

# Briefing

## Progressing a Child and Youth Mental Health and Addiction Prevalence Survey

**Date due to MO:** 19 July 2024      **Action required by:** 9 August 2024  


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**Security level:** IN CONFIDENCE      **Health Report number:** H2024042404  


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**To:** Hon Matt Doocoy, Minister for Mental Health  


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**Consulted:** Health New Zealand:

### Contact for telephone discussion

Name	Position	Telephone
Dean Rutherford	Deputy Director-General, Evidence, Research and Innovation	s 9(2)(a)
Robyn Shearer	Deputy Director-General, Clinical, Community and Mental Health	

### Minister's office to complete:

- Approved       Decline       Noted  


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 Needs change       Seen       Overtaken by events  
 See Minister's Notes       Withdrawn

Comment:

# Progressing a Child and Youth Mental Health and Addiction Prevalence Survey

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**Security level:** IN CONFIDENCE      **Date:** 19 July 2024

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**To:** Hon Matt Dooney, Minister for Mental Health

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## Purpose of report

1. This briefing responds to your request for advice on options for progressing a mental health and addiction prevalence survey with an initial focus on children and young people.
2. It follows discussion at your meeting with Ministry of Health Officials on 20 May 2024.

## Recommendations

We recommend you:

- a) **Note** work to test potential mental health and addiction survey tools with children and young people aged 2–19 years is underway **Yes/No**
- b) **Note** the Ministry of Health is collaborating with the Ministry of Social Development to deliver timely and improved data related to mental health and substance use and service use via the Youth Health and Wellbeing Survey 2025 **Yes/No**
- c) **Note** the Ministry of Health has committed to providing approximately \$300k of additional, one-off baseline funding to support delivery of new and improved mental health and substance use data via the Youth Health and Wellbeing Survey 2025 **Yes/No**
- d) **Note** that the Ministry recommends delivering a mental health and addiction prevalence survey in three phases over a three-year period, beginning with a survey for children and youth aged 4–24 years **Yes/No**
- e) **Note** this approach will require funding of approximately \$6m over three years, or approximately \$2m per annum, and that providing funding on an ongoing basis will allow information needs to be met sustainably with a clear pathway to full population prevalence data **Yes/No**
- f) **Note** that the Ministry of Health and Health New Zealand will seek your final decisions about use of uncommitted Budget 2019 and Budget 2022 mental health and addiction funding for a package of initiatives, including a child and youth prevalence survey, through a separate briefing by the end of July 2024 **Yes/No**

- g) **Agree** to meet with Ministry of Health Officials to discuss the recommended **Yes/No** approach to a mental health and addiction prevalence survey



Dean Rutherford

**Deputy Director-General**

**Evidence, Research and Innovation**

Date: 18 July 2024

Hon Matt Doocey

**Minister for Mental Health**

Date:



Robyn Shearer

**Deputy Director-General**

**Clinical, Community and Mental Health**

Date: 18 July 2024

PROACTIVELY RELEASED

# Progressing a Child and Youth Mental Health and Addiction Prevalence Survey

## Background

1. In early 2024, the Ministry of Health | Manatū Hauora (the Ministry) commenced work to identify the tools and infrastructure that will be required to support future mental health and addiction prevalence studies in New Zealand [Weekly Reports of 7 March, 17 April and 10 July 2024 refer]. Ministry Officials have met with you to discuss this work, the need for a national mental health and addiction prevalence survey and a potential pathway towards this, as set out in May 2024 [H2024039734 refers].
2. At your meeting with Ministry Officials on 20 May 2024, you requested further advice on options for a mental health and addiction prevalence survey, initially focussed on children and young people. This briefing responds to that request.
3. Ministry Officials are available to meet with you to discuss this briefing and can provide additional material if this is required.

## Context

4. In his report, [Meeting the mental health needs of young New Zealanders](#), the Auditor-General emphasises that agencies require detailed information on the nature, extent and distribution of young people's mental health needs in order to support well-informed decisions. The Auditor-General recommends that the Ministry prioritises work to understand the prevalence of mental health conditions in the population.
5. A survey on mental health and addiction prevalence in New Zealand (Te Rau Hinengaro) was last conducted in 2003/04, and this did not include children. Decisions related to resource allocation and mental health and addiction service design are currently being made without detailed understanding of prevalence, and the relationship between existing service use and service need.
6. At a time where services are under pressure and high rates of distress are reported by young people, New Zealand does not have data to understand mental health and substance use related conditions among our children and young people. Prevalence data for adults (previously collected through Te Rau Hinengaro in 2003/04) is outdated and unlikely to accurately represent the realities of today.
7. In the absence of a mental health and addiction prevalence survey, we cannot determine the range, proportion, or distribution of specific diagnosable conditions, and critically, what services are required to respond to existing or unmet need, with certainty that it matches population needs.

