Template 1: Budget Initiative template

Overview and context

Key Question/area	Comment/answer
Portfolio of lead Minister	Hon Dr David Clark
Portfolio(s) of other Ministers involved (if this is a joint initiative)	N/A
Votes impacted	Vote Health
Initiative title	**Expanding access and choice of primary and community mental health and addiction responses**
Initiative description	This funding will provide for national expansion of access and choice of primary and community mental health and addiction responses for New Zealanders. The package includes expansion and enhancement of responses for those with mild to moderate needs, including s 9(2)(f)(iv) suicide prevention, digital service options, primary and community mental health and addiction responses, School Based Health Services, s 9(2)(f)(iv)
Type of initiative	**Priority aligning**
If this initiative relates to a priority, please outline the specific priority/ies it contributes to	This package aligns with the Budget 2019 priority to support mental wellbeing for all New Zealanders, with a special focus on under 24s. The package will also contribute to the following priorities: • Lifting Māori and Pacific incomes, skills and opportunities • Reducing child poverty and improving child wellbeing, including addressing family violence • Supporting a thriving nation in the digital age through innovation, social and economic opportunities.
Does this initiative relate to a commitment in the Coalition Agreement, Confidence and Supply Agreement, or the Speech from the Throne?	**Yes** • Speech from the Throne commitment to increase resources for frontline workers to make it easier for people with mental health problems to get the help they need • Confidence and Supply Agreement commitments to provide timely access for everyone to high-quality mental health services including free counselling for under 25 year olds • Coalition Agreement commitment to provide Teen Health Checks for all Year 9 students This package also contributes to 'Our plan for a modern New Zealand we can all be proud of', the Coalition Government's long-term plan.
Agency contact	Name: Maree Roberts, Acting Deputy Director-General, Mental Health and Addiction Agency: Ministry of Health Email address: maree_roberts@moh.govt.nz Phone number: s 9(2)(a)
Responsible Vote Analyst	s 9(2)(a)

Funding

Funding Sought ($m)	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29 & outyrs	TOTAL
Operating	s 9(2) (f)(i…)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Funding Sought ($m)	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29 & outyrs	TOTAL
Capital	-	-	-	-	-	-	-	-	-	-	-

1. Strategic Context and Executive Summary

1.1 STRATEGIC CONTEXT

***He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* calls for a transformation of New Zealand's approach to mental health and addiction and sets out a vision of mental health and wellbeing for all.**

The Inquiry into Mental Health and Addiction presents a once-in-a-generation opportunity for change, with the potential for New Zealand to be an international leader in its commitment to supporting mental wellbeing.

We know the direction we are heading – we must build a system that provides pathways to wellbeing that deliver a continuum of care across mental health and addiction issues; provides choice and supports recovery; and delivers equitable outcomes for specific populations.

And we know what transformation requires – Government, sectors and society must take shared responsibility and commit to significant and sustained change. Transformation must be done in genuine partnership with Māori, people with lived experience and other population groups to design the ideal future state. Getting to this future state must be supported by additional investment over multiple years, combined with fundamental changes to system settings (including legislation, accountability arrangements, commissioning and funding mechanisms, etc.), to break the barriers to a transformed approach.

Budget 2019 presents an opportunity to build momentum and demonstrate commitment to supporting mental wellbeing.

Work to transform our approach is already underway. The Government has pushed ahead with a number of mental health and addiction initiatives while the Inquiry conducted its work, including:

- the Mana Ake programme, putting mental health support in primary and intermediate schools in Christchurch and Kaikoura
- extending School Based Health Services to locate nurses in all public decile 4 secondary schools to promote wellbeing and intervene early
- funding the construction of new alcohol and drug detoxification beds in Auckland
- launching the Integrated Therapies pilot to provide better access to evidence-based interventions for 18-25 year olds experiencing mild to moderate mental distress
- providing a major funding boost of $200 million (over four years) for mental health services provided by DHBs through Budget 2018
- setting aside $8.6 million for an Acute Drug Harm Response Discretionary Fund over four years, with up to a further $8 million (over two years, $4.6 in 2018/19 and $3.4-million in 2019/20) used from the proceeds of crime to establish a Drug Early Warning System, develop and deliver 'Addiction 101' training in communities experiencing harm from synthetic drugs and fund other Ministry of Health drug and alcohol initiatives.

We can build on these actions and this momentum in our response to the Inquiry into Mental Health and Addiction, supported by additional investment through Budget 2019. The Government has announced mental wellbeing as a priority for this Budget, and there are high expectations for the Government to take action in response to the Inquiry.

Budget 2019 investment presents further opportunity to demonstrate this Government's long-term commitment to improving New Zealand's approach to mental health and wellbeing, and will build momentum as the first stage in a phased whole-of-government response to the Inquiry and cross-sector multi-year investment plan. This initial funding injection will accelerate transformation that will be continued through the Government's broader Inquiry response, spanning fundamental system setting changes, new ways of working and multiple years of additional investment.

Whole-of-government and society commitment to improve mental wellbeing and related social determinants is needed.

This initiative forms part of a cross-sector Budget 2019 package to support mental wellbeing that begins to address New Zealanders' complex needs and to support populations with specific mental health and social needs. Initiatives span expansion and enhancement of health services, including facilitating better pathways to social supports; improving outcomes for people with mental health needs through enhanced welfare support; working with victims of serious crime to respond to their mental health needs; providing tailored interventions to people interacting with the justice system; and tackling homelessness.

The cross-sector investment proposed includes a complementary package of initiatives that aims to kick-start transformation and build the foundations for a transformed approach; to relieve significant pressures being borne by our sector partners; to build

confidence of the sector and public that we're committed to change and to demonstrate that we've heard them through the Inquiry; and to deliver for and improve outcomes for groups that continue to experience poor mental health and addiction outcomes, particularly Māori. The package complements and enhances Government efforts across other priorities, including improving child wellbeing, addressing family violence, lifting Māori and Pacific opportunities, improving housing and reforming the criminal justice system.

Collectively the package proposes investment across the continuum of care and life course, and begins to embed new ways of working. The package also reflects a proportionate universalism approach, with a mix of universal responses for all New Zealanders supplemented with additional, targeted support for population groups including Māori, young people and prisoners who have specific mental health and addiction needs.

Vote Health investment will contribute to a transformed approach to mental wellbeing, including through a comprehensive and integrated package that enables change.

Realising our aspirations of mental wellbeing for all will require bold funding commitments. Current systems provide a foundation from which to build a transformed approach, but services are under pressure and key components of the system are missing. We must build a system that enables equitable access to effective responses for all; provides pathways to wellbeing that deliver a continuum of care; provides choice and supports recovery; and delivers equitable outcomes for specific populations.

He Ara Oranga notes a need to improve support for people with mild to moderate mental health and addiction needs, without losing focus on responding to those with more severe mental health and addiction needs. Vote Health investment proposed through Budget 2019 supports this balance through:

- a package of initiatives to expand access and choice of primary and community mental health and addiction responses for New Zealanders with mild to moderate mental health and addiction needs
- investment to maintain acute and forensic mental health and addiction services for those with more severe needs
- the establishment of a potential Mental Health Commission to strengthen leadership of a transformed approach.

Underpinning the package of initiatives proposed in this bid are a number of common and interlinked components. Workforce will be a particular challenge, and we envisage significant commonality in the models of care and training requirements across these different settings where elements of training for school nurses, primary care practice workers, midwives and youth clinicians may be shared. There is the potential to build national competencies and training recognition for peer workers across the different service areas, which may aid their career progression and sustainable employment opportunities in smaller population centres. The investment in e-therapies and telehealth for clinical services, community initiatives and suicide prevention are likely to be enabled by common "back-end" infrastructure where economies of scale will reduce cost. Additionally, much of this common infrastructure could ease and reduce the cost of developing future cross-agency or non-health initiatives targeting people with mild to moderate mental health issues in a number of settings.

1.2 EXECUTIVE SUMMARY

A. Short summary of the proposed initiative and expected outcomes.

The transformation called for in *He Ara Oranga* is substantial and presents an exciting opportunity to reorient Government's and society's approach to mental health and addiction to one genuinely grounded in wellbeing. Significant shifts in ways of working and new system builds are required to give effect to the vision of mental wellbeing for all.

