

CONFERENCE ABSTRACT

Can social and educational markers predict risk for future health vulnerabilities? A population health approach for vulnerable young people on the Central Coast of NSW Australia

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Sarah Bradfield

Central Coast Local Health District, Australia

Introduction: Lifestyle choices, social and environmental factors impact 60% of health outcomes, while health system impacts 10%. Why then, do we continue to focus on health as the place for early intervention with young people?

Young people become vulnerable through a combination of their circumstances, stages of development and barriers to participation. Vulnerabilities can be a combination of health (physical, mental health, substance use), educational (disengagement from school) and social factors (homelessness, unemployment, financial hardship).

Description: This case study, describes the process of partnership for health, education` and social care partners on the Central Coast of NSW, Australia delivering an integrated school based model of early intervention to impact vulnerabilities within a population of 10,000 school students (5-18years) and their families.

Working with schools we can identify youth vulnerabilities before they become clinically significant, and intervene by strengthening family links with their health care neighborhood.

Change: An early intervention approach, using risk factors identified in schools as markers for vulnerability and providing an upstream preventative health and social care response.

Targeted: Socioeconomically deprived school communities, a combined student population of 10,000+.

Timeline: A six month process of co-design has built social capital and trust amongst partners. Implementation has been phased over three school terms in 2016/17, with each program running for minimum of 12 months in each school.

Highlights: Partners have designed local solutions, built around existing resources, and leveraged partnerships to address service gaps across health and social care agencies.

Collaborative approaches have supported levels of clinical, professional and organisational integration across health and social care agencies.

Sustainability: This program has been seed funded by Government agencies with additional funding from participating schools. If effective, the program would continue to be funded through the partnerships in the schools Education wellbeing budgets.

Transferability: The educational infrastructure, combined with the co-design approach, provide potential for the model to be transferable across NSW and Australia.

Conclusions: Impacting health outcomes for vulnerable young people requires a collective response with shared investment and accountability, and cannot be achieved with a traditional disease focused health service delivery model.

Effective early intervention health responses for young people require a shift from identification of health risk factors to early signs of vulnerability as they impact on the young person's primary role as a learner.

Discussions: Integration of health, education and social care agencies around the needs of a school population provides common purpose and can make a meaningful difference to vulnerable populations

Lessons: Wrapping health and social care services around a school community requires flexibility and challenges health agencies to reconsider their importance in the world of children and families.

Placing leadership within the school ensures that service models remain focused on the needs of the young person and the family rather than the health system.

Opportunities are emerging for joining health and education data to better understand the trajectory of service use and vulnerability for families.

Challenges remain to measure medium and long term benefits from this model and to measure cost impact over time.

Keywords: vulnerable children and young people; co-design; social care; partnerships
