Value for Money review of the National Depression Initiative programme

Ministry of Health
FINAL
February 2013
Disclaimer

The report has been prepared solely in accordance with the specific terms of reference set out in the engagement letter agreed between KPMG and the Ministry of Health and for no other purpose. Other than KPMG’s responsibility to the Ministry of Health, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this opinion. Any reliance placed is that party’s sole responsibility.

KPMG expressly disclaims any and all liability for any loss or damage of whatever kind to any person acting on information contained in the opinion, other than the Ministry of Health. Additionally, KPMG reserves the right but not the obligation to update the report or to revise the information contained therein because of events and transactions occurring subsequent to the date of this report.
## Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Click through rate (CTR)</strong></td>
<td>The rate at which people click to the target website from an impression, calculated as clicks divided by impressions</td>
</tr>
<tr>
<td><strong>Cost per click (CPC)</strong></td>
<td>The cost of the advertisement, divided by the number of registered clicks on that website</td>
</tr>
<tr>
<td><strong>Economy</strong></td>
<td>The cost of a service (spend)</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td>The balance between outputs produced and outcomes achieved</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td>The balance between spend and outputs produced</td>
</tr>
<tr>
<td><strong>E-therapy</strong></td>
<td>E-therapy is defined as the subset of e-mental health services that are primarily user directed, computer system automated, and delivered online, or by mobile phone. E-therapy can be used on its own or as an addition or adjunct to traditional talking therapies and services allowing for interventions to complement face-to-face (or video conference) sessions. E-therapy must be evidence-based through procedures such as meta-analysis, systematic review, randomised control trial, case control and cohort studies or expert opinion</td>
</tr>
<tr>
<td><strong>E-tools</strong></td>
<td>E-tools are considered to be any online method used to create awareness or support individuals</td>
</tr>
<tr>
<td><strong>Impression</strong></td>
<td>The appearance of the online advertisement in a website banner</td>
</tr>
<tr>
<td><strong>Landing page</strong></td>
<td>The page at which a user first enters a website</td>
</tr>
<tr>
<td><strong>MaGPie</strong></td>
<td>Acronym for Mental Health and General Practice Investigation. A mental health research group based at the University of Otago</td>
</tr>
<tr>
<td><strong>Mild-to-moderate (depression)</strong></td>
<td>This terminology is used repeatedly in NDI literature but has no formal definition; for example, it does not necessarily mean Common Mental Disorders (CMD). In Phoenix Research Ltd reports into the efficacy of the Journal, the terms “mild” and “moderate” refer to PHQ-9 score ranges, however those definitions are not consistently used beyond Phoenix’s research.</td>
</tr>
<tr>
<td><strong>PHQ-9 score</strong></td>
<td>PHQ-9 is the nine item depression scale of the Patient Health Questionnaire which is used to assist primary care clinicians in diagnosing depression as well as selecting and monitoring treatment.</td>
</tr>
<tr>
<td><strong>Reference Network</strong></td>
<td>The Reference Network is a team representing the Ministry of Health, Health Promotion Agency, primary care practitioners and academics who meet up to three times per year to discuss issues and topics relating to the NDI. Members of the Reference Network are listed at Appendix 1</td>
</tr>
<tr>
<td><strong>Service providers</strong></td>
<td>The service providers referred to in this report are the three organisations which provide services to the Ministry of Health as part of the National Depression Initiative. These organisations are DraftFCB, Phoenix Research Ltd and Lifeline. More detail is provided on the role of these organisations within the NDI in this report</td>
</tr>
<tr>
<td><strong>TARPS</strong></td>
<td>Target Audience Rating Points – a method to measure exposure to target audience</td>
</tr>
<tr>
<td><strong>Value for Money (VfM)</strong></td>
<td>The optimal balance of inputs, outputs and outcomes</td>
</tr>
</tbody>
</table>
Executive summary

Introduction

Context

Results

International Context

Appendices

1. Reference Network membership

2. Stakeholders consulted

3. Summary of Phoenix Research Ltd Review of International Depression Campaigns to inform NDI development

4. Bibliography / literature consulted
Executive summary

Section 1 – Executive Summary
Section 2 – Introduction
Section 3 – Context – NDI programme in New Zealand
Section 4 – Results
Section 5 – International context
Appendices
Section 1 – Executive Summary

1.1 Background, objectives and scope

Background – Depression in New Zealand

Mental health is a global health issue. The World Health Organisation predicts that depression will be a leading cause of disability globally by 2020, second only to cardiovascular disease.

Research in New Zealand has identified the high incidence of Common Mental Disorders (CMDs) and the low levels of support available for diagnosis and management in primary care. For example, the MaGPie research and Te Rau Hinengaro: The New Zealand Mental Health Study, showed that, in common with other OECD countries, there is a high prevalence of depression and other CMDs - one fifth (20.7%) of New Zealanders experience a mental disorder in any 12 month period.

In 2005, the New Zealand Ministry of Health released targeted funding for primary care mental health. Evaluation of the first 41 of these Primary Mental Health Initiatives demonstrated that access to services had increased for those with mild-to-moderate (see glossary for description) severity CMD, however, targeting initiatives to Māori, Pasifika and low income New Zealanders indicated a substantial unmet need.

This kind of research and other topical factors provided the impetus for a campaign to raise public awareness and support assessment and management strategies for health professionals.

The New Zealand National Depression Initiative (NDI) was launched in 2006. It is one of a suite of initiatives that seeks to address mental health issues in New Zealand. Other initiatives include:

- Like Minds Like Mine, a public education programme
- MH101, a mental health learning programme
- The Mental Health Foundation, which provides awareness-raising for depression and other mental illnesses at the following website: http://www.mentalhealth.org.nz/page/28-welcome

NDI Programme key objectives

The NDI Programme key objectives are to:

- Strengthen individual, family and social factors that protect against depression
- Improve community and professional responsiveness to depression.

Background of this review

Value for Money Review of the National Depression Initiative

In 2012, the Ministry of Health requested that a Value for Money (VfM) review of the NDI be undertaken, which KPMG was subsequently commissioned to complete. The ultimate purpose of the review is to improve the efficiency and effectiveness of services delivered under the NDI programme.

It is important to understand, therefore, that this is not a programme evaluation. A VfM review will inevitably draw some high level conclusions as to the overall performance of the programme under review; it should do so primarily from a VfM perspective. Put another way, where a programme evaluation might conclude that the programme has or has not effectively delivered against the programme objectives, a VfM review is concerned with the optimal balance of inputs, outputs and outcomes. Therefore, although both kinds of review are concerned with outcomes, a VfM review evaluates the delivery of outcomes in the context of inputs and outputs.

Gathering evidence to demonstrate VfM in the Public Sector is challenging since outcomes, a crucial component of VfM, are difficult to define and achieve. However, attempting to track, demonstrate and achieve VfM is the right thing to do, in our view.
Objectives of the Value for Money Review

The objectives of this review are to:

- Examine the cost-effectiveness of existing NDI programme services delivered by Ministry of Health (the “Ministry”) and Health Promotion Agency (HPA) funded NDI service providers
- Analyse NDI programme participation and service usage including client demographics where available
- Compare NDI with international services / delivery structures for people experiencing depression
- Compare NDI with other services for people experiencing depression provided to New Zealanders in the New Zealand context
- Analyse the impact of NDI services on Māori, Pasifika and Asian at-risk populations, based on available information
- Assess the NDI programme’s methodology to obtain clinical and non-clinical advice
- Recommend improvements to NDI programme effectiveness or reach.

The review is intended to identify whether services are being delivered in the most efficient and effective ways to meet Government objectives and to generate the maximum benefit for the level of expenditure. Options for improving the efficiency and cost-effectiveness of the NDI have been provided, where appropriate.

Scope of this review

The scope of this review is confined to the spend for the NDI (for FY 2012-13 this will be $5.13m). The project scope comprises the following actions:

- A review of agreed international and Ministry literature
- A detailed consultation with key stakeholders including the three service providers (DraftFCB, Phoenix Research Ltd and Lifeline), members of the NDI Reference Network, the Ministry and the HPA
- A review of the cost-effectiveness of services delivered by the three service providers and the Reference Network.
Section 1 – Executive Summary

1.2 Approach

**KPMG has undertaken quantitative and qualitative analyses in this review. Our views are based on evidence from three sources: hard data on the provision of services, stakeholder interviews and relevant literature. These data sources are generally used in different report sections:**

- Hard/quantitative data is used to analyse performance metrics, as well as to substantiate stakeholder interview data
- Stakeholder interview data is primarily used to support the analysis of strategy and overall operations, as well as to support quantitative data
- Literature-based data is used in the literature review section.

The data presented here has been validated by key stakeholders (see page 37).

Our approach is based on a review of the three core drivers that affect VfM: the Economy, Efficiency, and Effectiveness of services; commonly referred to as the ‘3Es’. The services providers reviewed are:

- **DraftFCB** who maintain the NDI website and its online self-management tool, produce the featured celebrity and talent case studies, and manage the media programme, online advertising and promotion
- **Lifeline Aotearoa** who deliver a range of services including depression helpline and other real time support, offer counselling staff, and provide sector co-ordination
- **Phoenix Research Ltd** who produce qualitative social research, NDI media campaign tracking research, and conduct programme evaluations and other ad hoc research.

The diagram below presents a high level of the 3Es approach as applied to each provider.
Section 1 – Executive Summary

1.2 Approach

Analysis of the three data types is combined to form the basis for this VfM assessment (see diagram below)

Key for following tables

The tables in the following pages show our VfM rating for each driver and overall.

Key

<table>
<thead>
<tr>
<th>Color</th>
<th>Character</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>R</td>
<td>Low rating.</td>
</tr>
<tr>
<td>Amber</td>
<td>A</td>
<td>Medium rating.</td>
</tr>
<tr>
<td>Green</td>
<td>G</td>
<td>Good rating.</td>
</tr>
<tr>
<td>Grey</td>
<td>U</td>
<td>Unable to conclude.</td>
</tr>
</tbody>
</table>
Overall Value for Money

We were unable to draw an overall conclusion on the VfM of the NDI Programme (as distinct from a programme evaluation) due to a lack of data in some key areas.

Our review is based on two forms of quantitative data: data on NDI services over time and comparison of NDI service data and data from analogous services.

For any given driver, the absence of the first kind of data means that we cannot quantify performance in a given year or identify a trend. The absence of the second kind of data means that even if we can quantify performance and/or a trend, we cannot assess whether it is ‘better or worse’ than we might expect within the market.

We also note the complexity of the NDI programme and the difficulty of measuring public awareness outcomes.

However, we identified key areas where sufficient quantitative data was available to allow complete driver assessments. Those areas were:

- There is evidence that awareness and reach within the general population and some target sub-populations is good
- There is evidence that campaign advertising has driven increased help-seeking behaviour amongst the general population and some target sub-populations
- There is evidence that the media campaign is comparatively cost effective (by unit cost)
- There is evidence that the internal research component drives programme development to good effect.

The table opposite (bottom) shows our conclusions on VfM based on drivers which we were able to assess. (i.e. where there was sufficient data to draw conclusions).

In addition, we found no quantitative evidence of poor performance in any area. Although the NDI generates a lot of detailed programme data, most of it is not suitable for a VfM review as it provides limited insight on the Economy, Efficiency and Effectiveness of services. Consequently a major and recurring opportunity for VfM improvement is the collection of appropriate data.

## Summary of Conclusions

### Overall Conclusion

We were unable to draw an overall conclusion on the VfM of the NDI Programme (as distinct from a programme evaluation) due to a lack of data in some key areas.

Our review is based on two forms of quantitative data: data on NDI services over time and comparison of NDI service data and data from analogous services.

For any given driver, the absence of the first kind of data means that we cannot quantify performance in a given year or identify a trend. The absence of the second kind of data means that even if we can quantify performance and/or a trend, we cannot assess whether it is ‘better or worse’ than we might expect within the market.

We also note the complexity of the NDI programme and the difficulty of measuring public awareness outcomes.

However, we identified key areas where sufficient quantitative data was available to allow complete driver assessments. Those areas were:

- There is evidence that awareness and reach within the general population and some target sub-populations is good
- There is evidence that campaign advertising has driven increased help-seeking behaviour amongst the general population and some target sub-populations
- There is evidence that the media campaign is comparatively cost effective (by unit cost)
- There is evidence that the internal research component drives programme development to good effect.

The table opposite (bottom) shows our conclusions on VfM based on drivers which we were able to assess. (i.e. where there was sufficient data to draw conclusions).

In addition, we found no quantitative evidence of poor performance in any area. Although the NDI generates a lot of detailed programme data, most of it is not suitable for a VfM review as it provides limited insight on the Economy, Efficiency and Effectiveness of services. Consequently a major and recurring opportunity for VfM improvement is the collection of appropriate data.

### Conclusions continued

<table>
<thead>
<tr>
<th>Overall conclusion based on all drivers (31 of 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. VfM Overall</td>
</tr>
<tr>
<td>2. VfM Economy</td>
</tr>
<tr>
<td>3. VfM Efficiency</td>
</tr>
<tr>
<td>4. VfM Effectiveness</td>
</tr>
<tr>
<td>5. Trend</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provisional conclusion based on 13 of 31 drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. VfM Overall</td>
</tr>
<tr>
<td>2. VfM Economy</td>
</tr>
<tr>
<td>3. VfM Efficiency</td>
</tr>
<tr>
<td>4. VfM Effectiveness</td>
</tr>
<tr>
<td>5. Trend</td>
</tr>
<tr>
<td>6. Confidence in data</td>
</tr>
</tbody>
</table>
Conclusion 1: based on available quantitative evidence, the overall VfM of the NDI is rated Green

Overall VfM is the value received for the money spent (i.e. the ratio of total costs compared to the total quantified benefits, or value delivered).

Our overall rating of Economy, Efficiency and Effectiveness, based on drivers for which sufficient assess data is available, is Green in each case. Therefore our overall rating of the VfM of those assessed drivers is also Green.

Conclusion 2: drivers of Economy, for which sufficient assessment data is available, are rated Green overall

Two drivers out of ten had sufficient data to draw conclusions, as follows:

<table>
<thead>
<tr>
<th>Driver</th>
<th>Rating</th>
<th>Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 1 (cost of media placement and implementation)</td>
<td>G</td>
<td>$1.3m-$2.8m</td>
</tr>
<tr>
<td>Driver 9 (cost to deliver annual Tracking Survey)</td>
<td>A</td>
<td>$80k p/a avg.</td>
</tr>
</tbody>
</table>

Given that the weight of spend was overwhelmingly within Driver 1 (see table above), we have concluded that the Economy drivers for which data was available are Green overall.

Our conclusion is supported by a high level comparison with the Australian initiative, Beyondblue, which is also a population health campaign to combat depression. In 2011-12, Beyondblue received AUS $33m of funding compared with the NDI’s 2011-12 budget of NZD $4.9m. These figures give per capita (as at June-July 2012 in both countries) spends of AUD$1.46 per person for Beyondblue and NZD $1.10 per person for the NDI.¹

Conclusion 3: drivers of Efficiency, for which sufficient assessment data is available, are rated Green overall.

Four drivers out of ten had sufficient data to draw conclusions as follows:

<table>
<thead>
<tr>
<th>Driver</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 11 (DraftFCB delivery against contract performance measures)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 13 (unit cost per media campaign)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 14 (percentage of Phoenix recommendations implemented)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 18 (extent that Lifeline delivers against contract performance measures)</td>
<td>A</td>
</tr>
</tbody>
</table>

The majority of drivers are rated Green. Driver 18 is rated Amber due to some detailed reporting absences that may be addressed through Lifeline’s new contact system.

¹ Population figures were taken from the Australian Bureau of Statistics and Statistics New Zealand.
Conclusions continued

Conclusion 4: drivers of Effectiveness, for which sufficient assessment data is available, are rated Green overall

Seven drivers out of eleven had sufficient data to draw conclusions as follows:

<table>
<thead>
<tr>
<th>Driver</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 21 (campaign effectiveness (reach))</td>
<td>G</td>
</tr>
<tr>
<td>Driver 22 (campaign effectiveness (impact))</td>
<td>G</td>
</tr>
<tr>
<td>Driver 23 (website effectiveness)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 27 (relevance of research)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 28 (applicability of recommendations)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 29 (proportion of recommendations implemented by DraftFCB)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 30 (proportion of recommendations implemented by Lifeline)</td>
<td>A</td>
</tr>
</tbody>
</table>

The ratings for these drivers are overwhelmingly Green, therefore our overall rating for the assessed Effectiveness drivers is Green.

However, we were unable to conclude on some significant Effectiveness drivers including drivers that measure service provider performance against the NDI strategic objectives; drivers that are essential to assessing the overall VfM Effectiveness of the NDI. For that reason we were unable to draw a conclusion on the overall Effectiveness of the NDI.

Conclusion 5: where available data shows a trend, the trends tends to be positive.

Examples of positive trends are:

- High degree of cost certainty around sector co-ordination and cost to produce the Tracking Survey
- Television costs consistently below comparators and delivering strong added value
- Online unit costs reducing over time with measures of use (i.e. click through rates) improving over time
- Use of Depression.org and the Lowdown websites increasing over time
- Research consistently relevant to the Programme over time.

We found an apparent negative trend for the Lowdown in terms of a decreasing proportion of users that spent 30 minutes or more on the site. However that is a high level indicator of a phenomenon that requires further detailed analysis.

Conclusion 6: where conclusions are formed, our confidence in the data on which we base our conclusions is rated Amber.

While we were confident that data provided was good quality, it was not always a ‘best fit’ to the driver for which it was used. For example, some data was proxy data, some data was insufficiently detailed or complete, and other data provided limited insight on the Economy, Efficiency and Effectiveness of services. Also, due to the lack of ‘best fit’ in some cases and the high level nature of this review, some analyses lacked the level of robustness that would have increased our confidence in the conclusions.

For these reasons, where we formed conclusions, our confidence in the data overall is rated Amber, which implies a medium level of confidence.
### Section 1 – Executive Summary

#### 1.3 Overall Conclusion – Economy drivers

**Overall Driver Conclusion based on 10 indicators**

**Provisional Driver Conclusion based on 3 indicators**

<table>
<thead>
<tr>
<th>Driver</th>
<th>Service provider</th>
<th>VfM Conclusion</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 1 – Cost of media placement and implementation</td>
<td>DraftFCB</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Driver 2 – Cost of website hosting and development</td>
<td></td>
<td>U</td>
<td>U</td>
<td>G</td>
</tr>
<tr>
<td>Driver 3 – Cost of management of media and PR/communications</td>
<td></td>
<td>U</td>
<td>U</td>
<td>G</td>
</tr>
<tr>
<td>Driver 4 – Cost of development of education and promotional resources</td>
<td></td>
<td>U</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Driver 5 – Cost of maintaining the multi-channel helplines</td>
<td>Lifeline Aotearoa</td>
<td>U</td>
<td>A</td>
<td>R</td>
</tr>
<tr>
<td>Driver 6 – Cost to provide other services for the Lowdown</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 7 – Cost to perform sector co-ordination and relationship management</td>
<td></td>
<td>U</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Driver 8 – Cost to deliver annual Evaluation Report</td>
<td>Phoenix Research Ltd</td>
<td>U</td>
<td>U</td>
<td>G</td>
</tr>
<tr>
<td>Driver 9 – Cost to deliver annual Tracking Survey</td>
<td></td>
<td>A</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Driver 10 – Cost to deliver annual ad hoc/topical reports</td>
<td></td>
<td>U</td>
<td>U</td>
<td>G</td>
</tr>
</tbody>
</table>
## Executive Summary

### 1.3 Overall Conclusion – Efficiency drivers

<table>
<thead>
<tr>
<th>Driver</th>
<th>Service provider</th>
<th>VfM Conclusion</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 11 – Extent that provider delivers against contract performance measures</td>
<td></td>
<td>G</td>
<td>G</td>
<td>A</td>
</tr>
<tr>
<td>Driver 12 – Website return on investment</td>
<td>DraftFCB</td>
<td>U</td>
<td>A</td>
<td>G</td>
</tr>
<tr>
<td>Driver 13 – Unit cost per media campaign</td>
<td></td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Driver 14 – Percentage of Phoenix recommendations implemented</td>
<td></td>
<td>G</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>Driver 15 – Unit cost of multi-channel helplines</td>
<td>Lifeline Aotearoa</td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 16 – Staff utilisation</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 17 – Post-contact service</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 18 – Extent that provider delivers against contract performance measures</td>
<td></td>
<td>A</td>
<td>A</td>
<td>G</td>
</tr>
<tr>
<td>Driver 19 – Timeliness of reports to inform NDI</td>
<td>Phoenix Research Ltd</td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 20 – Timeline from recommendation to signoff</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
</tbody>
</table>
### Section 1 – Executive Summary

#### 1.3 Overall Conclusion – Effectiveness drivers

**Overall Driver Conclusion based on 11 indicators**

**Provisional Driver Conclusion based on 7 indicators**

<table>
<thead>
<tr>
<th>Driver</th>
<th>Service Provider</th>
<th>VfM Conclusion</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 21 – Campaign effectiveness (reach)</td>
<td>DraftFCB</td>
<td>G</td>
<td>A</td>
<td>G</td>
</tr>
<tr>
<td>Driver 22 – Campaign effectiveness (impact)</td>
<td>DraftFCB</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Driver 23 – Website effectiveness</td>
<td>Lifeline Aotearoa</td>
<td>U</td>
<td>U</td>
<td>R</td>
</tr>
<tr>
<td>Driver 24 – Link to NDI objectives</td>
<td>Lifeline Aotearoa</td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 25 – Quality of multi-channel help lines</td>
<td>Lifeline Aotearoa</td>
<td>U</td>
<td>U</td>
<td>R</td>
</tr>
<tr>
<td>Driver 26 – Link to NDI objectives</td>
<td>Lifeline Aotearoa</td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 27 – Relevance of research</td>
<td>Phoenix Research Ltd</td>
<td>G</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>Driver 28 – Applicability of recommendations</td>
<td>Phoenix Research Ltd</td>
<td>G</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>Driver 29 – Proportion of recommendations implemented by DraftFCB</td>
<td>Phoenix Research Ltd</td>
<td>G</td>
<td>U</td>
<td>R</td>
</tr>
<tr>
<td>Driver 30 – Proportion of recommendations implemented by Lifeline</td>
<td></td>
<td>A</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>Driver 31 – Proportion of recommendations implemented by the Ministry or HPA</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
</tbody>
</table>
Section 1 – Executive Summary

1.4 NDI Programme Strengths

National Depression Initiative – Programme Strengths

1. In the views of respondents, the NDI is a world-leading programme in terms of its sound theoretical basis, its linkage to a suicide prevention strategy, the whole-of-country approach and the accessibility of services for those suffering from depression. However, some sector experts consider Australia’s depression campaign to be more advanced in some aspects including:

- Stronger evidence of clinical effectiveness based on Randomised Control Trials (RCTs)
- Stronger linkage to primary care and health outcomes
- Dedicated programmes for sub-populations (i.e. Aborigine and Torres Strait Islander populations).

Respondents with international expertise in the field of depression consider the NDI to be more advanced than Canadian programmes, and describe UK initiatives as having similar components to the NDI (i.e. celebrity endorsement), but lacking a single, national, population-wide, holistic programme.

2. There is evidence to suggest that the NDI enjoys strong reach and awareness creation across the general population and targeted at-risk populations. According to Phoenix’s research into the reach of the NDI Programme, an average of 81% (across 4 surveys between 2010 and 2012) of focus group participants recalled NDI advertising when unprompted. Recall rose to 88% when participants were prompted or provided a description of the advertising. The equivalent figures for Māori were 82% unprompted and 92% when prompted or provided a description, and for Pasifika, 64% and 81%. Comparative evidence suggests that recall of the NDI is the same as, or stronger than, analogous campaigns.

3. There is evidence to suggest that the NDI encourages positive attitudes to, and positive behavioural changes towards, depression. In addition to evidence in the Phoenix Tracking Reports, some respondents provided anecdotal evidence that the NDI supports the de-stigmatisation of depression. Several stakeholders with positions in primary health care (i.e. GPs and mental health professionals) indicated that it is easier to engage with patients about depression as a result of the NDI awareness campaign, however those views may not accurately represent experiences in Māori and Pasifika primary care. Also, it is important to note that this may not entirely be attributable to the NDI given the other depression-related campaigns and initiatives currently operating in New Zealand (see page 5). Additionally, to our knowledge, this impact has not been formally measured.

4. Whilst the Journal’s clinical effectiveness has not been independently tested, changes in user PHQ-9 scores suggest that it may be effective in reducing feelings of depression. The Journal is the NDI’s online self-management tool which provides users with a series of six lessons to help manage feelings of depression. Users’ feelings of depression are quantified using PHQ-9 scores (see glossary of terms, page 2). Scores are recorded before Lesson 1, midway (Lesson 3) and after Lesson 6.

Phoenix data indicates sharp decreases in proportions of users with scores indicating mild, moderate and severe depression after completion of half or all of the lessons. Decreases in proportions of scores that indicated mild, moderate and severe depression after Lesson 6 were 7%, 25% and 26% respectively. 75% of scores after Lesson 6 indicated “not depressed,” a 58% increase from the 17% of scores that indicated “not depressed” prior to Lesson 1.

While the reported decreases are encouraging, some caveats do apply. For example, this evidence is not as strong as evidence that might be demonstrated using other research methods (e.g. RCTs). Also, the classifications “mild” and “moderate” used in Phoenix’s research should not be taken to align with the undefined “mild-to-moderate” target group that appears in other NDI literature. Finally, changes in PHQ-9 scores should be interpreted with the understanding that there is a high (30%-50%) spontaneous resolution rate for mild, anxious depression. Therefore, changes in PHQ-9 scores in this area may not be unexpected or unusual. A perhaps unexpected positive outcome that the PHQ-9 evidence indicates is the significant impact on those with moderate to severe depression (however defined), recognising that there is more capacity for improvement from a more “severe” starting point.

5. The NDI leverages the skills and competences of service providers in a powerful way and, for the most part, the service providers interact and collaborate positively for the greater good of the Programme: There are two parts to this strength: the quality of the service providers and the quality of their interaction. KPMG observed and consulted with a powerfully motivated, passionate and committed sector during the course of this review. Throughout the review, the service providers demonstrated strong content knowledge on the NDI and the developmental journey of the NDI. They understand the strengths and limitations of the programme and demonstrate a strong collective passion to support people suffering from depression.

We are grateful for the input of the large number of stakeholders, listed at Appendix 3.
National Depression Initiative – Programme Strengths  (continued)

6. The impact of Sir John Kirwan: In the views of many respondents, Sir John Kirwan’s pro bono involvement in the Programme has provided exceptional value for money. Stakeholders spoke passionately of Sir John’s “phenomenal impact”, “incredible mana” and “charisma” in driving increased awareness of depression and in supporting de-stigmatisation. Phoenix’s research on reach and awareness (see paragraph page 15) may be interpreted to broadly support those claims. For example, in order to prompt recall of the NDI awareness campaign, participants were asked if they recalled advertisements featuring Sir John. That prompting resulted in additional recall. However, to our knowledge, neither the actual impact on awareness of Sir John’s participation nor the economic impact of his pro-bono involvement have been formally studied. In order to demonstrate benefits, (or costs), additional analysis would be required to, for example, evaluate specifically whether and how Sir John’s celebrity directly translates into number of website hits, calls to helplines or completion of the Journal modules, as well as evaluating this against international comparators where celebrities were not used.

7. In the views of respondents, the Reference Network has been influential in the NDI initiation, provides positive opportunities for the sector to meet and a pool of skilled practitioners from which the Programme can draw. The positive role of the Reference Network in shaping the Programme at its initiation should be acknowledged. However, the limitations of the Reference Network in its current form, and its need to evolve, are outlined in this review.
National Depression Initiative – issues to address

1. The strategic direction of the NDI needs firmer articulation and communication: During the course of this review, we identified eight key symptoms amongst the service providers and Reference Network, which indicate that the NDI's future strategic direction needs to be outlined and communicated in a clear way. The eight symptoms are summarised in the diagram below, and described in detail thereafter. We then present opportunities for improvement relating to each symptom.

Symptom a – Lack of clarity amongst some stakeholders on what the NDI actually is:
Respondents presented a range of interpretations and definitions of the NDI. In our view this symptom presents a risk that stakeholder activities may not align with the NDI strategy.

Symptom b – Uncertainty amongst some stakeholders about who leads the NDI:
Respondents had different ideas about who leads the NDI, with suggestions as varied as the Ministry, the HPA, the Chairman of the Reference Network, Sir John Kirwan or one of the service providers. This lack of clarity may derive from historical staff turnover and a loss of institutional memory, and from recent structural changes such as the addition of the HPA. In our view this symptom presents a risk that stakeholder activities may not align with the NDI strategy.

Symptom c – Uncertainty amongst service providers and the Reference Network about future operational structure:
The Ministry has been responsible for the NDI since programme inception. Its role has been to develop strategy, administer policy, lead channel funding and manage service providers’ contracts (Ministry contract management is now only for the Lifeline Aotearoa contract). The HPA was formed on 1 July 2012, at which time it became responsible for managing and monitoring contracts for the NDI and health promotion Programmes. Within the NDI, the HPA is responsible for the contracts for DraftFCB and Phoenix Research Ltd. The HPA will take on a more strategic leadership role with the Ministry of Health from 1 July 2013 onwards.