This package begins to build a new system response for New Zealanders, focusing on supporting those with mild to moderate mental health and addiction needs for whom there are few options for support. The package invests in national coverage of a mix of mental health and addiction responses, spanning promotion, prevention and early intervention. This includes:

- s 9(2)(f)(iv) [redacted]
- National suicide prevention package
- Package of e-therapy initiatives and tailored telehealth supports
- Enhanced primary and community-based mental health and addiction responses
- [redacted]
- School Based Health Services
- [redacted]

- s 9(2)(f)(iv) [redacted]

The package aims to ensure support is accessible to all who need it, whatever their needs are, wherever they are and in settings they can choose. It represents a mix of enhancement and national expansion of existing services in a variety of settings; investment in new ways of working, including significant co-design with Māori, people with lived experience, communities, tāngata whaiora and whānau; and investment in key enablers for transformation, including workforce development and the expansion of peer, cultural, support and clinical workforces.

This package begins to respond to significant levels of unmet need and persistent inequitable outcomes. The package applies a proportionate universalism approach, co-designing and delivering targeted support for Māori and other groups who continue to experience poor outcomes and have with specific needs.

Collectively, the investment proposed will contribute to four of the Budget 2019 priorities:

- Supporting mental wellbeing for all New Zealanders, with a special focus on under 24s
- Reducing child poverty and improving child wellbeing, including addressing family violence
- Lifting Māori and Pacific income, skills and opportunities
- Supporting a thriving nation in the digital age through innovation, social and economic opportunities.

This package aligns with a key theme in *He Ara Oranga* to expand access and choice of mental health and addiction responses. Investment in this new system response demonstrates Governments long-term commitment to the transformation of New Zealand's approach to supporting mental wellbeing and will build momentum that will be carried through the broader response to the Inquiry into Mental Health and Addiction.

Note: this template attaches a spreadsheet capturing detailed costs, assumptions and scaling options, as well as nine appendices with additional detail on each component of the package.

2. The Investment Proposal

2.1 Description of the initiative and problem definition

What is this initiative seeking funding for?

This package invests in national coverage of a broad range of primary and community mental health and addiction responses. The package has been designed to support equitable access for all and to broaden available options across the needs spectrum and appropriate for all stages of the life course wherever people are.

He Ara Oranga maintains that we do not have a complete continuum of care with components of the system missing for New Zealanders with mild to moderate mental health and addiction needs who do not meet the threshold for specialist services. *He Ara Oranga* describes a system with people at the centre; responsive to different ages, backgrounds and perspectives; and greater community-based support, using a mix of peer, cultural, support and clinical workforces.

The transformation called for in *He Ara Oranga* needs exciting and significant shifts in ways of working. This will not be achieved taking a piecemeal approach – a coordinated and co-designed new system build is required.

This investment sets the foundations for change, tests news ways to manage change, and begins to build a new system response by expanding and enhancing components across the early continuum of care at a national level. The proposed package focuses on:

- Universal wellbeing promotion and prevention activities to support all New Zealanders to build resilience and stay well
- Early intervention to help New Zealanders to achieve mental health as a state of wellbeing, by enhancing primary and community responses with wide geographic coverage and capacity for uptake by those with mild to moderate mental health and addiction needs or distress
- Prevention of mental illness through reducing risk factors, preventing or delaying recurrences, and decreasing the impact of illness through early intervention, increased access and choice, and increased participation and social inclusion.

In line with the vision of a system responsive to different ages, backgrounds and perspectives, the package applies a proportionate universalism approach, under which those in greater need are provided with greater investment of resources and support. The package includes a mix of universal approaches with additional investment in tailored responses for population groups experiencing poorer outcomes or with specific mental health needs. s 9(2)(f)(iv) [redacted]

The components of the package represent a mix of enhancement and national expansion of existing services and responses to facilitate consistent, universal access; investment in new ways of working; alongside with investment in enablers such as evaluation, information system solutions, and workforce development and expansion of a mix of peer, cultural, support and clinical workforces. s 9(2)(f)(iv) [redacted]

This package will provide multiple entry points to access mental health and addiction support in a range of settings according to people's preferences, with clear and streamlined pathways between service options, and will collectively contribute to four of the Budget 2019 priorities:

- Supporting mental wellbeing for all New Zealanders, with a special focus on under 24s
- Reducing child poverty and improving child wellbeing, including addressing family violence
- Lifting Māori and Pacific income, skills and opportunities

- Supporting a thriving nation in the digital age through innovation, social and economic opportunities.

The table below outlines the components proposed as part of this primary and community package. Further detail on each component is appended to this proposal and attached in a detailed costing spreadsheet.

Components of the package	Description	Target population / aim
s 9(2)(f)(iv) [redacted]	[redacted]	[redacted]
Suicide prevention	Mix of national and local services across the continuum of suicide prevention	• All New Zealanders (particularly for the more than 500 New Zealanders that die by suicide each year; 150,000 that think about attempting suicide; 50,000 that will make a plan to take their own life; and 20,000 that will attempt suicide) • Wellbeing promotion, suicide prevention, targeted intervention and postvention support for people bereaved by suicide
Digital and telehealth service options	Package of e-therapy initiatives and tailored telehealth supports	• New Zealanders experiencing distress, to prevent escalation to a diagnosable disorder • Estimated 17% of New Zealanders with mild to moderate mental health and/or addiction conditions, to prevent escalation requiring specialist supports and to improve self-management • Increase access to support, particularly rural communities
Primary mental health and addiction responses	National coverage of enhanced responses involving mental health and alcohol and drug professionals and support workers working alongside general practice teams	• Estimated 17% of New Zealanders with mild to moderate mental health and/or addiction conditions, to prevent escalation requiring specialist supports and to improve self-management
s 9(2)(f)(iv) [redacted]	[redacted]	[redacted]

	s 9(2)(f)(iv) [redacted]	[redacted]
[redacted]	[redacted]	[redacted]
School-based services	Expansion of School Based Health Services [redacted]	• All young people in state and state-integrated secondary schools to promote health and wellbeing, identify issues early and manage both physical and mental health needs
s 9(2)(f)(iv) [redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Why is it required?

Significant levels of unmet need and persistent inequitable outcomes

As set out in *He Ara Oranga*, we do not have a continuum of care. Over 50–80% of New Zealanders will experience mental distress or addiction challenges or both in their lifetime. The current system is skewed towards the 3% of people with the most serious mental health and addiction needs. While 3% of the New Zealand population may have needs appropriate for specialist services, an additional 17% are expected to have a diagnosable disorder in any 12 months, and the remaining 80% are exposed to and must cope with general life stressors.

These are not static groups, as people move up and down the needs spectrum.

An estimated 50% of New Zealanders have unmet mental health and addiction needs, with greater proportions of those with mild and moderate needs. The last national mental health survey Te Rau Hinengaro (2006) found that of the people who met the threshold for a serious mental health condition, only 58% had a mental health visit within the last 12 months. Further, only 36.5% of people meeting the threshold for a moderate mental health condition, and 18.5% of people meeting the threshold for mild mental health conditions, had a mental health visit within the last 12 months. While this survey data is now over 12 years old, it is reasonably consistent with what we understand of the current unmet need, if not under-representative.

There are significant disparities in service access and outcomes for some population groups. Māori experience significantly higher rates of mental illness, higher rates of suicide and greater prevalence of addictions, despite accessing services at a higher rate than non-Māori. In primary

care, there is evidence that Māori present more often with mental health problems but their problems are underdiagnosed. In secondary care, Māori are more likely to be admitted to hospital, to be readmitted after discharge, to be secluded during admission, and to be compulsorily treated. Other groups experiencing inequitable access and outcomes include young people, Pacific Peoples, rural communities, Rainbow communities, refugees and migrants, disabled people and prisoners.

Few support options for many New Zealanders

The current system does not respond adequately to people in serious distress, and there are few options for many people with common, disabling problems such as stress, depression, anxiety, trauma and substance use. By failing to provide support early to these groups, we're losing opportunities to improve their outcomes.

