP or health service**	**Student unable to use transport to other health services**
1	5	4	5
2	10	7	8
3	7	5	4
4	11	9	11
5	11	4	9
6	8	4	6
7	3	2	2
8	5	5	6
9	3	3	1
10	5	2	2

* Cross-tabulation percentages
Note: N = 235

Table 15 compares school decile ratings with three of the reasons why nurses considered students choose to visit school clinics 'very often' or 'often'. (More detail is available in Tables A7, A8 and A9 in Appendix 5.) 'Confidentiality' was selected to see whether it remained static across the decile ranges, and 'transport' and 'ability/willingness to pay' were selected as reasons that might show differences across school deciles. It does seem that all three reasons are more likely to be given for lower decile schools than high-decile schools. However, there are peaks in the mid-decile ranges, the reasons for which are not clear. There are also still reasonably high numbers of students in the higher decile schools that appear to have issues around parents' ability/willingness to pay and transport them to other health providers.

These findings concerning reasons why students choose school health services support international and local research, described earlier, that the most common barriers to students accessing health services are:

- not knowing how to access health care
- attitudes and feelings (not wanting to make a fuss, can't be bothered, embarrassment, reluctance to admit problems, too scared)
- distance to travel
- inconvenient times
- don't feel comfortable with the health provider
- lack of cultural appropriateness
- lack of privacy
- concerns about confidentiality
- cost of doctor's visit and/or prescriptions are too expensive (Adolescent Health Research Group 2003a, 2003c; Mathias 2002; Smith et al 2004).

Many of the nurses interviewed were very aware of these barriers to students' use of health services and had already instigated policies and practices that create 'youth-friendly' health services within schools. They described practices they employed to protect students' confidentiality and privacy. These included keeping confidential to

the student information about appointments; texting students with appointments or test results; ensuring that student health notes are not available to anyone else at the school – either through access to records or the computer – and reassuring students of this fact; providing a school intranet site with general health information; and, on occasions, using their own car to deliver students to other clinics.

> *So we've started texting for some students … how do I get in touch with you to let you know and … do you want me to text you? Who else will read this text so I know how much information I need to put on …*

> *And she was happy to go to the family doctor. Well she didn't want her mum there, just because of the relationship, and I said that's fine. I had to battle through the receptionist to get her to the doctor's − the doctor was busy. Anyway, I got her there. I said it's either there or I'm taking her straight to A&E.*

Consultation arrangements

Nurses were asked to select all the ways in which students arrange to visit their clinics. Most nurses indicated that students may be referred by teachers or other health professionals, but in many cases students make their own appointments or just queue up (see Table 16).

Table 16: How students arrange to meet the nurse at school

	Percent
Students make own appointments to visit you	70
Students just queue up	75
Teachers make referrals	81
Parents make referrals	60
Counsellor or other health professional makes referrals	80
All Year 9 students attend for assessment	10
Don't know	0

Notes: N = 235. Totals sum to more than 100% as respondents could select more than one option

High proportions of nurses indicated that teachers and parents sometimes refer students to the school clinics. This implies positive attitudes from teachers and parents towards the health services provided at schools. The high numbers of nurses who indicated referrals from counsellors or other health professionals also suggests positive and collaborative working relationships between nurses and individuals from these groups.

Table 17: How consultations are arranged, by type of employer

Arrangement	Nurse employed by (%)		
	The school	Public health	DHB
Students make own appointments to visit you	60	78	72
Students just queue up	87	59	73
Teachers make referrals	81	76	86
Parents make referrals	59	53	63
Counsellor or other health professional makes referrals	79	74	86
All Year 9 students attend for assessment	16	2	10
Don't know	0	0	1

Notes: N = 235. Totals add to more than 100% as respondents could select more than one option

Students are somewhat more likely to 'just queue up' to visit school-employed nurses than to visit nurses employed by other agencies or organisations. They are more likely to make appointments to visit the public health or DHB-employed than school-employed nurses. Teachers, counsellors and parents more commonly refer students to DHB-employed nurses than to nurses employed by schools or public health. More school-employed nurses are undertaking health assessments of all Year 9 students than nurses employed by other agencies.

Nurses interviewed emphasised the importance of encouraging students to develop independence, and therefore of assisting them to take responsibility for their own health and to access health providers independently of the school service. They see their role as facilitators in this way; students will not always be at school, clinics are not open in school holidays, and it is important that young people learn to be aware of and attend to their own health needs. They also talked about the advantages of students visiting their family GP because they have the student's medical and health history.

Although all nurses attempt to encourage students to use their own family GPs, some are less emphatic about this and will find ways of accessing another GP to meet a student's health needs. The difference in approach here may well be one of access and availability: for some areas, or some students, where it is more likely that students can and will access their own GP, nurses are likely to support that; in other areas or for other students, where it is unlikely students can or will access their own GP, nurses will find ways around this.

Public health nurses described strong links to families. Within public health units nurses were responsible for all school-aged children, and worked with families through their links to schools:

> *So it's really school-aged children: we don't cover universities and we don't do pre-schools. Having said that… when you're dealing with the family, as there's a big link between school and family, there might be pre-schoolers there and you're giving out health information, you wouldn't ignore it if somebody had a younger child who had, say, rotting teeth. You'd give*

information and help out someone with access to services. So it's a big link thing with home and school. That's a huge part of our job, really.

4.2.7 Scope of services

Nurses surveyed were asked to indicate the most common reasons why students attend their clinics.

Table 18: Most common reasons for consultations

Reason	'Very Often' or 'Often'		'Sometimes' or 'never'	
	Number	Percent	Number	Percent
For advice on sexual matters, contraception, STIs, etc	168	72	54	23
For advice on healthy eating, etc	44	19	178	76
For advice on fitness, physical activity, etc	25	11	194	82
For advice on weight loss or body shape	31	13	191	81
For treatment for injuries or general sickness (eg, sprains, asthma, headaches, skin conditions)	149	63	72	30
To talk about mental health issues such as depression, anxiety	79	34	144	61
To talk about coping with family problems	75	32	147	63
Bullying/violence issues	47	20	174	74
For advice on smoking cessation	14	6	206	88
For advice on alcohol or drugs	32	14	188	80

Notes: N = 235. STI = sexually transmitted infection. Totals across table are less than 100% as some respondents did not provide any responses to some options.

The most common reason students seek consultations is for advice on sexual health/contraception, and the next most common is for treatment of injuries and general sickness. High proportions of nurses indicated that students 'hardly ever' or 'never' seek consultations for advice on lifestyle issues, nutrition, exercise, alcohol and drugs, or smoking. Only about a third of nurses indicated that students seek help from the nurse for mental health issues or family problems, and a fifth are likely to see the nurse because of bullying issues.

'Other' reasons nurses cited for students seeking consultations included help with school projects, hearing/vision testing, just wanting to talk to someone or wanting information on health issues, and for health assessments. A number also indicated in this free text section that students come for help on relationship or family issues, or for mental health issues.

In the survey, nurses were also asked who determined their scope of services.

Table 19: Scope of services

Who determines scope of services	Number	Percent
The school	10	4
The employer	60	26
Both in consultation	79	34
You alone	3	1
Not employed by an organisation outside of the school	61	26

Note: N = 235

For nurses employed by an organisation outside the school, their scopes of service were decided most often by the employer in consultation with the school, and next most often by the employer alone.

Nurses interviewed described how the role of the nurse in schools is commonly misunderstood, and that nurses often have to negotiate the role over time. A new registered nurse appointed to a school would begin by having to undertake school administration tasks, such as reception, lost property, enrolments and so on in addition to any nursing tasks. One nurse described continuing negotiation with the school management team so that after two years she managed to be doing just nursing. This sometimes led to resentment from other support staff in the school. Nurses frequently described their own initiative and advocacy to senior school staff regarding the need for extended health services. However, in the survey some principals indicated an awareness of the advantages of a 'dedicated' nurse:

> *[We would like] more time allocated – currently the nurse combines her nursing duties with reception duties, and they tend to dominate.*

> *Have the government recognise that this is an essential service and provide for it properly within the operations grant. Then we could offer better pay scales and keep the fine people we recruit, who sometimes leave.*

Where there was a lack of understanding of the role of the nurse in the school, nurses would often develop considerable autonomy in determining their role and sometimes worked with other school nurses to formulate an appropriate role and job description.

> *The job description that I was given at interview, I wasn't happy with quite a bit of it, so we're working in with each other to try and actually formulate the role really. So … they're very supportive of whatever it takes to get this up and running.*

In some cases nurses described reacting immediately to pressing needs. For example, a nurse employed by a PHO which had opened clinics in four schools in response to a perception that they were not seeing young people in their practice commented:

> *When all four clinics opened it was sort of like go, and we were sort of running and just responding to what was coming in rather than actually developing some sort of structure as to how we should deliver care. And I*

think that has taken us quite a long time because we don't seem to get a time to have a break.

A nurse from public health commented:

Because it's really driven by the students and their needs. So it really is what comes through the door and you never know what it might be from day to day.

When setting priorities, nurses worked with the specifications of the job within the school or within their contracts, looked at the minimum level of service and then the priorities, and worked out how far their services could reach. Sometimes a school profile was undertaken to see what services were available in the community, and what the trends and issues were for health needs, and these were considered alongside the national and local priorities set by public health.

Comments made by principals indicated that in many cases they have their own views on what sorts of services they like to see available in their schools (see Appendix 4). A total of 26 principals described the services of a doctor or GP as being available in their school. Doctors are available at schools for a range of times, from one hour a week through to three days a week, and one described availability 'at school and as a referral during school hours'. In some cases doctors were described as being available at a local youth health centre. However, an additional 14 principals also stated that they would like to have the services of a doctor at their schools, or, if they were already available, would like these services extended:

Need longer hours available for nurse and doctor. Nurse here 7 hrs per week. Doctor here 3 hours.

Our local doctor holds a clinic here for 2 hours once a week. We could easily extend this to 3 or 4 hours.

We are exploring the possibility of bringing in a doctor once a week for students who do not have or are unable to access a GP.

We need a doctor in our health centre 30 hours a week. We have superb facilities but there is a paucity of doctors wanting to be school doctors.

Around a quarter of principals considered that the scope of nursing services provided did not meet the health needs of their students, and of these about a third wanted extended hours for the nurses. Other principals saw a need for additional sexual health/family planning services, mental health/counselling services, and for the nurse to take part in health education and health promotion activities. There were also some who wanted extended hearing, vision and dental services.

Over recent years there has been increased mainstreaming of children with chronic health conditions, many requiring the assistance of the nurse at school (eg, students with pacemakers or feeding tubes). There is also a role for the nurse in enabling the student to manage their own condition:

There's a very big role [for] the registered nurse in the management of chronic conditions. And that's not necessarily managing them, but teaching the young person to manage them through their journey in life so that they can leave school at 18 and … this kid who is epileptic, knowing how to manage that … how to access the health system.

To manage through the period of conflict where the student doesn't want to do what the parents have been telling them to do for the last 15 years and you have to manage. You might have a kid who is diabetic who's refusing to take their insulin.

Nurses also described educating school staff in the management of students with chronic illness:

And the other thing with schools with diabetics, educating the teachers as to the needs of those diabetic kids … [One student] felt she was going hypoglycaemic, needed to eat, no you can't eat you're in class and what happened, she ended up in trouble. It's an education thing.

The issue of the safety of students with chronic health needs was raised, as some parents were stating that schools were not providing a safe environment for their children because no one knew how to manage their children: 'It's a huge responsibility on untrained staff in schools.'

There was one view expressed that the scope of practice of public health nurses in schools is firmly within the public health area, which does not include primary health care:

I'm seeing a child … tell me about the family, tell me about the house, tell me about the street, tell me about the water that you drink, tell me about the food that you eat, tell me about your class, tell me about your teacher, tell me about the middle school, tell me about the whole school, tell me about the school grounds, tell me about the street that your school is in, tell me about your water, tell me about what you eat. That's what public health nurses look at …they're not primary caregivers… [they] are delivering health advice and support to well children as well as unwell. Their focus is on the health of the community, not just those that are sick.

4.2.8 Links to other services

Principals were asked about other services available to students at their schools.

Table 20: Health services available at school

Health service	Number	Percent
Teacher or other staff member with first-aid training	143	93
School counsellor available at school	141	92
Regular clinic with nurse from outside organisation	93	60
Hearing/vision testing available at school	59	38
Dental services available at school	46	30
Regular clinic with school nurse on staff	43	28
Physiotherapist available at school	33	21
Other services	36	23

Most schools have a first aid-trained staff member and a counsellor, and high proportions have a regular clinic with a nurse. In addition to the hearing and vision, dental and physiotherapy services, a number of principals also indicated the availability of 'other' health services at their schools. These included doctors, other counsellors, other nurses, family planning, other sexual health services, Māori providers of health and social services, social workers, mental health services or psychologists, and health support workers.

It appears that schools that have one or more nurses are also more likely to have other health services (such as counsellors, doctors, Māori service providers) than schools that have no nurse (see Appendix 3, section 1). This may be a reflection of the higher needs of students in these schools, but it is also very likely a reflection of the fact that the nurses at these schools are active in linking students to these other services.

The survey asked nurses about other health or social service providers to which they referred students. High numbers of nurses refer students to counsellors and GPs; referrals to Family Planning clinics and medical specialists are also commonly made (see Table 21 and Figure 1). These rates of referral reflect the reasons why students visit, as indicated by the nurses (see Table 18 above); that is; most commonly for advice on sexual matters, and about a third of consultations are to talk about mental health and family issues.

Table 21: Referrals to health or social service providers

Nurses refer students to:	Number	Percent
Counsellor	206	88
Own family GP/PHO	189	80
The Family Planning clinic	152	65
A specialist	126	54
Another GP/PHO	100	43
A youth health centre	93	40
Social worker	84	36
A GP who makes regular visits to the school	83	35
Resource Teachers: Learning And Behaviour (RTLB)	82	35
Do not make referrals	5	2
Other	57	24

Note: N = 235

The 'Other' providers listed by nurses in the survey included mental health providers, social workers or CYF, other nurses, sexual health services, dentists, physiotherapists, hearing and vision therapists, GPs, youth health centre, and other school staff. The full list is available in Appendix 7.

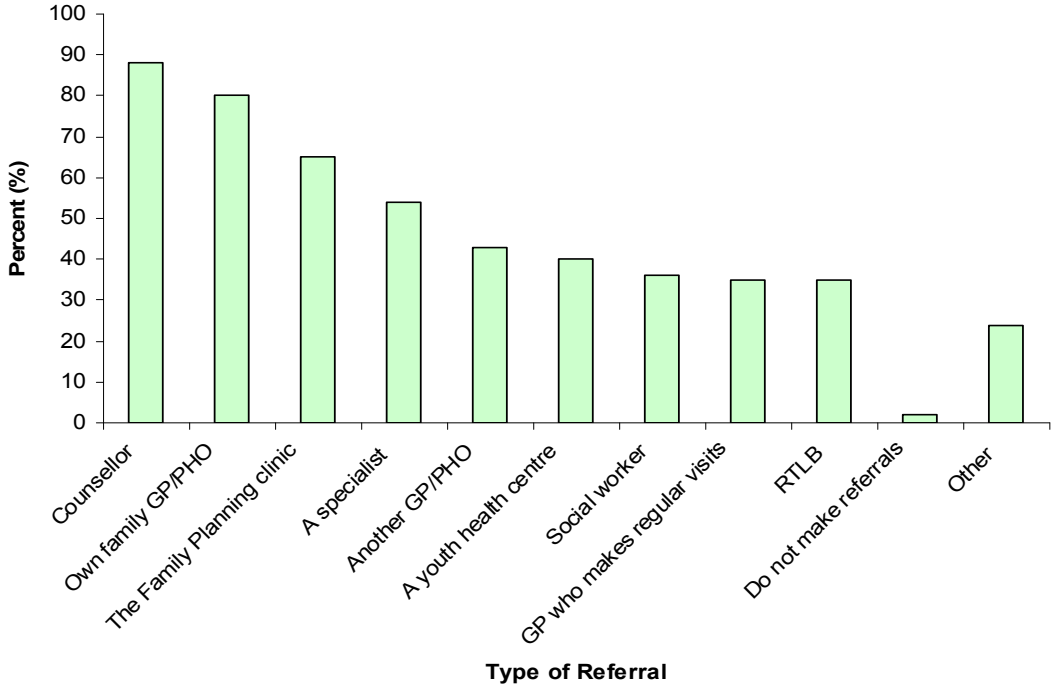

Figure 1: Referrals to other health or social service providers

School-employed nurses are the most likely to refer students to GPs other than family GPs, and to counsellors (Table 22). They are less likely to refer students to specialists, a youth health centre or a social worker than DHB-employed or public health nurses. DHB-employed nurses are slightly more likely to refer students to their own family GP/PHO, a Family Planning clinic and a social worker than other nurses. Public health nurses are more likely to refer students to a specialist and a youth health centre than nurses employed by schools or DHBs.

Table 22: Referrals, by type of employer

	Percentages of nurses employed by:		
Nurse makes referrals to:	**The school**	**Public health**	**The DHB**
Own family GP/PHO	81	79	83
Another GP/PHO	52	45	32
A specialist	42	67	58
Family Planning clinic	65	62	69
Youth health centre	30	50	45
A GP who makes regular visits to the school	44	26	32
Social worker	25	43	45
Counsellor	95	84	85
RTLB	38	38	32
Other	24	24	27

Note: N = 235

The nurses surveyed were also asked about their schools' levels of need for other health services.

Table 23: School's level of need for providers listed

	Level of access (%)				
Provider	**Adequate access**	**Some access, but needs more**	**No access, but needs**	**Does not need**	**Don't know/NA**
Social worker	24	29	26	4	14
Psychologist	15	29	25	5	21
Occupational therapist	13	6	13	24	37
Counsellor	64	29	3	0.4	1
Drug and alcohol counsellor	32	38	15	2	11
Sexual health nurse	46	31	12	2	6
Fitness adviser	32	23	16	6	21
Family adviser	17	19	20	3	33

Note: N = 235

The only health providers that a majority of nurse respondents considered their schools had adequate access to were counsellors. The principals' survey indicated that 92 percent of schools had counsellors available. However, only around two-thirds of nurses think the availability of counsellors is adequate, and almost a third indicated that more access is needed. More than half of nurse respondents considered their schools need better access to social workers, psychologists and drug and alcohol counsellors, and high proportions also considered there was less than adequate access to sexual health nurses, fitness advisers and family advisers.

Nurses interviewed described links to local health centres, youth health centres, GPs or PHOs with whom they had 'close links' or 'good relationships' and where students would be referred when necessary. Often this was for confidentiality reasons, but other reasons included that their families could not pay, had no phone and could not be contacted; there was no suitable transport; or for some other reason the families did not co-operate in getting the student to the GP:

I would like a GP in here once a week but I am having trouble finding one that will commit to two hours a week or something like that because ... kids have needs and there are things that I want to be seen and the parents won't do this.

...usually [I refer to] the family GP, but if it's sexual health it might be [named local youth health centre]. You have to give them the options. You can't make decisions for them. Well look, there's [local youth health centre], there's your GP, you wouldn't discount the GP, but quite often what you find is that for sexual health they don't want to go to the GP cos mum will find out – they don't want their mums to find out.

...we have access to direct referrals to paediatricians and specialists and things here, and often send a copy to the GP if we want, or encourage the person to go to the GP, you know, give them some options. Empower people, really.

The nurses interviewed also described their own links and referrals to a wide range of other services. These included: youth mental health units, Child, Youth and Family, Family Planning, paediatricians and other specialists, district nurses, public health nurses, physiotherapists, asthma educators, quit smoking services, alcohol and drugs services, counselling services, social workers, dental services, as well as liaising with teaching staff at the school:

But the nurses do not wait for a referral. They will do a referral and say, 'I have started by doing ...' So they also have a process where they follow up because, particularly − there's a government agency that is particularly difficult to bring on board, and we've had four notifications in the last week of term last year and beginning of March they still have not contacted the family... So that's why there's that process in place. All referrals are followed up.

I'm not a trained counsellor ...and then I thought I'm sure there's [quit smoking] specialists out there on [named] Marae...[I] spoke to some quit coaches there, they're trained in that. I think its win-win. We'll tap in. Why should we do a job that they're specialised in? So it was a good link ...that's how I see my role, as a link person.

Sometimes nurses referred to the proximity of other health services that students might be referred to. Services close by are an advantage not just because they eliminate transport problems, but also because they mean that students do not have to be absent long from school in order to attend:

If I send a kid out they don't come back to school today, or drop them somewhere they don't come back to school. When they've finished they'll still be down town so they get picked up by the cops and brought in. So everything really needs to be a one stop shop, I guess.