Service providers are currently not clear about how the Ministry and HPA will work together to administer the NDI programme.

Symptom d – Uncertainty amongst service providers and Reference Network members about the role and remit of the Reference Network: While many respondents praised the Reference Network’s historical role in establishing the NDI, there was less certainty about its current value beyond a forum for sharing information. In addition, the current membership does not appear aligned with the population-wide awareness creation and self-help intent of the NDI; membership (different from attendance) is significantly weighted towards primary care experts. Given these features, there is a risk that the Reference Network may exacerbate the challenge of pulling the NDI in unintended directions.

Symptom e – Uncertainty amongst some service providers and Reference Network members about the alignment of research with the strategic goals of the NDI: Some respondents expressed a concern that research undertaken by Phoenix may not properly align with the NDI strategic goals. We are unable to substantiate that concern and quantitative evidence suggests the opposite to be true. For example, our high level analysis under Driver 27 indicates that 96% of Phoenix’s recommendations are considered as within the NDI Programme scope. The question of the appropriateness of research, therefore, appears to reinforce the lack of clarity on what the NDI actually is and what research should be undertaken to support the future strategic direction.
Symptom f – Strong belief amongst service providers that the NDI has become static and has not evolved with the times: whilst there was significant momentum in the NDI’s initiation phase to create a programme that responded to a coherent strategic plan, in the views of some respondents the NDI may now be in a position where it needs to evolve further or move into a steady state maintenance phase. Both positions would require strategic revisions to reflect the new state.

Evolution or steady state may be best applied to aspects of the Programme rather than the programme as a whole. For example, aspects to evolve may include:

- Content – of advertising campaigns, websites etc
- Method of delivery (i.e. new technologies or platforms such as apps)
- New target at-risk groups
- Services – develop a full e-therapy tool, development of technical links with primary care providers.

Steady state may include:

- Retaining current functionality and status of the Journal
- Maintaining general population focus

According to respondents, there has also been a (recent) historical issue around the speed with which proposed changes receive approval. However, those issues should be alleviated with the recent addition of the HPA and strategic work described on pages 21-22.

Symptom g – Uncertainty amongst some service providers and Reference Network members whether appropriate audiences are being targeted: whilst the NDI was originally intended as a population-wide Programme, there is a question as to whether sub-populations can and should receive special attention. Respondents with expertise in population health are positive about the NDI’s current and historical ability to accommodate that issue; the combination of Phoenix’s research on targeted populations (Māori, Pasifika and Youth) and Reference Network expertise has helped focus and refine the NDI awareness campaign for those groups. However, we believe that there are ongoing questions as to the efficacy and appropriateness of current activities in respect of those sub-populations.

Symptom h – Uncertainty within all stakeholder groups (though not all members of those groups) of how the NDI fits within broader Government, Ministry and HPA strategies: although literature surrounding the NDI refers to broader mental health strategies (i.e. Te Tāhuhu, the Ministry’s Suicide Prevention Strategy 2006-2016), some respondents are unclear how the NDI fits within these broader strategies. In addition, some respondents are unclear how it will fit within new mental health strategies such as the Youth Mental Health Strategy.

KPMG understands that historically the NDI received its funding through the Suicide Prevention Plan but that is no longer the case. Given that change there may be benefit in re-articulating how the NDI does or does not fit within existing strategies, such as the Suicide Prevention Plan and how it will fit within forthcoming strategies, such as the Youth Mental Health Strategy.

It is essential that any future strategic reviews keep these alignment issues in sight as they proceed.

In addition, many programme stakeholders pointed to a need for an improved Whole-of-Government approach to combating depression, with improved alignment and co-ordination of the activities of different government departments, especially the Ministry of Social Development (MSD) and the Ministry of Health (MoH).

© 2012 KPMG, a New Zealand partnership and a member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative (“KPMG International”), a Swiss entity. All rights reserved. Printed in New Zealand.
National Depression Initiative – issues to address

2. To ensure clarity across the sector on what the NDI is, and how it should potentially evolve, some critical questions must be answered. The eight symptoms showing the need for greater communication and articulation of the NDI’s strategic direction, as outlined on the previous pages, highlighted a lack of clarity amongst stakeholders as to what the NDI actually is and how it will operate in future. There is a lack of clarity and consistency on the answers to questions such as whether the NDI’s focus is at a general population level or a sub-population level, or whether the NDI is solely focussed on those with mild-to-moderate depression. In KPMG’s view, in order to bring strategic clarity, the Ministry and the HPA should provide clarity and communicate consistent responses to these and the following questions:

• **Is the Journal an e-therapy?** We identified opposing views amongst service providers and Reference Network members as to whether the Journal is or should be considered an e-therapy. This is not a semantic question. For the NDI to be considered an e-therapy, it would need:
  - A formal description as such
  - To be surrounded by a standard framework of clinical support including alignment with primary care referral and feedback
  - To meet Ministry standards of clinical efficacy.

The NDI was not established to deliver e-therapy or treatment as such, but was rather focussed on driving awareness of depression, promoting help-seeking behaviour, and introducing potential depression service users to the kinds of services they might encounter in primary, secondary and tertiary care. In that context, the Journal was developed as a self-management tool.

KPMG understands that the Ministry does not currently intend the NDI to be a clinical intervention or treatment tool, however there is strong interest within the sector for it to become so. Research indicating improved PHQ-9 scores supports and perhaps encourages the perception that the NDI is, or could become, a treatment tool.

Some implications for developing the Journal into an e-therapy are:

- **Cost:** it may be expensive to demonstrate the Journal’s clinical effectiveness to the required level
- **Access:** As an e-therapy clinical tool subject to regulation, access may be restricted to mental health professional referral only, rather than open access.
- **Demonstrable efficacy:** Users and mental health professionals could have greater confidence in the clinical efficacy of the Journal programme.

The Ministry and the HPA may find it useful to reach formal agreement as to the Journal’s future state based on a cost-benefit analysis.

• **Do primary care practitioners have a role in the NDI?** If the NDI is based on a population-wide health approach, what role, if any, do primary care practitioners have? To support answering this question, there needs to be greater clarity amongst all stakeholders of the boundaries of the NDI, i.e. what the NDI is, and what it isn’t. The risk of being unclear on the scope and boundaries of the NDI is that it fuels people’s perceptions that the NDI should be all things to all people.

• **Should primary care practitioners have access to the Journal in order to support and monitor people’s ongoing progress?** In the interest of creating a more integrated depression service offering, there may be value in allowing GPs access to the Journal if their people use that tool. However, this option should be conducted in line with other decisions (i.e. the boundary between the NDI and primary care), and in full consideration of wider issues such as privacy. In addition, there may be costs associated with creating that access (i.e. connecting the Journal with the various GP Patient Management Systems). Therefore, this option should be subject to a robust cost-benefit analysis.
National Depression Initiative – issues to address

• Are young people engaging sufficiently? Rates of reach and awareness amongst Youth populations (16-24 year olds) indicated by NDI research – an average of 29% prompted recall across four surveys between 2010 and 2012 – indicate that consideration should be given to whether the NDI currently meets the needs of that audience. From our interviews and surveys, we understand that many respondents consider the Lowdown as it currently exists to be “out of date” with respect to the Youth population.

We acknowledge that the NDI has put considerable effort into researching youth engagement and that, as a target population, it possesses some characteristics that may require a specific set of programme responses or strategies. For example, the Youth population may exhibit a high level of churn (individuals may move through that population quickly), or the relevance of the delivery platform or content may have a shorter lifespan than with other audiences. It may be, therefore, that decision making and approvals processes in respect of the Youth population may be different (i.e. quicker or more often) from other audiences.

Future work on youth engagement depends on Ministry and HPA decisions around the Lowdown. If development is approved, then youth engagement may be assessed on the effectiveness of that development. If development is not approved, then the NDI may conduct a further review of its youth engagement approach.

• How should the NDI evolve to bring the next wave of the population into accessing these services? Whilst the general awareness-raising of the NDI has been positive through its “proportionate universalism” approach, KPMG encountered differing views as to whether the needs of specific sub-populations are effectively supported by wider mental health services.
### Symptom Opportunities for Improvement

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Opportunities for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptom a - Lack of clarity on what the NDI actually is</strong></td>
<td>• Strengthen the focus and definition of what the NDI is. Generating a clear definition of the NDI will improve stakeholder clarity and help focus stakeholder activities and interaction, which in turn will help maximise the value derived from the Programme.</td>
</tr>
</tbody>
</table>
| **Symptom b – Uncertainty about who leads the NDI** | • Provide greater clarity on the leadership roles of the Ministry and the HPA, and the relationships between the leadership, the service providers and the Reference Network  
• Establish a formal set of accountabilities and relationships that can improve the operation of the Programme  
• Implement formal change management processes that can mitigate against future “key person” or structural change risk. |
| **Symptom c – Uncertainty about future operational structure** | • Establish a clear, shared understanding of the new NDI structure and the accountabilities and duties that arise from it. |
| **Symptom d – Uncertainty about the role and remit of the Reference Network:** | • Redefine the Reference Network’s Terms of Reference (ToR), specifically its membership and their responsibilities and accountabilities. However, these actions should be based on prior work to address symptoms a-c. |
| **Symptom e – Uncertainty on the alignment of research with the strategic goals of the NDI** | • A review of historical research topics could be undertaken, however, the costs and benefits of conducting such a review should be evaluated prior to any work taking place  
• In order to ensure future alignment, work to address symptoms a-c should be completed, including a formal system for commissioning research and / or the collecting appropriate market intelligence that aligns with the strategic direction. |
| **Symptom f – Strong belief that the NDI has become static and has not evolved with the times** | • Determine appropriate state of NDI (i.e. steady state or evolving)  
• Improve decision making procedures, for example, small scale ‘business case approach’; create log of decisions made and justification (could be based on business case approach). |
| **Symptom g – Uncertainty whether appropriate audiences are being targeted** | • Review and restate the NDI’s position in respect of the focus on the general population and / or targeted populations. Based on that statement, the NDI can be managed to allocate resources (i.e. research, awareness campaigns) and funding accordingly.  
• Review current spending and approaches to generating awareness within targeted sub-populations. There may be more efficient, effective or economic ways to deliver targeted awareness campaigns than are currently used. |
| **Symptom h – Uncertainty about how the NDI fits within broader Government, Ministry and HPA strategies** | • Establish a future strategic direction for the NDI that takes in the new shared Ministry and HPA structure and the strategic requirements of those two organisations. |
Section 1 – Executive Summary

1.5 NDI Programme Opportunities for Improvement

**Structural and process opportunities for improvement**

In addition to the strategic work described above, we believe there are opportunities to improve the structure and processes of the NDI Programme.

Possible changes that may be considered in light of that strategic review are:

1. **Scope current NDI activities and activities that will be required under the revised strategy.** Match activity lists to identify activity gaps and/or redundant current activities. Consider a) whether and how activity gaps could be filled, and b) whether redundant activities should be eliminated.

2. **Scope and create appropriate resource and functions to support sector cohesion and alignment towards the agreed strategy.** These resources should provide programme oversight, support sector cohesion and ensure alignment of the work to the Programme’s agreed strategic goals. The resource could be located within the Ministry or the HPA.

3. **Create an NDI Governance Board with appropriate membership and Terms of Reference to support an agreed strategic direction.** A Governance Board could be created, with appropriate experience in population-wide health programmes, technology and programme governance, to support the strategy and direction of the Programme. If appropriate, time-bound working groups comprising Board members could be created to advise on particular topics. For example, a sub-group may be required to advise on the ongoing maintenance or evolution of the Journal and the Lowdown.

Consideration should be given as to whether creating a Governance Board removes the need for a Reference Network.

If a Board is established, the Chair could be an elected representative of the Ministry or HPA.

4. **Develop more transparent procedures for receiving, recording and responding to recommendations from the sector on Programme enhancements.** In order to ensure that sector-led recommendations for improvements to, or development of, the Programme align with the new strategy, a more transparent process could be developed. A suggested format may be a one page “business case” which articulates the opportunity, demonstrates the potential costs and benefits of the opportunity and outlines how the opportunity aligns with the NDI strategy.

Care should be taken that the procedures are not onerous, do not require too much resourcing, or do not deter parties from making recommendations.
# Introduction

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Executive Summary</td>
</tr>
<tr>
<td>2</td>
<td>Introduction</td>
</tr>
<tr>
<td>3</td>
<td>Context</td>
</tr>
<tr>
<td>4</td>
<td>Results</td>
</tr>
<tr>
<td>5</td>
<td>International context</td>
</tr>
<tr>
<td></td>
<td>Appendices</td>
</tr>
</tbody>
</table>
Section 2 – Introduction

2.1 Background

Mental health is a global health issue. The World Health Organisation predicts that depression will be a leading cause of disability globally by 2020, second only to cardiovascular disease.

Research in New Zealand has identified the high incidence of Common Mental Disorders (CMDs) and the low levels of support available for diagnosis and management in primary care. For example, the MaGPie research and Te Rau Hinengaro: The New Zealand Mental Health Study, showed that, in common with other OECD countries, there is a high prevalence of depression and other CMDs - one fifth (20.7%) of New Zealanders experience a mental disorder in any 12 month period.

In 2005, the New Zealand Ministry of Health released targeted funding for primary care mental health. Evaluation of the first 41 of these Primary Mental Health Initiatives demonstrated that access to services had increased for those with mild-to-moderate (see glossary for description) severity CMD, however, targeting initiatives to Māori, Pasifika and low income New Zealanders indicated a substantial unmet need.

This kind of research and other topical factors provided the impetus for a campaign to raise public awareness and support assessment and management strategies for health professionals.

The New Zealand National Depression Initiative (NDI) was launched in 2006. It is one of a suite of initiatives that seeks to address mental health issues in New Zealand. Other initiatives include:

- Like Minds Like Mine, a public education programme
- MH101, a mental health learning programme
- The Mental Health Foundation, which provides awareness-raising for depression and other mental illnesses at the following website: http://www.mentalhealth.org.nz/page/28-welcome

NDI Programme key objectives

The NDI Programme key objectives are to:

- Strengthen individual, family and social factors that protect against depression
- Improve community and professional responsiveness to depression.

Value for Money Review of the National Depression Initiative

In 2012, the Ministry of Health requested that a Value for Money (VfM) review of the NDI be undertaken, which KPMG was subsequently commissioned to complete. The ultimate purpose of the review is to improve the efficiency and effectiveness of services delivered under the NDI programme.

It is important to understand, therefore, that this is not a programme evaluation. A VfM review will inevitably draw some high level conclusions as to the overall performance of the programme under review; it should do so primarily from a VfM perspective. Put another way, where a programme evaluation might conclude that the programme has or has not effectively delivered against the programme objectives, a VfM review is concerned with the optimal balance of inputs, outputs and outcomes. Therefore, although both kinds of review are concerned with outcomes, a VfM review evaluates the delivery of outcomes in the context of inputs and outputs.

Gathering evidence to demonstrate VfM in the Public Sector is challenging since outcomes, a crucial component of VfM, are difficult to define and achieve. However, attempting to track, demonstrate and achieve VfM is the right thing to do, in our view.
Objectives of the Value for Money Review

The objectives of this review are to:

- Examine the cost-effectiveness of existing NDI programme services delivered by Ministry of Health (the “Ministry”) and Health Promotion Agency (HPA) funded NDI service providers
- Analyse NDI programme participation and service usage including client demographics where available
- Compare NDI with international services / delivery structures for people experiencing depression
- Compare NDI with other services for people experiencing depression provided to New Zealanders in the New Zealand context
- Analyse the impact of NDI services on Māori, Pasifika and Asian at-risk populations, based on available information
- Assess the NDI programme’s methodology to obtain clinical and non-clinical advice
- Recommend improvements to NDI programme effectiveness or reach.

The review is intended to identify whether services are being delivered in the most efficient and effective ways to meet Government objectives and to generate the maximum benefit for the level of expenditure. Options for improving the efficiency and cost-effectiveness of the NDI have been provided, where appropriate.

Scope of the Value for Money Review

The scope of this review is confined to the spend for the NDI (for FY 2012-13 this will be $5.13m). The project scope comprises the following actions:

- A review of agreed international and Ministry literature
- A detailed consultation with key stakeholders including the three service providers (DraftFCB, Phoenix Research Ltd and Lifeline), members of the NDI Reference Network, the Ministry and the HPA
- A review of the cost-effectiveness of services delivered by the three service providers and the Reference Network.
Section 2 – Introduction

2.2 What is Value for Money?

Value for Money methodology

VfM describes the optimal balance of spend and inputs in order to deliver optimal outputs and outcomes. In economists’ language, VfM is about maximising the net present value of (government) spending, subject to other non-quantifiable constraints. In plain English, it is about getting “more bang for your buck.”

In the context of the NDI, the Ministry has an obligation to ensure that its investment in the Programme meets a clear VfM test. A key focus of the Ministry’s mental health strategy is to reduce the impact of depression on the lives of New Zealanders by aiding early recognition, appropriate treatment and recovery – so ensuring that those who suffer from depression can be identified, supported and, if necessary, treated in the most efficient and effective ways.

VfM is about reducing costs whilst simultaneously improving the efficiency and effectiveness of spending. VfM should seek to support service quality whilst lowering unit costs and should help agencies to manage growing public expectations for public services and growing demand, whilst supporting those most in need.

There are three key components of VfM; these are Economy, Efficiency, Effectiveness (commonly referred to as the three Es). The diagram below illustrates the relationship between the components of VfM: Spend, Inputs, Outputs and Outcomes - and how collectively they contribute to VfM. Section 4.5 of this report, ‘VfM drivers’, provides analysis of each of these components against the three key areas of depression service provision.

Diagram 3: VfM Components

<table>
<thead>
<tr>
<th>Spend</th>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>economy</td>
<td>efficiency/productivity</td>
<td>effectiveness</td>
<td>external influences</td>
</tr>
<tr>
<td>value for money</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Despite service provision from DraftFCB and Lifeline accounting for over 90% of the total programme budget. However, in this review, KPMG has ensured equal focus on the costs of all programme constituents, especially given the importance of the role of Phoenix Research Ltd in ensuring a strong evidence base for the Programme and the Ministry in providing strategic leadership and coordination for the Programme.
Section 2 – Introduction

2.3 Approach

Approach

The approach to this VfM review has been tailored to achieve the review objectives. Our approach has six key stages. The diagram below sets out the timescale for this review and provides an overview of key stages of our approach.

Timescale & approach

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1:</td>
<td>12</td>
<td>19</td>
<td>26</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Literature</td>
<td>2</td>
<td>9</td>
<td>16</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>Review</td>
<td>7</td>
<td>14</td>
<td>21</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>Stage 2:</td>
<td>11</td>
<td>18</td>
<td>25</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Consultation</td>
<td>1</td>
<td>8</td>
<td>15</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td>Phase</td>
<td>23</td>
<td>30</td>
<td>4</td>
<td>11</td>
<td>19</td>
</tr>
</tbody>
</table>

Scope

Stage 2: Consultation and Stakeholder interviews

In this stage KPMG collected qualitative data through interviews with key stakeholders, including the three service providers and members of the Reference Network. Network members consulted included clinical and population health experts at the University of Auckland and University of Ottawa, and representatives of relevant sector organisations such as Le Va (Pasifika focus). A full list of stakeholders consulted is provided in Appendix 2 of this report.

The primary purpose of our consultation with stakeholders was to obtain their perceptions of the VfM of the NDI. Through this process we identified strengths of current service delivery and opportunities for improvement. Wherever possible, we sought data to support statements from stakeholders. Statements that couldn’t be corroborated are stated as anecdotal evidence. The results of this analysis are presented in Section 4. We also considered strengths and issues identified by stakeholders in light of literature relevant to depression services and activities undertaken internationally.

Stage 3: VfM Driver Analysis

This stage focused on quantifying available data from service providers, the Ministry and HPA and analogous services. We identified a series of drivers, defined as factors that cause or affect VfM. For example, the degree of impact of the media campaign will drive or affect the overall VfM. So, using the concept of *ceteris paribus*, “all other things being equal”, it is possible to assert that the greater the impact of the media campaign, the greater the overall VfM.

The drivers were initially based on NDI service contracts and an ideal view of what we would expect to see in a VfM review in the sector. The drivers were then presented to the Ministry and the service providers for feedback, validation and refinement.

For each of the service provider s we identified drivers that affect the three components of VfM, the “3Es” of Economy, Efficiency and Effectiveness.

Except where indicated, KPMG has not collected its own quantitative data to support this review. Quantitative data used has been supplied by the three service providers. KPMG has conducted quantitative analysis of the data supplied. We have signalled where our confidence in the data is low.

Stage 1: Literature Review

This stage involved reviewing New Zealand and International literature relevant to depression to understand the national and international context. Relevant aspects of literature from this stage have been referenced in this document. A full list of selected literature used is provided in Appendix 4.
Approach (cont.)

For each driver we identified a measure designed to track the performance of that driver. So, for example for Driver 1, “the cost of media placement and implementation,” the measure is the total budgeted cost to deliver the media campaign through each channel.

Performance levels have been assessed in two ways, depending upon available data:

- How NDI services have changed over time
- By comparison with analogous services, such as the MSD-led Family Violence Campaign, problem gambling, Cervical Screening Awareness Month and the HPA’s alcohol campaign (formerly the Alcohol Advisory Council (ALAC)).

The tables on the following pages list each of the drivers that we identified and indicate what we were seeking to measure with the driver and the relationship between the drivers and VfM.

Review team

KPMG Review Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Chew</td>
<td>Project Leader</td>
</tr>
<tr>
<td>Professor Tony Dowell</td>
<td>NDI subject matter expert</td>
</tr>
<tr>
<td>Mark Henare</td>
<td>Analyst</td>
</tr>
</tbody>
</table>

Source: KPMG
The table below identifies the drivers of VfM relevant to DraftFCB measures used to assess performance:

<table>
<thead>
<tr>
<th>Driver (DraftFCB specific)</th>
<th>VfM Measure (how to track the performance of the driver)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 1 – Cost of media placement and implementation</td>
<td>The total budgeted cost to deliver the media campaign through each channel</td>
</tr>
<tr>
<td>Driver 2 – Cost of website hosting and development</td>
<td>The total budgeted cost to host and develop the named websites and functions</td>
</tr>
<tr>
<td>Driver 3 – Cost of management of media and PR / communications</td>
<td>The total budgeted cost to provide media and PR / communications</td>
</tr>
<tr>
<td>Driver 4 – Cost of development of education and promotional resources</td>
<td>The total budgeted cost of educational and promotional material</td>
</tr>
<tr>
<td>Driver 11 – Extent that provider delivers against contract performance measures</td>
<td>Reported delivery against service goals</td>
</tr>
</tbody>
</table>
| Driver 12 – Website return on investment | • The Journal: total registrations and lesson completion rates  
• Depression.org: unique and repeat visitors to the site and length of stay  
• The Lowdown: unique and repeat visitors, length of stay, and demand for/use of chat and text services |
| Driver 13 – Unit cost per media campaign | Unit cost measures used to assess four key channels: Television (TARPS purchased and/or delivered); Radio; Online (click through rate, cost per click and monthly cost); and print |
| Driver 14 – Percentage of Phoenix recommendations implemented | Evaluation of the recommendations made by Phoenix Research Ltd and evaluation of the extent (percentage) to which they have been implemented |
| Driver 21 – Campaign effectiveness (reach) | The percentage of the target population (general population, Youth, Māori, Pasifika and Asian) that recall advertising connected with the awareness campaign |
| Driver 22 – Campaign effectiveness (impact) | Tracking Survey research on the impact of the NDI advertising |
| Driver 23 – Website effectiveness | • The Journal: change in user PHQ-9 scores from entry into the Journal through to exit  
• Depression.org: daily visitors, average time on site, page views, repeat traffic, individual page views  
• The Lowdown: time on site, visit duration, traffic (hours of day), traffic (days of week) |
| Driver 24 – Link to NDI objectives | Assess how qualitative and quantitative data demonstrates achievement of the NDI strategic objectives |
The table below identifies all of the drivers of VfM relevant to Lifeline Aotearoa and the measures used to assess performance:

<table>
<thead>
<tr>
<th>Driver (Lifeline specific)</th>
<th>VfM Measure (how to track the performance of the driver)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 5 – Cost of maintaining the multi-channel helplines</td>
<td>The total budgeted cost to maintain the multi-channel helplines</td>
</tr>
<tr>
<td>Driver 6 – Cost to provide other services for the Lowdown</td>
<td>The total budgeted cost to deliver online and text-based services for the Lowdown</td>
</tr>
<tr>
<td>Driver 7 – Cost to perform sector co-ordination and relationship management</td>
<td>The total budgeted cost to deliver the sector co-ordination and relationship management</td>
</tr>
<tr>
<td>Driver 15 – Unit cost</td>
<td>Unit cost measures used to assess five key help-line channels: toll free services, email, online messaging, support for online self-management, and text messaging</td>
</tr>
<tr>
<td>Driver 16 – Staff utilisation</td>
<td>The measure to assess this driver is the proportion of total staff time that is used to respond to contacts that originate from the NDI campaign</td>
</tr>
<tr>
<td>Driver 17 – Post-contact service</td>
<td>No measure identified</td>
</tr>
<tr>
<td>Driver 18 – Extent that provider delivers against contract performance measures</td>
<td>Reported delivery against service goals</td>
</tr>
<tr>
<td>Driver 25 – Quality of multi-channel help lines</td>
<td>Benchmark against industry standards</td>
</tr>
<tr>
<td>Driver 26 – Link to NDI objectives</td>
<td>Assessment of how qualitative and quantitative data demonstrates achievement of the NDI strategic objectives</td>
</tr>
</tbody>
</table>
Section 2 – Introduction

2.3 Approach

The table below identifies all of the drivers of VfM relevant to Phoenix Research Ltd and the measures used to assess performance:

<table>
<thead>
<tr>
<th>Driver (Phoenix specific)</th>
<th>VfM Measure (how to track the performance of the driver)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 8 – Cost to deliver annual Evaluation Report</td>
<td>The total budgeted cost to provide this report</td>
</tr>
<tr>
<td>Driver 9 – Cost to deliver annual Tracking Survey</td>
<td>The total budgeted cost to provide this report</td>
</tr>
<tr>
<td>Driver 10 – Cost to deliver annual ad/hoc/topical reports</td>
<td>The total budgeted cost to provide this report</td>
</tr>
<tr>
<td>Driver 19 – Timeliness of reports to inform NDI</td>
<td>Assessment of final submission against estimated submission date</td>
</tr>
<tr>
<td>Driver 20 – Timeline from recommendation to signoff</td>
<td>Assessment of the time period between recommendation and sign-off</td>
</tr>
<tr>
<td>Driver 27 – Relevance of research</td>
<td>Percentage of recommendations that the Ministry deems out of scope</td>
</tr>
<tr>
<td>Driver 28 – Applicability of recommendations</td>
<td>The effectiveness of Phoenix’s research in terms of the applicability of its recommendations</td>
</tr>
<tr>
<td>Driver 29 – Proportion of recommendations implemented by DraftFCB</td>
<td>Proportion of recommendations implemented by DraftFCB</td>
</tr>
<tr>
<td>Driver 30 – Proportion of recommendations implemented by Lifeline</td>
<td>Proportion of recommendations implemented by Lifeline</td>
</tr>
<tr>
<td>Driver 31 – Proportion of recommendations implemented by the Ministry or HPA</td>
<td>Proportion of recommendations signed-off by the Ministry or HPA</td>
</tr>
</tbody>
</table>
VfM Driver Analysis (cont.)

The diagram to the right sets out all the drivers applied in this review and the overall VfM. This is called a driver tree since there is a causal relationship between all drivers and VfM.

We identified 31 drivers to analyse VfM. Note: This is an analysis approach and not a recommendation for ongoing VfM review. We developed measures of achievement for all of these drivers. For 13 of these drivers we were able to conclude on VfM. For the remaining 18 drivers we were unable to conclude for one of the key reasons listed below:

- A lack of data
- Concerns over quality of available data
- Contradictory indicators within the data (i.e. positive and negative results), which results in inconclusive analysis.

The individual driver trees for each of the three service provider areas of programme input are summarised on the following three pages.
DraftFCB – Driver Tree

DraftFCB is a media strategy and PR company with offices in Auckland and Wellington. DraftFCB maintain the NDI website and produce the featured celebrity and talent case studies. They also manage the media programme and online advertising and promotion. The drivers set out in the diagram below outline how we have evaluated VfM across Economy, Efficiency and Effectiveness for the $2.6m of programme spend which is utilised by DraftFCB to provide the aforementioned services.