While we must continue to support those most in need, we need to expand access and options for New Zealanders with mild to moderate mental health and addiction needs and those experiencing distress. We also must support the rest of the population to stay well, to avoid moving into the 20% of New Zealanders expected to have a diagnosable disorder.

A key theme in *He Ara Oranga* is expanding access and choice of mental health and addiction responses, by broadening the types of mental health and addiction services available, particularly for people with mild to moderate mental health needs. This calls for a new system build early in the continuum of care.

Accelerating transformation through a comprehensive and integrated package that enables change

The system build needed to give effect to the long-term vision outlined in *He Ara Oranga* cannot be achieved by marginal changes to what we already have. Bold investment and commitment to fundamental change are required.

This packaged approach to expanding access and choice of supports earlier in the continuum of care will build momentum and accelerate transformation that will be carried through the broader response to the Inquiry into Mental Health and Addiction. The packaged approach has additional benefits, as there are a number of common and interlinked components.

- National coverage of a mix of service options is needed to ensure support is accessible to all who need it, whatever their needs are, wherever they are and in settings they can choose.
- A proportionate universalism approach is required to respond to the needs of population groups for whom mainstream services do not work well, who either cannot or choose not to engage with traditional services, and with specific needs that require tailored support.
- This system build must be co-designed with people at the centre – working alongside Māori, people with lived experience, communities, tāngata whaiora and whānau to design our ideal future state.
- Workforce will be a particular challenge, and this package allows for efficiencies in training, for examples where training for school nurses, primary care practice workers, s 9(2)(f) and youth clinicians may be shared. There is also the potential to build national competencies and training recognition for peer workers.
- Additional efficiencies are possible through packaged investment in e-therapies and telehealth for clinical services, community initiatives and suicide prevention, which are likely to be enabled by common "back-end" infrastructure where economies of scale will reduce cost.
- Much of this common infrastructure could ease and reduce the cost of developing future cross-agency or non-health initiatives targeting people with mild to moderate mental health issues in a number of settings.

	• Building up the missing components of the early continuum of health care lays the foundation for the health sector to better support New Zealanders engaging with other social services as part of a whole-of-government transformed approach to mental wellbeing. • (2)(f)(iv) [redacted]
2.2 Options analysis and fit with existing activity	
What other options were considered in addressing the problem or opportunity?	The Inquiry into Mental Health and Addiction identified a shared, widespread and strong desire from people to change our way of thinking about, and our collective approach to dealing with, mental health and addiction. *He Ara Oranga* calls for a new system that builds on the solid foundations of publicly funded services and support, to include mental health promotion and resilience-building, investment and development in primary and community care, and expanded access for people in distress to get the care and support they need as part of a continuum of care. Also, a new system will place people at the centre and be responsive to their different ages, backgrounds and perspectives, including differential outcomes. A focus on both Māori wellbeing and Pacific Peoples' wellbeing highlights the importance of this. A shared responsibility for improving mental health and wellbeing in our society is one key principle that underpins the Inquiry recommendations. This includes solutions across and outside the health system and government agencies. As does discussion of the poor outcomes for refugees and migrants, rainbow communities, disabled people, and for people who are detained. These emphases provided the basis of different options to deliver this package to expand access and options for support for New Zealanders: • *Service improvement approach to build on existing service delivery* allows accelerated action. However, the result will be more and better of what we have without expanding services across the continuum. • *New service design to fill gaps in the continuum of care* will directly address unmet need, especially for those in serious distress. However, it is likely that individual initiatives will be restricted by issues of inconsistency, slow development, scaling and missing foundations highlighted by the Inquiry team. • *Population focus to target unmet need and inequity of outcome* promotes putting people at the centre and addressing their needs as well as known inequity of outcome. This is transformative thinking. However, accelerated expansion is likely to emphasise doing more of the same for specific populations and so duplicate investment. • An *integrated package approach* is the recommended option as it provides opportunity to use the positives of each approach to manage the negatives. It is important to note that one integrated package alone will not deliver the new system build. But, this foundational package does test and help develop a change management approach.
What other similar initiatives or services are currently being delivered?	*He Ara Oranga* calls for a new system built on the foundations already in place. A number of pilots and new services exist across the continuum of care to promote wellbeing and respond to people in distress. These evidence-based initiatives provide foundations for further development, and the proposed package will complement and enhance this service landscape. **Wellbeing and resilience promotion** The Health Promotion Agency is funded to deliver: • The *National Depression Initiative* (which includes The Journal and the Lowdown) providing information and support for people experiencing mental distress

- The *Like Minds, Like Mine* campaign which uses mental health literacy to underpin key messages to address stigma and discrimination associated with mental illness.

The Incredible Years (IY) an evidence-based, group-based programme for parents and/or teachers delivered in 14 weekly sessions that provide parents and teachers the tools they need to manage problem behaviours in children.

The Positive Parenting Programme (Triple P) which is designed to provide parents with simple and practical strategies to help them build strong, healthy relationships, confidently manage their children's behaviour and prevent problems developing. A culturally adapted version Te Whānau Pou Toru, also exists.

The Travellers programme which supports students at school by helping them to build resilience and enhance connections.

Tūturu, a school based programme currently offered in 11 secondary schools across New Zealand which aims to introduce a healthy and preventative school environment, education about drugs and alcohol through integration with the school curriculum, and support of the wider school to work alongside young people experiencing drug and alcohol problems.

Tu Kotahi, a student-led early intervention programme, which will be piloted in four Auckland schools in 2019. This programme connects young people to the support they need using a group of trained peer-supporters, to support overall resilience and wellbeing.

MH101, a programme designed to increase the confidence of people to recognise, relate and respond to people experiencing mental illness or distress. This one-day workshop has been delivered since 2009, and has had over 30,000 attendees amongst frontline government, social and health agencies. Ongoing evaluation has consistently evidenced significant changes in knowledge, attitudes and behaviours of those who attend the workshop.

All Right? campaign

All Right was established in 2013 as a response to the impacts of the greater Christchurch earthquakes on the wellbeing of Cantabrians. The campaign uses established practice models and theories for health promotion and has been delivered in several phases. Research on All Right has continually demonstrated that the campaign is effective in helping people in greater Christchurch to become more aware of their mental health, and the actions they can take to improve it.

The All Right campaign can be replicated in other communities in New Zealand. It uses cultural models of health promotion to guide projects. These include Te Whare Tapa Whā, Te Pae Mahutonga, TUHA-NZ, and Fonofale. Targeted campaigns have been developed, in particular, to reach Māori and Pacific communities. All Right supports the wellbeing of Māori, Pacific and Culturally and Linguistically Diverse (CALD) communities with culturally appropriate messaging and approaches, and by using appropriate models and frameworks.

Suicide prevention and postvention

LifeKeepers, a suicide prevention training which began in 2017 and provides training for those who work alongside vulnerable populations. The programme provides both face-to-face training, and online training.

Kia Piki te Ora a community development programme aimed at suicide prevention in Māori communities across eight DHB regions.

Waka Hourua, a national Māori and Pacific suicide prevention service that supports and coordinators suicide prevention in Māori and Pacific communities.

Suicide media response service, this service monitors media reporting on suicide and advises media on responsible reporting practice and is delivered by the Mental Health Foundation.

Family and Whānau information service, which provides practical information on suicide prevention for family and whānau.

Initial Suicide Postvention Response service, currently delivered by Victim Support, provides emotional support, personal advocacy and information to people bereaved by suicide

Community suicide postvention response service delivered by Clinical Advisory Services Aotearoa (CASA), provides support (consultation and clinical advice) to communities where there is a concern about suicide contagion or a suicide cluster to support local responses to reduce suicide risk and address community concerns.

Coronial Suspected Suicide Data Sharing Service, which provides a means for DHBs to access up-to-date information on suspected self-inflicted deaths in their area via a secure channel to help support local postvention.

Suicide bereavement peer support group service, which provides advice and guidance for people setting up and running peer support groups for people bereaved by suicide.

Waves Facilitator Training, this service trains facilitators of Waves, an 8-week specialist-facilitated New Zealand-developed grief education programme for adults bereaved by suicide.