## Work is underway to prepare for a mental health and addiction prevalence survey and fill immediate and ongoing information gaps

### Testing of potential survey tools has commenced

8. The Ministry has contracted Ipsos Limited to deliver testing of potential mental health and addiction survey tools with children and young people aged 2–19 years in New Zealand.
9. This work is being delivered through one-off time-limited funding of \$680k from the Ministry's baseline, and will be delivered across three stages:
  - a. **stage 1 (to be completed in July 2024)** – with support of subject matter experts, identify mental health and substance use survey tools for testing
  - b. **stage 2 (by end of September 2024)** – cognitive testing of tools identified in stage 1 with children and young people, from Māori, Pacific and Asian ethnic groups in their homes
  - c. **stage 3 (by end of December 2024)** – a small pilot survey to test delivery of tools in a survey format. This is not intended to deliver data, rather inform how future surveys could be conducted – e.g., interview format and materials, interviewer training and engagement methodology.
10. From this work, the Ministry aims to understand the effectiveness of internationally validated mental health and substance use survey tools in a New Zealand context – particularly how the meaning and acceptability of these tools may vary between ethnic groups.
11. The knowledge gained will inform what survey tools, including questionnaire sets, could be delivered in a New Zealand child and young people mental health and addiction prevalence survey.
12. Work with Ipsos Limited is expected to run through to the end of 2024, and a final report, with recommendations, is due with the Ministry in the first quarter of 2025.

### We are also progressing quick wins through the Youth Health and Wellbeing Survey 2025

13. The Ministry is collaborating with the Ministry of Social Development (MSD) to explore how the Youth Health and Wellbeing Survey 2025 (YHWS) could support the timely delivery of improved data related to substance use, mental health conditions, and access and barriers to mental health services.
14. The Ministry and MSD have collaborated to include baseline mental health questions, validated in the United Kingdom's National Health Services Mental Health of Children and Young People Survey, into the YHWS.
15. Inclusion of these questions will provide new insights for New Zealand faster than a full prevalence survey. Results from these questions are expected to highlight changes in the proportion of young people experiencing mental distress/probable mental health conditions over time, and whether the needs of those with conditions are being met by services for those aged 13–19 years. It is also expected some new data will be available for conditions that are not currently captured, including neurodevelopmental conditions and disordered eating.

16. The YHWS will not provide data on the prevalence of specific mental health conditions, or data for those younger than 12 years. It also will not provide data for the young adult cohort (those aged 18–24 years) who are considered a critical group in relation to developmental stage and associated heightened risk of emergence of serious mental health conditions and of death by suicide.
17. However, inclusion of additional questions in the YHWS is a low cost and effective way to deliver better data while work to design and deliver a prevalence survey commences.
18. The Ministry has committed to providing additional, one-off baseline funding to expand the size and representativeness of the YHWS 2025.
19. This will enable increased data quality to understand differences in mental wellbeing across New Zealand's youth population, informing the design of a mental health and addiction prevalence survey.
20. The YHWS 2025 is currently in its implementation phase, with findings reports expected to be available in late 2025.

### **We still need a mental health and addiction prevalence survey**

21. The health system has reached a point where updated mental health and addiction prevalence data is critical. A mental health and addiction prevalence survey will expand our evidence beyond what's currently available or possible through the YHWS 2025 (or its future iterations) and New Zealand Health Survey. It will also respond to the Auditor General's recommendations.
22. A prevalence survey is the only way to fill longstanding information gaps, including:
  - a. **diagnosable and condition specific information** – for example, distinguishing between normal experience of symptoms of anxiety (worry) and depression (sadness) and the experience of mental health conditions that require specialist treatment, and distinguishing between anxiety conditions such as post-traumatic stress disorder and obsessive-compulsive disorders which may require different service responses
  - b. **unmet need** – capture population experience and treatment need beyond existing service delivery or interactions with the system.
23. Filling the above longstanding information gaps will support more effective decisions and planning, including:
  - a. **needs-based allocation of resource** – funding based on what conditions exist, what services are used or needed and the distribution of these
  - b. **design targeted prevention, treatment, and care options** – for those in need or at risk, delivering interventions at the point that most makes sense and where the outcomes will be greatest, including early intervention and prevention approaches (which may be cross-sector or cross-portfolio)
  - c. **anticipating future need** – planning for workforce requirements and the settings required to support this – e.g., education and training pathways to meet gaps in services and review of migration settings
  - d. **evaluation of the effectiveness of current and future services** – investment in what's needed and what works, and disinvestment in what doesn't