Cost of media placement and implementation
Cost of website hosting and development
Cost of management of media and PR/communications
Cost of development of education and promotional materials

Extent that provider delivers against contract performance measures
Website return on investment
Unit cost per media campaign
Percentage of Phoenix recommendations implemented

Campaign effectiveness (reach)
Campaign effectiveness (impact)
Website effectiveness
Link to NDI objectives

Economy
Efficiency
Effectiveness
DraftFCB ($2.6M Budget)
Lifeline Aotearoa – Driver Tree

Lifeline is an Auckland-based charity that provides free 24 hour nationwide telephone counselling, 365 days a year. Lifeline delivers a range of services including support services, depression helpline and counselling staff. Lifeline also provides emergency intervention where suicide is imminent and manages a reference group that provides technical expertise for the NDI programme. Finally, Lifeline provides coordination, communication and engagement with a network of relevant Health Sector professionals.

The drivers set out in the diagram below outline how we have evaluated VfM across Economy, Efficiency and Effectiveness for the $2.07m of programme spend which is utilised by Lifeline to provide the aforementioned services.
Phoenix Research Ltd – Driver Tree

Phoenix Research Ltd is an Auckland-based research company that produces qualitative social research and media campaign tracking research for the NDI. Phoenix has conducted several programme evaluations. The drivers set out in the diagram below outline how we have evaluated VfM across Economy, Efficiency and Effectiveness for the $0.27m of programme spend which is utilised by Phoenix Research Ltd to provide the aforementioned services.

Economy
- Cost to deliver annual evaluation report
- Cost to deliver annual tracking survey
- Cost to deliver annual ad hoc/topical reports
- Timeliness of reports to inform NDI campaign
- Timeline from recommendation to signoff

Efficiency
- Relevance of research
- Applicability of recommendations

Effectiveness
- Proportion of recommendations implemented by DraftFCB
- Proportion of recommendations implemented by Lifeline Aotearoa
- Proportion of recommendations signed off by the Ministry

Phoenix Research ($0.27M budget)
Section 2 – Introduction

2.3 Approach

To assess the performance of each driver in terms of its impact on VfM we have applied up to three methods of comparison. The method(s) used was determined by the availability of data. Each of the methods are discussed below:

a) Self over time
Where available we examine historical data to identify trends, changes or issues in the VfM of the NDI to date.

b) Comparison with analogous (e.g. alcohol or family violence) services
We compared New Zealand depression services with available information for alcohol treatment services, cervical cancer screening, family violence campaigns and problem gambling service provision.

c) Comparison with international depression services
Within the literature review we examined how similar kinds of depression services are delivered in international jurisdictions. Comment includes Australia, the UK and Canada, the EU, USA and Hong Kong.

Stage 4: Draft Report
We prepared a draft report outlining the results of Stages 1 to 3 of this review and submitted this to the Ministry for comment.

Stage 5: Validation forums
In this stage we held two meetings, one with the Ministry and a second with a sample of NDI stakeholders. The purpose of these meetings were to:

- Obtain feedback on the factual accuracy of aspects of the information within the report
- Provide an overview of our approach to conducting the review
- Discuss the key strengths and development areas of our review
- Discuss key conclusions of the review.

The tables below and on the following page list the people that attended these sessions.

Ministry and HPA validation forum attendees

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memo Musa</td>
</tr>
<tr>
<td>Derek Thompson</td>
</tr>
<tr>
<td>Hannah Booth</td>
</tr>
</tbody>
</table>

Source: KPMG

Note: Validation does not imply confirmation or endorsement of findings.
2.3 Approach

**Stakeholder validation forum attendees**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allan Wyllie</td>
<td>Phoenix Research Ltd</td>
</tr>
<tr>
<td>Jo Denvir</td>
<td>Lifeline</td>
</tr>
<tr>
<td>Kayte Godward</td>
<td>Lifeline</td>
</tr>
<tr>
<td>Melanie Shaw</td>
<td>Lifeline</td>
</tr>
<tr>
<td>Paula Polkinghorne</td>
<td>Lifeline</td>
</tr>
<tr>
<td>Candace Bagnall</td>
<td>Le Va (Te Pou)</td>
</tr>
<tr>
<td>Robert Muller</td>
<td>Le Va (Te Pou)</td>
</tr>
<tr>
<td>Bruce Arroll</td>
<td>University of Auckland</td>
</tr>
<tr>
<td>Janet Fanslow</td>
<td>University of Auckland</td>
</tr>
<tr>
<td>Martin Orr</td>
<td>University of Auckland</td>
</tr>
<tr>
<td>Sarah Raine</td>
<td>DraftFCB</td>
</tr>
<tr>
<td>Brian van den Hur</td>
<td>DraftFCB</td>
</tr>
<tr>
<td>John Barker</td>
<td>Mental Health &amp; Addiction Services</td>
</tr>
</tbody>
</table>

**Stage 6: Finalise Report**

The final stage of this review was to incorporate the comments from validation forums and issue our report as final.
Context

Te Tähuhu had identified ten leading challenges that might improve New Zealand’s ability to address mental health issues. One challenge, Promotion and Prevention, focussed on the Government’s strategy to prevent suicide and suicide attempts, and the effects of depression. In particular, it discussed the move to broaden the focus from preventing youth suicide to preventing suicide within all age groups.

This broader focus was reflected in the Ministry’s Suicide Prevention Strategy 2006-2016 and the Suicide Prevention Action Plan 2008-2012.

The NDI programme sits within these broader plans and strategies and was launched in October 2006. It aims to reduce the impact of depression on New Zealanders’ lives by aiding early recognition, appropriate treatment, and recovery.

The NDI is made up of many components, including television, radio and online advertising, health resources, guidelines and workforce development for primary care, phone, online and text-support services, two websites (www.Depression.org.nz and www.thelowdown.co.nz) and research. The NDI also supports primary mental health service development and the implementation of guidelines for GPs on mental health issues, including depression.

The key features of the NDI since its inception are a depression awareness campaign personalised through the story of ex-All Black, Sir John Kirwan, and partnered by a telephone hotline, online support website and a specific website for young people fronted by “navigators” who would appeal to a young target population.

Mental health is a priority health area for Government and the Ministry. The NDI is a key programme within the Ministry’s mental health activities. According to the Ministry’s 2006 Te Rau Hinengaro: The New Zealand Mental Health Survey, for example, 47% of New Zealanders are predicted to meet criteria for a mental health disorder at some time in their lives and one fifth (20.7%) in any 12 month period.

Other relevant mental health research includes the MaGPlc Research Group (see http://journal.nzma.org.nz/journal/116-1171/379/).
Section 3 – Context

3.2 National Depression Initiative Programme relationship structure

**Context – NDI Relationship Structure**

The diagram below represents the key relationships within the National Depression Initiative:

- **Ministry of Health**: develops strategy, administers policy, channels funding and undertakes contract management role of the service providers.

- **Health Promotion Agency**: was formed on 1 July 2012, at which time HPA became responsible for managing and monitoring contracts for the NDI and health promotion Programmes. Within the NDI, the HPA is responsible for the contracts for DraftFCB and Phoenix Research Ltd. The HPA will take on a more strategic leadership role with the Ministry of Health from 1 July 2013 onwards.

- **Lifeline Aotearoa**: manages the 0800 helpline, undertakes the administration of the Reference Network and provides lookthrough to the Journal.

- **DraftFCB**: supplies website development and maintenance for the Lowdown, Depression.org and the NDI.org websites, develops and manages the awareness campaign and PR activities (including Sir John Kirwan’s involvement).

**Context – NDI Relationship Structure**

- **Phoenix Research Ltd**: Produce annual Evaluation Reports, Tracking Surveys and other ad hoc research as agreed.

- **Reference Network**: The NDI Reference Network was formed to provide advice, opinion, feedback and expertise from a range of perspectives at critical stages in the Programme’s development, and linkages with related sectors and activities. The full list of members is included in Appendix 1. The role of the Reference Network is:
  - To provide advice, feedback, input and expert opinion on the development and future direction of the various NDI campaigns and related activities
  - To provide critical and professional observations and reflections on progress of the campaign towards the identified goal and objectives
  - To provide suggestions and contribute towards linkages, alignment and synergy with initiatives and developments in other sectors
  - To enable and facilitate buy-in and active collaboration from a wide range of stakeholders
  - To reflect views and positions of specific sector, community or professional groups.

The Reference Network meets approximately three times per year.
The diagram below represents how the key organisations involved within the NDI interact with each other, with the Ministry and the HPA providing overall programme leadership and strategy development. The respective roles of each of the service providers can be seen below. A suggested boundary of the NDI programme has been drawn onto this diagram.

This diagram poses several questions:

- Does the current strategy of the NDI match the NDI programme boundary on the diagram?
- Do current NDI activities all fit within this boundary?
- If the Reference Network members’ clinical practice is in the field of primary care, how does this fit appropriately into the NDI?
Some users enter the programme as a result of the awareness campaigns, although the awareness campaigns may not be the sole driver for entry. Also, different aspects of or messages in the awareness campaigns may prompt entry.

Some users enter the programme at different stages through channels other than the NDI awareness campaigns.

Some users are referred by primary, secondary or tertiary care givers.

Some users proceed to primary treatment.

Users exit the programme at different stages for different reasons (i.e. the service they receive is successful).

The diagram below shows how the users (i.e. sufferers of depression) flow through the NDI Programme. Users are exposed to the NDI through different means (i.e. exposure to the media and online campaigns, referral, other means such as friends and family) and exit the Programme at different stages.
The diagram opposite shows the agreed NDI campaign logic as presented in Phoenix Research Ltd's Evaluation Reports. This is a ‘living’ diagram as it is subject to review and reworking.
The diagrams on the previous pages demonstrate that the suggested programme boundary of the NDI does not include a formal interface with primary care or a direct professionally supervised use of the Journal. The original focus of the NDI was in taking a "population-wide" approach to health care to support those suffering from mild to moderate depression. However, in taking a population approach, this naturally results in people or sufferers of severe depression also presenting themselves. The NDI therefore supports sufferers with the full range of depression symptoms.

By taking a population approach to healthcare, the NDI is seeking to promote awareness and encourage help-seeking behaviours, whilst linking to support services provided by organisations such as Lifeline, which in turn, link with both primary and secondary care.

The population approach of the NDI focuses primarily on awareness creation, with self-management modules in the websites, as summarised in the diagram below. These are not e-therapy, which is part of the supported care demonstrated below, but they do leverage some e-therapeutic theory. However, as explored further in this document, the boundary appears to be increasingly blurring as to what the Programme offers. Throughout the course of this review, stakeholders had significantly varying views on what the NDI is. Some felt it is a form of cognitive-behavioural therapy, some an awareness campaign and some e-therapy. Evidence-based trials would be needed for the NDI to be considered as e-therapy. Without such trials, there is a lower standard of proof of the NDI’s clinical effectiveness. Trials would help provide understanding of how the NDI fits into clinical pathways and clinical care.
# Results

<table>
<thead>
<tr>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1 – Executive Summary</td>
</tr>
<tr>
<td>Section 2 - Introduction</td>
</tr>
<tr>
<td>Section 3 – Context</td>
</tr>
<tr>
<td>Section 4 – Results</td>
</tr>
<tr>
<td>Section 5 – International context</td>
</tr>
<tr>
<td>Appendices</td>
</tr>
</tbody>
</table>
Section 4 – Results

4.1 Overall Conclusion

Summary of Conclusions

**Overall Value for Money**

We were unable to draw an overall conclusion on the VfM of the NDI Programme (as distinct from a programme evaluation) due to a lack of data in some key areas.

Our review is based on two forms of quantitative data: data on NDI services over time and comparison of NDI service data and data from analogous services.

For any given driver, the absence of the first kind of data means that we cannot quantify performance in a given year or identify a trend. The absence of the second kind of data means that even if we can quantify performance and/or a trend, we cannot assess whether it is ‘better or worse’ than we might expect within the market.

We also note the complexity of the NDI programme and the difficulty of measuring public awareness outcomes.

However, we identified key areas where sufficient quantitative data was available to allow complete driver assessments. Those areas were:

- There is evidence that awareness and reach within the general population and some target sub-populations is good
- There is evidence that campaign advertising has driven increased help-seeking behaviour amongst the general population and some target sub-populations
- There is evidence that the media campaign is comparatively cost effective (by unit cost)
- There is evidence that the internal research component drives programme development to good effect.

The table opposite (bottom) shows our conclusions on VfM based on drivers which we were able to assess. (i.e. where there was sufficient data to draw conclusions).

In addition, we found no quantitative evidence of poor performance in any area. Although the NDI generates a lot of detailed programme data, most of it is not suitable for a VfM review as it provides limited insight on the Economy, Efficiency and Effectiveness of services. Consequently a major and recurring opportunity for VfM improvement is the collection of appropriate data.

Conclusions continued

**Overall conclusion based on all drivers (31 of 31)**

<table>
<thead>
<tr>
<th>1. VfM Overall</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. VfM Economy</td>
<td>U</td>
</tr>
<tr>
<td>3. VfM Efficiency</td>
<td>U</td>
</tr>
<tr>
<td>4. VfM Effectiveness</td>
<td>U</td>
</tr>
<tr>
<td>5. Trend</td>
<td>U</td>
</tr>
</tbody>
</table>

**Provisional conclusion based on 13 of 31 drivers**

<table>
<thead>
<tr>
<th>1. VfM Overall</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. VfM Economy</td>
<td>G</td>
</tr>
<tr>
<td>3. VfM Efficiency</td>
<td>G</td>
</tr>
<tr>
<td>4. VfM Effectiveness</td>
<td>G</td>
</tr>
<tr>
<td>5. Trend</td>
<td>G</td>
</tr>
<tr>
<td>6. Confidence in data</td>
<td>A</td>
</tr>
</tbody>
</table>
Conclusions continued

Conclusion 1: based on available quantitative evidence, the overall VfM of the NDI is rated Green

Overall VfM is the value received for the money spent (i.e. the ratio of total costs compared to the total quantified benefits, or value delivered).

Our overall rating of Economy, Efficiency and Effectiveness, based on drivers for which sufficient assessment data is available, is Green in each case. Therefore our overall rating of the VfM of those assessed drivers is also Green.

Conclusion 2: drivers of Economy, for which sufficient assessment data is available, are rated Green overall

Two drivers out of ten had sufficient data to draw conclusions, as follows:

<table>
<thead>
<tr>
<th>Driver</th>
<th>Rating</th>
<th>Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 1 (cost of media placement and implementation)</td>
<td>G</td>
<td>$1.3m-$2.8m</td>
</tr>
<tr>
<td>Driver 9 (cost to deliver annual Tracking Survey)</td>
<td>A</td>
<td>$80k p/a avg.</td>
</tr>
</tbody>
</table>

Given that the weight of spend was overwhelmingly within Driver 1 (see table above), we have concluded that the Economy drivers for which data was available are Green overall.

Our conclusion is supported by a high level comparison with the Australian initiative, Beyondblue, which is also a population health campaign to combat depression. In 2011-12, Beyondblue received AUS $33m of funding compared with the NDI’s 2011-12 budget of NZD $4.9m. These figures give per capita (as at June-July 2012 in both countries) spends of AUD$1.46 per person for Beyondblue and NZD $1.10 per person for the NDI.1

Conclusion 3: drivers of Efficiency, for which sufficient assessment data is available, are rated Green overall.

Four drivers out of ten had sufficient data to draw conclusions as follows:

<table>
<thead>
<tr>
<th>Driver</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 11 (DraftFCB delivery against contract performance measures)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 13 (unit cost per media campaign)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 14 (percentage of Phoenix recommendations implemented)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 18 (extent that Lifeline delivers against contract performance measures)</td>
<td>A</td>
</tr>
</tbody>
</table>

The majority of drivers are rated Green. Driver 18 is rated Amber due to some detailed reporting absences that may be addressed through Lifeline’s new contact system.

---

1. Population figures were taken from the Australian Bureau of Statistics and Statistics New Zealand.
4.1 Overall Conclusion

Conclusion 4: drivers of Effectiveness, for which sufficient assessment data is available, are rated Green overall.

Seven drivers out of eleven had sufficient data to draw conclusions as follows:

<table>
<thead>
<tr>
<th>Driver</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 21 (campaign effectiveness (reach))</td>
<td>G</td>
</tr>
<tr>
<td>Driver 22 (campaign effectiveness (impact))</td>
<td>G</td>
</tr>
<tr>
<td>Driver 23 (website effectiveness)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 27 (relevance of research)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 28 (applicability of recommendations)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 29 (proportion of recommendations implemented by DraftFCB)</td>
<td>G</td>
</tr>
<tr>
<td>Driver 30 (proportion of recommendations implemented by Lifeline)</td>
<td>A</td>
</tr>
</tbody>
</table>

The ratings for these drivers are overwhelmingly Green, therefore our overall rating for the assessed Effectiveness drivers is Green.

However, we were unable to conclude on some significant Effectiveness drivers including drivers that measure service provider performance against the NDI strategic objectives; drivers that are essential to assessing the overall VfM Effectiveness of the NDI. For that reason we were unable to draw a conclusion on the overall Effectiveness of the NDI.

Conclusion 5: where available data shows a trend, the trends tends to be positive.

Examples of positive trends are:

- High degree of cost certainty around sector co-ordination and cost to produce the Tracking Survey
- Television costs consistently below comparators and delivering strong added value
- Online unit costs reducing over time with measures of use (i.e. click through rates) improving over time
- Use of Depression.org and the Lowdown websites increasing over time
- Research consistently relevant to the Programme over time.

We found an apparent negative trend for the Lowdown in terms of a decreasing proportion of users that spent 30 minutes or more on the site. However that is a high level indicator of a phenomenon that requires further detailed analysis.

Conclusion 6: where conclusions are formed, our confidence in the data on which we base our conclusions is rated Amber.

While we were confident that data provided was good quality, it was not always a ‘best fit’ to the driver for which it was used. For example, some data was proxy data, some data was insufficiently detailed or complete, and other data provided limited insight on the Economy, Efficiency and Effectiveness of services. Also, due to the lack of ‘best fit’ in some cases and the high level nature of this review, some analyses lacked the level of robustness that would have increased our confidence in the conclusions.

For these reasons, where we formed conclusions, our confidence in the data overall is rated Amber, which implies a medium level of confidence.
4.2 Strengths of the NDI in New Zealand

1. In the views of respondents, the NDI is a world-leading programme in terms of its sound theoretical basis, its linkage to a suicide prevention strategy, the whole-of-country approach and the accessibility of services for those suffering from depression.

Professor Simon Hatcher, Professor of Psychiatry at the University of Ottawa indicated:

“I’m not sure anyone has done it better internationally, apart from perhaps in Australia. Canada is way behind and whilst the UK has done some similar work, there is no holistic national initiative.”

Professor Tony Dowell, co-author of this review and Professor of Primary Health Care and General Practice at the University of Otago, provided similar views:

“the NDI is done well...only Australia might be seen to be ahead in terms of a focus on health outcomes, programme evaluation and the particular programmes for most at-risk populations such as Aborigine and Torres Strait Islander populations.”

A number of other sector experts consider Australia’s depression campaign to be more advanced in some areas. Several initiatives, particularly “Beyond Blue” (www.beyondblue.org.au) having demonstrated clinical effectiveness through the use of Randomised Control Trials. “Beyond Blue” has continued with its original strategic intent and produced particular campaigns relating to the elderly. The Australian-based depression awareness and e-therapy intervention sites are effectively linked with each other. “Beyond Blue” has links to the literacy site “Blue Pages” (https://bluepages.anu.edu.au), and a parallel e-therapy intervention support programme called Moodgym, which is a free self help programme to teach cognitive behaviour therapy skills to people vulnerable to depression and anxiety. (https://moodgym.anu.edu.au/welcome). Furthermore, the Australian programme is considered to have stronger linkage into primary care and health outcomes and there is also increased targeting of at-risk sub-populations, such as Aborigine and Torres Strait populations. Respondents with international expertise in the field of depression consider the NDI to be more advanced than Canadian programmes, and describe UK initiatives as having similar components to the NDI (i.e. celebrity endorsement), but lacking a single, national, population-wide, holistic programme.

2. There is evidence to suggest that the NDI enjoys strong reach and awareness creation across the general population and targeted at-risk populations. According to Phoenix’s research into the reach of the NDI Programme, an average of 81% (across 4 surveys between 2010 and 2012) of focus group participants recalled NDI advertising when unprompted. Recall rose to 88% when participants were prompted or provided a description of the advertising. The equivalent figures for Māori were 82% unprompted and 92% when prompted or provided a description, and for Pasifika, 64% and 81%.

Comparative evidence suggests that recall of the NDI is the same as, or stronger than, analogous campaigns.

When compared against the MSD Family Violence Campaign, which targets similar populations, the NDI appears to be more affective amongst Māori and Pasifika.

3. There is evidence to suggest that the NDI encourages positive attitudes to, and positive behavioural changes towards, depression. In addition to evidence in the Phoenix Tracking Reports, some respondents provided anecdotal evidence that the NDI supports the de-stigmatisation of depression. Several stakeholders with positions in primary health care (i.e. GPs and mental health professionals) indicated that it is easier to engage with patients about depression as a result of the NDI awareness campaign, however those views may not accurately represent experiences in Māori and Pasifika primary care. Also, it is important to note that this may not entirely be attributable to the NDI given the other depression-related campaigns and initiatives currently operating in New Zealand (see page 24). Additionally, to our knowledge, this impact has not been formally measured.
4. Whilst the Journal’s clinical effectiveness has not been independently tested, changes in user PHQ-9 scores suggest that it may be effective in reducing feelings of depression. The Journal is the NDI’s online self-management tool which provides users with a series of six lessons to help manage feelings of depression. Users’ feelings of depression are quantified using PHQ-9 scores (see glossary of terms, page 2). Scores are recorded before Lesson 1, midway (Lesson 3) and after Lesson 6.

The table below shows the recorded change in PHQ-9 scores measured at the start of the Programme, at the mid-point and at the end of Lesson 6. An ideal change is that the percentage of users scoring "not depressed" and the percentage of users with scores showing different depression severities, goes down.

<table>
<thead>
<tr>
<th>Change in PHQ-9 scores</th>
<th>Initial score</th>
<th>Midway score</th>
<th>Final score</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finished midway</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not depressed</td>
<td>13.3%</td>
<td>53.4%</td>
<td>Increased</td>
<td></td>
</tr>
<tr>
<td>Mild depression</td>
<td>25.1%</td>
<td>24.8%</td>
<td>Decreased</td>
<td></td>
</tr>
<tr>
<td>Moderate depression</td>
<td>30.8%</td>
<td>12.5%</td>
<td>Decreased</td>
<td></td>
</tr>
<tr>
<td>Severe depression</td>
<td>30.9%</td>
<td>9.3%</td>
<td>Decreased</td>
<td></td>
</tr>
<tr>
<td>Finished final lesson</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not depressed</td>
<td>17.1%</td>
<td>56.6%</td>
<td>75.3%</td>
<td>Increased</td>
</tr>
<tr>
<td>Mild depression</td>
<td>22.7%</td>
<td>24.0%</td>
<td>15.3%</td>
<td>Decreased</td>
</tr>
<tr>
<td>Moderate depression</td>
<td>29.1%</td>
<td>10.5%</td>
<td>4.1%</td>
<td>Decreased</td>
</tr>
<tr>
<td>Severe depression</td>
<td>31.1%</td>
<td>8.9%</td>
<td>5.4%</td>
<td>Decreased</td>
</tr>
</tbody>
</table>

Phoenix data indicates sharp decreases in proportions of users with scores indicating mild, moderate and severe depression after completion of half or all of the lessons. Decreases in proportions of scores that indicated mild, moderate and severe depression after Lesson 6 were 7%, 25% and 26% respectively. 75% of scores after Lesson 6 indicated “not depressed,” a 58% increase from the 17% of scores that indicated “not depressed” prior to Lesson 1.
5. The NDI leverages the skills and competences of service providers in a powerful way and, for the most part, the service providers interact and collaborate positively for the greater good of the Programme. There are two parts to this strength: the quality of the service providers and the quality of their interaction.

KPMG observed and consulted with a powerfully motivated, passionate and committed sector during the course of this review. Feedback from this broad range of stakeholders in our qualitative analysis particularly complimented:

- DraftFCB in the strength / credibility of media placement and media marketing
- Lifeline in their tracking, follow-up service, responsiveness and engagement with police and primary care, as well as the multi-cultural nature of the contact team which is representative of the client base
- Phoenix in the quality and robustness of their research and holding the Reference Network to account by ensuring a strong evidence base for the NDI
- The individual commitment of programme champions within the Ministry of Health and HPA, whilst recognising significant resource constraints.

Collectively, the three service providers above have strong institutional knowledge of the NDI, with strong relationships and links into primary care.

We also observed all stakeholders to present strong collective passion to support people suffering from depression.

We are grateful for the input of the large number of stakeholders, listed at Appendix 3.

It was outside of the scope of this review to evaluate the cost of services delivered by the current service providers against market rates or against other competitors in the marketplace. Whilst ongoing monitoring and management of contractual performance is important, KPMG recommends that any review of future contracts should be based on a holistic VfM perspective of current service delivery, rather than solely on the cost (economy) of delivering services.

6. The impact of Sir John Kirwan: In the views of many respondents, Sir John Kirwan’s pro bono involvement in the Programme has provided exceptional value for money. Stakeholders spoke passionately of Sir John’s "phenomenal impact", “incredible mana” and “charisma” in driving increased awareness of depression and in supporting de-stigmatisation. Phoenix’s research on reach and awareness (see paragraph page 49) may be interpreted to broadly support those claims. For example, in order to prompt recall of the NDI awareness campaign, participants were asked if they recalled advertisements featuring Sir John. That prompting resulted in additional recall. However, to our knowledge, neither the actual impact on awareness of Sir John’s participation nor the economic impact of his pro-bono involvement have been formally studied. In order to demonstrate benefits, (or costs), additional analysis would be required to, for example, evaluate specifically whether and how Sir John’s celebrity directly translates into number of website hits, calls to helplines or completion of the Journal modules, as well as evaluating this against international comparators where celebrities were not used.

7. In the views of respondents, the Reference Network has been influential in the NDI initiation, provides positive opportunities for the sector to meet and a pool of skilled practitioners from which the Programme can draw. The positive role of the Reference Network in shaping the Programme at its initiation should be acknowledged. However, the limitations of the Reference Network in its current form, and its need to evolve, are outlined in this review.
National Depression Initiative – issues to address

1. The strategic direction of the NDI needs firmer articulation and communication: During the course of this review, we identified eight key symptoms amongst the service providers and Reference Network, which indicate that the NDI’s future strategic direction needs to be outlined and communicated in a clear way. The eight symptoms are summarised in the diagram below, and described in detail thereafter. We then present opportunities for improvement relating to each symptom.

   - (a) Lack of clarity amongst some stakeholders about what the NDI actually is
   - (b) Uncertainty amongst some stakeholders about who leads the NDI
   - (c) Uncertainty amongst service providers and Reference Network about future operational structure
   - (d) Uncertainty amongst service providers and Reference Network about role and remit of Reference Network
   - (e) Uncertainty amongst service providers and Reference Network about research alignment with strategic goals
   - (f) Strong belief amongst service providers and Reference Network that NDI has become static
   - (g) Uncertainty amongst service providers and Reference Network whether appropriate audiences are being targeted
   - (h) Uncertainty amongst all stakeholders about how the NDI fits within wider mental health strategies

Symptom a - Lack of clarity amongst some stakeholders about what the NDI actually is: Respondents presented a range of interpretations and definitions of the NDI. In our view this symptom presents a risk that stakeholder activities may not align with the NDI strategy.

Symptom b – Uncertainty amongst some stakeholders about who leads the NDI: Respondents had different ideas about who leads the NDI, with suggestions as varied as the Ministry, the HPA, the Chairman of the Reference Network, Sir John Kirwan or one of the service providers. This lack of clarity may derive from historical staff turnover and a loss of institutional memory, and from recent structural changes such as the addition of the HPA. In our view this symptom presents a risk that stakeholder activities may not align with the NDI strategy.

Symptom c – Uncertainty amongst service providers and the Reference Network about future operational structure: The Ministry has been responsible for the NDI since programme inception. Its role has been to develop strategy, administer policy, lead channel funding and manage service providers’ contracts (Ministry contract management is now only for the Lifeline Aotearoa contract). The HPA was formed on 1 July 2012, at which time it became responsible for managing and monitoring contracts for the NDI and health promotion Programmes. Within the NDI, the HPA is responsible for the contracts for DraftFCB and Phoenix Research Ltd. The HPA will take on a more strategic leadership role with the Ministry of Health from 1 July 2013 onwards.

Service providers are currently not clear about how the Ministry and HPA will work together to administer the NDI programme.

Symptom d – Uncertainty amongst service providers and Reference Network members about the role and remit of the Reference Network: While many respondents praised the Reference Network’s historical role in establishing the NDI, there was less certainty about its current value beyond a forum for sharing information. In addition, the current membership does not appear aligned with the population-wide awareness creation and self-help intent of the NDI; membership (different from attendance) is significantly weighted towards primary care experts. Given these features, there is a risk that the Reference Network may exacerbate the challenge of pulling the NDI in unintended directions.
4.3 NDI Programme: issues to address

Symptom e – Uncertainty amongst some service providers and Reference Network members on the alignment of research with the strategic goals of the NDI: some respondents expressed a concern that research undertaken by Phoenix may not properly align with the NDI strategic goals. We are unable to substantiate that concern and quantitative evidence suggests the opposite to be true. For example, our high level analysis under Driver 27 indicates that 96% of Phoenix’s recommendations are considered as within the NDI Programme scope. The question of the appropriateness of research, therefore, appears to reinforce the lack of clarity on what the NDI actually is and what research should be undertaken to support the future strategic direction.