Community-based support

Nationally supported community-based initiatives that reach people with mental health support needs include:

- **Youth One Stop Shops** (YOSS) provide primary health care (including drop-in services) plus a range of other services for young people. YOSS use a youth development and holistic approach to addressing health needs.
- **Healthy Families NZ** is a large-scale prevention initiative that brings community leadership together in a united effort for better health through local solutions and local leadership.

Telehealth and e-therapy

The Ministry funds computerised CBT for adults and young people with depression and/or anxiety through e-therapy tools 'Beating the Blues' for adults, and 'SPARX' for young people. A range of telehealth services offering advice, tools, information and support are also available to New Zealanders, including the Alcohol Drug Helpline, Living Sober, 1737 Need to talk?, Depression Helpline, The Journal, The Lowdown, and Gambling Helpline.

Primary Mental Health (PMH) services

Young people can be referred to specialist mental health services by their family doctor, or if they are enrolled in school, their school's pastoral team, nurse, or counsellor.

All DHBs now fund limited access to primary mental health services for all young people aged 12 to 19, including access to up to six sessions of free counselling services.

Fit for the Future initiatives

Existing pilots have evaluated three different approaches which have trialled the integration of psychological therapies in primary and community settings. These have shown tangible benefits for clients seeking help for mild to moderate mental health needs. The trials have explored variations of service delivery, including health improvement practitioners (psychological therapists), health coaches (general lifestyle coaching support), community health sector NGO services (social and health supports). One was specifically grounded in a mātauranga Māori cultural approach.

Free GP services for under-14s

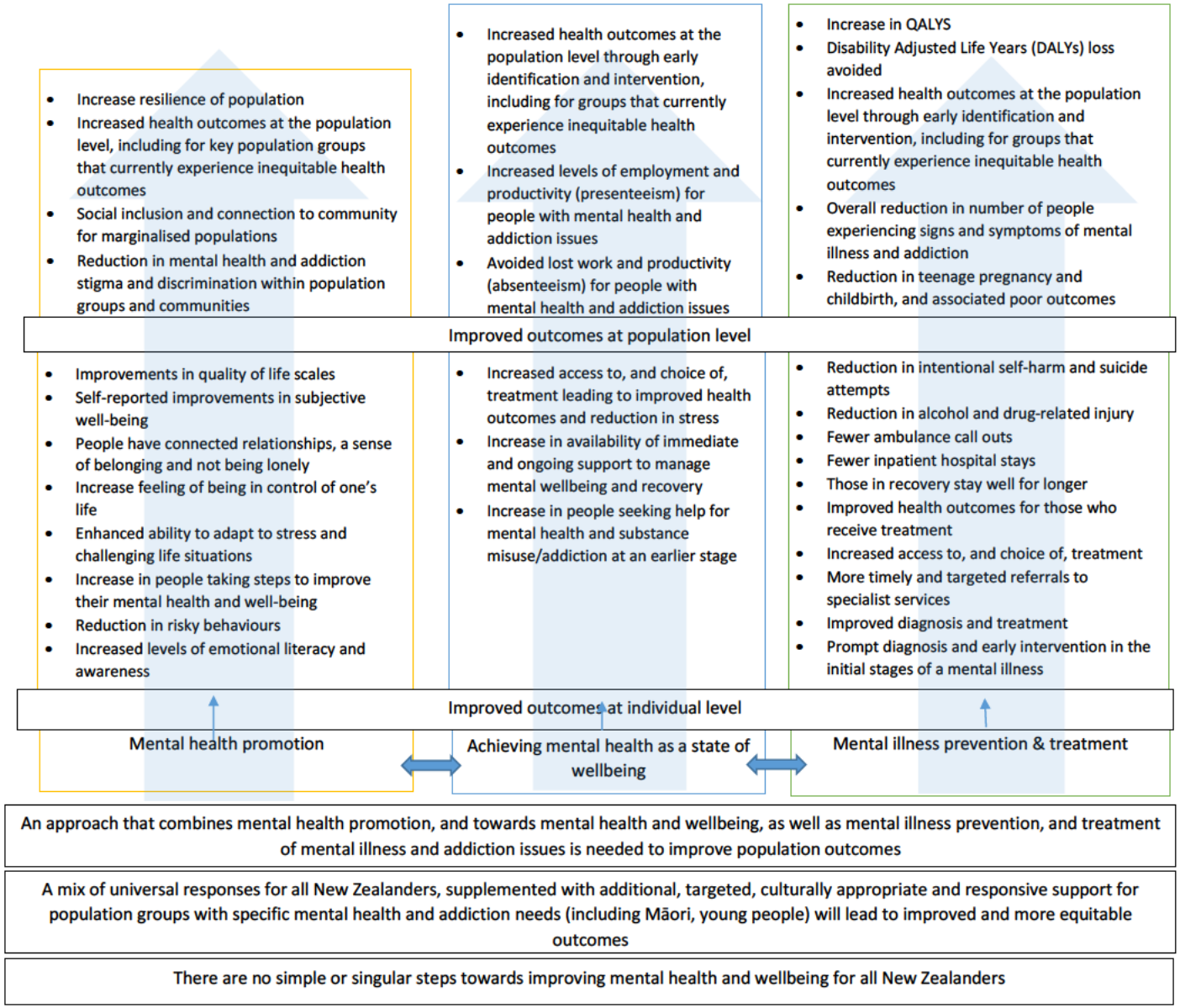
Free GP services are available for children up to the age of 14, reducing one barrier to accessing primary care. These providers can refer to other health services if necessary, and could potentially

	deliver a standardised health check. This service only benefits children up to the age of 14, and relies on the child (or their caregiver) accessing the primary care provider. **Discounted GP services for dependents of Community Service Card holders aged 14-17** From 1 December 2018, Community Service Card holders and their dependents aged 14 to 17 will be eligible for low cost GP visits. This will improve access to primary care for some young people, but the majority will not be covered, especially at decile 5-10 schools. In addition, the low cost visits will only be accessible at the family's usual medical practice. Some young people may be unwilling or unable to access the practice due to transport difficulties, inability to pay, or privacy concerns. **Integrated Psychological Therapies pilot** In Budget 2018, $10.5 million was provided for a three-year pilot of free counselling and evidence-based therapy service for young adults aged 18 to 25, to be trialled in one location, and modelled on England's Improving Access to Psychological Therapies. The pilot seeks to address the needs of the 18-25 year old population with mild to moderate mental health problems and who are not accessing existing services, and further develop this for a New Zealand context. Similar to the enhanced primary mental health and AOD responses initiative, this pilot will contribute to evidence of what works in New Zealand to increase access to primary mental health services and address mild to moderate mental health needs. **School Based Health Services** Currently, SBHS are provided at a ratio of 1 nurse FTE to every 750 students. This is managed through DHBs, which has led to a variety of service models to deliver SBHS. These include delivery via PHOs, public health nurses, Youth One Stop Shops (YOSS), and nurses employed directly by the school or DHB. Current SBHS are only available in decile 1-4 schools, serving 77,733 students. This leaves 187,770 students at decile 5-10 state and state integrated schools without access to SBHS. **Mana Ake – Stronger for Tomorrow** Mana Ake is a three year programme, which at its end will have a mental health support worker available to all primary and intermediate age school children in Canterbury and Kaikōura.
What other, non-spending arrangements in pursuit of the same objective are also in place, or have been proposed?	Both ongoing work on the response to the Inquiry into Mental Health and Addiction and the Health and Disability System Review are considering changes to system settings (e.g. commissioning and funding models, accountability and governance arrangements, information sharing practices, etc.) that will support a transformed approach to mental health and wellbeing. This package has been designed with the flexibility to accommodate potential changes, by investing in enablers in line with the expected direction of future reforms and supporting local and community innovation that can inform and be incorporated into future reforms.
Strategic alignment and Government's priorities/direction	**Inquiry into Mental Health and Addiction** *He Ara Oranga* aspires to a flourishing New Zealand where a good level of mental wellbeing is attainable for everyone and people have the resilience, tools and support they need to regain wellbeing. The Inquiry recommends its aspiration be achieved in part by expanding access and choice; transforming primary health care; strengthening the NGO sector; enhancing wellbeing, promotion and prevention; and placing people at the centre. This accelerated transformation package contributes to each of these actions as the aspiration as the outcome.