- e. **long-term and cross-sector analysis** – over time, support the ability to explore the relationship between mental health and addiction with other components of health (e.g., nutrition), and analysis of the influence of social and economic determinants of health.

## **Delivering a mental health and addiction prevalence survey, starting with children and young people**

- 24. Since meeting with you on 20 May 2024, the Ministry has worked with Health New Zealand | Te Whatu Ora (Health New Zealand) to define the information need more clearly – scrutinising what information is needed in order to develop options for how a mental health and addiction prevalence survey may be delivered.
- 25. This, alongside collaboration with MSD on the YHWS 2025, has allowed the Ministry to scale options for how a prevalence survey could be delivered, starting with children and youth, with a pathway towards understanding full population prevalence over time.

### **Process for delivering a mental health and addiction prevalence survey**

- 26. Work to deliver a mental health and addiction prevalence survey would be conducted in three phases over a three-year period. Appendix 1 illustrates these phases and associated milestones, alongside work already underway.

#### *Development and detailed design phase (September 2024 – December 2025)*

- 27. The development and detailed design phase is comprehensive, particularly when there is limited, outdated, or no available survey methodology to build on. Consistent with the development and design practices and timeframes of other government surveys and international practice, this phase includes:
  - a. selection or development of questions and sample design that will permit production of high quality and relevant statistics, including for sub-population groups, building on the initial tools testing underway and the YHWS 2025
  - b. testing of survey delivery approaches to ensure content is structured coherently, easily allows participation for all populations groups, and minimises respondent burden
  - c. given the sensitive subject matter, progressing through appropriate safeguards, such as the Health and Disability Ethics Council, to ensure the survey is ethically sound and does not cause harm to respondents
  - d. ensuring the right workforce, collateral, and systems are available to support data collection and delivery the survey – e.g., clinically trained or specialist expertise, pathways to care and services for respondents should they be needed.
- 28. The Ministry will leverage opportunities for efficiencies as they present, and take steps to minimise delays or disruption where possible. However, some timeframes are outside of the Ministry's control. For example, engagement with the Health and Disability Ethics Council is expected to be substantial and intensive, particularly for surveying children aged 4–12 years and their families.

### *Implementation phase (January 2026 – December 2026)*

29. The implementation phase involves taking the survey into the field and collecting data from individuals. It is routinely the most costly phase with key costs covering:
  - a. the recruitment or procurement and training of collection workforce and associated personnel costs – e.g., management and health and safety requirements
  - b. ensuring IT support and technical subject matter expertise is available to support interviewers deliver the survey effectively and efficiently.
30. Throughout the development and detailed design phase, options for how data collection could be executed may be identified e.g., school-based or home-based collection. However, consistent with the delivery of other government surveys that collect information from individuals (including the New Zealand Health Survey, General Social Survey, and Household Income and Living Survey) the Ministry anticipates a mental health and addiction prevalence survey would be collected over a 12-month period.

### *Analysis and reporting phase (January 2027 – June 2027)*

31. Through the analysis and reporting phase the Ministry will seek to utilise internal expertise and existing systems (including the Health Surveys Team) where possible and seek specialist epidemiological and mental health and addiction expertise where appropriate.
32. This phase includes:
  - a. processing of the data collected and organising data into a format for analysis
  - b. analysis, interpretation of data and preparation of proposed outputs – isolating key results and metrics, mock-ups of statistics and products and validating that these respond to information needs
  - c. application of quality, confidentiality, and privacy controls – peer review of outputs (including by subject matter experts) to ensure accurate and safe articulation and presentation of results and safeguarding the privacy of survey participants.