Symptom f – Strong belief amongst service providers that the NDI has become static and has not evolved with the times: whilst there was significant momentum in the NDI’s initiation phase to create a programme that responded to a coherent strategic plan, in the views of some respondents the NDI may now be in a position where it needs to evolve further or move into a steady state maintenance phase. Both positions would require strategic revisions to reflect the new state.

Evolution or steady state may be best applied to aspects of the Programme rather than the programme as a whole. For example, aspects to evolve may include:

- Content – of advertising campaigns, websites etc
- Method of delivery (i.e. new technologies or platforms such as apps)
- New target at-risk groups
- Services – develop a full e-therapy tool, development of technical links with primary care providers.

Steady state may include:

- Retaining current functionality and status of the Journal
- Maintaining general population focus.

According to respondents, there has also been a (recent) historical issue around the speed with which proposed changes receive approval. However, those issues should be alleviated with the recent addition of the HPA and strategic work described on pages 56-57.

Symptom g – Uncertainty amongst some service providers and Reference Network members whether appropriate audiences are being targeted: whilst the NDI was originally intended as a population-wide Programme, there is a question as to whether sub-populations can and should receive special attention. Respondents with expertise in population health are positive about the NDI's current and historical ability to accommodate that issue; the combination of Phoenix’s research on targeted populations (Māori, Pasifika and Youth) and Reference Network expertise has helped focus and refine the NDI awareness campaign for those groups. However, we believe that there are ongoing questions as to the efficacy and appropriateness of current activities in respect of those sub-populations.

Symptom h – Uncertainty within all stakeholder groups (though not all members of those groups) of how the NDI fits within broader Government, Ministry and HPA strategies: although literature surrounding the NDI refers to broader mental health strategies (i.e. Te Tāhuhu, the Ministry’s Suicide Prevention Strategy 2006-2016), some respondents are unclear how the NDI fits within these broader strategies. In addition, some respondents are unclear how it will fit within new mental health strategies such as the Youth Mental Health Strategy.

KPMG understands that historically the NDI received its funding through the Suicide Prevention Plan but that is no longer the case. Given that change there may be benefit in re-articulating how the NDI does or does not fit within existing strategies, such as the Suicide Prevention Plan and how it will fit within forthcoming strategies, such as the Youth Mental Health Strategy.

It is essential that any future strategic reviews keep these alignment issues in sight as they proceed.

In addition, many programme stakeholders pointed to a need for an improved Whole-of-Government approach to combating depression, with improved alignment and co-ordination of the activities of different government departments, especially the Ministry of Social Development (MSD) and the Ministry of Health (MoH).
Section 4 – Results

4.3 NDI Programme: issues to address

2. To ensure clarity across the sector on what the NDI is, and how it should potentially evolve, some critical questions must be answered. The eight symptoms showing the need for greater communication and articulation of the NDI’s strategic direction, as outlined on the previous pages, highlighted a lack of clarity amongst stakeholders as to what the NDI actually is and how it will operate in future. There is a lack of clarity and consistency on the answers to questions such as whether the NDI’s focus is at a general population level or a sub-population level, or whether the NDI is solely focussed on those with mild-to-moderate depression. In KPMG’s view, in order to bring strategic clarity, the Ministry and the HPA should provide clarity and communicate consistent responses to these and the following questions:

• **Is the Journal an e-therapy?** We identified opposing views amongst service providers and Reference Network members as to whether the Journal is or should be considered an e-therapy. This is not a semantic question. For the NDI to be considered an e-therapy, it would need:
  o A formal description as such
  o To be surrounded by a standard framework of clinical support including alignment with primary care referral and feedback
  o To meet Ministry standards of clinical efficacy.

The NDI was not established to deliver e-therapy or treatment as such, but was rather focussed on driving awareness of depression, promoting help-seeking behaviour, and introducing potential depression service users to the kinds of services they might encounter in primary, secondary and tertiary care. In that context, the Journal was developed as a self-management tool.

KPMG understands that the Ministry does not currently intend the NDI to be a clinical intervention or treatment tool, however there is strong interest within the sector for it to become so. Research indicating improved PHQ-9 scores supports and perhaps encourages the perception that the NDI is, or could become, a treatment tool.

• **Do primary care practitioners have a role in the NDI?** If the NDI is based on a population-wide health approach, what role, if any, do primary care practitioners have? To support answering this question, there needs to be greater clarity amongst all stakeholders of the boundaries of the NDI, i.e. what the NDI is, and what it isn’t. The risk of being unclear on the scope and boundaries of the NDI is that it fuels people’s perceptions that the NDI should be all things to all people.

• **Should primary care practitioners have access to the Journal in order to support and monitor people’ ongoing progress?** In the interest of creating a more integrated depression service offering, there may be value in allowing GPs access to the Journal if their people use that tool. However, this option should be conducted in line with other decisions (i.e. the boundary between the NDI and primary care), and in full consideration of wider issues such as privacy. In addition, there may be costs associated with creating that access (i.e. connecting the Journal with the various GP Patient Management Systems). Therefore, this option should be subject to a robust cost-benefit analysis.

Some implications for developing the Journal into an e-therapy are:

  o **Cost:** it may be expensive to demonstrate the Journal’s clinical effectiveness to the required level

  o **Access:** As an e-therapy clinical tool subject to regulation, access may be restricted to mental health professional referral only, rather than open access.

  o **Demonstrable efficacy:** Users and mental health professionals could have greater confidence in the clinical efficacy of the Journal programme.

The Ministry and the HPA may find it useful to reach formal agreement as to the Journal’s future state based on a cost-benefit analysis.
4.3 NDI Programme: issues to address

### Issues to address (continued)

- **Are young people engaging sufficiently?** Rates of reach and awareness amongst Youth populations (16-24 year olds) indicated by NDI research – an average of 29% prompted recall across four surveys between 2010 and 2012 – indicate that consideration should be given to whether the NDI currently meets the needs of that audience. From our interviews and surveys, we understand that many respondents consider the Lowdown as it currently exists to be “out of date” with respect to the Youth population.

  We acknowledge that the NDI has put considerable effort into researching youth engagement and that, as a target population, it possesses some characteristics that may require a specific set of programme responses or strategies. For example, the Youth population may exhibit a high level of churn (individuals may move through that population quickly), or the relevance of the delivery platform or content may have a shorter lifespan than with other audiences. It may be, therefore, that decision making and approvals processes in respect of the Youth population may be different (i.e. quicker or more often) from other audiences.

  Future work on youth engagement depends on Ministry and HPA decisions around the Lowdown. If development is approved, then youth engagement may be assessed on the effectiveness of that development. If development is not approved, then the NDI may conduct a further review of its youth engagement approach.

- **How should the NDI evolve to bring the next wave of the population into accessing these services?** Whilst the general awareness-raising of the NDI has been positive through its “proportionate universalism” approach, KPMG encountered differing views as to whether the needs of specific sub-populations are effectively supported by wider mental health services.
### Strategic review: in our view the biggest opportunity to improve the NDI is through a strategic review that address the symptoms identified and described above.

The table below lists some options and recommendations for addressing the symptoms.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Opportunities for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptom a - Lack of clarity on what the NDI actually is</strong></td>
<td>• Strengthen the focus and definition of what the NDI is. Generating a clear definition of the NDI will improve stakeholder clarity and help focus stakeholder activities and interaction, which in turn will help maximise the value derived from the Programme.</td>
</tr>
<tr>
<td><strong>Symptom b – Uncertainty about who leads the NDI</strong></td>
<td>• Provide greater clarity on the leadership roles of the Ministry and the HPA, and the relationships between the leadership, the service providers and the Reference Network • Establish a formal set of accountabilities and relationships that can improve the operation of the Programme • Implement formal change management processes that can mitigate against future “key person” or structural change risk.</td>
</tr>
<tr>
<td><strong>Symptom c – Uncertainty about future operational structure</strong></td>
<td>• Establish a clear, shared understanding of the new NDI structure and the accountabilities and duties that arise from it.</td>
</tr>
<tr>
<td><strong>Symptom d – Uncertainty about the role and remit of the Reference Network:</strong></td>
<td>• Redefine the Reference Network’s Terms of Reference (ToR), specifically its membership and their responsibilities and accountabilities. However, these actions should be based on prior work to address symptoms a-c.</td>
</tr>
<tr>
<td><strong>Symptom e – Uncertainty on the alignment of research with the strategic goals of the NDI</strong></td>
<td>• A review of historical research topics could be undertaken, however, the costs and benefits of conducting such a review should be evaluated prior to any work taking place • In order to ensure future alignment, work to address symptoms a-c should be completed, including a formal system for commissioning research and / or the collecting appropriate market intelligence that aligns with the strategic direction.</td>
</tr>
<tr>
<td><strong>Symptom f – Strong belief that the NDI has become static and has not evolved with the times</strong></td>
<td>• Determine appropriate state of NDI (i.e. steady state or evolving) • Improve decision making procedures, for example, small scale ‘business case approach’; create log of decisions made and justification (could be based on business case approach).</td>
</tr>
<tr>
<td><strong>Symptom g – Uncertainty whether appropriate audiences are being targeted</strong></td>
<td>• Review and restate the NDI’s position in respect of the focus on the general population and / or targeted populations. Based on that statement, the NDI can be managed to allocate resources (i.e. research, awareness campaigns) and funding accordingly. • Review current spending and approaches to generating awareness within targeted sub-populations. There may be more efficient, effective or economic ways to deliver targeted awareness campaigns than are currently used.</td>
</tr>
<tr>
<td><strong>Symptom h – Uncertainty about how the NDI fits within broader Government, Ministry and HPA strategies</strong></td>
<td>• Establish a future strategic direction for the NDI that takes in the new shared Ministry and HPA structure and the strategic require of those two organisations.</td>
</tr>
</tbody>
</table>
Section 4 – Results

4.3 NDI Programme Opportunities for Improvement

**Opportunities for improvement**

**Structural, process and other opportunities for improvement**

In addition to the strategic work described above, we believe there are opportunities to improve the structure and processes of the NDI Programme.

Possible changes that may be considered in light of that strategic review are:

1. **Scope current NDI activities and activities that will be required under the revised strategy.** Match activity lists to identify activity gaps and/or redundant current activities. Consider a) whether and how activity gaps could be filled, and b) whether redundant activities should be eliminated.

2. **Scope and create appropriate resource and functions to support sector cohesion and alignment towards the agreed strategy.** These resources should provide programme oversight, support sector cohesion and ensure alignment of the work to the Programme's agreed strategic goals. The resource could be located within the Ministry or the HPA.

3. **Create an NDI Governance Board with appropriate membership and Terms of Reference to support an agreed strategic direction.** A Governance Board could be created, with appropriate experience in population-wide health programmes, technology and programme governance, to support the strategy and direction of the Programme. If appropriate, time-bound working groups comprising Board members could be created to advise on particular topics. For example, a sub-group may be required to advise on the ongoing maintenance or evolution of the Journal and the Lowdown.

Consideration should be given as to whether creating a Governance Board removes the need for a Reference Network.

If a Board is established, the Chair could be an elected representative of the Ministry or HPA.

**Opportunities for improvement (continued)**

4. **Develop more transparent procedures for receiving, recording and responding to recommendations from the sector on Programme enhancements.** In order to ensure that sector-led recommendations for improvements to, or development of, the Programme align with the new strategy, a more transparent process could be developed. A suggested format may be a one page “business case” which articulates the opportunity, demonstrates the potential costs and benefits of the opportunity and outlines how the opportunity aligns with the NDI strategy.

Care should be taken that the procedures are not onerous, do not require too much resourcing, or do not deter parties from making recommendations.

5. **There is an opportunity to increase the quality of data** on users of the NDI, and thereby enhance the ability to make true VfM evaluations of the economy, efficiency and effectiveness of the Programme. As the driver chart on page 32 shows, there are a number of data gaps which make a full VfM evaluation impossible with current data constraints. On the other hand, we recognise that in some instances the effort to collect data may not be worth a VfM improvement that may be marginal. These potential trade-offs should be carefully considered where they are identified.

6. **Ensuring that branding within the NDI is up to date:** Many depression sites now make it clear that people accessing both websites and telephone lines suffer from symptoms other than “depression,” and will have separate information portals for anxiety and depression. An evaluation of the overall identity of the NDI should be made in terms of addressing common mental disorder and anxious depression rather than depression alone.

Furthermore, the branding of the Lowdown should be reviewed, given the rapidly changing ways that youth access different technology options and the speed with which “navigators” would be recognised or not by a target audience.
At stakeholder workshops, as part of this review, we asked participants to share their overall perceptions of the current level of VfM from each component of the NDI using a simple 0 to 10 scale, where 0 is poor and 10 is good. This was used as a basis for initial discussions. The results of this assessment have not influenced our overall conclusion.

Whilst this measure of our approach is subjective and non-scientific it allows us to place these comments into perspective. Once the general level of performance is assessed and shared, the context is provided and the focus can move to areas for potential improvement ("How to get 10/10").

Many responses to this question focussed on a view that the VfM of the NDI "used to be better." When respondents gave historical scores for the VfM of the NDI as a whole, these were generally higher (8.5/10) than their current scores (7.5/10). Equally, historical scores for the VfM of the Reference Network were significantly higher (8/10) than currently (5.7/10).

Based on this subjective and non-scientific measure, there is an indication that VfM is currently quite high but that there is room for improvement.

The population for this measure was split as follows:
- 3 Government representatives (Ministry and HPA)
- 26 sector representatives (service providers, academics, other interested parties).

Approximately 85% of those we met with provided their perceptions for this measure.

The dark blue lines show the average rating. The coloured columns show the range of scores.

**Key points**

- Government representatives had higher perceptions of the VfM of the current delivery structure and of the Reference Network than service providers
- Lower scores for DraftFCB were attributed by two organisations with views that the general population advertising was very strong, but with concerns that the advertising does not meet the needs of the most affected populations. This is perhaps more a reflection on the current intended strategic direction of the NDI, rather than any reflection on DraftFCB
- A lack of clarity of the respective roles of the Ministry and HPA, as well as the need for stronger programme coordination, were the two most common reasons given for lower delivery structure scores.
Section 4 – Results

4.5 Introduction to analysis of VfM drivers – Quantitative analysis

Introduction to analysis of VfM drivers

This section sets out how we present our analysis of the VfM drivers. In the following pages we have used a standard layout with a common set of headings.

In our approach section, we identified 31 drivers of VfM. These are measures of the Economy, Efficiency and Effectiveness of each of the components of depression services.

**Heading**

The heading of each driver identifies service provider to which this driver relates to e.g. DraftFCB. The text in bold sets out the title of the driver.

**Measurement**

Identifies factors that influence VfM.

This section also identifies:
- Driver of VfM
- Measure
- Assumptions
- Data source & confidence.

**Opportunities for improvement**

Identifies opportunities to improve the VfM of service provision.

**Analysis & Commentary**

Analyses the data within the driver, presents it graphically where possible discusses comparisons of issues of note.

**Conclusion**

Provides an overall conclusion for the driver. The framework for this conclusion is provided on the following page.

**VfM Components**

Indicates which of the components of our VfM methodology to which the driver relates: Economy, Efficiency or Effectiveness.

Example of a VfM driver analysis:

**Driver:** Cost of managing media and PR communication

**Analysis & Commentary:**

According to the data, DraftFCB has provided media and PR communication services for a fixed rate of $100k per annum for the period 2008-09 to 2011-12. The budget is typically as follows:
- $50k – promoting the Journal
- $40k – promoting the Lowdown
- $20k – Other costs

DraftFCB incurred costs of $580k, which is significantly less than the budgeted amount of $120k. According to the Ministry, the $20k increase for the Lowdown is linked to the renewal of sponsorship of the Smithson Report.

**Conclusion:**

Despite the cost savings, we are unable to draw conclusions on the VfM of this driver.
For each driver, we conclude on the VfM, trend and confidence in the data assessed. This uses the traffic-light system whereby red indicates poor performance, amber indicates fair performance and green indicates good performance. Our framework for applying the traffic-light system is described below and on the following page.

The assessment of VfM is based on analysis of the results, trends of the driver and compensating factors. Discussion of how and where compensating factors affect conclusions appear in ‘Analysis & Commentary’ sections. Assessments are based on quantitative data and qualitative evidence. The rating system for each driver is subjectively applied rather than based on quantifiable thresholds. The framework we have applied for applying the traffic-light system is below:

### Framework for assessing VfM under traffic-light system

<table>
<thead>
<tr>
<th>VfM Conclusion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>This driver suggests VfM is poor in this area. Significant opportunities for improvement exist</td>
</tr>
<tr>
<td>Amber</td>
<td>This driver suggests VfM is fair in this area. Some opportunities for improvement exist</td>
</tr>
<tr>
<td>Green</td>
<td>This driver suggests VfM is good in this area</td>
</tr>
<tr>
<td>Grey</td>
<td>Data for this driver was insufficient to provide a VfM conclusion. If confidence in the data for this driver was assessed as Red we have not provided a VfM conclusion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trend</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>The trend for this driver is negative. Performance has decreased over time</td>
</tr>
<tr>
<td>Amber</td>
<td>The trend for this driver is stable. Performance has remained stable over time</td>
</tr>
<tr>
<td>Green</td>
<td>The trend for this driver is positive. Performance has improved over time</td>
</tr>
<tr>
<td>Grey</td>
<td>The trend was not assessed for this driver</td>
</tr>
</tbody>
</table>
Framework for assessing VfM under traffic-light system (continued)

<table>
<thead>
<tr>
<th>Confidence in data</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Confidence in the data for this driver was low</td>
</tr>
<tr>
<td>Amber</td>
<td>Confidence in the data for this driver was moderate</td>
</tr>
<tr>
<td>Green</td>
<td>Confidence in the data for this driver was high</td>
</tr>
<tr>
<td>Grey</td>
<td>Insufficient data on which to base conclusions</td>
</tr>
</tbody>
</table>
### Section 4 – Results

#### 4.5 VfM driver conclusions – Quantitative analysis: Economy

<table>
<thead>
<tr>
<th>Driver</th>
<th>Service provider</th>
<th>VfM Conclusion</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 1 – Cost of media placement and implementation</td>
<td>DraftFCB</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Driver 2 – Cost of website hosting and development</td>
<td></td>
<td>U</td>
<td>U</td>
<td>G</td>
</tr>
<tr>
<td>Driver 3 – Cost of management of media and PR/communications</td>
<td></td>
<td>U</td>
<td>U</td>
<td>G</td>
</tr>
<tr>
<td>Driver 4 – Cost of development of education and promotional resources</td>
<td></td>
<td>U</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Driver 5 – Cost of maintaining the multi-channel helplines</td>
<td>Lifeline Aotearoa</td>
<td>U</td>
<td>A</td>
<td>R</td>
</tr>
<tr>
<td>Driver 6 – Cost to provide other services for the Lowdown</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 7 – Cost to perform sector co-ordination and relationship management</td>
<td></td>
<td>U</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Driver 8 – Cost to deliver annual Evaluation Report</td>
<td>Phoenix Research Ltd</td>
<td>U</td>
<td>U</td>
<td>G</td>
</tr>
<tr>
<td>Driver 9 – Cost to deliver annual Tracking Survey</td>
<td></td>
<td>A</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Driver 10 – Cost to deliver annual ad hoc/topical reports</td>
<td></td>
<td>U</td>
<td>U</td>
<td>G</td>
</tr>
</tbody>
</table>
# Section 4 – Results

## 4.5 VfM driver conclusions – Quantitative analysis: Efficiency

<table>
<thead>
<tr>
<th>Overall Driver Conclusion based on 10 indicators</th>
<th>Provisional Driver Conclusion based on 4 indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>G</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Driver</th>
<th>Service provider</th>
<th>VfM Conclusion</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 11 – Extent that provider delivers against contract</td>
<td>DraftFCB</td>
<td>G</td>
<td>G</td>
<td>A</td>
</tr>
<tr>
<td>performance measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driver 12 – Website return on investment</td>
<td></td>
<td>U</td>
<td>A</td>
<td>G</td>
</tr>
<tr>
<td>Driver 13 – Unit cost per media campaign</td>
<td></td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Driver 14 – Percentage of Phoenix recommendations implemented</td>
<td></td>
<td>G</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>Driver 15 – Unit cost of multi-channel helplines</td>
<td>Lifeline Aotearoa</td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 16 – Staff utilisation</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 17 – Post-contact service</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 18 – Extent that provider delivers against contract</td>
<td>Phoenix Research Ltd</td>
<td>A</td>
<td>A</td>
<td>G</td>
</tr>
<tr>
<td>performance measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driver 19 – Timeliness of reports to inform NDI</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 20 – Timeline from recommendation to signoff</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
</tbody>
</table>
## Section 4 – Results

### 4.5 VfM driver conclusions – Quantitative analysis: Effectiveness

#### Overall Driver Conclusion based on 11 indicators

#### Provisional Driver Conclusion based on 7 indicators

<table>
<thead>
<tr>
<th>Driver</th>
<th>Service Provider</th>
<th>VfM Conclusion</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 21 – Campaign effectiveness (reach)</td>
<td>DraftFCB</td>
<td>G</td>
<td>A</td>
<td>G</td>
</tr>
<tr>
<td>Driver 22 – Campaign effectiveness (impact)</td>
<td></td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Driver 23 – Website effectiveness</td>
<td></td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Driver 24 – Link to NDI objectives</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 25 – Quality of multi-channel help lines</td>
<td>Lifeline Aotearoa</td>
<td>U</td>
<td>U</td>
<td>R</td>
</tr>
<tr>
<td>Driver 26 – Link to NDI objectives</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>Driver 27 – Relevance of research</td>
<td></td>
<td>G</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>Driver 28 – Applicability of recommendations</td>
<td></td>
<td>G</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>Driver 29 – Proportion of recommendations implemented by DraftFCB</td>
<td>Phoenix Research Ltd</td>
<td>G</td>
<td>U</td>
<td>R</td>
</tr>
<tr>
<td>Driver 30 – Proportion of recommendations implemented by Lifeline</td>
<td></td>
<td>A</td>
<td>U</td>
<td>A</td>
</tr>
<tr>
<td>Driver 31 – Proportion of recommendations implemented by the Ministry or HPA</td>
<td></td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
</tbody>
</table>
Section 4 – Results

4.5 VfM driver conclusions – Driver tree

VfM Driver Tree conclusions

As outlined in our approach in Section 2.3, we have presented each of the VfM drivers in a driver tree. Each driver is colour-coded according to our conclusion. Our conclusions consider the overall relationship between Economy, Efficiency and Effectiveness and their impact on VfM.

This analysis relates solely to our quantitative analysis and does not consider the strengths or areas for development identified through stakeholder interviews.

Drivers shaded in grey represent areas where, for various reasons, we were unable to draw conclusion about VfM. These reasons include:

- A lack of data
- Concerns over quality of available data
- Contradictory indicators within the data (i.e. positive and negative results)

We have identified additional data collection and analysis amongst the opportunities for improvement in the respective drivers. However, we understand that collecting data in all of these areas may be impractical. KPMG recommends that the Ministry perform a cost-benefit analysis in order to decide which opportunities to pursue.

Source: KPMG
Section 4 – Results

4.5 VfM driver conclusions – Driver tree

Cost of media placement and implementation
- Cost of website hosting and development
- Cost of management of media and PR/communications
- Cost of development of education and promotional materials

Extent that provider delivers against contract performance measures
- Website return on investment
- Unit cost per media campaign
- Percentage of Phoenix recommendations implemented

Campaign effectiveness (reach)
- Campaign effectiveness (impact)
- Website effectiveness
- Link to NDI objectives

Source: KPMG
Section 4 – Results

4.5 VfM driver conclusions – Driver tree

Source: KPMG
Section 4 – Results

4.5 VfM driver conclusions – Driver tree

Cost to deliver annual evaluation report
Cost to deliver annual tracking survey
Cost to deliver annual ad hoc/topical reports
Timeliness of reports to inform NDI campaign
Timeline from recommendation to signoff
Relevance of research
Applicability of recommendations
Proportion of recommendations implemented by DraftFCB
Proportion of recommendations implemented by Lifeline Aotearoa
Proportion of recommendations signed off by the Ministry

Phoenix Research ($0.27M budget)
Section 4 – Results

4.6 DraftFCB Driver 1 – Cost of media placement and implementation

Driver
This driver covers the Economy of the NDI awareness campaign(s) across a range of media channels. The identified channels are:
- Television
- Radio
- Online
- Print.

Measure
The measure to assess this driver is the total budgeted cost to deliver the media campaign through each channel.

Data source and confidence
Data for 2006-07 to 2009-10 are from budgets in Ministry (now HPA) contracts. Data for 2010-11 to 2012-13 are from DraftFCB scope of work documents. Print figures provided by DraftFCB are actual spend rather than budget.

Confidence in the data is high.

Assumptions
Differences in data sources mean that budget allocations may not be consistent. Also, budget (and spend) figures allocated to some channels may capture activities that, given more granular analysis, may be better allocated to other channels.

Figures are not allocated consistently across financial or calendar years.

DraftFCB provides the media placement and implementation services for the NDI.

The chart below shows the total size and composition of DraftFCB’s contracts for the period 2006-07 to 2012-13. It shows that the budget has grown from nearly $1.7m in 2006-07 to an apparent steady state amount of $2.6m in 2010-11 continuing to 2012-13. In that time, the split of services has also changed, with three cost categories in 2006-07 and five in 2012-13.

**Television** – Budgets for television campaigns have historically been higher than current spending. This may be because the increasing range of channels required that budgets were split between more activities. The 2009-10 budget reflects additional advertising related to the launch of the Journal. A key cost factor in the television campaign is Sir John Kirwan’s *pro bono* involvement but the impact of any savings has not been quantified.

**Radio** – Radio represents a minor portion of the total budget. Radio was not used between 2008-09 and 2011-12. The 2012-13 budget is lower than historical budgets.

**Online** – Specific budgets for online placement and implementation appear to have started from 2010-11 after the development work on NDI.org, Depression.org and the Lowdown websites. Budgets for the last two years were similar.

**Print** – Figures used here are spend rather than budget figures and increase across the three years that they are recorded. There was no activity in this channel between 2007-08 and 2008-09 and no budget for 2011-12 to 2012-13.
DraftFCB use different media channels to target different populations. For example:

- Free to air, Sky and Prime are used to target general population populations
- Māori Television is used to target Māori populations
- Radio is used to target Pasifika populations.

There will inevitably be some cross-targeting, particularly through the general population television channels.

Comparators - overview

We found no comparators for the Radio or Print channels. Comparators for the television and online channels are presented below.

Television

The comparator is television campaign spending for the Family Violence Campaign. The measure is total annual spend for the campaign over six years. The chart opposite indicates that the NDI spent more on television than the Family Violence Campaign over the period. The peak in NDI spending in 2009-10 was due to additional promotion for the Journal. Differences between the campaigns mean that the spends are not directly comparable and only limited conclusions can be drawn.

Online

The comparators are online campaign spending for the HPA’s alcohol campaign (formerly ALAC), Quitline, the Family Violence Campaign and Cervical Screening Awareness Month.

The table opposite indicates average monthly spending for online advertising for Depression.org, the Lowdown and comparators. Average clicks per month can be interpreted as an index for the level of interest purchased.

Care should be taken in interpreting and comparing these figures, especially given the significant differences between the campaigns in terms of aim, target population and duration. In particular, the simple cost of placement may be affected by the complexity of each campaign; we have not sought to analyse that complexity. For example, Cervical Screening Awareness Month is an outlier because it is a month-long campaign while the others are ongoing, so it could be expected that Cervical Screening Awareness Month should generate a high level of interest and spend.

Despite those caveats it appears that the NDI websites currently attract a comparatively high level of spend but also generate a comparatively high level of interest. The cost per click figures may provide insight into the relative unit cost of the different campaigns, and by that measure the NDI website and the Lowdown are still comparatively expensive.
4.6 DraftFCB Driver 1 – Cost of media placement and implementation

**VfM assessment**

**Television**

When assessed against the two comparator campaigns, television placement and implementation for the NDI appears to offer good VfM.

**Radio**

We cannot draw a conclusion on the VfM of radio placement and implementation.

**Online**

When assessed against the three comparator campaigns, online placement and implementation for the NDI appears to offer reasonable VfM. Average clicks per month for Depression.org and the Lowdown are significantly higher than for the comparators but so is the cost.

**Print**

We cannot draw a conclusion on the VfM of print placement and implementation.

### Conclusion

The VfM of television appears to be good, however, there are contradictory indicators for online and no data or conclusions for print and online. On balance the overall rating VfM rating for this driver is Green.

Given that the overwhelming weight of spending is on television and online placement and implementation, we conclude even poor ratings for print and radio would do little to affect the overall VfM, although poor ratings might indicate that activities in those channels could be reviewed.

While the cost of Depression.org and the Lowdown appears to be relatively high so is the reach measured by clicks per month. Furthermore, the high quality of production, use of innovative technologies, and quality of presentation used in developing the NDI awareness campaign may be reflected in the high costs. That level of quality may support the sustainability and longevity of the campaign.