However, whereas a GP clinic at school might have all the advantages of easy availability, it does not promote students' independent access to health care.

Nevertheless, some schools do have GP clinics, and nurses sometimes spoke of the need for such a clinic, especially in cases where there is no accessible local clinic. Sometimes students are referred to Family Planning clinics, although this is not always ideal as they may be seen there by family members or friends of family. Occasionally, Family Planning team members will make regular visits to a school. Seven of the principals surveyed mentioned Family Planning as one of the services available at the school, either a Family Planning doctor or nurse, or just Family Planning generally.

Where nurses have relationships with local GPs or the Family Planning clinic doctors, they sometimes develop standing orders to administer medication for students; in other cases standing orders' templates are developed by a working party from a DHB, for example, and nurses undertake training before using standing orders under agreement with a GP. One of the major advantages of the nurse being able to administer medication is that the student can have the prescription immediately, instead of having to miss up to half a day's school being referred to a GP.

As mentioned earlier, interviewed nurses frequently referred to the importance of working with students' families, and of their preference that students talk to their parents and keep them informed and draw on family support. However, sometimes families do not provide the needed support, or students for their own reasons prefer to access health services independently of their families:

> *If I've asked three times for the family to take a student to the GP and they haven't done it, then I will just do it.*
>
> *Quite a few of our kids' parents don't have phones. I just can't contact them.*
>
> *I'll work with the child's interests. I don't work for the parents or the principals or teachers. I work for the children. So if I think it's in the children's best interests if they need to see a GP, I will take them to see one*.

They also noted that there are particular difficulties for rural students in accessing other health services:

> *In [this city district] we have a lot of different services with the child and adolescent centre here, but those services are not available in the rural districts, and getting to them is always a real problem. There's no finance for young people to get in here, and sometimes it is a confidentiality issue. We do encourage people to talk to their families and to get support that way more than anything, but it's just not an option for some young people. Transporting and access, and availability of service in a place they feel comfortable.*

The health services to which nurses most commonly refer students are counsellors, and almost all nurses interviewed spoke of the good working relations they had with counselling staff at their schools. In most cases they are located in offices near to counsellors and work collegially with them, seeing themselves as part of a 'pastoral care team', and often students are using both services. The nurses interviewed found it helpful to have counselling staff close by, and in cases where they are physically

distant, or on very rare occasions where there are poor relationships, nurses spoke with regret about the loss of this helpful working relationship.

Inspection of the comments by principals also shows that there is a wide range of issues of concern to them in terms of availability of services. The complete set of responses is available in Appendix 4, section 2, but following are some of the comments that indicated services could be improved or extended:

> *A one-stop shop with medical, social service and police personnel on hand at least some part of each day would be helpful.*
>
> *Concern about access to mental health services for students who are seriously at risk of self harm. Currently when there is a crisis situation, the family has to drive the student to obtain services, nearly a two hour drive across a mountain pass.*
>
> *Funding of health services is appalling! Our school of 900 students has 1 hour from a visiting doctor and 1 hour of a visiting 'sexual health' nurse. And nothing else! We have arranged for a physiotherapist to visit – he funds himself (ACC).*
>
> *Most health services are outside the school and town, especially specialist services, no public transport to services in larger centres.*
>
> *Real issues with access to health services in general and mental health in particular for rural students.*
>
> *Students have [a] very good service for pregnancy testing and advice re contraception. Would like to have the same level of service available for other medical and health concerns.*
>
> *We are exploring the possibility of bringing in a doctor once a week for students who do not have or are unable to access a GP. Some difficulty in getting health professionals to case conference so that they are not all working in isolation with individual students. Important to know that anything affecting a student's learning is reported back to the school somehow.*

Nurses noted that even if there was a range of health services available to families and young people, the greatest need for young people is being able to gain access to these health services:

> *The biggest thing is about how do they engage, and that's our priority: to get them to engage. And in long-term health, asking for help and seeking information from health … it may be a GP … a Māori health provider … but there's a big step for youth to make, between taking responsibility for their health and actually engaging in health.*

4.2.9 Health services and schools

Most of the principals surveyed (75 percent) received regular reports about clinical activities undertaken by the nurse, and over half (57 percent) indicated that reports also go to boards of trustees. In the survey of nurses, 80 percent of nurses indicated that they reported to senior staff within the school (principal, deputy principal, etc) and 35 percent indicated that they reported to boards of trustees (Table 24).

Table 24: Nurses' reports on activities

Report on activities to:	Number	Percent
Senior staff within school, principal, deputy principal etc	188	80
Outside employer	69	29
The board of trustees	83	35
No-one	8	3
Other	45	19

Note: N = 235

Table 25: Reports to boards of trustees

Nurses report to BoT through:	Number	Percent
The principal	90	38
Your employer, other than the principal	29	12
Directly	40	17
Do not report to the board of trustees	64	27

Note: N = 235

Of nurses who indicated that they report to boards of trustees, most of these report through the school principals, although some report directly (see Table 25).

Table 26: Subjects of reports

Nurses report to BoTs on:	Number	Percent
Throughput	75	32
Types of services offered	89	38
Other	40	17
Do not report to the board of trustees	58	25

Note: N = 235

Type of services offered were reported on by 38 percent of nurses, and 32 percent reported on throughput (Table 26).

'Other' subjects of reports that respondents mentioned included:

- projects
- statistics, improvements to the health centre, goals/changes for following year
- goals, achievements, emerging issues/trends, recommendations for service, health promotion, policies etc; link with DHB strategic plan
- trends observed where education needs to be addressed.

Table 27: Reporting, by type of employer

	Nurse employed by (%):					
Reports to:	**The school**	**Public health**	**DHB**	**PHO**	**Youth health centre**	**Another organisation**
Senior staff within school	91	72	76	40	0	71
Outside employer	2	52	37	80	100	71
The board of trustees	36	41	31	0	0	57
No-one	1	2	7	0	0	14
Other	20	19	17	60	0	14

Note: N = 235

Although 80 percent of nurses from all agencies report to senior staff within the school (Table 24), school-employed nurses are more likely to do so than nurses employed by other agencies (Table 27). However, quite high proportions of nurses employed by agencies outside the school also report to senior school staff and to boards of trustees.

In interviews, nurses occasionally mentioned reporting to boards of trustees:

> *I've only a couple of times gone in and discussed with the board of trustees about what the clinic does, because it's a new group of trustees, because if they've had a particular group of parents, maybe a new enrolment, who have a concern about the clinic, and then I might. I've only had to do that once – we don't really have a lot to do with the board of trustees process apart from sending them a report, and I can go to the meetings if they want to ask anything around a particular report. But generally speaking I might talk to the principal*
>
> *[The board of trustees] always write me a nice letter at the end of the year thanking me for my input and for the reports that I write and whatever, but really I don't, they don't know at grass roots how things are.*
>
> *To start working on the tuck shop you've got to have a health and food policy and there are enough of those …because if you want change the best way to get change is at board of trustees level.*
>
> *If you look at any of the strategic health sexual health for youth, if I can prevent a teen pregnancy… but I've not got the OK from any board of trustees to give them [condoms] out.*
>
> *We did the Family Planning training for ECP giving, and some of the nurses have gone to the nursing council for permission or authorisation, and then there's a process whereby we go to the board of trustees because they're the governing group representing the community to present what we want to do in the school, and then it's up to them whether they accept that or not.*

Nurses interviewed often commented on the need to develop good relationships with the school and how they worked hard to cement these, and almost all spoke of excellent relationships with teaching and senior staff at their schools:

> *I think you do get good teachers just about everywhere. And some of the lower socioeconomic schools you get some very dedicated teachers that are just doing amazing jobs. A lot of them are doing kind of pastoral social work as well, and that's just good to be able to support each other in that as well. Some of those cases with abuse and horrible things behind them, it's quite hard, and some teachers get a bit emotionally involved, and that makes it a bit hard for everybody really.*

> *I can go to the front desk and say, I really need to see this student today, and they will … spend the whole time there trying to find a student …Keep an eye out at morning tea break, they will say, 'Oh [the nurse] is after so and so. If they're in your class can you send them down?'*

Nurses spoke of teaching staff approaching them to discuss students they were concerned about, referring students to the nurse, and generally they did not have difficulties with teaching staff releasing students for appointments. However, nurses were aware of the potential for students to use the health services as a way of getting 'time out' from class, and described various methods they had adopted to identify and limit this behaviour.

On rare occasions the relationships do not work well, the nurse's role is not appreciated by senior staff in a school, or the nurse struggles to obtain the necessary resources to do her job. However, even where it works well, nurses recognise the need to be supported from within the health sector as well:

> *I know I'm paid out of the school operations grant, which has also been backed up by international students, and … that's their software and there is some resentment at having to pay that. Not for me personally, but the school resents that you're providing a health service so why does education have to pay … I think that it would be good to be supported by health, perhaps not wholly by health, because I think it's important that we do have a foot in the door, that we're grounded in the school and the students do trust us and you're part of the school community.*

Although rare, at times there is even open antagonism, with one senior teacher commenting to a nurse that she was 'costing me a lot of money'. In cases such as this, nurses see an even greater need to have support from outside the school and from within health.

Most nurses interviewed see themselves very much as part of the school and want to work with teachers and senior staff in positive and collegial ways. They see the benefits to students of a united approach to supporting students' health needs. However, they also see themselves very much as part of health, and recognise the need to be supported within the health profession.

There are situations where professional oversight and line management are more than just employment matters. For example, there are times when a nurse is obliged by her own professional ethics and practice within health to intervene for a student in a way that may not fit within the school's preferred mode of management of a situation. One of the nurses interviewed described a particular incident where the nurse's handling of the incident was compatible with her professional practice and ethics but she was criticised by the principal and was told not to intervene in such a way again. The isolation from professional support within health can leave nurses in schools exposed to challenges to their own 'safe practice'.

Health education

Most nurses surveyed indicated that they were involved in health education (78 percent) and health promotion (82 percent). They were also asked to indicate their involvement in the health curricula in the classroom.

Table 28: Nurses' involvement in health education

Nurses' involvement in health education:	Numbers of nurses	Percentage
Nurse and teacher *take health classes together* (eg, sexual health class)	74	32
Nurse *takes the health class alone*	34	15
Nurse *trains teachers* for delivery of health education (eg, puberty class)	21	9
Nurse *provides advice to teachers* on health classes	90	38
Nurse is *not involved* in teaching health classes	87	45
Other involvement in health curricula (described)	31	14

Note: N = 204

The largest proportion of nurses (45 percent) indicated that they are not involved in teaching health classes; however, just over a third provide advice to teachers on health classes, and almost a third join the teacher in taking health classes together. High proportions of nurses indicate that they are involved in health education and health promotion (Table 7), so these figures indicate that for most nurses their involvement in health education and health promotion is at a personal level − either advice to teachers or as part of consultations with students − or may be undertaken unilaterally by the nurses, separately from education in the classroom or the health curriculum.

There are, however, a reasonably high number of nurses who take health classes either alone or with teachers. Nurses interviewed described becoming involved in health education in the classroom at the request of the class teacher. This was usually for sexual health and puberty, and most often the nurse would attend for the question and answer session. Some nurses stated that they liked to know when a health topic was being discussed in class as students would often come to them afterwards with their questions:

> *I've always said to them I'm quite happy if it's not myself doing something, I'm quite happy to facilitate. I've got people who can come in and do presentations and things if they choose to use them ... and I said if you're teaching a particular topic I should be aware of it because a lot of students*

come back down to me and say oh Miss, you know, they were saying this in class but I didn't understand and I didn't want to put my hand up because they were getting fed up with people asking questions. And I'm thinking, oh my gosh, I wish I'd known this I would have put it at the forefront.

Recent changes have meant health education in schools once provided by public health is now undertaken by teachers as part of the health curriculum. Sometimes the public health nurse is called in:

...and now they sometimes do ask the public health nurse, and they do certainly for sexual health in the high schools ...We don't do all the sessions, but we do come in specifically for question and answer time, or maybe on reproduction or something. There is a concern out there that maybe sometimes people are giving information from a non-nursing or medical background, and some of that information isn't quite right. Not quite there. So, the teachers will often ask us just to come in for a couple of sessions.

There's some awesome pamphlets out ...like a really good resource out by Family Planning Association it's on 'This is Not Control', and it's about safe relationships, what you can expect from a good healthy relationship. Violence isn't dealt with. It's in the too hard basket. And this resource opens it all up and it slots into the curriculum just so well.

We also go into schools and support the teachers in their health curriculum so ... it could be smoke-free, could be drugs and alcohol, could be puberty. Like in [Catholic school] I did some of the puberty sessions with the Year 9s, which was great to promote the clinic as well, get the girls comfortable talking about all the issues.

The draft curriculum is quite generic for health and it can be interpreted in all sorts of ways, but I think the schools need to take responsibility for health education and they need to support and resource the nurse. They don't actually need the nurse delivering it.

Nurses interviewed also talked about providing education about burns and electric shock, running CPR classes 'mainly for the students who are babysitting but it's important', and bringing in programmes such as FADE (Foundation for Alcohol and Drug Education) and SADD (Students Against Drunk Driving). Some nurses talked about the general education and health promotion they undertook within the school generally. This might involve sending out pamphlets, putting up posters, or bringing in speakers or programmes to the school. Topics might include keeping kids home with communicable diseases, head lice, hand washing, hydration, obesity, nutrition and exercise, as well as drugs and alcohol, violence, and other relationship issues.

School holidays

There are gaps in services during school holidays. Nurses surveyed were asked what arrangements were made for students during the holidays, and in most cases nurses indicated that students made their own arrangements. However, about a third of nurses indicated that they can be contacted by students during the holidays (Table 29).

Table 29: Holiday arrangements

Arrangements made for holidays	Number	Percent
Nurses available for consultations	11	5
Nurses can be contacted	86	36
Some students provided with information about Family Planning clinic	70	31
No special arrangements made	76	33
Students make own arrangements	110	48
Other	56	25

Notes: N = 227. Percentage total is more than 100 as respondents could select more than one response category. The complete table with all options is available in Appendix 5, Table A11.

Nurses who could be contacted during the holidays were more likely to be public health or DHB-employed nurses (Table 30). In interviews it was indicated that school-employed nurses are often paid for only the 40 weeks of the school year, and not during holidays.

Table 30: Holiday availability, by employer

	Type of employer (%)					
	The school	**Public health**	**DHB**	**A PHO**	**Youth health centre**	Another organisation
Nurse can be contacted by students during the holidays	3	17	17	0	0	1

Note: N = 227

There are clearly gaps in the provision of nursing services for students during school holidays. Although some nurses attempt to encourage students to access health care independently, there are a number of reasons why some students are unable to do so. This may be due to cost or transport, or simply that some students don't know how or lack the confidence to access another health service on their own. Some students are advised about other health services but almost a third of nurses indicated that 'no special arrangements are made' and nearly half the nurses surveyed indicated that students make their own arrangements for health care during the holidays.

4.2.10 Nurses' professional issues

Scopes of practice

Nurses interviewed described their scopes of practice as being partly determined by their training, partly by the needs of the school, and partly by the availability of other health services:

> *Well we work as an RN [registered nurse] and, like, I'm an RGON [registered general and obstetric nurse] and my scope of practice covers quite a range of general things, and so I work within that. If we do, we work with standing orders with giving our medication. So we have a set of standing orders that*

we use in the clinic. We developed those − well I did a lot of that because I felt we needed to have something, and we tried to get other people to show us what they did. So that was something that was developed, and I think that's probably one area that we're not so good in health is that we're not good at sharing.

I decide my scope of practice. No one else is helping me to do it. And a lot of that I guess is identified through the students and what they need … you never know what you're going to meet … and so it's from there to link in with resources out in the community like the sexual health stuff … is that better to be providing here? It's catch 22. So how far do you stretch yourself and what you can't do and off-load onto someone else to do … it would be great if someone could come in and do it.

We look at the specs, what we're contracted to do, then we look at our resource and see how we might meaningfully affect the priorities identified in the specifications … and of course it has to be within the nursing scope of practice.

Nurses described the need to create 'safe' conditions around their practice, and that changes were needed in terms of workforce development, clinical oversight and facilities before some practices could be undertaken.

My concern about school nurses taking on [administration of penicillin] is we have insufficient training. Until we get some framework [for] nursing and some standards for nursing how do I know that your penicillin is going to be kept at the right temperature in the fridge … until we get that framework for nurses and have nurses actually being assessed clinically I'm not prepared to take that risk for those rheumatic fever kids. At the moment they are being provided the service by a service that is being audited. We know those kids are being looked after… [School clinics] are in converted cupboards a lot of them … and maybe the fridge will be in the staff room with the milk and everything and that's where the kid's penicillin is going to be kept. Who knows what temperature it's going to be kept at.

I work with a GP on what we think is okay. What do we think is working in this clinic, what would be safe practice, what would be unsafe practice and so we work within those guidelines. So we've had those discussions before.

Some nurses had standing orders with local GPs, which worked well, although it took time to set up and depended on building rapport with the GP: 'it all takes time and it's reliant on both parties willing, wanting to have this memorandum of understanding to work together'. Nurses described developing that sort of partnership as 'taking a year or two' if the nurse was new to the area.

There were also some nurses who preferred not to expand their scope of practice even if given the opportunity to do so:

I don't have standing orders to give any contraception or anything out, because I'm not really interested in doing that. I would prefer not to. I'm

happy to if [the doctor is] here, or if she has seen a girl and she doesn't come the next week, I might ring her at her surgery and say can I give the morning after pill or something like that, but I certainly wouldn't do it just like that or anything. I'm not prepared to take that responsibility… I know a lot of nurses want all that responsibility… but I'm happy to leave that sort of thing to the doctors. I guess it's with them.

Qualifications for providers

Most of the nurse respondents were registered nurses. There was a small number of enrolled nurses and a number of other staff responded who were trained in first aid (see Table 31).

Table 31: Basic qualification

	Number	Percent
A registered nurse	219	93
Teaching or administration staff trained in first aid	35	15
An enrolled nurse	13	6
Other	2	1

Note: N = 230

In the survey nurses were also asked whether they considered there is a minimum qualification required of them in the work they do, and if so, what it is. Most nurses (83 percent) responded positively, and of these, 74 percent indicated registered nurse was a minimum qualification.

The nurses were also asked about qualifications they had that were relevant to their roles as youth health nurses. Just over half had Family Planning qualifications and some also had postgraduate qualifications in child or youth health.

Table 32: Further relevant qualifications

Qualification	Number	Percent
Family Planning	118	50
Postgraduate child health	39	17
Postgraduate youth health	24	10
Other relevant to your position	74	32

Note: N = 179

'Other' relevant qualifications that nurses described included postgraduate rural health certificates and diplomas; sexual and reproductive health certificate; HEADSS training; ECP training; child and youth health papers; public health nurse; certificates in counselling, mental health, health education and promotion; asthma education diploma; and teaching diplomas.

Table 33: Nurses' qualifications, by type of employer

	Employer (%)					
	The school	**Public health**	**DHB**	**PHO**	**Youth health centre**	Another organisation
Family planning	33	62	62	20	100	86
Postgraduate child health	8	22	27	0	0	0
Postgraduate youth health	12	10	6	20	0	29
Other relevant to position	32	29	35	20	0	14

Note: N = 232

Public health and DHB-employed nurses are the most likely to have family planning training, which is also the commonest additional qualification for all the nurse respondents. For 'school nurses' the family planning qualification was considerably more common than child or youth health. The 'other' relevant qualifications listed by respondents are shown in Appendix 7. These include a range of qualifications in or papers towards child and youth health or paediatrics; sexual health qualifications, (mainly ECP endorsement); public health; rural health; mental health/counselling; maternal/Plunket; vaccination (including MeNZ B); and a variety of life and/or work experience.

Nurses interviewed described how schools sometimes advertise for an 'enrolled' nurse or 'first aider' and do not always appreciate the need for a registered nurse. However, once nurses were in the position, they were often able to initiate both a shift in thinking and a new job description, and in most cases schools very soon became positive about what the nurses could offer:

> *We all basically need to be a registered nurse, but two years post basic would be really important experience really, focusing on children and adolescent issues. All of our public health nurses that go into high schools have got a Family Planning Sexual Health and Contraception certificate. They've done that extra training and we encourage people to do a basic counselling course. Six of our team have got postgrad papers and one is working towards her master's this year. She has a Ministry of Health nurse practitioner scholarship and another one has a diploma, and a number of other ones are very close to getting their postgrad diploma. One of the public health nurses we had, we don't usually have new grads come in, but this one has been here for four years now and she was mentored for two years by a senior public health nurse. She's absolutely flying now, and she's got one more paper to go and she's got a postgrad diploma in adolescent health.*

In situations where the role of the public health nurse was seen more broadly, as being focused on health at the community level, competencies were seen quite differently:

> *What we say is, Johnny's fallen over, please ring an ambulance. Not my nurse's job to sort that and that's where the change is happening. So the competencies are around assessment and intervention. The clinical skills are used across a community or a population ... which is why they need to understand epidemiology rather than the child... they are your catalyst or*

your facilitator for primary health care. The work that they do is what primary care does not.