### **Recommended approach to a mental health and addiction prevalence survey**

33. The Ministry has explored different models for delivering a mental health and addiction prevalence survey, and options for scaling and phasing of these – e.g., cohort by cohort collection and scaling of content or sample size. Options were assessed based on delivery confidence, cost, timeframes, and ability to meet the defined information need. Appendix 2 presents the options considered and a high-level assessment of these.
34. The Ministry's recommended approach is to implement a three-yearly mental health and addiction prevalence survey – starting with children and young people over the period of 2024/25–2026/27.
35. This approach is feasible, cost effective, and prioritises meeting information needs for the highest priority population cohort first. Reconducting a survey at regular intervals safeguards the ongoing production and availability of data and allows creation of a

long-term timeseries. There are options in relation to the frequency with which a child and youth prevalence survey could be conducted, discussed further below.

36. The Ministry's recommended approach will require funding of approximately \$6m over three years, or approximately \$2m per annum, ongoing.
37. Milestones associated with process and timeframes above, alongside work currently underway, are set out below, with further information outlined in Appendix 1:
  - a. **December 2024** – completion of work with Ipsos Limited on testing potential mental health and addiction survey tools
  - b. **March 2025** – final report from testing of potential mental health and addiction survey tools delivered, with recommendations for survey design
  - c. **Late 2025** – findings from the YHWS 2025 available with information related to probable mental health conditions and service responsiveness for those aged 13–19 years, and new data on neurodevelopmental disorders and disordered eating
  - d. **December 2025** – completion of development and detailed design of a child and youth prevalence survey
  - e. **January 2026** – commencement of field work and data collection
  - f. **December 2026** – completion of data collection and commencement of analysis
  - g. **Mid-late 2027** – publication of survey results and reports on prevalence of mental health and substance use conditions in children and youth.

### **Funding for a child and youth mental health and addiction prevalence survey**

38. Ministry and Health New Zealand Officials recently provided you with advice on initiatives that could be funded utilising uncommitted Budget 2019 and Budget 2022 mental health and addiction funding [H2024044383 and HNZ00051267 refer]. At a discussion with Ministry Officials on 1 July 2024, you indicated an interest in progressing with a shortlist of priority initiatives, including a mental health prevalence survey.
39. Your Office has requested further advice on potential investment packages and scaling and phasing options. This further advice will seek your final decisions about use of uncommitted funding for a package of initiatives, including a child and youth prevalence survey, through a separate briefing by the end of July 2024. It will reflect the advice set out in this briefing and the estimated costs of a child and youth prevalence survey.
40. As previously indicated, the Ministry considers that progressing with a mental health and addiction prevalence survey would be a substantively new policy initiative and would trigger the threshold for ensuring Cabinet awareness. The Ministry will support you with this process pending your decisions about preferred investment packages.

### **Pathway to understanding full population prevalence**

41. As indicated earlier (see paragraph 35), there are options related to the frequency of conducting a mental health and addiction prevalence survey as well as the cohorts of focus for each survey. Decisions related to this should seek to balance the preference to

sustainably meet information needs, with cost implications and allowing sufficient time between surveys to register changes within and across the population.

42. While undertaking a child and youth-focused prevalence survey every three years would ensure robust and continuous data, it may be too frequent to add significant value for decision making. However, assuming a three-yearly survey cycle is supported, there is an opportunity to build towards understanding full population prevalence over six years – with the first three-year period focused on children and youth (those aged 4–24 years) as recommended, and the second three-year period focused on the adult population (those aged 25 years and above).
43. With ongoing funding, the Ministry recommends alternating the cohort of focus each time the survey is conducted years to maintain an understanding of full population prevalence. This provides a clear, feasible and sustainable pathway to mental health and addiction prevalence data across the whole population and maintaining this over time.
44. This does not require your decision at this stage, but Officials are available to discuss this with you in more detail.

## **Equity**

45. A mental health and addiction prevalence survey will improve understanding of inequities in needs, service provision, population behaviours and experiences, as well as factors that may contribute to these.
46. This, in turn, supports evidence informed investment for services that address inequities, and monitoring of the impact services have on mental health outcomes, and whether this impact is equitably distributed.
47. An ongoing, iterative prevalence survey can respond to dynamic population needs, for example, enhancing culturally responsive mental health care options to enable more equitable service use.