### Opportunities for VfM improvement

Opportunities for VfM improvement for this driver will depend on other strategic decisions around the NDI’s population approach and potential trade-offs between maintaining a high level of awareness within general populations and building awareness within other sub-populations. We believe that existing internal processes (i.e. the Evaluation Reports and the Reference Network) are effective mechanisms to identify sub-populations that are not being reached, and to improve or maintain awareness within existing populations.

Improvement opportunities are:

- Management and presentation of budget information could be improved.
- Data for comparators could be collected.
- Given the use of different channels to target different populations, it may be useful to conduct a cost-benefit analysis of spend, size and reach in each population by comparison with other awareness campaign approaches, for example, non-media-based or community-based approaches. The results of that analysis may help direct spending into the most effective awareness delivery channels.
Section 4 – Results

4.6 DraftFCB Driver 2 – Cost of website hosting and development

**Measurement**

**Driver**
This driver covers the Economy of developing and hosting NDI-related websites. It does not include media placement or other such activities. The websites and functions relevant to this driver are:
- The Lowdown.co.nz youth depression website
- The Depression.org.nz website
- The NDI programme website NDI.org.nz
- The Journal online self-management tool.

**Measure**
The measure to assess this driver is the total budgeted cost to host and develop the websites and functions.

**Data source**
Data for 2006-07 to 2009-10 are from budgets in Ministry (now HPA) contracts. Data for 2010-11 to 2012-13 are from DraftFCB scope of work documents. Confidence in the data is high.

**Assumptions**
Differences in data sources mean that budget allocations may not be consistent.

Figures are not allocated consistently across financial or calendar years.

---

**Analysis & Commentary**

The NDI’s internet presence has grown considerably since the Programme began. The approximate timeline is:
- Late 2006 DraftFCB contracted to provide a web portal through which to provide information on depression and NDI.org.nz launched
- Early 2007 DraftFCB contracted to oversee the development of a youth-oriented website. The Lowdown launched in 2008
- Early 2008 DraftFCB contracted to redevelop the NDI’s online presence. Depression.org launched in 2009
- Journal launched in 2010 as part of the Depression.org website after 12 month trial.

The costs associated with each development are shown in the chart below. The cost figure comprises development and operating costs.

Given the timeline presented above, it is unsurprising that website hosting and development spending has potentially not reached a steady state. Future spending, and the possible achievement of a steady state, will depend on strategic decisions around the NDI, such as whether to develop the Journal into a full e-therapy tool.

---

**Comparators**
We found no comparators for this driver.
Section 4 – Results

4.6 DraftFCB Driver 2 – Cost of website hosting and development

**VfM assessment**

**The Lowdown**
We cannot draw a conclusion on the VfM of the hosting and development spend on the Lowdown website due to:
- A lack of comparative data, partly due to the innovative nature of the Lowdown
- Uncertainty over the scale and cost of possible future developments
- The fact that no steady state spend has been identified.

**Depression.org**
We cannot draw a conclusion on the VfM of the hosting and development spend on the Depression.org website due to:
- A lack of comparative data
- The fact that no steady state spend has been identified.

**NDI.org**
We cannot draw a conclusion on the VfM of the hosting and development spend on NDI.org due to a lack of data.

**The Journal**
We cannot draw a conclusion on the VfM of the hosting and development spend on the Journal website due to:
- A lack of comparative data, partly due to the innovative nature of the Journal
- Uncertainty over the scale and cost of possible future developments
- The fact that no steady state spend has been identified.

**Conclusion**
Due to a lack of data and uncertainty around future developments we cannot draw conclusions on the overall VfM of this driver. We are confident that the available data is good quality but found no comparative data.

**Opportunities for VfM improvement**

Opportunities for VfM improvement will depend on prior decisions around the direction and possible development of the NDI web tools. Particular issues are:
- Whether to develop the Journal into an e-therapy.
- Whether development of the Lowdown is a matter of content (i.e. new navigators; more up-to-date information) or functionality (new features; apps).

Improvement opportunities are:
- Improving the detail of costs associated with NDI.org.
- Strong forecasting around the costs of future developments.
- Establishing whether the NDI’s web services are now in a steady state or require ongoing development.
Section 4 – Results

4.6 DraftFCB Driver 3 – Cost of managing media and PR/communications

Measurement

Driver
This driver covers the Economy of the media and PR/communications for the NDI programme. Activities that comprise this driver include:
- Media plan development
- Building and maintaining relationships with media
- Ensuring websites are profiled or otherwise mentioned in articles
- Driving awareness of the Journal through use of personalities and related events and sponsorship.

Some promotional activity is captured under the educational and promotional material driver.

Measure
The measure to assess this driver is the total budgeted cost to provide media and PR/communications.

Data source
Data for 2006-07 to 2009-10 are from budgets in Ministry (now HPA) contracts. Data for 2010-11 to 2012-13 are from DraftFCB scope of work documents.

Confidence in the data is high.

Assumptions
Differences in data sources mean that budget allocations may not be consistent.

Figures are not allocated consistently across financial or calendar years.

Analysis & Commentary

According to the data, DraftFCB has delivered its media and PR/communications services for a flat rate of $100k per annum for the period 2008-09 to 2011-12. The budget is typically split as:
- $60,000 – promoting the Journal
- $40,000 – promoting the Lowdown.

In 2012-13 the split was budgeted at $60,000 apiece with a total budget of $120,000. According to the Ministry, the $20,000 increase for the Lowdown is linked with the renewal of sponsorship of the Smokefree Rockquest.

According to DraftFCB, a General Manager of PR was appointed in 2010. All media analysis is now supposed to be documented annually. That data may be useful for tracking this driver in future.

Comparators
No comparators were identified for this driver.

VfM assessment

Conclusion
Due to the lack of comparative data, we are unable to draw conclusions on the VfM of this driver.

Opportunities for VfM improvement

Improvement opportunities are:
- Obtaining comparative data would enable the VfM of this driver to be assessed.
Section 4 – Results

4.6 DraftFCB Driver 4 – Cost of educational and promotional material

**Measurement**

**Driver**
This driver covers the Economy of providing educational and promotional material. This includes the following:
- Depression fact sheets distributed by the Mental Health Foundation and Lifeline
- Printed promotional materials that support the Lowdown’s sponsorship of the Smokefree Rock Quest (see the Lowdown Best Song Award)
- Other printed promotional material not included under the media and PR / communications driver.

**Measure**
The measure to assess this driver is the total budgeted cost for educational and promotional material.

**Data source**
Data for 2006-07 to 2009-10 are from budgets in Ministry (now HPA) contracts. Data for 2010-11 to 2012-13 are from DraftFCB scope of work documents.

Confidence in the data is medium.

**Assumptions**
Differences in data sources mean that budget allocations may not be consistent. Also, budget (and spend) figures allocated to some channels may capture activities that, given more granular analysis, may be better allocated to other channels.

Figures are not allocated consistently across financial or calendar years.

**Analysis & Commentary**

The chart below shows the budgeted cost (except where indicated) of educational and promotional material between 2006-07 and 2012-13. The time series is quite variable and uses different data sources (i.e. budgets and spend figures) so it is difficult to identify a reliable trend. The large budget in 2010-11 may relate to the launch of the Journal. It may be that 2011-12 and 2012-13 figures, which are all similar, indicate a level of steady state spend.

**Comparators**
We found no comparators for this driver.

**Conclusion**
Due to the lack of consistent historical data and comparative data, we were unable to draw conclusions on the VfM of this driver.

**Opportunities for VfM improvement**

Improvement opportunities are:
- Obtaining comparative data and keeping a good record of historical spending would enable the VfM to be tracked.
- Record reasons for budget changes from year to year in order to track VfM.
Section 4 – Results

4.6 Lifeline Aotearoa Driver 5 – Cost of maintaining the multi-channel helplines

**Measurement**

**Driver**
This driver covers the Economy of maintaining the multi-channel helpline. This includes the following:
- Toll free services
- Email
- Online messaging
- Support for online self-management
- Text messaging.

**Measure**
The measure to assess this driver is the total budgeted cost to maintain the multi-channel helplines.

**Data source**
Data is from budgets set out in Ministry contracts with Lifeline Aotearoa for the years 2009-10 to 2012-13, and other data provided by Lifeline Aotearoa on request.

Confidence in the data is low.

**Assumptions**
Differences in data sources mean that budget allocations may not be consistent. Also, budget (and spend) figures allocated to some channels may capture activities that, given more granular analysis, may be better allocated to other channels.

Figures are not allocated consistently across financial or calendar years.

**Analysis & Commentary**

The chart below shows the total budget and the composition of the budget allocated by platform activity (i.e. activities related to the three main online services and telephone services) for the period FY 2009-10 to FY2012-13. It indicates that since 2010-11, the budget may have reached a steady state for most activities, with the main variation found in activities that support the Journal.

It is difficult to allocate these budget figures to the five driver categories identified, except for the Journal.

It would be useful to construct a cost model for each driver comprising such categories as:
- Technology used (i.e. Lifeline’s new contact system)
- Salaries
- Cost of service (i.e. actual expenditure on texts, telephone calls etc).

Lifeline has provided some data that could be used in cost models, but it is not sufficient to complete the task.

In its response to the data request, Lifeline suggested that a ‘time and motion’ study could provide additional data. Also, Lifeline has recently installed a new contact system that, along with updated operational procedures may help to produce more detailed data for future assessments.
Section 4 – Results
4.6 Lifeline Aotearoa Driver 5 – Cost of maintaining the multi-channel helpline

VfM assessment

Conclusion
Since the available data does not match the majority of driver categories, we can only draw an overall conclusion based on total historical budgets. The cost to maintain the multi-channel helpline appears to have reached a steady state with some variation around the cost to support the Journal. However, due to the lack of detailed data around the driver categories, we are unable to draw a conclusion on the VfM of this driver.

Opportunities for VfM improvement
Improvement opportunities are:
- Develop more detailed cost data around the identified channels.
- Collect comparative data to benchmark current and future costs.

<table>
<thead>
<tr>
<th>VfM</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>A</td>
<td>R</td>
</tr>
</tbody>
</table>
Section 4 – Results

4.6 Lifeline Aotearoa Driver 6 – Cost to provide other services for the Lowdown

Measurement

Driver
This driver covers the Economy of providing other online and text-based support services to the Lowdown website.

Measure
The measure to assess this driver is the total budgeted cost of online and text-based support services to the Lowdown website.

Data source
Data is from budgets set out in Ministry contracts with Lifeline Aotearoa for the years 2009-10 to 2012-13, and other data provided by Lifeline Aotearoa on request.

Assumptions
None.

Analysis & Commentary

Under Lifeline’s contract with the Ministry, the provision of online and text-based support services is listed as one of a group of four other services including:

■ Content management
■ Monitoring message board
■ Provision of online and text-based support services
■ Quality assurance.

Those activities are funded at $900,000 per annum. However, we found no way to extract the online and text-based services portion from the overall amount. We are therefore unable to assess the VfM of this driver.

Comparators
We found no comparators for this driver.

VfM assessment

Conclusion
Due to the lack of data, we were unable to draw conclusions on the VfM of this driver. Lifeline’s new contact system and updated operational procedures may help to produce more detailed data for future assessments.

Opportunities for VfM improvement

Improvement opportunities are:

■ Collecting detailed data around this driver
■ Collecting comparative data to benchmark current and future costs.
Section 4 – Results

4.6 Lifeline Aotearoa Driver 7 – Cost to perform sector co-ordination and relationship management

The cost to provide sector co-ordination and relationship management services is a steady state $150,000 per year. The chart below shows that consistency.

**Analysis & Commentary**

**Driver**

This driver covers the Economy of providing sector co-ordination and relationship management. Those services include:

- Co-ordination of information and activities between NDI service providers and Ministry staff
- Facilitation of stakeholder input to NDI Programme through Reference Network
- Contribution to NDI evaluation activities
- Help to identify and encourage wider sector engagement
- Engagement with Māori health providers.

**Measure**

The measure to assess this driver is the total budgeted cost to provide sector co-ordination and relationship management.

**Data source**

Data is from budgets set out in Ministry contracts with Lifeline Aotearoa for 2009-10 to 2012-13, and other data provided by Lifeline Aotearoa on request. Comparative data was provided by the Ministry. Confidence in the data is high.

**Assumptions**

Figures are not allocated consistently across financial or calendar years.

**Comparators**

We have observed budget figures for sector co-ordination activities connected with two other national campaigns that are similar to the NDI. In both cases the budget the NDI sector co-ordination budget is significantly smaller than the comparator programmes. However, a proper comparison would require a detailed analysis of services provided.

**Cost of sector co-ordination and relationship management**

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost (NZD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-10</td>
<td>120,000</td>
</tr>
<tr>
<td>2010-11</td>
<td>120,000</td>
</tr>
<tr>
<td>2011-12</td>
<td>120,000</td>
</tr>
<tr>
<td>2012-13</td>
<td>120,000</td>
</tr>
</tbody>
</table>

**VfM assessment**

**Conclusion**

Due to the lack of comparative data we were unable to draw conclusions on the VfM of this driver. We note, however, that the budget trend is flat and we have confidence in the budget data.

**Opportunities for VfM improvement**

Improvement opportunities are to perform a more detailed analysis of comparators. Part of that process would be scope the past and current activities of each programme.
Section 4 – Results

4.6 Phoenix Research Ltd Driver 8 – Cost to deliver annual Evaluation Report

Measurement

Driver
This driver covers the Economy of the annual NDI Evaluation Report.

Measure
The measure to assess this driver is the total budgeted cost to provide the Evaluation Report.

Data source
Data is taken from Phoenix Research Ltd’s Evaluation Plan documents.

Comparative data was provided by Phoenix Research Ltd.

Confidence in the data is high.

Assumptions
Figures are not allocated consistently across financial or calendar years.

Analysis & Commentary

The cost to deliver the Evaluation Report has fluctuated considerably over time, as the NDI has evolved.

Spending in 2006-07 to 2007-08 appears to have been to establish the Evaluation Reports. No figures were reported for 2008-09 and the figures for 2009-10 and 2011-12 include cost for the normal Evaluation Report and the Youth Evaluation Report. The Evaluation Reports typically include topical sections that are funded through the ad hoc / topical research portion. Those costs are not included here.

Cost to deliver Evaluation Report

It is difficult to determine a trend over the time series since the data is inconsistent and the Evaluation Report does not appear to have achieved a steady state spend.
Section 4 – Results
4.6 Phoenix Research Ltd Driver 8 – Cost to deliver annual Evaluation Report

Analysis & Commentary

Comparators
Although we found no direct comparators against which to measure this driver, we have observed data that demonstrates that Phoenix’s salaries are generally competitive for the industry.

VfM assessment

Conclusion
Due to the lack of data we were unable to draw conclusions on the VfM of this driver. However we did identify positive aspects including that Phoenix’s salary costs are lower than the industry average, qualitative assessments of the quality and usefulness of Phoenix’s research is generally good (see driver 27), and Phoenix brings other attributes to its role (i.e. strong relationships, expertise in the Programme and sector).

Opportunities for VfM improvement

Improvement opportunities are:

- Keeping records that explain budget changes.
- Improved historical budget and spend figures.
- Collecting good quality comparative data.

<table>
<thead>
<tr>
<th></th>
<th>VfM</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>U</td>
<td>U</td>
<td>G</td>
</tr>
</tbody>
</table>
Section 4 – Results

4.6 Phoenix Research Ltd Driver 9 – Cost to deliver annual Tracking Survey

**Measurement**

**Driver**
This driver covers the Economy of the annual NDI Tracking Survey.

**Measure**
The measure to assess this driver is the total budgeted cost to provide the Tracking Survey.

**Data source**
Data is taken from Phoenix Research Ltd’s Evaluation Plan documents.

**Assumptions**
Figures are not allocated consistently across financial or calendar years.

**Analysis & Commentary**

The cost to deliver the annual Tracking Survey has fluctuated between $58k (2007-08) and $111K (2006-07) although it has tended to cost around $80k. The high cost in 2010-11 is because there were two Tracking Surveys in that year. Given the relative stability of the cost per Tracking Survey since 2009-10, we conclude that the cost trend is relatively flat.

**Comparators**
We found no comparators for this driver.

**VfM assessment**

**Conclusion**
Overall we concluded that the VfM of this driver is Amber. Phoenix’s competitive salaries and the relative cost certainty around the pricing of the Tracking Survey are positive indicators, however the lack of more appropriate comparative data prevents us from drawing a stronger positive conclusion. The trend has been rated as Green because of that relative cost stability.

**Opportunities for VfM improvement**

Improvement opportunities are:
- Collecting good quality comparative data and keeping a reliable time series with explanations of changes.
Section 4 – Results

4.6 Phoenix Research Ltd Driver 10 – Cost to deliver annual ad hoc/topical reports

**Measurement**

**Driver**
This driver covers the Economy of the annual ad hoc and topical reports. Historical topics have included:
- Primary care survey
- Review of NDI Programme logic
- Various topical surveys.

**Measure**
The measure to assess this driver is the total budgeted cost to provide ad hoc and topical reports.

**Data source and confidence**
Data is taken from Phoenix Research Ltd’s Evaluation Plan documents.
Confidence in the data is high.

**Assumptions**
Figures are not allocated consistently across financial or calendar years.

**Analysis & Commentary**

The cost to deliver the annual ad hoc / topical reports / activities has fluctuated over time, although the cost appears to have flattened in recent years, perhaps as an indication that the NDI is settling into a steady state budget. Ad hoc or topical research arises from issues or concerns identified in other Phoenix research.

**Cost to deliver ad hoc/topical reports/activities**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008-09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010-11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011-12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012-13</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comparators**
No comparators were identified for this driver.

**VfM assessment**

**Conclusion**
We were unable to conclude on this driver due to an absence of measurable contextual data. The cost of the ad hoc reports has generally increased over time while the number of reports / activities has dropped, which, in the absence of context may be interpreted negatively. However, the reports / activities may have increased in complexity or scope which may in turn drive cost per report. We have rated our confidence in the data as Green because we are confident that the data on cost and number of reports is accurate.

**Opportunities for VfM improvement**
Improvement opportunities are:
- A clear summary of the kinds of ad hoc activities that are produced and an evaluation of their relevance to the NDI.

© 2012 KPMG, a New Zealand partnership and a member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative (“KPMG International”), a Swiss entity. All rights reserved. Printed in New Zealand.
### Measurement

**Driver**

This driver covers the Efficiency with which DraftFCB fulfils its contractual obligations. This includes the following:

- Media placement and implementation
- Providing the Journal
- Media and PR management
- Maintenance and management of the Lowdown website
- Management and development of the NDI website
- Development of educational and promotional material.

**Measure**

The measure to assess this driver is to track reported delivery against service goals.

**Data source and confidence**

Data is taken from DraftFCB’s six monthly status reports to the Ministry.

Confidence in the data is medium.

**Assumptions**

None.

### Analysis & Commentary

The table below summarises DraftFCB’s reported service delivery against its annual schedule of work.

The method used to assess delivery in the table is:

1. Identify target activities within each service category (i.e. media placement, management of the Journal etc)
2. Allocate a completion rating against each activity based on six monthly reports. Allocate each rating a percentage ‘score’: complete (100%), partial completion (50%), failure to complete (0%)
3. Sum the scores within each service category. For example, media placement in year 2008-09(a) comprises four activities with scores of 100%, 100%, 100%, and 50%, for a total of 87.5% completion
4. That total is then colour coded as follows: Green = >95%; Amber = 80%-95%; Red = < 80%

This is not a quantitatively robust way to measure contract performance, but has been developed solely for this purpose.

Services were delivered according to the schedule in the majority of cases, however, the time series is not complete.

### Efficiency of meeting contract targets

<table>
<thead>
<tr>
<th>Service Category</th>
<th>2008-09(a)</th>
<th>2008-09(b)</th>
<th>2008-09(c)</th>
<th>2009-10</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media placement and implementation</td>
<td>88%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Management of the Journal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manage media and PR communications</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Manage ongoing development of the Lowdown</td>
<td>100%</td>
<td>83%</td>
<td>83%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Manage ongoing development of NDI website</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Develop educational and promotional resources</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Other</td>
<td>100%</td>
<td>50%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>96%</td>
<td>92%</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Note: Each column data indicates a different six month report. The time series is not complete.*

The Amber results in 2008-09 in the ‘Manage ongoing development of the Lowdown’ service category indicate the partial completion of several tasks during the development phases of that service. The ‘Other’ category covers Advertising and Production for Stage 2 of the NDI Campaign. The red result in 2008-09(b) is because that activity was in a development phase and had not been completed.

### Comparators

We found no comparators for this driver.
Section 4 – Results

4.6 DraftFCB Driver 11 – Extent that provider delivers contract performance measures

VfM assessment

Conclusion

Based on the available data we concluded that the driver offers good VfM as the majority of contract targets have been met and failures and/or partial completions can be reasonably explained. In addition, the trend appears to be positive as the majority of failures and/or partial completions occurred during development phases.

Opportunities for VfM improvement

Improvement opportunities are:

- Keeping a more complete record of services and delivery against targets.
- Developing a robust method to quantify service delivery against performance measures.

<table>
<thead>
<tr>
<th>VfM</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>G</td>
<td>A</td>
</tr>
</tbody>
</table>
Section 4 – Results

4.6 DraftFCB Driver 12 – Website return on investment

**Measurement**

**Driver**
This driver covers the Efficiency of the website investment. The web services captured under this driver are:
- The Journal
- Depression.org
- The Lowdown.

**Measure**
The measures used to assess this driver are specific to each website. They are:
- The Journal – total registrations and completion rates
- Depression.org – unique and repeat visitors to the site and length of stay
- The Lowdown – visitors and length of stay.

**Data source and confidence**
Journal registration and completion rates are from the NDI Evaluation Report 2012. Visitor and length of stay data is from Google analytics provided by DraftFCB.

Confidence in the data is high.

**Assumptions**
None.

**Analysis & Commentary**

**The Journal**
Data for use of the Journal dates from June 2010 when it went live. The charts below show two aspects of the Journal usage.

1) The first chart shows the number of users that register and then proceed to complete each lesson. It indicates that fewer people complete Lesson 1 than register, and that completion rates decrease with each succeeding lesson.

2) The second chart shows the ‘onflow’ from one completed Lesson to the next. For example, in June-December 2010, 69% of those who registered completed Lesson 1, 42% of those that completed Lesson 1 completed Lesson 2 and so on. It indicates that on-flow profiles in both years of operation are broadly similar. Around two-thirds of registered users complete Lesson 1. Thereafter, 45-65% of users complete each succeeding Lesson up to Lesson 5. Then, in both years, more than 70% of users that completed Lesson 5 then completed Lesson 6. In both years, 3% of those who registered completed Lesson 6.

Phoenix’s research on completion gives multiple reasons why users may stop using the Journal, including technical issues, lack of time, or that the user had got what they wanted from the Lessons they completed. We understand that DraftFCB is currently working to address some of the technical issues. However, further development of the Journal will depend on whether or not it becomes an e-therapy.

**Comparators**
We found no comparators for this driver.
4.6 DraftFCB Driver 12 – Website return on investment

Analysis & Commentary

Depression.org

The table opposite shows average monthly user data for 2011 as reported in the 2012 Evaluation Report. Equivalent data was not available for 2012.

The chart below (left) shows actual monthly visitor numbers for the period May 2010 to January 2013. The trend line indicates a very gradual increase. The steep decline in December and January are due to seasonality (for December) and that the January data is not for a full month.

The chart below (right) shows the distribution of visitors by time spent on the site for the period May 2010 to January 2013. Data was provided as a total, rather than by month or year, so detailed analysis is not possible.

Based on the assumption that a 3 minute visit indicates interest (see 2012 Evaluation Report), the chart shows that 22% of visitors over the period stayed on the website for more than 3 minutes.

Comparators

We found no comparators for this driver.

<table>
<thead>
<tr>
<th>Depression.org - users data</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average monthly visits</td>
<td>44,960</td>
</tr>
<tr>
<td>Average monthly unique users</td>
<td>32,429</td>
</tr>
<tr>
<td>Average monthly visits of greater than 3 minutes duration</td>
<td>9,561</td>
</tr>
</tbody>
</table>

![Monthly visitors to Depression.org](chart1)

![Distribution of time on Depression.org](chart2)
**Analysis & Commentary**

### The Lowdown

The chart opposite shows the actual number of visitors to the Lowdown website for the period June 2009 to December 2012. The trend line indicates a significant increase over the period.

The chart opposite and below shows the distribution visitors by time spent for the period 2009 to 2012 - data is only available for seven months of 2008-09 and nine months of 2012-13. Data was not available to show the 3 minute cut-off for the Lowdown; the chart can show a 2 minute cut-off. It shows that the proportion of visitors that stayed on the site for more than 2 minutes has declined over time. Possible reasons for this are discussed under Driver 23.

### Comparators

We found no comparators for this driver.
### Section 4 – Results

#### 4.6 DraftFCB Driver 12 – Website return on investment

**VfM assessment**

**Conclusion**

Due to a lack of data, and markedly different results for each website, we cannot draw a conclusion on the VfM of this driver.

We note some very positive aspects including increasing visitors at the Lowdown and Depression.org and successes around the Journal. However, we also note some areas of concern, including the decreasing proportion of users spending long periods on the Lowdown and technical issues in the Journal that discouraged some users from beginning or completing the programme of Lessons.

We are confident that the available data is good but did not find comparative data against which to benchmark performance.

<table>
<thead>
<tr>
<th>VfM</th>
<th>U</th>
<th>U</th>
<th>A</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>U</td>
</tr>
<tr>
<td>Confidence in data</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
</tbody>
</table>

**Opportunities for VfM improvement**

Improvement opportunities are:

- Collecting comparative or benchmark data.
Section 4 – Results

4.6 DraftFCB Driver 13 – Unit costs per media campaign

**Measurement**

**Driver**
This driver covers the Efficiency with which services are delivered through the four identified channels:

- Television
- Radio
- Online
- Print.

**Measure**
Different unit cost measures are used to assess the four different channels:

- Television – TARPS purchased and/or delivered, cost and added value
- Radio – Reach purchased and/or delivered, cost and added value
- Online – online metrics: clicks, click through rate (CTR), cost per click (CPC) and monthly spend
- Print – unit cost per item where available.

**Data source and confidence**
Data was provided directly from DraftFCB.

Confidence in the data is high.

**Assumptions**
None.

---

**Analysis & Commentary**

**Television**
Target Audience Rating Points (TARPS) are an advertising industry measure of exposure to target audience. The greater the number of TARPS purchased, the greater the estimated exposure.

The chart below shows variation of actual TARPS delivered against planned TARPS across a six year period. The purple line shows that in four out of the six years, actual TARPS delivered were higher than planned TARPS. Budgets for these periods were fixed so the chart shows, in effect, more TARPS delivered for the same cost in four out of six years.

On average, across the six years, DraftFCB delivered 4% per annum more TARPS than planned, or 7% more than planned in total.

**Added value**
Added value is the effective discount negotiated on the standard industry rate for the TARPS purchased. In five of the six years DraftFCB delivered significant added value through discounts achieved for the NDI programme.
4.6 DraftFCB Driver 13 – Unit costs per media campaign

**Television – comparators**

We analysed the annual unit cost, expressed as dollars per TARP, for the NDI, the Family Violence Campaign, and one data point for Cervical Screening Awareness Month. DraftFCB are the providers for both the NDI and Family Violence campaigns. We found that the NDI unit cost is generally lower than the Family Violence Campaign unit cost, and was lower than Cervical Screening Awareness Month in 2011-12.

Given that DraftFCB provide services for the NDI and Family Violence campaigns, competitive advantage can be discounted as a cause of the unit cost difference. Notably, with the exception of 2008-09, the NDI campaign typically purchases more TARPS than the Family Violence Campaign, which may give it a scale advantage in negotiating rates.

Due to the commercially sensitive nature of the data we are unable to show our results in detail.

**Radio**

The use of radio in the NDI Programme has been too inconsistent to develop a meaningful measure. The reasons for this are:

- Radio has only been used as a channel in 2006-07, 2007-2008 and 2012-13 so the time series is not continuous
- Radio use in those early years appears to have been different from the current use (i.e. uses different stations, for different audiences)
- Data for the three years is materially different (describes different things) so comparison is not feasible.

However, we found that in 2006-07 and 2007-2008, DraftFCB was able to negotiate added value of at least 50% across a range of stations.

**Radio – comparators**

We found that the Cervical Screening Awareness Month added value for 2011-12 was higher than DraftFCB’s historical average. Other than that we found no comparators.
Section 4 – Results

4.6 DraftFCB Driver 13 – Unit costs per media campaign

Analysis & Commentary

Online

The charts below show time series for four online metrics for the Depression.org and the Lowdown websites. Twelve months of data (June to May) are provided for each year except 2012-13 which contains four months of data (June to September).

Chart 1 shows average monthly CPCs for both websites, and indicates a downward trend in each case. It appears that the cause of the decreasing unit cost is due to a significant increase in clicks (see Chart 3). The CPC for Depression.org may have reached a steady state.