One nurse commented that 'public health nurses are a specialist field. They are public health practitioners who happen to be registered nurses.' This also has implications for pay rates:

Public health nurses are not paid as some other nurses and yet their scope is much more wide ranging. So ideally I'd like them to be recognised as nursing specialists.

Some nurses stated that the minimum qualification for a registered nurse working in a school is basic adolescent development papers (such as Paediatrics 712, Youth Health Clinical Skills, available at Auckland University). Qualifications in adolescent health were often referred to as being very useful, if not essential, to the role. Nurses also spoke of the need to have worked in the community (eg, as a practice nurse within a PHO) as being essential experience for a nurse in a school.

Some public health nurses working in schools have in-service training on such topics as the legal aspects of working with youth, family violence and partner violence, abuse and neglect, as well as HEADSS assessment and youth health assessment. However, at present such training is only recognised within the DHB. Some on-line training was beginning that would produce a certificate demonstrating what had been covered and could be verified by nurses' managers.

Presently within public health, the first-year orientation includes components such as child abuse, youth abuse, family violence, that can be 'ticked off and verified … but it's not logged onto NZQA'. These have the advantage that 'we're able to fashion what it is they need in practice', although they are not able to be recognised nationally and internationally − a disadvantage for nurses who frequently move around in their practice.

Table 34: Years working as a nurse in schools, by type of employer

	Employer (%)					
	The school	**Public health**	**DHB**	**PHO**	**Youth health centre**	**Another organisation**
0−5 years	62	55	37	80	100	57
6−10 years	27	17	28	20	0	29
11−15 years	7	12	23	0	0	14
16−20 years	2	5	11	0	0	0
Over 21 years	2	9	1	0	0	0

Note: N = 232

Most of the nurse respondents had worked for fewer than five years in schools. However, both school-employed nurses and DHB-employed nurses were more likely to have worked between 6 and 10 years than public health nurses. DHB-employed nurses were more likely than others to have worked over 11 years in schools, and school-employed nurses the least likely.

Table 35: Years spent working in schools, by nurse's age

	Years working as a nurse in schools (%)*				
Age range	0−5 years	6−10 years	11−15 years	16−20 years	over 21 years
20−29 years	4	0	0	0	0
30−39 years	10	3	0	0	0
40−49 years	24	9	5	1	0
50−59 years	13	12	7	3	1
over 60 years	2	0	0	1	2

* Cross-tabulation percentages
Note: N = 232

There is a small group of nurses in the youngest age range (20−29 years) who have worked in schools for less than five years, but most nurses working in schools are in the age ranges over 30 years, with the largest group in the 40−49 years age range (Table 35). Some nurses in the age ranges over 40 years have worked in schools for over 11 years (some up to 20 years), indicating that they have made careers within school nursing. The preponderance of nurses in the upper age ranges (40−59 years) has implications for future workforce planning: there needs to be growth in the numbers in lower age ranges so that there are experienced nurses following on to replace those who will retire in the next two decades.

Nurses' remuneration

Nurses were asked to indicate their salary level, or hourly rate if they worked part time. Most nurses who responded indicated a salary range of 'over $55,000'; however, high numbers skipped the question.

Table 36: Salary ranges, full-time nurses

Salary ($)	Number	Percent
Under 24,999	7	3
25,000 – 34,999	15	6
35,000 – 44,999	21	9
45,000 – 54,999	34	15
55,000 and over	73	31
Skipped question	85	36

Note: N = 235

Figure 2: Nurses' salary ranges, full-time nurses

Nurses who worked part time mostly earned between $20 and $29 an hour (Table 37), although as with full-time nurses, high numbers did not answer the question.

Table 37: Salary, part-time nurses

Salary per hour ($)	Number	Percent
15–19	11	5
20–24	52	22
25–29	47	20
30–34	19	8
40 or more	1	0.4
Skipped question	105	45

Notes: N = 235 There were no respondents reporting an hourly rate in the range $35- $39.

Table 38: Salary range, full-time nurses, by type of employer

	Employer (%)*		
Full-time nurse's salary range ($)	**The school**	**Public health**	**DHB**
20,000−24,999	5	0	1
25,000−29,999	3	0	0
30,000−34,999	10	0	0
35,000−39,999	7	3	0
40,000−44,999	10	0	4
45,000−49,999	7	3	1
50,000−54,999	5	17	11
55,000 and over	4	52	54
Skipped question	48	24	28

* Cross-tabulation percentages
Note: N = 235

Table 38 indicates that the nurses in the higher salary ranges (over $50,000) are most likely to be public health or DHB-employed nurses and very few in these groups earn salaries in the lower ranges. School nurses' salaries tend to be more evenly spread over the whole range of salaries, with most in the middle ranges ($30,000 to $45,000).

Table 39: Hourly rate, by type of employer

	Employer (%)*		
Rate per hour ($)	**The school**	**Public health**	**DHB**
15−19	11	0	0
20−24	41	9	10
25−29	22	22	14
30−34	1	5	20
40 or more	0	2	0
Skipped question	25	62	56

* Cross-tabulation percentages
Notes: N = 235 There were no respondents reporting an hourly rate in the range $35- $39.

Nurses employed by schools and working part time receive the lowest hourly rates (most earning between $20 and $24), compared with nurses employed by all other agencies. Public health nurses are more likely to be earning between $25 and $29 an hour, and nurses employed by DHBs are most likely to be earning $30−$34 an hour.

It should be noted here that high numbers of nurse respondents did not answer the questions regarding salary or rate of pay (36 percent of nurses on salaries and almost 45 percent of nurses on hourly rates).

Table 40: Salary, by qualification

	Qualification (%)*			
Salary range ($)	**Family planning**	**Postgraduate child health**	**Postgraduate youth health**	**Other**
20,000–24,999	1	0	1	2
25,000−29,999	2	1	0	2
30,000−34,999	3	0	1	1
35,000−39,999	2	1	0	4
40,000−44,999	7	1	0	3
45,000−49,999	4	1	2	2
50,000−54,999	8	4	2	9
55,000 and over	37	19	8	19

* Cross-tabulation percentages
Note: N = 119

From Table 40 it is apparent that nurse respondents in the highest salary range ($55,000 and over) are the most likely to have any of the qualifications listed, and in particular most commonly have family planning qualifications. Having postgraduate qualifications in child or youth health does not appear to make a difference in the low to medium salaries, but those receiving over $50,000 are more likely to have a postgraduate child health qualification than those on lower salaries.

Some nurses indicated very low hourly rates − less than $19 an hour. In interviews, nurses on low rates described their taking on the job and staying there as 'the passionate commitment to the job'. One nurse who had been involved in an accident and received ACC support said:

> *…the only reason I stay here is because ACC also help with my wages compared to what I was earning about ten years ago. So it's still not great, but without that I couldn't survive on the $400 a week they pay, no way.*

In some schools nurses are paid during holidays, on a 52-week year basis; others are paid only during attendance at the clinic. One participant described a minimum of $30 an hour (around $56,000 a year) as being the amount that should be paid to a nurse with the experience required to work in a school health clinic. Some of the nurses interviewed described how the working hours fit in with their families, or that they are unable to work in a hospital for health or other reasons, as explanations for staying in such poorly paid positions. Nurses also expressed strong commitment to the needs of young people and the importance of the job:

> *I love my job, I love the kids, I love what I do and you've got someone now who's taking on the job because she's passionate and sees the vision. But you know it's at the expense of … it's your own financial expense.*

In some cases the funding for the nurse is provided by the school as an 'ad hoc' teacher's salary:

> *It's only if the school can find the money to provide a salary, and that means that they have to provide that salary by meeting another teaching salary. So they have to rob Peter to pay Paul. Unless they're lucky enough to find some money elsewhere, which most of them aren't, and the really sad thing is, I mean, I support that we need to be getting to our lower decile people, but what I'm seeing is the high-decile schools have got huge problems as well.*

Some principals also commented on the 'limited' school funds available and that they would like the funding to come from health to support improvement to school health services:

1. *Funding by Health Dept. – school funds limited 2. Funding of release time for prof[essional] dev[elopement].*

> *Have the government recognise that this is an essential service and provide for it properly within the operations grant. Then we could offer better pay scales and keep the fine people we recruit, who sometimes leave.*

> *More funding to allow more qualified nurses to be employed to concentrate solely on nursing activities.*

> *Government funding would enable us to develop the service further.*

> *Full-time medical services funded for the school would be of assistance, especially in a low decile school like ours.*

Supervision and reporting

Nurses surveyed were asked whether they reported to someone in their professional capacity as a nurse. Of those who responded positively, just over half reported to a senior nurse and over a third to another professional in the organisation that employs them.

Table 41: Nurses' reporting in professional capacity

Report to	Percent
Senior nurse	53
Other professionals in organisation	40
Other	26

Note: N = 180

A number of respondents (16 percent in total) indicated that they did not report to anyone in a professional capacity. Most of these were 'school nurses' (see Table 42).

Table 42: Nurses' professional reporting, by employer type

Type of employer	Reports in a professional capacity (%)*	Does not report in a professional capacity (%)*
The school	22	14
Public health	26	1
The DHB, but not public health	29	3
A PHO	2	1
A youth health centre	1	0
Another organisation	3	0

*Cross-tabulation percentages

Note: N = 211

Nurses employed by schools rather than by a PHO, DHBs or public health have professional management relationships within the school. This means that their professional appraisals are completed by others within the school, such as the deputy principal, principal or sometimes the school counsellor. Nurses are aware of the limitations in this situation, and those interviewed often expressed concern at the professional isolation, and the lack of support from and oversight by others within their profession:

> *[The appraiser has] ... no idea whether I'm clinically competent or not. She basically does it on the administration ... on how I run the health team, how I link in with the school and the school management ... no one will come and see me physically working and know whether or not I'm clinically competent.*

> *The school can say, yes, she is meeting the school's needs, but they've got no idea whether she's a good nurse or not.*

Table 43: Clinical supervision

Nurses indicating clinical supervision	Number	Percent
Yes	148	63
No	77	33
Don't know	4	2
Skipped question	6	3

Note: N = 235

Almost one-third of nurses indicated that they did not receive clinical supervision, and almost all of these nurses are employed by schools (see Table A10, Appendix 5). Although most nurses described supervisors as senior nurses, managers, doctors, trained supervisors or senior colleagues, quite a number indicated that they received clinical supervision from colleagues, others from counsellors or social workers, and some mentioned a local 'cluster group' who made their own arrangements to meet competency requirements.

Nurses interviewed who were not employed within a health organisation often felt professionally isolated, and nurses working in schools raised issues of professional isolation and support:

> *No [not professionally supported]. It's very isolated, because you're working within an educational system, so you're kind of a one-off there. Some GPs are good; others you get kind of mixed responses from the GPs.*

> *For all of us it was really quite a new area of nursing because we were working quite independently, whereas previously we probably always worked under the guidance of a GP.*

Some school nurses made their own arrangements to meet competency requirements:

> *I can have peer supervision in a cluster ... that meets our needs around the HPCA [Health Practitioners Competence Assurance Act] ... because we're outside of health and not part of any structure. We have tried to encourage this cluster peer supervision so that we can meet our competencies within the Act.*

However, these clusters met in the evenings, and often the support that nurses did receive from one another was organised in their own time and cost them to attend, although sometimes the schools would reimburse registrations. Some frustration was expressed at this situation:

> *I'd like to go to them, but why should I go in my own time when I earn such a very small amount ... but it's all money, money, money and it really irks me.*

Professional development

Most nurses indicated that they were able to take paid study days or time, and a further quarter of respondents were able to take unpaid study days or time. For around a third of nurses, the school met training costs and over half indicated that their employer met training costs.

Table 44: Professional support available

Type of professional support	Number	Percent
Paid study days / time	214	91
Unpaid study days / time	60	26
Course costs for training met by the school	69	29
Course costs met by employing organisation	128	55
Other	32	14
Not applicable because don't want to undertake any study/ training	4	2

Notes: N = 235. Percentage total is more than 100 as respondents could select more than one response category.

Table 45: Professional support, by type of employer

	Percentages of nurses receiving each type of support				
Employer	Paid study time	Unpaid study time	Course training costs school	Course costs employing organisation	Other
The school	85	38	67	10	14
Public health	93	17	2	88	12
DHB	96	17	4	83	15

Note: N = 229

Table 45 shows the professional support received by nurses employed by different agencies. Nurses employed by schools are less likely to receive paid study time than nurses employed by other agencies. They also more commonly have unpaid study time (which, however, may simply indicate they are more likely to undertake study in their own time). DHBs and public health are approximately equally likely to meet nurses' training costs, but a smaller proportion of nurses employed by schools have their course costs met by the school.

Funding for study was an issue for many of the nurses interviewed, and even those who did obtain Clinical Training Agency (CTA) or other funding found it difficult to do papers on top of full-time work, or to organise to be away from work:

> *But with public health nursing there's not an extra person to come in and do our jobs. It's very hard to get people that will be able to come in effectively …and often your clients aren't interchangeable because you've built that relationship with young people and they don't readily take to someone else coming in and knowing all their stuff …*
>
> *The District Health Board are reasonably supportive. They give study days. They certainly want us all to continue with our health professional development, and they support that … but we do look for funding outside of the organisation, like CTA funding as well… It's helped many of us get some extra papers relevant to the job … The DHB here gives 5 study days per*

fulltime equivalent a year, but when people are doing papers they sometimes will give extra ones as well to support that.

[Named DHB] have also been very good with funding professional development ... because you've got to remember these nurses are not in-house so that the fact that health is funding their professional development is very generous on their part.

One issue, in terms of both cost and time, was the problem of travel to training institutes, exacerbated in one region for rural nurses in particular, by the shift in postgraduate training away from local polytechnics to the university in a more distant centre. On-line courses were seen as one possible solution to these problems.

Nurses described a shift over the last five years or so in how the role of the 'school nurse' is viewed. In the earlier view the nurse was viewed as responsible for 'panadol and band aids', whereas now the school nurse is seen as having a much broader role, one described as an 'adolescent health nurse'. Nurses who spoke strongly of the need for professional development envisaged this broad and expanding role for the 'school nurse.' They viewed the 'band aid' role description as minimal or inadequate, and expressed concerns about the unmet health needs of large numbers of students. There were also some who were in the job because 'it's comfortable and … not necessarily wanting to further their career but also want to attend relevant study days that would help them.' However, almost all the nurses who were interviewed were keen to see a career pathway for school nurses or adolescent health nurses, with relevant and accessible training made available.

There have been some positive recent developments in youth-based health care, both in terms of standards for services (Kidz First Centre for Youth Health and the Youth Health Expert Working Group 2006; Ministry of Health 2004a), and also the development of vocational scopes of practice. The nurses interviewed acknowledged the relevance and importance of undertaking professional development in the area of youth health and look forward to the establishment of career pathways for adolescent health nurses.

Nurses in public health were also concerned that there be competencies within public health nursing for adolescent health:

They need to be recognising specialist nursing fields. There needs to be an adoption of competencies nationwide and Ministry recognised. The Ministry needs to work with the Ministry of Education to say this is a public health nursing service and this is what it does. There needs to be a further specification for public health nursing. There is not one.

4.2.11 Prioritisation

Prioritisation decisions made by public health, DHBs or PHOs concerning which schools have health services and what level of services are provided are likely to consider school decile level. Table A12 in Appendix 5 compares the school decile level with the types of health services being provided at schools.

The main differences by decile are as follows.

- Nurses in lower decile schools (deciles 1−3) tend to undertake more health and HEADSS assessments; are slightly more likely to provide personal health services; are more likely to administer medications, provide vaccinations and immunisations; and are more likely to undertake home visits than nurses in the high-decile schools (deciles 8−10), although there are no consistent trends for these services across low- to high-decile schools.
- Referrals to other health providers, health promotion and educating staff on health issues seem to be about the same for both low- and high-decile schools.
- Nurses in schools in the decile mid-ranges (deciles 4 and 5) are undertaking more health assessments, and are more likely to refer students to other health professionals, provide personal health services, be prescribing, undertake health promotion and education, develop health plans, and educate staff on health issues than nurses in both low- and high-decile schools.
- Nurses in high-decile schools are more likely to be providing first aid, and are slightly more likely to provide health promotion and to develop a specific health plan than nurses in low-decile schools.

It is interesting that the provision of personal health services and making referrals to other health professionals remains so high for the mid-decile-range and high-decile schools; this supports the view that there is a need for these health services for young people across all school decile ranges.

Table 46: Need for other services, by school decile

	Percentage of nurses who indicated less than adequate access to these services*				
Decile	**Social worker**	Psychologist	**Drug and alcohol advisor**	**Sexual health nurse**	**Family adviser**
1	1	5	5	3	3
2	7	8	7	5	6
3	7	6	6	4	6
4	8	7	7	7	6
5	7	6	7	5	8
6	7	5	4	5	3
7	2	4	2	2	2
8	6	6	5	4	5
9	1	2	1	2	1
10	3	5	3	2	2

*Cross-tabulation percentages

Table 46 shows nurses' responses, combining 'has some access but needs more' and 'no access but needs' to the question concerning their school's need for these services. The schools rated decile 1 show less need for access to all services than the mid-range deciles, possibly indicating that these schools already have additional access to these

other services. The lower to mid-range decile schools appear to be in greater need of all services than the higher decile schools. However, the need for psychologists and social workers is quite high across all deciles, and high overall compared with the need for other services. Low- and mid-decile schools show a higher need for drug and alcohol and family advisers than high-decile schools.

Table A13 in Appendix 5 shows the hours nurses are available for consultation, by school decile rating. The data show a fairly even spread of hours available across the decile ranges. Schools with decile ratings 9 and 10 have the high proportions of nurses available for more than 21 hours compared with schools in other decile ranges. Some of the decile 9 and 10 schools will be boarding schools with full-time nurses.

Numbers of consultations were compared across school decile ranges (Table A14, Appendix 5). Across the range of all deciles, consultation numbers peak at both ends: that is, fewer than 20 students and more than 120 students per week. The mid-range decile schools tend to be more likely to see fewer than 20 students, but otherwise there is a fairly even spread of numbers of consultations across the deciles.

Table 47: Type of employer, by school decile

	Employer (%)*			
Decile	**The school**	**Public health**	**DHB**	**PHO**
1	3	1	4	0
2	4	1	3	0
3	5	3	1	0
4	8	2	3	0
5	6	4	2	0
6	4	2	3	1
7	5	1	0	0
8	4	2	1	1
9	10	1	0	1
10	9	0	1	1

* Cross-tabulation percentages
Note: N = 136

DHBs are more often employers of nurses in schools in the lower decile ranges than in the higher decile ranges (Table 47). Nurses employed by public health are more commonly in lower to mid-decile range schools than in higher or very low-decile schools. Nurses employed by the school − the most common employer − are fairly evenly spread across the decile ranges, although highest in the top deciles (9 and 10). Some of these are likely to be private and/or boarding schools with their own nurses.

The type of employer was also considered in relation to school size. Table 48 shows employer type by school roll.

Table 48: Type of employer, by school roll

	Employer (%)*			
School roll	**The school**	**Public health**	**DHB**	**PHO**
0–199	2	0	2	0
200–399	5	2	4	0
400–599	3	5	5	1
600–799	7	2	5	0
800–999	11	5	2	0
1000–1199	10	0	1	0
1200–1399	5	1	1	1
1400–1599	5	1	0	0
Above 1600	10	1	0	2

*Cross-tabulation percentages
Note: N = 135

There are more nurses employed by public health and DHBs in schools with lower rolls than in schools with higher rolls. School-employed nurses are found across all schools sizes, but predominate in the schools with higher rolls. While there are also public health and DHB-employed nurses in these larger schools, it is likely that some of these schools have seen a need for an additional nurse.

The hours worked by nurses were considered in relation to school roll sizes. Figure 3 illustrates these data. The full data are given in Table A15, Appendix 5.