## **Next steps**

48. The Ministry is available to discuss this briefing you with you and respond to any feedback or questions you have.
49. The Ministry and Health New Zealand will present advice by the end of July and seek your final decisions regarding use of uncommitted funding, including investment in a child and youth mental health and addiction prevalence survey.
50. Following this advice and your decisions, the Ministry will progress work to support to give effect to your decisions.
51. The Ministry will continue to update you via the Weekly Report on its work with Ipsos Limited on testing of potential survey tools.

**ENDS.**

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# Progressing a Child and Youth Mental Health and Addiction Prevalence Survey

At a time where services are under pressure, prevalence data is critical to ensure we understand mental health and substance use-related conditions and the need for services.

Investment in a mental health and addiction prevalence survey will fill longstanding information gaps and support more effective decisions and planning, including:

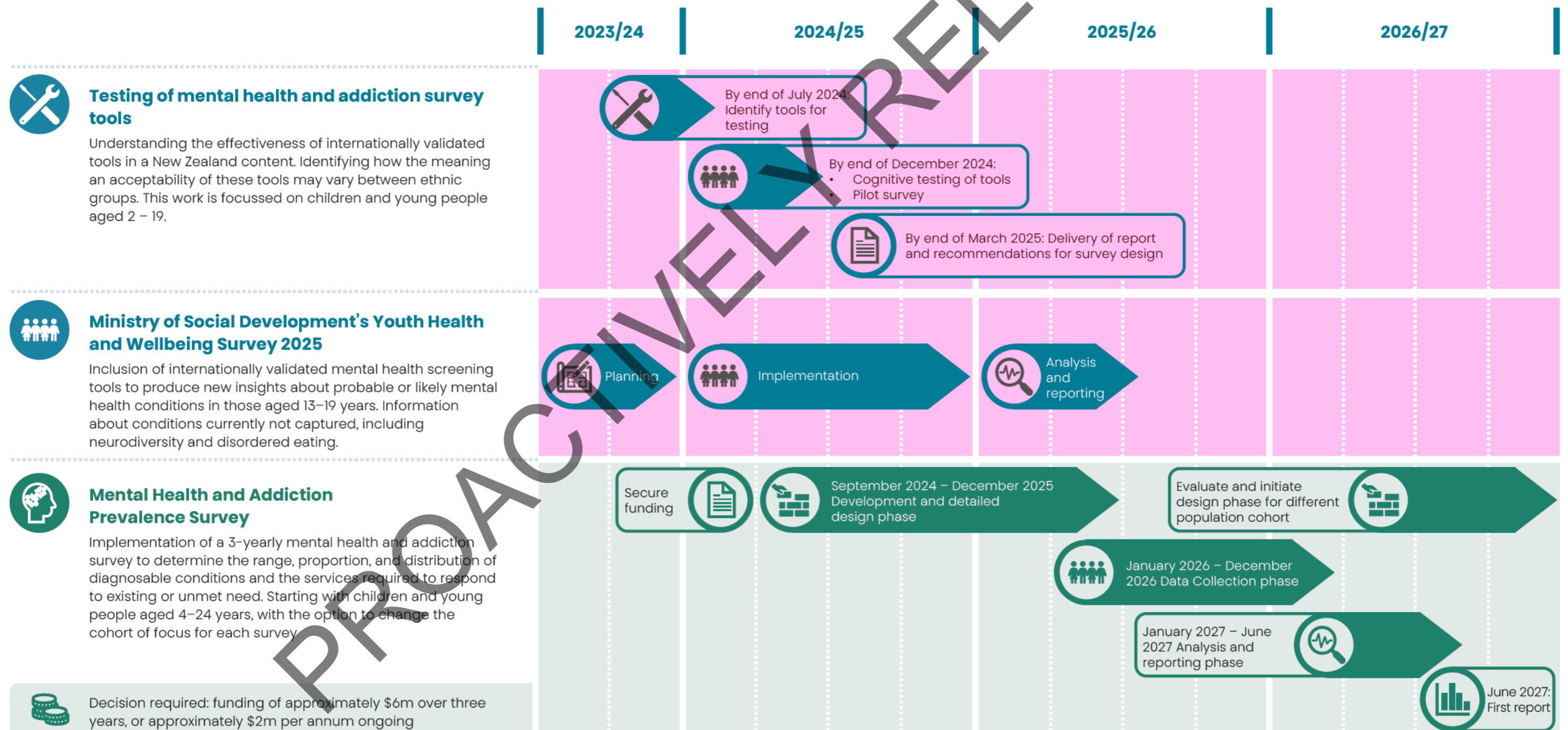
- needs-based allocation of resource
- design of targeted treatment and care options
- anticipation of future needs
- evaluation of current and future services.