Chart 2 shows average monthly CTRs for both websites. The CTR is number of clicks as a percentage of the number of times a banner advert appears. It indicates that the trend for users clicking through to Depression.org has increased significantly over time, while the trend for the Lowdown has been a marginal increase.

Chart 3 shows average monthly clicks for both websites. It indicates that the trend for the number of users clicking through to both websites has increased over time, but that the increase and overall use is significantly greater for Depression.org than for the Lowdown. That should be unsurprising since the Lowdown is targeted at younger users while Depression.org is aimed at the general population.

Chart 4 shows average monthly cost for both websites and that costs have increased for both websites over time, although the increase has been greater for Depression.org than for the Lowdown.
Analysis & Commentary

Online - comparators

The table below shows the online metrics for the Depression.org and the Lowdown websites against three comparators: HPA’s alcohol campaign (formerly ALAC), Quitline and Cervical Screening Awareness Month. The figures for all datasets have been calculated as monthly averages, in order to improve comparison.

Average monthly clicks measures the number of times users click into the website from an advertisement. The CTR is the percentage of clicks as a proportion of the number of times an online advertisement appears (these are known as ‘impressions’). A high CTR indicates that a large number of users click on the online advertisement and are directed to the websites. The CPC is the cost of providing the advertisements for the month divided by the number of clicks that directed users to the websites. A high CTR and a low CPC may indicate a very efficient online advertising campaign.

The table indicates that the unit costs (CPC) of the NDI websites are higher than the two ongoing campaigns (HPA’s ALAC and Quitline) but lower than the limited month-long campaign (Cervical Screening Awareness Month). Care should be taken in interpreting these figures, however, because the different campaigns have different aims, target populations, durations, and levels of complexity, so the figures are not directly comparable.

With that in mind, it appears that the NDI websites currently attract a comparatively high level of spend but also generate a comparatively high level of interest. Cervical Screening Awareness Month is an outlier because it is a month-long campaign while the others are ongoing, so it should be expected that Cervical Screening Awareness Month should generate a high level of interest and spend in a short timeframe.

Further comparative work could be undertaken to assess whether building a larger response (number of clicks) requires a relatively higher spend (CPC). If it does, the NDI figures might appear in a better light.

<table>
<thead>
<tr>
<th>Online metrics</th>
<th>Avg clicks per month</th>
<th>Avg Monthly CTR</th>
<th>Avg Monthly CPC</th>
<th>Avg monthly cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression.org (53 months data)</td>
<td>5,887</td>
<td>2.80%</td>
<td>1.65</td>
<td>8,338</td>
</tr>
<tr>
<td>The Lowdown (42 months data)</td>
<td>3,217</td>
<td>1.26%</td>
<td>2.03</td>
<td>6,196</td>
</tr>
<tr>
<td><strong>Comparators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPA (ALAC) (16 months data)</td>
<td>1,635</td>
<td>3.21%</td>
<td>1.33</td>
<td>2,140</td>
</tr>
<tr>
<td>Quitline (32 months data)</td>
<td>1,381</td>
<td>5.03%</td>
<td>0.81</td>
<td>1,230</td>
</tr>
<tr>
<td>Cervical screening month</td>
<td>12,272</td>
<td>0.11%</td>
<td>2.84</td>
<td>34,805</td>
</tr>
</tbody>
</table>
Analysis & Commentary

Print

Based on data provided we have calculated some high level unit costs for a range of types of printed and educational material. It should be noted, however, that due to data gaps, the level of accuracy of the calculated values may not be high.

The unit costs and types of material are shown in the table below.

<table>
<thead>
<tr>
<th>Unit cost</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factsheets</td>
<td>-</td>
<td>4.24</td>
<td>4.31</td>
<td>2.79</td>
<td>5.47</td>
</tr>
<tr>
<td>DLE Flyers</td>
<td>2.50</td>
<td>1.42</td>
<td>0.15</td>
<td>1.08</td>
<td>-</td>
</tr>
<tr>
<td>Hope Cards</td>
<td>-</td>
<td>-</td>
<td>1.35</td>
<td>0.50</td>
<td>-</td>
</tr>
<tr>
<td>Journal Factsheet</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.44</td>
<td>0.11</td>
</tr>
<tr>
<td>Wallet Cards</td>
<td>1.52</td>
<td>1.27</td>
<td>-</td>
<td>0.73</td>
<td>-</td>
</tr>
<tr>
<td>Posters</td>
<td>-</td>
<td>-</td>
<td>0.05</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Data on other printed advertising is incomplete and difficult to report.

According to DraftFCB data, NDI campaign advertisements have appeared in NZ Rugby and New Zealand Women’s Weekly magazines. Printed insertions have also appeared in primary care sector publications including:

- NZ Doctor
- MIMS New Ethical
- LOGIC (Formerly The Practice Nurse)
- Express Magazine.

Based on available data, we cannot provide unit cost assessments for this print advertising.

Print - comparators

We have data for print advertising expenditure for the Cervical Screening Awareness Month, but it is not sufficient for comparison. We found no other comparative data.
### VFM assessment

**Television**

When assessed against the comparator campaigns, the NDI’s television campaign appears to offer good VFM on average. It must be remembered, however, that our analysis has assessed overall unit costs by year, rather than unit cost by television channel. A granular analysis like that may reveal more about the VFM of the NDI.

The overall trend for the television unit cost appears fairly flat; the figure for 2008-09 was an outlier driven by lower than average TARPS and relatively high cost.

**Radio**

We cannot draw a conclusion on the VFM of the NDI’s radio campaign.

**Online**

We have no clear view on the VFM of the NDI’s online campaign, because the indicators appear somewhat contradictory and may require expert interpretation.

When assessed against the three comparator campaigns, the NDI appears expensive, however it also appears to be effective at attracting traffic.

In terms of its own performance, the trend generally appears positive. The Cost per click for both websites has decreased, as have click through rates, though the increase on the Lowdown has been marginal, and average monthly clicks are up. However, costs have also increased over the period.

**Print**

We cannot draw a conclusion on the VFM of the NDI’s print placement and implementation.

### Opportunities for VFM improvement

**Opportunity opportunities are:**

- Improved unit costs measurements.
- Collect data for comparative activities.

<table>
<thead>
<tr>
<th>VFM</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
</tbody>
</table>

### Conclusion

Overall we consider the VFM of this driver to be Green. Despite ambiguous indicators for online, there were good results for television. The non-results for print and radio are unlikely to influence the overall rating.
### Section 4 – Results

#### 4.6 DraftFCB Driver 14 – Percentage of Phoenix recommendations implemented

**Driver**
This driver covers the Efficiency with which recommendations are implemented within the NDI programme.

**Measure**
The measure to assess the percentage of recommendations that DraftFCB have implemented.

This measure is high level and therefore lacks some important context. For example, there may be several reasons that a given recommendation is not implemented including:

- That it was not appropriate for, or relevant to, the Programme
- That the Ministry or HPA was not able to provide a quick decision or approval (i.e. needed to find additional funding or secure other approval).

**Data source and data**
Data is taken from service provider feedback to a questionnaire.

Confidence in the data is medium.

**Assumptions**
None.

**Analysis & Commentary**
Data for this driver was collected using the following methodology:

1. Survey reports to identify recommendations. Some reports contained discussion points and conclusions that could be implemented and were therefore counted as ‘recommendations’
2. Compile the list and validate with Phoenix Research Ltd
3. Ask for feedback as to which recommendations they did and did not action. The range of responses was ‘Yes’, ‘No’, ‘In part’. Answers were supplemented with some descriptive context
4. Based on qualitative feedback recommendations were assigned as relevant to one of DraftFCB, Lifeline and the Ministry
5. Answers of ‘Yes’ and ‘In part’ were counted as Implemented (see table)
6. Answers of ‘No’ were checked against qualitative feedback and assessed as “Awaiting signoff” or “Recommendation rejected”
7. Based on qualitative feedback some recommendations were designated as “Out of scope” or “In process – Ministry”. The latter means that it is subject to further review and/or work before Ministry (or HPA) approval is issued.

This is not a quantitatively robust way to analyse the percentage of Phoenix recommendations implemented. The results presented should be taken as indicative only.

<table>
<thead>
<tr>
<th>Recommendation implementation - DraftFCB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>52</td>
</tr>
</tbody>
</table>

The table above indicates that 31% of Phoenix Research Ltd's recommendations were relevant to DraftFCB and that DraftFCB has implemented (in full or in part) 88% of those relevant recommendations.

**Comparators**
We found no comparators for this driver.
## Section 4 – Results

### 4.6 DraftFCB Driver 14 – Percentage of Phoenix recommendations implemented

#### VfM assessment

**Conclusion**

The result that 88% of relevant recommendations have been implemented means that we have rated the VfM as Green. We have no trend data because we were unable to link the results with time periods in a robust way. The difficulty is that different recommendations require different time periods through the approvals and implementation process. Our confidence in the data is rated Amber due to the high level nature of our methodology.

#### Opportunities for VfM improvement

**VfM** | **G**
--- | ---
**Trend** | **U**
**Confidence in data** | **A**

**Improvement opportunities are:**

- One of our strategic recommendations is to develop a business case approach to proposing and implementing changes to the NDI. We consider that this will bring greater transparency and clarity to the process as well as helping to ensure strategic alignment. It is important, however to create a business case process that is not onerous or overly complicated, which would add cost and decrease efficiency.

- The business case process would also allow better records of recommendations and changes to be kept, which in turn would allow better tracking of VfM.
Section 4 – Results

4.6 Lifeline Aotearoa Driver 15 – Unit cost of multi-channel helplines

**Measurement**

**Driver**
This driver covers the Efficiency with which services are delivered through the helpline channels:
- Toll free services
- Email
- Online messaging
- Support for online self-management
- Text messaging.

**Measure**
The measure to assess this driver is the unit cost of each service.

**Data source and confidence**
Due to recent technological and ongoing procedural changes within Lifeline Aotearoa, we were not able to get consistent historical data for this driver.

**Assumptions**
None.

**Analysis & Commentary**

**Insufficient data was available to measure this driver.**

Ideally we could construct a historical cost structure for each service and estimate a unit cost based on historical demand. We have some unit cost data but not enough to complete a meaningful analysis.

**Comparators**
We found no comparators for this driver.

**VfM assessment**

**Conclusion**
Due to a lack of data we cannot draw a conclusion on the VfM of this driver. Lifeline's new contact system and updated operational procedures may help to produce more detailed data for future assessments.

**Opportunities for VfM improvement**

Improvement opportunities are:
- Develop a full cost structure for each service and estimate a unit cost based on historical demand. Track unit cost changes over time
- Identify appropriate comparators against which to measure performance.
## Section 4 – Results

### 4.6 Lifeline Aotearoa Driver 16 – Staff utilisation

<table>
<thead>
<tr>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Driver</strong></td>
</tr>
<tr>
<td>This driver covers the Efficiency of staff utilisation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>The measure to assess this driver is the proportion of total staff time that is used to respond to contacts that originate from the NDI campaign.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data source and confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to recent technological and ongoing procedural changes within Lifeline Aotearoa, we were not able to get consistent historical data for this driver.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>None.</td>
</tr>
</tbody>
</table>

### Analysis & Commentary

#### Insufficient data was available to measure this driver.

Lifeline provides services under several contracts. Ideally, Lifeline would be able to track staff activity and allocate it to a specific cost centre associated with one of those contracts. In practice that maybe difficult to achieve, not least because of the challenge of determining which contract a given contact (telephone call, email or text) might fall under. In many cases contacts could reasonably be allocated to more than one contact service (i.e. Like Minds Like Mine or NDI).

We note that Lifeline reports on the frequency of different kinds of contact by time of day in its six monthly reports. Lifeline also reports current direct telephone counselling resource of 14.3 FTE. Staffing is reported as:

- 3 staff from 8am-noon, 7 days per week; and
- 5 staff from noon- midnight, 7 days per week.

### Comparators

We found no comparators for this driver.

### VfM assessment

#### Conclusion

Due to a lack of data we cannot draw a conclusion on the VfM of this driver. Lifeline’s new contact system and updated operational procedures may help to produce more detailed data for future assessments. We understand that the new system possesses the ability to predict and model staff utilisation. The system may also enable contacts to be allocated to different cost centres (contact service). As the contract manager, the Ministry may have an interest in the mechanics of any allocation process that is developed.

#### Opportunities for VfM improvement

Improvement opportunities are:

- Develop a means to easily allocate staff activities to different contract services. This may require some arbitrary cut-off points or boundaries. In such cases, a clear record of the rationale behind the cut-off point should be kept. One challenge would be to make the allocation process as easy and inexpensive as possible. A complicated process may risk adding cost and / or reducing service quality.
Section 4 – Results

4.6 Lifeline Aotearoa Driver 17 – Post-contact service

**Measurement**

**Driver**
This driver covers the Efficiency of post-contact service, including follow up telephone calls

**Measure**
We found no measure to assess this driver.

**Data source and confidence**
Not applicable.

**Assumptions**
None.

**Analysis & Commentary**

Insufficient data was available to measure this driver.

The Annual Evaluation Report notes that:

“Lifeline offer callers the opportunity to be called back to provide support, check on progress being made and make sure they have received any professional help they needed. Lifeline has noted that it is very rare that they are unable to get in contact with an individual. Occasionally they are given the wrong number and are unable to locate the correct one on their call record system. They estimate that they would eventually connect with 99% of people who have been set for a call-back.”

Based on data from Lifeline’s new contact system, Lifeline reports that 97% of Journal users and 98% of NDI callers received successful follow up telephone calls.

**Comparators**
We found no comparators for this driver.

**VfM assessment**

**Conclusion**
Due to a lack of data we cannot draw a conclusion on the VfM of this driver. Lifeline’s new contact system and updated operational procedures may help to produce more detailed data for future assessments.

**Opportunities for VfM improvement**

Improvement opportunities are:
- Identify a measure for this driver.
- Collect data for this driver.
4.6 Lifeline Aotearoa Driver 18 – Extent that provider delivers against contract performance measures

**Measurement**

**Driver**
This driver covers the Efficiency with which Lifeline Aotearoa fulfils its contractual obligations.

**Measure**
The measure to assess this driver is reported delivery against service goals.

**Data source and confidence**
Data is taken from Lifeline’s six month reports and Ministry contracts. Confidence in the data is high.

**Assumptions**
None.

**Analysis & Commentary**

The Ministry contracts require Lifeline to provide six-monthly reports that contain a prescribed range of information:

- Caller ethnicity*
- Number of calls using tape talk
- Total cost of toll charges
- Ring time of calls
- Caller age
- Summary of questions
- Referral type
- Caller gender
- Summary of responses
- Publications requests
- Number of calls (days and hours)
- Calls by geography
- Improvements opportunities
- Number of messages left
- Call frequency against advertising

*Note: Specific categories may change by contract

We have observed that Lifeline produce the six-monthly reports as required and that they report the majority of required information. We have not observed reporting against some performance measures around contact answering, for example that 80% of telephone calls are answered within 20 seconds. Lifeline’s new contact system reports 83% of calls answered within 20 seconds across the NDI, Journal, LMLM, MH101, but no historical data is available.

**Comparators**
We found no comparators for this driver.

**VfM assessment**

**Conclusion**
Our conclusion for this driver is based on observed reporting rather than quantitative data. We recognise that Lifeline typically reports against some performance measures (i.e. the six monthly report) but not others (i.e. contact answering). We note the recent call answering data indicates good performance but the lack of historical or comparative data means that we are unable to assess that performance properly. Lifeline’s new contact system may help to collect appropriate performance data in future. For that reason we rate the overall VfM of this driver as Amber. We rate the trend as Amber on the basis that reporting could improve.

**Opportunities for VfM improvement**

Improvement opportunities are:
- Review reporting practices and requirements
- Collect data on reporting performance.
Section 4 – Results

4.6 Phoenix Research Ltd Driver 19 – Timeliness of reports to inform NDI campaign

Measurement

Driver
This driver covers the Efficiency of the suite of annual and topical reports and activities. This includes the following:
- The annual Tracking Survey
- The annual Evaluation Report
- All other reports and activities as contracted by the Ministry.

Measure
The measure to assess this driver is to assess final submission date against estimated submission date.

Data source and confidence
Data is taken from Phoenix’s annual Evaluation Plan and the final date of the listed reports.

Assumptions
None.

Analysis & Commentary

Our approach for measuring this driver is to identify the date that a report is due and compare that date with the date on the final version. Due dates were taken from Phoenix’s annual Evaluation Plans. However, some due dates were for draft versions only and other reports were not given due dates within the Plans. The table below indicates how the driver might be measured, but it is incomplete due to missing data.

Comparators
We found no comparators for this driver.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimate</td>
<td>Actual</td>
<td>Estimate</td>
<td>Actual</td>
<td>Estimate</td>
<td>Actual</td>
<td>Estimate</td>
</tr>
<tr>
<td>Tracking survey</td>
<td>Jan-07</td>
<td>Aug-07</td>
<td>Jun-08</td>
<td>Feb-08</td>
<td>Mar-09</td>
<td>Mar-09</td>
<td>Jun-11</td>
</tr>
<tr>
<td>Ad hoc/topical reports/activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 1</td>
<td>Dec-06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dec-11</td>
</tr>
<tr>
<td>Activity 2</td>
<td>Dec-06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>May-12</td>
</tr>
<tr>
<td>Activity 3</td>
<td></td>
<td>Feb-08</td>
<td>Aug-08</td>
<td></td>
<td></td>
<td></td>
<td>Mar-12</td>
</tr>
<tr>
<td>Activity 4</td>
<td>May-07</td>
<td></td>
<td>Oct-08</td>
<td>Mar-09</td>
<td>Apr-09</td>
<td>Mar-09</td>
<td>Dec-10</td>
</tr>
<tr>
<td>Activity 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 6</td>
<td></td>
<td>May-08</td>
<td>Sep-08</td>
<td>Apr-09</td>
<td>Mar-09</td>
<td>May-09</td>
<td></td>
</tr>
<tr>
<td>Activity 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Opportunities for VfM improvement
Improvement opportunities are to keep a schedule of expected and actual report submission dates.

Conclusion
Due to a lack of data, we cannot draw a conclusion on the VfM of this driver.

VfM assessment

<table>
<thead>
<tr>
<th>VfM</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
</tbody>
</table>

© 2012 KPMG, a New Zealand partnership and a member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative (“KPMG International”), a Swiss entity. All rights reserved. Printed in New Zealand.
### Measurement

**Driver**
This driver covers the Efficiency of the suite of annual and topical reports and activities. This includes the following:
- The annual Tracking Survey
- The annual Evaluation Report
- All other reports and activities as contracted by the Ministry.

**Measure**
The measure to assess this driver is to estimate the average time for the recommendation to be signed off.

**Data source and confidence**
We found insufficient data with which to measure this driver.

**Assumptions**
None.

### Analysis & Commentary

**Given currently unavailable data, this driver is not measurable at this time. The unavailable data is the sign-off date.**

**Comparators**
We found no comparators for this driver.

### VfM assessment

**Conclusion**
Due to a lack of data, we cannot draw a conclusion on the VfM of this driver.

<table>
<thead>
<tr>
<th>VfM</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend</td>
<td>U</td>
</tr>
<tr>
<td>Confidence in data</td>
<td>U</td>
</tr>
</tbody>
</table>

### Opportunities for VfM improvement

Improvement opportunities are:
- Improvements in measuring the VfM of this driver should flow from improvements in processes and structures around the NDI. For example, our recommendations for improved Governance and oversight, scoping and creating appropriate resource and functions to support sector cohesion and alignment towards the agreed strategy, improved clarity around strategy and more transparent process such as the business case approach, should improve Phoenix’s ability to make recommendations that can reasonably be implemented. Similarly, a clear approvals process for the Ministry and the HPA should facilitate more speedy implementation. It should be noted that Phoenix may have no control over the actual implementation.
- A schedule of recommendations signed off could help the VfM measurement of this driver.
Section 4 – Results

4.6 DraftFCB Driver 21 – Campaign effectiveness (Reach)

**Measurement**

**Driver**
This driver covers the Effectiveness of the reach of the NDI awareness campaign delivered by DraftFCB. Reach here refers to the campaign’s penetration into a set of target populations. The ‘target populations’ are:

- The general population
- Youth (16-24)
- Māori
- Pasifika
- Asian.

We have focussed on the general population and the Youth population to reflect the NDI’s focus. The inclusion of Māori, Pasifika and Asian populations reflect specific requirements of these populations.

**Measure**
This driver is measured by the percentage of the surveyed target population that recalls advertising connected with the awareness campaign.

Results are compared against market reach figures for the Family Violence Campaign.

**Data source and confidence**
NDI data is from the annual Tracking Survey. Comparative data is from the Family Violence Campaign.

Confidence in the data is high.

**Assumptions**
None.

**Analysis & Commentary**

The chart below shows the percentage of surveyed population that recalled campaign advertising. The time series reflects results across four survey points. The figures for each point are an aggregate of:

- Unprompted recall; plus
- Prompted recall; plus
- Recall prompted by more detailed description.

The chart indicates that recall was generally high amongst the general population and Māori, slightly lower amongst Pasifika, and very low amongst Youth. Recall was highest within the Māori population. It should also be noted that the three non-Youth population results relate to the NDI programme as a whole, while the Youth results relate solely to the Lowdown website.

We found no data on Asian populations.

Reach of awareness of four target audiences

- General population
- Māori
- Pasifika
- Youth (16-24 year olds)
Section 4 – Results
4.6 DraftFCB Driver 21 – Campaign effectiveness (Reach)

Analysis & Commentary

Comparators
The graphs below compare the campaign recall figures for the NDI against campaign recall figures for the Family Violence Campaign. There is no New Zealand comparative data for Youth.

In each case, recall of the NDI advertisements outperforms recall of the Family Violence Campaign in the directly comparable years (2010 and 2011). However, in earlier years (2007 to 2009) recall of the Family Violence Campaign appears to have been higher and comparable to recall of the NDI.

International comparators
Evidence from Australia’s beyondblue initiative shows that nearly 62% of surveyed people had heard of it. That is a lower recall rate than for the NDI.

However, other evidence indicates that beyondblue may have better penetration than the NDI within the Youth population (12-25 years old in Australia and 16-24 years old in New Zealand). 44% of young people were aware of beyondblue, including 1% who spontaneously recalled beyondblue as an organisation related to mental health problems.

We recognise that comparison with Australia is difficult given differences between the two initiatives. We also recognise that the different age ranges for the Youth populations between New Zealand and Australia may affect the recorded recall rates.
Section 4 – Results

4.6 DraftFCB Driver 21 – Campaign effectiveness (Reach)

### Conclusion

Overall, the VfM of the awareness campaigns appears to be good, with high rates of recall amongst most target populations.

Recall amongst Youth populations appears to be problematic. Evidence from Australia, where recall in the Youth population is also lower than in the general population, indicates that the Youth population may simply be a harder market to penetrate. We believe that DraftFCB has a good grasp of the issues and is attempting to address challenges specific to that population.

The trend has been identified as Amber because in most cases it appears flat. We note, however, that reach within the Youth population appears to have increased significantly since 2010.

Confidence in the data is good, however we note the absence of data specifically related to Asian populations.

### Opportunities for VfM improvement

- Better comparative data.
- As is described under Driver 1, it may be useful to review approaches to awareness for different populations, possibly by looking outside of media-based approaches.

<table>
<thead>
<tr>
<th>VfM</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>A</td>
<td>G</td>
</tr>
</tbody>
</table>
Section 4 – Results

4.6 DraftFCB Driver 22 – Campaign effectiveness (Impact)

**Measurement**

**Driver**
This driver covers the Effectiveness of the impact of the NDI awareness campaign delivered by DraftFCB. Impact here refers to the campaign’s ability to influence behaviour. The ‘target populations’ are:
- The general population
- Youth (16-24)
- Māori
- Pasifika
- Asian.

**Measure**
This driver assesses qualitative descriptions of behaviour influenced by the awareness campaign.

**Data source and confidence**
Data is taken from the annual Tracking Survey.
Comparative data is from Phoenix Research Ltd ‘s reports on the Family Violence Campaign.
Confidence in the data is high.

**Assumptions**
None.

**Analysis & Commentary**

The Tracking Survey shows time series (four surveys from early 2010 to March 2012) of responses to advertising across eight key behaviours:
- Helped or encouraged you to give assistance or support to someone who was feeling depressed
- Helped or encouraged you to suggest to someone that they seek help about depression
- Helped or encouraged you to talk to a friend or relative about feelings of depression you were experiencing
- Helped or encouraged you to visit a website or call a helpline about depression another person was experiencing
- Helped or encouraged you to visit a website or call a helpline about feelings of depression you were experiencing
- Helped or encouraged you to talk to a GP or someone else at their practice about your concern for another person with signs of depression
- Helped or encouraged you to talk to a GP or someone else at their practice about feelings of depression you were experiencing
- Helped or encouraged you to seek other forms of professional help for feelings of depression you were experiencing

Survey data is available for general population, Māori and Pasifika populations, but not for Asian populations.
Based on the survey data, it appears that NDI advertising has generally positively influenced the rates at which the eight behaviours occur. However, differences appear at sub-populations level, as the charts overleaf indicate.
The charts above indicate that across the two year (four survey) period there were increases in all behaviours amongst general population and Māori populations, and decreases in all behaviours amongst Pasifika populations. The change profiles for each population are different. For example, behaviours amongst Pasifika populations increased for the middle two surveys before decreasing for the most recent survey. Trends amongst Māori populations were generally flatter and increasing, and general populations’ best results often appeared for the second survey.

Comparators
Data from the Family Violence Campaign is a good comparator for the above results.

The table opposite shows the percentage of behaviours that, based on survey data, appear to have changed as a result of the advertising. It indicates that the NDI may have been more successful at changing Māori and general population behaviours but less successful at changing Pasifika population behaviours. This table should not be taken at face value, however, as there are considerable differences between the campaigns and the surveys from which the data is taken.

**Comparison: impact of advertising**

<table>
<thead>
<tr>
<th></th>
<th>Increase</th>
<th>Decrease</th>
<th>No change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Violence Campaign</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Māori (male)</td>
<td>80%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Māori (female)</td>
<td>80%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Pasifika (male)</td>
<td>80%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Pasifika (female)</td>
<td>80%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Other (male)</td>
<td>40%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Other (female)</td>
<td>80%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>NDI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pasifika</td>
<td>12.5%</td>
<td>75%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Māori</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>General population</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Section 4 – Results

4.6 DraftFCB Driver 22 – Campaign effectiveness (Impact)

### VfM assessment

**Conclusion**

We have concluded that this driver represents good VfM. The trends appear to be positive and the data appears to be good. Phoenix puts considerable effort into studying the impact of the advertising campaigns; indeed they also provide the research on the Family Violence Campaign.

### Opportunities for VfM improvement

Improvement opportunities are:

- A direct and detailed comparative study of the two campaigns could provide some good insights (to both campaigns) that could drive improved VfM for this driver.
Section 4 – Results

4.6 DraftFCB Driver 23 – Website effectiveness

**Driver**
This driver covers the Effectiveness of the websites and online tools provided by DraftFCB. The relevant websites and online tools are:
- The Journal
- Depression.org
- The Lowdown.

**Measure**
The measures used differ according to the website. The measures are:
- The Journal – change in user PHQ-9 scores from entry into the Journal to exit
- Depression.org – daily visitors, time on site
- The Lowdown – time on site, visit duration (average/month), traffic: hours of day, traffic: days of week.

**Data source and confidence**
Data for the Journal is taken from the 5 Year Evaluation Report.
Data for Depression.org and the Lowdown is from DraftFCB.
Confidence in the data is high.

**Assumptions**
None.

**Analysis & Commentary**

**The Journal**
The PHQ-9 is the nine item depression scale of the Patient Health Questionnaire (PHQ) which is used to assist primary care clinicians in diagnosing depression as well as selecting and monitoring treatment. Users generate PHQ-9 scores before beginning the Journal Lesson, at the beginning of Lesson 3 and part way through the final lesson.

The Journal’s effectiveness is measured here by the change in PHQ-9 scores across those three points. It should be noted that Phoenix Research Ltd has produced considerable research around the use of the Journal, which provides a compelling case to support its effectiveness. However, to properly substantiate the Journal’s effectiveness, and particularly its clinical effectiveness, would require a full RCT or other evidence-based process. Undertaking that process may allow the Journal to be formally categorised as an e-therapy.

The charts below show changes in the PHQ-9 scores for two groups of users: those that completed the Journal to the mid-point and those that completed the final lesson. Both charts show the proportion of users with PHQ-9 scores showing ‘not depressed’ as increasing, and the proportion of PHQ-9 scores showing ‘moderate’, ‘mild’ and ‘severe’ depression as decreasing. This indicates that the Journal may be an effective tool to help reduce the incidence and severity of depression amongst users.

It is also important to note that the changes in PHQ-9 scores should be interpreted with the understanding that there is a high spontaneous resolution rate of up to 30%-50% for mild anxiety and depression. Changes in PHQ-9 scores may therefore not be unexpected, unusual or even caused by using the Journal.

**Comparators**
We found no comparators for this driver.
Depression.org

The chart opposite shows the average visits per day at Depression.org over an approximate three year period (recognising that 2010-11 shows 11 months of data and 2012-13 shows 10 months of data). The views per day is calculated from the number of views divided by the number of days for which viewing figures are available (not number of days in the period).