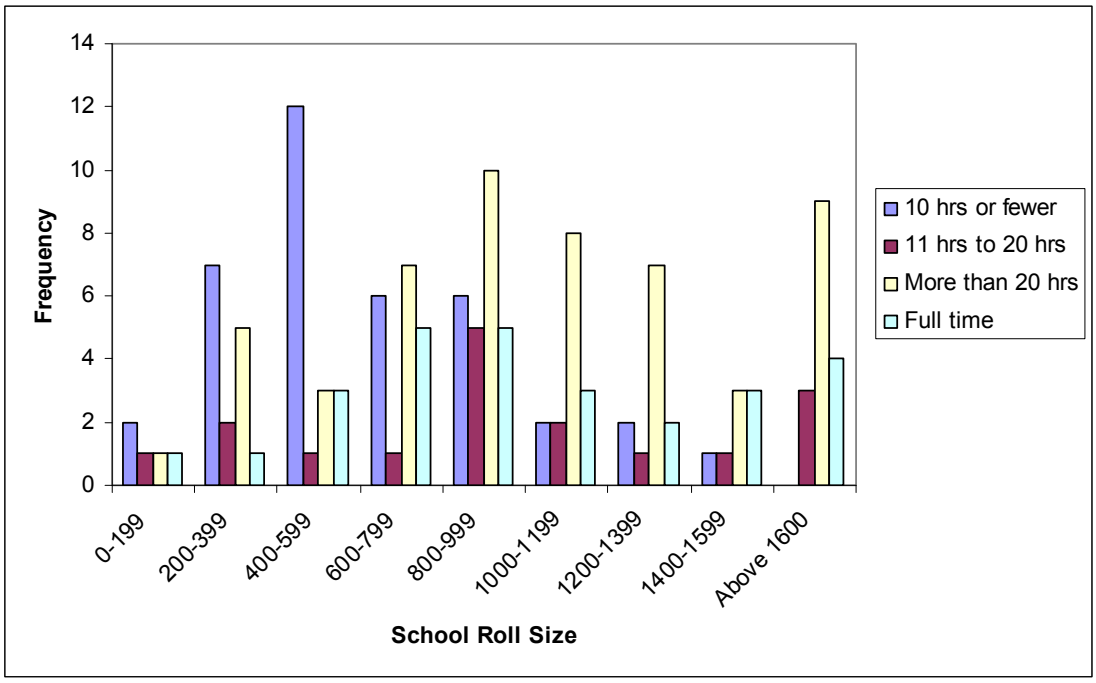

Figure 3: Hours worked by nurses, by school roll size

Nurses working 10 or fewer hours per week are more likely to be working in the smaller or middle-sized schools (roll sizes less than 1000) than in the larger schools. Conversely, nurses who are working over 20 hours a week are more likely to be working in middle-sized and large schools than in small schools (roll sizes less than 600).

Nurses interviewed were asked about how decisions were made as to which schools have clinics and what levels of services are provided. A number of different factors were considered, depending on the provider of services, but school decile level was a primary consideration. For example, the AIMHI schools, which all have school health clinics, are all decile 1 schools with limited resources; public health generally selects schools first on the basis of decile, although other determinants of need are also taken into account. In other cases, where clinics are funded through the school or local PHOs, clinics were often started up on the basis of assessments of needs:

> *So basically the DHB recognised that this was a good initiative. They did a pilot with four high schools that worked really well, and then they extended it to all the decile 1 to 5 schools and put a service in as many as they could. And then within a couple of years it was rolled out to all decile 1 to 10. It's at every school. It's available for them.*

> *It was initiated in 2000, and that was from a wish really from the community from a study that they'd done here in [district named] in youth health and of course alongside that government were also doing their own studies and research, and part of that was that youth health was an area that we weren't catering for. So from that, the head at [local PHO] went and petitioned health funding really to see if we could actually have a project and this pilot project came out; and the schools had to be decile 1 or 2, there had to be high need, there had to be a relatively high percentage of Pacific/Māori population, and they were pretty much the criteria set.*

> *...and two GPs who were working with me at the time (I was a practice nurse), and they decided that they would like to go into youth health, really, and just to see, because they knew in their practices they weren't seeing young people.*

As described above, in schools where health services were delivered by public health, or where a provider was contracted by the DHB, schools were prioritised according to decile. However, planning was undertaken each year, and if there were particular high needs identified (such as rural isolation), or a significant transient population, or specific needs for some groups such as Māori, Pacific or other ethnic groups, they focused resources there. Public health nurses in some districts were involved in running clinics in schools, and in other districts visited schools but did not undertake consultations.

Although prioritisation is usually decile-based, many nurses stated that the need for adolescent health services is 'not a decile thing'. There are a number of reasons why some adolescents might have greater need for school-based services than others. These include access to services and/or access to transport, for rural students in particular, but also for students in cities who are unable to pay for transport; time lost from school; privacy; and confidentiality. These accessibility issues apply across the socioeconomic boundaries. Moreover, nurses described how adolescent health issues cross socioeconomic boundaries:

> *It's an adolescent health thing because kids at [a high-decile city school] are taking as many risks around sex, drugs, alcohol, mental health, all that kind of*

thing as the kids in [city area with low decile schools]. And so our kids become marginalised in the same category as Māori and Pasifika. I believe adolescents are marginalised as well because access [and] affordability are as big a problem for the kids in [high socioeconomic area] as they are in other areas … in fact it's often harder for a student in a higher socioeconomic area to get $40 to see a doctor, to try to get there. And nurses out in the 10 decile school areas will tell you they have as many problems. They just manifest in a different way.

I think every college should have a clinic, a proper clinic, a proper doctor clinic, nurse one day, doctor and nurse another… If there was more funding for [local youth health centre] and maybe more funding in youth health they could get the clinics in every college. I really feel, even in the high-decile schools, there's a need … Definitely, when I look at the teen pregnancy rate. They've shown that, if sexual health was done properly …[and] it's Chlamydia Capital.

Nurses interviewed described how the funding system can create inequities for students, because GPs in different areas charge differently, meaning students from high socioeconomic areas have to pay a higher fee to see a doctor than students in low socioeconomic areas. But adolescents do not have their own money, and if they want to access a GP independently from their families, a student in a high socioeconomic area might have just as much difficulty acquiring $35 for the fee as a student in a low socioeconomic area.

It's like decile 10 schools out there, so there's perceived to be no financial problems or that type of thing. But there are still young people who are still taking the same risks as are the kids in [the low-decile area] but the kids of [the low-decile area] get free health care because in [the high-decile area] it's only partly subsidised out there.

Yes, because even though they might, they perceive that the students have got the money, sometimes they actually have to justify where they're spending it, you know. The parents will say where's that $35 gone; and, you know, like a top or a bag or … they can't say I spent it on my lunch can they?

Nurses can become ACC registered, which provides extra funding. This can provide anything 'from $6,000 to $10,000 a year' and covers all consultations that are a result of accidents or injuries. Other income includes money for extra staff to undertake HEADSS[10] assessments in some DHB districts; Services to Improve Access (SIA)[11] funding for some services; for public health nurses, funding is provided via DHB funding and planning to public health, and clinics run alongside the school dental and school vision/hearing services.

[10] HEADSS is a youth health assessment tool referring to home, education, activities, drugs, sexuality and suicide.

[11] Services to Improve Access (SIA) funding is available for all PHOs to reduce inequalities among those populations that are known to have the worst health status: Māori, Pacific people and those living in NZDep index 9−10 decile areas. The funding is for new services or improved access. Examples of the successful use of SIA funding are: the provision of clinics at work sites, marae, church groups and schools; and transport services to help people get to clinics.

Nurses also have to budget for supplies, as one nurse described:

> *The budget is, like, $2,000 a year. The facilities are part of the school. It's more for any equipment, or dressings and medications and things like that. [It's] just [enough]. I worked out last year that it costs about $8.50 to run the clinic a day, which isn't much, but at the same time I tend to be quite thrifty and try and get things donated and stuff, and there is a support out there. Like I have a pharmacy that helps me out, because without having a doctor we can't do the MPSOs,[12] where doctors can sign things and get lots of panadol and condoms for their medical centre. So we've got another doctor who is signing those for me, and she's kind of covering me a little bit … because it's things like that that are hard to get, that normally in a doctor's surgery you can just get, like, Ventolin inhalers, panadol or condoms, all those things that are generally really easy to get − peak flow meters, spacers.*

Other nurses also describe inadequate or minimal funding for supplies. One nurse described a budget of $1,500 'which is pathetic. I spent that on day one on supplies'.

Some nurses raised the issue of students' health funding going through PHOs. For some schools there is only one PHO in an area, so all the students at the local schools are enrolled in that PHO. However, in other areas students could be enrolled in many different PHOs, so referring students to a GP outside of their own PHO would require some 'claw back' from their PHO. This meant that if the nurse referred a student to a GP in a PHO other than the one the student was enrolled in, commonly the GP saw the student for free:

> *And so, you know, she [GP] she really works as a charity service, which is wrong because that shouldn't be the way it is run, but because of the way funding has gone with PHOs … funded to look after [their] enrolled population, and that works well in a place where you have one PHO and one DHB … a school like [school named] which draws from a wide radius, I could have kids in the school from 15 different PHOs. It's really hard, and so, you know, that's where I think adolescents' needs have not been met in the funding stream of PHOs.*

Twenty-four of the 154 principal respondents indicated that GP clinics or visits were available at their schools. Of the nurses surveyed, 80 percent indicated that they sometimes make referrals to the students' own GPs, and 43 percent indicated that they sometimes make referrals to another GP. GP visits to schools are sometimes seen as an answer to the difficulties of referring students who would not otherwise access care:

> *I've kind of looked into it [a doctor on site] from the funding side of things. And then there's other GPs that say no, the kids should go to their own GPs, which I agree with. But the reality is that some of them won't go at all, and*

[12] Medical practitioners supply orders: there is a list of agents which can be obtained by medical practitioners on a special order form for personal administration to patients in emergencies or to initiate treatment.

they just end up getting sicker and sicker, when all they needed was some simple antibiotics.

Nurses interviewed described the efforts they often made to access funding for students whose families were unable or unwilling to access the health services the students needed. They also described working around systems, such as sometimes using the health centre's funds for students who could not afford the fee for a GP, or transporting students to other health services in their own cars. It appears that GPs are not using 'claw back' in most cases, but funding is regularly sought through SIA, ACC or some other means, and nurses use these sources of funding for referrals as far as possible.

Other referrals depend on the generosity of the GPs used by the school nurses. In these cases the GPs are seeing the students 'out of the goodness of [their] hearts'. Both GPs and nurses are in some cases providing services without payment, in terms of consultations and (at times) nurses transporting students to other health providers.

I find it really hard when it's not a sexual health thing, like a chest infection that's just not going away, and mum and dad won't take them to the doctor. I find that really hard, because then it comes to the cost thing. And I've been staying in the path with taking it out of the health clinic budget and not getting any of it back.

4.2.12 Improvements to services

The principals' survey asked an open-ended question: 'What do you think needs to be done to improve the nurse services at your school?' Table 49 summarises the main issues that principals provided in response to this question:

Table 49: Main issues mentioned

Issue	Number	Percent
Facilities	8	11
Funding	11	14
Liaison	5	8
More hours	28	37
OK	22	30

Note: N = 76

Some principals described improvements they would like to see made to the scope of nursing services in their schools, and while a good proportion mentioned more hours (37 percent), others mentioned 'funding' (14 percent) and 'better facilities' (11 percent). Most principal respondents (63 percent) thought that the scope of nursing services available met the health needs of students in their schools. However a reasonably high proportion (26 percent) thought they did not, while 12 percent did not know. The complete set of responses is available in Appendix 4, but some typical responses are provided below.

Facilities**:**

Relocation and refitting of the sick bay so that it is well away from the staff room.

Better facilities. At present, small room and the office and the actual sick bay are one room − makes confidential enquiries quite difficult.

Would be good to have an otoscope available to look in ears. Would be good to have air conditioning and better lighting.

More hours**:**

We need to have a 'registered nurse' available to visit the school on a regular basis – weekly.

Would be better if we had a public health nurse available daily.

We struggle to fund one nurse full-time but the demand sometimes exceeds her ability to respond in a timely fashion. The nurse could also be doing more teaching of health and nutrition if she had more time so we could be more proactive rather than reactive.

Extended hours. Presently they are available only on certain days. A nurse available daily would be of great advantage.

In a low-decile secondary school such as ours, we very much need the availability of health/nursing services. The pressure on the public health nurse in our rural area is immense. Having someone 'on call' or able to run a regular clinic would be useful.

More frequent visits – at present we get 40 mins (lunchtime) per week. The counsellors often have to refer students to outside nurses (under a contraceptive contract).

Funding:

Full-time medical services funded for the school would be of assistance; especially in a low-decile school like ours.

Have the government recognise that this is an essential service and provide for it properly within the operations grant. Then we could offer better pay scales and keep the fine people we recruit who sometimes leave.

I would like to see her able to be paid more as she does an awesome service. But here at [named school] we have a health centre with excellent facilities. Our nurse has regular supervision and professional development.

Funding to employ a registered nurse.

Funding to allow for nurse supervision / study leave etc.

A substantial proportion of principals (30 percent) also felt that services were 'OK'. Some of the comments provided by this group were:

> *Every Wednesday lunch time we have a doctor or nurse that spends up to an hour in our clinic seeing students. If there are students that want to see a Dr outside this time, I make an appointment in town and there is no cost.*
>
> *Nothing – they are excellent.*
>
> *The service is in fact too good. It is difficult to keep it to emergencies and accidents, which is what it is designed for. There is a tendency for it to be used as a regular health check up / monitoring/ flu / colds etc.*

Nurses interviewed could see gaps in services and student health needs that were not being met. In some cases they considered extra staff were needed; in others, more frequent clinics and extended hours. They also talked about the problems experienced when trying to refer students to other health services and the difficulties in getting outside help, whether from mental health services that were over-stretched or from CYF, or difficulties finding the funding that would enable students to use other services. Most of the nurses interviewed would expand services if they could, but they were inhibited by funding availability:

> *We need more of us. You'd hear that from everybody. Some of the nurses are very busy and some of the cases that we have are very complex and not just a one-off thing and need on-going support. Some young people are not well identified with their family and feel as though the world's against them, and if you can help them make better choices then we'd love to be able to do that.*
>
> *They are absolutely flat out … the school nurses are getting burnt out because they're absolutely drowning with what they're seeing. They're burnt out.*
>
> *There is a huge resource issue really. Especially … seeing 60 kids a day. You know, how do you do all this other stuff? It's a difficulty getting all this done when there's no down time. The only down time is after work and … while it needs to be done, you're constantly doing a 55-hour week as I do.*
>
> *[I see] anywhere between 20 and 40, and with the paperwork now it's the accident register, ACC forms. I have to document the notes. Once a month it has to go to the principal and it's just endless.*
>
> *My big wish would be, actually, that we were adequately resourced so that we wouldn't feel so stretched sometimes, that I don't actually feel like I really meet the needs of young people well. It would be great to be able to spend time with them. I would dearly love to be able to do the needs assessments … I keep saying we've got special needs out in our area and it's an adolescent thing not a decile thing.*

5 Summary

5.1 The role of the nurse in schools

Schools are required to have a staff member trained in first aid, and most schools appear to comply. Around three-quarters of schools have a nurse attending or visiting, and almost 20 percent of schools have more than one nurse attending or visiting. There are some discrepancies in the data obtained from the principals' and nurses' surveys in relation to the number of nurses employed by schools and other organisations, but it appears that about half of nurses working in schools are employed by DHBs (including public health) and about a third are employed by the school.

Regionally, South Island schools are less likely to have school-employed nurses than North Island schools, and within the North Island, apart from Northland, more schools in districts north of Taranaki have school-employed nurses than schools in southern districts. Only three DHB districts appear to have PHO-employed nurses.

Scopes of service are most often determined by the nurse's employers in consultation with schools, or by the employer alone. Interviews with nurses indicated that they are based on an assessment of the needs of students within a school or local schools, in conjunction with the resources available. Where health services are delivered by public health, or where a provider was contracted by the DHB, nurses indicated that schools are prioritised according to decile, although in some regions almost all schools are covered by public health. However, planning is undertaken each year, and if there are particular high needs identified − such as rural isolation, or a significant transient population, or specific needs for some groups such as Māori, Pacific or other ethnic groups − resources are focused there.

Although nearly all the nurses working in schools are registered nurses, nurses interviewed stated that schools sometimes advertise for an 'enrolled' nurse or 'first aider' and do not always appreciate the need for a registered nurse. However, 'school nurses' indicated that once in the role they often initiated both a shift in thinking and a new job description.

Around two-thirds of nurses indicated that they are using HEADSS assessments, and some nurses are undertaking a complete HEADSS assessment of all Year 9 students. This is a time-consuming task, but the nurses interviewed indicated that in addition to providing a base assessment of students' health status when they first entered secondary school, it had the benefits of bringing students into the health service and familiarising them with it.

Most nurses surveyed indicated that 'health education' and 'health promotion' are part of their services, and many speak to groups or classes and provide students with health-related information. Some also undertake development of school and/or specific health plans. Nurses interviewed also described other contributions to health and safety measures at schools, such as holding the chemical hazards register. With increased mainstreaming of students with chronic health conditions, nurses are involved in managing these conditions, teaching the students to manage their

conditions, and educating school staff in the management of students with chronic illness.

5.2 Students

Nurses indicated that the most common reasons that students seek consultations with nurses are for advice on sexual health issues such as contraception and STIs, followed by injuries and general sickness. Around one-third of consultations are for mental health and about a third are for family issues.

Although most nurses are consulting fewer than 20 students per week, about a fifth of nurses are seeing over 100 students a week. These are most often school nurses working in large schools. The majority of school-employed nurses are available for over 25 hours a week. Public health and DHB-employed nurses are mostly seeing fewer than 20 students per week, reflecting the brief clinics they hold in schools: often one or two lunch-hour visits per week. The majority of public health and DHB-employed nurses are available for consultation for fewer than five hours each week.

Nurses indicated that the most common reasons for students using school-based health services are for reasons of 'accessibility' – in terms of both proximity and student comfort. Reasons of confidentiality and problems of transport to other services are also common, and other reasons include parents being unable or unwilling to pay, and students either not knowing about or not knowing how to access other health services. Nurses in lower decile schools are more likely than nurses in higher decile schools to cite transport and payment difficulties as reasons for students' use of school-based clinics, but there are also quite high numbers in mid-range and high-decile schools who indicate that students use school-based health services because of difficulties with payment or transport to other services.

Most nurses indicated that teachers and counsellors or other health professionals will refer students to the nurse. Around two-thirds of nurses also indicated that parents sometimes make referrals. These figures indicate positive attitudes towards the school health clinics from teachers, counsellors and other health professionals, and from parents. Almost three-quarters of nurses indicated that students will also make their own appointments or just queue up, which also suggests positive attitudes towards the school clinics on the part of students.

Students are somewhat more likely to 'just queue up' to visit school-employed nurses than to visit nurses employed by other agencies. Teachers, counsellors and parents more commonly refer students to DHB-employed nurses than nurses employed by schools or public health. More school-employed nurses undertake health assessments of all Year 9 students than nurses employed by other agencies.

Nurses interviewed emphasised the importance of students' independence in accessing health care and encouraged and facilitated students to take responsibility for their health and to access health care independently of the school health services wherever possible. However, for reasons of access, affordability and confidentiality this is not always feasible.

5.3 Health services and schools

Most nurses report to principals or senior staff about clinical activities, and principals indicated that more than half the reports also go to boards of trustees. About a third of nurses indicated that they report to boards of trustees on both types of services offered and throughput.

Most nurses indicated that they were involved in providing some health education within schools, and many also provide some in-class teaching or assistance in the health education curriculum or provide advice to teachers taking health classes.

In the interviews with nurses it was apparent that acceptance by the school community and their relations with other staff were important to nurses, and that they work hard to develop and maintain these relations. Comments by principals also indicate a high level of respect for and understanding of the need for the services the nurses are providing. The high number of teacher referrals indicates that teaching staff find the nursing services appropriate and beneficial. However, in interviews with nurses there were some cases where the nurses' work was not valued by school staff, and was seen as being outside the domain of education.

Around two-thirds of principals who responded thought that the scope of nursing services available met the needs of the students at their schools. Of those who would like to see improvements, most wanted more hours, but improved funding and facilities were also mentioned.

Less than half the nurses surveyed indicated that they have a clinic area available, although around one-third share rooms that are used only for health purposes. Others are using rooms such as a classroom, library, or school changing rooms. The degree of privacy varied, and in interviews with nurses they sometimes indicated that both facilities and privacy are inadequate to meet their needs in terms of service provision and the students' needs for confidentiality.

5.4 Links to other services

A number of other health services are available in schools, including counsellors, hearing/vision testing, dental services, GPs, family planning, physiotherapists, and social workers. More than half the nurses surveyed indicated there was a need for improved access to social workers, psychologists, and drug and alcohol counsellors. Less than half considered access to the services of a sexual health nurse (often themselves) was adequate. Some principals also indicated a need for extended services, in particular doctors and mental health services.