	Mental health and addiction Mental health and addiction is a key priority on the Ministry's work programme (aligned with the Ministry's Statement of Strategic Intentions 2017 – 2021), and an explicit priority for the Government. This initiative is strongly aligned to the 'supporting mental wellbeing for all New Zealanders, with a special focus on under 24s' Budget 2019 priority. It will enable increased access to effective mental health and AOD services for both youth and adults, providing early intervention and a range of services that address all levels of mental health and AOD need, as well as social needs that impact on mental health (such as housing, employment, and income). **Child Wellbeing** With regards to the Government's Budget 2019 priority area of 'reducing child poverty and improving child wellbeing…' this initiative has strong links with improving child and parent mental wellbeing, as it has a major focus on early intervention. Improving parental mental health will have indirect positive impacts for children, helping to mitigate the risk of poor social outcomes associated with mental illness. It will therefore contribute to the Government's priority to 'make New Zealand the best place in the world to be a child'. **Primary Care** This initiative relates to the Government's intention to reduce access barriers to primary care through increased investment in a multi-disciplinary workforce to enable a more efficient model of primary health care. Additional funding is explicitly provided to help people get to the GP, for whom cost is a barrier for accessing care. **Māori and Pacific** This initiative is also aligned with the 'lifting Māori and Pacific income, skills and opportunities' Budget 2019 priority. Investment in services to improve mental health and wellbeing (of which Māori and Pacific people disproportionately experience negative outcomes) will have positive flow on effects for employment, and therefore income, for Māori and Pacific people. Access to services within the NGO and social sector (through connection with an NGO support worker) will also enhance opportunities for Māori and Pacific people. Furthermore, this initiatives proposes investment in workforce development to improve culturally-appropriate responses, and commits to co-designing and refining models of primary mental health and AOD care for Māori, specifically grounding at least four of the 12 sites in a mātauranga Māori approach. **Our plan for a modern New Zealand we can all be proud of** This package aligns with all three themes of the Coalition Government's long-term plan (An Economy that is working for all of us; Improving the wellbeing of New Zealanders and their families; Making New Zealand Proud). There is a strong linkage to supporting wellbeing, in particular the objective of 'supporting healthier safer and more connected communities'.
2.3 Outcomes	
Overall outcomes expected from this initiative	The proposed package is expected to contribute to the following outcomes: • Improved resilience and long-term life and health outcomes • Equity of outcome for Māori, Pacific Peoples and other populations • Reduce number of people presenting with suicidal behaviours, including suicide, attempted suicide, deliberate or intentional self-harm and suicidal ideation. • Expanded access to and choice of a range of immediate health and social support options in their community, including family and whānau support • People can access culturally appropriate Kaupapa Māori and Pacific services in their community, including family and whānau support

	• Improved transition between services, especially through child development and across the life course • People are seen and treated as a whole person (in response to complex individual and family situations).
2.4 Implementation, Monitoring and Evaluation	
How will the initiative be delivered?	This package will be implemented as part of the Ministry's Mental Health and Addiction Transformation Programme, which sits within the dedicated Mental Health and Addiction Directorate. Design for this programme is underway as part of the Inquiry response and implementation planning phase, and is due to be reported to Cabinet in June 2019. Implementation considerations for each component of the package are outlined in the appendices.
How will the implementation of the initiative be monitored?	The Mental Health and Addiction Transformation Programme, including governance and stakeholder structures, will monitor and report implementation as agreed through the Inquiry response process. There are opportunities to leverage the proposed packaged approach, as the package has been phased to enable continuous improvement and adjustments as detailed service design is undertaken and implemented. The implementation of the package as a whole will be overseen by a central governance group within the Ministry. This group will: • coordinate implementation of the various components • identify opportunities for efficiencies in implementation • share learnings as components are implemented and adjust as required • track progress towards outcomes. *He Ara Oranga* identifies markers of a system under stress. These are used to indicate measures of performance improvement that can be monitored. For example: • reduced demand for specialist services • reduced waiting times • reduced rates of compulsion • reduced number of complaints.
Describe how the initiative will be evaluated	Each initiative within this package has plans and resource for evaluation, as outlined in the appendices. Each evaluation includes mechanisms to provide high-quality data and information to inform project management, service performance and improvement, and workforce planning and development. Providers will report service and system level measures, including consumer satisfaction, population data and outcome measures as appropriate. Also, a summative evaluation of national delivery and performance will be completed periodically. Evaluation results will be monitored by the Mental Health and Addiction Transformation Programme and central governance group.

2.5 Intervention logic map



3. Wellbeing Impacts and Analysis

3.1 Wellbeing domains – People's experience of wellbeing over time

Domains		Impact(s) description	Who are affected?	Magnitude of impact Anticipated economic benefits by reaching high coverage and achieving a high rate of positive mental health outcomes:	How big?	Realised in	Evidence base	Evidence quality
Mental health promotion as "the creation of individual, social and environmental conditions that enable optimal psychological and psychophysiological development… [the achievement of] positive mental health, enhancement of quality of life and narrowing the gap in health expectancy between groups. It is an enabling process done by, with and for the people								
Subjective wellbeing	s 9(2)(f)(iv) [redacted] Enhanced primary MHA responses [redacted] Digital and data	Increase resilience and feeling of being in control of one's life Self-reported improvements in subjective well-being Improvements in quality of life scales Ability to adapt to stress and challenging life situations Increase resilience and feeling of being in control of one's life Increase in people taking steps to improve their mental health and well-being	Individuals (all ages) [redacted]	Common mental health problems (including substance misuse and addiction) have both behavioural and emotional elements, providing a strong case for promoting psychological wellbeing: resilience, emotional literacy and awareness. Poor mental health (including substance misuse and addiction) is related to societal factors such as social inequalities and discrimination (1, 2) There is evidence that interventions to promote positive mental health and prevent mental health disorders (including substance misuse and addiction) are effective (3, 4, 5, 6) Taking steps to improve mental health of the population is important, as it contributes to the nation's wellbeing and social, humane and economic capital (4, 5) [redacted] Assumes that 54 percent of people accessing enhanced primary MHA responses will feel more empowered to manage their lives (7)	High	5-10 and ongoing	1. Pickett K, Wilkinson R. Inequality: an underacknowledged source of mental illness and distress. Br J Psychiatry 2010;197:426–8. 2. Thornicroft G, Brohan E, Rose D, et al. Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. Lancet 2009;373: 408–15. 3. Jane´-Llopis E, Katschnig H, Mcdaid D, Wahlbeck K. Supporting decision-making processes for evidence-based mental health promotion. Health Promot Int 2011;26: i140–6. 4. O'Connell ME, Boat T, Warner KE, editors. Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. Institute of Medicine; National Research Council. Washington, DC: The National Academies Press, 2009. 5. Herrman H, Jane´-Llopis E. The status of mental health promotion. Public Health Rev 2012;34:1–21. 6. Barry MM, Clarke AM, Jenkins R, Patel V. A systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries. BMC Public Health 2013;13:835. 7. New Zealand evaluation of enhanced integrated practice teams (Fit for the Future evaluation)* [redacted]	
Social connections	[redacted] Enhanced primary MHA responses [redacted]	People have connected relationships, a sense of belonging and not being lonely Social inclusion and connection to community for marginalised populations Leading to greater community cohesion and resilience, and in turn protective factors to help people keep well and to enable early conversations and intervention when needed. [redacted]	Individuals / families and whānau / community. Society. Govt [redacted]	[redacted] Increased participation and inclusion will enable early conversations and intervention when needed. Participation in Interventions that promote positive	Medium	5-10 and ongoing	[redacted]	