Average visits per day appears to have increased from around 1,550 per day in 2010-11 and 2011-12 to approximately 1,670 per day in 2012-13.

The chart opposite and below shows the distribution of visitors by time spent on the site.

The chart shows that 56% of all visitors spend less than 10 seconds on the site. These are likely to be accidental visitors. A further 22% of visitors spent up to 3 minutes. In the Evaluation Report Phoenix uses 3 minutes as the cut-off point for assuming that the visitor finds the site content to be interesting.

13% of visitors stayed on the site for 3-10 minutes, which indicates visitors that found something interesting on the site whether or not they were accidental visitors.

8% of visitors (approximately 21,000) stayed on the site for longer than 10 minutes. These are likely to be users that found significant value in the website, whether from information, contact details or access to the Journal.

However, since data is unavailable by year, we cannot track changing distribution over time.
Section 4 – Results

4.6 DraftFCB Driver 23 – Website effectiveness

Analysis & Commentary

The Lowdown

The chart opposite shows that the average number of visitors per day on the Lowdown website increased between 2009-10 and 2012-13, from approximately 350 per day to approximately 630 per day.

Average visits per day is significantly lower than for Depression.org, however Depression.org targets the general population while the Lowdown targets youth (16-24).

The chart opposite and below shows the distribution of visitors by time spent on the site over a five year period - data is only available for seven months of 2008-09 and nine months of 2012-13.

It is interesting to note that the proportion of visitors that stayed for more than 30 minutes was higher in 2008-09 and 2009-10, when traffic was also lower, than in 2012-13.

Analysis (see chart below) shows a negative correlation between the proportion of users that spent 30 minutes or more on the site and the number of visitors. In other words, as more people visit, proportionately fewer people spend more than 30 minutes on the site.

There may be several explanations for this relationship, which, for the purposes of discussion might include:

■ That the Lowdown is not attracting or holding the target audience as well as it had in the past
■ That the proportion of the Youth population that might ‘need’ the Lowdown fluctuates over time.

More analysis is needed to explain the relationship.
Section 4 – Results

4.6 DraftFCB Driver 23 – Website effectiveness

VfM assessment

<table>
<thead>
<tr>
<th>The Journal</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The available PHQ-9 data indicates that the Journal may be effective in helping users reduce feelings of depression. However, the data does not meet the standards required to demonstrate clinical effectiveness. Confidence in this data is therefore medium, however our overall confidence in data for this driver is high for the reasons highlighted below.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Depression.org

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The available data on visits per day to the website indicates increased traffic in 2012-13, however the time series is not long enough to determine a full trend. The available data on time spent on the website is not granular enough to base a conclusion. Confidence in the available data is high, but there is not enough data to draw a conclusion.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Lowdown

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The available data on visits per day to the website indicates increasing traffic over the last four years. However, analysis of the data on time spent on the website may indicate decreasing effectiveness. Confidence in the available data is high but further analysis would be useful.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Opportunities for VfM improvement

<table>
<thead>
<tr>
<th>Improvement opportunities are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ For the Journal, improved VfM may be achieved by demonstrating clinical effectiveness through RCTs or other means specified under the Ministry guidance on e-therapy.</td>
</tr>
<tr>
<td>However, any gains may be offset by other outcomes. For example, submitting the Journal to an RCT may require it to be ‘frozen’ (i.e. for development to cease) for the term of the RCT. Furthermore, changes made after the RCT may negate the results of the RCT. Also, having the Journal become an e-therapy may render it subject to additional restrictions or regulation (i.e. only clinical referrals) which may in turn limit access.</td>
</tr>
<tr>
<td>■ Collect more granular user data from Depression.org</td>
</tr>
<tr>
<td>■ Conduct more research on the possibility that the Lowdown is becoming less effective at retaining visitor interest.</td>
</tr>
</tbody>
</table>
4.6 DraftFCB Driver 24 – Link to NDI objectives

Measurement

Driver
This driver covers the Effectiveness of DraftFCB in meeting the NDI objectives. The objectives are to:

- Strengthen individual, family and social factors that protect against depression
- Improve community and professional responsiveness to depression

Measure
The measure to assess this driver is how qualitative and quantitative data demonstrates achievement of the NDI strategic objectives.

Data source and confidence
Proxy data is from the Phoenix Research Ltd Primary Care Survey and the annual Tracking Survey.

Assumptions
None.

Analysis & Commentary

We found no way to measure DraftFCB’s performance against this driver directly. There are several reasons for this:

- We found no formal measure of success for the objectives
- The objectives are high level and are not well defined.

There are, however, some proxy indicators of DraftFCB’s performance against the two strategic objectives.

First, the evidence of the impact of the NDI campaign in motivating behavioural change (described under Driver 22) indicates that the Programme may be strengthening individual, family and social factors that protect against depression.

Second, DraftFCB has undertaken promotional activities with the primary care sector and continue to do so. Also, the 2011 Phoenix Research Ltd Primary Care Survey gave the following awareness results:

<table>
<thead>
<tr>
<th>Primary care sector - NDI awareness</th>
<th>Unprompted recall</th>
<th>Prompted recall</th>
<th>Knowledge of Lifeline helpline connection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression.org</td>
<td>47%</td>
<td>83%</td>
<td>34%</td>
</tr>
<tr>
<td>The Lowdown</td>
<td>16%</td>
<td>45%</td>
<td>19%</td>
</tr>
<tr>
<td>The Journal</td>
<td>NA</td>
<td>43%</td>
<td>NA</td>
</tr>
</tbody>
</table>

The chart above indicates varying rates of recall and knowledge of NDI services amongst primary care workers – including primary mental health specialists, GPs, practice nurses and receptionists.

The survey also showed that 22% of surveyed sector workers had referred up to five patients to the Journal and 17% had referred more than five patients.

It is difficult to assess whether the survey figures indicate good performance because there is limited benchmark data available and we cannot identify a trend.
Section 4 – Results

4.6 DraftFCB Driver 24 – Link to NDI objectives

VfM assessment

Conclusion
Due to a lack of data we cannot draw a conclusion on the VfM of this driver. However we note that there are two forms of proxy data:

1) The first is taken from Driver 22, which suggests that the NDI campaign has positively influenced the rates at which the eight help-seeking behaviours occur. Driver 22 is rated Green for VfM, trend and confidence in data.

2) The second form of proxy data is from the Phoenix Primary Care Survey. Due to a lack of context (i.e. benchmark, trend) we are unable to conclude whether or not it indicates good performance.

Opportunities for VfM improvement

Improvement opportunities are:

- A strategic review that identifies and defines more concrete Programme objectives, identifies ways to measure progress against those objectives, and assesses DraftFCB’s behaviour against those objectives.

- Require DraftFCB to collect and report data that demonstrates its performance against NDI strategic objectives.
Section 4 – Results

4.6 Lifeline Aotearoa Driver 25 – Quality of multi-channel help lines

**Measurement**

**Driver**
This driver covers the Effectiveness of Lifeline’s multi-channel help lines in terms of quality. The help lines are:
- Toll free services
- Email
- Online messaging
- Support for online self-management
- Text messaging.

**Measure**
There is currently no measure to assess the quality of Lifeline’s multi-channel help lines.

**Data source and confidence**
Annual Evaluation Report.
Confidence in the data is low.

**Assumptions**
None.

**Analysis & Commentary**

The annual Evaluation Reports summarises some user responses to Lifeline service.

The table below shows responses to an online survey of users of services connected with the Lowdown. The results are indicatively good but the response sizes are very small.

<table>
<thead>
<tr>
<th>Survey - how do Lowdown services meet needs</th>
<th>Total respondents</th>
<th>Always or mostly met needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Text</td>
<td>17</td>
<td>13</td>
</tr>
</tbody>
</table>

The Evaluation Report also indicates positive user assessments of the service. However there was also a low response rate to that survey.

We note that the Evaluation Report reports on use of other services (the 0800 Helpline and the Journal support services) but that is generally use data, which might indicate quality by implication – we might expect a low quality service to have low or reducing use. However, as the chart below shows, monthly use is variable. We not therefore consider the use data to be a good direct indicator of quality.

We do note, however, the high level of appropriate education of Lifeline’s staff, which includes, eight diplomas or post-graduate diplomas in relevant disciplines and 15 degrees and Masters degrees in relevant disciplines.
Section 4 – Results
4.6 Lifeline Aotearoa Driver 25 – Quality of multi-channel help lines

VfM assessment

Comparators
The most practical way to measure ‘quality’ is comparatively; to find an industry benchmark and to assess an organisation’s performance against that benchmark. In this sense, quality is measured as a relative characteristic (i.e. relative to the industry standard or average).

We found no industry standards for delivering help line services through these channels.

Conclusion
Due to a lack of comparative data we cannot draw a conclusion on the VfM of this driver. Our confidence in the existing data is rated Red because of the response sizes used are so small.

Opportunities for VfM improvement

Improvement opportunities are:

- Identify industry benchmarks.
- Improve existing data.
### Measurement

**Driver**
This driver covers the Effectiveness of Lifeline Aotearoa in meeting the NDI objectives. The objectives are to:

- Strengthen individual, family and social factors that protect against depression
- Improve community and professional responsiveness to depression

**Measure**
The measure to assess this driver is how qualitative and quantitative data demonstrates achievement of the NDI strategic objectives.

**Data source and confidence**
Data is from qualitative feedback, the annual Evaluation Report, and an overall view of the relevant metrics analysis.

**Assumptions**
None.

### Analysis & Commentary

We found no way to measure Lifeline’s performance against this measure. There are several reasons for this:

- We found no formal measure of success for the objectives
- The objectives are high level and are not well defined

There is, however, one proxy indicator of Lifeline’s performance against the second strategic objective: to improve community and professional responsiveness to depression.

Lifeline is responsible for sector co-ordination, which may contribute to the second strategic objective. One activity specified in the contract service description is to:

"Maintain and develop mechanisms for keeping the various sectors informed about campaign progress and achievements, and encourage participation."

Phoenix’s annual Evaluation Report comments on 'sector engagement activities. According to the 2011 and 2012 reports subscriptions for the NDI Updates newsletter and membership for the online Depression Network have both increased since 2010.
4.6 DraftFCB Driver 24 – Link to NDI objectives

**Conclusion**
Due to a lack of data we cannot draw a conclusion on the VfM of the this driver.

<table>
<thead>
<tr>
<th>VfM</th>
<th>Trend</th>
<th>Confidence in data</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
</tbody>
</table>

**Opportunities for VfM improvement**

- A strategic review that identifies and defines more concrete Programme objectives, identifies ways to measure progress against those objectives, and assesses Lifeline’s behaviour against those objectives.
- Require Lifeline to collect and report data that demonstrates its performance against NDI strategic objectives.
### Section 4 – Results

#### 4.6 Phoenix Research Ltd Driver 27 – Relevance of research

<table>
<thead>
<tr>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Driver</strong></td>
</tr>
<tr>
<td>This driver covers the Effectiveness of Phoenix’s research in terms of the applicability of its recommendations.</td>
</tr>
<tr>
<td><strong>Measure</strong></td>
</tr>
<tr>
<td>The measure to assess this driver is the proportion of Phoenix’s recommendations that are out of scope.</td>
</tr>
<tr>
<td><strong>Data source and confidence</strong></td>
</tr>
<tr>
<td>Data is taken from feedback to a questionnaire. Confidence in the data is medium.</td>
</tr>
<tr>
<td><strong>Assumptions</strong></td>
</tr>
<tr>
<td>None.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysis &amp; Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>This data is described under point 7 of the methodology description in Driver 14.</td>
</tr>
<tr>
<td>Based on qualitative feedback some recommendations were designated as “Out of scope”</td>
</tr>
<tr>
<td>Based on this assessment, two of 52 (4%) of Phoenix’s recommendations were considered out of scope for the NDI Programme. This indicates that Phoenix’s research may be well aligned with the NDI strategy and may therefore be highly relevant.</td>
</tr>
</tbody>
</table>

**Comparators**

We found no comparators for this driver.

<table>
<thead>
<tr>
<th>VfM assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conclusion</strong></td>
</tr>
<tr>
<td>The VfM of this driver has been rated Green due to the high level of relevance of research. We have no trend data because we were unable to link the results with time periods in a robust way. The difficulty is that different recommendations require different lengths of time through the approvals and implementation process. Our confidence in the data is rated Amber due to the high level nature of our methodology.</td>
</tr>
</tbody>
</table>

**Opportunities for VfM improvement**

- Improvement opportunities are:
  - A strategic review will help all stakeholders align behaviours (including research) with strategy and scope.
Section 4 – Results

4.6 Phoenix Research Ltd Driver 28 – Applicability of recommendations

**Measurement**

**Driver**
This driver covers the Effectiveness of Phoenix’s research in terms of the applicability of its recommendations.

**Measure**
The measure to assess this driver is the proportion of Phoenix’s recommendations that are considered in scope but are otherwise not implemented.

**Data source and confidence**
Data is taken from feedback to a questionnaire. Confidence in the data is medium.

**Assumptions**
None.

**Analysis & Commentary**

This data is described under point 6 of the methodology description in Driver 14:

*Answers of “No” were checked against qualitative feedback and assessed as “Awaiting signoff” or “Recommendation rejected”*

Based on the above assessment, two of the 50 recommendations that were considered within scope for the NDI Programme, were rejected for other reasons. This indicates that approximately 4% of total recommendations and / or relevant recommendations were not applicable to the NDI. Overall this indicates a high level of applicability.

**Comparators**
We found no comparators for this driver.

**VfM assessment**

**Conclusion**
The VfM of this driver has been rated Green due to the apparently high level of recommendation applicability. We have no trend data because we were unable to link the results with time periods in a robust way. Our confidence in the data is rated Amber due to the high level nature of our methodology.

**Opportunities for VfM improvement**

- A strategic review will help all stakeholders to align behaviours (including research) with strategy and scope.
Section 4 – Results

4.6 Phoenix Research Ltd Driver 29 – Proportion of research implemented by DraftFCB

**Measurement**

**Driver**
This driver covers the Effectiveness of Phoenix’s research and recommendations to DraftFCB.

**Measure**
The measure to assess this driver is the proportion of Phoenix’s recommendations which are implemented by DraftFCB.

**Data source and confidence**
Data is taken from feedback to a questionnaire. Confidence in the data is low.

**Assumptions**
None.

---

**Analysis & Commentary**

The methodology that underpins the data presented here is described under Driver 14.

The table below indicates that over 88% of recommendations relevant to DraftFCB have been implemented to some degree – the feedback rates implementation as in part or in full.

We note that there is a large amount of work around upgrading the Lowdown website that could reasonably be considered relevant to DraftFCB, but awaiting sign-off. Based on qualitative feedback, we have allocated those recommendations to the Ministry, due to the large amount of work necessary to achieve sign-off. Reallocating those outstanding recommendations to DraftFCB would drastically alter the proportion of implemented recommendations.

**Comparators**
We found no comparators for this driver.

**VfM assessment**

**Conclusion**
Based on the high level of implementation indicated, we have rated this driver as Green. However, we understand that a large amount of work awaiting sign-off that relates to the Lowdown could be classified as relevant to DraftFCB. Since the matter of allocation is methodological, and the high level methodology does not produce highly robust conclusions, our confidence in the data is Red. We have no trend data because we were unable to link the results with time periods in a robust way.

**Opportunities for VfM improvement**

Improvement opportunities are:

- A business case approach to proposing and implementing changes to the NDI will bring greater transparency and clarity to the process as well as helping to ensure strategic alignment.
- The business case process would also allow better records of recommendations and changes to be kept, which in turn would allow better tracking of VfM.
Section 4 – Results

4.6 Phoenix Research Ltd Driver 30 – Proportion of research implemented by Lifeline Aotearoa

**Measurement**

**Driver**
This driver covers the Effectiveness of Phoenix’s research and recommendations to Lifeline.

**Measure**
The measure to assess this driver is the proportion of Phoenix’s recommendations are implemented by Lifeline.

**Data source and confidence**
Data is taken from feedback to a questionnaire. Confidence in the data is medium.

**Assumptions**
None.

**Analysis & Commentary**

The methodology that underpins the data presented here is described under Driver 14.

The table below indicates that half of recommendations relevant to Lifeline, that have not been rejected, have been implemented to some degree – the feedback rates implementation as in part or in full.

Based on qualitative feedback it appears that the Lifeline-related recommendations awaiting sign-off are subject to additional work and information.

**Comparators**
We found no comparators for this driver.

**VfM assessment**

**Conclusion**

Based on the moderate level of implementation indicated, we have rated this driver as Amber. The high level methodology does not produce highly robust conclusions, however, we are more confident that the recommendations have been allocated accurately for Lifeline than for DraftFCB (see Driver 29), so our confidence in the data is Amber. We have no trend data because we were unable to link the results with time periods in a robust way.

**Opportunities for VfM improvement**

Improvement opportunities are:

- One of our strategic recommendations is to develop a business case approach to proposing and implementing changes to the NDI. We consider that this will bring greater transparency and clarity to the process as well as helping to ensure strategic alignment. It is important, however to create a business case process that is not onerous or overly complicated, which would add cost and decrease efficiency.

- The business case process would also allow better records of recommendations and changes to be kept, which in turn would allow better tracking of VfM.
Section 4 – Results

4.6 Phoenix Research Ltd Driver 31 – Proportion of recommendations signed off by the Ministry or HPA

**Measurement**

**Driver**
This driver covers the Effectiveness of Phoenix’s research in terms of the applicability of its recommendations.

**Measure**
The measure to assess this driver is the proportion of Phoenix’s recommendations that the Ministry have signed-off.

**Data source and confidence**
Data is taken from feedback to a questionnaire.

**Assumptions**
None.

**Analysis & Commentary**

The methodology that underpins the data presented here is described under Driver 14.

The table below indicates that 44% (23 out of 52) of all recommendations made by Phoenix have been implemented and 48% (13 out of 40) are in process.

<table>
<thead>
<tr>
<th>Recommendation implementation - Ministry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>52</td>
</tr>
</tbody>
</table>

This is not a precise measure of sign-off, since implementation is not the same as sign-off; for example a recommendation could have been signed-off but not implemented. Also, the relatively large number of recommendations that are currently classified as ‘In process’ have been classified as such for a wide range of different reasons. For example, the Ministry may have asked for more work to be undertaken on the recommendation or proposal, the Ministry may be undertaking further research or may require other sign-off, or there may be other hold-ups or resource constraints.

**Comparators**

We found no comparators for this driver.

**VfM assessment**

**Conclusion**
Since the implementation data is not a direct measure of sign-off, we cannot draw a conclusion on the VfM of this driver.

**Opportunities for VfM improvement**

Improvement opportunities are:

- Develop a schedule of recommendations, required approvals and progress through the approvals / sign-off process.
International context

Section 1 – Executive Summary
Section 2 - Introduction
Section 3 – Context
Section 4 – Results
Section 5 – International context
Appendices
One aspect of our approach to this review was to compare the New Zealand National Depression Initiative (NDI) with initiatives both in New Zealand and overseas. This section of the report discusses aspects of depression initiatives under the following key areas:

Conceptual framework of comparisons
- Policy contexts.
- Strategic intents
- Overview of service delivery.

This information will be framed within the following themes:
- Alignment with other jurisdictions.
- Similarities and differences.

Overall policy context
Mental health problems are a significant health issue, with depression being predicted to be the second global cause of disability by 2020. One fifth (20.7%) of people in NZ experience a mental disorder in any 12 month period, and most of the care for these people occurs in primary care settings.

The National Depression Initiative NDI was launched in 2006 and in the 10 years prior to its launch there had been a number of international mapping exercises which had highlighted the high prevalence of Common Mental Disorders (CMD) and the low levels of support available for diagnosis and management in primary care. In New Zealand the MaGPie 4 and Te Rau Hinengaro 2 studies showed that in common with other OECD countries there was a high prevalence of depression and other CMD providing an impetus for a campaign that would raise awareness among the public and support assessment and management strategies for health professionals.

The last ten years has seen rapid growth in primary mental health initiatives, both here and overseas. In 2005 the New Zealand Ministry of Health released targeted funding for primary care mental health. Evaluation of the first 41 of these Primary Mental Health Initiatives demonstrated that access to services had increased for those with mild to moderate severity CMD, though the targeting of the initiatives to Māori, Pasifika and low income New Zealanders means that there is still substantial unmet need.

Alignment with other jurisdictions
To determine how much the NDI is in alignment with other similar international initiatives, it is necessary to review again the defined objectives and strategies of the NDI;

Key objectives: strengthening individual, family and social factors that protect against depression and improving community and professional responsiveness to depression.

Framework strategies include elements of protecting people from depression, increased awareness of depression and awareness of interventions and improving the capability of health professionals to respond to depression. There are also elements in the strategy which are concerned with coordination of services and research evaluation and monitoring.

The key features to deliver this strategy has been a depression awareness campaign personalised through the story of ex-All Black John Kirwan and partnered by a telephone hotline, online support website and a specific website for young people fronted by ‘Navigators’ who would appeal to a young target population.

In light of the above, international comparators should consider the following:

1) The nature of depression. The NDI is targeted at “mild to moderate” depression, though initial funding from suicide prevention defined a focus on the prevention of “severe” events. From the outset however many of the people to whom the campaign was addressed would not have had depression as defined by a psychiatrist or by the DSM 4/ICD-10, but rather the most common picture of common mental disorder seen in primary care “anxious depression.”

For the purposes of this review the NDI has been compared with programmes addressing Depression or CMDs, recognising that in the future the NDI will need to be explicit about this, in its strategic intent and its branding.
2) Depression awareness or something else? Initial depression awareness campaigns were very much targeted at “depression literacy,” and did not include elements of e-therapy or other styles of intervention. Some campaigns have now either evolved to include intervention and self-management, or partner with such programmes. A number of countries have developed a focus on patient experience being part of the awareness raising, with video clips explaining the depression experience. These are analogous to the John Kirwan campaign, though not using “celebrity” to the same extent, for example, Health Talk online http://www.healthtalkonline.org/mental_health/Depression. There is evidence of effectiveness for both depression awareness and intervention campaigns, with a good proportion of the evaluation and research coming from Australia. This is explored further over the following pages.

3) The place of an intervention. While therapeutic intervention was not part of the original objectives of the NDI, “The Journal” and the telephone “helpline” could be perceived as being therapy delivery. Over the last 10 years there has been a continuing proliferation of the online delivery of psychological therapies. There is evidence that the effectiveness of these depends to a significant extent on having structured support for people working through therapy modules.

This review will include literature on the effectiveness of online therapy and helplines since they are deemed to be part of the operation of the NDI.

Overall alignment of the Programme with international comparators.

There is no directly comparable international programme to the NDI, though many OECD countries have programmes with some similar features. However, we summarise below the similarities and differences of depression campaigns internationally.

Similarities

Many OECD countries and all of the usual NZ comparators have recognised the problems associated with awareness, identification and management of high prevalence common mental disorders.

Similarities (continued)

- All countries have initially addressed the problem using the “brand” of depression
- Common elements of depression initiatives include public media information campaigns to raise awareness, the presence of telephones helplines and internet-based advice and therapy programmes
- A number of campaigns (e.g. beyondblue) have a specific focus on young people
- All identified campaigns share the “depression” space with multiple other providers, either as part of health sector initiatives, or NGO and charity projects.

Differences

- Few programmes incorporate a celebrity as a key element of awareness and guided self help
- Many programmes separate the awareness, helpline and therapy components.
Prior to the start of the NDI, Phoenix Research Ltd was commissioned to produce a review of existing campaigns. This report covered campaigns from the United Kingdom, Australia, the United States and Germany, and was produced in 2005.

The Programmes covered in that review were:

- The Defeat Depression Campaign was conducted across the UK from 1992 to 1996. It was run by the Royal College of Psychiatrists.

- The Changing Minds Campaign, a more general campaign to reduce stigma associated with mental health problems in the UK, which ran from 1998 to 2003. This was also run by the Royal College of Psychiatrists.

- The US National Institute of Mental Health (NIMH) Depression Awareness, Recognition and Treatment Programme (DART) was established in 1998 and hosts a range of initiatives aiming to help educate different communities about depression.

- The US National Depression Screening Day (an offshoot of DART) was initiated in 1990 and continues as an annual event supported by various screening sites.

- The Nuremberg Alliance Against Depression was conducted in Nuremberg, Germany between 2000 and 2001.

- Beyondblue: Australia’s national depression initiative began in 2000 and is still running.

We believe the methodology and synthesis of literature in Phoenix Research Ltd’s review of existing campaigns to be sound and some of the conclusions remain valid, for example:

- Mass media can raise awareness and change attitudes towards depression. The sustainability of attitude changes following mass media campaigns is unclear.

- Some attitudes held by the public about depression and its treatment are not evidence-based and may require a particular approach in a communications campaign.

- Improving recognition and treatment of depression cannot be tackled by GP education alone. The best way of targeting GPs is by using multiple channels. Guidelines for recognition and management of depression had the most impact on GPs in the UK Defeat Depression campaign.

Findings from the beyond blue evaluation suggest that that awareness campaigns do not necessarily lead to sudden, increased demand for GP services.

Depression initiatives have included a range of strategies which include:

- Mass media
- GP Education
- Community education initiatives
- Web based interventions
- People with experiences of depression and carers
- Work place interventions
- School based interventions
- Support research and evaluation

A summary of the findings about each of the above campaigns is provided in Appendix 3 of this report.
While the NDI has an important place and profile in New Zealand depression awareness it shares the ‘depression’ space with a number of other organisations. Since the 1970s, the Mental Health Foundation has provided awareness raising for depression and other mental illness. While it provides links to the NDI website, it also has information on its own pages about depression and its treatment, and a google link labelled “out of the blue.”


Other health information sites predominantly link to the NDI site, the health navigator site for example promoting the “Journal” component of the NDI as a “self-management” programme.

http://www.healthnavigator.org.nz/health-topics/depression/
Australia is a useful international alignment comparator as the health service delivery is relatively similar, the overall prevalence of common mental disorder is comparable and there has been a national depression initiative, Beyond Blue, operating over a similar time frame to the NDI.

Beyond Blue

Beyond blue was initially a five-year Australian initiative which took a population health approach to combating depression. It had five priority areas:

1. Destigmatise depression by increasing community awareness
2. Support national consumer and carer advocacy
3. Promote prevention of and early intervention for depression
4. Promote primary care training and partnerships for service reform
5. Fund strategic and applied research

Each of the five priority areas above was a staged activity, with an initial phase focusing on a few key objectives. For example, in the community awareness domain there was a need to first capture community and health professionals’ attention (“depression awareness”), then to move progressively to “depression understanding” and then “changes in attitudes.”

In the primary care domain, fundamental structural reform of the financial and professional support systems was identified as the necessary precursor to any serious change in the quantity and quality of treatments provided. Once that was achieved, activity could move to the educational, professional training and secondary support systems required to sustain reform.

Achievement of Beyond Blue Objectives

The achievements of beyondblue have been subjected to a number of evaluations 9, 10 and have also been included in a systematic review of depression awareness campaigns 11. The findings from the effectiveness review are summarised below:

- **Lower-level objectives achieved**: key initiatives in place leading to greater availability of information about depression, improvements in consumer networks, better support for mental health care delivery in primary care settings and increases in targeted research.

- **Intermediate-level and high-level objectives partly achieved**: headway made into community “depression literacy,” acknowledgement of the consumer/carer perspective, health workforce programmes to enable professionals to deal with depression, the likelihood that individuals will seek help, the range of prevention and early intervention options, the role of primary care practitioners in mental health care, and scientific knowledge about depression.

- **Highest-level objective not realised**: society does not optimally understand, respond to or work actively to prevent depression. Beyondblue has begun to make an impression, but it is unrealistic to expect systemic and cultural change of this magnitude to occur quickly.

Effectiveness and Impact of Beyond Blue

Recognition of beyondblue became high. 61.9%, (1982/3200) of those interviewed in a telephone survey had heard of beyondblue and knew something about its purpose and working 12. Those who lived in states that received beyondblue funding had greater change in beliefs about some treatments, particularly counselling and medication, and about the benefits of help-seeking in general.10

Beyondblue reached a good proportion of Australian young people; 44% of young people were aware of beyondblue, including 121% who spontaneously recalled beyondblue as an organisation related to mental health problems. Awareness was associated with better mental health literacy. Males and younger adolescents could be targeted for improvements in awareness.13

Beyond Blue has priority areas which remain focused on Community awareness and destigmatisation, but also support prevention and early intervention, the education and training of primary care practitioners and support for research.

It has not developed into a therapy intervention programme.
Beyondblue has continued with its original strategic intent and produced particular campaigns relating to the elderly (http://www.beyondblue.org.au/index.aspx?link_id=101). Australia. Also, like other countries including the UK and New Zealand, it has a number of other awareness sites relating to specific groups e.g. women in the antenatal and postnatal period. (www.panda.org.au).