Most nurses see themselves as part of a team of other health and wellbeing providers, and link students to other services, including counsellors, family planning / sexual health providers, medical specialists, youth health centres, social workers, dental services, and RTLBs.[13] Most refer students to a family doctor or PHO, and many refer students to other GPs. Interviews with nurses indicated that often nurses develop links to local GPs where they can refer students whose parents are unable or unwilling to pay, or where because of transport difficulties or for reasons of confidentiality students were unable to access their own family GPs. Nurses also sometimes

[13] RTLB is Resource Teachers: Learning and Behaviour

developed standing orders with these local GPs in order to administer medications to students.

Nurses interviewed indicated that they attempt to involve the students' families in students' health care choices, and try where possible to refer students to their own family doctors. However, in many cases the health services being provided either from schools or through nurses' referrals to their own linked providers are the only options available. For rural students there are particular issues, as transport into the nearest town to visit a health centre may not be available or may be expensive. Without the health services available at schools, it is almost impossible for rural students to access services independently from their parents.

Given that for some students school-based health services may be the only practical option available to them, the issue of what happens in the school holidays becomes critical. Over one-third of nurses indicated that they can be contacted by students during the holidays. Some nurses made efforts to advise all students of other services available, such as Family Planning clinics or youth health centres, and others link students they have concerns about to these services. However, high proportions of nurses in the survey indicated that students make their own arrangements for health care in the holidays or that no special arrangements are made. This suggests that there are gaps in the provision of care or the 'hand-over' of care to other providers when schools are closed for the holidays.

5.5 Nurses' professional issues

Most nurses report to someone in their professional capacity as a nurse: just over half report to a senior nurse in their employing organisation, others to another professional in their organisation, and others to their employing body. Some stated that they report to colleagues, while some indicated that they did not report to anyone in a professional capacity. Most of these were nurses employed by schools.

One-third of nurses indicated that they do not receive clinical supervision, almost all of these being nurses employed by schools. For nurses employed by bodies such as DHBs, public health or PHOs, this supervision is usually provided within the organisation. For school-employed nurses there may be no structure available for them to access such supervision, and a number indicated that they make their own arrangements for this. Quite a number of nurses indicated that they received clinical supervision from peers or colleagues and make their own arrangements to meet competency requirements.

The number of school-employed nurses who do not report to anyone in a professional capacity and who do not receive clinical supervision indicates that there may be issues for these nurses in ensuring and supporting their 'safe practice'. Some of the nurses interviewed also raised the issue of 'safe practice' and the need to have clinical oversight, as well as adequate training, if nurses in schools are to provide a full range of services. There is a need to establish professional support structures for these school-employed nurses.

Almost all nurses in schools are registered nurses. Qualifications in family planning are held by about half the nurses and some have postgraduate qualifications in child health and/or youth health. The nurses surveyed also listed qualifications in rural

health, public health, sexual health, ECP dispensing, HEADSS training, child and family health, asthma, master's of nursing, mental health and paediatric health, and health education and teaching. Almost all nurses indicated registered nurse was the minimum qualification needed to work in a school.

Some nurses interviewed stated that the minimum qualification for a registered nurse working in a school includes basic adolescent development papers (such as Paediatrics 712, Youth Health Clinical Skills). Qualifications in adolescent health were often referred to as being very useful − if not essential − to the role. Nurses also spoke of the need to have worked in the community; for example, as a practice nurse within a PHO.

Other training that nurses described included family planning, which many had undertaken; in-service training in such topics as the legal aspects of working with youth, family violence and partner violence, abuse and neglect; as well as HEADSS assessment and other youth health assessment. At present this training, which is available to some public health nurses, is only recognised within the DHB. Within public health the first-year orientation currently includes components such as child abuse, youth abuse and family violence, but these are not part of NZQA qualifications. These components can be fashioned to what is needed in practice, but they are not recognised nationally and internationally, which is a disadvantage for nurses who often move around in their practice.

Nearly all the nurse respondents to the survey indicated that they received paid study days or time, and over three-quarters had course costs met by the school or their employing organisation. A few nurses also indicated that they had costs met by CTA funding, and some said they paid for their own professional development. No nurses indicated that they did not want to undertake any study or training.

Funding for study was an issue for many of the nurses interviewed, some of whom found it difficult to do papers on top of full-time work, or to organise to be away from work. The problem of travel to training institutes, in terms of both time and cost, was an issue for some nurses, particularly for rural nurses. On-line courses were seen as one possible solution to this problem.

Although most nurse respondents in the survey have worked for less than 10 years as a nurse in schools, many have long experience working in a wide range of nursing roles. There is also a reasonably high proportion of nurses who have made their careers within school nursing, having worked for 10 or more years in schools. Most nurse respondents were in the age ranges 40−59 years, and taking into account their wide experience within nursing, nurses currently working in schools are a highly qualified and widely experienced group. However, there is a preponderance of nurses in the upper age ranges (40−59 years), which has implications for future workforce planning.

5.6 Salaries and funding

Salaries for full-time nurses are mostly in the ranges over $50,000, but part-time nurses mostly earn between $20 and $29 an hour. Nurses in the higher salary ranges over $50,000 are more likely to be public health or DHB-employed nurses. School-

employed nurses are more likely to be earning middle-range salaries ($30,000 to $45,000).[14] School-employed nurses working part time are also the most likely to be earning the lowest hourly rates. The most highly paid nurses are also the ones most likely to have additional qualifications in family planning, and postgraduate child and youth health.

The link between health and education − healthy students will learn better − supports the presence of nurses in schools. Nurses in schools also consider that they need to be part of the school and wider community. However, for school-employed nurses, being supported only within education leaves them exposed to isolation from professional support and can expose them to challenges to their own 'safe practice'. Many of the nurses interviewed commented that funding for school health services should be through health.

To help fund health services for students, nurses can become ACC registered, which covers all consultations that are a result of accidents or injuries. In some DHB regions other money is provided for extra staff to undertake HEADSS assessments. Nurses also access Services to Improve Access (SIA)[15] funding for some services. For public health nurses, funding is provided via DHB funding and planning to public health, and clinics run alongside the school dental and school vision/hearing services.

Issues relating to funding through PHOs were raised by some nurses in interviews. In some cases there is only one PHO in an area, so all the students at the local schools are enrolled in that PHO. However, in some schools students could be enrolled in many different PHOs, so referring them to a GP who did not belong to their own PHO would require some 'claw back' from their PHO. This means that if the nurse refers a student to a GP in a PHO other than one the student is enrolled in, other sources of funding need to be found, or − what seems to be a common outcome − the GP sees the student for free. It appears that generally GPs are not using 'claw back', but funding is regularly sought through SIA, ACC or some other means and nurses use these sources of funding for referrals as far as possible. The other referrals depend on the goodwill of the GPs used by the schools' nurses.

Nurses interviewed also described the funding system as creating inequities for students, because GPs in different areas charge differently, meaning students from high socioeconomic areas have to pay a higher fee to see a doctor than a student in a low socioeconomic area. But adolescents do not have their own money, and if they want to access a GP independently from their families, a student in a high socioeconomic area might have just as much difficulty acquiring $35 for the fee as a student in a low socioeconomic area.

[14] These figures are from the survey of nurses; however, over a third of full-time nurses and nearly half of part-time nurses did not answer the questions on salary/wages.

[15] Services to Improve Access (SIA) funding is available for all PHOs to reduce inequalities among those populations that are known to have the worst health status: Māori, Pacific people and those living in NZDep index 9−10 decile areas. The funding is for new services or improved access. Examples of the successful use of SIA funding are: the provision of clinics at work sites, marae, church groups and schools; and transport services to help people get to clinics.

6 Conclusions and Recommendations

A key finding in this study is the variation in both the types of health services in schools and their funding provision, across different parts of the country and across school decile. In particular, it appears that the types and scope of health services available in schools does not depend on the provider so much as on the assessed health needs of the students, and scopes of services tend to be decided by the employer in consultation with the school.

The range of health services provided comprises first-aid and health assessments, personal health services (including administering medications and vaccinations), home visits, and referrals to other services. Nurses are also involved in the provision of health education, health promotion and the development of health plans within schools. Differences in services offered appear to be mainly dependent on the amount of time nurses are available in schools and on their levels of training and professional support.

Both nurses and principals would like to see health services in schools extended. Some nurses − school-employed nurses in particular − undertake very high numbers of consultations every week, and many principals indicated that they would like to see an extension of the nurse hours available at their schools. Young people are more likely than other age groups to:

- have unmet needs for GP services
- engage in high-risk behaviours such as the use of alcohol and drugs, driving while intoxicated, suicidal ideation and attempts, and non-use of contraceptives
- see GPs outside their normal providers (Ministry of Health 2008).

It appears from this research that most schools need better access to social workers, psychologists and drug and alcohol counsellors, and that many have less than adequate access to sexual health nurses, family advisers and fitness advisers.

Levels of met and unmet needs for these health services are not strongly related to school decile level. Both the numbers of consultations and services provided are much the same for high- and low-decile schools, although lower and mid-range-decile schools have the highest numbers of consultations and are more likely to be providing personal health services. These are also the schools more likely to be in need of other health and wellbeing services. Students in lower decile schools are slightly more likely than those from high-decile schools to use school health clinics for reasons of cost, transport difficulties or confidentiality. However, the differences are not large, and students from mid-decile schools are more likely than those from low-decile schools to attend for those reasons. Students in schools of all decile levels are engaging in the high-risk behaviours referred to above, and other differences between students, such as rural students' difficulties with transport to health services, are important reasons for meeting students' needs for health services within schools.

Most nurses refer students to a range of other health providers, such as GPs, specialists, family planning clinics, social workers, counsellors or education specialists. The most common referrals are to counsellors, and high numbers are made to students' family GPs and Family Planning clinics. It appeared from interviews with nurses that they work hard to develop links with other health providers and see themselves as part of a wider health team that includes other health providers at school (such as counsellors, physiotherapists and specialist education staff), but also outside agencies such as mental health providers and (particularly) GPs. Sometimes students are unable or unwilling to attend their family GP, and nurses usually have links to a local 'friendly' GP who will provide services at no or low cost. School-based health services are meeting these students' needs as far as possible, but there does appear to be a need for more ready access to GPs for students who are unable or unwilling to attend their family GPs.

School-based health services are situated within both health and education. The role of the nurse is a health role, but nurses working in schools are dealing with school students in the school environment. The role supports education as well as health, as students with high levels of physical and mental health and wellbeing are more likely to participate in education, leading to improved educational outcomes. In addition, many nurses undertake health education in schools and provide other services, such as the development of school health plans. Nurses who were interviewed expressed the wish and the need to work positively with schools, but were also very clear about being based in health.

On the one hand, nurses in schools are filling a gap in the unmet health needs of students who are failing to access other health services; on the other hand, they are supporting schools to enable students to learn better. For these reasons, it could be argued that funding for nurses in schools should come from both education and health, and many nurses in schools would favour this approach as they can see the need to be supported in both domains.

Potentially countering this argument is a view of the role of the public health nurse in schools. This view is that the role is just one part of the wider role of public health nurses to promote the health and wellbeing of students within the wider community. The two roles − the nurse in school and the public health nurse − are complementary, however, and there is evidence that public health nurses favour a collaborative model of practice (Alcorn 2001). Moreover, in some districts public health nurses are providing primary health care clinics in schools with exactly the same types of services as school-employed or other nurses. The main difference in general between the 'school nurse' and the public health nurse appears to be the hours available in schools.

An important difference between school-employed nurses and others concerns the clinical and professional support nurses receive. Most nurses employed by schools do not receive clinical oversight, and many do not report to anyone in a professional capacity. The professional isolation of school-employed nurses is an issue that needs to be addressed, as these nurses are not being professionally supported and need this oversight and support to ensure their own 'safe practice'. Whichever model for school health services develops, it needs to ensure there is professional support for nurses in schools.

Part of this concerns clarification of the role of the 'school nurse' within schools. The perception held by some of the school nurse as providing 'panadol and band aids', and who can also assist with some of the administration tasks, has helped sustain the low levels of professional support and lack of clinical oversight. It has also helped maintain the low levels of pay of some nurses in schools, and of part-time nurses in particular. Developments in youth health education are taking place and it is to be hoped that these will lead to adolescent health career pathways for nurses in schools. Almost all nurses in schools appear to be motivated to undertake further education, although some have difficulty obtaining funding and the other support needed to access further training. Although it appears that nurses employed by schools are receiving similar support to nurses employed by other agencies, ongoing support from employers for nurses to undertake further training, particularly along an adolescent nurse career pathway, seems more likely to occur if they are employed within health.

Health services currently available in schools have evolved from the earlier public health provisions, from schools' own initiatives, or from DHBs and PHOs in some districts in response to a perceived local need for a school-based health service. However, the absence of a policy concerning school-based health services and allowing ad hoc development of these services might lead to discrepancies in availability and access to services. Indeed, some school staff have indicated concerns about education money going into health services.

One way forward might be for DHBs to take responsibility for nursing services in schools, and to be equitably funded for this. They would need to come to arrangements with schools so that existing structures are not disrupted. Ideally, PHOs would be involved as part of linking to the wider health system. Links need to be made in particular to youth health centres, as not all students or young people are in school. There is a demand for extended GP services that are more accessible to students, as well as other health services, and links with PHOs might also enable nurses in schools to more easily link their students to these other health services.

The key research questions that were investigated in this research project were:

- What nursing services are provided in secondary schools?
- How are these services funded?
- How do they link to other health services?
- What are some of the professional issues for nurses working in schools?

In this study we have not determined which models of school-based health centres are the most effective. This was an exploratory study, which aimed to find out what sorts of school-based health services there are and to describe some of the issues relating to these services. There is New Zealand literature available that provides high-quality information on how to implement effective school-based health services (Ministry of Health 2004a; Winnard et al 2005). These guides are based on national and international literature and input from local stakeholders, so school-based health centres employing these guides should work well for students.

Neither have we obtained the views of students. What we know about how receptive students are to school-based nursing services is apparent only in their own uptake of

services: a high percentage of nurses say students make their own appointments or queue up. However, we do know that many of the barriers to young people accessing health services as outlined in the literature (not knowing how to access care, transport, inconvenient times, and cost) are unlikely to exist in school-based clinics.

Nor has this report explored the differences among students and schools (except school decile rating), such as student ethnicity, boarding or day students, single-sex or coeducational schools. There are likely to be differences in students' preferences concerning health services provision that are aligned to ethnicity and gender and what sorts of schools students attend. It is recommended in the literature (Ministry of Health 2004a; Winnard et al 2005) that school-based health services should engage with the school and community and should focus on youth involvement and participation. Such engagement, and particularly the involvement of young people, will help expose the differences and preferences concerning the delivery of health services that might exist between different student populations.

Suggestions for further research

As mentioned above, this research did not assess models of nursing services. Further information on the different models of school-based health services already in existence, and some evaluative understanding of these, would be useful in the development of further services. There are a number of different models already operating, and it would help in the development of new services if there was more information available about the different services they provide, how they link to other health services, and how they are situated in schools.

Further research should also investigate the views of students. They are the major stakeholders, and we need to learn more about what they need in terms of health services, how they would like health services provided, by whom, and the preferred types and arrangements of health services.

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Appendix 1: 'Other' services available at the schools

(based on the survey of principals)

Services questions

Which of the following health services for students are available at your school?

Table A1: Health services available in schools

Health service	Number	Percentage
Teacher or other staff member with first-aid training	143	93
School counsellor available at school	141	92
Regular clinic with nurse from outside organisation	93	60
Hearing/vision testing available at school	59	38
Dental services available at school	46	30
Regular clinic with school nurse on staff	43	28
Physiotherapist available at school	33	21
Other services	36	23

The section below shows the free text responses entered by principals in response to the option to enter 'Other services for students not included above'. Some of the responses mentioned one service; others mentioned several. No attempt has been made to edit or split the responses. Where there were several services mentioned, the whole of the response text has been shown under each of the different service headings. Where there is more than one identical response under a particular heading it means there were identical responses from two different principals. Where there were reasonably large numbers of principals mentioning a service, these numbers have been included. The headings are in alphabetical order.

Counselling

Eleven principals in total mentioned counselling as a health service available in their schools:

- adventure development counselling
- child and adolescent, alcohol and drug service, smoking cessation, other as needed
- counselling
- doctor, [named] drug and alcohol, family planning, sexual health counsellor
- drug & alcohol, and trauma counsellors
- drug and alcohol counselling
- mental health, sexual health, [named provider] − drug and alcohol counselling
- mental health, sexual health, [named provider] − drugs and alcohol, family planning
- outside agencies (eg, drug and alcohol, smoking cessation including nicotine replacement therapy)
- psychologist for ACC − sensitive claims work; youth worker from [named provider]; drug and alcohol counsellor from [named provider]; chaplin.

Dental

Mobile dental service available, as well as access to physio.

Doctors
A total of 26 principals described the services of a Doctor or GP as being available in their schools:

- daily doctor clinic (free)
- doctor
- doctor and family planning nurse
- doctor and family planning nurse
- doctor available at school and as a referral during school hours
- doctor available once per week
- doctor clinics currently suspended as no Dr willing to take the contract
- doctor in school
- doctor on site three days per week
- doctor on site once per week
- doctor one morning per week
- doctor through [named] youth health centre
- doctor visits for one hour per week
- doctor, [named provider] drug and alcohol, family planning, sexual health counsellor
- doctor, social workers, whānau liaison officer
- doctor/family planning/social worker
- doctor's clinic once a week
- doctor's clinic weekly
- doctor − twice a week
- family planning, social worker, doctor and physiotherapist when available
- free doctor consultation if needed
- GP
- regular clinic with outside doctor
- sexual health nurse and a doctor half-day clinic
- Youth Health Centre
- two visiting doctors (two mornings a week) employed by [named] PHO.

Family planning
Seven principals mentioned family planning as one of the services available at the school:

- doctor and family planning nurse
- doctor and family planning nurse
- doctor, [named provider] drug and alcohol, family planning, sexual health counsellor
- doctor/family planning/social worker
- family planning
- family planning, social worker, doctor and physiotherapist when available
- mental health, sexual health, [named provider] − drugs and alcohol, family planning.

Health support

- support staff
- two health support workers.

Health trust

- [Named provider] Iwi Social Services, Ngati Hine Health Trust
- [Named provider] Iwi Social Services, Ngati Hine Health trust.

Māori services

Six principals mentioned some sort of health service from a Māori provider:

- doctor, social workers, whānau liaison officer
- [named PHO]health
- kaiawhina
- [named provider] Iwi Social Services, [named] health trust
- [named provider] Iwi Social Services, [named] health trust
- psychologist for ACC − sensitive claims work; youth worker from [named provider]; drug and alcohol counsellor from [named provider]; chaplin.

Mental health

- mental health, sexual health, [named provider] − drug and alcohol counselling
- mental health, sexual health, [named provider] − drugs and alcohol, family planning.

Nurses

- full-time sick bay attendant in job share position − one of the job-sharers was a registered nurse in UK, the other has first aid training
- HEADS Assessment, registered nurse, enrolled nurse, social worker
- nurse employed by the school funded by PHO for the students
- occasional visits from district health nurse.

Psychologist

Psychologist for ACC − sensitive claims work; youth worker from [named provider]; drug and alcohol counsellor from [named provider]; chaplin.

Physiotherapy

- family planning, social worker, doctor and physiotherapist when available
- mobile dental service available, as well as access to physio.

Sexual health

Five principals mentioned sexual health services, separately from family planning:

- doctor, [named provider] drug and alcohol, family planning, sexual health counsellor
- mental health, sexual health, [named provider] − drug and alcohol counselling
- mental health, sexual health, [named provider] − drugs and alcohol, family planning
- sexual health nurse and a doctor half-day clinic
- specialist sexual health nurse/clinic Monday mornings.

Social worker
Five principals named social workers as providing other services at their schools:

- doctor, social workers, whānau liaison officer
- doctor/family planning/social worker
- family planning, social worker, doctor and physiotherapist when available
- HEADS Ass, reg. nurse, enrolled nurse, social worker
- social worker.

Other

- a very large number
- adolescent health centre, adjacent to school
- HEADS Ass, reg. nurse, enrolled nurse, social worker
- psychologist for ACC − sensitive claims work; youth worker from [named provider]; drug and alcohol counsellor from [named provider]; chaplin.

Appendix 2: Other employers of nurses

(from survey of principals)

1. **Who employs the nurse, if it is not public health, the school, PHO, a GP or youth health?**

Note: *To protect respondents' anonymity, actual names of PHOs have been replaced by [Named].*

First nurse:

- [Named] school's hostel
- [Named] PHO
- Plunket
- [Named] Trust
- [Named] High School pays nurse funded by the PHO
- [Named] Trust
- [Named]Youth Health Centre
- [Named] PHO

Second nurse:

- [Named]Trust
- [Named] Māori Health Provider

2. **Who pays the nurse at your school?**

Who pays your first school nurse?