		s 9(2)(f)(iv) [redacted]		mental health and prevent mental health disorders (including substance misuse and addiction) will improve health outcomes (4, 5, 6). [redacted]				
Working towards mental health as "a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"								
Health Primary health care	Enhanced primary MHA responses [redacted] Digital and data Suicide prevention package Digital and data	Increase access to immediate and ongoing support to manage mental wellbeing and recovery Increased health outcomes through early identification and intervention. [redacted] s. Enhanced resilience, emotional literacy and awareness leading to improved health outcomes and reduction in stress Increased access and health outcomes through greater integration of workforce and services	Individuals all ages	The rates of disorder requiring mental health and addiction treatment are far higher than the current level of service provision can cope with. (23, 24) Chronic stress undermines positive mental health and is a risk factor for developing mental illness (including addiction) as well as physical illness (25). Prompt diagnosis and early intervention in the initial stages of a mental illness (including addiction) can have significant positive impacts and including improved diagnosis and treatment, more timely and targeted referrals to specialist services, and improved confidence and engagement of primary care providers.(27, 28, 29) [redacted]) People with mental health and addiction conditions tend to have worse physical health than their counterparts in the general population, and a shorter life expectancy. Diabetes, cardiovascular disease, metabolic syndrome, cancer and oral health issues are more common for this population group (21, 22) Mental health and/or addiction service users have significantly higher cancer mortality than the general population, even though both groups have similar rates of cancer. The higher mortality was found in part due to reduced access to screening, delayed identification and cancer treatment for MHA users (26) Collaborations between primary care and mental health professionals can be successful in improving physical health of MHA consumers (22, 7) Those who are experience mental health issues, are at higher risk for suicidal behaviour, and often use primary health services to access initial supports. Prompt, appropriate intervention reduces the likelihood of death by suicide (38,44-46)	High	<5 and ongoing	21. Equally Well: Physical Health, Te Pou o te Whakaaro Nui (2016) 22. Disability Rights Commission. Equal Treatment: Closing the Gap. A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problem. Disability Rights Commission: London; 2006. Link https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/DRC-Health-FI-main.pdf 23. Science Advisors, (2017): Toward a Whole of Government/Whole of Nation Approach to Mental Health 24. Andrews G, Titov N. Changing the face of mental health care through needs based planning. Australian Health Review 2007; 31(5): 122-8. 25. Benson, H. (2008). Stress Management: Approaches for preventing and reducing stress. Boston: Harvard Health Publications. 26. Cunningham, Sarfati, Stanley, Peterson & Collings (2015) http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-127-no.-1394/6126 27. Thomas S, Jenkins R, Burch T, et al. Promoting Mental Health and Preventing Mental Illness in General Practice. London J Prim Care (Abingdon). 2016;8(1):3-9. Published 2016 Feb 24. doi:10.1080/17571472.2015.1135659 28. Knapp M, McDaid D, Parsonage M. Mental health promotion and prevention: the economic case. 2011. http://www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf 29. Russell, L. (2018). Te Oranga Hinengaro: Report on Māori Mental Wellbeing Results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey. Wellington: Health Promotion Agency/Te Hiringa Hauora. (Page 8, 9)	
Jobs and earnings	Enhanced primary MHA responses [redacted] Suicide prevention package	Increased employment and productivity (presenteeism) Avoided lost work and productivity (absenteeism)	Individuals, working age (25-64 year olds)	People who experienced psychiatric disorders (including depression, anxiety etc.) in young adulthood are less likely to be in paid employment, up to four times more likely to be benefit dependent, have lower incomes, and less chance of owning their homes. (30,) Negative outcomes increase with number of episodes and/or types of psychiatric disorder, so prevention and early treatment would both have positive effects on these outcomes. (30) Gainful , mentally health employment is a protective factor in relation to suicidal risk. Loss of employment or disengagement increase risk factors. Ensuring that an	Moderate	<5 years and ongoing	30. Gibb, S. J., Fergusson, D. M. and Horwood, L. J. (2010). Burden of psychiatric disorder in young adulthood and life outcomes at age 30. British Journal of Psychiatry, 197: 122-127 31. Superu/PWC, Cost-benefit analysis of the Prime Ministers Youth Mental Health Project Wittchen HU, Jacobi F, Rehm J, et al. The size and burden of mental disorders and other disorders of the brain in Europe 2010. Eur Neuropsychopharmacol 2011;21: 668–9. 32. Dewa C, Thompson A, Jacobs P. The association of treatment of depressive episodes and work productivity. Can J Psychiatry 2011;56:743–50.	

	s 9(2)(f)(iv) [redacted] Digital and telehealth SHBS			individual is mentally well, and able to engage in suitable employment will positively impact on rates of suicides in NZ (38,44-46) Anticipated increase in employment through reduction in impact of mental distress/illness and addiction.(30) Anticipated increase in employment and productivity through prevention and early treatment.(30) Youth with mental illness are 1.34 times more likely to receive benefits estimates a benefit saving of $376 + increased PAYE receipts of $601 per young person positively impacted per year. Individuals earn $3,022 more per year each. (31)				
Mental illness prevention as aiming "to reduce the incidence, prevalence, recurrence of mental disorders, time spent with symptoms, or risk factors for a mental illness, preventing or delaying recurrences and decreasing the impact of illness in the affected person, their families and society								
Health	Suicide prevention package [redacted] Digital and telehealth Enhanced primary MHA responses [redacted]	Increases in mental wellbeing as factor in reducing the prevalence of common mental illness Increased health outcomes for those who receive treatment People with mental distress and those in recovery stay well for longer Fewer inpatient hospital visits Reduce intentional self-harm and suicide attempts Reduction in number of people experiencing signs and symptoms of mental illness Fewer ambulance call outs QALY gains Fewer emergency room visits Value of a statistical life	Individuals / families and whānau. and society Government – District Health Boards - Ministry of Health, ACC Ambulance service providers	Longitudinal studies show that behavioural and emotional aspects of health are contagious, even among the so called non-communicable diseases such as depression. (33) [redacted] Increased participation and inclusion will enable early conversations and intervention when needed. Participation in Interventions that promote positive mental health and prevent mental health disorders (including addiction) will improve health outcomes (36, 37, 38). Higher levels of wellbeing will be recognised at the population level. Increased access to treatment assumes that those receiving CBT for depression will experience an average increase of 0.067 QALYs over 12 months (compared to treatment as usual) (34) [redacted] Suicide prevention package: • Reduce suicidal behaviours including suicide, attempted suicide, deliberate or intentional self-harm and suicidal ideation (increasing protective factors and reducing risk factors) (37 – 47) 40 • Reduced suicidal attempts amongst suicide bereaved (44, 45) • Reduce use of emergency services time responding to suicidal behaviours by up to 10% per year (43, 44, 45, 46) • QALY gains, based on reduced self-harm and suicide attempts (37 – 47) • Reduced loss of lives by up to 10% per year (approximately 50–60 deaths per year) (40-44)	Moderate	<5 years and ongoing	33. Christakis, N. A., & Fowler, J. H. (2009). Connected: The surprising power of our social networks and how they shape our lives. New York, NY: Little, Brown and Co. 34. Dickerson, J. F., Lynch, F. L., Leo, M. C., DeBar, L. L., Pearson, J., & Clarke, G. N. (2018). Cost-effectiveness of Cognitive Behavioural Therapy for Depressed Youth Declining Antidepressants. Pediatrics, 141(2) [redacted] 37. Hawton K, Witt KG, Taylor Salisbury TL, et al. 2015. Interventions for self-harm in children and adolescents. Cochrane Database of Systematic Reviews, 12: CD012013. Doi: 10.1002/14651858.CD012013. 38. Clark, TC., Robinson.E., Crengle, S., Fleming, T., AMerataunga, S., Denny, S., Bearinger,L., Sieving,R., and Saewyc, E. Risk and Protective factors for suicide attempt among indigenous Māori youth in New Zealand (2011) National Aboriginal Health Organisation (NAHO) March 2011 39. Hawton K, Witt KG, Taylor Salisbury TL, et al. 2015. Interventions for self-harm in children and adolescents. Cochrane Database of Systematic Reviews, 12: CD012013. Doi: 10.1002/14651858.CD012013. 40. HQSC. 2016. Ngā Rāhui Hau Kura. Suicide Mortality Review Committee Feasibility Study 2014–15. Report to the Ministry of Health. URL: https://www.hqsc.govt.nz/assets/SUMRC/PR/SuMRC-full-report-May-2016.pdf. 41. HQSC & NZIER. 2015. Estimating the benefits of investment in ongoing suicide mortality review – A cost benefit analysis. URL: www.hqsc.govt.nz/assets/SUMRC/PR/Suicide_Mortality_Review_Cost_Benefit_Analysis.pdf. 42. Mann JJ, Apter A, Bertolote J, et al. 2005. Suicide prevention strategies: A systematic review. JAMA, 294(16): 2064–2074. 43. Ministry of Health. 2016. The Cost of Suicide in New Zealand. URL: www.health.govt.nz/system/files/documents/pages/cost-suicide-in-nz-apr17.docx. 44. Monasterio, E., McKean, A., Sinhalage, V., Frampton, C and Mulder, R (2018) Sudden death in patients with serious mental illness (Draft) New Zealand Medical Journal December 2018, Vol 131 NO 1487 45. Pitman, A (2018) Editorial: Addressing suicide risk in partners and relatives bereaved by suicide. British Journal of Psychiatry 2018 212, p197-198 46. Shand, FL.,Batterham, PJ., Chan, JKY, Pirkis, J., Spittal, J, Woodward, A and Christensen, H (2018) Experience of Health Care Services After a Suicide Attempt: Results from an Online Survey. Suicide and Life-Threatening Behaviour 48 (6) December 2018 pp779-787 47. Zalsman G, Hawton K, Wasserman D, et al. 2016. Suicide prevention strategies revisited: 10-year systematic review. The Lancet Psychiatry, 3(7): 646–659.	