Delivering a child and youth mental health and addiction prevalence survey over three years presents the best balance across affordability and timeliness, and prioritises the most pressing information gaps.

Allocation of sustained funding of \$2m per annum will permit a prevalence survey to be conducted every 3 years. There is an option to alternate between children and young people aged 4–24 years and people aged 25 and above – with data for each cohort available every 6 years.

The Ministry of Health and Health New Zealand will present and seek your final decisions regarding use of uncommitted funding.

At a discussion with Ministry Officials on 1 July 2024, you indicated an interest in progressing with a shortlist of priority initiatives including a prevalence survey.



	<b>Feasibility</b> What is the overall delivery confidence?	<b>Meets information needs</b> Does the option provide prevalence data, or new mental health and substance use data?	<b>Timeframes</b> When will the survey be implemented and when will data be available?	<b>Cost</b> What is the cost? Are funding decisions required?	<b>Summary and overall assessment</b>
<b>Status quo:</b> No mental health and addiction prevalence survey, additional questions and increased sample size and representativeness in the Youth Health and Wellbeing Survey 2025	High.  Planning is complete, existing survey infrastructure in place and implementation has commenced.	Does not provide prevalence data.  Focussed on those aged 13 – 19 only.  However, is expected new data will be for conditions that are not currently captured, including neurodiverse conditions and disordered eating.	Implementation has commenced.  Collection intended to take place in the first half of 2025.  Reporting intended to be available in the second half of 2025.	No funding decisions required.	Does not meet defined information needs but is a feasible and cost-effective way to deliver better data while work to deliver a prevalence survey commences.
<b>Option 1:</b> No mental health and addiction prevalence survey – sustain approach to the Youth Health and Wellbeing Survey 2025	High – continuation of existing approach.	Does not provide prevalence data.  Focussed on those aged 13 – 19 only.  Will maintain the increased level of information achieved through the Youth Health and Wellbeing Survey 2025.	Conducted every 3 years.	Funding decision required: ~\$300k every 3 years.	Feasible and cost effective but does not meet defined information needs.  <b>Not recommended.</b>
<b>Option 2:</b> One-off Child and Youth Mental Health and Addiction Prevalence Survey	High.  Based on understanding of current risks, and practices associated with other government surveys, including the New Zealand Health Survey.	Provides one-off point in time prevalence data for highest priority population cohort.  Does not meet information needs on an ongoing basis.	Delivered in three phases over 3 years: <ul style="list-style-type: none"> <li>development and detailed design (September 2024 – December 2025)</li> <li>implementation (January 2026 – December 2026)</li> <li>analysis and reporting (January 2027 – June 2027)</li> </ul>	Funding decision required: \$6m over 3 years.	Feasible, cost effective and meets the defined information need for the highest priority population cohort on a one-off basis.  Does not permit ongoing meeting of information needs.  <b>Not recommended.</b>
<b>Option 3:</b> 3-yearly Mental Health and Addiction Prevalence Survey – starting with children and youth	High – same as option 2.	Provides prevalence data.  Prioritises prevalence data for highest priority population cohort.  Provides pathway to full population prevalence data given option to alternate the cohort of focus in each iteration.	Same as option 2 for initial survey.  Provides prevalence data every 3 years.	Funding decision required: \$6m over 3 years, ongoing.	Feasible, cost effective and meets the defined information need for the highest priority population cohort.  Provides pathway to full population prevalence data.  Reconducting a survey every 3 years safeguards the ongoing production and availability of data and allows creation of a long-term timeseries.  <b>Recommended.</b>
<b>Option 4:</b> 6-yearly Mental Health and Addiction Prevalence Survey – starting with children and youth	Medium.  Higher risks associated with maintaining survey infrastructure and retaining workforce.	Same as option 3.	Same as option 2 and 3 for initial survey.  Less timely ongoing prevalence data compared to option 3 – every 6 years.	Funding decision required: \$6m over 6 years, ongoing.	Cost effective and meets the defined information need for the highest priority population cohort first.  Provides pathway to full population prevalence data.  Less timely ongoing delivery.  <b>First alternative.</b>