	Own funds	Trust	AIMHI	Don't know	Other
	39	0	0	0	6

Who pays your second school nurse?

	Own funds	Trust	AIMHI	Don't know	Other
	11	0	0	0	4

3. **Who pays your school nurse if it is not your own funds, a trust or charity, or AIMHI?**

First school nurse:

- [Named] School's Hostel
- District Health Boards (named six times)
- included with wages from School Support
- PHOs (named twice)
- parents' donations

Second school nurse:

- PHO (named twice)
- District Health Board and PHO
- parents' donations.

Appendix 3: Health services available

(from survey of principals)

1. Health services offered by schools with no nurse, one nurse and more than one nurse

The services mentioned by principals have been conflated so that multiple instances of, say, 'doctor once a week' have been shown only once. The columns indicate where the particular service has been mentioned by a principal of a school with none, one, or more than one nurse. As far as possible the entries have been placed in a logical sequence.

	None	**1**	**> 1**
Counselling			
Child and adolescent			X
Counselling			X
Trauma counsellors		X	X
Drug counselling	X	X	X
Alcohol counselling	X	X	X
Smoking cessation	X		X
Adventure development counselling	X		
Dental			
Mobile dental service available		X	
Doctors			
Doctor	X	X	X
Daily doctor clinic (free)		X	
Free doctor consultation if needed			X
Doctor available at school and as a referral during school hours		X	
Doctor on site 3 days per week			X
Doctor twice a week			X
2 visiting doctors (2 mornings a week)		X	
Doctor available once per week.		X	
Doctor 1 morning per week		X	
Doctor half-day clinic	X		
Doctor visits for 1 hour per week	X		
Regular clinic with outside doctor	X		
Doctor clinics currently suspended as no Dr willing to take the contract		X	
Vibe		X	
Family planning			
Family planning	X	X	X
Health support			
Support staff		X	
2 health support workers			X

Māori services			
Whānau liaison officer			X
[named PHO]Health		X	
Kaiawhina		X	
Youth worker from [named provider]		X	
[Named] Health Trust	X		X
[Named provider] Iwi Social Services	X		X
Mental health			
Mental health		X	X
Nurses			
Sick bay attendant			X
Reg. nurse, enrolled nurse			X
Nurse employed by the school funded by PHO for the students		X	
Occasional visits from district health nurse	X		
Psychologist			
Psychologist for ACC − sensitive claims work		X	
Physiotherapy			
Physiotherapist when available		X	X
Sexual health			
Sexual health counsellor	X		X
Sexual health [named provider]		X	
Sexual health nurse	X	X	
Social worker			
Social worker		X	X
Other			
Adolescent health centre, adjacent to school			X
HEADS Ass.			X
Chaplin		X	

2. Services available at schools with no nurse

There were 37 schools without a nurse. The services principals said they had were:

- Ngapuhi Iwi Social Services, Ngati Hine Health Trust
- outside agencies (eg, drug and alcohol, smoking cessation including nicotine replacement therapy)
- regular clinic with outside doctor
- doctor visits for one hour per week
- sexual health nurse and a doctor half-day clinic
- doctor, Rubicon Drug and Alcohol, family planning, sexual health counsellor

- occasional visits from district health nurse
- adventure development counselling.

Appendix 4: Improvements to health services

(from survey of principals)

1. **If you think the scope of nursing services available does not meet the health needs of students at your school, what else could the nurse do that would fill these needs?**

Topic	Response text
Facilities	Better facilities. At present, small room and the office and the actual sick bay are one room − makes confidential enquiries quite difficult.
	Better facility.
	More hours and better facilities.
	More space overall, including confidential space.
	More time available and better facilities at school for clinic.
	Relocation and refitting of the sick bay so that it is well away from the staff room. Funding to employ a registered nurse.
	We are currently recruiting an additional part-time nurse to cover the busy interval and lunch periods. We are also interested in the free doctor's clinic available and are restricted presently by lack of space at our current sick bay.
	Would be good to have a[n] otoscope available to look in ears. Would be good to have air conditioning and better lighting.
Funding	1. Funding by Health Dept. − school funds limited 2. Funding of release time for prof[essional] dev[elopement].
	Full-time medical services funded for the school would be of assistance; especially in a low-decile school like ours.
	Funding to allow for nurse supervision / study leave etc.
	Government funding would enable us to develop the service further.
	Have the government recognise that this is an essential service and provide for it properly within the operations grant. Then we could offer better pay scales and keep the fine people we recruit who sometimes leave
	I need to have her full time; currently can't afford that.
	I would like to see her able to be paid more as she does an awesome service. But here at [the school] we have a health centre with excellent facilities. Our nurse has regular supervision and professional development.
	More funding for a school-based nurse as opposed to having [to] use the hostel services.
	More funding to allow more qualified nurses to be employed to concentrate solely on nursing activities.
	Relocation and refitting of the sick bay so that it is well away from the staff room. Funding to employ a registered nurse.
	We are a decile 1 school and needs for health services are very high.
Liaison	Include the service in health education programmes and whole-school programmes.
	More advice to parents about the legality of such services, especially the sexual health side.

	More liaison with the PE [Physical Education] and health faculty so that she can be used as a learning resource.
	We are a large school so better advertising of when they visit would be better.
	We need to meet and review more than we do currently.
More hours	Daily attendance during school hours enabling the range of services to be expanded.
	Extended hours. Presently they are available only on certain days. A nurse available daily would be of great advantage.
	In a low-decile secondary school such as ours we very much need the availability of health/nursing services. The pressure on the public health nurse in our rural area is immense. Having someone 'on call' or able to run a regular clinic would be useful.
	It would be good to have the nurse in school more frequently than the current 1 hour per week.
	More frequent visit − at present we get 40 mins (lunchtime) per week. The counsellors often have to refer students to outside nurses (under a contraceptive contract).
	More hours; AIM HIgh year 9 health screening to broaden our data base and build confidence to attend health room in the year 9 age group for future years.
	More hours and better facilities.
	More hours available.
	More hours available for full time.
	More hours for health nurse.
	More paid time made available; it is only 4 hours a week.
	More people, more time.
	More regular visits from a public health nurse. Two hours a week for a school of 140 is insufficient.
	More regularity. At present they come 1 day per week.
	More time allocated − currently the nurse combines her nursing duties with reception duties, and they tend to dominate.
	More time available and better facilities at school for clinic.
	More time is needed. She comes once a week, possibly increased to twice a week.
	More time. At present she has a clinic only once a week for 2 hours. We could easily use her services for a whole day.
	Need longer hours available for nurse and doctor. Nurse here 7 hours per week. Doctor here 3 hours.
	Need more time. She works only 1 hour a week and we could do with 4−6 hours a week.
	The nurse is here 1 lunchtime a week. It would be good to see more of her; eg, 2 times a week.
	The PH nurse is here only 2 hours per week and works in a 'tight medical paradigm'. It would be useful for them to (a) gain a greater awareness of other student support paradigms (eg, therapeutic) and (b) have ready access to clinical and cultural supervision.
	They already give us 2 days, which are fully utilised, and come in at other times if requested. We could always use more.

	We need a full-time social worker and full-time doctor. Family Planning come in 1 day a week. We have had no Family Planning assistance for anything up to a term at a time because of their difficulties in getting suitably qualified people.
	We need to have a 'registered nurse' available to visit the school on a regular basis − weekly.
	We struggle to fund one nurse full time, but the demand sometimes exceeds her ability to respond in a timely fashion. The nurse could also be doing more teaching of health and nutrition if she had more time so we could be more proactive rather than react.
	Would be better if we had a public health nurse available daily.
	Would like a nurse stationed at the school for more hours who could also be involved in the curriculum of the school.
Services are adequate	Can't say that I have thought about this.
	Currently we do not have a health nurse available as there is a recruitment process in place to replace the nurse who resigned at the beginning of the year. This is being done by the [Named] DHB.
	Every Wednesday lunch time we have a doctor or nurse that spends up to an hour in our clinic seeing students. If there are students that want to see a Dr outside this time, I make an appointment in town and there is no cost.
	Going well with a reg. nurse and a PHO-funded nurse / health care specialist.
	Have a great service: 2 full-time nurses and a GP 12 hours a week.
	It's an excellent service.
	Just want to clarify that the nurse employed by the school has enrolled nurse qualifications but we use her more as a 'first aider' to treat what needs to be attended to and then handing over to parents or other member of the team if appropriate.
	Maybe a weekly regular visit by a public health nurse would be good, but I think that has been trialled and many weeks there was no one for her to see.
	n/a
	No as we have 2 FT nurses and a doctor visits 3 times a week.
	None.
	Nothing − they are excellent.
	Nothing at present.
	Our public health nurse has begun a self-referral clinic. It is in the very early stages, so not sure at this stage, but the nurse's clinic was set up in response to survey and focus groups carried out in 2007.
	She has just started and is setting up the service.
	Sufficient to our needs.
	Supported by doctor.
	The role of the nurse is closely integrated with the work of the guidance department. Teachers may refer directly to the nurse, but more often it is through guidance. The service is already excellent and we are blessed by our location − next to [named district].
	The service is in fact too good. It is difficult to keep it to emergencies

	and accidents, which is what it is designed for. There is a tendency for it to be used as a regular health check up / monitoring / flu / colds etc.
	Too new in the job to comment.
	We had a public health nurse in the past; for some reason that service ceased; we have just been given a public health nurse again.
	Works well.
Staffing	Stability of staffing.
	We should have two nurses.

2. **Are there any issues regarding student health services at your school that you would like to comment on? These may include any plans to extend health services.**

Topic	**Comments**
Rural issues	1) No dental service for secondary students. Any referrals go to [city] 2 hrs away. TOTALLY USELESS. 2) Limited visits by public health nurse running a clinic on site. 3) Health clinic on boundary runs a pretty good service.
	Most health services are outside the school and town, especially specialist services; no public transport to services in larger centres.
	Real issues with access to health services in general and mental health in particular for rural students.
Extension of services	A one-stop shop with medical, social service and police personnel on hand at least some part of each day would be helpful.
	An increase in visits.
	As a decile 1 school we have ongoing health issues with students and their families; there are occasions when students: 1. share medications; 2. have to 'nurse' siblings or their care givers, especially grandparents; 3. [have] easy access for students to pregnancy testing and contraception but not to personal medical care.
	Funding of health services is appalling! Our school of 900 students has 1 hour from a visiting doctor and 1 hour of a visiting 'sexual health' nurse. And nothing else! We have arranged for a physiotherapist to visit − he funds himself (ACC).
	Some days it would be good to have extra help − but it cannot be foreseen.
	Students have very good service for pregnancy testing and advice re contraception. Would like to have the same level of service available for other medical and health concerns.
	Students often go off site to visit the One Stop Youth Shop − during school time. It would be better to have this service on-site. However, there is an issue for us as a Catholic school with some of the information/advice given not sitting well with the values and beliefs of the Catholic church and the fact that parents are not aware of their child's attendance.
	The doctor's services link us with the PHO. I would prefer better communication and an annual review from the PHO. I think funding

	from the PHO is inadequate.
	We have had to battle for the mobile dentist. Thankfully [it] is coming now. We need counselling help to assist students to cease smoking.
	We have 2100 students and it makes sense that we become a 'large' central health care provider. BUT without external funding we will always only be able to scratch the surface.
	Working with DHB to extend services.
	Our local doctor holds a clinic here for 2 hours once a week. We could easily extend this to 3 or 4 hours.
	Huge demand on staff time to volunteer their services for first aid. Huge cost involved in delivering first aid; huge cost in maintaining qualifications for first aid.
Improved mental health services	Concern about access to mental health services for students who are seriously at risk of self-harm. Currently when there is a crisis situation, the family has to drive the student to obtain services, nearly a 2-hour drive across a mountain pass.
	Counselling time is too limited.
	I would like to offer more hours − we really only have one person but job share; more need for mental health services to support our young women.
	It would be useful to have a regular counsellor, doctor at the adolescent health centre.
	Like to have a smoking clinic to ensure that the level of support/counselling is available − currently guidance counsellor is too busy to provide the amount of support required.
	More PD [professional development] for all staff about mental health issues and eating disorders.
More nurses/nurse hours	Difficulty in getting qualified nurses.
	For the last few years we have had a nurse from regional public health for about 1.5 hours a week. That has not been available this year. We are undergoing major reviews of the food sold at our tuckshop and provided in the boarding school.
	Having a practice nurse available would be good, as well as having the sexual health service.
	The health nurse visits once a fortnight for one half-hour clinic − minimal service.
	We cannot afford a nurse so only offer a minimal service and have to advise families that this is the case.
	We get a very poor service from the district health nurse.
	We would very much like to have a second nurse to help us deal with the constant need to provide emergency care as well as preventive care, particularly in the sexual health and eating disorder areas.
	Inconsistent patterns of nurses being available. We are hoping this year will be better.
More	Have asked for support to screen students' vision and hearing but

vision/hearing	this has not been forthcoming from local DHB.
	Improve the hearing testing facilities.
More sexual health services	We are continually challenged about how students access urgent sexual health services on days when the health nurse is not in the school and the students do not have the knowledge/consent of their parents.
	We have a doctor clinic for 3 hours once every week. This is adequate for our needs. We have a sexual health nurse for 2 hours once a fortnight; this does not come close to meeting our needs and have been trying without success to get that extended.
More Dr hours/services	I would love to have the services of a doctor also or physio, especially after sport, but funding is always an issue.
	We are exploring the possibility of bringing in a doctor once a week for students who do not have or are unable to access a GP. Some difficulty in getting health professionals to case conference so that they are not all working in isolation with individual students. Important to know that anything affecting a student's learning is reported back to the school somehow − NAG 2 [National Administration Guidelines for school administration].
	We need a doctor in our health centre 30 hours a week. We have superb facilities, but there is a paucity of doctors wanting to be school doctors.
	We need a funding stream for doctors in schools.
	Would love to have a doctor's clinic at school on a Monday morning.
	Would love to extend to doctor's clinic, family planning clinic, etc. Again it will be funding and also time to brokerage such with local organisations.
	Our local doctor holds a clinic here for 2 hours once a week. We could easily extend this to 3 or 4 hours.
Improved facilities	Lack of facility to adequately accommodate a full-time nurse station.
	We would like to build partnerships with all health organisations working with young people who are enrolled with us. We need better spaces for this to occur.
	We would like to extend the health centre so it could house the guidance team as well.
	We would like to have a consulting room provided for the doctor and the nurse clinic as well as any other specialists coming into the school, but [we are] unable to provide this due to lack of funding.
Services OK	As above. [The service is too good.] We have all parents sign at enrolling that they have read the health policy, which includes the purpose of the clinic, the range of medications given, etc. At the same time they fill in a form indicating the health status of their child and any medication/conditions. The nurse also keeps a list of high-needs health students (eg, those with EpiPens [Used for treating Anaphylactic Shock].) that all staff need to know about. Photos of them are in the main office and the gym, and their names are published each term in our internal newsletter for staff.

	As commented above at [named school] we have a very extensive health service. As well as those already quoted above we have 2 full-time counsellors, a daily prescription service and pathlab visiting daily.
	Very fortunate to have a school nurse who is extremely proactive about health initiatives across whole school − not just concerned with health centre.
	Vital service. Would not be able to afford it ourselves. Probably saves more money for health services than it costs.
	We also offer free alcohol- and drug-counselling services. We have a confidential fully staffed wellness centre, which has operated brilliantly for over 9 years.
	We have a particularly supportive health environment at school. Students are very well catered for.
	No [issues]
	No [issues]
	No[issues]
	No [issues]
	No[issues]
	Not at this stage.
	Not sure what will be provided.
	Nothing at present.
Other general comments	PHO-funded nurse (PHO call her the students' health co-ordinator) is WONDERFUL. BUT there have been ongoing issues re who 'calls the shots'. She is PHO funded and PHO have constraints and expectations, but she is employed by the school and we have constraints and expectations. In our local situation it has been surprisingly difficult to get on the same page as the PHO, when the ultimate concern of both agencies is the student.
	PHO is setting up more services that we will have access to.
	Better role definition of the following positions: student health nurse, head of health guidance counsellor / pastoral care. We are currently going through this process now as we work our way through the contract for the student health nurse's contract.
	I am not sure who our 'nurse' is supposed to be and would like to know the process for re-establishing this contact.
	I would like to see peer sexual health mentoring by senior students trained in this, as happens in some schools in [named city].
	The nurses' team teach in health lessons and are like de facto staff members.
	The school and the PTA raised funds for all equipment etc inside the health centre. Salaries come out of operation grant.
	Too new in the job to comment.
	We are a small rural secondary school. We work closely with the various organisations in the community that are interested in the health of our students.
	We are in the throes of providing for a doctor to be on site for 3 hours a week.
	We are pleased to have this free service provided by the [Named]

	Medical Centre since l995.
	We discovered recently that our nurses have been carrying out routine injections for some students that previously would have been cared for by the district nurse. It is a concern that DNs [district nurses] are expecting school nurses to take on some of their responsibility.
	We have a community-funded youth mentor who works at our school part time. She also does very valuable work outside of the school with our students. This position is only possible through the funding gained by a charitable trust in the community.
	We have the public health nurse visit regularly − maybe more regularly in the past than now.
	We hope to have the services of a visiting GP on board soon.
	We require all nursing services to be in keeping with the special character of the college.
	Would like to comment at this stage that the school nurse is not a qualified nurse: 3 of us are first-aid trained and have regular visits from Diabetes Awareness to instruct with injecting procedure should it be necessary.