Other recent initiatives - Australia

There are a number of Australian based depression awareness and e-therapy intervention sites which are effectively linked with each other. These include the literacy site “blue pages,” (https://bluepages.anu.edu.au) intervention packages “moodgym (https://moodgym.anu.edu.au/welcome) and e-couch” and “Beacon,” which is a portal to online applications for mental and physical health problems. (https://beacon.anu.edu.au)
The UK hosted one of the first depression awareness campaigns with “Defeat depression,” which in the early 1990s demonstrated shifts in both public and professional opinion towards depression.

As in New Zealand, there are a number of different organisations and charities with depression awareness as a theme. There is little coherent linkage between them. Prominent among them are the Depression Alliance and SANE. [http://www.sane.org.uk/](http://www.sane.org.uk/)

Current campaigns use standard drop down menus to provide information about the nature of depression and various treatment options. For example, The Depression Alliance aims to give information to the public and work with healthcare professionals to secure better service provision for people with depression, and lobby government to influence policymaking in this health field.

The Alliance also organises various events to raise awareness of a particularly serious or prevalent aspect of depression. Depression Awareness Week™, for example, is an annual initiative supported by health professionals, politicians, celebrities and the media.

While most campaigns have not been focused around a single “celebrity” in the way that New Zealand has, the UK SANE campaign is currently using a range of wellknown celebrities (Stephen Fry and Rory Bremner) to tell their stories about depression.
The German Nuremberg programme is quoted in the review from Phoenix in 2005 (see Appendix 3).

The “Nuremberg Alliance Against Depression” was initiated as a community-based model project within the large-scale ‘German Research Network on Depression and Suicidality’ in 2001. The ‘Nuremberg Alliance Against Depression’ was an action programme, conducted in the city of Nuremberg (500,000 inhabitants) in 2001/2002, addressing four intervention levels. Based on the positive results of the Nuremberg project (a significant reduction of suicidal behaviour by more than 20%) 18 international partners representing 16 different European countries established the ‘European Alliance Against Depression’ (EAAD) in 2004.

Based on the four-level approach of the Nuremberg project, all regional partners initiated respective regional intervention programmes addressing depression and suicidality. Evaluation of the activities takes place on regional and international levels. The four level approach that has been implemented in 16 European nations is summarised below.

### Four-level approach implemented in 16 European Nations

1. **Co-operation with general practitioners and pediatricians:** GPs and pediatricians are invited to educational workshops on how to recognise and treat depression and explore suicidal tendency in the primary care setting. Information materials (e.g. video tapes) will be distributed to GPs who can hand them out to their people.

2. **Public Awareness Campaign:** The broad public will be addressed by large-scaled public awareness campaigns including posters, cinema spots, information leaflets, brochures, public events and internet homepages. The aim is to improve knowledge about adequate treatments of depression and to reduce the stigmatisation of the topic “depression” and the affected individuals.

3. **Offers for high risk groups and self-management activities:** “Emergency Cards” will be handed out to high risk groups (first of all young people in adolescent crisis and persons after suicide attempt) guaranteeing direct access to professional help in a suicidal crisis. Initiatives will be started to found regional self-management groups and support them with expert advice. Partnerships with patient associations will be established and intensified.

4. **Training sessions for multipliers:** Educational workshops are provided to various target groups playing an important role in disseminating knowledge about depressive disorders (e.g. health care professionals, priests, counsellors, police). Particular emphasis can be put e.g. on special offers for parents, youth workers and teachers in order to reach children and adolescents suffering from depression, deliberate self harm and suicidal behaviour (e.g. information sessions and prevention programmes in schools). A close co-operation with the media will take place to strengthen the public discussion. Special guidelines on media coverage of suicidal tendency are distributed to prevent imitative suicides.
In 2004, the World Health Organisation (WHO) published “Mental Health Promotion: Case Studies from Countries providing an overview of 35 mental health initiatives across a range of 19 low to high income nations.

A programme with a number of similar characteristics to the NDI is the Defeat Depression Campaign in Hong Kong among the Chinese community. A summary of the case study is provided below. Full details are within the World Health Organisation Report.

**Defeat Depression Project - A multilevel mental health education programme for Chinese-speaking communities in Hong Kong Special Administrative Region (SAR)**

The Defeat Depression Project is a comprehensive educational programme designed for Chinese-speaking communities in China, Hong Kong SAR. The programme takes language and cultural dimensions into consideration with regard to the recognition, treatment and prevention of depressive illness. The target groups were residents of the New Territories West (NTW) cluster of Hong Kong SAR, an area with one million inhabitants, but the information and results were useful for other Chinese-speaking communities in China and throughout the world.

The need for better awareness of depression was indicated by four factors:

- The possibility that depression will be the leading cause of disability by 2020 (World Health Organization, 2001) and that unipolar major depression is the second largest contributor to the burden of disease in China (Murray and Lopez, 1996)
- Research evidence showing that the lower rates of depression in Chinese communities were related to denial and a tendency to express depression somatically (Parker, Galdstone and Chee, 2001)
- Statistics in Hong Kong SAR which showed that consultation and specialist treatment in the Hospital Authority for depressive illnesses increased by 40% between 1999 and 2002
- Local community survey in 1999, found that 39% of respondents reported significant depressive symptoms, but 46% did not know that depression is a mental illness and 62% did not know that it is treatable.

**Aims of the Hong Kong Defeat Depression Project**

The aims of the Defeat Depression Project were threefold:

1. To educate the general public and high-risk populations about depression as a mental illness, and its prevention and treatment
2. To provide evidence based information and the sharing of skills to family doctors and other community healthcare professionals
3. To reduce the disability related to depression by empowering people and carers.

**Budget**

The Defeat Depression Project had a budget of HK$1 million (approximately US$128,000) with which to provide education for the public, patient groups and professionals.

**Results**

Data from the post-project survey showed that the general public was better educated about depression and its social impact. Improved public awareness of depression as a mental illness was reflected in the significant difference in public knowledge between the pre- and post-Project surveys (Institute of Mental Health, 1999 and 2002). Improvements were noted in the areas of symptom knowledge, potential risks of suicide, and readiness to seek professional help (overall, 53.5% in 1999 and 76.7% in 2002, p<0.01).

Stigmatisation of people who sought professional help for depression was gradually decreasing. Those affected by mental illness and other interested readers had better access to the wealth of information available and were encouraged to adopt a healthy and positive lifestyle.
**Telephone Helplines – international comparators**

Telephone helplines provide 24 hour, non-directive crisis and counselling services to large numbers of callers in the community using a volunteer workforce. In 2009, major helplines in the United Kingdom received over 4 million calls. In Australia, over 850,000 calls are answered annually by the large telecounselling providers, with 20% of callers referred by healthcare providers. There is evidence that telephone counselling for depression can be effective. The potential of self-management resources such as this to be successfully disseminated and delivered through a national mental health telephone information service is discussed.

There is clearly a difference between a telephone hotline in which a “crisis” is answered and telephone as a means of delivering therapy over a number of telephone sessions. While both may be effective there is a need for clarity of purpose in order to maximise clinical effectiveness, VfM and appropriate staff training.

Telephone monitoring and counselling has also been found to be effective when used in conjunction with other web based treatments.

Lifeline Aotearoa offers support and information through a 24/7 phone counselling service. There is also an associated New Zealand “Kidsline” and Chinese lifeline for Mandarin and Cantonese speakers.

As with internet based health literacy sites there are other local NZ initiatives which could be seen as targeting the same market as Lifeline. These include for child and youth “Youthline” www.youthline.co.nz, Child Helpline, Kidsline, Whatsup and a number of alcohol and drug helplines e.g. www.adanz.org.nz/Helpline/home. In terms of international crisis “branding,” the New Zealand Samaritans also offers a 24/7 helpline.

In Australia the most easily found help lines offer immediate phone response and associated internet based information, including self help tools and patient experience stories. They do not offer face to face contact for counselling. Beyondblue offers links to other helplines and SANE provides both phone and internet based help.

In the UK there are a plethora of mental health helplines with relatively poor linkage between them. Many also offer internet based information and advice. The “Samaritans” do offer a drop-in help service, as well as offering 24/7 crisis and other counselling.

In the US and Canada, as expected, telephone helpline services tend to be State and Province based, with little integration. Many of the more general depression awareness websites in the US offer links to the same crisis helplines including the Samaritans and the Suicide prevention lifeline.
Effectiveness of Internet-based Therapies

Internet based programmes to prevent and manage anxiety and depression have been shown to be effective, in a number of different countries and primary care settings. There has been debate about the effectiveness of internet-based therapy, with or without guidance and support for participants. This guidance can include input from therapists or lay facilitators, or email reminders. Reviews have reported greater effect sizes for internet and other self-management programmes when the intervention incorporated therapist assistance, though internet programmes can be effective without therapist support compared to usual practice.

The Journal

The “Journal” component of the NDI contains elements of a guided internet therapy, with a degree of data collection and monitoring. In New Zealand there are other options for people seeking to engage in online e-therapy. These include accessing overseas based internet sites like “moodgym,” and being able to participate in a New Zealand programme “Beating the Blues.”

Beating the Blues

The “Beating the Blues” programme was jointly designed and developed in the UK by Dr Judy Proudfoot and her team at the Institute of Psychiatry, Kings College, London and Ultrasis plc. It is now available in New Zealand funded by the Ministry of Health. Free access to the online programme is managed by GPs through ManageMyHealth™, with accredited trainers offering training to practices in their area. It has been clinically proven in independent Randomised Controlled Trials (RCTs) and has been recommended for use in the National Health Service, UK, by the National Institute for Health and Clinical Excellence (NICE). Implementation of the Programme in New Zealand is consistent with Evidence-Based Best Practice Guidelines. It consists of 8 x 50 minute sessions, which are supported with information and follow up sessions with the people GP (http://www.beatingtheblues.co.nz).
Effectiveness of telephone and internet-based interventions on youth and adolescents

Telephone and internet based interventions have been specifically assessed in young people and found effective, with telephone counselling appearing to offer some advantages. There is evidence that web-based programmes are more effective at reducing symptoms of anxiety than depression.

In general, services for youth make a distinction between awareness raising and therapy interventions. The Youth Beyondblue site (http://www.youthbeyondblue.com) in Australia, for example, offers to other help lines and websites including the telephone ‘Lifeline’ and therapy sites such as moodgym.

Effectiveness of Youth Awareness Campaigns

There are few evaluations of the effectiveness of youth awareness campaigns. In Australia, the Compass campaign included the use of multimedia, a website, and an information telephone service. Multiple levels of evaluation of this service have been conducted. They included a cross-sectional telephone survey of mental health literacy undertaken before and after 14 months of the campaign. The Programme was judged to have an impact on the following variables, as indicated by significant region-by-time interaction effects:

- Awareness of mental health campaigns
- Self-identified depression
- Help for depression sought in the previous year
- Correct estimate of prevalence of mental health problems
- Increased awareness of suicide risk
- A reduction in perceived barriers to help seeking.

These effects may be underestimated because media distribution error resulted in a small amount of print material "leaking" into the comparison region.

What is clear is that young people themselves will be very adept at using “celebrity” figures and their stories as part of mental health awareness and they will use multiple media outlets to do this. An example can be found at the following link with a screen print shown below. http://otbristol.org.uk/campaigns/celebrities-and-mental-health

Celebrities featured on the website include:

- **Freddie Flintoff**: “Ashes-winning cricketer, comedy show panellist, national treasure, LAD. But also, Freddie Flintoff is a sufferer of depression and alcohol dependency. In the midst of the masculinised world of sport – and TV comedy – Freddie found himself lost, and not wanting to leave his bed.”

- **Lady Gaga**: “Probably the biggest pop-star in the world has described how she fought anorexia as a teen – and still has weight issues to this day.”

- **David Beckham**: “and finally, even David Beckham has a mental health disorder: OCD”
Economic Evaluations of Depression Campaigns

Economic Evaluations of Depression Campaigns

There are few readily available economic evaluations of depression campaigns. A UK systematic review explored the costs and consequences of enhanced primary care for depression, with a focus mainly on delivery of care models to people. Clinician education strategies were associated with increased costs and no impact on improved management or outcome. 27

Beyondblue

Beyondblue has many comparisons with the NDI. While there has been no formal evaluation of its cost-effectiveness, it has a much greater operating budget / population capita than the NDI with revenue AUS $32m in 2011 and project expenses of AUS $19m.
Conclusions from International Literature Review

Following the evaluation of national and international literature and comparing the NDI against international comparator programmes, the following key conclusions are drawn:

**Need for strategic clarity and structure:** The strategic purpose of depression initiatives should be made clear and the alignment between different campaigns and services should be optimised. Many of the international comparator initiatives began as public awareness and de-stigmatisation campaigns. Some, including the NDI have added telephone helplines and e-therapy interventions to the work that they do. There is often a lack of clarity about the overall purpose of different initiatives, leading to reduplication of different sorts of support for the public.

**Integration and sharing of available information to drive consumer-centricity:** There is a plethora of available websites and services with little integration and information sharing between them. In Australia an attempt has been made to provide a navigator to different sites called ‘Beacon’, and an evaluation has rated those sites. 28

**Need for clarity between depression and anxiety:** Many depression sites now make clear that people accessing both websites and telephone lines suffer from symptoms other than “depression,” and will have separate information portals for anxiety and depression. The NDI is still branded as a ‘depression’ initiative, despite having information now about anxiety.

**Evolving offerings to meet the needs of youth:** The branding of the Lowdown should be reviewed, given the rapidly changing ways that youth access different technology options and the speed with which ‘navigators’ would be recognised or not by a target population.
Appendices

Section 1 – Executive Summary
Section 2 - Introduction
Section 3 – Context
Section 4 – Results
Section 5 – International context
Section 6 – Service delivery Model

Appendices
## Appendix 1: Reference Network Membership

<table>
<thead>
<tr>
<th>Name (and input role on the Reference Network)</th>
<th>Organisation</th>
<th>Sector Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof. Bruce Arroll (Chair)</td>
<td>Auckland School of medicine general practice</td>
<td>Primary care/academic</td>
</tr>
<tr>
<td>George Hill (kaumatua)</td>
<td>Lifeline Aotearoa</td>
<td>Primary care</td>
</tr>
<tr>
<td>John Barker (mental health consumer)</td>
<td>Now independent worked for a consumer advocacy group in the mental health sector</td>
<td>Focus on primary and secondary care from consumer advocacy perspective</td>
</tr>
<tr>
<td>Carole Maraku (Māori mental health)</td>
<td>Service Manager Te Menenga Pai Trust in Newtown, Wellington</td>
<td>Primary sector – Māori mental health</td>
</tr>
<tr>
<td>Dr David Codyre (primary/mental health)</td>
<td>Procare</td>
<td>Primary care psychiatrist</td>
</tr>
<tr>
<td>Angela Verhoeven (primary mental health)</td>
<td>Primary care</td>
<td></td>
</tr>
<tr>
<td>Dr John Cosgriff (primary care)</td>
<td>Mental Health GP liaison, Counties Manukau DHB</td>
<td>Primary/secondary care</td>
</tr>
<tr>
<td>Dr William Fergusson (primary care)</td>
<td>GP Kumeu Village Medical Centre</td>
<td>Primary care</td>
</tr>
<tr>
<td>Bernard Te Pa (CMDHB)</td>
<td>General Manager, Māori Health, Counties Manukau DHB</td>
<td>Primary/secondary care</td>
</tr>
<tr>
<td>Monique Faleafa (Te Pou)</td>
<td>Registered clinical psychologist. Te Pou is a mental health sector workforce development agency</td>
<td>Across all sectors</td>
</tr>
<tr>
<td>Dr Martin Orr (University of Auckland, telepsychiatry)</td>
<td>Psychiatrist, academic</td>
<td>Primary/secondary care</td>
</tr>
<tr>
<td>Janet Peters (NDI strategic advice)</td>
<td>Registered psychologist specialised in service development and project work in mental health and addictions</td>
<td>Service development and project work</td>
</tr>
<tr>
<td>Dr Sally Merry (Auckland University and the Werry Centre) youth mental health</td>
<td>Senior lecturer in Child and Adolescent Psychiatry. Principal investigator for studies of e-therapy and mobile phone technology as interventions for young people with depression</td>
<td>Secondary care</td>
</tr>
<tr>
<td>Dr. Janine Bycroft</td>
<td>University of Auckland</td>
<td>Primary care/academic</td>
</tr>
<tr>
<td>Diana O'Neill</td>
<td>Ministry of Health, Senior Advisor</td>
<td>Primary care</td>
</tr>
<tr>
<td>Hannah Booth</td>
<td>Manager Mental Health and Minimising Gambling Harm</td>
<td>Mental health manager/lead, HPA</td>
</tr>
<tr>
<td>Dr Janet Fanslow</td>
<td>Senior lecturer in mental health promotion, School of Population Health, University of Auckland</td>
<td>Academic, population health</td>
</tr>
<tr>
<td>Boris Sokratov</td>
<td>Formerly represented the Mental Health Foundation, now an independent consultant</td>
<td>Consultant</td>
</tr>
<tr>
<td>Hinerangi Himiona (Māori engagement)</td>
<td>Freelance consultant, working in Māori heritage development, management and research</td>
<td>Consultant</td>
</tr>
<tr>
<td>Bice Awan (Mental Health Commissioner)</td>
<td>Mental Health Commission</td>
<td>Primary/secondary care</td>
</tr>
<tr>
<td>Sam Liebert (Depression and physical activity)</td>
<td>Ministry of Health</td>
<td>Ministry oversight</td>
</tr>
<tr>
<td>Derek Thompson</td>
<td>Ministry of Health</td>
<td>Ministry oversight</td>
</tr>
<tr>
<td>Memo Musa</td>
<td>Ministry of Health</td>
<td>Ministry oversight</td>
</tr>
</tbody>
</table>
Appendix 2: Stakeholders Consulted

KPMG is grateful to a large number of stakeholders who have provided time and input into this review. All stakeholders consulted are listed below by organisation and then by surname.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darren Lauese</td>
<td>Finance Director</td>
<td>DraftFCB</td>
</tr>
<tr>
<td>Sarah Raine</td>
<td>Senior Account Manager</td>
<td>DraftFCB</td>
</tr>
<tr>
<td>Brian van den Hurk</td>
<td>Managing Director</td>
<td>DraftFCB</td>
</tr>
<tr>
<td>Hannah Booth</td>
<td>Manager Mental Health and Minimising Gambling Harm</td>
<td>Health Promotion Agency</td>
</tr>
<tr>
<td>Sarah Helm</td>
<td>Marketing manager</td>
<td>Health Promotion Agency</td>
</tr>
<tr>
<td>Candace Bagnall</td>
<td>Consultant, Te Pou o Te Whakaaro Nui</td>
<td>Le Va</td>
</tr>
<tr>
<td>Monique Faleafa</td>
<td>National Manager</td>
<td>Le Va</td>
</tr>
<tr>
<td>Robert Muller</td>
<td>Project lead for Le Va’s Pasifika disability portfolio</td>
<td>Le Va</td>
</tr>
<tr>
<td>Jo Denvir</td>
<td>Chief Executive</td>
<td>Lifeline</td>
</tr>
<tr>
<td>Kayte Godward</td>
<td>Sector Relationship Manager</td>
<td>Lifeline</td>
</tr>
<tr>
<td>Dylan Norton</td>
<td>Helplines Manager</td>
<td>Lifeline</td>
</tr>
<tr>
<td>Paula Polkinghorne</td>
<td>Helplines Manager</td>
<td>Lifeline</td>
</tr>
<tr>
<td>Melanie Shaw</td>
<td>Mental health specialist</td>
<td>Lifeline</td>
</tr>
<tr>
<td>John Barker</td>
<td>Consumer adviser on mental health</td>
<td>Member of Reference Network</td>
</tr>
<tr>
<td>Teresa Pomeroy</td>
<td>Project Manager, Family and Community Services</td>
<td>Ministry of Social Development</td>
</tr>
<tr>
<td>Memo Musa</td>
<td>Senior Adviser, Mental Health Service Improvement</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Derek Thompson</td>
<td>Team Leader, Mental Health Service Improvement Group</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Jeanette McKee</td>
<td>Director of Qualitative Research</td>
<td>Phoenix Research Ltd</td>
</tr>
<tr>
<td>Allan Wyllie</td>
<td>Director of Social Research</td>
<td>Phoenix Research Ltd</td>
</tr>
<tr>
<td>Bruce Arroll</td>
<td>Professor, General Practice and Primary Health Care, School of Population Health</td>
<td>University of Auckland</td>
</tr>
<tr>
<td>Janet Fanslow</td>
<td>Senior Lecturer, Social and Community Health, School of Population Health</td>
<td>University of Auckland</td>
</tr>
<tr>
<td>Sally Merry</td>
<td>Associate Professor, Psychological Medicine, School of Medicine</td>
<td>University of Auckland</td>
</tr>
<tr>
<td>Martin Orr</td>
<td>Honorary Clinical Senior Lecturer, Epidemiology and Biostatistics, School of Population Health</td>
<td>University of Auckland</td>
</tr>
<tr>
<td>Tony Dowell</td>
<td>Professor, Primary Health Care and General Practice</td>
<td>University of Otago</td>
</tr>
<tr>
<td>Simon Hatcher</td>
<td>Professor of Psychiatry</td>
<td>University of Ottawa</td>
</tr>
<tr>
<td>Anil Thapliyal</td>
<td>Former head of Lifeline and NDI Programme foundation member</td>
<td>CEO HealthTRx</td>
</tr>
</tbody>
</table>
Appendix 3: Summary of Phoenix Research Ltd’s 2005 Review of International Anti-Depression Campaigns to inform NDI development

The tables below summarise the findings of Phoenix Research Ltd in reviewing international anti-depression campaigns, prior to the launch of the NDI.

<table>
<thead>
<tr>
<th>Name of campaign</th>
<th>Where</th>
<th>When</th>
<th>Overall aim</th>
<th>Main strategies for achieving change</th>
<th>Key evaluation findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defeat Depression Campaign</td>
<td>UK</td>
<td>1992-1996</td>
<td>Reduce stigma associated with depression, education of the public about the</td>
<td>Information based media campaign directed toward the general public; GP education plus material;</td>
<td>Attitudes of the general public to depression and its treatment changed positively. Most of the changes involved shifts in view of between 5-10%.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>disorder and its treatment, and encouragement of earlier treatment seeking. (Paykel et al, 1998). In addition, it aimed to assist</td>
<td>Defeat Depression Action Week; Scientific conferences</td>
<td>Attitudes to GPs as primary treaters of depression were mixed. Among treatments, the public regarded counselling very positively, but viewed antidepressants with some doubt (Paykel et al, 1998).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>healthcare professionals in the recognition and treatment of depressive illness (Baldwin et al, 1996)</td>
<td></td>
<td>Two thirds of GPs were aware of the campaign and 40% had definitely or possibly made changes in practice as a result of it. Impact of material was highest for a consensus statement on the recognition and management of depression in general practice and for guidelines derived from it. (Rix et al, 1999). Rix (1999) notes that other initiatives influencing GP attitudes and their practice were occurring at the same time.</td>
</tr>
<tr>
<td>Changing Minds Campaign</td>
<td>UK</td>
<td>1998 – 2003</td>
<td>Reduce stigma and discrimination;</td>
<td>Development of tool kit of materials for different</td>
<td>Regarding GPs, while a national campaign of this kind can have a useful impact, it needs to be supplemented by local and practice-based teaching activities. (Rix et al, 1999). Hart (personal communication) also notes the importance of primary care work on depression being owned at a local level with local commitment, for example via a network of family doctors. In addition, primary care nurses are an important audience. (Deborah Hart, personal communication).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A baseline survey showed that stigmatising opinions about people with psychiatric disorders.</td>
</tr>
</tbody>
</table>
Appendix 3: Summary of Phoenix Research Ltd’s 2005 Review of International Anti-Depression Campaigns to inform NDI development

The tables below summarise the findings of Phoenix Research Ltd in reviewing international anti-depression campaigns, prior to the launch of the NDI.

<table>
<thead>
<tr>
<th>Name of campaign</th>
<th>Where</th>
<th>When</th>
<th>Overall aim</th>
<th>Main strategies for achieving change</th>
<th>Key evaluation findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression, Awareness, Recognition and Treatment Campaign (DART)</td>
<td>US</td>
<td>1988, ongoing</td>
<td>Increase acceptance and knowledge of depression symptoms and treatment</td>
<td>A public campaign (information and education) to educate both the public and professionals (primary care physicians and mental health specialists) that depressive disorders are common, serious and treatable. Effort was put into profession education in anticipation of increased demand for services. (Regier et al, 1988).</td>
<td>No overall evaluation to date. An evaluation of one training programme targeting professionals who provide services to rural residents was conducted in 1996. Following the training programme, participants (physicians, psychologists, social workers and nurses) showed significant increases in level of knowledge of depression and a high degree of satisfaction with most elements of the programme. A six month follow up indicated a continued positive evaluation of the programme (O’Hara et al, 1996).</td>
</tr>
<tr>
<td>National Depression Screening Day</td>
<td>US</td>
<td>1991, ongoing</td>
<td>Raise profile of depression on a national level; Educate the public about its symptoms and effective treatments; Offer individuals the opportunity to be screened for depression; Connect</td>
<td>National Depression Screening Day is held each October during Mental Illness Awareness Week. Public education through written and electronic media</td>
<td>Starting with only 90 sites in its first year, the Screening Day program has grown to reach more than 85,000 people at 3,000 sites nationwide. To respond to the year-round need, the program also maintains a toll-free, year-round phone line for free, anonymous screening locations in local areas. <a href="http://www.nmha.org/ccd/support/screening.cfm">http://www.nmha.org/ccd/support/screening.cfm</a>. Impact of the initiative on attitudes changes have not been evaluated.</td>
</tr>
</tbody>
</table>
Appendix 3: Summary of Phoenix Research Ltd’s 2005 Review of International Anti-Depression Campaigns to inform NDI development

The tables below summarise the findings of Phoenix Research Ltd in reviewing international anti-depression campaigns, prior to the launch of the NDI.

<table>
<thead>
<tr>
<th>Name of campaign</th>
<th>Where</th>
<th>When</th>
<th>Overall aim</th>
<th>Main strategies for achieving change</th>
<th>Key evaluation findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuremberg Alliance Against Depression</td>
<td>Germany</td>
<td>2001-2002</td>
<td>Establish and assess the effectiveness of a 4-level intervention programme for improving the care of depressed patients; Reduce the number of suicides by improving awareness and treatment of depression; Implement a community based intervention program</td>
<td>Training of family doctors and support through different materials, Public relations campaign informing about depression; Co-operation with community facilitators (teachers, priests, local media, etc); Support for self-help activities as well as for high risk groups. (Althaus, 2005).</td>
<td>Reduction of approximately 20% of suicide acts (suicides + suicide attempts). This effect was confirmed statistically in comparison to the baseline and a control region (Wuerzburg popn. 270,000) for the total of suicide acts and for suicide attempts (Althaus, 2005). On the basis of the results, the 4 level approach has been adapted to other regions in Germany and Europe, and the European Alliance Against Depression was created in 2004</td>
</tr>
<tr>
<td>European Alliance Against Depression</td>
<td>Europe</td>
<td>2004-</td>
<td>Improve the care of depressed patients</td>
<td>The 4-level intervention programme developed in the Nuremberg Alliance (as above)</td>
<td>At this stage regional networks have been set up, common intervention and evaluation instruments have been agreed, some training has been conducted, and some partners have collected baseline data. (Tim Pfeiffer-Gerschel, personal communication). (<a href="http://www.eaad.net">www.eaad.net</a>)</td>
</tr>
<tr>
<td>beyondblue</td>
<td>Australia</td>
<td>2000-2010</td>
<td>To increase the capacity of the Australian community to prevent and</td>
<td>Increase community awareness of depression and reduce stigma via mass media initiatives,</td>
<td>In terms of increasing awareness and depression literacy, data from the depression monitor survey conducted by beyondblue, and the Australian National Mental Health Literacy</td>
</tr>
</tbody>
</table>
Appendix 3: Summary of Phoenix Research Ltd’s 2005 Review of International Anti-Depression Campaigns to inform NDI development

The tables below summarise the findings of Phoenix Research Ltd in reviewing international anti-depression campaigns, prior to the launch of the NDI.

<table>
<thead>
<tr>
<th>Name of campaign</th>
<th>Where</th>
<th>When</th>
<th>Overall aim</th>
<th>Main strategies for achieving change</th>
<th>Key evaluation findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>respond effectively to depression. (Cost of campaign: $35 million - $17.5 million from the Commonwealth Government and $17.5 million from the Victorian Government).</td>
<td>community activities and education campaigns; Provide people living with depression and their carers with information; Develop depression prevention and early intervention programs; Improve training and support for GPs and other healthcare professionals; Initiate and support depression-related research (Pirkis, 2004).</td>
<td>Surveys suggest that beyondblue has enhanced the mental health literacy of the Australian community. More specifically, there were increases in public awareness of prevalence of depression (54% to 61% between 2002 and 2004), and knowledge of its symptomatology (50% to 70% between 2001 and 2002), causes and treatment (Pikis, 2004). Other evaluation findings suggest a range of programme initiatives (website, celebrity spokespeople, etc) have raised the level of depression literacy, and the profile of beyondblue and their work on depression.</td>
</tr>
</tbody>
</table>
Appendix 4: Bibliography/Literature Consulted


Appendix 4: Bibliography/Literature Consulted