				Assumptions: There is no single approach or programme for preventing suicide that stands out above others as being the most effective – a combination of approaches spanning the suicide prevention, intervention and postvention spectrum are required (47) The increase of protective factors and decrease of protective factors associated with suicide will reduce the likelihood of individuals to experience suicidal behaviours during challenging life experiences (37-47) Investment into support for the suicide bereaved leads to a reduction in distress and suicide attempts (44,45) Increased access to a wider array of service responses across the spectrum will ensure more people with suicidal behaviour are being supported in a timely and appropriate way (37-47) Other countries have been able to reduce their suicide rate by 10-20% through comprehensive suicide prevention strategies and initiatives, and the same is possible here (43-36) Substantial proportions of people who die by suicide in New Zealand have previously come to the attention of Police, ambulance services, the Department of Corrections or Oranga Tamariki.				
	SBHS	Reduction in number of students experiencing depression Reduction in number of students at risk of suicide Early identification and treatment of youth with mental illness Emergency Department healthcare savings Disability Adjusted Life Years (DALYs) loss avoided Reduction in teenage pregnancy and childbirth, and associated poor outcomes	Students at decile 5-10 secondary schools	Strong association between SBHS and students having fewer depression symptoms - SBHS is associated with an average decline in depressive symptoms of up to 13.6%, when adjusted for student and school demographics. Moderate correlation between SBHS and reduced suicide risk - SBHS is associated with an average decline in suicidality of up to 9.5% (range of 0.5-9.5%), when adjusted for student and school demographics. Moderate association between HEEADSSS screening and reduced suicide risk. Moderate association between HEEADSSS screening and reduced Emergency Department use. Moderate association between more than 2.5 hours of nursing time per 100 students per week (which both 750 and 700 pupil ratios should provide) and reduced Emergency Department (ED) use. Youth with anxiety and depressive disorders lose 0.0732 DALYs each per year. Adolescent Health Research Group found 12.8% of secondary students had significant depressive symptoms. SBHS is moderately associated with more frequent contraceptive use and fewer student pregnancies. The cost of teenage childbirth in the US has been estimated at $8,184.87 (NZ$12,527.72) per annum per teen parent, including factors such as increased incarceration rates for male children of teenage mothers, foster care, out of pocket children's health care costs, etc. In 2017 the birth rate for 15 to 19 year olds in NZ was 15 per 1000, or 0.75% of the total 15-19 population. We can assume that about 66% of these births are to women who have finished secondary school or were at decile 1-4 schools, leaving 469 teenage mothers. Reducing this number by 5% would save NZ$5,880,845 per annum using the US cost figure.	High to moderate	Ongoing	48. Denny S, Grant S, Galbreath R, et al. 2014. Health Services in New Zealand Secondary Schools and the Associated Health Outcomes for Students. Auckland: University of Auckland, page 25 49. Denny S, Howie H, Grant S, et al. 2018. Characteristics of school-based health services associated with students' mental health. Journal of Health Sciences Research & Policy. 23(1): 7-14 50. Superu/PWC. 2016. Youth Mental Health Report: Cost-Benefit Analysis, page 67, available at http://thehub.superu.govt.nz/resources/prime-ministers-youth-mental-health-project/ 51. Copland R, Denny S, Robinson M, et al. 2011. Self-reported pregnancy and access to primary care among sexually experienced New Zealand high school students. Journal of Adolescent Health. 49(5): 518-524. https://doi.org/10.1016/j.jadohealth.2011.04.002 52. Denny S, Robinson E, Lawler RN, et al. 2012. Association between availability and quality of health services in schools and reproductive health outcomes amongst students: A multilevel observational study. American Journal of Public Health. 102: e14-e20. DOI: 10.2105/AJPH.2012.300775 53. Rosenthal MS, Ross JS, Bilodeau R, et al. 2009. American Journal of Preventative Medicine. 37(6): S280-87, https://doi.org/10.1016/j.amepre.2009.08.014 Denny S, Grant S, Galbreath R, pages 8, 26Adolescent Health Research Group, p 97	
Cultural identity	Enhanced primary MHA responses s 9(2)(f)(iv) [redacted]	Strengthen cultural identity due to culturally appropriate and responsive service provision Equitable health outcomes	Individuals (Māori, all ages) / families and whānau / community. Society	Te Kupenga 2013 identified that for most Māori, involvement in Māori culture is important (Statistics New Zealand/Tatauranga Aotearoa, 2014). Māori who feel strongly connected to their culture are more likely to speak te reo Māori, know their pepeha, be connected to their tūrangawaewae, and practice manaakitanga. Māori respondents who could speak te reo Māori in day-to-day conversation, who knew much of their peeha, had visited their ancestral marae, and	Low	<5 years	54. Russell, L. (2018). Te Oranga Hinengaro: Report on Māori Mental Wellbeing Results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey. Wellington: Health Promotion Agency/Te Hiringa Hauora. 55. Oakley, Browne et.al, 2006: Te Rau Hinengaro 56. New Zealand evaluation of enhanced integrated practice teams (Fit for the Future evaluation)* 57. Anecdotal evidence from evaluation of enhanced integrated practice teams (Fit for the Future evaluation)* 58. All Right? (2018) Annual evaluation	

	s 9(2)(f)(iv) [redacted] Digital and telehealth [redacted]	Promote fairness in equality of opportunity. Also includes rainbow communities, youth Involvement in Māori culture contributes to improved wellness for tangata whaiora Māori. Kaupapa Māori responses provide connection to the te ao Māori world.		found it easy to provide help to others, were more likely to report feeling connected to their culture. (54) Of the four different aspects of connectedness to culture for Māori associated with identity, the ability to speak te reo Māori in day-to-day conversation appears to have a particularly strong relationship with feeling connected to culture. (54) Primary care services delivered in a mātauranga Māori way and staff working in culturally appropriate ways will lead to increased feelings of cultural identity for people using services. (54, 56, 57) Wellbeing messages and campaigns will resonate and are effective for Māori and Pacific peoples as they are developed locally and cultivate an understanding of wellbeing that is defined by the communities they are aimed at. (58) Assumes more equitable outcomes for Māori and other groups with evident disparity will be achieved, based on enhanced primary mental health and addiction responses. (56, 57)				
Knowledge and skills	Enhanced primary MHA responses Kaupapa Māori responses	Increased mental health and AOD training for practitioners Costs of initiative for enhanced primary mental health and AOD responses (including harm minimisation approaches)	Primary health care workforce Government – primary health sector	We do not have sufficient trained personnel to deal with the burden of mental illness in New Zealand (Science Advisors) Research shows cost-effectiveness of training the primary care team to assess, education and monitor people experiencing depression (59) Evaluations of continuing medical education efforts show that programs based on the principles of adult learning that build clinician skills using interactive, sequential learning opportunities in settings such as workshops, small groups, and individual training sessions appear to have the greatest influence on clinician practices and patient outcomes (60) A culturally competent workforce which reflect the population they serve will lead to better health outcomes as it would make the service more equitable and approachable. Study has shown a change in staff attitudes and skills following training (61) Assumes 50% of the national primary care workforce will receive additional training in brief psychological intervention, and FTE included in the 12 sites will receive training to better respond to mental health and social needs, and provide culturally appropriate mental health services. Costed based on service delivery to [redacted] people that have access to enhanced primary mental health responses [redacted] workforce development for [redacted] of the national primary care workforce, and workforce expansion. Assumes constant service provision and workforce development/expansion each year. [redacted]	Moderate	<5 years ongoing	59. Pyne JM, Rost KM, Zhang M, Williams DK, Smith J, Fortney J. Cost-effectiveness of a primary care depression intervention. J Gen Intern Med. 2003;18(6):432-41. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1494878/ 60. D Davis, M.A O'Brien, N Freemantle, F.M Wolf, P Mazmanian, A Taylor-VaiseyImpact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? JAMA, 282 (1999), pp. 867-874 61. Cultural competence in mental health care: a review of model evaluations: https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-7-15	