Appendix 5: Additional tables from survey of nurses

Table A2: Holiday arrangements

Holiday arrangements	Percent
Do not see students for personal consultation	8.1
Nurse available for consultations at school during the holidays	4.7
Before the holidays, *all* students are provided with information about another nurse clinic they can attend	11.9
Before the holidays, *all* students are provided with information about a GP clinic they can attend	14.0
Before the holidays, *all* students are provided with information about how to access the Family Planning clinic	10.2
Before the holidays, students *you have concerns about* are provided with information about how to access the Family Planning clinic	29.8
No special arrangements made	32.3
No information given to students by school or nurse at end of term about alternative arrangements for health care	10.2
Students make their own arrangements for health care	46.8
You can be contacted by students during holidays	36.6
Other	23.8

Table A3: Hours available for consultation, by hours worked

	Hours nurse available for consultations (%)							
Hours worked per week	**0−5**	**6−10**	**11−15**	**16−20**	**21−25**	**26−30**	**31−35**	**Over 35**
≤ 10	27.17	3.26	2.17	2.17	1.63	0.54	1.63	2.72
11−20	3.80	0.54	1.09	1.63	1.09	1.63	1.09	2.17
More than 20, but less than full time	6.52	2.17	0.00	1.09	2.17	8.70	4.35	3.80
Full time	3.80	1.09	0.00	1.09	1.63	1.63	3.26	4.35

Table A4: Type of employer, by job title

	Type of employer (%)					
Job title	**The school**	**Public health**	**DHB**	**PHO**	**Youth health centre**	Another organisation
School nurse	34.35	0.43	4.35	0.43	0.00	1.74
Public health nurse	0.00	23.91	25.22	0.00	0.00	0.00
Youth health nurse	0.87	0.87	0.00	0.00	0.00	0.00
Rural nurse	0.43	0.00	0.43	0.00	0.00	0.43
Non-nurse	1.74	0.00	0.00	0.00	0.00	0.00
Other	2.17	0.00	0.00	1.74	0.00	0.87

Table A5: Type of employer, by DHB district

	Employer (%)					
	The school	**Public health**	**DHB**	**PHO**	**A youth health centre**	**Another organisation**
Northland	0.86	3.00	2.15	0.00	0.00	0.00
Waitemata	6.44	1.29	1.29	0.00	0.00	0.43
Auckland	12.02	0.86	3.43	0.00	0.00	0.00
Counties Manukau	5.58	0.00	1.29	0.00	0.00	0.43
Waikato	4.29	2.15	3.86	0.00	0.00	0.43
Bay of Plenty	2.15	0.00	0.00	1.29	0.00	0.00
Lakes	0.43	0.00	0.43	0.00	0.43	0.43
Tairawhiti	0.43	0.00	0.00	0.43	0.00	0.00
Taranaki	0.43	0.43	3.43	0.00	0.00	0.00
Hawke's Bay	0.86	3.00	2.15	0.00	0.00	0.43
MidCentral	0.86	2.15	0.00	0.00	0.00	0.00
Whanganui	0.43	1.72	0.00	0.00	0.00	0.00
Hutt	0.43	1.72	0.00	0.00	0.00	0.00
Capital & Coast	0.43	0.86	0.00	0.43	0.00	0.43
Wairarapa	0.43	0.00	0.43	0.00	0.00	0.00
Nelson Marlborough	0.86	1.29	0.43	0.00	0.00	0.00
West Coast	0.00	0.43	0.00	0.00	0.00	0.00
Canterbury	1.72	2.15	6.44	0.00	0.00	0.43
South Canterbury	0.43	0.00	2.15	0.00	0.00	0.00
Otago	0.00	3.86	1.29	0.00	0.00	0.00
Southland	0.00	0.00	1.72	0.00	0.00	0.00

Table A6: DHB regions ranked by type of employer
Cross-tabulation percentages

	Type of Employer
DHB region	The school (Percentages)
Auckland	12.02
Waitemata	6.44
Counties Manukau	5.58
Waikato	4.29
Bay of Plenty	2.15
Canterbury	1.72
Hawke's Bay	0.86
MidCentral	0.86
Nelson Marlborough	0.86
Northland	0.86
Capital & Coast	0.43
Hutt	0.43
Lakes	0.43
South Canterbury	0.43
Tairawhiti	0.43
Taranaki	0.43
Wairarapa	0.43
Whanganui	0.43
Otago	0
Southland	0
West Coast	0

	Type of Employer
DHB Region	DHB (Percentages)
Canterbury	6.44
Waikato	3.86
Auckland	3.43
Taranaki	3.43
Hawke's Bay	2.15
Northland	2.15
South Canterbury	2.15
Southland	1.72
Counties Manukau	1.29
Otago	1.29
Waitemata	1.29
Lakes	0.43
Nelson Marlborough	0.43
Wairarapa	0.43
Bay of Plenty	0
Capital & Coast	0
Hutt	0
MidCentral	0
Tairawhiti	0
West Coast	0
Whanganui	0

	Type of Employer
DHB Region	Public Health (Percentages)
Otago	3.86
Hawke's Bay	3
Northland	3
Canterbury	2.15
MidCentral	2.15
Waikato	2.15
Hutt	1.72
Whanganui	1.72
Nelson Marlborough	1.29
Waitemata	1.29
Auckland	0.86
Capital & Coast	0.86
Taranaki	0.43
West Coast	0.43
Bay of Plenty	0
Counties Manukau	0
Lakes	0
South Canterbury	0
Southland	0
Tairawhiti	0
Wairarapa	0

	PHO
DHB Region	(Percentages)
Bay of Plenty	1.29
Capital & Coast	0.43
Tairawhiti	0.43
Auckland	0
Canterbury	0
Counties Manukau	0
Hawke's Bay	0
Hutt	0
Lakes	0
MidCentral	0
Nelson Marlborough	0
Northland	0
Otago	0
South Canterbury	0
Southland	0
Taranaki	0
Waikato	0
Wairarapa	0
Waitemata	0
West Coast	0
Whanganui	0

	A youth health centre
DHB Region	(Percentages)
Lakes	0.43
Auckland	0
Bay of Plenty	0
Canterbury	0
Capital & Coast	0
Counties Manukau	0
Hawke's Bay	0
Hutt	0
MidCentral	0
Nelson Marlborough	0
Northland	0
Otago	0
South Canterbury	0
Southland	0
Tairawhiti	0
Taranaki	0
Waikato	0
Wairarapa	0
Waitemata	0
West Coast	0
Whanganui	0

	Another organisation
DHB Region	(Percentages)
Canterbury	0.43
Capital & Coast	0.43
Counties Manukau	0.43
Hawke's Bay	0.43
Lakes	0.43
Waikato	0.43
Waitemata	0.43
Auckland	0
Bay of Plenty	0
Hutt	0
MidCentral	0
Nelson Marlborough	0
Northland	0
Otago	0
South Canterbury	0
Southland	0
Tairawhiti	0
Taranaki	0
Wairarapa	0
West Coast	0
Whanganui	0

Tables A7–A9 show reasons for students' use of school health services, by school decile.

Table A7: Desire for confidentiality, by school decile

Decile	Very often/often	Sometimes or never for this reason
1	4.6	3.8
2	9.9	0.0
3	6.9	3.8
4	11. 5	1.5
5	11. 5	2.3
6	7.6	1.5
7	3.1	3.1
8	5.3	3.1
9	3.1	7.6
10	5.3	4.6

Table A8: Parents unwilling/unable to pay, by school decile

Decile	Very often/often	Sometimes or never for this reason
1	3.9	4.7
2	7.0	3.1
3	4.7	6.2
4	9.3	3.9
5	3.9	10.1
6	3.9	5.4
7	2.3	3.9
8	4.7	3.1
9	3.1	7.0
10	2.3	7.8

Table A9: Transport inaccessible, by school decile

Decile	Very often/often	Sometimes or never for this reason
1	4.6	3.9
2	8.5	1.5
3	3.9	6.9
4	10.8	2.3
5	9.2	4.6
6	6.2	3.1
7	1.5	4.6
8	6.2	1.5
9	0.8	10.0
10	2.3	7.7

Table A10: Nurses receiving clinical supervision, by type of employer

Type of employer	Percentages	
	Yes	No
The school	17.0	21.1
Public health	22.4	3.6
DHB	23.8	7.2
PHO	0.9	0.9
A youth health centre	0.4	0.0
Another organisation	1.3	1.3

Table A11: Holiday arrangements

Holiday arrangement	Number	Percentage
Not available for personal consultations	19	8
Nurses available for consultations	11	5
All students provided with information about **nurse clinic**	28	12
All students provided with information about **GP clinic**	33	15
All students provided with information about **Family Planning clinic**	24	11
Some students provided with information about **Family Planning clinic**	70	31
No special arrangements made	76	33
No information is provided	24	11
Students make own arrangements	110	48
Can be contacted during holidays	86	38
Other	56	25

Note: Percentage total sums to more than 100 because respondents could select more than one response category.

Table A12: School decile, by health services provided

Type of health service provided	Decile level of school (%)*										
	1	2	3	4	5	6	7	8	9	10	Total
First aid	6.6	8.1	6.6	9.6	7.4	7.4	5.2	5.9	10.3	9.6	57.5
Health assessment	6.6	8.8	8.1	11	11	7.4	4.4	5.9	5.2	6.6	75
HEADDS assessment	7.4	8.8	8.1	8.8	8.1	7.4	2.9	6.6	2.9	4.4	65.4
Refer students to other health providers	7.4	9.6	9.6	13.2	13.2	9.6	5.9	8.1	9.6	9.6	57.4
Personal health services for students	5.9	8.1	8.8	10.3	12.5	5.9	4.4	7.4	5.9	6.6	75.8
Prescribing where appropriate	4.4	6.6	5.2	7.4	6.6	4.4	1.5	5.9	3.7	2.2	47.9
Vaccinations and immunisations	3.7	2.2	3.7	5.2	3.7	1.5	1.5	2.2	5.2	1.5	30.4
Home visits	3.7	4.4	4.4	4.4	4.4	4.4	1.5	2.9	0.7	1.5	32.3
Health promotion	5.2	8.8	7.4	11	11.8	8.1	5.9	5.9	8.8	8.8	81.7
Health education	5.9	8.1	8.8	11	9.6	8.1	4.4	6.6	6.6	5.9	65.4
Work as nurse with school to develop school health plan	4.4	4.4	4.4	5.2	6.6	2.9	1.5	2.2	2.9	2.9	37.4
Work as nurse with school to develop a specific health plan	3.7	2.9	7.4	8.1	5.9	2.9	5.2	4.4	5.2	5.2	50.9
Educating staff on health issues	4.4	6.6	8.1	8.8	12.5	7.4	5.9	5.2	6.6	7.4	72.9
Other	1.5	1.5	2.9	2.9	2.9	0.7	0	0.7	1.5	1.5	16.1

Notes: N = 136. Percentage totals are more than 100 as respondents could select more than one response category. *Cross-tabulation percentages.

Table A13: Hours available for consultation, by school decile

	Hours available (%)*							
Decile	0–5	6–10	11–15	16–20	21–25	26–30	31–35	Over 35
1	1	0	0	1	1	2	1	3
2	4	0	0	2	1	0	2	2
3	2	1	0	1	1	3	1	2
4	0	2	0	2	1	2	4	3
5	4	1	0	0	0	3	3	1
6	8	0	0	0	2	2	1	0
7	0	1	0	0	1	2	1	1
8	2	3	2	0	1	2	0	0
9	3	0	0	1	1	1	3	4
10	1	0	0	0	11	4	2	3

Note: N = 136.

*Cross-tabulation percentages.

Table A14: Number of consultations, by school decile

	Number of consultations (%)*						
Decile	**< 21**	**21−40**	**41−60**	**61−80**	**81−100**	**101−120**	**120+**
1	3	2	1	1	1	0	2
2	4	2	1	1	1	0	2
3	4	2	1	0	2	2	1
4	4	2	0	0	1	1	5
5	5	4	1	3	0	0	2
6	6	2	0	1	1	1	0
7	1	1	1	1	0	0	2
8	3	2	0	1	0	1	2
9	3	3	1	1	0	0	3
10	2	1	0	2	2	0	5

Note: N = 136

*Cross-tabulation percentages

Table A15: Hours nurse works in school, by school roll

	Hours worked (%)*			
School roll	**10 or less**	**11 to 20**	**More than 20, less than full time**	**Full time**
0−199	2	1	1	1
200−399	5	2	4	1
400−599	9	1	2	2
600−799	4	1	5	4
800−999	4	4	7	4
1000−1199	2	2	6	2
1200−1399	2	1	5	12
1400−1599	1	1	2	2
Above 1600	0	2	7	3

Note: N = 135

*Cross-tabulation percentages

Table A16: Job titles for DHB-employed nurses

Job title	Number of DHB-employed nurses
School nurse	10
Public health nurse	58
Adolescent health nurse	0
Rural nurse	1
Non-nurse	0
Other	0
Skipped	2

Appendix 6: Nurse respondents 'other' qualifications

Other qualifications relevant to your position	
Qualifications or papers towards youth/child health	One youth health paper, ADN.
	Postgraduate youth health papers.
	Advanced diploma nursing − focus adolescence.
	Have done some youth health papers and population health.
	Child protection and advocacy, HEADDS training, family planning, ECP certified.
	Studied youth health, done 1 paper so far.
	Grad diploma in mental health nursing with an adolescent focus.
	Postgrad child was inclusive of up to 14 yr olds.
	Paediatrics assessment.
	Undertaking PG youth health currently.
	Paeds; 712 & currently Paeds 719.
	Postgrad child and family
	Master's in nursing youth focus
	PG Cert Well Child few papers at uni; health studies sexual health training over past 30 years.
	PG rural health; MN research portfolio on youth health.
	1 paper in postgrad youth health (Paeds 712); cert in alcohol and drug studies.
	PCP in paediatrics.
Rural health	Postgraduate certificate in rural health, postgraduate diploma in rural health.
	PG rural health; MN research portfolio on youth health.
Sexual health	Sexual and reproductive health cert.
	NZ resuscitation council instructor (level 2), national certificate in sexual and reproductive health (level 4).
	Child protection and advocacy, HEADDS training, family planning, ECP certified.
	ECP dispensing.
	National parenting strengths-based practice, counselling, clinical supervision, sexual health training.
	Authorisation for ECP.
	In-service training re ECP.
	PG Cert Well Child. Few papers at uni; health studies sexual health training over past 30 years.
	Just finished family planning qual. but cant practice in school.
	Doing postgrad sexual health.
	ECP endorsement.
Work/life experience	1979 – enrolled nurse; ward ex-medical/surgery; 2004 registered nurse BA; meningococcal B – team campaign, vaccination, PHN 2 years.
	Life experience.
	Worked A & GP practices. 30 yrs primary health, hospital trained,

	RGON.
	25 yrs [Named] hospital, acute setting, 8 yrs school nurse.
	Practising practice nurse.
	2 yrs OU/SU. 5yrs emergency department. 4 yrs district nurse.
	Ambulance officer.
	Mental health experience.
	ADN, BN, Certificate in Adult Teaching, clinical supervision level 5, care and protection advisor for CYFs and other nurses, CPR instructor.
	NZRN − 9 years − medical/surgical/plastics/ICU. NZ midwife 2 years. Childbirth educator 2 years.
	Paeds, district, practice, MeNZB programme, spinal
Vaccinator	Vaccinator, smoking cessation provider.
Mental health/counselling	RN, FP trained, BA nursing, cert in counselling, cert in Health Ed/Promotion.
	National parenting strengths-based practice, counselling, clinical supervision, sexual health training.
	Mental health experience.
Maternal/Plunket	Lactation consultant.
	Advanced diploma in maternal and child health.
	Plunket nurse.
	SRN, SCM.
	R Midwife / R Occupational health.
	PGDip Midw.
	BHS (nursing), Plunket nurse.
Public Health	PHN
	PHC and nurse.
	PHN
	Dip Pub Health.
	DPH (Diploma Public Health).
	Postgrad cert PH.
Health education/promotion	RN, FP trained, BA nursing, cert in counselling, cert in Health Ed/Promotion.
Other	PG Dip.
	Post grad cert − postgrad dip nursing finish 08.
	RGON/BN/Tchg Dip (Sec).
	BEd, Tchg Dipl.
	National parenting strengths-based practice, counselling, clinical supervision, sexual health training.
	BA Nursing, health teaching.
	Postgraduate in primary health.
	BA – double major in nursing and education.
	Asthma education diploma.

	Masters of Nursing.
	BN
	RCpN with Masters.
	Health visitor training (UK).
	Teaching cert; counselling cert both UK quals.
	Dip Nursing, BHSc Nursing.
	Expert PDRP; BHSc; Dip Sec Teaching.
	MN, Cert Adult teaching.
	RN [listed by 14].
	Comprehensive nursing.
	Post-grad trained primary health care.
	CAT (cert adult teaching).
	RGN
	2 teaching diplomas plus first aid quals.
First aid	First aid.
	Red Cross emergency first-aid certificate.
	First-aid certificate.
	Bachelor of Health Sciences but employed as admin staff and have a first-aid certificate.
	First-aid certificate.
	Emergency care – postgraduate certificate.
	First aid and CPR, updated 2 yearly.
	First aid.
	First-aid certificate and common sense.
	Advanced CPR trained.
	First-aid certificate.
	First-aid certificate.
	First-aid cert.
	First-aid cert.
	SRN and first aid updated every 2 yrs by St John's.
	First-aid cert validated every 2 yrs.
	Current first-aid cert.
	Trauma and emergency first-aid instructor.
	Comprehensive first aid.
	National Certificate in Ambulance. The other staff have workplace first aid.
	First-aid certificate, mother of 3 children.

Notes: Abbreviations used as in text, except: A & GP = Accident and General Practice; ADN = Associate Degreed Nurse or Advanced Diploma of Nursing; BHS = Bachelor of Health Science; BHSc = Bachelor of Health Science; BN = Bachelor of Nursing; CPR = Cardiopulmonary Resuscitation; FP = Family Planning; ICU = Intensive Care Unit; MN = Master of Nursing; NZRN =New Zealand Registered Nurse; PG = Post graduate; PH = Public Health; PHC = Primary Health Care; PHN =Public Health Nurse; RCpN = Registered Comprehensive Nurse; RGN =Registered General Nurse; RGON = Registered General & Obstetric Nurse; SCM = State Certified Midwife; SRN = State Registered Nurse.

Appendix 7: 'Other' services to which nurses make referrals

'Other' health or social service providers to which nurses refer students

Mental health	Mental health team, CAMHs
	Mental health team
	Mental health services
	Youth community mental health
	Mental health services
	Anger management/brief intervention/Caps/ family support
	Mental health services
	Mental health
	Mental health services
	CAMHS
	CAMHS
	Mental health team
	Mental health
	Secondary services, mental health services, drug and alcohol services
	Child and adolescent mental health service
	Child and youth mental health
	Mental health providers
	Eating awareness team (EAT); CYFS; SCAN (internal C+P of DHB)
	Child and adolescent community mental health
	Child and adolescent mental health service
Nurses	Visiting PHN
	PHN
	PHN
	Independent nurses who provide free consults to under 20s
	Referral to own M/O & base clinic PHN
Sexual health	Sexual health services
	Sexual health clinic
	Sexual health clinic, rape crisis
	DHB sexual health clinic
Dentist	Dental therapist/dentist
	Dentist
	Dentist
	Dentist and physio
	Dental care
Hearing and vision	Ear nurse; vision hearing technician; optometrist
	Hearing & vision tests
	Optometrist
Social workers	External social workers service
	Social worker, home support worker, community workers
	Mentor; CYFS
	Strengthening Families, dietician

	Community social services
	CYFS
	CYFS if required
	CYFS
	CYFS; SCAN (internal C+P of DHB)
	CYF service; Child Development Centre − Waikato Hosp; Strengthening Families
Physiotherapist	Physio, dentist
	Physio
	Physio
	Physio
	Physiotherapist
	Physio
Within school	Senior management team
GP or other	Local GP for sexual & green prescription
	Medical officer within service
	Emergency medical centre
	A&E
Youth centre	The 123 Clinic, The Pulse (one stop youth shop)
School	To their home room teacher/dean, particularly if they are worried about school workloads. Careers adviser or they worry about the future.
	Staff involved in pastoral care
	School Māori, PI liaison officer
Other	Group Special Ed; community dietician; Sport Waikato lifestyle coach
	Podiatrist.
	Paediatric home care
	Eating awareness team (EAT)
	Hospital clinics

Note: For abbreviations used, see notes to Appendix 6. In addition: A&E = Accident and Emergency; CAMHS = Child and Adolescent Mental Health Services; Caps = Child Abuse Prevention Services; PHN = Public Health Nurse; PI = Pacific Island.

Appendix 8: Principals' Survey

Health Services in Schools

Survey of Principals of Secondary Schools

Health Services Research Centre
Victoria University of Wellington
PO Box 600, Wellington

This survey is being sent to prinicpals in all secondary schools in New Zealand. It is part of a research project being carried out for the Ministry of Health investigating what health services are available in schools and how they are funded and managed. We appreciate your time in taking part in this survey. *It should take about five minutes to complete*.

Please do not send this form to the Nurse or other health provider. We are interested here in the views of the teaching staff, not the nursing or other health care staff. Separate work is being undertaken with the nursing group.

This survey is designed to be returned by email. Please save the survey form attached, fill it out and then 'reply' with your completed survey attached.

Your information will be treated confidentially and only the members of the research team will read your responses. No names or identifying characteristics will be reported. If you wish to receive a summary of the research results, you will need to include your name on the survey form. However, your information and details will not be seen by anyone except the research team. The survey forms will be destroyed five years after the project is completed.

Data from this survey will be analysed and written up into a report for the Ministry of Health and publication as articles in academic journals and presentation at conferences.

Ethical approval for this research project has been obtained from the Victoria University of Wellington Human Ethics Committee.

Student health services

1. What health services for students are available at your school?

Insert' x' or other symbol in left hand column wherever appropriate. You may select more than one.

	Teacher or other staff member with first aid training
	Regular clinic with school nurse on staff
	Regular clinic with nurse from outside organisation
	School counsellor available at school
	Physiotherapist available at school
	Hearing/vision testing available at school
	Dental services available at school
	Other *please describe* …

The following questions ask about the services provided by the Nurse so if there is no Nurse at your school, visiting or attending, please ignore the following questions and return the form.

***2.* Is the Nurse in the school employed by:**

Insert 'x' or other symbol in box on left hand column wherever appropriate. You may select more than one.

	Public Health
	The School
	A PHO (primary health organisation) or a general practitioner
	The District Health Board (DHB) but not Public health
	A youth health centre
	Another Organisation (Please name or describe) …
	Not Sure
	No Nurse at school

3. If there are two Nurses attending your school, is the second Nurse employed by:

Insert 'x' or other symbol in box on left hand column wherever appropriate. You may select more than one.

	Public Health
	The School
	A PHO (primary health organisation) or a general practitioner
	The District Health Board (DHB) but not public health
	A youth health centre
	Another Organisation (Please name or describe) …
	Not Sure
	No Nurse at school

4. If the Nurse is a 'school Nurse' - employed and paid through school, is s/he paid through

Insert 'x' or other symbol in box on left hand column wherever appropriate. You may select more than one.

	School's own funds
	Local Trust or charity
	AIMHI
	Other funding to school *(please describe)*…
	Don't know
	Nurse is not a 'school Nurse'
	No Nurse at school

How well do the health services work for the students and the school?

Insert 'x' or other symbol in box on left hand column where appropriate.

5. Do you receive regular reports about clinical activity undertaken by the Nurse?

	NO
	YES
	DON'T KNOW

6. Do teachers refer students to the Nurse?

	NO
	YES
	DON'T KNOW

7. Do students need their parent/guardian's permission to go to visit the Nurse?

	NO
	YES
	DON'T KNOW

8. Are there reports to the BOT about the nursing services?

	NO
	YES
	DON'T KNOW

9. Do you think the scope of nursing services available meets the health needs of students at your school?

	NO
	YES
	DON'T KNOW

10. If NO, what else could the Nurse do that would fill these needs?

Please write in box provided.

Other Issues

Are there any other issues regarding student health services at your school that you would like to comment on? These may include any plans to extend health services.

Please write in box provided.

Thank you for taking part in this survey

If you have any questions or would like any further information please feel free to contact:

Sue Buckley on 463 7480 or email sue.buckley@vuw.ac.nz

Please send me a summary of the final research report. Provide your name and address below only if you wish to receive a copy of the summary report.

Name:
Address or email:

Appendix 9: Nurses' Survey

Health Services in Schools

Survey of Nurses in Secondary Schools

Health Services Research Centre
Victoria University of Wellington
PO Box 600, Wellington

This survey is being sent to all Nurses working in secondary schools in New Zealand. It is part of a research project being undertaken for the Ministry of Health, investigating what health services are available in schools and how they are funded and managed. We appreciate your time in taking part in this survey.

We are interested in the views of the Nurses providing health services at the school. If you are not the Nurse who provides health services please send this questionnaire on to him/her.

You may have received this survey form from more than one source. We ask that you please fill out this survey *one time only.*

I would very much appreciate it if you can complete the forms enclosed and send them back to me by 21 May 2008.

All participants who return forms by 21 May 2008 can go in a draw to win $100 worth of book vouchers. If you would like to enter the draw make sure to include your name and address on the final page of the questionnaire.

Your information will be treated confidentially and only the members of the research team will read your responses. If you wish to receive a summary of the research results, you will need to include your name on the survey form. However, your information and details will not be seen by anyone except the research team.

Data from this survey will be analysed and written up into a report for the Ministry of Health and publication as articles in academic journals and presentation at conferences. No names or identifying characteristics will be reported.

The survey forms will be kept in a locked filing cabinet and will be destroyed five years after the project is completed.

Ethical approval for this research project has been obtained from the Victoria University of Wellington Human Ethics Committee.

Section A

1. **Which of the following services do you provide at school/s?**

Tick more than one if appropriate

- ☐ First Aid
- ☐ Health Assessment
- ☐ HEADSS Assessment
- ☐ Refer students to other health providers
- ☐ Personal health services for students
- ☐ Prescribing where appropriate e.g. ECP, antibiotics, Ventolin
- ☐ Vaccinations and Immunisations
- ☐ Home visits
- ☐ Health Promotion
- ☐ Health Education
- ☐ Works as Nurse with school to develop a school health plan
- ☐ Works as Nurse with school to develop a specific health plan e.g. pandemic
- ☐ Educating staff on health issues e.g. epilepsy and use of Epipen
- ☐ Other ***please describe*** _____

_____
_____

2. **How do you provide consultations to students?**

Tick as many as appropriate

- ☐ On a one-to-one basis (in school or on home visits or other)
- ☐ On a one-to-one basis but they can bring friends (in school or on home visits or other)
- ☐ Only talk to classes or groups, don't provide consultations
- ☐ Don't know
- ☐ Other ***please specify***_____
  _____

If you provide consultations, go to Q.3
If you do not provide consultations, go to Q. 10, Section C

Section B: Consultations to students

Only those respondents who provide consultations should answer Questions 4 – 8. Other respondents please go straight to Question 10, Section C.

3. What are the clinic facilities available to you at your school/s?

- ☐ A school-based health centre with clinic area for Nurse
- ☐ A room that is used only for health services (may be shared by other users such as counsellor/physiotherapist)
- ☐ Use of a non-health room such as school hall changing rooms
- ☐ Use of some other non-private area e.g. part of school hall
- ☐ Other ***please specify***_____

4. How many hours a week are you are available to students for consultation?

_____hours

5. How do students arrange to visit you?

Tick as many as appropriate

- ☐ Students make own appointments to visit you
- ☐ Students just queue up
- ☐ Teachers make referrals
- ☐ Parents make referrals
- ☐ Counsellor or other health professional makes referrals
- ☐ All Year 9 students attend for assessment
- ☐ Don't know

6. Approximately how many students visit you for a consultation each week? *Note: if students come in a group to support one student, please count as 'one consultation'. However, if they come in a group, but all want a consultation, count the total number of students.*

Please tick appropriate box. *If you provide consultations at more than one school, please add the total number of consultations you provide each week over all your schools.*

- ☐ Less than 20
- ☐ 21–40
- ☐ 41–60
- ☐ 61–80
- ☐ 81–100
- ☐ 101–120
- ☐ 120+

7. What arrangements are made for students during the holidays?

Tick more than one if appropriate

- ☐ I don't see students for personal consultations so not an issue
- ☐ You, or another Nurse, is available for consultations at school during the holidays
- ☐ Before the holidays, *all* students are provided with information about another Nurse clinic they can attend
- ☐ Before the holidays, *all* students are provided with information about a GP clinic they can attend
- ☐ Before the holidays, *all* students are provided with information about how to access the Family Planning clinic
- ☐ Before the holidays, students *you have concerns about* are provided with information about how to access the Family Planning Clinic
- ☐ No special arrangements made
- ☐ No information given to students by school or Nurse at end of term about alternative arrangements for health care
- ☐ Students make their own arrangements for health care
- ☐ You can be contacted by students during holidays
- ☐ Other, ***please describe*** _____

8. **What do you think are the <u>most frequent reasons</u> that students choose to visit <u>you rather than another service</u> for a consultation?**

   a. **For reasons of confidentiality -**

□ Very often □ often □ sometimes □ never for this reason

   b. **Because the school Nurse is close by (handy) at the time?**

□ Very often □ often □ sometimes □ never for this reason

   c. **Because parents are unwilling or unable to pay for GP or other health service**

□ Very often □ often □ sometimes □ never for this reason

   d. **Because student is unable to use suitable transport to other health service (e.g. either no transport available or student can't afford)**

□ Very often □ often □ sometimes □ never for this reason

   e. **Because it's 'comfortable' (friends can come too, it's familiar etc)**

□ Very often □ often □ sometimes □ never for this reason

   f. **Student doesn't know any other health service**

□ Very often □ often □ sometimes □ never for this reason

   g. **Students doesn't know how to access another health service**

□ Very often □ often □ sometimes □ never for this reason

   h. **Student is referred to you by a teacher**

□ Very often □ often □ sometimes □ never for this reason

   i. **Don't know** □

   j. **Other reasons why students prefer to use school health service not covered above, *please describe*-**
   _____

9. What are the <u>most common</u> reasons for consultations?

k. For advice on sexual matters, contraception, STIs etc

□ Very often □ often □ sometimes □ never

l. For advice on healthy eating etc

□ Very often □ often □ sometimes □ never

m. For advice on fitness, physical activity etc

□ Very often □ often □ sometimes □ never

n. For advice on weight loss or body shape

□ Very often □ often □ sometimes □ never

o. For treatment for injuries or general sickness e.g. sprains, asthma, headaches, skin conditions

□ Very often □ often □ sometimes □ never

p. To talk about mental health issues such as depression, anxiety

□ Very often □ often □ sometimes □ never

q. To talk about coping with family problems

□ Very often □ often □ sometimes □ never

r. Bullying / violence issues

□ Very often □ often □ sometimes □ never

s. For advice on smoking cessation

□ Very often □ often □ sometimes □ never

t. For advice on alcohol or drugs

□ Very often □ often □ sometimes □ never

u. There is no real pattern □

***v.* Are there any other common reasons for consultations not listed above? *Please describe* _____**

Section C: Other services

All respondents please answer Questions 10 onwards

10. If you make student referrals, which of the following health or social service providers do you refer students to -

Tick more than one if appropriate

- ☐ I don't make referrals
- ☐ Their own family GP/PHO
- ☐ Another GP/PHO
- ☐ A Specialist (e.g. dietician, paediatrician, ENT…)
- ☐ The Family Planning Clinic
- ☐ A youth health centre
- ☐ To a GP who makes regular visits to the school
- ☐ Social worker
- ☐ Counsellor
- ☐ Resource Teachers: Learning and Behaviour (RTLB)

Other ***please describe***

11. Do you work as part of a team of other health / wellbeing providers such as counsellor, social workers, RTLBs, GP and so on?

- ☐ Yes
- ☐ No
- ☐ Don't know/Not Applicable

12. Looking at the following providers, can you indicate your school's level of need for their services?

a. Social Worker

☐ Adequate access ☐ Has some access but needs more ☐ No access but needs
☐ Does not need ☐ Don't know/Not applicable

b. Psychologist

☐ Adequate access ☐ Has some access but needs more ☐ No access but needs
☐ Does not need ☐ Don't know/Not applicable

c. Occupational Therapist

☐ Adequate access ☐ Has some access but needs more ☐ No access but needs
☐ Does not need ☐ Don't know/Not applicable

d. Counsellor

☐ Adequate access ☐ Has some access but needs more ☐ No access but needs
☐ Does not need ☐ Don't know/Not applicable

e. Drug and alcohol counsellor

☐ Adequate access ☐ Has some access but needs more ☐ No access but needs
☐ Does not need ☐ Don't know/Not applicable

f. Sexual health Nurse

☐ Adequate access ☐ Has some access but needs more ☐ No access but needs
☐ Does not need ☐ Don't know/Not applicable

g. Fitness advisor

□ Adequate access □ Has some access but needs more □ No access but needs
□ Does not need □ Don't know/Not applicable

h. Family Advisor

□ Adequate access □ Has some access but needs more □ No access but needs
□ Does not need □ Don't know/Not applicable

i. Is there a need for some other health or wellbeing providers?

Please describe_____

13.Your involvement in health education curricula in the classroom

Tick this column wherever appropriate	**Your involvement in class**	**Please state how often you do this every year**
	You and the teacher *take health classes together* e.g. sexual health class	
	You *take the health class alone*	
	You *train teachers* for delivery of health education e.g. puberty class	
	You *provide advice to teachers* on health classes	
	You are *not involved* in teaching health classes	
	Other involvement in health curricula ***please describe*** ...	

Section D: Professional Issues

Management structure for Nurse

14. To which of the following do you report on your activities in the school

Tick more than one if appropriate

- ☐ Senior staff within school, principal, deputy principal etc
- ☐ Outside employer
- ☐ The board of trustees
- ☐ No-one
- ☐ Other ***please describe***_____

15. If you report to the board of trustees do you do this through –

- ☐ The Principal
- ☐ Your employer, other than the Principal
- ☐ Directly
- ☐ Do not report to the board of trustees

16. If you do report to the board of trustees, do you report on –

Tick more than one if appropriate

- ☐ Throughput
- ☐ Types of services offered
- ☐ Other ***please specify***_____
- ☐ Do not report to the board of trustees

17. Do you report to anyone in your professional capacity as a Nurse?

- ☐ Yes ***now, go to Q. 18***
- ☐ No ***now go to Q. 19***
- ☐ Don't know ***now go to Q. 19***

18. If you answered Yes to previous question, which of the following do you report to

- ☐ A more senior Nurse in the organisation that employs me
- ☐ Other professionals in the organisation that employs me
- ☐ Other ***please describe*** _____

19. In your opinion, is there a minimum qualification required of you as a Nurse at the school/s where you work?

- ☐ Yes ***now go to Q. 20***
- ☐ No ***now go to Q. 21***
- ☐ Don't know ***now go to Q. 21***

20. If you answered Yes to previous question, what is minimum qualification required?

Please specify qualification required_____

21. If you are employed by an organisation outside the school, who determines your scope of services?

- ☐ The School
- ☐ The employer
- ☐ Both in consultation
- ☐ You alone
- ☐ Not employed by an organisation outside the school

22. Do you receive clinical supervision

☐ Yes ☐ No ☐ Don't know

23. If Yes to Question 19, please write who provides this clinical supervision / oversight?

_____

_____

Professional Development

24. Which of the following types of professional development support is available to you?

Tick more than one if appropriate

- ☐ Paid study days/time
- ☐ Unpaid study days/time
- ☐ Course costs for training are met by the school
- ☐ Course costs met by your employing organisation
- ☐ Other ***please describe***_____
  _____
- ☐ Not applicable because you don't want to undertake any study/ training

Section E: Demographic Questions

Finally, some questions about you.

25.How many hours a week do you work in the school/s (as a Nurse)

- ☐ Ten or less
- ☐ Eleven to twenty
- ☐ More than twenty but less than full time
- ☐ Full time

26. What decile is the school (or schools) that you work in?

Please write Decile of school (or schools) if you know it_____
Write deciles of all schools you work in.

27.Are you

Please tick one box

- ☐ Teaching or administration staff trained in first aid
- ☐ An enrolled nurse
- ☐ A registered nurse
- ☐ Other ***please describe***_____

28.Your age:

- ☐ 20–29 years
- ☐ 30–39 years
- ☐ 40–49 years
- ☐ 50–59 years
- ☐ Over 60 years

29.Your gender

- ☐ M
- ☐ F

30.Which of these qualifications do you have?

Tick more than one if appropriate

- ☐ Family Planning
- ☐ Post-graduate child health
- ☐ Post-graduate youth health
- ☐ Other relevant to your position ***please describe***_____

31. Please describe your professional experience

_____
_____
_____
_____

32. How many years have you been working as a Nurse within schools?

- ☐ 0–5 years
- ☐ 6–10 years
- ☐ 11–15 years
- ☐ 16–20 years
- ☐ Over 21 years

33. Who is your employer?

- ☐ The School
- ☐ Public Health
- ☐ The DHB, but not public health
- ☐ A PHO
- ☐ A youth health centre
- ☐ Another organisation, ***please specify***_____

---

34. What is your job title? (E.g. school nurse, public health nurse, family planning nurse…)

---

35. Which of the following DHB regions are you working in?

- ☐ Northland
- ☐ Waitemata
- ☐ Auckland
- ☐ Counties Manukau
- ☐ Waikato
- ☐ Bay of Plenty
- ☐ Lakes
- ☐ Tairawhiti
- ☐ Taranaki
- ☐ Hawke's Bay
- ☐ MidCentral
- ☐ Whanganui
- ☐ Hutt
- ☐ Capital & Coast
- ☐ Wairarapa
- ☐ Nelson Marlborough
- ☐ West Coast
- ☐ Canterbury
- ☐ South Canterbury
- ☐ Otago
- ☐ Southland

36. What is your salary / rate of pay for your work as a Nurse within schools?

If you work full-time as a Nurse (even if only part of that time is in schools), what is your salary range (before tax)?

- ☐ $20,000 – 24,999
- ☐ $25,000 – 29,999
- ☐ $30,000 – 34,999
- ☐ $35,000 – 39,999
- ☐ $40,000 – 44,999
- ☐ $45,000 – 49,999
- ☐ $50,000 – 54,999
- ☐ $55,000 and over

If you work part time, what is your hourly rate of pay (before tax) as a Nurse in schools?

- ☐ Less than $15 an hour
- ☐ $15 – $19 an hour
- ☐ $20 – $24 an hour
- ☐ $25 – $29 an hour
- ☐ $30 – $34 an hour
- ☐ $35 – $39 an hour
- ☐ $40 or more an hour

Thank you for taking part in this survey

Please place the survey form in the Free Post envelope provided and post it to:

Sue Buckley
Nursing Survey
Health Services Research Centre
School of Government
Victoria University of Wellington
PO Box 600
Wellington

Please send me a summary of the final research report: □ Yes □ No

Please supply your name and address if summary requested or if you wish to enter the prize draw:

Name: _____

Postal or email address: _____

Appendix 10: Qualitative Study

Information Sheet
School Health Services Research Project

A School Nursing Research Project is being undertaken over the next few months in order to investigate what sorts of nursing services are available in schools and what are some of the issues that schools face in relation to school nursing.

Currently little data has been gathered on school nursing services and little is known about what sorts of health services are provided at schools, to whom, how they are funded and what other services they link to. With this research project we hope to find out some of this information. We also to hope to find out whether there are gaps in services, what are the priority health issues identified by school nursing providers and how these fit with key national health priorities for young people.

In undertaking this research, we will send a brief questionnaire to secondary schools throughout New Zealand asking about any health services, education or promotion programmes that are available. This questionnaire will consist of no more than five questions and its purpose is to scope what sorts of health services and programmes are currently available in schools throughout New Zealand.

We will also be conducting interviews with a number of people in nine schools throughout New Zealand. We hope to interview a range of people, including school health service providers, school principals / senior teachers and others who are identified as having an interest in school nursing. We will ask questions about the provision and funding of health services in schools, how these services link to other health services and what are some of the wider health issues that school nursing services address.

We would like you to take part in an interview with one of our researchers. If you agree to participate we will arrange an interview time with you of approximately one hour. The interview will be tape-recorded, with your consent. The tapes will be transcribed and the transcript will be sent to you.

Data from the interviews will be analysed and written up into a report for the Ministry of Health. Your contribution will be anonymous and neither you nor any of the people participating in interviews will be identified in this report. The tapes and transcripts will be kept in a secure filing cabinet and made available only to the research team. The tapes will be destroyed five years after the project is completed.

A summary of the report will be made available to you if you wish, and to the school, when it is completed in 2007. It is intended to seek publication of the findings as articles in academic journalsand presentations at academic conferences.

We will be asking for your consent to participate in the interview, and will provide a consent form for you to sign. However, at any time over the course of the project you are free to withdraw from the project and to withdraw the information you have provided.

Ethical approval for this research project has been obtained from the Victoria University of Wellington Ethics Committee.

We hope you agree to take part in this research. If you have any questions about the project, now or at any stage in the future, please feel free to contact:
Sue Buckley on 04 463 7480 or email sue.buckley@vuw.ac.nz

Consent Form

School Health Services Research Project

I have read the Information Sheet and understand what this project is about. I understand that I am free to request further information at any stage and I know who to contact.

I understand that:

- my participation in the project is voluntary
- I am free to withdraw from the project at any time. If I do withdraw any data I have provided will be returned to me or destroyed
- the interview will be audio-taped with my consent
- the audio-tapes and transcripts from this interview will be kept in a secure filing cabinet and destroyed after 5 years
- the research team members are the only people who will have access to the tapes and transcripts
- neither I nor my school will be identified in any report on the project. Any information or opinions I provide will be kept confidential and reported only in an aggregated form that will not identify me
- that the information I provide will be used only for this research project and that any further use will require my written consent
- the results of this project will be written up into a report for the Ministry of Health. I can request a copy of this report or a summary of the project findings
- ethical approval for this research project has been obtained from the Victoria University of Wellington Ethics Committee.

I consent to take part in this project

……. …….

(Signature of Participant) (Date)

I would like to receive a summary of the research findings: Yes ☐ No ☐

School Health Services Research Project

Interview Schedule for Health Providers

- What are the health services that are provided in this school?
- What nursing services do you provide? Are these 'mainstream' nursing services – could someone else do them?
- Do you know how these services are funded?
- Is your position full time or part time? How many hours a week?
- Do you have other roles eg, practice nurse…How many hours on these?
- Who is your employer? DHB? PHO? What is the structure of management e.g. who and how are you accountable to?
- What is the role of the school in organisational, delivery decisions? How does this work? – do you report to anyone? Does the Board of Trustees have a role?
- Which sorts of students use the services? What Years/ages? Why the school nursing service rather than other services?
- What are the most common reasons for students' use of these services?
- What arrangements are there for referrals to other services?
- What other health services do you link to?
- How did this school nursing service come about? For example, what was the background to its development, who/what drove it, what changes have occurred over time and why?
- What qualifications are held by nurses in this service and are required for this service?
- What training and support is provided?
- By whom? School? Employer?
- Do you enjoy the job? Do you know if there have been or are any recruitment and retention issues?
- Who decides your scope of practice and how? Have any gaps in services been identified? By whom? What are they?
- Why do these occur? Are there of ways of managing these issues?

- Is there a mechanism for feedback from stakeholders and users, ie, schools and school students?

- Do you know what the perceptions are of students (both users and non-users), parents, GPs (and other relevant health providers), teachers etc, both of these services but also on what else might be needed?

- Do these services work on particular issues such as obesity, physical exercise, smoking, alcohol and drug use?

- How are they working with young people with chronic illness, and injuries?

- What are the priorities for you in the provision of services? Are there boundaries? Who determines what these are?

- Any plans to expand or change? What are they? What is needed for this to happen?

- Do you consider that there are gaps in priority issues for nursing services in schools? What plans are there to fill these gaps? What barriers are there to filling these gaps?