Safety	Suicide prevention [redacted]	Increase in pro-social behaviours Fewer hours of police time used Reduced reoffending rates	Individuals – Prisoners with severe mental health needs Communities Government – Police, Justice, Corrections	Access to necessary, and quality, mental health treatment with the full continuum of care to assist in community reintegration improves the safety of the individual and communities by reducing rates of psychiatric relapse and reoffending. (62) Reduce the hours of police time used and number of suicide-related calls received by up to 10% per year. (63)	Moderate	<5 years ongoing	62. Morgan RD, Flora DB, Kroner DG, Mills JF, Varghese F, Steffan JS (2012) Treating Offenders with Mental Illness: A Research Synthesis. *Law and Human Behavior*, 36: 37–50. 63. RANZCP Professional Body Statement: https://www.ranzcp.org/News-policy/Policy-submissions-reports/Document-library/Principles-for-the-treatment-of-persons-found-not	

3.2 Wellbeing capitals – Sustainability for future wellbeing		
Capitals	**Describe the impact and its magnitude**	**Realised in** <5 / 5-10 / 10+ years
Financial/Physical	**Decrease.** This package draws down financial capital to fund the cost of services and responses proposed.	<5 years as the cost is immediate
Human	**Increase.** This package is focussed on improving individual, whānau and community mental health and wellbeing. The initiative will help to build the stock of human capital by increasing the quality of life for an individual, reducing mental distress, improving other social outcomes that affect mental health (such as housing and employment) through integration with other supports, and promoting resilience, mental wellbeing and productivity. There will also be an increase in human capital through the significant investment in workforce expansion and development.	<5 year as some impacts of improvements to mental health and wellbeing will be immediate
Natural	**Maintain**. This pacakage has no impact on natural capital.	N/A
Social	**Increase.** This package will help improve connections between people and communities, and contribute to building cultural identity and trust in the health sector. Mental health is intricately linked with social supports/interactions, societal structures and resources, and cultural values. Improvements to mental health and wellness positively affect our sense of self and cultural identity, our sense of belonging to community, and our ability to communicate with others and have successful social interactions[1]. At a societal level, provision of easily accessible and effective mental health and AOD responses will begin to normalise the experience of mental distress/illness, leading to reduced stigma and greater social bonding/empathy.	<5 years when services begin

3.3 Risk and resilience narrative	
Does the initiative respond to or build resilience?	This package can be described as both building resilience (positive mental health and wellbeing) and responding to risk (mental disorder, distress and addiction): • **Building resilience**: Mental health is considered a resource for experiencing the world around us. It is essential to subjective wellbeing and to our ability to perceive, comprehend and interpret our surroundings, to adapt to them or to change them if necessary, and to communicate with each other and have successful social interactions. Healthy human abilities and functions enable us to experience life in a meaningful way; helping us to be creative and productive members of society, with sufficient resilience to deal with life's ups and downs. • **Risk mitigation**: Mental ill-health relates to mental disorders, symptoms and problems (including those related to substance use) which inhibit our ability to function fully in society.

[1] Lehtinen, V., Ozamiz, A., Underwood, U. and Weiss, M. (2005) Chapter 4: The intrinsic value of mental health; in *Promoting mental health: concepts, emerging evidence, practice*. World Health Organisation

	This has implications for our development, social interactions, productivity, and broader subjective wellbeing. Through promotion of wellbeing, prevention and effective early intervention in the course of mental disorder, distress and addiction, it is anticipated that the risk of poor mental health is mitigated, and positive mental health is enhanced, thereby building resilience for future threats to mental wellbeing.

4 Costing understanding and options

4.2 Detailed funding breakdown

Please provide a breakdown of the costs of this initiative

The package to expand access to, and choice of, mental health and addiction responses will need to be phased over multiple years to build the foundations for change. Investment is proposed in both service delivery and enablers, including workforce, co-design and engagement, national coordination and change management support.

Each component of the package is phased taking into account implementation constraints and feasibility of roll-out. Overall, the proposal is to build up to national geographic coverage of all components over a 10-year period.

The attached spreadsheet sets out detailed costings for the components of the package.

Components	Reach	Phasing of roll-out	Year 1 ($m)	4-year total ($m)	10-year total ($m)
[redacted]	[redacted]	s 9(2)(f)(iv) [redacted]			
Suicide prevention	Resources available to all New Zealanders plus local initiatives spread nationally				
Telehealth and digital therapies	Resources available to all New Zealanders				
Primary mental health and addiction responses	[redacted] of the population (expected uptake of services by those with mild-moderate needs)				
[redacted]	[redacted]				
[redacted]	[redacted]				
School-based services	[redacted]				
[redacted]	[redacted]				

[redacted]

4.3 Options for scaling and phasing

Scaling, phasing or deferring - including 75% and 50% scenarios

Please refer to the attached spreadsheet for more detailed about scaling (including impacts on reach) and phasing.

s 9(2)(f)(iv)

[redacted]

50% scenario

[redacted]

s 9(2)(f)(iv)

5 Collaboration

5.2 Collaboration and evidence	
What type of cross-agency and/or cross-portfolio initiative is this?	This initiative is not a cross-agency and/or cross-portfolio bid where there is collective responsibility, but there are **cross-agency relationships and implications.**
Agencies and Ministers that have been engaged in initiative development	Associate Minister of Health Genter has been involved in the development of components of this package. Health Workforce New Zealand (HWNZ) has been consulted on components within the proposed package to understand the constraints of the current workforce and whether the proposed approach accurately reflects the operating environment. Ministry of Health officials have engaged with representatives of social, justice and education sector agencies on iterations of the components proposed in this package. The purpose of engagement was to identify complementary initiatives and gaps in cross-agency investment (in the context of *He Ara Oranga* and the spread across the continuum of care and life course) and to better understand demands for shared workforces.
Impact of cross-agency collaboration	Cross-sector consideration of mental wellbeing initiatives proposed across agencies identified gaps in investment and led to the inclusion of two additional components in this package: • s 9(2)(f)(iv) [redacted] This package focuses on enhancing mental health and addiction responses at a national scale, in a variety of settings (including schools), and for different population groups (including Māori). The package also spans the early continuum of care (including wellbeing promotion) and aims to enhance links to other social supports. This presents opportunities for partnering with other agencies on the detailed service design and implementation of the package. Further collaboration will be undertaken with the Health Promotion Agency, Te Puni Kōkiri, Ministry for Pacific Peoples, Oranga Tamariki, Child Wellbeing Unit, Ministry of Education, Ministry of Social Development, Ministry of Housing and Urban Development, Housing New Zealand, justice sector agencies and the Treasury as detailed service design is undertaken and the package is implemented.
Risks and challenges	Further cross-agency engagement is needed to fully understand the impacts of the proposed national package and [redacted] on shared workforces, and to optimise the mix and scale of workforce development and expansion included in all bids.